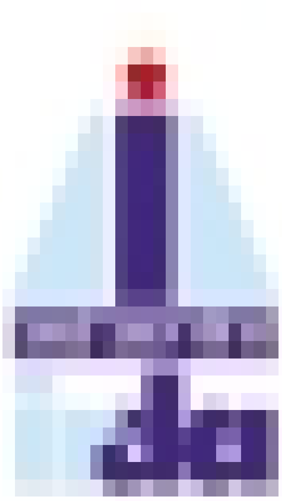

Journal

Right Selection and Classification

The Touchstone of Underwriting

बीमा विनियामक और विकास प्राधिकरण

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From the Publisher

There are several vital functions that insurers have to complete with a great deal of efficiency and skill if they are to succeed in insurance business. Investments, for example, is an area which has to be handled with lot of expertise and a deep sense of understanding of the financial market. However, the most vital function that ultimately makes or mars the business of insurance is 'Underwriting'. It may be possible for an insurer to absorb the losses of a few 'bad' investment decisions; but a few underwriting decisions that go wrong could spell disaster for the insurers.

The eventual success of the function of underwriting is heavily dependent on a free and fair flow of information between the parties. In a market that is still nascent in its development, there could be a great deal of asymmetry of information flow, especially when it comes to the prospect disclosing information. This makes the job of the underwriters crucial in ensuring that the information provided is as wholesome as is possible. There is need for a better understanding of the contractual roles by the parties to the contract so that the ills arising out of such 'asymmetry' of information are minimized.

The underwriting role has been greatly structured in a market that is under tariff; as the leverage given to the underwriter itself is limited. With de-tariffing of the non-life market round the corner, it would throw innumerable challenges to the underwriters. It is easy to get carried away by the unending 'opportunities'; but the wisdom of dealing with the risks sensibly would eventually decide the winners. While I am confident of the maturity of the players in this area, I would not lose any opportunity to exhort them of the need for caution.

With just more than a couple of months separating us from a 'free' market, the emphasis would naturally be on the readiness of the players in various areas. Accordingly, the focus of the next issue of the Journal would be on 'Detariffing', in all its hues.

C.S. Rao

C.S. Rao

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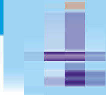


Underwriting – The Eternal Challenge!

It has been said, time and again, that underwriting forms the crux of insurance business. While the statement itself would sound vague for the uninitiated, would it not be reasonable to say that the assessment of various risks being assumed by an insurer should be done objectively? In life insurance business, for example, if two persons in different age groups good enough to being father and son are charged the same premium; the insurer is bound to run into rough weather; and eventually will have to close business. The example itself might look too simplistic, but then does it not lay the foundation for the objectivity; or 'equitability' in insurance parlance?

Accomplishing equitability among the risks is the prime objective for an insurer; and in order that insurers are successful in achieving this, underwriters play a crucial role. Even before achieving equitability in the assessment of risks by charging a premium commensurate with the risk; underwriters sometimes have the onerous responsibility of having to reject some business opportunities - an extension of the same logic. The corporate strategies of the insurance companies would define and delineate the boundaries within which the underwriters have to fulfill their role diligently.

The challenges of underwriting in different classes of insurance vary from each other. In the life arena, the underwriter has to keep himself abreast of the developments in medical technology; research with regard to diseases etc. He has to make use of these developments in association with the basic mortality/ morbidity statistics if he were to be very objective. Similarly, in the non-life class also, unless the underwriter takes into account the latest developments in associated areas; he would fail in his role. In a tariff regime, this role had to be played within the parameters previously assigned; but with detariffing of the market on the anvil, there is altogether a new set of challenges for the underwriter. It is these challenges in different areas of operation that form the focus of this issue of the **Journal**.

Coming to the contents of the issue, we open with an article by Mr. K.K. Srinivasan in which he deals in detail the role of the regulator in a changing paradigm. Motor insurance, as a class, has always remained an enigma in the Indian context; Mr. B.G. Patki throws light on the new challenges in this class. Life insurance underwriting has been undergoing a great deal of progressive metamorphosis, tele-underwriting being the latest technique. We have Mr. T.S. Ramakrishna Rao explaining the concept. Mr. G.V. Rao deals with the likely challenges of the detariffed environment in detail.

How cross-subsidization, an inherent component in the tariff regime, would behave in the new environment, is explained by Ms. Meena Nair. Mr. D.V.S. Ramesh talks about the importance of undoing adverse selection for a life insurer. In the end, we have the second part of the Research Paper on Health Insurance for the poor, by Mr. Debasis Bagchi. Besides, we have the statistics of the quarterly performance of the insurers; apart from the usual monthly business figures.

The roadmap for a detariffed market has been drawn up fifteen months in advance, in September 2005 to be precise. It was considered good enough time for the insurers to gear up themselves for the ensuing challenge; and the feedback about the readiness of the market is quite satisfactory. The next issue of the **Journal** would be focusing on various aspects pertaining to 'Detariffing'; and we are looking forward to a wonderful collection of articles.

Here is wishing all our readers a great festive season.

.U. Jawaharlal

Report Card:LIFE

Premiums Rise 160.56% over August, 2005

Individual premium:

The life insurance industry underwrote Individual Single Premium of Rs.1006304.98 lakh during the period ended August, 2006, of which the private insurers garnered Rs.78855.88 lakh and LIC garnered Rs.927449.10 lakh. The corresponding figures for the previous year were Rs.276989.74 lakh for the industry, with private insurers underwriting Rs.33180.53 lakh and LIC Rs.243809.21 lakh. The Individual Non-Single Premium underwritten during April-August, 2006 was Rs.1051634.72 lakh of which the private insurers underwrote Rs.367186.09 lakh and LIC Rs.684448.63 lakh. The corresponding figures for the previous year were Rs.496284.12 lakh, Rs.160225.63 lakh and Rs.336058.49 lakh respectively.

Group premium:

The industry underwrote Group Single Premium of Rs.266671.08 lakh of which the private insurers underwrote Rs.20448.23 lakh and LIC Rs.246222.85 lakh; the lives covered being 5982289, 340793 and 5641496 respectively. The corresponding numbers for the previous year were Rs.117911.79 lakh with private insurers underwriting Rs.9819.78 lakh and LIC Rs.108092.01 lakh; and the lives covered being 2546506, 293858 and 2252648 respectively. The Group Non-Single Premium underwritten during April-August, 2006 was Rs.31995.70 lakh which was underwritten entirely by the private insurers, covering 1607598 lives. The corresponding numbers for the previous year were Rs. 13244.74 lakh and covering 795816 lives.

Segment-wise segregation:

A further segregation of the premium underwritten during the period indicates that Life, Annuity, Pension and Health contributed Rs.1401719.48 lakh (59.52%), Rs.56986.11 lakh (2.42%), Rs.895686.40 lakh (38.03%) and Rs.557.59 lakh (0.02%) respectively. In respect of LIC, the break up of life, annuity and pension categories was Rs.955409.04 lakh (51.42%), Rs.54691.97 lakh (2.94%) and Rs.848019.57 lakh (45.64%) respectively. In case of the private insurers, Rs.446310.44 lakh (89.83%), Rs.2294.14 lakh (0.46%), Rs.47666.83 lakh (9.59%) and Rs.557.59 lakh (0.11%) respectively was underwritten in the four segments.

Unit linked and conventional premium:

Analysis of the statistics in terms of linked and non-linked premium indicates that 42.74% of the business was underwritten in the non-linked category, and 57.26% in the linked category, i.e., Rs.1006516.53 lakh and Rs.1348433.04 lakh respectively. In case of LIC, the linked and non-linked premium was 49.17% and 50.83% respectively, as against which for the private insurers taken together, this stood at 87.51% and 12.49% respectively. During the corresponding period of the previous year, linked and non-linked premium indicates that 57.96% of the business was underwritten in the non-linked category, and 42.04% in the linked category, i.e., Rs.523553.08 lakh and Rs.379742.86 lakh respectively. In case of LIC, the linked and non-linked premium was 31.77% and 68.23% respectively, as against which for the private insurers taken together this stood at 74.84% and 25.16% respectively.

'First Year Premium Underwritten by Life Insurers for the Period Ended August, 2006

Sl No.	Insurer	Premium u/w (Rs. In Lakhs)			No. of Policies / Schemes			No. of lives covered under Group		
		August, 06	Up to August, 06	Up to August, 05	August, 06	Up to August, 06	Up to August, 05	August, 06	Up to August, 06	Up to August, 05
1	**Bajaj Allianz**									
	Individual Single Premium	4540.84	40794.76	15694.37	4032	18043	18777			
	Individual Non-Single Premium	12464.87	58696.95	26261.02	81044	353326	129407			
	Group Single Premium	73.49	246.90	0.00	0	1	0	132	913	0
	Group Non-Single Premium	159.76	894.12	961.04	16	77	106	13187	237937	71329
2	**ING Vysya**									
	Individual Single Premium	236.75	1505.95	2.38	182	1037	349			
	Individual Non-Single Premium	1385.41	14451.40	4390.06	11074	70893	28789			
	Group Single Premium	0.00	203.41	375.62	0	0	0	0	477	1026
	Group Non-Single Premium	119.45	346.20	142.14	1	21	29	317	6712	9451
3	**Reliance Life**									
	Individual Single Premium	444.53	5603.21	2703.05	683	8710	4403			
	Individual Non-Single Premium	2520.84	14856.43	1121.51	15143	81114	16452			
	Group Single Premium	39.18	753.27	60.69	2	11	0	0	7880	0
	Group Non-Single Premium	64.80	319.95	244.29	8	53	41	21003	77551	37311
4	**SBI Life**									
	Individual Single Premium	3035.98	10436.60	1595.41	3352	13985	2415			
	Individual Non-Single Premium	4600.58	27924.09	3901.24	25055	118435	56273			
	Group Single Premium	2126.26	7435.81	6429.52	0	2	2	12287	47027	87422
	Group Non-Single Premium	358.45	5092.46	1289.46	40	178	620	111698	392966	193249
5	**Tata AIG**									
	Individual Single Premium	21.06	230.13	180.85	0	0	0			
	Individual Non-Single Premium	3697.64	18432.54	13302.77	29701	142523	110205			
	Group Single Premium	564.81	2109.43	693.06	0	3	0	31754	115665	60482
	Group Non-Single Premium	168.36	803.96	874.39	4	49	132	14615	113713	226735

6	**HDFC Standard**									
	Individual Single Premium	722.28	4965.36	4057.83	18057	30166	22895			
	Individual Non-Single Premium	6416.99	33747.22	19801.77	16288	89227	79670			
	Group Single Premium	789.79	3297.60	1768.89	10	48	47	10460	102752	43005
	Group Non-Single Premium	359.59	1793.46	1356.57	4	7	14	422	1486	8106
7	**ICICI Prudential**									
	Individual Single Premium	1822.73	10130.86	2343.53	2823	16110	7494			
	Individual Non-Single Premium	20427.61	111384.07	52778.41	108688	509582	208989			
	Group Single Premium	1578.64	5630.79	171.02	-5	69	46	-23214	51360	96273
	Group Non-Single Premium	2722.00	15170.70	7172.52	39	167	52	53173	157437	30041
8	**Birla Sunlife**									
	Individual Single Premium	170.31	1194.52	435.47	2937	6499	17607			
	Individual Non-Single Premium	3749.37	21196.82	14334.82	15156	71804	48246			
	Group Single Premium	81.34	450.08	217.03	0	0	0	444	2639	1993
	Group Non-Single Premium	665.87	3449.69	558.16	5	25	17	4078	18860	4582
9	**Aviva**									
	Individual Single Premium	145.65	1054.74	145.21	188	810	973			
	Individual Non-Single Premium	3845.51	22073.77	9423.96	18879	90759	35102			
	Group Single Premium	38.05	120.07	57.58	0	1	0	188	699	369
	Group Non-Single Premium	378.17	1415.95	113.25	4	30	4	32455	124500	74539
10	**Kotak Mahindra Old Mutual**									
	Individual Single Premium	337.98	1721.13	587.44	229	1797	894			
	Individual Non-Single Premium	2771.20	11050.51	5502.93	7953	33248	24163			
	Group Single Premium	71.20	200.87	46.17	1	2	1	3178	11381	3088
	Group Non-Single Premium	552.38	1742.08	246.54	18	55	20	55468	93303	24538
11	**Max New York**									
	Individual Single Premium	14.23	35.70	63.60	28	82	84			
	Individual Non-Single Premium	4623.58	24899.48	11418.88	40581	186955	123662			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	16.36	143.20	58.00	3	24	29	4202	21193	22681
12	**Met Life**									
	Individual Single Premium	38.84	196.82	197.62	94	394	379			
	Individual Non-Single Premium	1439.19	6828.93	2899.61	6554	29046	27405			
	Group Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Group Non-Single Premium	90.07	730.16	228.38	17	113	83	33045	258809	95307
13	**Sahara Life**									
	Individual Single Premium	84.10	557.52	18.95	217	1419	56			
	Individual Non-Single Premium	30.12	159.81	243.48	1098	4787	10744			
	Group Single Premium	0.00	0.00	0.20	0	0	3	0	0	200
	Group Non-Single Premium	0.00	93.76	0.00	0	2	0	0	103131	0
14	**Shriram Life**									
	Individual Single Premium	416.03	428.57		938	966				
	Individual Non-Single Premium	443.65	1399.27		5451	21214				
	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	84.81	84.81		72	72				
	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	12031.32	78855.88	28025.70	33760	100018	76326			
	Individual Non-Single Premium	68501.38	367186.09	165380.46	382737	1802985	899107			
	Group Single Premium	5362.76	20448.23	9819.78	8	137	99	35229	340793	293858
	Group Non-Single Premium	5655.28	31995.70	13244.74	159	801	1147	343663	1607598	797869
16	**LIC**									
	Individual Single Premium	155759.21	927449.10	243809.21	497625	2142152	698616			
	Individual Non-Single Premium	225435.86	684448.63	336058.49	1506572	5683280	7163478			
	Group Single Premium	74176.34	246222.85	108092.01	1586	6426	5662	3172908	5641496	2252648
	Group Non-Single Premium	0.00	0.00	0.00	0	0	0	0	0	0
	Grand Total									
	Individual Single Premium	167790.53	1006304.98	271834.91	531385	2242170				
	Individual Non-Single Premium	293937.24	1051634.72	501438.95	1889309	7486265				
	Group Single Premium	79539.10	266671.08	117911.79	1594	6563		3208137	5982289	2546506
	Group Non-Single Premium	5655.28	31995.70	13244.74	159	801		343663	1607598	797869

Note: Cumulative premium up to the month is net of cancellation which may occur during the free look period.

* Commenced operations in August, 2006

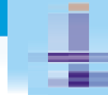
FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE FIRST QUARTER ENDED JUNE, 2006

INDIVIDUAL NEW BUSINESS - SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June 2005	June 2006	June 2005	June 2006	June 2005	June 2006
	Non linked*						
1	Life						
	with profit	4,793.73	3,242.65	6,346	4,321	7,260.26	4,908.09
	without profit	10,273.93	26,433.93	29,359	46,866	60,421.19	83,941.02
2	General Annuity						
	with profit	685.31	0.00	1,059	0	6.22	0.00
	without profit	2,197.34	36.28	850	28	0.00	0.00
3	Pension						
	with profit	292.10	3,002.85	270	1,601	47.69	53.74
	without profit	36.50	76.18	12	21	36.50	45.71
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
A.	**Sub total**	**18,278.92**	**32,791.90**	**37,896**	**52,837**	**67,771.85**	**88,948.56**
	Linked*						
1	Life						
	with profit	0.95	-0.25	2	0	0.76	0.00
	without profit	15,959.17	121,240.35	25,150	125,903	20,630.00	123,447.49
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	-50.00	0	0	0.00	0.00
3	Pension						
	with profit	0.00	0.15	0	0	0.00	0.00
	without profit	82,411.74	577,313.72	274,962	1,242,406	151.42	130.24
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
B.	**Sub total**	**98,371.86**	**698,503.97**	**300,114**	**1,368,309**	**20,782.17**	**123,577.73**
C.	**Total (A+B)**	**116,650.77**	**731,295.87**	**338,010**	**1,421,146**	**88,554.03**	**212,526.30**
	Riders:						
	Non linked						
1	Health#	0.76	0.00	4	13	20.00	20.41
2	Accident##	4.49	0.61	374	190	301.69	218.94
3	Term	0.81	0.06	36	3	23.11	1.85
4	Others	0.00	0.00	0	0	0.00	0.00
D.	**Sub total**	**6.05**	**0.67**	**414**	**206**	**344.80**	**241.20**
	Linked						
1	Health#	0.05	0.83	1	17	1.00	18.95
2	Accident##	0.14	1.60	7	64	8.50	131.15
3	Term	0.00	0.19	0	3	0.00	7.25
4	Others	0.00	0.00	0	0	0.00	0.00
E.	**Sub total**	**0.19**	**2.62**	**8**	**84**	**9.50**	**157.35**
F.	**Total (D+E)**	**6.24**	**3.30**	**422**	**290**	**354.30**	**398.55**
G.	****Grand Total (C+F)**	**116,657.01**	**731,299.16**	**338,010**	**1,421,146**	**88,908.33**	**212,924.85**

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.



FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE FIRST QUARTER ENDED JUNE, 2006

INDIVIDUAL NEW BUSINESS - NON-SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		POLICIES		SUM ASSURED	
		June 2005	June 2006	June 2005	June 2006	June 2005	June 2006
	Non linked*						
1	Life						
	with profit	177,813.88	258,786.33	3,123,170	2,819,288	2,652,958.79	2,478,493.73
	without profit	9,181.95	5,809.91	185,055	175,617	297,728.99	328,610.75
2	General Annuity						
	with profit	37.88	5.43	407	51	780.77	82.81
	without profit	0.00	0.00	0	0	0.00	0.00
3	Pension						
	with profit	1,948.65	895.05	15,935	4,261	7,974.45	4,375.50
	without profit	0.00	145.24	0	819	0.00	0.00
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	92.58	308.25	3,771	22,129	6,759.81	94,339.26
A.	**Sub total**	**189,074.93**	**265,950.22**	**3,328,338**	**3,022,165**	**2,966,202.81**	**2,905,902.05**
	Linked*						
1	Life						
	with profit	33.53	6.06	117	24	231.94	66.05
	without profit	57,894.94	206,712.80	178,926	750,587	557,135.35	1,794,572.90
2	General Annuity						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	1,291.27	3,801.93	10,289	20,092	3,673.89	6,947.25
3	Pension						
	with profit	8.97	2.68	23	3	0.00	0.00
	without profit	4,451.72	18,301.03	22,567	58,277	905.46	1,377.17
4	Health						
	with profit	0.00	0.00	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0.00	0.00
B.	**Sub total**	**63,680.44**	**228,824.50**	**211,922**	**828,983**	**561,946.64**	**1,802,963.37**
C.	**Total (A+B)**	**252,755.37**	**494,774.72**	**3,540,260**	**3,851,148**	**3,528,149.45**	**4,708,865.43**
	Riders:						
	Non linked						
1	Health#	81.71	78.09	7,242	4,628	8,821.42	6,341.79
2	Accident##	274.57	141.84	86,309	85,251	128,640.46	252,994.90
3	Term	25.33	11.35	8,065	1,825	3,890.64	2,072.11
4	Others	93.54	438.72	2,836	1,009	7,152.12	43,535.78
D.	**Sub total**	**475.16**	**670.00**	**104,452**	**92,713**	**148,504.63**	**304,944.58**
	Linked						
1	Health#	55.70	113.19	1,789	2,466	12,980.81	24,226.69
2	Accident##	48.37	113.34	8,635	20,619	15,979.01	37,555.88
3	Term	14.20	17.88	1,331	1,721	2,667.92	3,541.00
4	Others	14.33	20.88	2,925	4,045	310.67	426.06
E.	**Sub total**	**132.60**	**265.29**	**14,680**	**28,851**	**31,938.42**	**65,749.62**
F.	**Total (D+E)**	**607.76**	**935.29**	**119,132**	**121,564**	**180,443.05**	**370,694.20**
G.	****Grand Total (C+F)**	**253,363.13**	**495,710.01**	**3,540,260**	**3,851,148**	**3,708,592.50**	**5,079,559.63**

* Excluding rider figures.
** for policies Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders.
The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE FIRST QUARTER ENDED JUNE, 2006

GROUP NEW BUSINESS -- SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		June 2005	June 2006	June 2005	June 2006	June 2005	June 2006	June 2005	June 2006
	Non linked*								
1	Life								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	9,681.43	22,800.39	249	321	54,377	114,751	24,408.21	132,693.12
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	56.61	1,057.87	123	166	25,294	29,756	16,926.98	43,869.98
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	175.69	69.67	165	190	117,435	163,203	53,272.71	50,782.22
d)	Others								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	9,940.82	42,201.76	2,225	2,537	851,837	1,444,605	432,828.29	844,101.03
2	General Annuity								
	with profit	0.00	17,489.61	0	0	0	725	0.00	0.00
	without profit	13,727.19	13,493.42	3	10	2,409	1,926	0.00	0.00
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	30,671.89	27,005.92	16	35	10,863	51,311	0.00	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	**Sub total**	**64,253.63**	**124,118.64**	**2,781**	**3,259**	**1,062,215**	**1,806,277**	**527,436.19**	**1,071,446.35**
	Linked*								
1	Life								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	581.23	1,209.43	1	4	1,086	24,801	10.86	174.02
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	Others								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	183.00	0.00	0	0	0	0	0.00	0.00
2	General Annuity								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	24.72	414.91	0	7	0	4,633	0.00	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	**788.95**	**1,624.34**	**1**	**11**	**1,086**	**29,434**	**10.86**	**174.02**
C.	**Total (A+B)**	**65,042.58**	**125,742.97**	**2,782**	**3,270**	**1,063,301**	**1,835,711**	**527,447.05**	**1,071,620.37**
	Riders:								
	Non linked								
1	Health#	5.38	9.90	8	5	4,309	2,416	5,573.44	4,669.54
2	Accident##	11.98	14.94	11	10	3,268	5,972	31,428.12	34,409.60
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
D.	**Sub total**	**17.36**	**24.85**	**19**	**15**	**7,577**	**8,388**	**37,001.56**	**39,079.15**
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.00	0.00	0	0	0	0	0.00	0.00
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	**Sub total**	**0.00**	**0.00**	**0**	**0**	**0**	**0**	**0.00**	**0.00**
F.	**Total (D+E)**	**17.36**	**24.85**	**19**	**15**	**7,577**	**8,388**	**37,001.56**	**39,079.15**
G.	****Grand Total (C+F)**	**65,059.94**	**125,767.82**	**2,782**	**3,270**	**1,063,301**	**1,835,711**	**564,448.60**	**1,110,699.52**

* Excluding rider figures. ** for policies Grand Total is C. # All riders related to critical illness benefit, hospitalisation benefit and medical treatment. ## Disability related riders. The premium is actual amount received and not annualised premium.

FIRST YEAR PREMIUM OF LIFE INSURERS FOR THE FIRST QUARTER ENDED JUNE, 2006

GROUP NEW BUSINESS -- NON-SINGLE PREMIUM (INCLUDING RURAL & SOCIAL)

(Rs lakh)

Sl No.	PARTICULARS	PREMIUM		NO. OF SCHEMES		LIVES COVERED		SUM ASSURED	
		June 2005	June 2006	June 2005	June 2006	June 2005	June 2006	June 2005	June 2006
	Non linked*								
1	Life								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	238.03	3,819.04	5	7	2,488	16,438	7,867.61	11,565.67
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	204.94	0	0	0	38,915	0.00	82,292.00
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	240.14	196.45	66	81	136,144	170,668	66,689.33	126,687.98
d)	Others								
	with profit	9.15	0.00	2	0	1,020	0	7,510.95	0.00
	without profit	1,137.09	1,487.88	491	258	253,375	533,677	665,810.23	1,320,848.89
2	General Annuity								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	31.08	16.49	0	2	680	36	186.50	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
A.	**Sub total**	**1,655.48**	**5,724.80**	**564**	**348**	**393,707**	**759,734**	**748,064.63**	**1,541,394.54**
	Linked*								
1	Life								
a)	Group Gratuity Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	1,842.93	7,830.32	30	88	16,102	102,974	1,304.33	139,372.27
b)	Group Savings Linked Schemes								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
c)	EDLI								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
d)	Others								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	149.75	163.54	1	4	12	73	23.04	6.99
2	General Annuity								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	157.90	1,317.74	3	2	29	348	157.90	1,317.74
3	Pension								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	4,844.45	5,904.49	37	57	1,550	7,875	0.00	0.00
4	Health								
	with profit	0.00	0.00	0	0	0	0	0.00	0.00
	without profit	0.00	0.00	0	0	0	0	0.00	0.00
B.	**Sub total**	**6,995.04**	**15,216.09**	**71**	**151**	**17,693**	**111,270**	**1,485.28**	**140,697.00**
C.	**Total (A+B)**	**8,650.51**	**20,940.89**	**635**	**499**	**411,400**	**871,004**	**749,549.90**	**1,682,091.54**
	Riders:								
	Non linked								
1	Health#	11.02	3.59	1	1	767	776	12,595.53	2,689.98
2	Accident##	2.28	2.83	6	6	11,117	3,042	38,163.68	3,810.57
3	Term	0.02	0.02	0	0	0	18	0.00	27.00
4	Others	0.02	0.02	0	0	2	0	309.00	0.00
D.	**Sub total**	**13.34**	**6.46**	**7**	**7**	**11,886**	**3,836**	**51,068.21**	**6,527.55**
	Linked								
1	Health#	0.00	0.00	0	0	0	0	0.00	0.00
2	Accident##	0.00	16.06	0	9	0	8,528	0.00	65,630.01
3	Term	0.00	0.00	0	0	0	0	0.00	0.00
4	Others	0.00	0.00	0	0	0	0	0.00	0.00
E.	**Sub total**	**0.00**	**16.06**	**0**	**9**	**0**	**8,528**	**0.00**	**65,630.01**
F.	**Total (D+E)**	**13.34**	**22.51**	**7**	**16**	**11,886**	**12,364**	**51,068.21**	**72,157.56**
G.	****Grand Total (C+F)**	**8,663.86**	**20,963.40**	**635**	**499**	**411,400**	**871,004**	**800,618.11**	**1,754,249.11**

* Excluding rider figures. ** for policies Grand Total is C. # All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
Disability related riders. The premium is actual amount received and not annualised premium.

Achieving Total Freedom …

"De-tariffing, while breaking the shackles, would be a huge challenge; and insurers should exhibit maturity in dealing with the risks in order to emerge successful' writes U. Jawaharlal.

Insurance industry in India has drawn a full circle - from being a private enterprise to government control; and then being opened up to private participation again. The circumstances prevailing at the respective times demanded the change. When it was in the hands of private players prior to nationalization, several unethical developments took place and some insurers blatantly abused the resources at their disposal purely for personal gains. This led to the nationalization of the life insurance industry in 1956; and then the non-life sector in the year 1971. The immediate emphasis then was on arresting the fraudulent trends and on bringing in total discipline in the management of policyholders' funds.

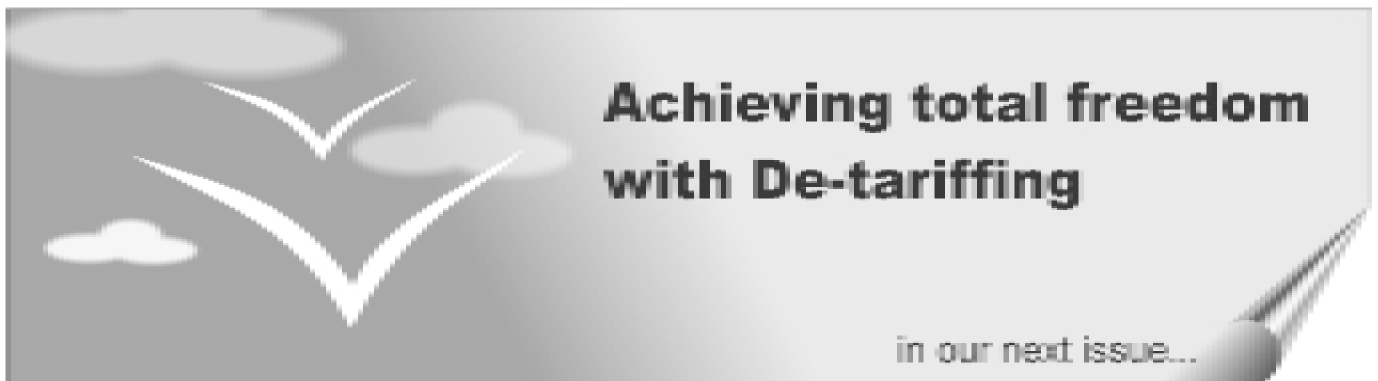
The insurance industry in government control performed very well and achieved all that was envisaged. Insurance companies mainly made a great contribution towards nation-building activities. It was; however, felt in due course that the market potential was not being totally tapped by the industry and more than that, the thrust of competition was conspicuously missing. All this and the winds of change blowing across the globe - those of globalization and liberalization - led to the reforms in the insurance industry and the eventual privatization. In order to ensure that the market does not end in a 'free-for-all', a major part of the non-life arena was tariff-driven.

The goals of privatization have been more than accomplished; and the performance of the players far exceeded what was anticipated originally. The public sector incumbents were equal to the task of competition and consolidated their positions progressively. However, it was always felt that the real benefits of competition were still not coming to the fore because of the existence of a tariff regime. It has been argued that the existence of tariff is stifling the freedom of the players. Watching the progress that the market has made and the experiences gained by the players over the years, a roadmap has been drawn in Sep. 2005 for withdrawal of the tariff control with effect from 1st Jan. 2007. It marks a very significant event in the insurance history of the country.

It is going to be a great challenge and competition among the players is going to be fierce. It has to be realized that market behaviour could seriously affect the solvency margins. Insurers should be guided by these possible pitfalls while pricing the products which should be based on sound technical considerations. It imposes a huge task on the actuaries and the underwriters who should act in unison to accomplish the right balance. Similarly, the marketing personnel should avoid getting carried away by the initial lures and consider all the aspects of the risks comprehensively. It boils down to the fact that there is need for further educating and training the marketing personnel; and insurers should spare no efforts in ensuring that.

All the efforts to monitor the progress being achieved on this front have indicated that we are progressing towards readiness for the monumental task. But considering its enormity, it would make good sense to ensure that everything is in its place, even at the cost of repetition.

'Detariffing' and the various challenges associated with it would be the focus of the next issue of the **Journal**. We are looking forward to a collection of interesting articles in different areas of this important development.



CIRCULAR

Circular No. 019/IRDA/LIFE/ SEP-06 26th September, 2006

Re: Guidelines on Anti Money Laundering programme for Insurers

To,

CEOs of All the Life Insurance Companies/Life Insurance Council

Dear Sir/Madam,

Further to our circular no. 043/IRDA/LIFE/AML/MAR-06 dt. 31/03/06, and No. 013/IRDA/LIFE/ JUL-06 dt. 27th July 2006 on "Guidelines on Anti-Money Laundering Programme for Insurers". The following clarifications/relaxations are being issued in response to the concerns raised by the insurers.

1. Documentation for identity and proof of residence:

   Doubts have been raised by insurers regarding the documents to be collected as valid identity/residence proof apart from what has been given in Annexure I to the guidelines. It is clarified that the list of documents provided in Annexure I of the guidelines for establishment of identity and residence proof may be deemed as illustrative. However while providing this flexibility to insurers on satisfactory documentation for this purpose; the Authority would reiterate that there should be no dilution of the requirement. Documents which are easily obtained in any name like birth certificates, an identity card issued by the employer of the applicant even if bearing a photograph, credit cards, business cards, driving licenses (not bearing a photograph), provisional driving licenses and student union card should not be accepted mechanically and adequate safeguards should be in place to satisfy its acceptance. In other words, any other document that is accepted by the insurer to establish the identity and proof of residence as required under Rule 9 of the PMLA rules should be such that it would satisfy competent authorities (regulatory/enforcement authorities), if need be at a future date, that due diligence was in fact observed by the insurer in compliance with the guidelines and the Act.

2. Requirement of recent photograph /address proof under PMLA Rules:

   a. We observe that documentation of permanent address and current address is mandatory for all the new contracts as required by Rule 9 of the PMLA rules. With the enlargement of the list of documents for establishment of identity as at para 2 above, the obtaining of appropriate documents for establishing the proof of residence would not be a major constraint and insurance companies are advised to comply fully with this statutory requirement in all cases.

   b. There were requests to do away with the mandatory collection of the photograph in case of individual clients as required under Rule 9 of the PMLA Rules 2005. The issue was represented to FIU-IND for which they have clarified that the requirement of submitting a copy of the recent photograph by an individual client is justified and cannot be relaxed. Mandatory requirement of a recent photograph of the client would be taken up again with FIU-IND in view of the representation received from the industry. In the interim, insurers are advised to comply with the PMLA Rules until the issues are resolved by FIU-IND.

3. We have examined other suggestions/requests received from Life Insurance Companies and advise that the other requirements listed in the circular dated 31st March 2006 should remain unchanged. Insurers are advised to take note of the above modifications and ensure compliance with the framework in entirety.

Yours faithfully,

(C. R. Muralidharan)

Member

Changes in the Insurance Markets Globally

- Regulator's Perspective

(This is an article based on the Keynote address by Mr. K.K. Srinivasan, Member, IRDA; at the APRIA Conference, Tokyo on 31.8.06)

Insurance markets world over are undergoing rapid changes. If the insurance regulator cannot stay ahead of the changes, he at least needs to keep pace with the rapid changes. This paper attempts to identify some of the key areas of change that require the regulator's urgent attention.

1. Globalization and the Regulator

Globalization in the financial services sector has led to strong international linkages. The process of linkages and convergence across sectors and borders creates risks by which financial markets, financial institutions and consumers in one jurisdiction can be adversely affected by a disturbance in another market. The resulting contagion effect has wide ramifications across jurisdictions. This has made the need for international cooperation and co-ordination amongst regulators an imperative.

Consequently, an urgent need for all regulators to make regulatory environment fall in line with international benchmarks has emerged. While a regulator has to be supportive of industry development he has at the same time to play a positive role in enhancing international competitiveness and sustainability of the players within the jurisdiction. New regulatory approaches would also be required in coordination with regulators in other jurisdictions to monitor transnational and trans-sectoral business practices arising from convergence of industries across boundaries.

2. Regulation of Conglomerates

Corporates seeking global reach and economies of scale through investments; mergers and acquisitions etc. has led to the emergence of large financial conglomerates operating across sectors and across jurisdictions, hastening the need for instituting necessary regulatory approaches to supervise such organizations in a comprehensive manner; and at the same time rigorously look at their sectoral integrity through the respective prudential sectoral standards.

Issues arise as to how to asses their capital adequacy; and the fit of their systems and controls that spans many jurisdictions and financial sectors.

Regulators will need to acquire capabilities to address the issues thrown up by the large size and scales of operations of conglomerates to ensure systemic stability and the resilience of the market.

Regulators will need to acquire capabilities to address the issues thrown up by the large size and scales of operations of conglomerates to ensure systemic stability and the resilience of the market. Also financial convergence increases the need for cross-sectoral coordination.

3. Products & the Regulator

Very often, insurers follow the practice of "deal now, detail later". The coverage dispute between insurers, brokers and reinsurers in the World Trade Center disaster has brought the need to ensure contract certainty to the front burner. The regulator has to ensure the policy terms are clear and unambiguous. This could mean tightening the product filing requirements.

The transformation of financial products where life insurance policies offer investment opportunities and compete with mutual funds, and reinsurance policies which bridge the insurance market with capital markets etc., are blurring the traditional distinct nature of insurance products. Regulators need to keep in mind these changes to understand the impact on the solvency position of companies and on the long term impact of the nature of assumed risks as well as the attendant market and management risks.

There is thus a need to re-examine the ways in which regulations are organized and their relationships with counterparts in other sectors so that there are no regulatory gaps or unnecessary overlaps.

4. E-Commerce & the Regulator

The internet is having an increasingly larger impact on the financial services markets. It seeks to make financial transactions a borderless business. This exposes the business to many potentially unknown risks. All regulators are concerned with finding ways to protect the consumer and prevent the risks inherent in this volatile area by examining ways to implement surveillance approaches and cross-border cooperation.

Apart from the consumer end of the e-business, e-commerce has great impact on almost all other production areas such as outsourcing of individual functions including policy administration, claims management, and investment within or outside national borders. In such a scenario, the regulator will find it difficult to determine where the risk carrying activities reside and which function is the subject matter of regulations. Some regulators have attempted to tackle this issue by proscribing outsourcing of 'core' functions. How far this approach will work remains to be seen.

E-business also helps outsiders to enter the insurance industry without the load of legacy systems, often in competition with other established channels. Regulators will need to deal with such unorthodox entrants and determine to what extent they need to be regulated and how customer interests are to be safeguarded.

5. Regulator and Consumer Confidence

Regulator has to play an increasing role in guiding insurers to meet heightened expectations of the consumers and the society. Enforcement of adherence to regulatory requirements is a key factor in consumer confidence. The consumer has become aware that the regulator is expected to keep vigil against various risks such as:

- Technical Risks: Risk of insufficient rates, Deviation risk, Evaluation risk, Reinsurance risk, Operational Expense risk, Growth risk.
- Investment Risk: Depreciation risk, Liquidity risk, Matching risk, Interest rate risk, Derivatives risk, Market risk, Credit risk
- Non-Technical risk: Management risk, Operational risk, Business risk

The idea of regulation as a risk management tool operates at three different levels - (1) Off and on-site supervision by the regulator to enforce regulations (2) Self-regulatory approaches including setting industry level standards and benchmarking by industry associations and (3) Effective implementation of corporate governance norms by individual insurers.

6. Consumer Protection and Market Conduct

Consumer protection is a dominant theme in insurance market in view of the intangibility of the product and prospective nature of claims. Therefore, market conduct regulation involving best sales and marketing practices, guidelines on unfair practices, policyholder protection methods - including product disclosure and transparency guidelines - are to be in place.

Consumer education is a critical challenge, especially in countries with low consumer awareness, to ensure that consumers have the necessary capability to make well informed choices.

Consumer education is a critical challenge, especially in countries with low consumer awareness, to ensure that consumers have the necessary capability to make well informed choices. Such consumer awareness also fosters market discipline and efficient allocation of resources by forcing insurers and intermediaries to keep costs low and service standards high.

7. Channel Proliferation

Many new channels are pouring into the insurance sector either as standalone intermediaries or as alliance partners with independent clout. The methodologies of intermediation include:

- Agents, brokers, banks, shops
- Mail, telephone, internet
- Companies, employers, unions, associations
- Buying groups and on-line auctions

Market expansion; and consumer preferences and convenience drive innovations in the distribution area. This makes it imperative that there is regulatory vigil to ensure fit and proper capabilities on the part of the intermediaries so that there is no mis-selling; and the customer is properly advised and assisted. New regulatory approaches in areas such as corporate agency, referral, bankassurance and internet selling are required to ensure that the core values of insurance transactions are not lost sight of while encouraging new channels.

8. Corporate governance.

Enforcement of corporate governance has become a necessary requirement in most jurisdictions so as to meet stakeholder expectations more appropriately and effectively. Companies are required to implement various measures regarding the level of transparency, integrity and professionalism. The IAIS principles on corporate governance are clear that the supervisor should set the requirements with respect to the roles and responsibilities of the board of directors and managements of insurance entities.

The duties of the board are manifold. It is expected to act independently in the

interests of all stakeholders. It should participate actively in shaping the strategic objectives and provide the overall prudential oversight and leadership in the running of the business. It must set clearly accountability and responsibility within the hierarchy with adequate checks and balances.

Another key aspect of corporate governance is promoting transparency and disclosure. It is recognized that insurance is a complex business and assessing the financial strength of insurers is far from easy. Apart from the shareholders funds, a substantial portion of the insurance funds belong to the policyholders who are also entitled to know how their funds are put to use. Regulator therefore has the duty to set norms for transparency and disclosure. Sound accounting and transparent financial information is a fundamental pillar of any business, including insurance business.

Transparency and disclosure is equally important in the case of intermediaries. The regulator has to ensure that the intermediary's duty to the client is not compromised by his relationship with the insurer. There is a need to have an optimal blend of formal regulation and self-regulation.

9. Market liberalization.

Deregulation of markets to meet customer aspirations on merit pricing and the need for competitiveness based on risk based parameters, has made it necessary to phase out rule-based systems such as tariffs. Such steps in deregulation have brought risk based supervision systems which is a structured process aimed at identifying the critical risks faced by each insurer. The regulator in such a system intends to assess the company's management of those risks and the vulnerability faced in doing so. This new model includes supervisory review of company policies, internal governance practices, the audit and control system it has, and the whether the industry standards are being adhered to.

In order to ensure a smooth transition to a risk based regulatory environment, suitable road maps have to be laid down to enable the industry to roll over with confidence having taken care to build robust internal systems with necessary technological inputs to capture data; develop risk based rating practices; internal guidelines and controls; and initiate suitable training and R&D.

It is recognized that insurance is a complex business and assessing the financial strength of insurers is far from easy.

10. Socio-economic and Developmental Challenges.

Insurers are called on to play an increasingly larger role in the financial protection of the economy at all levels. This includes areas such as healthcare and insurance for the rural and social sectors. To meet the increasing demand for healthcare financing, regulators need to look at putting in place necessary guidelines in favour of customers where needed; and creating specialized institutions such as standalone health insurers and third party administrators so that these volatile portfolios adhere to prudential norms while actively promoting their development..

Similarly, in the area of rural insurance, penetration and ensuring reach of insurance to those in the social margins are important responsibilities cast on regulators. In such cases the regulator needs to monitor the rural and social obligations of insurers and consider ways to reach micro-insurances to the poor through innovative intermediary channels by way of appropriate guidelines. Similarly, facilitation in servicing far-flung and marginal customers needs to be taken care of through efficient networking so that in times of distress, the claims filed by the small claimants are promptly attended to.

11. RBC and the Regulator

The world wide trend to adopt Risk Based Capital norms poses its own regulatory challenges. The conventional solvency system provides regulatory convenience since, a) it is simple b) it does not require micro-management and c) uniform formula avoids disputes in computation. Some experts consider that the RBC standard scores over the conventional solvency system for the following reasons,

i) It accurately represents the financial strength of an insurer since RBC system is based on statutory financial statements, taking into account asset risks, credit risks, underwriting and pricing risks; and the risk that the return from assets is not aligned with the requirements of the company's liabilities and general business risk.

ii) It is the industry benchmark across jurisdictions.

iii) The information needed to calculate the RBC ratio is readily available in the annual statutory financial statements.

However RBC to be implementable needs regulatory action with respect to:

- The components that make up the RBC charge;
- The data used to assign values to the various components, and the reliability of the data;
- The rationale behind any judgmental adjustments to values derived from the data;
- The details of any other judgmental factors like loadings or discounts for factors such as 'management competence'; and
- The way in which the various components are combined to arrive at the RBC charge.

The regulator shall also need to examine the valuation methods used to calculate the value of insurers' assets and outstanding liabilities; though the regulator should expect them to be the same as for the solvency tests including, normally, opinion of an actuary. This can be a worrisome area. For example as it happened in a recent case, given an equalization reserve of 150%, the solvency factor of 260 got reduced to 60 with wrong asset securitization. Also the last word on the choice of RBC formula (S&P, NAIC etc.) is yet to be pronounced. Experts consider that in different ranges different methods give different results.

12. Integrating Technology

Insurance industry world wide is getting technology driven. The regulator cannot afford to be left behind. Regulators need to integrate technology in their supervision functions like integrating internet in market conduct surveillance and enforcement for violations such as illegal solicitations and unlicensed operations. Paper and documents will have to be gradually replaced by electronic reporting wherever possible.

> Insurance industry world wide is getting technology driven. The regulator cannot afford to be left behind.

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

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Underwriting in Detariffed Era

- Issues in "Motor"

'Some sections of the insuring community of motor are very much worried that, in future, they will be made to shell out more cash every year in buying Motor insurance to fully cover themselves' opines B.G. Patki.

At long last, non-life insurance market will go into a different underwriting pattern with effect from 1-1-07 when the industry enters the detariffed era. Tariff has always meant a highly regulated and restricted underwriting of the Motor insurance business. Detariffing means or rather should mean a total freedom to the underwriters to transact the business as per their perception based on their own individual exposure/experience. While freedom in any field is always welcome and hence should be a matter of joy and happiness to every one concerned, the industry watchers are observing that the detariffed phase is being received by the market constituents with mixed feelings, to say the least.

Before we go into the details, it is essential to have a look at what underwriting is all about? In practice this word 'Underwriting' is normally associated to only the routine work of accepting or for that matter declining the proposal and issue the document if the proposal is accepted. This understanding at the level of insurance officials may have developed because of the restricted or regulated market that has been in vogue for a long long time.

Underwriting generally means entire product management. Even today when it is said that a particular company has made underwriting profit or underwriting loss, along with the income generated through premium, the outgo arising from the claims is also included. Therefore, it will have to be borne in mind that the underwriting will comprise of both the abovementioned aspects. After all, risk acceptance, premium income generation and the subsequent resultant claims outgo are all interrelated factors quite dependent on one another.

Product design i.e. perils to be covered, add-on covers etc., exclusions, setting up of the various terms and conditions of the contract, and then the pricing of the product are the most important basic aspect of underwriting. The second aspect, equally important, if not more important, is the resultant factor of the sold product i.e. claims management.

> While freedom in any field is always welcome and hence should be a matter of joy and happiness to every one concerned, the industry watchers are observing that the detariffed phase is being received by the market constituents with mixed feelings, to say the least.

For a long long time, in the tariff regime; the designing of the product as well as the pricing i.e. the premium rate structure was not left to insurance companies. The manufacturing of the product and its pricing was centrally administered by Tariff Advisory Committee (TAC). Only the trading of the manufactured product with the stipulated pricing was left to the insurance companies, which were thus only the traders of this highly regulated product. However, the claims management was still left to the insurance companies.

Detariffing the product or Free Market era would have normally meant leaving the designing of the product as well as the pricing to the underwriters. It is here that the motor market became jittery and apprehensive; and in a few cases even diffident to enter into such a totally free market phase.

As experienced earlier, when some products were detariffed, the market did face a chaotic situation. Hence the current thinking of entering the Free Market era in a phased manner is, perhaps, the most appropriate step. Till such time i.e. up to 31-3-08 at least, the current product i.e. perils covered, exclusions, add-ons, terms & conditions etc. will continue to remain the same as per the existing tariff and will remain regulated. However, the underwriters can do the pricing i.e. premium rate structure as per their individual perception of the risk, exposure/experience etc. albeit after getting the nod for their premium rate structure from the regulator. This very important leeway now given to insurance companies at least will eliminate one excuse rampantly given by the companies for their higher claims ratios resulting into underwriting losses.

Some sections of the insuring community of motor are very much worried that, in future, they will be made to shell out more cash every year in buying Motor insurance to fully cover themselves. Insurance premium is a regular recurring expense account for motor vehicle owners.

That the current premium structure is lopsided is not disputed. Because of unscientific rating for some very high risk models of various makes, many manufacturers, their dealers, owners of such vehicles etc. have enjoyed the benefits at the cost and chagrin of the underwriters for all these years. In case the companies really adopt a real risk assessment pattern of each make and model which they must; and fix the premium accordingly, the customers i.e. owners of such makes and models of vehicles will certainly be required to pay more than the other owners of the other models of vehicles. Following example will illustrate the point:

The premium rate structure should take into account the manufacturers' spare part cost of their models; the labour charges that their dealers will be charging for the accident repairing jobs; their paint technology and its cost involved as well as the design of their models in positioning of certain vehicle components which may become more accidentally damage prone. In case of accident, these factors will determine the claims cost vis-à-vis the claims outgo.

Naturally the models of vehicles found cost-prohibitive to the underwriter will attract higher premium for such vehicles to make them cost-effective. The owners of such vehicles, therefore, will be required to incur higher recurring expenses for buying the insurance cover for their vehicles.

In such a scenario, in future, the cost conscious automobile customers may decide not to opt for buying such vehicles but may choose vehicles which might be available for much lower insurance premium because it is quite certain that for cost-effective vehicle models, the premium rates may even be lower than the current ones. Such a difference in the recurring expenses will be one of the various essential points that the customers will have at the back of their mind. Manufacturers of such vehicles, who hitherto enjoyed the benefits of the current Tariff rate pattern, may have to rethink about their marketing strategies in the pricing of spare parts [especially the accident prone parts], labour charges etc. This is expected to be the real effect of underwriting in free-market era.

On the other hand, since each company will have a different premium rate structure, the vehicle owners will have a wide range of choice to choose their underwriter.

Initially to start with, there may be turmoil in the market. But this will only be a teething trouble phase. Ultimately the market will stabilize. However, this article will be incomplete without mentioning the second important aspect of the underwriting which is claims management. That there is a leakage and inflated claims both in own damage and liability sections is not disputed. With proper, scientific, methodical risk management approach, leakage and excess outgo can be effectively curbed and eliminated making the claims outgo realistic and much lower than the current one.

This will be the need of the hour. Such a situation will certainly give edge to the underwriter to fix quite competitive premium rates and be aggressive in marketing; and still will manage to make the portfolio profitable. For this they will have to adopt professional, controlled claims management process to stay ahead of their competitors. Detariffed era will witness quite a fierce competition in the market. The companies, which will have a professional claims management, will emerge winners in the underwriting of the motor insurance at reasonably low premium price which in turn will give them a larger customer base. It will be a win-win situation both for the insuring public as well as to the underwriters and the health of the motor insurance underwriting will improve making the product quite viable both in the Liability as well as in the Own Damage segments.

The companies, which will have a professional claims management, will emerge winners in the underwriting of the motor insurance at reasonably low premium price which in turn will give them a larger customer base.

It is a known fact that the Motor market is also quite a volatile market. There are many types of risks underwriters, as per their perception, may not like to underwrite and hence they may decline the same or may underwrite with a very high premium. This is expected to cause hardships to the insuring public in certain cases. Government has evolved a solution for such situations so that no individual finds himself or herself in a precarious condition of no underwriter being ready to cover the proposed risk. For such cases, a pool is being formed in the name of India Motor Insurance Pool. This pool where all the insurance companies in the Indian domestic market are the members, will underwrite such declined risks in motor on behalf of the pool. This will mean that no one will be left high and dry without Motor Insurance. While all the companies in both public sector and private sector will underwrite on behalf of the pool, such declined risks and manage the same; GIC has been given the responsibility of the coordinator as a Pool Manager. This move of IRDA to form a pool for such risks is appreciated by the market. Even though these will be declined risks, they will be managed with a professional approach to endeavor to make the portfolio viable. GIC, as a Pool Manager, will have to see that this project becomes a success. I am quite confident that GIC with the experience of all the pool members and their cooperation will achieve this success.

The success in the management of underwriting of such risks will pave the way for a much healthier Motor Insurance Market in India and as such this arrangement of Pool management will be observed by the Industry watchers with keen interest and enthusiasm.

As they say "LET US WAIT AND WATCH".

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Tele-Underwriting in Life Insurance

- Is it time yet?

'Knowledgeable underwriting is the key to a gainful future for an insurance company' avers T.S. Ramakrishna Rao.

Life is less ephemeral today than what it was a few decades ago. Life spans and life expectancies across the globe are increasing. Age is arterial, not chronologic. During the terminal stages of life, there is no wealth greater than health. Though old age is said to be the golden age; it is however, loaded with diseases. The terminal diseases are aptly called ABCD. The four letters stand for Arthritis, Blood Pressure, Cancer & Diabetes.

The insurance industry in India has been under-serving health. The country has high health spending. The health care system is primarily private and therefore the cost to individuals becomes a major economic burden. The primary use of micro loans to the poor in India, it is gathered, is to pay medical bills.

UNDERWRITING:

Underwriting is the lifeblood of insurance business .The global insurance underwriting industry is estimated to be about $1,600 billion. It continues to grow unabated. The IT spending of the insurance industry is in the region of 2.5 per cent now and is projected to grow to about 3.5 per cent shortly thereby indicating a positive trend. Many big insurance companies continue to rely on legacy systems. Gradually even these laggards are in the process of modernizing their infrastructure and IT enabling a good part of their services.

Knowledgeable underwriting is the key to a gainful future for an insurance company. Underwriting profits are directly proportional to the skill level of the underwriters. The old systems of underwriting were quite slow and expensive. The exercise used to take an hour or more involving culling out medical information from the prospect and completing the application. The number of questions was in the region of hundred or more.

A risk which cannot be quantified cannot be underwritten; is the golden rule of insurance. Underwriting is the process of selecting and classifying exposures. Unless the underwriter selects from among its applicants, the result to be expected will be unfavorable to the insurance company.

> The reduction of human intervention in the underwriting process will reduce subjectivity and also enhance the risk management practices of the insurance company.

In the more advanced markets, under traditional underwriting, life insurance agents are responsible for gathering medical information from the prospects. ECGs, X-rays, inspections and physician reports are the underwriting tools that are used. Medical records are tediously slow and detested. The acronym MRODS (Medical Records Over Dependency Syndrome) became popular due to the overdependence of traditional underwriters on it. Traditional underwriting makes sales difficult and the issue of policy expensive. It is cost-effective only for big size policies. The requirement for Attending Physician Statements (APS), paramedical exams, or fluids further slows down the evaluation process.

Underwriters are often criticized as the sales prevention department by angry advisors. The total time taken is sometimes of the order of 6 weeks. There is a growing need to upgrade underwriting skills in tune with the improvement in mortality.

TIME TO SHIFT GEAR

The three primary focus areas for any insurance company are cost of sales, underwriting and servicing the customers. Faster, cheaper and better delivery is the mantra. The process of underwriting can be streamlined by mechanizing most of the decisions. The reduction of human intervention in the underwriting process will reduce subjectivity and also enhance the risk management practices of the insurance company. This also aids to even out the processing load which shows high variations in the life insurance business.

A few other tools that can speed up the underwriting process and issue of insurance policies include electronic applications / signatures and also the use of the Medical Information Bureau (MIB), which makes its information available on the World Wide Web. Another fast-emerging, powerful tool for speedy underwriting is the Motor vehicle record (MVR). Besides technology advancements, a new way in which this endeavor can be achieved is through the magic wand of teleunderwriting.

Many insurance companies are gearing up to adopt teleunderwriting. The move would help them lower acquisition cost, speed up application process, maintain the mortality goals and of course help customer friendliness. It reduces paper work thereby helping the field staff to sell more without digressions. It totally transforms the underwriting functions.

TELEUNDERWRITING

"Teleunderwriting" had its origin in the early nineties. The modus operandi is; the call center professionals conduct telephonic interviews with insurance applicants with the exclusive aim of ordering medical records. Thereby this leads to both cost and time saving for the insurance companies. A great idea, it has the potential for substantial savings. It helps the insurance companies to obtain applications and medical history through interviews on telephone. Facilitating speed in turnaround time and the least possible personal contact with the applicant, it cuts through the need for APS, General Practitioner reports, medical examination / reports, blood tests, etc. Teleunderwriting insists on chest x-rays, ECG, and Medical examination only if required.

Many insurance companies are already applying this process with positive results. It is a step in the right direction and is a big benefit to the advisor. It reduces for the agent the burden of taking a personal history or asking an applicant medical questions. Thus it would allow them more time to concentrate on selling. It is a win-win situation. The client is benefited. Even the insurance company reaps benefits as it is able to obtain quality underwriting information. The reasons are not far to seek - the personnel asking the questions are experienced underwriters.

Reflexive (drill-down) medical questions are used to get an accurate picture of applicants. This neutral third-party interview is much superior to an agent or an underwriter interview in terms of the quality of information obtained. Teleunderwriting leads to a significant drop in the cycle time i.e. the intervening period between the submission of an application and the time the policy is issued. The figures touted are 30% to 50%. Some say it could be as much as 300%.

The decentralization of the underwriting process reduces processing time to ten to eleven days. The actual interview may last from less than ten minutes to as long as fifteen to twenty minutes, depending on how many questions are asked and, of course, the length of the answers. If the interview is confined to the risk-related questions on the application, it takes lesser time than the one which has to use the drilldown questions for certain answers.

THE ADD ON- DRILLDOWN

A teleunderwriting interview becomes more comprehensive if some questions are answered in a certain manner. The idea is called "drilldown questions". These questions are used when the insurance prospect acknowledges the presence of an impairment or situation which is of significance to underwriting. The tele-underwriter is prompted by a pop up to ask additional "drill-down" questions on a particular condition. For example, if one is a diabetic, a screen will pop up to ask further questions about diabetes. This process helps the specialist underwriters to assess more complex cases.

> The mandate is to elicit risk-salient information with the least possible questions. The better the questions, the superior is the protective information.

To exemplify let us say that an applicant states that she/he is a diabetic. Once the teleinterviewer comes to know this he uses a drop-down list of questions designed to amplify aspects of diabetes and have a bearing on underwriting:

- When was it diagnosed?
- What type of treatment is taken?
- Is there any problem with the prospect's vision or kidneys?
- Have there been any complications?
- What is his/her recent blood sugar reading?
- Is urine checked for sugar regularly? Is the test usually negative or positive?
- What does his/her physician say about the control of blood sugar?

and so on.

These questions are the basis for risk assessments. They are triggered to clarify the situation. They help elicit protective information that may allow the underwriter to make a decision without ordering for more requirements. The specialist underwriter helps designing the drilldown questions. The mandate is to elicit risk-salient information with the least possible questions. The better the questions, the superior is the protective information.

ADVANTAGES OF TELEUNDERWRITING

Teleunderwriting has turned out to be a win-win win situation for all the participants in the business process: Applicant, agent, and the insurance company. The benefits, by participants, are:

Applicant

- The applicant need not reveal sensitive medical information to the advisor. A trained professional asks the prospect questions over the phone.
- The cover can be obtained in half the time or less than that with a conventional or traditional underwriting process.
- It is a "once-and-done" method and therefore very easy for the applicant. All information is obtained from the applicant in a solitary phone call. It is no longer a long drawn process with multiple contacts.

Agent/Advisor

- The percentage of cases placed when teleunderwriting is used is higher than the percentage of cases placed when the traditional process is used.
- The above increase in volumes translates to higher overall commissions for advisors which is definitely a major motivating point for the field staff.
- The commissions are received faster, due to the shorter process time.
- The agents also save valuable sales time, because the point of sale paperwork is minimal- a small worksheet, rather than the traditional unending list of medical questions.

Insurance Company

- The enhanced medical information acquired from the tele-interview results in reduced need for physicians' records. To put it succinctly excellent information is procured at a significantly lower overall cost.
- Higher volumes definitely lead to more revenue.
- The improved information and reduced non-disclosure translates to better claims experience.
- Most assurers experience huge delays due to incomplete applications. With properly designed teleunderwriting this problem should stop.
- The insurer enjoys faster, easier processing with fewer errors.

Brokers and Advisors have widely accepted teleunderwriting. What about the reinsurers? How do they take it? Do they contest its efficacy? Like direct writers even reinsurers are very particular about getting the best risk information. The telephone interview has relatively more value than the MD report. Though teleunderwriting has certain drawbacks like higher startup costs and the cost of retraining the staff, its advantages are far too many. Therefore, many reinsurers are today advocates of teleunderwriting.

TO OUTSOURCE OR NOT

The million dollar question is what should be our approach to teleunderwriting. Should it be outsourced or should it be done by the insurance company's employees? Could it be better handled by pleasant female voices or trained underwriters? Whatever be the method adopted, the need for developing the best template for a tele-interview cannot be ruled out.

One stark reality about life and health underwriting is the shortage of well-trained and experienced underwriters. Both in-house and outsourcing approaches have pros and cons. The in-house approach offers a certain satisfaction at the insurance company level but it has some major drawbacks like higher start up costs, training of personnel and of course, to cap it all, high risk. Outsourcing avoids all these, and if proper arrangements are arrived at with the external suppliers the issues of control and performance can definitely be sorted out. In both the routes the quality of planning and implementation is vital.

> Though teleunderwriting has certain drawbacks like higher startup costs and the cost of retraining the staff, its advantages are far too many.

Since distance is no longer a barrier to engage the best talent a few insurance companies have taken to the concept of outsourced underwriting. They have gone to the extent of engaging offshore firms for assessing risk. The method leverages internet technologies to engage the talent of experienced underwriters anywhere in the world in conducting telephone interviews with applicants.

There can be significant benefits from global outsourcing of simple initial underwriting, new business administration and risk assessment to cite a few. A new term has been added to the lexicon to identify the idea of offshore tele-underwriting. It is called Delhi-underwriting.

THE ROAD AHEAD

The mindset required for the current century (21st) is very different to what was followed in the twentieth century. It is indeed strange that in this age of nanotechnology, broadband, wireless, real time gross settlements, Straight Through Processing (STP) solutions and any time any where banking etc.; insurance underwriting continues at a snail's pace with its total dependence on APS, PHI etc.

Is it not time to shed the antiquated age old methods, draw a cue from the other financial services sectors and make the policy processing and selling process faster, speedier and quick? An unavoidable need is there to discover processes that curb delay, speed up the underwriting delivery process and cause utmost customer satisfaction.

With the convergence in the financial service sector; and the marriage between banking, insurance and investments; insurance agents and brokers are rapidly evolving from product- specific salespeople to personal financial advisors. Teleunderwriting makes this possible by freeing the advisors from tedious paperwork.

The writing on the wall is clear - traditional underwriting, teleunderwriting and............real time underwriting. With bated breath we look forward to the writing of a new chapter in the history of the insurance industry.

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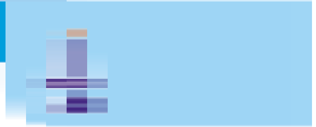

Preparing Underwriters

- In a Detariffed Scenario

'The underwriter should be able to visualize the risk even if he did not visit it, from the reports given and from the detailed proposal form furnished' states G V RAO.

The article seeks to highlight a few aspects on underwriting risk acceptances that are important in a detariffed scenario. If ill-trained or inadequately trained underwriters were put on the job, both the consumers and insurers would suffer from serious but avoidable problems. Any amount of homework may be found not enough for the problems that consumers and brokers may pose.

This article would also analyze how even in the sale of non-tariff covers like the Mediclaim insurance, insurers have probably misread the data available with them; and are going after consumers that may not be responsible for their major losses. It is hoped that detariffing would confer benefits on consumers as well and it would not merely result, as a weapon to fight competition.

Tariffs & Underwriting:

Till now underwriting, as it is commonly understood in free markets, of acceptance of risks and pricing them adequately, has been the basic statutory function of the Tariff Advisory Committee in the segments of fire, engineering, motor and workmen's compensation portfolios that control over 70 percent of the market premium. The tariffs are prescriptive both in cover wordings and the minimum prices to be charged by insurers. It is a sort of cartel of insurers; and punishments are meted out to those insurers that breach them. It has imposed strict disciplinary standards on the insurers rather than on the consumers, who had no choice but to submit to the requirements demanded by insurers. The saving grace in the entire process, for the consumers has been that the minimum tariff rates also became, in reality, the maximum rates that got charged. Indian market has seen tariff structured rates for the last five decades or more.

> The tariffs are prescriptive both in cover wordings and the minimum prices to be charged by insurers. It is a sort of cartel of insurers; and punishments are meted out to those insurers that breach them.

With liberalization of the market and the entry of foreign players through joint ventures, the logical extension of freeing the last of the controls on doing business is now sought to be removed. Market forces of supply and demand of products and services would fix the pricing and cover mechanisms. The IRDA has announced a road map to take effect from 1st January 2007 and the details are getting fine-tuned.

Role of an Underwriter:

What is the role of an Underwriter in a free market? How would he be guided to set rates and cover provisions and its limitations? What knowledge, skills and expertise should he possess to discharge his functions and responsibilities, in a fair manner, both to his employer and to the consumers? What are the insurers currently doing to get ready and be battle trim to face competition, not only based on elements of customer service, post-sales; but also before even a product gets sold on

pricing and cover issues? How would consumer buying behavior profiles change? What roles should the distribution channels play?

These questions need answers and a broad consensus has to be developed on how all the stakeholders to this single objective should play their respective roles. Should it eventually turn out that each stakeholder would only play for his selfish financial ends, market chaos might ensue that would not be beneficial to anyone.

What a good underwriter needs:

- An Underwriter needs to know the risk features and factors of every risk offered for acceptance. His risk analysis must determine the serious physical hazards inherent in the particular risk and the steps taken by an insured to minimize them. He should be able to visualize the risk even if he did not visit it, from the reports given and from the detailed proposal form furnished. The above pre-supposes that the insurer provides him with the expertise needed in respect of each industry that he is asked to underwrite.
- An Underwriter should be aware of the minimum risk management steps to impose by insurers in respect of each risk. He should evaluate the risk management steps a proposer on his own has implemented: such as safety audit measures; staff drills to fight fires and breakdowns; investigations and remedial steps taken to prevent recurrence of fires and breakdowns etc.
- The moral hazard of the proposer in respect of house-keeping, staff relations, compliance with legal enactments, the effectiveness of corporate governance and past claims experience; and steps taken to avoid recurrence of accidents.
- The environmental issues of a proposer such as his competition, peculiarities of his particular trade or business and its vagaries must also be evaluated.
- The Underwriter should be exposed to the claim occurrences of the risks that he usually accepts.
- A report of an insurer quoted that: whereas they issued one crore polices in the year 2005/06, the claims reported in the year were about six lakhs. This shows that the claims frequency in India is a very low 6 percent, unlike in international markets. If losses are incurred, it is entirely due to the severity of losses that need more investigation to reduce their impact.
- If there are consumers to the tune of 94 lakhs that do not put in claims, they should not be equated with others, by charging them more; as a part of solving the issue of poor risk exposures in case of 6 lakh customers.
- IT familiarity to extract data and information, and analytical skills to reduce problems to their bare bones is another skill that is needed.

> The frequency of claims reporting thus is 3.8 percent that is even lower than the company's overall frequency reporting of 6 percent. Yet the claims experience of the insurer is over 120 percent.

Medi-claim underwriting:

Medi-claim insurance cover is one of the fastest growing portfolios, at an annual growth rate of 38 percent. The business is entirely consumer driven. It deserves a special mention in this article, as it is the third largest portfolio of insurers after motor and fire. It began to be transacted only in 1987.

- One insurer has reported, in the annual financial statements for 2005/06, that they had covered 32 lakh persons under this class of business in the year under review. The claims reported in the year are 1.2 lakhs. The frequency of claims reporting thus is 3.8 percent that is even lower than the company's overall frequency reporting of 6 percent. Yet the claims experience of the insurer is over 120 percent.

- Should medi-claim premiums be raised for over 30 lakh insured that did not report any claims for the sake of 1.2 lakh claimants? There is a need to analyze and categorize the claimants: are they from metros? Or are they from corporate and group insured?
- Remedial action has to be taken after analyzing the pattern of claims lodged by this select group of 1.2 lakhs.

This example is quoted to show that one of the basic functionalities of an underwriter should be that he should not merely be led by the overall claims experience of the insurer that may be bad; but who and what is causing them and whether the issue can be tackled by categorizing the claimants and dealing with that particular category, rather than penalize the entire medi-claim insured community. There is thus a need for an underwriter to make a choice of what solution would offer to keep good customers with the insurer and how to weed out those that have caused regular or high losses, as can be seen from their track record of claims.

Here, developing customer profiles would go a long way in terms of retention of those customers that are asked to leave the fold of insurers either because there is no information on customer loyalty in terms of length of relationship or profitability that one has given due to no claims having been lodged. The lumping of loyal and good customers with those that are claimants of high severity resulting in rate raising for all would be a self-defeating proposition, in the absence of segregating customer data and profiles.

Final word:

The role of an underwriter is at the heart of business acceptance. Public sector with their highly decentralized set up has given liberal underwriting authority to lower formations. Technical mastery is centralized at the Head Offices. How can they match these two aspects in a competitive environment? With lack of customer profiles and with audit and other restrictions, what assurances could one give the underwriters?

> The lumping of loyal and good customers with those that are claimants of high severity resulting in rate raising for all would be a self-defeating proposition, in the absence of segregating customer data and profiles.

Like all issues, the detariff situation eventually would find its own levels sooner or later. But in the interim, insurers would have to deal with unexpected situations that, with the best of preparations, is difficult to visualize. If this leads to occasional loss of business, one can hit the panic button. Since non-life products are due for renewal every year, there is a chance to regain lost business. But basic fundamentals of underwriting should be ingrained to sustain insurers over the long haul.

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[1] *Claims frequency here is defined to mean Number of claims per policy exposed during the period under consideration.*

[2] *Average claims severity means Amount of claims incurred divided by number of claims during the period in consideration.*

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Underwriting in a Detariffed Market

- Impact on the Cross-Subsidization Phenomenon

'Underwriting requires a kind of discipline which can exist only if all the insurers work collectively towards a common interest - that of a healthy bottom-line' writes Meena Nair.

Introduction

There is an often-heard debate in the insurance industry. Is underwriting a science or an art? While there is no conclusive answer to this, the fact that it is heavily reliant upon statistics and data, tilts the scales towards it being a science. While the collecting of data and analyzing it is a science, the art of applying this analyzed information into insurance underwriting is an art. In this article, we go on to discuss whether it is getting its due care i.e. is underwriting being done after studying the risk, and more specifically what impact de-tariffing would have on the phenomenon of cross subsidization .

What is underwriting?

Underwriting is the expertise required by the insurer in acceptance of a risk, weighing all the pros and cons in analyzing the risk. The terms, conditions, deductible etc. would need to be well analyzed for arriving at the premium rate chargeable and the risk accepted by the insurer.

What is the present state of underwriting?

Underwriting generally works in cycles of hard (where demand exceeds supply) and soft (vice versa) markets. For instance, following the 9/11 tragedy, the terrorism market had hardened and the number of insurers willing to accept the risk of terrorism was on a decline. The terrorism market is now soft.

Underwriting requires a kind of discipline which can exist only if all the insurers work collectively towards a common interest - that of a healthy bottom-line. In a newly 'opened-up' market like India, discipline would naturally take second position to top-line (premium) growth till the players establish themselves and reach a stage of maturity. As a result, the market has seen various hues of underwriting discipline at various stages - starting from an 'at-any-cost' scramble for large, attractive corporate risks; to a cooling off and re-alignment towards more profitable lines and retail markets by some insurers.

Underwriting is the expertise required by the insurer in acceptance of a risk, weighing all the pros and cons in analyzing the risk. The terms, conditions, deductible etc. would need to be well analyzed for arriving at the premium rate chargeable and the risk accepted by the insurer.

One of the more interesting phenomena of underwriting in a liberalized yet tariffed market has been the concept of cross subsidization.

What is Cross-Subsidization?

Every risk has a 'pure-risk' rate of premium that an underwriter basically recommends as a sound and viable rate. Commercial considerations may then prevail (for instance, the marketing team's eagerness to retain an important client); and the final rate charged may be far lower than the "pure-risk" rate. In a tariffed market, this reduction could only have been extended to Non-Tariff products like Health, Accident, Marine, Miscellaneous etc.

Cross subsidization is basically the acceptance of a Non-Tariff risk at less than the "Risk-Rate" recommended (read: accepting a loss portfolio) because it is being offset by a significant volume of Tariff Premium from the same customer. In effect, the "profitable" tariff lines are subsidizing the "unprofitable" non-tariff lines - leading to a cross-subsidy across product lines.

During recent years, we have all heard cases of Marine being quoted at nominal rates (almost as a free add-on cover) and Group Health policies getting renewed at as low as 50-60% of average claims paid over the last 2-3 years. These are clearly examples of commercial considerations over-ruling underwriting principles.

On a macro level, if you ignored the fact that a particular line was doomed for consistent underwriting losses, cross subsidization was a Win-Win proposal for both the insurer and the customer. Thanks to a high-priced and rigid Tariff rate, the insurer was making an 'obscene' profit from around 60-80% of the customer's premium portfolio. Companies with sound risk management practices and favourable loss records felt, perhaps justifiably, that they deserved commensurate benefit somewhere else. Insurers, on their part, were naturally eager to oblige in

the non-tariff area, so long as the overall customer portfolio was profit-making (in effect, the insurer was collecting a 'higher than pure risk' rate on the Tariff component and a corresponding 'lower than pure risk' rate on the Non-tariff component.

Impact of De-tariffing on Cross Subsidisation

Most insurers have different goals. While one may want top line growth, the other may yearn for underwriting profits. Yet another may be aggressive only in particular lines of business; and another may try his best to balance both, the top line and bottom line. Until now, with 70% of the market falling under the tariff, there was no sufficient reason to suspect that there would be an imbalance in the acceptance of risks in the industry. There is a possibility that in the market post Jan 1st, 2007; this balance could be in jeopardy, at least initially. It would be only a price game with almost all the insurers keen on volumes. Consequently, there could be a sharp drop of about 20-25% in the prices of hitherto "tariffed" lines. In the areas of Fire, followed by Engineering, being considered as the more 'profitable' businesses; all insurers would vie to have the icing on the cake **at any cost**. With the IRDA opening the door only for freedom in pricing (freedom to negotiate clauses, terms and conditions etc will be allowed only in 2008), a price war is a near-certainty.

What then will happen to the above-mentioned Non-Tariff products? Will they continue to enjoy any subsidies at all?

The commonly-held belief is that Cross Subsidies will slowly but surely come down. With the progressive drop in prices of Fire and Engineering covers as outlined above, insurers will have to start pricing their Health & Marine portfolios more realistically and follow the underwriters' guidelines.

In effect, companies which enjoyed ridiculously low Marine rates and Group Health renewal prices; will be well-advised to prepare for a hike in their outflow. At the same time, customers with large Tariff premiums (eg: large well-managed manufacturing & construction companies) are expected to have a net benefit (with a drop in tariff and hike in non-tariff premium). Others like IT & services Companies (where health & marine premium dominate) are expected to suffer a net increase in premium pay-outs.

An intermediary's role in a detariffed regime

A de-tariffed market would certainly enhance the role of the broker. Both, the insurer as well as the customer would need the services of a professional broker.

The brokers would not merely participate in the price war but would need to give quality submissions to the insurers conveying all the material and non material aspects of the risk to be covered. He would be the catalyst between the customer and the insurer and assist in guiding the competition along healthy lines and ensure the sustenance of the parties involved. He will play the role of a consultant in the true sense; and risk management in the true sense would require to be advised.

> Corporates with sound risk-management practices stand to benefit in the long run; and all medium and large companies would be well-advised to focus on this aspect of their operations instead of merely negotiating a short-term price advantage.

To get the best rate from the insurer he would need to

- Have knowledge of individual risk peculiarities and the industry as a whole.
- Be able to assess as to what could be the maximum potential losses that the risk & a peril could produce.
- Estimate the customer's capabilities for prevention and minimization of losses.
- Suggest the indicative rates, terms, and conditions and deductibles.
- Assess the moral hazard relating to the customer.

The quality of the homework done by the Broker; and the data on losses and quality of risk collected and submitted by him will go a long way in pricing the risk scientifically. Where non-tariff premium is shooting up, the Broker can advise on loss control mechanisms to avoid a steep increase (eg: analysis of Health claims and designing a more cost-effective coverage for employees and dependants).

Conclusion

All indications point to a price war for Tariff lines to begin with, with a gradual cooling off over a year or two. As the market stabilizes, and insurers move from "top-line" to "bottom-line" focus, underwriting practices are expected to improve.

The effect of all this on Cross Subsidies remains to be seen - large, well-managed companies will continue to ask for a portfolio-based, and not a line-wise, pricing model. And insurers will continue to oblige. Corporates with sound risk-management practices stand to benefit in the long run; and all medium and large companies would be well-advised to focus on this aspect of their operations instead of merely negotiating a short-term price advantage.

As India Inc. moves towards improved corporate governance in other areas, it is hoped that de-tariffing and the consequent improvement in underwriting practices, will provide the much-needed impetus for corporates to adopt better risk management practices.

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The author is Vice President, India Insure Risk Management Services P Ltd.

ISSUE FOCUS

Undoing Adverse Selection

- Life Insurance Underwriting

'Continuous analysis of the data relating to life insurance and pension business is one of the key drivers of sustained growth of the industry' says D.V.S. Ramesh.

Of all those operational functions of an insurer, it may be accepted that underwriting is truly a technical subject. The underwriting policy of an insurance company is rarely designed by itself without the involvement of its nearest stakeholder - the active role of an outside entity that claims its stake in its strategy namely the reinsurer, who has an equal stake in the designing of a prudent underwriting policy.

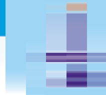
Underwriting in its simple meaning is acceptance of insurance business. Unlike in other areas of business; in insurance, not everybody who is to willing to pay a price will be sold a life insurance product, unless he qualifies to be a suitable individual to buy insurance commensurate with his individual needs. Hence, the need to assess an individual's requirement, his paying capacity, his categorization to determine the quantum of price etc. forms the entire picture. A comparison of buyer and seller in normal businesses assessing each other's products and prices with that of insurance product may reveal an interesting way of dealing. In case of tangible products, say a television, the buyer assesses the types of products he chooses to purchase and once the decision of opting for a particular product is reached the role of seller is limited to complete the sale and it is the buyer who assesses the quality of the product he is taking during the process of sale. But in an intangible service product like life insurance, the buyer's role will be limited to analyzing the product he chooses to take during the pre- sale process and once a decision is taken to opt for a particular product, he cannot claim to be the owner of that product as the seller will step in to prudently exercise his choice of selecting the buyer.

Is underwriting essential?

Before entering into the intricacies of underwriting, it may be worthwhile to place the rationale behind the underwriting operations of a life insurer. Business of life insurance is embedded with an element of social responsibility with its origin in a co-operative endeavour of 'one for all and all for one'. It is expected that the group of policyholders who have taken insurance policies on their respective lives are supposed to have come forward to share the burden of compensating the monetary loss of deceased individuals' dependants to mitigate their monetary strains. Hence, every individual who is taking a policy of life insurance has a stake on the lives of others who are joining to take such life policies. If all the individuals that are joining the group to take life policies happen to be below par (sub-standard in underwriting parlance) lives, it affects the interests of the genuine joiners of the group due to draining away of the funds by way of death claims. This is referred to as 'adverse selection' in insurance parlance. Here comes the role of the insurer who manages the life funds as part of his responsibility of protecting the interests of genuine policyholders. Besides, the life insurer holds the social responsibility of extending the life insurance coverage at a fairly reasonable price to all sections of the society. This can be ensured if only healthy lives select the insurer and constitute his portfolio. Hence, the need for selection of lives by assessing and classifying the prospects through a process called underwriting for a viable life insurance business.

If all the individuals that are joining the group to take life policies happen to be below par (sub-standard in underwriting parlance) lives, it affects the interests of the genuine joiners of the group due to draining away of the funds by way of death claims.

The manner in which a life insurer designs the underwriting policy depends on various factors like the experience of the life insurer, the ability to retain the risk and the type of products offered etc. The underwriting of an individual life is done in two stages. The life insurance advisor/agent screens the particulars of the life to be assured before canvassing the policy. In view of the nature of the business, the life insurer depends on the agent/advisor to ensure that the particulars revealed by the life to be assured are true and fair. Hence, an insurance intermediary is hailed as a first line underwriter.



Once the application is submitted, the underwriter of the life insurer assesses and classifies the risk to be assumed. For this function, an underwriter relies on various documents submitted by the prospect like proposal form, proofs of income, identity etc. Based on the disclosures in the proposal form, an underwriter may exercise his discretion of calling for a medical report or any further diagnostic reports. Owing to the fact that these are the documents that determine whether or not the prospect is entitled for a life policy and if so at what premium; it is necessary for the insurer to collect as much information as possible; and the proposal form is designed accordingly. Based on the disclosures made by the prospect, the underwriter determines if it is required to call for any further information. Hence, the proposal form should contain such questions and in such a manner as to draw the attention of the prospect to the importance of revealing all the information.

During the pre-nationalisation phase, some insurance companies used to classify all the Indian prospects as substandard lives. Some Indian insurance companies, however, started rating the eligible Indians as standard lives, not just based on the nationality of the applicants. It is apt to mention here that as per Section 2606 of insurance law of New York, there shall be no discrimination because of race, colour, creed or nationality. Also as per Section 2607 of the same Act, there shall be no discrimination because of sex or marital status. It is praiseworthy to note that no Indian life insurer did ever discriminate at the time of underwriting a prospect's life on factors that do not influence the risk, though there is no statute that prohibits the life insurers in doing so. This indicates the true professionalism of the life insurers' method of selecting the lives from the very beginning of their operations.

Underwriting is done by the life insurer in two stages - the financial underwriting and the medical underwriting. Financial underwriting deals with determining the eligible total amount of life assurance coverage while medical underwriting determines the types of the medical/ diagnostic reports to be called for based on the type of product applied for and the disclosures made in the application form.

Despite having a prudent underwriting policy, the life insurers still may face certain areas of concerns while accepting the lives. Existing life insurance coverage on the life of a prospect is one of the core issues that affect the underwriting decision of a life insurer. Even in the post-nationalisation period, this has been a critical issue as it was very difficult to track if a prospect takes a multiple number of policies from various operational offices of the life insurer. The absence of a developed technology to track the number of policies based on the name and date of birth of the prospect was also an issue. Absence of an industry level information sharing system at least at the time of settling early death claims may vitiate the objectives of having in place a prudent underwriting policy. Application preferred by the sub-standard lives whose policies were declined by other life insurers is another area of concern. To counter these problems the industry should resort to developing a robust system to avoid a possible adverse selection against life insurers. Internally, every insurer should have a close monitoring of the cases of early death claims, and should check if any issues in its underwriting policy are to be plugged. Modifying the policies based on one's own experiences will go a long way in shaping a prudent underwriting policy.

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There are certain other issues that are closely associated with the subject of underwriting.

Mortality and Morbidity Investigation Bureau (MMIB):

Continuous analysis of the data relating to life insurance and pension business is one of the key drivers of sustained growth of the industry. The cost of insurance and the annuity rates will not remain unchanged. The developments in the medical field, changing life styles and advancement of medical technology are a few factors that are to be studied to monitor whether or not the mortality and morbidity tables in use are in tune with present day requirement. Studies of this bureau, which was constituted jointly by Life Insurance Council and Actuarial Society of India, will help the insurers tune their underwriting policies for determining the extra mortality rates for sub-standard lives and to ensure the fair price to the standard lives.

Underwriting - A profession (?):

Though, it is widely accepted that underwriting in insurance industry is one of the technical areas, the underwriting profession has neither evolved nor been nurtured on professional lines. Absence of an exclusive professional course catering to the needs of the industry could be one of the contributing factors. In some of the advanced markets there are such certificate courses (CLU - Certified Life Underwriter & CPCU - Certified Property and Casualty Underwriter in USA) in underwriting for both life; and property and casualty (non life insurance) segments. Prescribing

a manual-driven underwriting decision may impair the objective assessment of individual cases based on the disclosures made in the proposal form. Just as at times it requires lifting the corporate veil to look in to the management practices of the companies; an underwriter could go beyond the disclosures of the proposal forms, especially in cases where moral hazard is involved, for which technical expertise in the specific area is paramount. Post liberalisation, the industry is gradually tapping the services of the qualified medical professions for their underwriting divisions. Doctors being aware of the consequences of various impairments disclosed both in the personal and family history will be in a position to gauge the risk more meticulously. In light of the developments taking place in the industry, developing an exclusive course may be largely beneficial to the underwriters for furtherance of their technical skills.

Need to educate the intermediaries: Despite the emergence of the other alternate channels, a one-to-one interaction with a prospect will be intact in the near future; hence the role of an intermediary remains pivotal in ensuring the prudent underwriting policy of the life insurers. With the introduction of mandatory training requirements, though this need would have been successfully met, with the emergence of special classes of businesses like micro insurance and health insurance, there may be felt a need to impart the fundamental knowledge (surface level) of underwriting issues of these classes, say about the covariate risk in case of micro insurance etc.

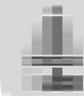
Effects of development in medical technology: Progressive development in the medical technology is a boon to the human race. It is not only reducing the pains of the suffering individuals but also enabling them to avoid a possible recurrence through timely diagnostic services. Some of these tests, like genetic tests, indicate the probability of an individual's exposure to the risk. While the fears of insurance industry using these advanced developments in rating the individual's lives are making the rounds, there is a possibility of prospects using these tests leading to adverse selection. Some markets placed a voluntary moratorium against seeking information pertaining to the genetic tests undergone for clinical reasons, as the prospects could be under the notion that this information could eventually affect the insurance decisions pertaining to their near relatives. However, this issue has no immediate significance in our country due to unavailability of these tests.

> Post liberalisation, the industry is gradually tapping the services of the qualified medical professions for their underwriting divisions.

Changing paradigms in lifestyles - Affects on underwriting decisions: With increased urbanisation, most of the habitats in urban areas are choked with contagious problems like air pollution, increased presence of carbon monoxide due to increased vehicular traffic etc. Lack of proper assessment of these lives could lead to an indirect cross subsidisation of the premium rates. Assessing these factors based on supporting data by institutions like MMIB may ensure fair pricing in the long run based on the life styles of individuals. In the detariffed regime, a motor car would be having a determinable rate based on various factors that may affect its safety; similarly, long term life insurance coverage does deserve to consider the related issues of the individuals for charging a fair price. Occupation is considered as one of the key elements affecting the longevity of the lives in life insurance. Stressful occupations may be termed as additionally deleterious to the current generation. While their job itself is subject to stress, the biological factors will further contribute to health hazards. Researches have revealed that stress will have serious adverse effects like increased risk to cardio vascular diseases, gastro-intestinal problems, depression, sleeplessness and more a dreaded disease like cancer. Gauging the levels of stress by a mere cursory look at the occupations is next to impossible. Continuous monitoring of the data relating to various occupational matters by the institutions like the one that is referred above will enable the insurance companies to devise suitable underwriting policies. It is reported by the World Health Organisation that 50% of world heart attacks will be from India by the year 2012; and the proneness of young Indians is likely to be 12 - 15 times higher when compared to other ethnic groups in the world. (Source - Times of India 24.09.2006)

Though the concept of underwriting has undergone a sea change over the last few decades (like introduction of non medical underwriting for high sum assured, calling for mandatory special diagnostic reports like Elisa tests for high sum assured cases etc.), it is sure to witness more developments in the years ahead especially in the light of the above referred issues to ensure a fair price to the genuine policy holders.

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



A Model for Health Insurance for the Poor in India - Part II

- (Continued from the previous issue)

Debasis Bagchi asserts that a likely viable model for providing the poor an effective health insurance must include building up awareness; and providing initial and basic health service and referral activities as service provider.

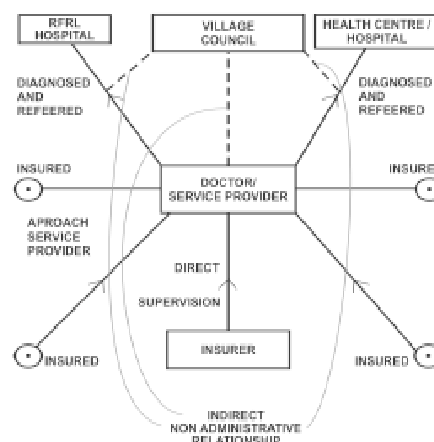
Section VI - A Viable Model

The analysis given earlier points to some basic reasons for failure. First, the severe hindrances faced by the poor in the access of quality health care services coupled with failure of the government to build up an affordable health care infrastructure, stand out to be big impediments in the way of providing an acceptable level of health care services to the poor. Second, a large section of the poor would simply avoid treatment due to their extreme poverty, as they are unable to bear the cost of treatment and although they appreciate and feel the need for alternate source of fund for meeting the medical expenses, yet they are not inclined to take cover under health insurance. Even they reject the idea of involving NGOs or reputed social service organization to help them in this regard. Under such conditions, a likely viable model for providing the poor an effective health insurance must include building up awareness and providing initial and basic health service and referral activities as service provider.

As the circumstances suggest, the insurers are required to be intimately associated with the insured to provide services at their doorsteps. Otherwise lack of infrastructure and the basic health care services would render these people to reject the insurance coverage since no benefit will accrue to them at the time of their need. The insurer at the start is required to adopt a specific geographical area, conveniently a village, for induction of the scheme and gradually develop it.

Accordingly, the model envisages a two dimensional approach, viz., the model should be people centric and community based. The scheme should be simple, easily understandable and least problematic for processing of the claim. The model should ensure that once medical treatment becomes necessary for the insured, the service provider should arrange for it. In such cases therefore, service provider should be a qualified allopathic doctor employed for the purpose. He is required to perform a dual role, (1) act as a representative of the insurer and (2) advise medical treatment of the insured including referral advice. For the proper administration of the scheme the model involves the village elective council to play a major role. Diagrammatically, the model can be represented as below:

> Lack of health care services and infrastructure, high illiteracy, lack of trust on the health insurance schemes stand out to be most important factors that impede the acceptance of health insurance by the poor people.



Conclusion

The health insurance for the poor could be an effective alternate mechanism for providing much needed health security to the most neglected section of the society. However, the government's effort to introduce a universal health insurance with a very low premium for the poor meets with a complete market failure. In order to find out the economic, environmental and psychological factors that are responsible for the failure, we carry out a pilot survey of one hundred households, predominantly belonging to the poorest section of the society. Analysis reveals several interesting facts. Lack of health care services and infrastructure, high illiteracy, lack of trust on the health insurance schemes stand out to be most important factors that impede the acceptance of health insurance by the poor people. The poor servicing and incomprehensibility of the health insurance by the poor people are also partly responsible for the failure. These factors finally culminated in the ultimate rejection of the product by the targeted mass. After assessing the finer points of failure, a viable model for the scheme is suggested that is developed on a two dimensional approach, viz., employment of a service provider, who should be a doctor and also involvement of the village council to help in the administration of the services to be rendered. The coverage should be specific and payment of claim should either be cashless or be prompt. This people centric and community based approach is expected to yield the desired results.

Table - I : AGGLOMERATION SCHEDULE

	Cluster Combined		Coefficients	Stage Cluster First Appears		Next Stage
Stage	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	97	98	.000	0	0	2
2	87	97	.000	0	1	5
3	93	95	.000	0	0	96
4	92	94	.000	0	0	5
5	87	92	.000	2	4	7
6	88	90	.000	0	0	90
7	87	89	.000	5	0	91
8	85	86	.000	0	0	9
9	2	85	.000	0	8	11
10	83	84	.000	0	0	11
11	2	83	.000	9	10	13
12	81	82	.000	0	0	13
13	2	81	.000	11	12	15
14	79	80	.000	0	0	15
15	2	79	.000	13	14	20
16	41	78	.000	0	0	50
17	74	77	.000	0	0	20
18	75	76	.000	0	0	19
19	1	75	.000	0	18	23
20	2	74	.000	15	17	29
21	71	73	.000	0	0	23
22	69	72	.000	0	0	25
23	1	71	.000	19	21	26
24	68	70	.000	0	0	26
25	31	69	.000	0	22	31
26	1	68	.000	23	24	47
27	44	67	.000	0	0	47
28	64	65	.000	0	0	29
29	2	64	.000	20	28	42
30	61	62	.000	0	0	31
31	31	61	.000	25	30	33
32	59	60	.000	0	0	33
33	31	59	.000	31	32	36
34	36	58	.000	0	0	55
35	56	57	.000	0	0	36
36	31	56	.000	33	35	43
37	49	55	.000	0	0	43
38	50	54	.000	0	0	42
39	52	53	.000	0	0	40
40	13	52	.000	0	39	48
41	43	51	.000	0	0	48
42	2	50	.000	29	38	44
43	31	49	.000	36	37	51
44	2	48	.000	42	0	72
45	40	47	.000	0	0	51
46	9	45	.000	0	0	65
47	1	44	.000	26	27	54
48	13	43	.000	40	41	64
49	16	42	.000	0	0	67
50	4	41	.000	0	16	56
51	31	40	.000	43	45	53
52	38	39	.000	0	0	53
53	31	38	.000	51	52	58
54	1	37	.000	47	0	83
55	29	36	.000	0	34	63
56	4	35	.000	50	0	67
57	33	34	.000	0	0	58
58	31	33	.000	53	57	59
59	31	32	.000	58	0	88
60	7	8	3.000	0	0	76
61	3	22	5.000	0	0	62
62	3	21	5.500	61	0	72
63	24	29	7.000	0	55	86
64	13	14	9.000	48	0	68
65	6	9	11.000	0	46	71
66	11	12	13.000	0	0	73
67	4	16	14.000	56	49	69
68	10	13	15.167	0	64	69
69	4	10	16.857	67	68	71
70	19	20	18.000	0	0	79
71	4	6	18.564	69	65	73
72	2	3	19.667	44	62	76
73	4	11	22.063	71	66	75
74	27	28	24.000	0	0	77
75	4	15	25.389	73	0	80
76	2	7	25.711	72	60	87
77	26	27	26.000	0	74	79
78	25	30	27.000	0	0	84
79	19	26	34.333	70	77	81
80	4	63	35.895	75	0	83
81	19	23	36.200	79	0	85
82	5	17	37.000	0	0	84
83	1	4	45.100	54	80	85
84	5	25	46.500	82	78	86
85	1	19	48.756	83	81	87
86	5	24	55.625	84	63	89
87	1	2	57.718	85	76	92
88	31	46	60.000	59	0	93
89	5	99	73.625	86	0	92
90	18	88	75.000	0	6	95
91	87	91	78.000	7	0	93
92	1	5	80.503	87	89	95
93	31	87	87.090	88	91	94
94	31	96	104.885	93	0	96
95	1	18	110.020	92	90	97
96	31	93	112.519	94	3	97
97	1	31	129.460	95	96	0

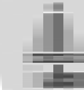


Table - II :
INITIAL CLUSTER CENTERS

	Cluster 1	2	3	4	5
Attribute 1	1.00	5.00	5.00	1.00	1.00
Attribute 2	4.00	4.00	5.00	5.00	5.00
Attribute 3	3.00	5.00	3.00	1.00	3.00
Attribute 4	5.00	5.00	5.00	5.00	5.00
Attribute 5	5.00	3.00	5.00	5.00	5.00
Attribute 6	3.00	5.00	5.00	1.00	1.00
Attribute 7	5.00	1.00	5.00	5.00	5.00
Attribute 8	5.00	1.00	5.00	5.00	5.00
Attribute 9	5.00	2.00	5.00	5.00	5.00
Attribute 10	1.00	1.00	5.00	1.00	1.00
Attribute 11	1.00	5.00	5.00	1.00	1.00
Attribute 12	1.00	1.00	5.00	1.00	1.00
Attribute 13	2.00	4.00	5.00	1.00	5.00
Attribute 14	2.00	5.00	5.00	1.00	5.00
Attribute 15	5.00	1.00	5.00	5.00	5.00
Attribute 16	1.00	2.00	5.00	4.00	1.00
Attribute 17	4.00	5.00	5.00	3.00	5.00
Attribute 18	1.00	5.00	5.00	5.00	1.00
Attribute 19	1.00	5.00	5.00	5.00	1.00
Attribute 20	1.00	5.00	5.00	5.00	1.00
Attribute 21	4.00	5.00	5.00	3.00	1.00
Attribute 22	1.00	4.00	5.00	5.00	5.00
Attribute 23	1.00	1.00	5.00	5.00	5.00
Attribute 24	3.00	1.00	5.00	1.00	3.00
Attribute 25	3.00	5.00	5.00	1.00	3.00
Attribute 26	5.00	4.00	5.00	1.00	5.00
Attribute 27	1.00	5.00	5.00	1.00	5.00
Attribute 28	1.00	5.00	5.00	1.00	5.00

ANALYSIS OF VARIANCE

	Cluster Mean Square	df	Error Mean Square	df	F	Sig.
Attribute 1	26.681	4	.492	93	54.209	.000
Attribute 2	6.988	4	1.250	93	5.592	.000
Attribute 3	11.217	4	1.114	93	10.070	.000
Attribute 4	5.631	4	1.385	93	4.065	.004
Attribute 5	3.957	4	1.142	93	3.466	.011
Attribute 6	17.987	4	.418	93	43.041	.000
Attribute 7	44.320	4	.594	93	74.640	.000
Attribute 8	52.750	4	.627	93	84.125	.000
Attribute 9	11.488	4	.911	93	12.607	.000
Attribute 10	3.227	4	.415	93	7.768	.000
Attribute 11	62.905	4	.504	93	124.897	.000
Attribute 12	9.561	4	.576	93	16.588	.000
Attribute 13	34.008	4	.407	93	83.474	.000
Attribute 14	22.451	4	.557	93	40.283	.000
Attribute 15	33.445	4	.854	93	39.167	.000
Attribute 16	18.109	4	1.352	93	13.390	.000
Attribute 17	5.498	4	.897	93	6.131	.000
Attribute 18	55.696	4	7.715E-02	93	721.932	.000
Attribute 19	22.946	4	.554	93	41.450	.000
Attribute 20	22.798	4	.502	93	45.446	.000
Attribute 21	4.657	4	.837	93	5.565	.000
Attribute 22	6.226	4	.700	93	8.889	.000
Attribute 23	26.643	4	1.553	93	17.159	.000
Attribute 24	3.878	4	1.221	93	3.177	.017
Attribute 25	8.621	4	.636	93	13.546	.000
Attribute 26	2.373	4	.318	93	7.451	.000
Attribute 27	19.917	4	.447	93	44.519	.000
Attribute 28	19.199	4	.792	93	24.230	.000

Table - IV :
DISTANCES BETWEEN FINAL CLUSTER CENTERS

Cluster	1	2	3	4	5
1	0.000	9.398	8.668	7.253	9.559
2	9.398	0.000	6.265	7.757	12.697
3	8.668	6.265	0.000	7.512	10.177
4	7.253	7.757	7.512	0.000	11.553
5	9.559	12.697	10.177	11.553	0.000

The F tests are used only for descriptive purposes because the clusters have been chosen to maximize the differences among cases in different clusters. The observed significance levels are not corrected for this and thus cannot be interpreted as tests of the hypothesis that the cluster means are equal.

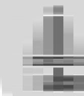
Appendix - I

Questionnaire

Name:	Age:	Sex:
Occupation:	Income:	No of dependent family members:
Education:		

1. Strongly agree
2. Agree
3. Can't decide
4. Disagree
5. Strongly disagree

Sl no	Questions (Attributes)	1	2	3	4	5
1	If you are sick you will go to the nearest town for treatment(3)					
2	If you are sick you will go to the rural health center for treatment(2)					
3	If you are sick you will go to rural private practitioner for treatment(1)					
4	If you are sick you will depend on alternate medical treatment, like homeopathy, which costs much less than allopathic treatment					
5	If you are sick you will go to quacks for treatment(6)					
6	You can bear your medical expenses comfortably(7)					
7	You need to take loan for your catastrophic medical expenses(8)					
8	You need to sell assets for your catastrophic medical expenses(9)					
9	You will need charitable monetary help from your relatives or acquaintances in case of catastrophic medical expenses(10)					
10	You feel that the health center of your village is not well equipped and/or that rural practitioners lack knowledge and experience(5)					
11	You want private nursing homes for your treatment					
12	You want alternative sources of money to meet your medical expenses					
13	You would like to join a health insurance scheme where you may be paid up to Rs 30,000 for hospitalization					
14	You would like to pay Rs 165 annual premium for this purpose					
15	You are not able to pay even Rs.165 at a time					
16	You are able to pay the premium but the scheme has no credibility					
17	You would like to consult an informed person/family friend before you decide to join such scheme					
18	You don't like to join any health insurance scheme because you perceive poor servicing from the agent of the insurance company					
19	You don't like to join any health insurance scheme because you perceive lot of hassles during settlement of claim					
20	You don't like to join any insurance scheme because in the past fraud or misfeasance occurred in some other schemes					
21	You don't like to join any health insurance scheme because you would then have to visit urban branches or urban nursing homes which you cannot because of your own inconvenience					
22	You would like to take community initiative to health insure the poor people of your locality for their economic upliftment					



23	You would like to take initiative to health insure the poor people of your lo cality, if you are given remuneration for this					
24	You want others to take initiative to enroll you in universal health insurance scheme					
25	You want the government to take initiative, like opening up rural branch of insurance companies or appointment of rural agents to enroll you in the scheme					
26	You want very famed charitable non profit organizations like, Ramakrishna Mission, Bharat Sevashram Sangha etc. and other NGOs to enroll you in the health insurance scheme					
27	You would be more interested in the schemes if you get some additional benefits (like, out-patient expenses) from the scheme					
28	You would be more interested in the schemes if you get some cash refund in case of no claim					

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प्रकाशक का संदेश

यदि बीमाकर्त्ता को बीमा व्यवसाय में सफलता प्राप्त करनी है तो उन्हें बहुत निपुर्णता तथा कुशलता के साथ बहुत से कार्यो को पुरा करना होता है। उदाहरणतः निवेश, एक ऐसा क्षेत्र है जिसकों वित्तिय बाजार की विशेष जानकारी तथा विशेष कुशलता के साथ देख्ना पड़ता है। फिर भी बीमा बाजार का सबसे महत्वपूर्ण कार्य बीमालेखन ही है। बीमाकर्त्ता के लिए यह संभव हो सकता है कि वह कुछ बुरे निवेश निर्णयों को अवशोषित का सके लेकिन कुछ बुरे बीमालेखन निर्णय बीमाकर्ता के लिए बिपदा की स्थिति उत्पन्न कर सकते हैं।

पक्षो कें बीच स्वतन्त्र तथा उचित सूचना का आदान प्रदान ही बीमा लेखन कि सफलता को सुनिशचित करता है। एक ऐसा बाजार जो अपने विकास के शैशव काल मे है। सूचना प्रवाह के लिए आधारभूत आवश्यकता होगी विशेष रूप से जब भावी सूचना के प्रकटीकरण की बात हो। यह बीमालेखकों के कार्य को अधिक महत्त्वपूर्ण इस दृष्टि से बनाता है कि प्रदान की गई सूचना अधिक से अधिक सम्पूर्णता में होना चाहिये। समझोते के पक्षो में बेहतर तालमेल होना चाहिये जिससे समझतों से उत्पन्न होने वाली अवैधता को कम से कम किया जा सके।

बीमालेखन की भूमिका प्राशुल्क के बाजार में मुख्य रूप से संगठित ही होती है, क्योकि दिया गया नियंत्रण काफी सीमित होता है। साधारण बीमा क्षेत्र में प्राशुल्क मुक्ति सामने खड़ी है यह बीमाकत्तओं के लिए बडी चुनौती है। यह बहुत सरल है कि पूर्वाधिकार अवसरों के साथ बह जाये लेकिन जोखिम से संवेदनशीलता से व्यवहार करने के लिए महत्वपूर्ण है कि विवेक का प्रयोग करने वाला ही विजेता होगा। मुझे इस क्षेत्र में व्यवसायियों की परिपक्वता पर विश्वास है लेकिन में कोई अवसर नही छोडुगां जहाँ उन्हें सावधान न किया जाए।

हम खुले बाजार से कुछ ही माह दूर हैं प्रकृतिक रूप से दबाव विभिन्न क्षेत्रों के व्यवसायियों की तैयारी पर होगा। तदानुसार जर्नल के अगले अंक का केन्द्र बिन्दु अपने पूर्ण गुंजन के साथ **प्राशुल्क मुक्ति** होगा।

सी. एस. राव

"संयुक्त रूप से जोखिम के मूल्यांकन तथा प्रारंभ होने को लेकर बीमाकर्त्ता तथा ग्राहक का एक साझा हीत है तथा इसलिए यह जोखिम के मानचित्र को तैयार करने के लिए सहमत होते हैं।"

श्री पेट्रिक दी ला मौरिनिरी, अध्यक्ष,
मैरिन बीमा का अर्न्तराष्ट्रीय संगठन (आईयूएमआई)

"एक प्रभावशाली विनियामक को भूंडलीय अर्थव्यवस्था तथा वित्तिय बाजार के एकीकरण के साथ सामंजस्य बनाये रखना चाहिये। आर्थिक वृद्धि तथा खुले बजार को बढावा देने के लिए पर्यवेक्षक को एक सुदढ़ तथा प्रभावशाली विनायमक तंत्र कि आवश्यकता होती है।"

श्री अलिसैन्ट्रो इयूपा, अध्यक्ष,
नैशनल ऐसोसियेशन आफ इंशूरेन्स कमिशनर (एनएआईसी)

"हम बाजार की अनिश्चितता तथा रूकावटों को इससे पहले कि हम टीआरआईए कार्यक्रम कि गतावधि तक पहूचें अच्छी नितियाँ बना कर इसे दूर करना चाहिये।"

श्री हार्वड माईल्स
- न्यूर्याक बीमा विभाग के पर्यवेक्षक

"विश्व भर में प्राशूल्क मुक्ति कदम से कदम मिलाने कि प्रक्रिया है। हम बीमाकत्ताओं से कह रहे कि वर्तमान प्राशुल्क शर्तो को अभी जारी रखें, क्योंकि कोई भी परिवर्तन बाजार में भ्रम ही पैदा करेगा।"

श्री सी.एस. राव, अध्यक्ष,
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"आपका विस्तृत तथा विशेषज्ञः ज्ञान आपको यह सुविधा देता है कि आप फ्रीमा के प्रति अधिक व्यापक दृष्टिकोण अपना सकें। आपके भूतकाल की समझ तथा वर्तमान के ज्ञान के आधार पर आप भविष्य के लिए एक दृष्टि विकसित कर सकते हैं।"

श्री पीटर एल मिलर,
अमेरिकन इंस्टियुट के अध्यक्ष तथा मुख्यकार्यपालक, सीपीसीयू को सम्म्रोधित करते हुए।

"हमारी रक्षा सेवाओं के कार्मिकों की वित्तिय सुरक्षा के लिए प्रार्थना करते हैं उनसे राज्य बीमा का आधिकारी वचनबद्धता को बाटॅते हैं, रक्षा सेवाओं के कार्मिकों के लिए उच्च दर्जे का उपभोगता संरक्षण होना चाहिये।"

श्री अलिसैन्ट्रो इयूपा, अध्यक्ष,
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साधारण बीमा शुल्क परिवर्तन

- बीमाकर्ताओं के लिये चुनौती

अनुराग रस्तोगी ने लिखा है कि विगत में साधारण बीमाकर्ताओं द्वारा शुल्क कटौती के साथ किये गये अन्य प्रयास जहाँ एक ओर कटु अनुभव सिद्ध हुये है। वहीं दूसरी ओर हर किसी के लिये कुछ सीखने योग्य वर्तमान बेहतर माहौल आशंकाओं के साथ उम्मीदें भी जगाता है।

गैर जीवन बीमा उद्योग में शुल्क निर्धारण के बारे में बहुत कुछ कहा और लिखा जा चुका है। जनवरी 2007 में शुल्क कटौती करने के लिये आईआरडीए द्वारा तैयार की गई कार्य योजना से इस मुद्दे पर व्यापक बहस छिड़ी हुई है। उद्योग को अब मात्र इसके नतीजे का इंतजार और मसलों को सुलझाने के प्रयास किये जा रहे हैं। हालांकि यह अभी तक कोई भी नही जान पाया है कि शुल्क कटौती के बाद उद्योग से किस प्रकार की प्रतिक्रिया आएगी। शुल्क कटौतीके बारे में भारतीय बाजार का अनुभव मात्र 1994 में आया है, जब मरीन कार्गो बीमा के बारे में शुल्क कटौती की गई थी। अधिकांश लोगों का मानना है कि इस बार का अनुभव पिछड़ी बार की तरह कडवा नही होगा। आशंकाओं के साथ उम्मीदों से भरा यह समय हर किसी के लिये कुछ सीखने लायक होगा। इस लेख में मैनें गैर नियमन क्षेत्र के शुल्क निर्धारकों की समस्याओं पर विचार करने के अलावा शुल्क निर्धारण व्यवस्था की व्यावहारिक समस्याओं पर चर्चा करने का प्रयास किया है।

शुल्क निर्धारण साहित्य में शुल्क निर्धारण की विभिन्न पद्धतियों के अल्वा शुल्क निर्धारण से संबंधित विभिन्न मुद्दे शामिल हैं। अधिक से अधिक हम इन पद्धतियों तथा शुल्क निर्धारण में संबंधित लोगों कार्यो के बारे में चर्चा कर सकते हैं इससे अधिक कुछ नही। मुझे विश्वास है कि जब तक हमारे पास गुणवत्तापूर्वक तथ्या (डाटा) और तथ्यों को जुटाने के लिये निर्दोष पद्धति नही हो, तब तक हमें सफलता नही मिल सकती। इसी कारण इस लेख का महत्वपूर्ण अंश शुल्क लागू होने से पूर्व उससे संबंधित समस्याओं एवँ तथ्यों (डाटा) के लिये समर्पित किया गया है।

तथ्य (डाटा):

किसी भी बीमा कंपनी को बेहतर शुल्क रणनीति अपनाने के लिये पहली आवश्यकता तथ्यों की उपलब्धता है। व्यापक संबद्ध एवँ विश्वसनीय तथ्य, जो आवश्यक पहलुओं से युक्त हो, शुल्क अमलावरी की सार्थक प्रक्रिया के लिये आवश्यक होते हैं। शुल्क निर्धारण के लिये कौन से तथ्य महत्वपूर्ण हैं इस बात का निर्धारण करना अनिवार्य होता है। आज हम जो तथ्य जुटाने का निर्णय लेते हैं, वह 3-4 वर्ष बाद उपयोग में आता है। इसी कारण इस मामले पर बारीकी से ध्यान लगाने के साथ ही भविष्य के तथ्यों की आवश्यकता पूर्ण करने के लिये भी उस पर गंभीरता से विचार करना होता है।

- यह तथ्य दो चरणो पर जुटाये जा सकते हैं- दावा चरण और रहस्योद्घाट्न शामिल है।
- रहस्योद्घाटन चरणः रहस्योद्घाटन के तथ्य बीमा कराये जाने के समय के अलावा प्रत्येक पॉलिसी से संबंधित समय में जुटाया जाना आवश्यक होता है। उदाहरण के तौर पर प्रत्येक पॉलिसी से निम्नलिखित तथ्य जुटाये जा सकते हैं।

बीमा सुरक्षा की तिथियाँ अर्थात् बीमा पॉलिसी की शुरूआत और समाप्ति की निधियाँ।

सभी रहस्यात्मक बातों के उद्घाटन के मानदंड इसके तहत अधिकांशतः संपत्ति बीमा संबंधी राशि को लिया जा सकता है लेकिन उत्तरदायित्व एवँ स्वास्थ्य जैसी अन्य श्रेणियों में यह कुछ भिन्न हो सकते हैं।

अनुराग रस्तोगी, वरिष्ठ प्रबंधक (बीमा शुल्क निर्धारण) बजाज अलायंस जनरल इंश्योरेंस कंपनी लि. पुणे।

> मुझे विश्वास है कि जब तक हमारे पास गुणवत्तापूर्वक तथ्या (डाटा) और तथ्यों को जुटाने के लिये निर्दोष पद्धति नही हो, तब तक हमें सफलता नही मिल सकती।

सबंधित सभी पहलुओं से संबंद्ध विवरण- मात्र वर्तमान रेटिंग पहलुओं के विवरण ही नही, बल्कि भविष्य में डाटाबेस तैयार करने के लिये उपयोग में आने वाली सभी संभावित रेटिंग पहलुओं का समावेश इसमें होता है।

उदाहरण के तौर पर वाहन बीमा में चालक की आयु आज रेटिंग का मुद्दा नही है। लेकिन यदि हम उसका उपयोग रेटिंग के मुद्दे के रूप में करना चाहते हैं, तो हमे सभी पॉलिसियों में चालक की आयु दर्ज करनी होगी ताकि हम रेटिंग मुद्दे के रूप में निर्धारण के लिये पर्याप्त आंकडें उपलब्ध हो जाये।

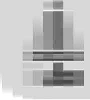
वसूले जाने वाले प्रीमियम के विवरणः यदि पॉलिसी, पैकेज पॉलिसी हो, तो वह खंड के अनुसार उपलब्ध होनी चाहिये। यदि पॉलिसी के दायरे में एक साथ आने वाले संकटों को भी लिया गया हो, जिसमें संकटों के शामिल करने अथवा हटाने की गुंजाइश हो, तो वह एक साथ आने वाले संकटों संबंधी तथ्य खंड के अनुसार जुटाने का बेहतर माध्यम सिद्ध हो सकता है ताकि जब भी जरूरत महसूस हो, संकटों के समूह के अनुसार प्रीमियम के विश्लेषण जुटाये जा सके।

उपरोक्त विश्लेषण के अनुसार यह स्पष्ट होता है कि रहस्योद्घाट्न के डाटा में शुल्क निर्धारण के लिये न्यूनतम आवश्यकतायें समायी होनी चाहिये। वास्तविक परिप्रेक्ष्य में बीमाकर्ता के पास विभिन्न मुद्दो पर आधारित डाटा होना चाहिये ताकि वह बीमा संबंधी अपने कार्यालय, पॉलिसियों की संख्या, बिक्री करने वाले मध्यस्थ, कमीशन दर, नये व्यवसाय, सह बीमा, पुनर्बीमा, बीमा के दायरे में आने वाले मुद्दे, पॉलिसी जारी किये जाने की तिथि, प्रीमियम संग्रहण, कवर टिप्पणी, प्रकाल्पनिक स्थिति और अन्य गतिविधियों का संचालन कर सके।

दावा चरणः भविष्य के शुल्क निर्धारण के लिये दावा चरण पर डाटा एकत्रित करने के लिये दावा निर्धारकों की भूमिका महत्वपूर्ण होती है। क्योंकि शुल्क निर्धारण भविष्य में दावों की होने वाली संख्या और जोखिमों के स्वरूप संबंधी कडे रूख पर निर्भर होता है। एक संकेत के अनुसार कोई भी डाटा जुटाने के लिये निम्नलिखित बातों पर ध्यान देना आवश्यक है।

- दावे की तिथि
- सूचना देने / दावा जमा करने की तिथि
- भुगतान की गई राशि और तिथियों का विवरण
- कुल राशि का अनुमान
- शामिल पॉलिसियों की सूची।
- दावे का स्वरूप (स्वंय का नुकसान अथवा वाहन बीमा में तीसरे पक्ष को पहुँचा नुकसान)
- संकटों का स्वरूप (अग्नि दुर्धटना बीमा में अन्य परिणाम)

इसके अलवा उपरोक्त क्षेत्रों संबंधी डाटा जुटाने समय बीमाकर्ता वास्तविक रूप से न्यूनतम आवश्यकता के बजाये अन्य कई मामले से संबंधित विवरण भी एकत्रित करना पड़ता है ताकि अपने व्यवसाय का समुचित रूप से संचालन किया जा सके। एक बार यह तथ्य किया जाये कि किस प्रकार का डाटा जुटाना है, तो प्रस्ताव रखने के लिये अवश्य डाटा एकत्रित करने के लिये सभी स्तरों पर समर्पित भाव के साथ कार्य आवश्यक होता है। और बाद में कंपनी के कंप्यूटर में सही मायने दर्ज करना आवश्यक होता है। कई बार डाटा जुटाते समय आवश्यक सावधानियां बरतने और निर्धारण कार्य योजना के अनुसार कार्य करने के बावजूद अपेक्षित गुणवत्ता नही आ पाती। यह निम्नलिखित एक अथवा कई कारणो से संभव है-



- प्रस्ताव फार्म में आवश्यक विभिन्न क्षेत्रों संबधी जानकारी के महत्व के महत्व के मूल्यांकन का अभाव बड़ा लक्ष्य हासिल करने का दबाव और बीमा के प्रति सामान्य पॉलिसी धारकों की उदासनीनता प्रस्ताव फॉर्म पूरी तरह से नही भरा जाना और कंप्यूटर में पॉलिसी संबंधी जानकारी, सुरक्षित कर प्रीमियम की गणना के लिये आवश्यक सूचना उपलब्ध ना होना। परिणाम स्वरूप प्रस्ताव स्वीकृति के लिये प्रस्तुतकर्ता द्वारा अनुपलब्ध जानकारी के स्थान पर कुछ गलत सूचनायें दी जाती हैं। पहली समस्या सूचना प्रौद्योगिकी व्यवस्था का उपयोग कर सुलझाये जा सकती है, जिसमें आवश्यक जानकारी उपलब्ध हुये बिना आगे नही बढ़ा जा सकता। लेकिन दूसरी समस्या, जो बीमा उद्योग में बड़े पैमाने पर फल फूल चुकी है, से निजात पाना काफी कठिन है, और उसका समाधान करने के लिये कंपनी प्रबंधन को समर्पित भावना से कार्य करने के अलावा डाटा जुटाने के मामले में गुणवत्ता के साथ किसी भी प्रकार का समझौता नही करना चाहिये और अग्रपंक्ति के अपने कर्मचारियों के साथ ही प्रस्तुतकर्ताओं और बिक्री मध्यस्थों को आवश्यक प्रशिक्षण देना चाहिये।

- यदि प्रस्ताव फार्म में आवश्यक जानकारी उपलब्ध की जाने के बावजूद उसे दर्ज करने वाले कर्मचारी उसका महत्व नही जान पाये, तो वह विभिन्न महत्वपूर्ण क्षेत्रों संबंधी आवश्यक जानकारी के मामले गंभीर साबित हो सकता है। यह फिर कंपनी के समर्पण भाव और कर्मचारियों को उत्तरदायित्व संबंधी प्रशिक्षण के अलावा डाटा दर्ज करने वाले कर्मचारियों के कार्य के मूल्यांकन से जुडा मामला है।

- गुणवत्ताहीन डाटा के लिये जिम्मेदार तीसरा कारण सूचना प्रौद्योगिकी व्यवस्था से संबंधित है। सूचना प्रौद्योगिकी व्यवस्था दर्ज किये जाने वाले डाटा की समुचित जाँच करने में सक्षम होना चाहिये। उदाहरण के तौर पर कई मामलों में हम तब पसोपेश में पड़ जाते हैं। जब वाहन बीमा संबंधी पॉलिसी वाहन खरीदी / पंजीकरण तिथि प्रस्ताव तिथि के बाद भी होती है अथवा जीवन बीमा के मामले में पलिसीधारक की जन्मतिथि बीमापॉलिसी की प्रस्ताव तिथि के बाद की होती है। इस प्रकार की गलतियाँ सामान्य लापरवाही के कारण होती है और इन्हें मानक सूचना प्रौद्योगिकी व्यवस्था का निर्माण कर दूर किया जा सकता है। एक अन्य मुद्दा विभिन्न क्षेत्रों संबंधी मूलपाठ दर्ज करने का है, जिसमें विभिन्न प्रकार का डाटा दर्ज करने वाले लोग अपने प्रत्यक्ष ज्ञानबोध एवँ सूझ बूझ के आधार पर अनावश्यक डाटा संबंधी सांख्यिकीय विश्लेषण करते हैं।

सूचना प्रौद्योगिकी व्यवस्थाएँ, डाटा भंडार एवँ डाटा माइनिंगः

बड़े पैमाने पर डाटा संग्रहण करते समय यदि मजबूत सूचना प्रौद्योगिकी व्यवस्था उपलब्ध ना हो, तो उसका समुचित उपयोग नही किया जा सकता। डाटा संग्रहण कार्य शुरू करने से पूर्व ही सूचना प्रौद्योगिकी व्यवस्था की स्थापना की जानी चाहिये। गत कुछ समय तक आमतौर पर यह धारण रहा करती थी कि अधिकांश डाटा के मूल्यांकन के लिये एक बेहतर ऑफिस प्रोडक्शन सिस्टम काफी है, जो अंतर्निहित मूल्यांकन साधनों की उपलब्धता भी कर सकता है। यह कुछ नयी कंपनियों के लिये यथार्थ भी साबित हुआ, जब उनका डाटा सीमित था और उनके उपयोगकर्ता भी गिने चुने थे। हालांकि बदलते समय के अनुसार और उपयोगकर्ता की बढ़ती संख्या के क्रम में एकल उत्पादन सह विश्लेषणात्मक सॉफ्टवेयर सिस्टम तैयार करने के लिये कडे प्रयास किये जा रहे हैं। जिससे डाटा एंट्री के साथ उसे एक्सेस करने और उसका विश्लेषण करे के लिये कम समय लगेगा। हालांकि डाटा संग्रहण एवँ पृथक विश्लेषणात्म सॉफ्टेवेयर की जरूरत महसूस हो रही है। ताकि डाटा उत्पादन सिस्टम से निकालकर उसे ठीक किया जा सके और डाटा वेयर हाउस में उसका संग्रहण किया जा सके। इसके बाद ऐसे डाटा का उपयोग समुचित डाटा माइनिंग सॉफ्टवेयर अथवा अधिक सुनिश्चित उद्देश्य, शुल्क निर्धारण, रिजर्विंग अथवा मॉडलिंग सॉफ्टवेयर के जरिये विश्लेषण अथवा व्यवहार कुशलता के लिये किया जा सके।

शुल्क निर्धारण- किसी भी बीमा के बारे में शुल्क निर्धारण करने के पीछे ऐसा शुल्क मुहैया करने का लक्ष्य होता है, जो सभी प्रकार के दावों का मूल्य अदा करने के लिये पर्याप्त हो सके। इसी शुल्क को (शुद्ध प्रीमियम) के रूप में जाना जाता है। शुद्ध प्रीमियम में किसी भी प्रकार का दावा समायोजना निपटारा खर्च और बीमाकर्ता का प्रबंधन खर्च शामिल नही रहता। वह तो मात्र मुहैया की जाने वाली बीमा सुरक्षा के लिये सुरक्षा के लिये व्यवसाय के विशिष्ट मानकों के अनुसार वसूली जाने वाली संभावित दावा भुगतान राशि होती है, जिसके लिये शुल्क का निर्धारण किया जाता है।

> बड़े पैमाने पर डाटा संग्रहण करते समय यदि मजबूत सूचना प्रौद्योगिकी व्यवस्था उपलब्ध ना हो, तो उसका समुचित उपयोग नही किया जा सकता। डाटा संग्रहण कार्य शुरू करने से पूर्व ही सूचना प्रौद्योगिकी व्यवस्था की स्थापना की जानी चाहिये।

यहाँ अब हम बीमा सुरक्षा मुहैया किये जाने वाले भविष्य के दावों के अनुमान पर विचार करेंगे। यह निम्नलिखित बातों के आधार पर सुलभ हो सकता है-

- विगत दावों संबंधी डाटा पर अध्ययन
- जोखिमों के स्वरूप के अनुसार उपयुक्त रणनीति का स्वीकार
- दावों की बारम्बारिता एवँ मजबूत प्रस्तुतिकरण के लिये योग्य वितरण तथा
- समान दावों की बारम्बारिता और भविष्य के लिये औसत दावा मजबूती का अनुमान हालांकि यह काफी आसाना है।

लेकिन अब यह देखते है कि क्या गलत हो सकता है।

विगत में हुई किसी बड़ी घटना के अनुभवों के आधार पर भविष्य के लिये अतिरिक्त उपायों की तैयारी। लेकिन हम जैसा सोचते हैं, वैसा ही भविष्य में होगा ऐसा नही। निम्नलिखित कारक भविष्य में दावों के आने वाले अनुभवों का सामना करने के लिये सहायक सिद्ध हो सकते हैं।

1. भविष्य की अनुमानित आर्थिक स्थिति बीते समय की आर्थिक स्थिति के समान नही हो सकती। ऐसे मामलों में भविष्य के दावों की अनुमानित राशि उपलब्ध डाटा के अनुसार आंकलन की गई राशि से अधिक हो सकती है।

2. ऐसी भी एक प्रवृत्ति उभर सकती है, जो दावों की बारम्बारिता एवँ अथवा दावों के मजबूत प्रस्तुतिकरण के मामले में आर्थिक स्थिति से संबंध रखती हो। उदाहरण के लिये कुछ प्रारूपों के दावों की बारम्बारिता में बढ़ोतरी का रूप हो, तो उसकी पहचान करना जरूरी है और उसके आधार पर भविष्य के दावों की बारम्बारिता का अनुमान लगाया जाना चाहिये। अन्यथा हमारे पास भविष्य के दावों की बारम्बारिता और उनकी मजबूती के बारे में गलत अनुमान रहेंगे।

3. व्यवसाय का तरीका समय के अनुसार बदल दिया जाना चाहिये। इससे बारम्बारिता और सख्त प्रस्तुतिकरण पर प्रभाव पड़ सकता है। भले ही दावों का विश्लेषण जोखिमों के प्रत्येक समूह द्वारा पृथक रूप से किया गया, तो भी डाटा की गुणवत्ता एवँ विश्वसनीयता के लिये कुछ अन्य बातों की जरूरत होती है। उदाहरण के तौर पर दुपहिया वाहनों की सभी प्रकार की जोखिमें कुछ कारणों से उभरती हैं। खासतौर पर स्कूटर एवँ मोटरसाइकिल खंड एक दूसरे से काफी भिन्नता रखते हैं। अधिक गहराई से विचार करने पर कहा जा सकता है कि प्रत्येक खंड को इंजन क्षमता, भौगोलिक क्षेत्र एवँ मालिक तथा चालक की आयु के आधार पर श्रेणीबद्ध किया जा सकता है। इन सभी खंडों के दावों का स्वरूप भी भिन्न होता है। यदि इन भिन्न जोखिम खंडों में व्यवसाय रणनीति बदली गई तो दावों की बारम्बारता और मजबूती अनुमानित संख्या से भिन्न हो सकती है।

4. समीक्षाधीन अवधि में पॉलिसी की शर्ते / स्थितियाँ परिवर्तित हो सकती है, जिससे दावों की अनुमानित बारम्बारता और सख्ती में भी परिवर्तन आ सकता है। उदाहरण के तौर पर जुलाई 2002 से सभी प्रकार की निजी कार पॉलिसियों में कटौती लागू किये जाने के बाद दावों की संख्या और मजबूती में भारी अंतर नजर आया।

5. दावा प्रबंधन प्रक्रिया में परिवर्तन से भी दावों की बारम्बारता और सख्ती में परिवर्तन आ सकता है। जैसे भारतीय बाजार में सभी स्वास्थ्य बीमा दावे प्रतिपूर्ति के आधार पर निपटाये

जाते हैं। तीसरे पक्ष में प्रबंधन की प्रस्तुति के बाद यह राशि विरहित आधार पर निपटाये जा रहे हैं। इसका भी स्वास्थ्य बीमा संबंधी दावों की बारम्बारता पर असर होगा।

6. नियमन तथा कानून संबंधी बदलाव भी दावों की बारम्बारता अथवा बीमा की निश्चित श्रेणियों की सख्ती पर असर हो सकती है। उदाहरण के तौर पर यह ध्यान रकने योग्य है कि गैर जीवन उद्योग की इच्छानुसार भारतीय संसंद ने मोटर वाहन अधिनियम 1988 में संशोधन करते हुये मोटर वाहन संबंधी तीसरे पक्ष के बीमा में निजी चोट अथवा मौत संबंधी उत्तरदायित्व खत्म करने के साथ मुआवजे के रूप में 7.5 लाख रूपये देने का प्रावधान भी खत्म किया। इससे मोटर वाहन संबंधी तीसके पक्ष के बीमा खंड में किये जाने वाले दावों की औसत में भारी परिवर्तन आयेगा।

यह मात्र कुछ तथ्य हैं, जो दावों के निपटारे से नजदीकी संबंध रखते हैं और भविष्य के दावों की बारम्बारता और मजबूती को ध्यान में रखते हुये अनुमान लगाने के लिये इन्हें कारक बनाया जाना चाहिये।

आई बी एन आर के मामले

जब हमने दावों के बारे में बात की, उसमें विगत समीक्षाधीन अवधि के दौरान दावों की जिम्मेदारी स्वंय पर लेने संबंधी विचार किया गया था। यह दावों संबंधी किये गये भुगतान से भिन्न है, और इसमें समीक्षाधीन अवधि के दौरान रिजर्व रखे गये दावे भी शामिल रहते हैं।

दुर्भाग्य से अभी तक भारतीय गैर जीवन बीमा बाजार में आई बी एन आर को उसकी प्रतिपूर्ति हासिल नही हुई है और कई लोग आज भी इस उद्योग में गंभीर नही है। आईबीएनआर के मुख्यः दो रूप होते हैं-

- अस्तित्व में रहने के बावजूद जिसके बारे में सूचना प्राप्त हुई हो (आईबीएनवाईआर)
- अस्तित्व में रहने के बावजूद पर्याप्त सूचना नही मिली हो, (आईबीएनईआर) यह एक तकनीकी शब्द है जिसके बारे में प्रावधान किया जा रहा है।

पारम्परिक तौर पर सार्वजनिक क्षेत्र की बीमा कंपनियों द्वारा आईबीएनआर की गणना इस प्रकार की जाती थी।

- मोटर तथा अभियांत्रिकी संबंधी आरक्षित दावों के .1005 प्रतिशत
- अन्य क्षेत्र संबंधी व्यापार के लिये आरक्षित दावों के 5.5 प्रतिशत

वर्ष 2002 से आईबीएनआर की गणना में बीमाकर्ताओं ने कुछ मानकों का उपयोग करना शुरू किया। इसी श्रृंखला में वर्ष 2003 में एक अंसारी द्वारा किये गये सर्वेक्षण में बताया गया है कि वर्ष 2001 की तुलना में मोटर वाहन खंड सबंधी तीसरे पक्ष के बीमा के दावों का आईबीएनआर 38 प्रतिशत तक बढ़ गया है। आज जब मार्च 2006 के अंच में मोटर वाहन संबंधी तीसरे पक्ष के बीमा दावों का दायरा 15000 करोड़ रूपये तक होने का अनुमान लगाया जाता है, तभी आईबीएनआर का महत्व मात्र सामान्य गणना से आंका जा सकता है। इसमें कुल 1500 करोड़ तक की राशि संबंधी अनुमान में (-) 10 प्रतिशत तक का ही अंतर लाने की दिशा में प्रावधान किये जा रहे हैं।

इससे उद्योग की लाभकारिता में 1500 करोड़ रूपये तक विस्तार लाया जा सकेगा। दूसरे शब्दों में कृत्रिम रूप से विस्तारित लाभांस का भुगतान मालिकों को होता है और कर का भुगतान सरकार को होता है। शुल्क निर्धारण में जब से आईबीएनआर दावा शुल्क का अंतर्निहित हिस्सा बन गया है, तब से यह विगत में किये गये दावों की राशि की जानकारी देकर भविष्य के दावों संबंधी अनुमानित राशि को प्रस्तुत करने में महत्वपूर्ण सिद्ध हो रहा है। इसका लाभ शुल्क निर्धारण में हो पायेगा। और यह ना भूलें कि हम यहाँ मात्र मोटर वाहन के तीसरे पक्ष बीमा खंड के बारे में ही सोच रहे हैं। यदि आईबीएनआर के लिये प्रावधान के प्रभाव का विचार संपूर्ण गैर जीवन बीमा क्षेत्र के लिये किया जाये, तो काफी बडा होगा और उससे गैर जीवन बीमा क्षेत्र के शुल्क निर्धारण एवँ लाभकारिता में कई तरह की समस्याएँ उत्पन्न होगी।

दुर्भाग्य से अभी तक भारतीय गैर जीवन बीमा बाजार में आई बी एन आर को उसकी प्रतिपूर्ति हासिल नही हुई है और कई लोग आज भी इस उद्योग में गंभीर नही है।

इस तरह विगत में बीमित पॉलिसियों के दावों के बारे में राशि का अनुमान लगाने के लिये आईबीएनआर की सही गणना करना महत्वपूर्ण कार्य है आईबीएनआर की गणना करने के कई मानक तरीके हैं। लेकिन सभी में डाटा की गुणवत्ता के अनुसार आईबीएनआर भिन्न होता है। प्रत्येक तरीके के अपनी विशेषताएँ और खामियाँ होती है। व्यवहारिक तौर पर प्रत्येक बीमाकर्ता विभिन्न तरीकों का उपयोग करते हुये आईबीएनआर की गणना करता है और उससे प्राप्त होने वाले नतीजे के आधार पर ही न्यायसंगत एवँ विवेकपूर्ण आंकडा निश्चित करता है।

खंड निर्धारणः

हमने जोखिमों के स्वरूप के बारे में विचार किया है। यह स्वरूप खास तौर समान अथवा व्याख्यापूर्व जोखिम या दावों के स्वरूप समूह होता है। अधिक खंड निर्धारण, भविष्य के सटीक अनिमान और बेहतर स्थिति के लिये शुल्क निर्धारण आवश्यक है। जिससे प्रत्येक वर्ग की जोखिमों का सही पता चलचा है। लेकिन शुल्क ढाँचे की शुद्धता और फलदायिता में आपसी सामंजस्य का अभाव रहता है। दूसरा महत्वपूर्ण मुद्दा डाटा का आकार रहा है। वृहद् डाटा होने के बावजूद अत्यधिक खंड निर्धारण करने से प्रत्येक खंड के आकार में भारी कमी आयेगी। इससे भविष्य की परियोजनाओं के लिये डाटा की उपभोगिता और विश्वसनीयता के बारे में कई तरह के सवाल उभरेंगें।

विशिष्ट प्रकार के पोर्टफोलियों की पहचान करने की दो पद्धतियाँ है। एक पद्धति पूर्व के अनुभवों के आधार पर धैर्य जुटाने पर निर्भर है, यह पद्धति काफी अधिक विषय वादिता के जरिये उत्साहवर्धक नतीजे दे सकती हैं। एसे विशिष्ट स्वरूप के जोखिमों के समूह तैयार करने के लिये समूह विश्लेषण पद्धति जैसी सांख्यिकीय पद्धतियों का उपयोग किया जा सकता है। जिसमें दावों का डाटा पूर्व परिभाषित मानदंड के अनुसार निर्धारित किया गया हो। बीमित लोगों के पूर्वानुभवों और दावा प्रबंधकों का उपयोग यहाँ खंड को समुचित रूप देने के लिये किया जा सकता है। सूत्रबद्ध खंड विश्लेषण और दावा प्रबंधक एवँ शुल्क भिन्नता पॉलिसीधारकों के लाभकारी खंडों को आकर्षित करने और उन्हें अपने अधिकार में रखने के अलावा लाभकारिता के साथ विकास बनाये रखने के लिये विपणन प्रयासों को उभारने में महत्वपूर्ण माध्यम सिद्ध हो सकते हैं।

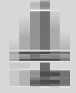
शुल्क निर्धारण में रेटिंग घटकों के सापेक्षिक महत्व

एक बार दावों के अंतिम शुल्क का अनुमान लगाया जाता है, तो अगला कदम किसी उत्पाद के शुल्क निर्धारण के लिये उपयोग में लाये जाने वाले विभिन्न रेटिंग घटकों के सापेक्षिक महत्व की पहचान करता होता है। हालांकि उत्पाद के कुल शुल्क को निर्धारण करने से पूर्व उन विभिन्न घटकों की भी पहचान की जानी चाहिये, जो दावों पर महत्वपूर्ण प्रभाव डालते हैं और जिनका उपयोग रेटिंग घटक के रूप में भी किया जा सकता है। यह पहचान आमतौर पर सामान्यीकृत लाइनर मॉडलिंग तकनीकों का उपयोग कर की जा सकती है। जब शुल्क विभिन्न रेटिंग घटकों पर निर्भर होता है, तब अंतिम शुल्क मात्र प्रत्येक घटक के पृथक शुल्क का गुणन नही हो सकता क्योंकि विभिन्न हेटिंग घटक एक दूसरे से सह संबंधित हो सकते हैं।

हम शुल्क निर्धारण के लिये सामान्य मॉडलिंग तकनीक का सुलभतम रूप क्या कर सकता है, वह समझने के लिये एक उदाहरण देखते हैं। निम्नलिखित तालिका पुरूष एवँ महिला चालकों के लिये एक तरफा दावा बारम्बारिता को दर्शाती है-

चालक के लिंग आधारित दावे

	वाहनों की संख्या	दावा बारम्बारिता	संबंधित बारम्बारता
पुरूष	1100	0.39	1.46
महिला	1100	0.15	0.54
संयुक्त	2200	0.27	1.00



टिप्पणीः संबंधित बारम्बारता प्रत्येक वर्ग की बारम्बारिता को संयुक्त बारम्बारिता से विभाजित कर हासिल की जा सकती है।

इस तालिका से यह स्पष्ट होता है कि यदि संयुक्त अनुभव के आधार पर गणना की जाये, तो पुरुष चालकों को प्रीमियम पर 46 प्रतिशत का बोझ डालकर महिला चालक को 46 प्रतिशत की रियायत दी जा सकती हैं।

दूसरे शब्दों में हम यह कह सकते हैं कि महिला चालकों की तुलना में पुरूप चालकों से 1.46 / 0.54 गुना अधिक प्रीमियम वसूला जा सकता है।

क्षेत्र सुधार दावे

	वाहनों की संख्या	दावा बारम्बारिता	संबंधित बारम्बारता
क्षेत्र ए	1100	0.37	1.39
क्षेत्र बी	1100	0.16	0.61
संयुक्त	2200	0.27	1.00

अब हम एक अन्य एक तरफा दावा बारम्बारिता तालिका पर विचार करेंगें, जो दो विभिन्न भौगोलिक क्षेत्रों से संबंधित है-

इस तालिका से स्पष्ट होता है कि क्षेत्र ए के चालकों की प्रीमियम राशि क्षेत्र बी के चालकों के प्रीमियम की तुलना में 1.39 / 0.61 गुना अधिक अर्थात् 2.28 गुना होनी चाहिये। अब यदि हमने चालकों के लिंग एवँ क्षेत्र के रेटिंग घटकों को मिला दें, तो यह कहा जा सकता है कि क्षेत्र ए के पुरूष चालकों को क्षेत्र बी की महिला चालकों की 2.69 X 2.28 अर्थात् 6.12 गुना अधिक प्रीमियम राशि का भुगतान करना चाहिये। अब दो तरफा दावा बारम्बारिता तालिका पर नजर डालेंगे-

क्षेत्र एवँ लिंग आधारित दो तरफा दावा बारम्बारता तालिका

	वाहनों की संख्या			दावा बारम्बारिता			क्षेत्र बी की महिलाओं से संबंधित बारम्बारता	
	पुरूष	महिला	सभी	पुरूष	महिला	सभी	पुरूष	महिला
क्षेत्र ए	1000	100	1100	0.40	0.10	0.37	2.67	0.67
क्षेत्र बी	100	1000	1100	0.30	0.15	0.16	2.00	1.00
कुल	1100	1100	2200	0.39	0.15	0.27		

दो तरफा तालिका विश्लेषण के अनुसार क्षेत्र बी की महिला चालकों की तुलना में 2.67 गुणा अधिक प्रीमियम अदा करना चाहिये, जो दो समूहों से वूले जाने वाले प्रीमियम का सही मार्ग है। वास्तविक जीवन के परिप्रेक्ष्य में कई संबंद्ध घटक रहेंगे।

सामान्यीकृत लाइनर मॉडेलिंग मूल्य निर्धारण में विभिन्न रेटिंग घटकों के महत्व की स्थापना करने मे मदद करता है और बाद में मल्टीलेवल रिग्रेशन एनालिसिस के माध्यम से जोखिम के कुल शुल्क के प्रत्येक खंड में संबंद्ध सापेक्षिक महत्व की पहचान करता है।

कार्यालय प्रीमियमः

अब तक हमने शुद्ध प्रीमियम अथवा जोखिम प्रीमियम क्षेत्र के बारे में विचार किया, जो मात्र दावों के मूल्य पूर्ति करने के लिये पर्याप्त है, और उसमें खर्च, लाभ, पुनर्बीमा आदि के लिये उपयोग में लेने योग्य कसी भी प्रकार की राशि शामिल नही रहती। दूसरी और कार्यालय प्रीमियम में निम्नलिखित मुद्दे निहित रहते हैं-

- दावा निपटारा व्यय
- कमीशन एवँ प्रोक्युअरमेंट व्यय
- प्रशासनिक व्यय
- पुनर्बीमा
- अन्य मामले

इस कार्यालय प्रीमियम में संभावत निवेश लाभ के तहत रियायत देना आवश्यक है। खर्च से निपटने के कई रास्ते हैं। सबसे आसाना रास्ता सभी प्रकार के खर्च का ध्यान रखने के लिये एकल परसेंटेज लागू किया जाना चाहिये। अधिक विस्तृत और सही पद्धति प्रत्येक तरह का खर्च स्थिर, अर्धस्थिर एवँ अस्थिर घटकों की मांग खत्म करना है। प्रीमियम की गणना करने का आसाना सूत्र नीचे दिया गया है।

$$GP = \frac{CFXCAX(1+h)(1+i)^{-t} + VE}{1-c-f-v-r-p}$$

GP = कुल प्रीमियम

CF = संभावित दावा बारम्बारिता

CA = संभावित औसत दावा शुल्क

c = कमीशन प्रतिशत

f = स्थिर खर्च, कुल प्रीमियम का प्रतिशत

v = अन्य अस्थिर खर्च, कुल खर्च का प्रतिशत

VE = अन्य पॉलिसी अस्थिर खर्च

h = लाभ एवँ संभावित खर्ता, कुल प्रीमियम का प्रतिशत

r = पुनर्बीमा प्रीमियम

i = मासिक निवेश आय दर

यह सबसे आसाना सूत्र नमूना है और दिये गये स्पष्टीकरण के अनुसार इसके लिये नातो विभिन्न राशि की आवश्यकता है और ना ही रेटिंग / घटकों के उपयोग की जरूरत है। हालांकि इन घटकों का उपयोग आवश्यकता के अनुसार किया जा सकता है।

पश्च शुल्क निर्धारण

शुल्क निर्धारण कुछ एक ही प्रयास में होने वाला कार्य नही है। प्राथमिक तौर पर सामने आने वाले शुल्क को नवीनतम अनुभवों के आधार पर निश्चित रूप दिया जाना चाहिये। नियमित पोर्ट फोलियो विश्लेषण, खंड विश्लेषण, प्रवाह विश्लेषण, प्रतिस्पर्धी का विश्लेषण, लाभ परीक्षण एवँ समुचित तथा सही समय पर उठाये जाने वाले कदमों से कंपनी पॉलिसी धारकों के लिये लाभ योग्य विपणन प्रयासों को मजबूती से सामने रखने के अलावा सशक्त शुल्क निर्धारण रणनीति का विविधता के साथ उपयोग कर सकता है। निश्चत ही इसके लिये डाटा गुणवत्ता में सुधार के लगातार प्रयास करने के साथ उभरती जरूरतों के अनुसार डाटा जुटाने के नये क्षेत्रों की पहचान करना आवश्यक है। पश्च शुल्क निर्धारण में बीमाकर्ताओं के पास दो विकल्प होते हैं। पहला और आसान विकल्प खंडो के लिये संभावना की तलाश तथा दूसरा एवँ कुथ मुश्किल विकल्प लाभकारिता के पथ पर बढ़ने के साथ शुल्क बीमा करना एवँ डाटा गुणवत्ता में सुनियोजन बनाये रखना है। बीमा उद्योग में ऐसे कई उदाहरण हैं जिनमें विकास अवधि में कंपनी की लाभकारिता प्रभावित हुई है और उसी अवधि में अन्य कंपनियाँ लाभ में रही हैं। इससे सभी कंपनियों के प्रबंधनों को सबक लेना चाहिये। यह भी कंपनियो के प्रबंधनों के लिये एक चुनौती है और अब यह उन पर निर्भर है कि वे पश्च शुल्क विनियमन के लिये कौन सा मार्ग अपनाते हैं।

संदर्भः

1. अभ्यास सामग्री शुल्क निर्धारक संस्थान, लंदन की है।

लेखक बजाज अलायंज जनरल इंश्योरेंस कंपनी लिमिटेड, पुणे के वरिष्ठ प्रबंधक (बीमा शुल्क निर्धारण) है। लेख में प्रस्तुत विचार लेखक के अपने हैं और यह जरूरी नही है कि वह कंपनी के विचारों को उदघाटित करते हों जिसमें लेखक कार्यरत हैं।

केन्द्रीय मुद्दे

'गैरशुल्कीकरण' की अवस्था में मूल्य निर्धार

- आगे समय चुनौतीपूर्ण है

यज्ञप्रिय भरत कहते हैं ऐसी परिस्थिति में जबकि बीमा कीमतों का नियमन होता है, प्रीमियम की दर का निर्धारण कोई बड़ी समस्या नही है। नियमन न होने की स्थिति में, दर निर्धारण या कीमत निर्धारण विचारणीय हो सकता है।

'चूंकि अब वो वक्त नही रहा जब व्यापारियों की यह सोच थी, इन दोनों क्षेत्रों में और विदेशों में भी, कि जब भी वे कोई बड़ा सौदा करते थे (विशेषतः सूदूरवर्ती क्षेत्रों में), तो वे अपने माल, बिक्री योग्य वस्तुओं, जहाजों और व्यापारिक सामानों की सुरक्षा सुनिश्चितता हेतु कुछ व्यक्तियों (जो की काफी संख्या में होते थे) को इस प्रकार और इस दर पर कुछ रकम दे देते थे जो कि बीमक और बीमाकर्ता दोनों पक्षों को मान्य हो - और यह प्रक्रिया सामान्यतः बीमा पॉलिसी कहलाती थी। इस प्रकार की बीमा पॉलिसी से, जहाज के डूब जाने या माल की क्षति की स्थिति में हानि का वहन किसी एक व्यक्ति द्वारा नही किया जाता था, बल्कि हानि का भार कुछ व्यक्तियों द्वारा भारी मात्रा में वहन करने के बजाये बहुत सारे व्यक्तियों द्वारा थोड़ी थोड़ी मात्रा में वहन करने से हल्का हो जाता था। और व्यापार से जुड़े व्यक्तियों के बजाये व्यापार से असंल्गन व्यक्तियों पर हानि का भार अधिक पड़ता था। ऐसे में सभी व्यापारी, विशेषतः युवा वर्ग ऐसे व्यापार से अपेक्षाकृत अधिक इच्छा के साथ तथा अधिक रूप में आकर्षित होते थे।'

सन् 1601 में यूके में पारित संविधान के अधिनियम की यह प्रस्तावना न सिर्फ पर्याप्त रूप से बीमा के उद्देश्य का वर्णन करती है, बल्कि बीमा की कार्यविधि की भी समान रूप से व्याख्या करती है। जहाँ 'कुछ लोगों द्वारा अधिक मात्रा में हानि वहन करने के बजाय अधिक लोगों द्वारा कम मात्रा में हानि का वहन' अपने आप में बीमा का एक आवश्यक लक्षण है वहीं 'रकम (प्रीमियम) में रियायत', 'ऐसी दर से' तथा 'इस प्रकार' बीमा की कार्यविधि हेतु आवश्यक है। बीमा औसत के कानून अथवा अधिक संक्या के कानून पर आधारित है। एक बीमाकर्ता उचित प्रीमियम पर सुरक्षित बीमा चाहता है तथा इसके लिये अधिक संख्या के कानून के अनुसार उसे पर्याप्त लेनदेन करने होंगे। उचित प्रीमियम के निर्धारण हेतु बीमाकर्ता को कीमत निर्धारण प्रक्रिया से गुजरना होगा। कीमत निर्धारण वह प्रक्रिया है जो कि कीमत तथा प्रीमियम निर्धारण में प्रयुक्त होती है। कीमत से तात्पर्य है- एक्सपोजर (जैसे प्रतिशत, प्रति माइल) का प्रति ईकाई मूल्कय एक्सपोजर की ईकाई, बीमाकर्ता की हानि के एक्सपोजर के आकार का पैमाना है। प्रीमियम, दर तथा एक्सपोजर का गुणनफल होता है।

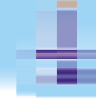
ऐसी परिस्थिति में, जहाँ कि बीमा कीमत का विनियमन होता है, प्रीमियम दर का निर्धारण कोई बड़ी समस्या नही है। विनियमन न होने की स्थिति में प्रीमियम या कीमत निर्धारण कुछ मुश्किल हो सकता है। कम कीमत निर्धारण का मतलब होगा व्यवसाय में घाटा तथा परिणामतः व्यवसायी की पूंजी का इस्तेमाल और अधिक कीमत निर्धारण करना मतलब प्रतिद्वंदियों को आमंत्रित करना कि वे कीमतें कम रखें और व्यापार हड़प लें। बीमाकर्ता की ऋण भुगतान की सक्षमता बीमित व्यक्ति के लिये सर्वाधिक महत्वपूर्ण होती है। जब कोई बीमाकर्ता निरंतर कम मूल्य रखता है तब ऐसी स्थिति में उसके दिवालिया हो जाने का बहुत जोखिम रहता है। जबकि कोई बीमित उससे भारी हर्जाने का दावा करता है और अपने बीमा द्वारा प्रदेय सुरक्षा का लाभ उठाना चाहता है। इसी प्रकार भारी प्रीमियम भुगतान भी बीमित के लिये हितकर नही होता है।

> कम कीमत निर्धारण का मतलब होगा व्यवसाय में घाटा तथा परिणामतः व्यवसायी की पूंजी का इस्तेमाल और अधिक कीमत निर्धारण करना मतलब प्रतिद्वंदियों को आमंत्रित करना।

कीमत निर्धारण करते वक्त बीमाकर्ता के समक्ष विभिन्न व्यावसायितक विचार हो सकते हैं। परंतु उनसे ही चिपके रहने की बजाय बीमाकर्ता को इस प्रकार से कीमत निर्धारण करना चाहिये जो कि स्थिर हो तथा साथ ही हानि एक्सपोजर में परिवर्तन सापेक्ष भी हो। बीमाकर्ता को यह तो सुनिश्चित करना ही होगा कि उसके द्वारा निर्धारित कीमतें उचित हैं। सरलतः कहें, तो बीमाकर्ता के लिये यह दो कारकों के निर्धारण का प्रश्न है- 'धन का आना (प्रीमियम तथा निवेश आय)' और 'धन का जाना (हानि अथवा दावे, व्यय तथा लाभ)'। यद्यपि उचित दर निर्धारण की समस्या का समाधान बहुत आसान नही होता है। जब परिस्थितियाँ भौतिक रूप में परिवर्तित होती हों, ऐसी स्थिति को छोड़कर यह सत्य है कि पूर्व अनुभवों के सांख्यिकी आधार को बढ़ाने की बजाय यह अपेक्षाकृत आसान होगा कि सभावित भविष्य के दावों की कीमतों को ध्यान में रखा जाये। इस प्रकार, सांख्यिक के कुछ आधारों अथवा अनुभवों. जिनके आधार पर दर की गणना की जाती है, की अनुपस्थिति में बीमा का सुरक्षित व्यवसाय नही हो सकता है। इसी तरह, यह भी अनिवार्य है कि बीमाकर्ता जिस डाटाबेस पर निर्भर करता है वह विश्वसनीय हो।

कीमत निर्धारण के सिद्धांतो पर एक नजर डालना उपयोगी होगाः

- कीमत, भविष्य की लागत को अपेक्षित मूल्य का अनुमान है। कीमत के सामान्यतः उठायी गयी हानि, विनिधानित दावों के व्यय, गैर विनिघानित दावों के व्यय (जो कि किसी विशेष दावों के लिये प्रत्यक्षतः नही निर्धारित होते हैं), कमीशन और दलाली खर्चे सम्मिलित होते हैं।
- समस्त लागतों के लिये प्रावधानित कीमत में जोखिम स्थानांतरण भी सम्मिलित होता है। बीमितों में निष्पक्षता बरकरार रखने हेतु, कीमत निर्धारण के व्यक्तिगत जोखिम की लागत का प्रावधान होना चाहिये। जब किसी व्यक्तिगत जोखिम का अनुभव इन अनुमानित लागतों के लिये विश्वसनीय आधार नही प्रदान करता है, तब इस प्रकार के जोखिमो के औसत अनुभव को ध्यान में रखना चाहिये।



- कीमत उचित होनी चाहिए (न बहुत ज्यादा / न बहुत कम) और पक्षपातपूर्ण नही होनी चाहिये।

बीमांककों द्वारा कीमत निर्धारण की कई विधियाँ उपयोग में लायी जाती है। कोई भी विधि प्रयोग में लायी जाये, यह महत्वपूर्ण है कि तथ्यों की धारणा / अनुमान का दस्तावेजीकरण हो तथा वे प्रकटीकरण के लिये उपलब्ध हो।

कीमत निर्धारण हेतु सामान्यतः ध्यान में रखी जाने वाली बातें निम्नलिखित हैं:

एक्सपोजर इकाईः एक उचित एक्सपोजर ईकाई या प्रीमियर आधार का निर्णय अनिवार्य है।

आधार सामग्री (डाटा): ऐतिहासिक प्रीमियम, एक्सपोजर, हानि और खर्चों के आंकडें आवश्यक हैं।

डाटा संगठनः चाहे वह कैलेंडर वर्ष, एक्सीडेंट वर्ष, रिपोर्ट वर्ष या पॉलिसी वर्ष पर आधारित हो।

समूहों का वर्गीकरण या श्रेणीकरणः जब अनुभवों को जोखिम की समानता के आधार पर उपविभाजत कर दिया जाता है तब कीमत निर्धारण की सटीकता बढ़जाती है।

आंकडों की विश्वसनीयताः एक समूह को सांख्यिकीय रूप से विश्वसनीय होने हेतु पर्याप्त रूप से बड़ा होना चाहिये।

प्रत्याशित हानि का निर्धारणः दावों का अनुमानित मूल्य तथा दावों की लागत।

प्रीमियम तथा दावों की प्रवृत्तिः प्रीमियम में संभावित परिवर्तन तथा दावों को ध्यान में रखा जाता है।

आकस्मिक विपत्ति का प्रभावः इसका ध्यान रखा जाना चाहिये।

पुनर्बीमाः पुनर्बीमा के प्रभावों को ध्यान में रखना चाहिये।

इस प्रकार, प्रतियोगिता की स्थिति में जोखिम सुरक्षा हेतु बीमाकर्ता ऐसी दर चाहता है जिसमें कि लाभ का अंश भी हो, आने वाले दावों की लागत भी शामिल हो तथा आवश्यक खर्चों की लागत भी समाहित हो जहाँ यह किसी विशेष प्रकार के व्यवसाय को आकर्षित करने की इच्छा है, डिस्काउंट्स का प्रलोभन दिया जा सकता है। दूसरी तरफ, कुछ बीमाओं की कीमत वृद्धि हो सकती है क्योंकि वे अवांछित लक्षण प्रस्तुत करती है। अभी, भारत में शुल्क के तहत अधिकांश जोथिम संपत्ति जोखिम है। गैरशुल्कीकरण के तहत पृष्ठांकन समूह / गैर जीवन बीमा कंपनियों के विभाग को इस आकर्षक कार्य में अवश्य शामिल होना चाहिये। जिसमें कि गैरशुल्कीकृत वातावरण में कार्य करने की चुनौतियाँ स्वीकारने हेतु तैयारी की जाती है। कंपनियों को अपने पृष्ठांकन दिशा निर्देशों का वृहद् स्पष्टीकरण करना चाहिये। और चाहे अपने आंतरिक निर्देशित मूल्यों की योजना पर कार्य करना हो, या जो संभवतः हो चुके हों उन पर करना हो- उन पर दृढ़रहना चाहिये। कीमत निर्धारण प्रक्रिया में कीमत निर्धारण के अलावा और भी कई बातें ध्यान में रखी जाती है जैसे- विपणन लक्ष्य, प्रतियोगिता, कानूनी प्रतिबंध आदि।

'पृष्ठांकन' तथा 'मूल्यांकन' का गैरशुल्कीकरण स्थिति में अत्यंत महत्व होता है। बीमा के ये दो आधारभूत कार्य साथ साथ चलते हैं। सच्चे अर्थों में पृष्ठांकन का कंपनियों में आगमन गैरशुल्कीकरण का ही परिणाम है। पृष्ठांकन की प्रक्रिया, सुरक्षा हेतु आधारभूत दर का निर्धारण करती है। प्रीमियम की गणना में मूल्य आधार से मूल्यांकन तत्वों की श्रंखला का उपयोग होता है। मूल्यांकन तत्व ऐसे तत्व हैं जो कि आधार मूल्य को परिवर्तित कर देते हैं। क्योंकि बीमाकर्ता का यह दृढविश्वास होता है कि यह तत्व जोखिम में अंतर को प्रदर्शित करता है। मूल्यांकन तत्व जोखिम में अंतर को प्रदर्शित करता है। मूल्यांकन तत्व मूल्य को बढ़ा सकता है (अधिभार) या घटा सकता है (छूट)।

> कीमत निर्धारण, मूल्यांकन और पृष्ठांकन पर गैर-जीवन बीमा उद्योग में आज पहले से कहीं अधिक चर्चा की जा रही है।

तीन मुख्य व्यवसाय, जो कि गैरशुल्कीकृत होने वाले हैं- अग्नि, मोटर तथा इंजीनियरिंग बीमा। अग्नि बीमा हेतु, मूल्य निर्धारण करते वक्त एक पृष्ठांकक, संबंधित जोखिम की श्रेणी निर्धारण के लिये पूर्व हानियों के आंकडों से निर्देशित होता है। वह तब यह देखता है कि क्या बीमा हेतु प्रस्तावित संपत्ति अपने वर्ग का उत्तम जोखिम है अथवा नही। कुछ बातें जो कि किसी पृष्ठांकक को अवश्य ध्यान में रखनी चाहिये- क्या बीमित परिसर में आग लगने की संभावना है? क्या परिसर में गर्मी, रोशनी और सूखा है? इन प्रक्रियाओं हेतु क्या तरीके अपनाये जा रहे हैं? क्या स्टॉक ज्वलनशील है? यदि आग लग जाती है, तो क्या वह जल्दी से फैल सकती है? इमारत की ऊचाई की कितनी है? क्या वहाँ निर्मित सूखा आग की भयंकरता का कारण हो सकता है? क्या इस प्रकार की इमारत में अग्निशमन कर्मचारियों को अग्नि नियंत्रण में परेशानी हो सकती है? क्या वहाँ खतरनाक कार्य किये जा रहे हैं? क्या वहाँ पैट्रोलियम है?- इन प्रश्नों कै उत्तर आधार मूल्य को घटा या बढ़ा सकते हैं। कुछ अच्छे कारकों पर कीमतों में कमी प्रस्तावित की जा सकती है जैसे कि अग्निरोधक उपकरणों हेतु। उच्च जोखिम परिस्थितियों में उच्च प्रीमियम जायज है। भौतिक जोखिमों के अतिरिक्त, कार्यालय प्रबंधन की गुणवत्ता का भी प्रभाव पड़ता है। अच्छा प्रबंधन छूट का भागी होता है जबकि खराब प्रबंधन उच्च दर के लिये जिम्मेदार होता है। अतः कीमत निर्धारण प्रक्रिया में जोखिम के समस्त कारक विचारणीय होते हैं।

जब मोटर वाहन क्षति के बीमा की बात होती है, तब प्रीमियम का निर्धारण— वाहन के प्रकार, उसके उपयोग का भौगोलिक क्षेत्र, वाहन की एचपी अथवा सीसी क्षमता, वाहन की उम्र , वाहन में बैठने की संख्या की क्षमता (यदि यह एक यात्री वाहन), वाहन की कीमत आदि पर निर्भर करती है।

सामान्य मूल्यांकन करते वक्त इन सब तथ्यों को ध्यान में रखना चाहिये। शायद बीमाकर्ता कुछ विशेष बातों को भी ध्यान में रख सकता है जैसे कि खराब दुर्घटना रिकार्ड, बहुत युवा चालक जो कि अनुभवहीन या लापरवाह हो, कुछ विशेष व्यवसाय (जैसे मोटर स्पोर्टर्स) जो कि उच्चतर जोखिम वाले हों, गाड़ी के ऐसे मॉडल जो कि बहुत तेज गति वाले हों, या ऐसी गाड़ी जिनकी मरम्मत महंगी हो या जो कि बहुत खराब स्थिति में हो पुरानी होने की वजह से आदि। तृतीय पक्ष के मोटर बीमा जोखिम का मूल्यांकन न सिर्फ संबंधित प्रचलित कानूनों पर निर्भर करता है बल्कि बीमाकर्ता के अनुभव पर भी निर्भर करता है।

इंजीनियरिंग जोखिम में- विभिन्न प्रकार की मशीनों के बंद हो जाने, बायलर विस्फोट जैसे जोखिमों के साथ ही जटिल विधुतीय उपकरण तथा संरचना जोखिम भी शामिल है। छूट या अधिभार निश्चित करने से पूर्व यह अध्ययन आवश्यक है कि प्रत्येक मशीनरी या संरचना जोखिम के अच्छे और बुरे लक्षण होते हैं।

निष्कर्षतः कीमत निर्धारण, मूल्यांकन और पृष्ठांकन पर गैर-जीवन बीमा उद्योग में आज पहले से कहीं अधिक चर्चा की जा रही है। गैर - जीवन बीमा उद्योग के समक्ष चुनौतीपूर्ण तथा आकर्षक समय सामने है।

★★★

लेखक आईआरडीए में कायर्रत हैं।

Report Card: GENERAL

G. V. Rao

August Growth is 16.8 percent.

There is a slight deceleration in the premium growth momentum in the month of August 2006, compared to the high growth rates recorded in the previous months of the fiscal. The premium growth in August 2006, nevertheless, is an impressive 16.8 percent with a premium accretion of Rs.264 crore. But this lowered growth rate, however, has brought the overall growth rate, at the end of August 2006, down to 20.3 percent.

The reason for the slight deceleration in the growth rate is due to a lowered growth rate, recorded by the established players, of 5.9 percent. The new players have recorded a growth rate of 43 percent, but lower than the usual: in excess of the 50 percent growth rates of earlier months.

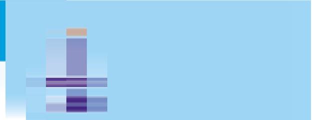
There is an uneven scale of accretions recorded among the established players and the new players too, pointing out that, with competition getting tougher, all the players' marketing efforts seem to be driven by strategies quite independent of each other.

'GROSS PREMIUM UNDERWRITTEN FOR AND UP TO THE MONTH OF AUGUST, 2006

(Rs.in lakhs)

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	4479.30	24511.28	3900.00	19020.00	28.87
Tata-AIG	6236.67	34348.93	5030.99	25330.37	35.60
Reliance General	5933.74	27353.55	886.25	6609.82	313.83
IFFCO-Tokio	8224.13	57086.03	7518.48	48424.39	17.89
ICICI-lombard	24805.59	128452.44	13044.91	70454.83	82.32
Bajaj Allianz	12540.91	71356.78	12572.38	53863.69	32.48
HDFC CHUBB	1573.92	7651.63	1785.04	7765.68	-1.47
Cholamandalam	2377.78	12808.05	1612.44	10708.12	19.61
New India	36311.00	209307.00	36539.00	186958.00	11.95
National	27259.00	154231.00	25781.00	149465.00	3.19
United India	25993.00	148882.00	24367.00	138899.00	7.19
Oriental	28199.00	166744.00	24588.00	149378.00	11.63
SPECIALISED INSTITUTIONS:					
ECGC	4721.99	23830.22	4145.43	21941.44	8.61
Star Health & Allied Insurance*	34.06	89.55	0.00	0.00	

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



ICICI- Lombard with an accretion of Rs.118 crore, Reliance with Rs.50 crore and Oriental with Rs.36 crore lead the premium league (77 percent of total accretion) in August 2006. Surprisingly, New India has dropped its renewal premium by Rs.2 crore and Bajaj-Allianz by a few lakhs. HDFC-Chubb too has dropped its premium by Rs.2 crore.

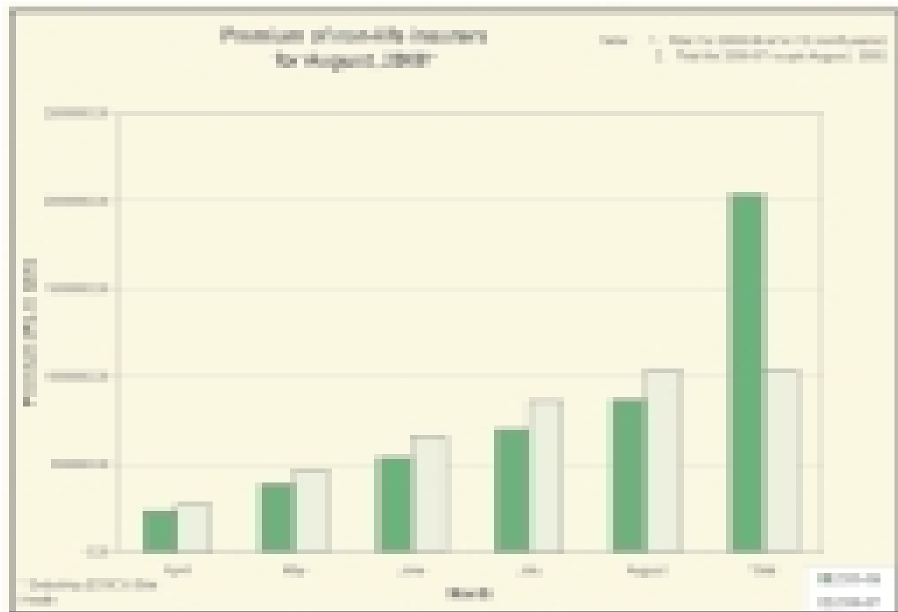
Another feature of the August monthly showings is that the premium of ICICI-Lombard of Rs.248 crore is about 95 percent of the United India's of Rs.260 crore and 91 percent of the National Insurance. The gap between the established players and one new player at least is fast closing. The gap between ICICI -Lombard and the next ranked Bajaj-Allianz is also widening to the point that the premium of the former at the end of August is twice the size of the latter.

Reliance is sprinting, fast catching up with others for the earlier lost time. The August month has shown it has recorded Rs.50 crore in its accretion on its meager Rs.9 crore renewal premium.

Up to August 2006:

At the end of August 2006, the non-life market has recorded an accretion of Rs.1760 crore at a growth rate of 20.3 percent. The overall market premium at the end of August has crossed Rs.10,429 crore against the corresponding Rs.8670 crore. The established players have achieved a growth rate of 8.7 percent and an accretion of Rs.543 crore. The new players have recorded an accretion of Rs.1216 crore at a growth rate of 50.2 percent.

Among the private players, ICICI-Lombard leads in premium accretion



with Rs.580 crore accretion. New India with an accretion of Rs.223 crore comes next. Reliance with Rs.208 crore, Bajaj-Allianz with Rs.175 crore and Oriental with Rs.173 crore follow. These five players together account for Rs.1359 crore of the total accretion achieved of Rs.1759 crore.

The market share of the new players continues to remain at 35 percent as in the previous months.

Final word:

In the absence of the portfolio increase analysis, one cannot gauge and comment on the key drivers in the market. But the premium growth of over 20 percent is quite impressive. With detariffing scenario likely to emerge in the next four months, it would be interesting to observe if the premium levels of each player would change. Reliance has shown a market aggressiveness not seen in recent times.

The drop in the growth rate of the established players in the month of August 2006 to 5.9 percent is not a particularly welcome sign. The run up to the detariffing stage must show more signs of activity on the part of the market players, as a whole. With current rates in fire, engineering and motor likely to drop, as expected, there should be more vigorous signs of persuading the fence sitters among the consumers to take the insurance plunge. More premiums in the kitty mean more investment income. Would the market see a new effervescence in the marketing efforts in the next four months? Market logic would seem to suggest so; but the reality check of inertia may call in a different tune. There are bound to be interesting times ahead, whatever happens.

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

GROSS PREMIUM UNDERWRITTEN BY NON-LIFE INSURERS WITHIN INDIA

Rs. in Lakhs

Sl No.	Insurer	Fire	Marine	Marine Cargo	Marine Hull	Engineer-ing	Motor	Motor OD
1	Royal Sundaram	4,544.96	687.82	687.82	0.00	924.91	6,335.58	5,686.82
	Previous year	3,552.00	494.00	486.00	8.00	645.00	5,184.00	4,624.00
2	TATA-AIG	6,445.42	1,890.25	1,890.25	0.00	998.25	7,132.91	6,544.43
	Previous year	5,144.89	1,319.34	1,319.34	0.00	573.79	5,209.95	4,761.26
3	Reliance	7,244.94	486.06	423.24	62.82	1,648.60	3,346.70	3,341.98
	Previous year	1,496.24	1,213.94	319.38	894.56	580.28	424.74	413.51
4	IFFCO Tokio	15,042.78	4,000.99	1,262.21	2,738.78	2,093.42	11,227.74	9,283.74
	Previous year	11,565.73	978.46	861.08	117.38	1,729.02	6,305.07	5,504.92
5	ICICI Lombard	17,051.99	4,372.75	1,486.43	2,886.33	4,772.29	23,373.30	20,948.08
	Previous year	12,941.57	3,904.34	1,346.91	2,557.44	2,909.86	8,179.41	7,140.87
6	Bajaj Allianz	14,080.11	2,044.13	1,845.05	199.08	5,204.53	15,583.65	11,969.76
	Previous year	9,544.79	1,528.86	1,051.47	477.39	3,459.99	11,309.50	7,539.67
7	HDFC Chubb	278.50	57.66	57.66	0.00	85.78	3,098.23	2,935.99
	Previous year	106.19	14.65	14.65	0.00	69.29	3,168.68	2,998.92
8	Cholamandalam	3,200.15	625.56	608.37	17.20	747.62	1,562.40	1,440.22
	Previous year	3,040.53	393.39	370.56	22.83	604.93	1,572.46	1,391.53
9	New India	30,829.73	7,359.26	3,839.19	3,520.07	5,755.42	52,990.00	35,300.60
	Previous year	28,223.34	6,395.64	3,987.18	2,408.46	3,920.53	47,735.93	32,194.78
10	National	19,318.28	5,137.39	3,279.23	1,858.16	3,028.94	46,053.04	31,626.66
	Previous year	16,945.21	4,570.79	3,702.72	868.07	3,059.83	47,614.25	33,225.59
11	United India	25,016.65	10,279.83	3,806.01	6,473.82	5,264.68	28,597.18	19,267.38
	Previous year	24,618.95	9,519.98	3,518.08	6,001.90	4,442.12	27,834.14	17,279.89
12	Oriental	20,231.99	8,561.22	4,694.49	3,866.73	5,343.78	39,816.28	27,703.29
	Previous year	19,610.47	7,303.74	3,181.56	4,122.18	5,398.94	35,598.10	25,434.08
	Grand Total	163,285.51	45,502.93	23,879.95	21,622.98	35,868.21	239,117.01	176,048.94
	Previous year	136,789.91	37,637.13	20,158.93	17,478.21	27,393.58	200,136.24	142,509.03
	SPECIALISED INSTITUTIONS							
13	ECGC *							
	Previous year							
14	Star Health & Allied Insurance**							
	Previous year							

Note: In case of public sector insurance companies, the segment wise data submitted may vary from the flash Nos filed with the Authority. As such, the industry totals may vary from the flash figures published for the month of June, 2006

*Pertains to Credit Insurance.

** Pertains to Health Insurance. Commenced operations in May, 2006

The Quarterly segment-wise business figures are being given in the Journal for the first time.

(SEGMENT WISE) : FIRST QUARTER ENDED JUNE, 2006

Motor TP	Health	Aviation	Liability	Personal Accident	All Others	Grand Total
648.76	1,905.68	0.00	345.01	603.81	180.38	15,528.15
560.00	1,161.00	0.00	287.00	581.00	131.00	12,035.00
588.48	1,142.39	0.00	1,996.70	1,971.11	639.47	22,216.51
448.69	963.43	2.22	2,000.97	1,390.59	291.45	16,896.64
4.72	1,665.30	187.04	230.80	463.94	1,145.72	16,419.10
11.23	187.41	174.77	97.53	186.61	412.08	4,773.60
1,944.00	1,452.34	39.64	361.18	357.33	1,876.25	36,451.67
800.15	1,091.66	0.00	327.53	272.30	1,358.62	23,628.39
2,425.22	17,212.37	606.08	4,101.34	2,806.30	7,077.54	81,373.96
1,038.54	5,420.86	1,213.00	2,771.77	2,079.83	2,918.40	42,339.04
3,613.89	3,856.05	57.76	890.86	653.09	2,595.97	44,966.16
3,769.83	2,658.83	78.16	489.46	320.99	2,513.73	31,904.31
162.24	217.43	0.00	111.56	275.46	313.70	4,438.33
169.76	93.07	0.00	30.20	256.96	503.28	4,242.32
122.18	752.76	0.00	313.74	229.61	536.04	7,967.87
180.93	501.68	0.00	247.18	303.54	502.56	7,166.27
17,689.40	19,660.28	2,050.60	1,755.17	2,237.19	13,764.94	136,402.59
15,541.15	15,680.04	542.26	1,673.49	1,997.01	11,738.68	117,906.92
14,426.38	9,614.74	1,517.32	996.70	1,567.18	9,775.42	97,009.01
14,388.66	8,474.54	1,119.10	1,079.41	1,431.19	9,892.58	94,186.90
9,329.80	10,149.12	31.37	1,850.52	1,567.58	14,358.80	97,115.73
10,554.25	8,094.66	73.80	1,485.45	1,463.25	12,159.50	89,691.85
12,112.99	11,202.57	2,382.66	1,476.54	2,008.06	11,988.61	103,011.71
10,164.02	9,201.06	3,947.62	1,131.11	1,754.29	9,367.75	93,313.08
63,068.07	78,831.04	6,872.47	14,430.12	14,740.65	64,252.84	662,900.78
57,627.21	53,528.24	7,150.94	11,621.09	12,037.56	51,789.62	538,084.32
					13,710.24	13,710.24
					13,435.87	13,435.87
					16.82	16.82
					0.00	0.00

We will be publishing Quarterly business figures henceforth as a regular feature.

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (IRDA) ORGANIZED 'IAIS-CGAP MEETING ON MICRO INSURANCE' ON 30TH AUG. AND 1ST SEP. 2006 AT HYDERABAD.

Photograph shows (from L to R):
Ms. Martina Weidmaier-Pfister, GTZ, Germany; Mr. C.S. Rao, Chairman, IRDA (India); and Mr. Arup Chatterjee, Member of Secretariat, IAIS, Basel, Switzerland.

Delegates from various countries who attended the meeting.

INSURANCE BROKERS ASSOCIATION OF INDIA (IBAI) ORGANIZED THE THIRD ANNUAL CONFERENCE ON 19TH SEPTEMBER AT MUMBAI. BOOKS AUTHORED BY SOME OF THE MEMBERS WERE RELEASED ON THIS OCCASION.

Photograph shows the release of two books authored by Mr. S.K.Jain viz. Compilation of Legal Decisions in (1) Life Insurance and (2) General Insurance.

Photograph shows (L to R) Mr. Sohanlal Khadel, Director & VP, IBAI; Mr. S.K.Jain; Mr.C.S. Rao, Chairman, IRDA; Mr. Bharat J.Boda, President, IBAI; Mr. Hari Padmanabhan, Dy.MD, 3i Infotech Ltd.; Mr. Anirudh Prabhakar, COO, 3i Infotech; Mr. Nitin Dossa, Director & Treasurer, IBAI.

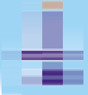
Chairman, IRDA releasing the book 'Best Guide to buy Health Insurance' by Mr. Suresh K. Sethi.

यह आपका भविष्य है। उसकी सुरक्षा करें।

बीमा से सम्बन्धित कुछ शंकाओं का समाधान !

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

आप इस विज्ञापन को अपने आंतरिक प्रकाशन में बेहिचक मुद्रित कर सकते हैं।



09-10 Oct 2006
Venue: Mumbai
Tenth Insurance Summit
By Confederation of Indian Industry

09-11 Oct 2006
Venue: Pune
Workshop on Reinsurance
By NIA Pune

12 Oct 2006
Venue: Mumbai
Risk Summit 2006
By Asia Insurance Post

12-13 Oct 2006
Venue: Hainan Island, China
7th China Rendezvous
By Asia Insurance Review, Singapore

16-18 Oct 2006
Venue: Pune
Insurance Management of Energy Risk
By NIA Pune

30 Oct - 04 Nov 2006
Venue: : Pune
Integrated Management
Program for Line Managers
By NIA Pune

01 Nov - 02 Nov 2006
Venue: New Delhi
Developing Pro-Poor Health Insurance in India
By FICCI

06 Nov - 11 Nov 2006
Venue: Pune
Reinsurance Management
By NIA Pune

20 Nov - 21 Nov 2006
Venue: Pune
Seminar on Incidence Response Management
By NIA Pune

20 Nov - 21 Nov 2006
Venue: Shanghai
4th Asian Conference on Claims Management
By Asia Insurance Review, Singapore

23 Nov - 24 Nov 2006
Venue: Shanghai
3rd Asian Conference on
Pensions & Retirement Planning
By Asia Insurance Review, Singapore

RNI No: APBIL/2002/9589

VIEW POINT

"Insurers and customers have one common interest - to jointly contribute to the assessment and evolution of risks; and thus agree on the mapping of risks."

- **Mr Patrick de la Morinerie, President,**
International Union of Marine Insurance (IUMI).

"An effective regulator must keep up with the increasingly rapid pace of the integration of global economies and financial markets. To sustain economic growth and promote open markets, supervisors must require a sound, strong and efficient regulatory framework "

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

"We can avoid market uncertainty and disruption by developing good policy before we get too close to the expiration of the existing TRIA (Terrorism Risk Insurance Act) program."

- **Mr. Howard Mills**
Superintendent of the New York Insurance Department.

"The world over, detariffing is a step-by step process. We have been telling insurers to continue the existing tariff conditions at present, as any alteration will add to the confusion in the market."

- **Mr. C.S. Rao, Chairman,**
Insurance Regulatory and Development Authority, India

"Your broad base of specialized knowledge allows you a more holistic view of the insurance industry. By assimilating your understanding of the past and your knowledge of the present, you can develop a vision for the future."

- **Mr. Peter L Miller,** American Institute President & CEO,
addressing CPCU' 2006 class.

"State insurance officials share the commitment to combat those who prey on the financial security of our military personnel; and to provide the men and women in the armed forces with the highest level of consumer protection."

- **Mr. Alessandro Iuppa,**
NAIC President