भारतीय बीमा विनियामक और विकास प्राधिकरण

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

Promoting insurance. Protecting insured.

www.irdai.gov.in www.policyholder.gov.in

CONSUMER AFFAIRS BOOKLET

Bima Bemisaal

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FOREWORD

Dr. Subhash Chandra Khuntia
Chairman

Protection of the interest of the policyholders is part of the mission statement of IRDAI. Consumer grievance redressal framework in Insurance sector has undergone a sea change with the notification of Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017 and Insurance Ombudsman Rules, 2017. These are aimed to ensure that all regulated entities fulfil their obligations towards the policyholders.

At present the Indian Insurance industry is going through a rapid digital transformation with the advent of new technologies, new age Insurers and digitisation of distribution channels. During this phase, we must ensure that the interests of policyholders are adequately safeguarded at all times.

In this background, Consumer Affairs Department is publishing this booklet with analysis of policyholder grievances, complaint statistics, measures taken by IRDAI to reduce complaints, claims data etc. for the years 2017-18 and 2018-19. It is hoped that this booklet will provide important information and inputs to Insurers and other regulated entities and to other stakeholder so that research and analysis of data would ultimately result in improvement of services to the customers.

Regulatory Framework for Protection of Policyholders - Major developments during 2017-18 & 2018-19

A. Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017.

The Basic framework governing policyholder protection was laid out in Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2002.

IRDAI notified Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017 on 22nd June, 2017 in supersession of the above mentioned regulations.

These regulations cover important aspects such as procedures for code of conduct to be followed at point of sale, claim settlement, grievance handling mechanism etc. which are aimed to ensure policyholder centric governance by insurers.

An illustration comparing PPHI Regulations, 2002 vis-a-vis PPHI Regulations, 2017 has been made for informational purposes and placed on our website. You may access this comparison on our website.

B. Insurance Ombudsman Rules, 2017:

In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance up to a certain limit, Government introduced a system of Ombudsman in the Insurance Sector by notifying Redressal of Public Grievances Rules, 1998 with effect from 11th November 1998.

Government of India vide Gazette Notification dated 25th April, 2017 had notified Insurance Ombudsman Rules, 2017 in supersession of the Redressal of Public Grievances Rules, 1998.

These rules cover important aspects such as appointment of Insurance Ombudsman; manner, timelines and grounds on which a complaint can be made to Insurance Ombudsman; timelines for disposal of complaints, compliance of awards by Insurers etc.

An illustration comparing Redressal of Public Grievances Rules, 1998 vis-a-vis Insurance Ombudsman Rules, 2017 has been made for informational purposes and placed on our website. You may access this comparison on our website.

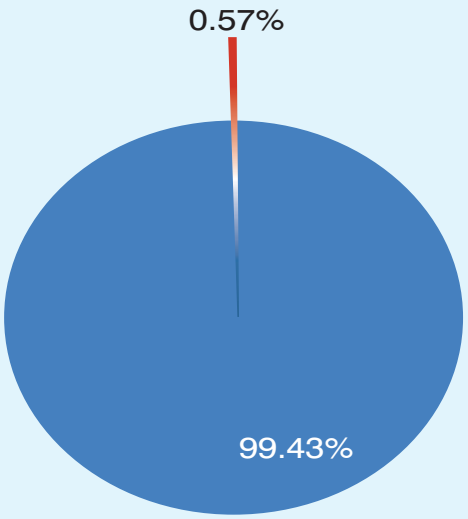
C. Circulars issued by Consumer Affairs Department during the past 2 financial years.

1. Insurance Regulatory and Development Authority of India vide its circular Ref. IRDAI/CAD/CIR/MISC/001/01/2019 dated 21-01-2019 directed all Life insurers to submit quarterly statements on Mis-selling complaints with a view to monitor market conduct of Agents, Insures and Insurance Intermediaries in an efficient way.

2. Insurance Regulatory and Development Authority of India observed instances of non-compliance of awards passed by Insurance Ombudsman by Insurance Companies. Therefore, IRDAI had issued a circular Ref. IRDAI/CAD/ CIR/MISC/038/ 03/2019 dated 05-03-2019 cautioning insurance companies to comply with the awards passed by Insurance Ombudsman or file an appeal within the stipulated timelines under Insurance Ombudsman Rules, 2017.

Snapshot - Grievances

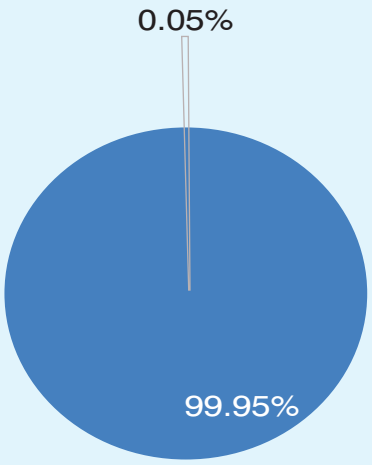
COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS NEW BUSINESS - NO. OF POLICIES SOLD (INDIVIDUAL BUSINESS WITHIN INDIA) - 2018-19



No.of New Policies sold in2018-19	: 28687812*
No.of Complaints Registered in 2018-19	: 163264
Percentage of complaints registered to new policies issued	: 0.57%

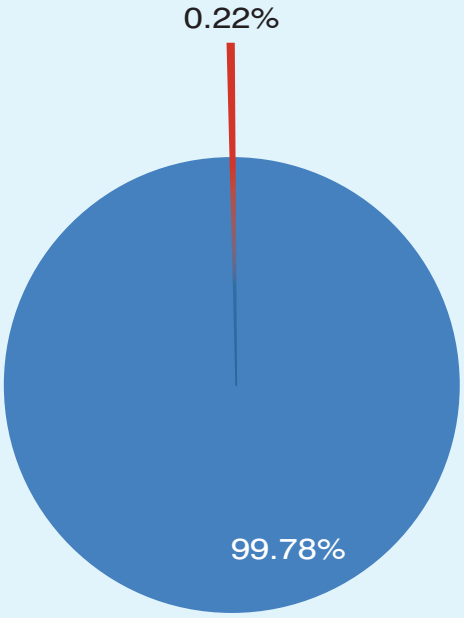
*Provisional Figures

COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS BUSINESS FORCE (INDIVIDUAL BUSINESS WITHIN INDIA)



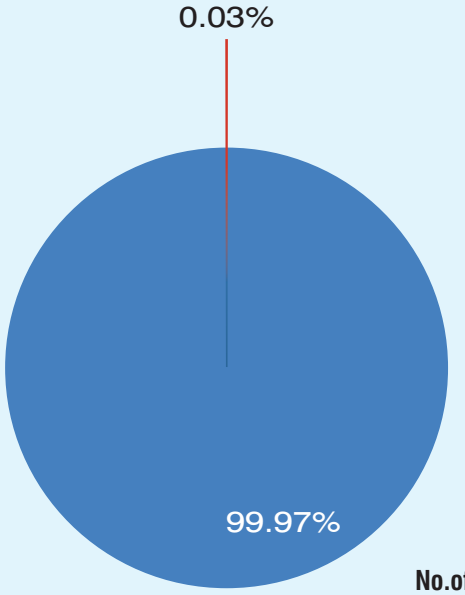
Business in force - No. of Polices as at 31.03.2018	: 331485085
No. of Complaints registered in 2017-18	: 154367
Percentage of complaints registered in 2017-18 to Business in force as 31.03.2018	: 0.05%

ANALYSIS OF LIFE INSURANCE COMPLAINTS VIS-A-VIS NO.OF DEATH CLAIMS



No.of Death claims intimated during the year 2017-18: 1607754
No.of Complaints on Death Claims registered during the year 2018-19 : 3586
% of complaints on death claims to death claims intimated : 0.22%

ANALYSIS OF NON-LIFE INSURANCE COMPLAINTS VIS-A-VIS NO.OF POLICIES SOLD



No.of Policies sold in 2017-18 : 164371786
No.of Complaints Registered in 2017-18: 43995
Percentage of complaints registered to policies issued in the year 2017-18:0.03%

No.of Complaints Registered in the year 2018-19 : 42761
%of complaints registered in 2018-19 to the policies issued in 2017-18 : 0.03%

SUMMARY OF GRIEVANCES – 2018-19

Integrated Grievance Management System (IGMS)

"Integrated Grievance Management System" (IGMS) is a comprehensive solution which not only has the ability to provide a centralized and online access to the insurance customer but also provides for access to IRDAI for customer grievances. IGMS provides an alternate channel for online registration and tracking of complaints by insurance customers. It captures the resolution provided by insurer to the complaints. It also captures complaints registered by insurers and resolution provided to these complaints by them by replicating the insurer database of complaints on IGMS and vice-versa. Thus, IGMS provides a standard platform to all insurance companies to resolve proposer or policyholder's grievances and provides IRDAI with a tool to monitor the effectiveness of the grievance redress system of insurance companies. Therefore, apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool of IRDAI.

Grievances handling at IRDAI

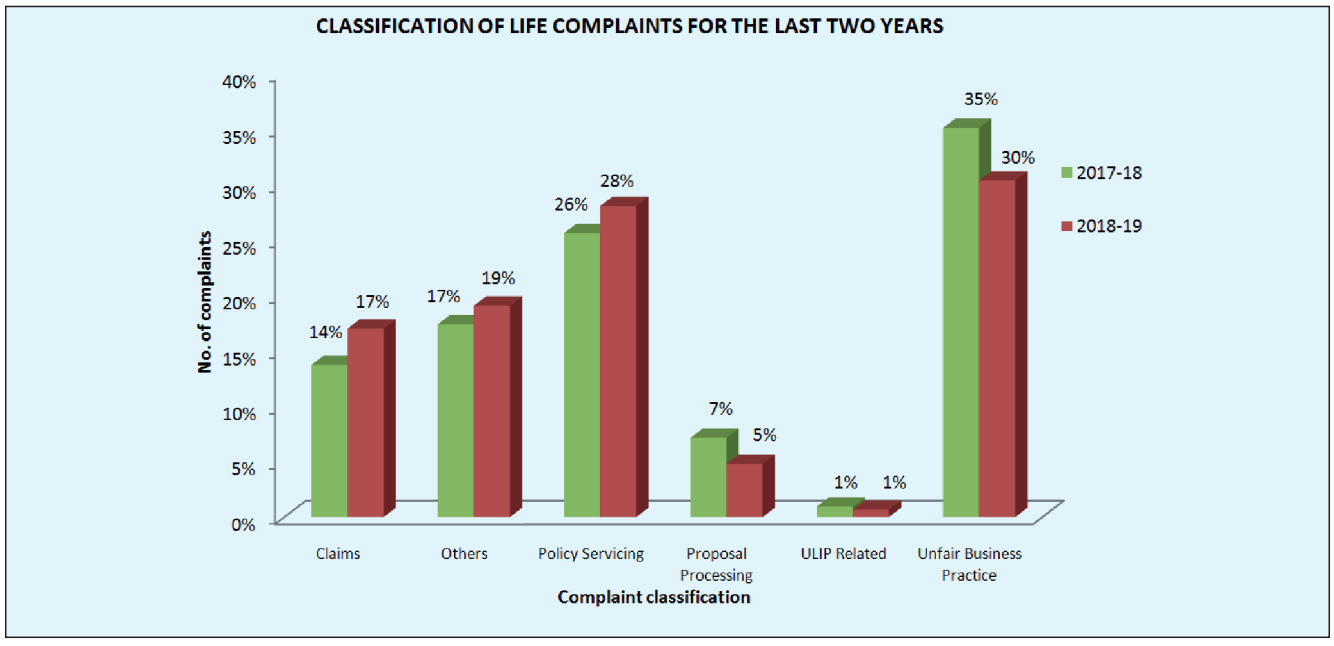
The complaint is registered with a unique token number. An acknowledgement of complaint with the complaint token number is sent to the complainant by email or if no email id is registered, by letter to his postal address. A brief description of the grievance is given on the IGMS. The documents relating to the complaint are captured and forwarded to the insurance company for resolution. The insurance company is required to examine the complaint and attend to it within two weeks by responding to the complainant. The action taken on the complaint has to be updated by the insurance company in the IGMS. The status of the complaint and the description of action taken can be checked by the complainant from the IGMS or by calling up the IRDAI Grievance Call Centre by using the token number assigned to the complaint. In case the complainant does not come back within 8 weeks of the insurance company attending to the complaint and recording the action taken, the complaint will be closed by the insurance company. In case the company does not respond even after 15 days or if the complainant is not satisfied with the action taken, he can again escalate the complaint to IRDAI. IRDAI will then take up the complaint with the company for its resolution and responding to the complainant. In case the complainant is not satisfied with the resolution of the insurance company, he may approach the Insurance Ombudsman or the appropriate legal authority.

STATUS OF GRIEVANCES - AS PER IGMS

Life Insurers

STATUS OF GRIEVANCES - LIFE INSURERS DURING 2018-19				
Insurer	**Outstanding as on 1st April, 2018**	**Grievances Reported during 2018-19**	**Resolved during 2018-19**	**Outstanding as on 31st March, 2019**
LIC	0	102127	102127	0
PRIVATE	201	61137	61254	84
TOTAL	**201**	**163264**	**163381**	**84**

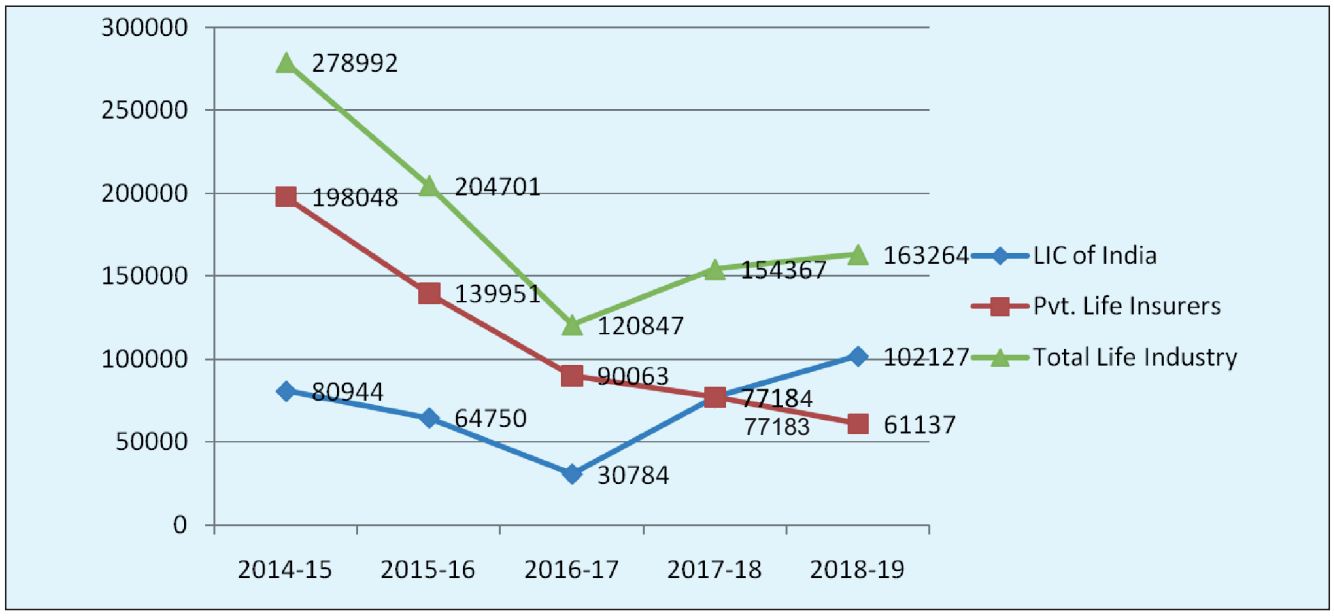
During 2018-19, the insurance companies resolved 99.95 per cent of the complaints handled. The private life insurers resolved 99.86 per cent of the complaints reported, while LIC resolved 100 per cent of the complaints as a result of which there were no pending complaints of LIC as at 31.3.2019.



As can be seen from the above, the classification as per the IGMS in terms of grievance Redressal guidelines, indicates a substantial decrease of 5% in the complaints under Unfair Business Practices and marginal decrease of 2% in the complaints under Proposal Processing during 2018-19 over 2017-18; increase of 3% in the complaints under Claims and increase of 2% in the complaints under Policy Servicing and Others during the year 2018-19 over 2017-18. The complaints under ULIP Related have maintained the same share to the total complaints during the last 2 years.

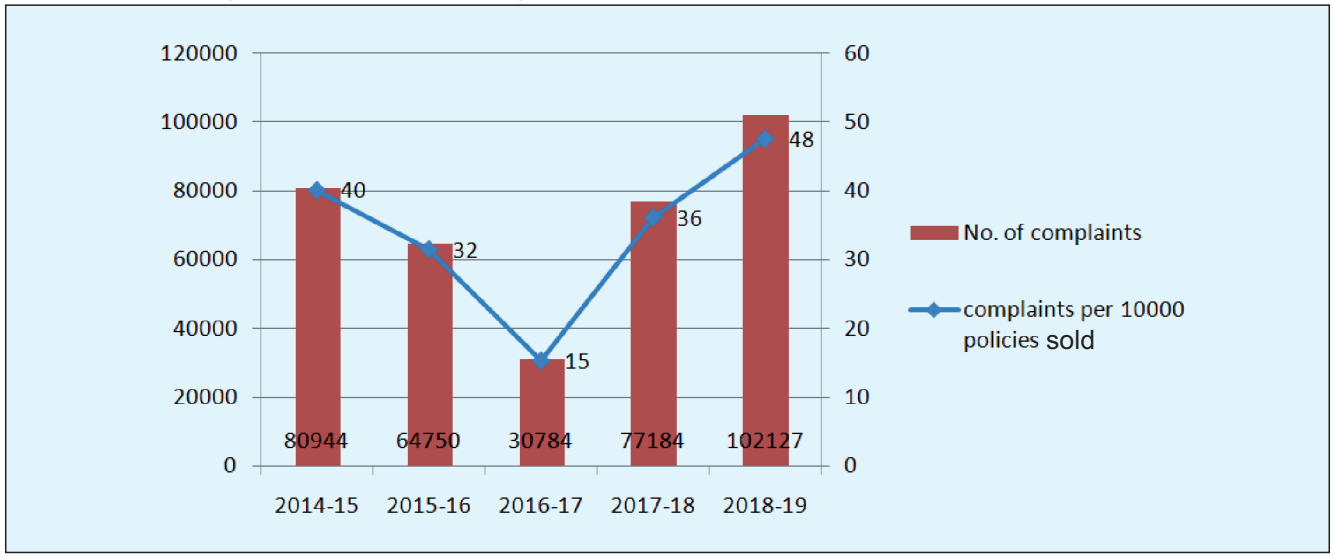
Trends in no. of complaints over the past 5 financial years- IGMS:

a. No. of complaints over the years-Total Life Insurance complaints:



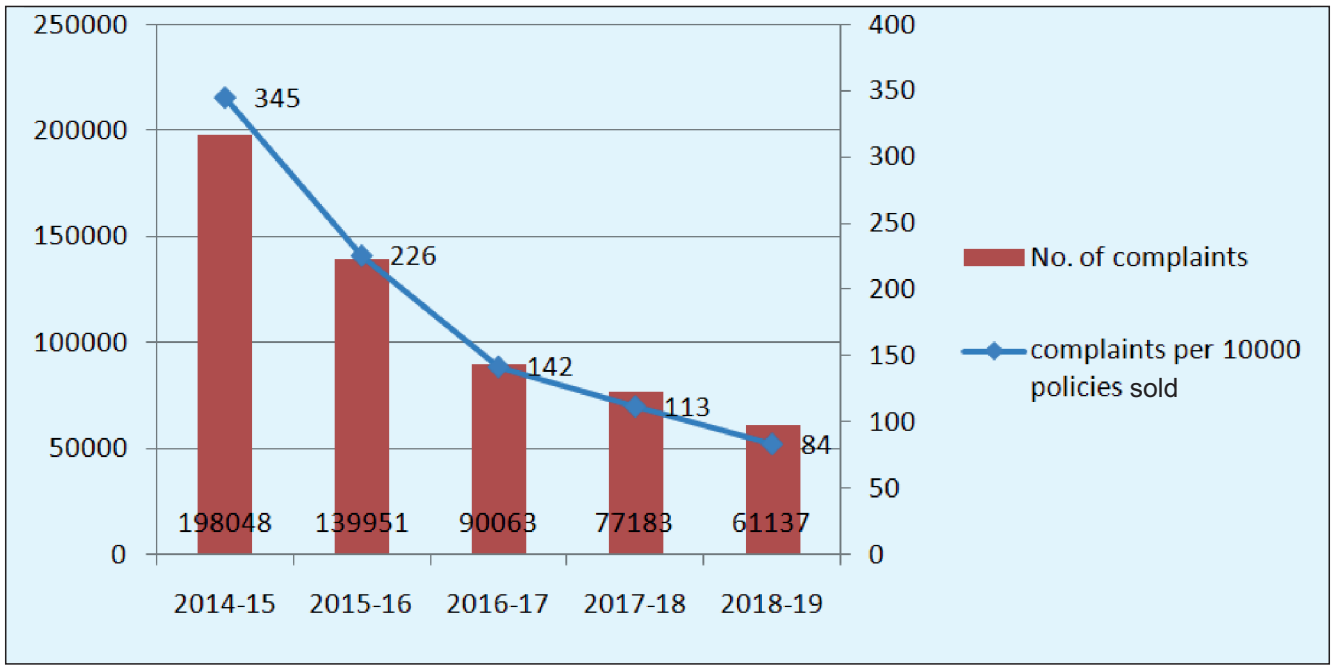
The no. of Life Insurance complaints has shown an decreasing trend from FY. 2014-15 to FY 2016-17. However, no. of Life Insurance complaints have increased from FY 2017-18 onwards. This is due to increase in no. of complaints against LIC of India. Overall, there has been a decrease of 41% in no. of complaints over the past 5 financial years(278992 in 2014-15 to 163264 in 2018-19).

b. No. of complaints vis-a-vis no. of policies sold-LIC of India



There has been a reduction of 20.01% and 52.46% in no. of complaints in F.Y. 15-16 and 16-17 respectively. However, there is an increase of 150.72% and 32.31% in the no. of complaints registered against LIC of India in the past 2 financial years respectively. Overall there has been an increase in no. of complaints from 80944 in 2014-15 to 102127 in 2018-19. (26% increase over the years)

c. No. of complaints vis-a-vis no. of policies sold-Pvt Life Insurers

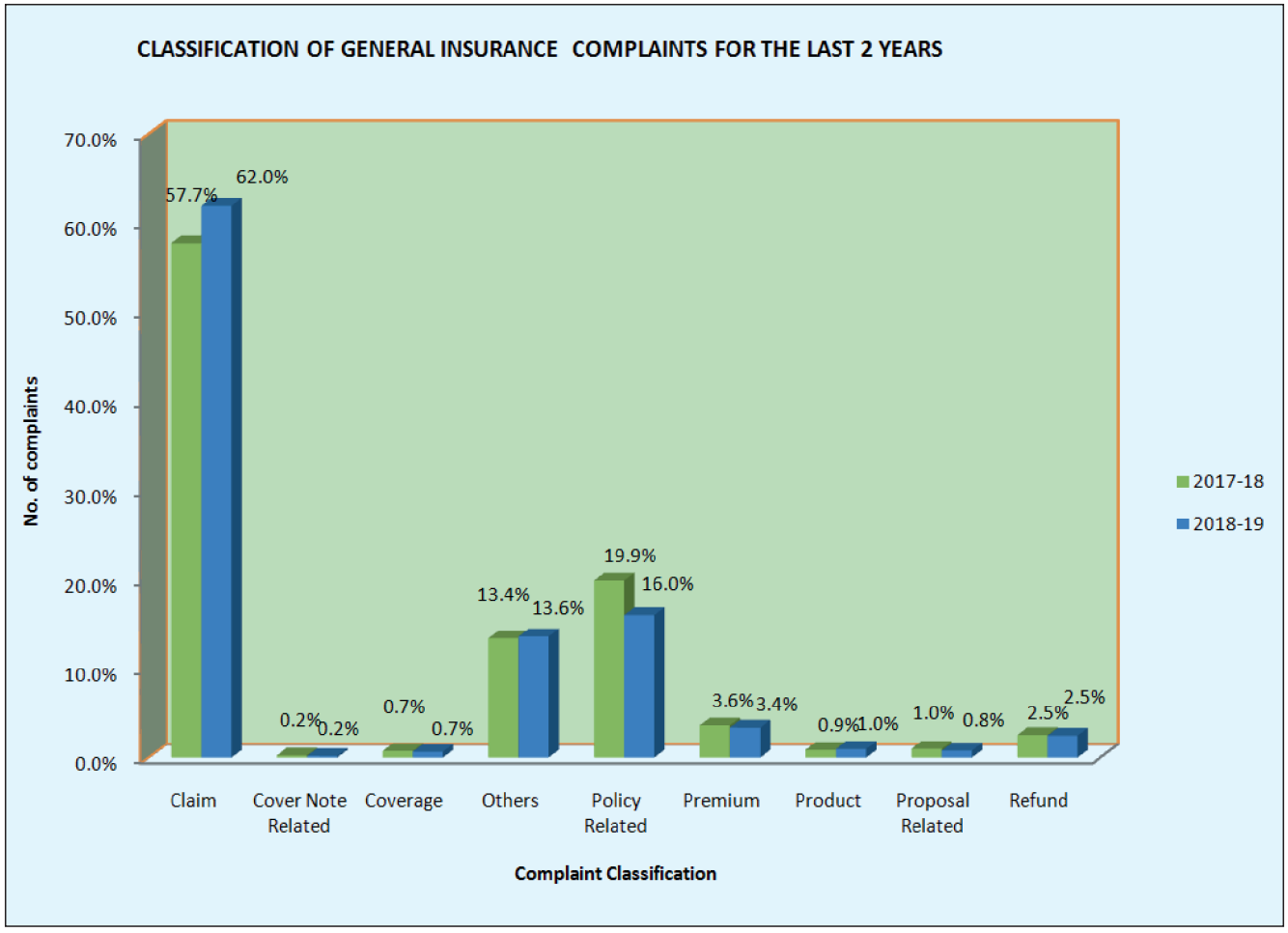


There has been a good reduction in no. of complaints from 198048 in 2014-15 to 61137 in 2018-19 against Private Life Insurers over the years (69% reduction over the years). Further, incidence of complaints for every 10,000 policies sold has also reduced drastically over the years.

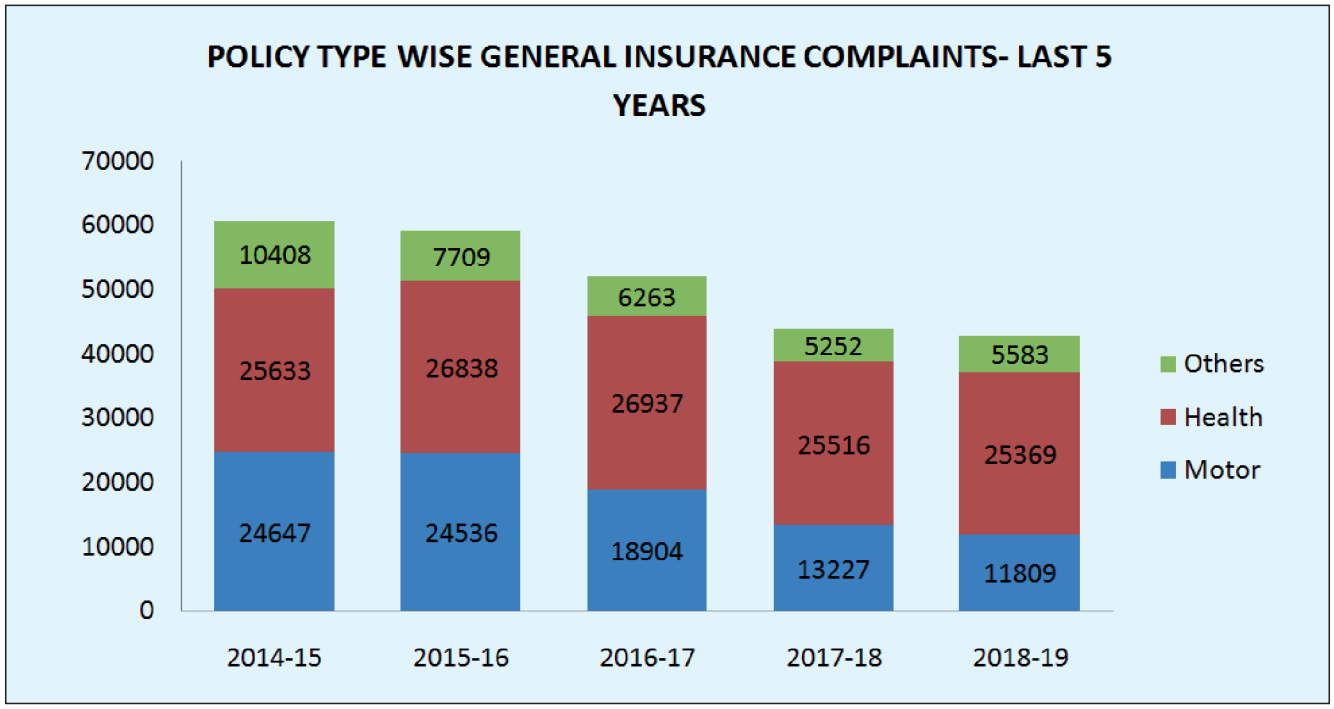
General Insurers

STATUS OF GRIEVANCES - LIFE INSURERS DURING 2018-19				
Insurer	**Outstanding as on 1st April, 2018**	**Grievances Reported during 2018-19**	**Resolved during 2018-19**	**Outstanding as on 31st March, 2019**
PUBLIC	1302	20968	21931	339
PRIVATE	344	21793	21876	261
TOTAL	**1646**	**42761**	**43807**	**600**

The General insurance companies resolved 98.65 per cent of the complaints handled during the year 2018-19. The private General insurance companies resolved 98.82 per cent and public General insurance companies resolved 98.48 per cent of the complaints handled by them. As at 31st March, 2019, a total of 600 complaints were pending for resolution, out of which 261 were belonging to private sector insurance companies and 339 were pertaining to public sector insurance companies.

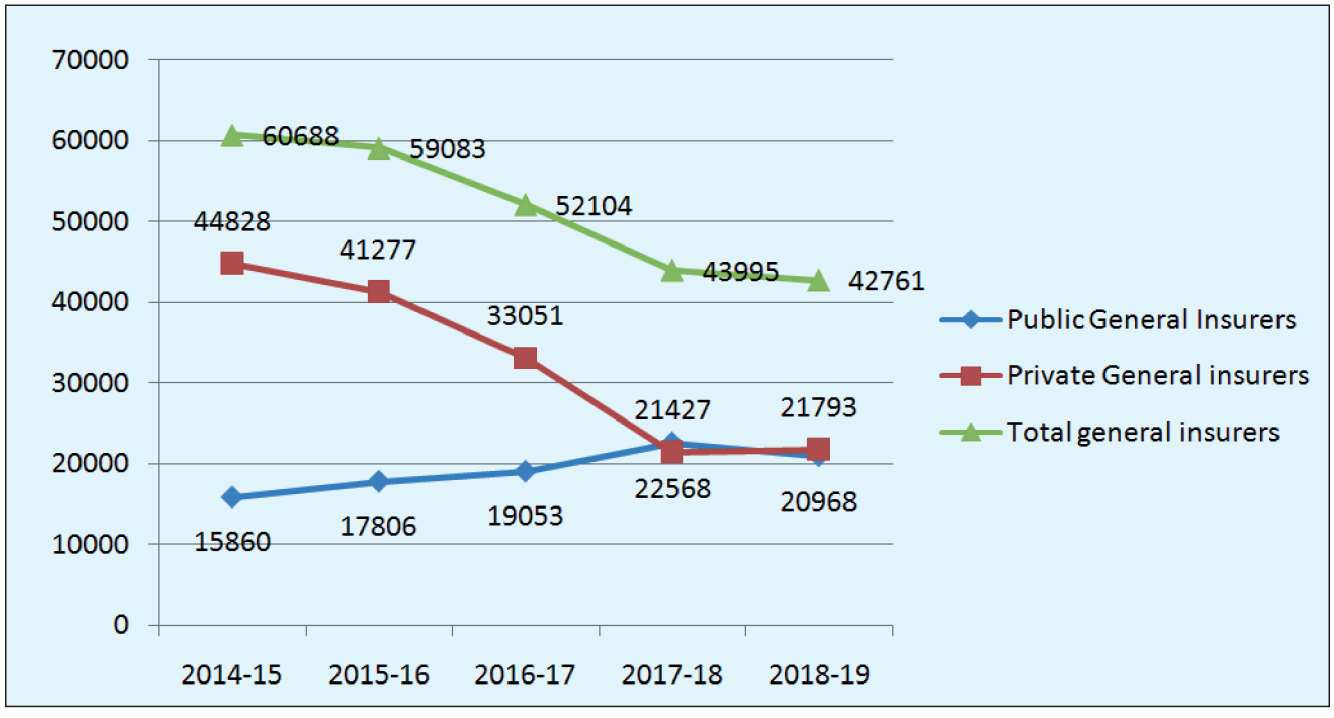


It can be seen from the above graph that there is a 4% reduction of the complaints reported under policy related. There is an increase of 4% in the complaints reported under Claims in the complaints reported during the year 2018-19 as compared to 2017-18. Complaints reported under all other categories have maintained the same share as that of the previous year.



The analysis of the complaints under policy type indicates that health insurance complaints are more during the last 5 years as compared to the complaints reported under motor insurance.

No. of complaints over the past five years-Total General Insurance complaints



No. of general insurance complaints has shown a decreasing trend over the years from 60668 in 2014-15 to 42761 in 2018-19 (reduction of 29%). In respect of Public General Insurers, there has been an increase in no. of complaints from 15860 in 2014-15 to 20968 in 2018-19 (32% increase over the years). In respect of Private General Insurers, there has been an reduction in no. of complaints from 44828 in 2014-15 to 21793 in 2018-19 (51% reduction over the years).

Insurers who have registered NIL pending in No. of complaints as at 31.3.2019

Insurers who have registered NIL pending in No. of complaints as at 31.3.2019							
S.No	Life Insurers	Pending Complaints at		S.No	General Insurers	Pending Complaints at	
		31.3.2019	31.3.2018			31.3.2019	31.3.2018
1	LIC	0	0	1	Agriculture	0	0
2	Aegon Life	0	0	2	ECGC	0	53
3	Aviva	0	0	3	Acko General	0	0
4	Bharti Axa	0	0	4	Aditya Birla	0	1
5	DHFL Pramerica	0	4	5	Chola MS	0	2
6	Edelweiss Tokio	0	0	6	DHFL Gen	0	0
7	Exide Life	0	0	7	Edelweiss Gen	0	0
8	Future Generali	0	0	8	FG General	0	3
9	IDBI Federal	0	0	9	Go Digit	0	0
10	Max Life	0	0	10	HDFC ERGO	0	0
11	Reliance Life	0	11	11	L&T General	0	0
12	SBI Life	0	0	12	Liberty General	0	0
13	Star Union	0	0	13	Magma HDI	0	49
14	TATA AIA	0	0	14	Max Bupa Health	0	0
				15	Raheja QBE	0	1
				16	Reliance Gen	0	7
				17	Reliance Health	0	0
				18	Shriram General	0	0
				19	Universal Sompo	0	0

DATA ON INSURANCE OMBUDSMEN – 2018-19

DISPOSAL OF COMPLAINTS BY INSURANCE OMBUDSMEN DURING 2018-19											
Insurer	O/S as on 1.4.18	Received during 2018-19	Total	Disposed during 2018-19	No.of Complaints disposed by way of						O/S as on 31.3.19
					(I)	(II)	(III)	(IV)	(V)	(VI)	
Life	5320	11859	17179	12103	501 [4.14%]	2980 [24.62%]	744 [6.15%]	0 [0%]	1392 [11.50%]	6486 [53.59%]	5076
General	5263	10805	16068	9864	328 [3.33%]	2845 [28.84%]	945 [9.58%]	0 [0%]	1338 [13.56%]	4408 [44.69%]	6204
Combined	**10583**	**22664**	**33247**	**21967**	**829 [3.77%]**	**5825 [26.52%]**	**1689 [7.69%]**	**0 [0%]**	**2730 [12.43%]**	**10894 [49.59%]**	**11280**

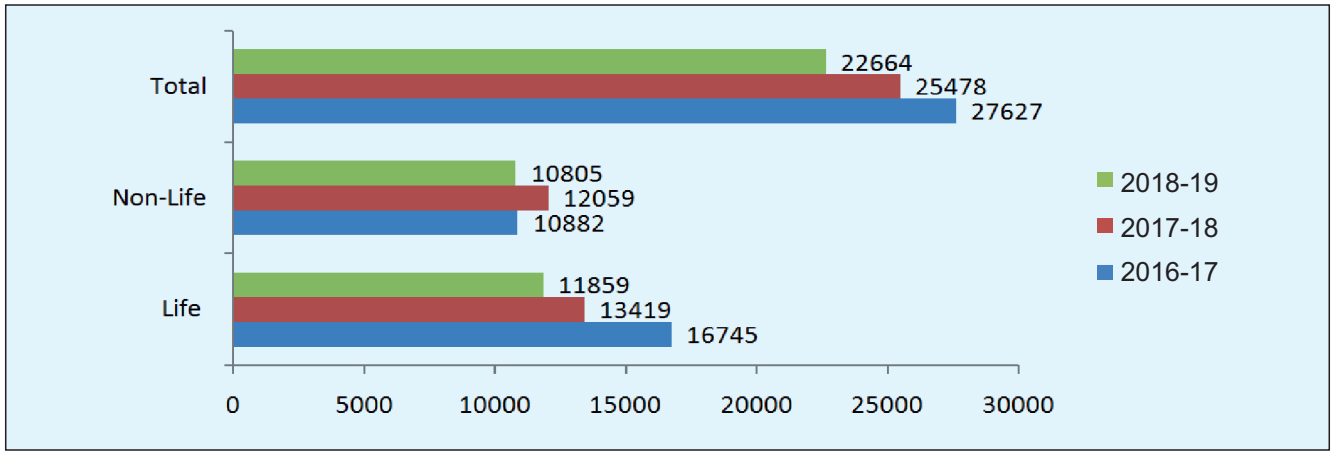
Note: O/S : Outstanding
(I) Recommendations (II) Awards (III) Withdrawal
(IV) Non-acceptance (V) Dismissal awards fvg. Ins. Co. (VI) Not-entertainable

During 2018-19, the Seventeen Ombudsmen centers spread across India have received a total of 22664 complaints. While 11859 complaints (about 52 per cent) pertained to life insurers, the remaining 10805 complaints (about 48 per cent) related to General insurers. This was in addition to 10583 complaints pending with various offices of Ombudsmen as at the end of March 2018.

During 2018-19, Ombudsmen disposed of 21967 complaints. Out of these complaints, Ombudsmen declared 49.59 per cent of the complaints as non-entertainable. Awards/recommendations were issued for 30.29 per cent of total complaints. Other than this, 7.69 per cent of the complaints were withdrawn/settled, while nearly 12.43 per cent of the complaints were dismissed. 11280 complaints were pending as on 31st March, 2019.

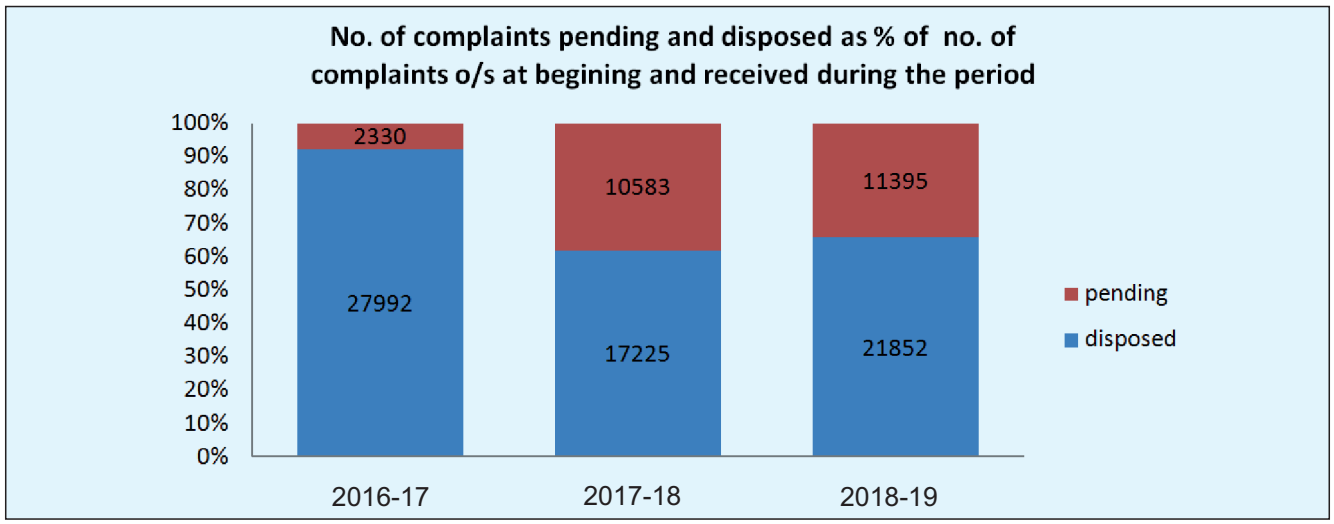
Trends in complaints received at Ombudsman centers:

1. No. of complaints over the past 3 years:



No. of complaints being received across various Ombudsman centers has reduced over the past 3 years from 27627 in 2016-17 to 22654 in 2018-19. No. of complaints in respect of Life Insurance has reduced drastically over the years from 16745 in 2016-17 to 11859 in 2018-19 (reduction of 29%). No. of complaints in respect of General insurance have remained relatively unchanged.

2. Pendency of complaints



Pendency % has been calculated as (No. of complaints pending at the end of period) /(No. of complaints received during the period +No. of complaints pending at the beginning of the period).

Pendency% was 7.68% at the end of financial year 2016-17. However, pendency increased drastically during the FY 2017-18 and was 38.06% at the end of FY 2017-18.

There has been slight reduction in pendency% as at end of FY 2018-19.(34.27%)

COMPLAINTS RECEIVED THROUGH CENTRALISED PUBLIC GRIEVANCE REDRESS AND MONITORING SYSTEM - CPGRAMS PORTAL

Centralized Public Grievance Redress And Monitoring System (CPGRAMS) is an online web-enabled system developed by NIC, in association with Directorate of Public Grievances (DPG) and Department of Administrative Reforms and Public Grievances (DARPG).

The grievances pertaining to insurance are received by DFS-finance ministry directly in the portal and also from various sources – DARPG, DPG, PMO, President secretariat, Minister's office. Consumer Affairs Department(CAD) receives the grievances from DFS that are pertaining to insurance companies, intermediaries and others that come under IRDAI purview. However if the grievances are related to Public sector insurance companies, DFS directly sends it to them and escalates to CAD only if such grievances require IRDAI intervention. Each grievance received is then examined by CAD and taken up with the concerned insurer(s) or taken up within office for speedy and proper redress of these grievances.

REPORT ON GRIEVANCES RECEIPT:

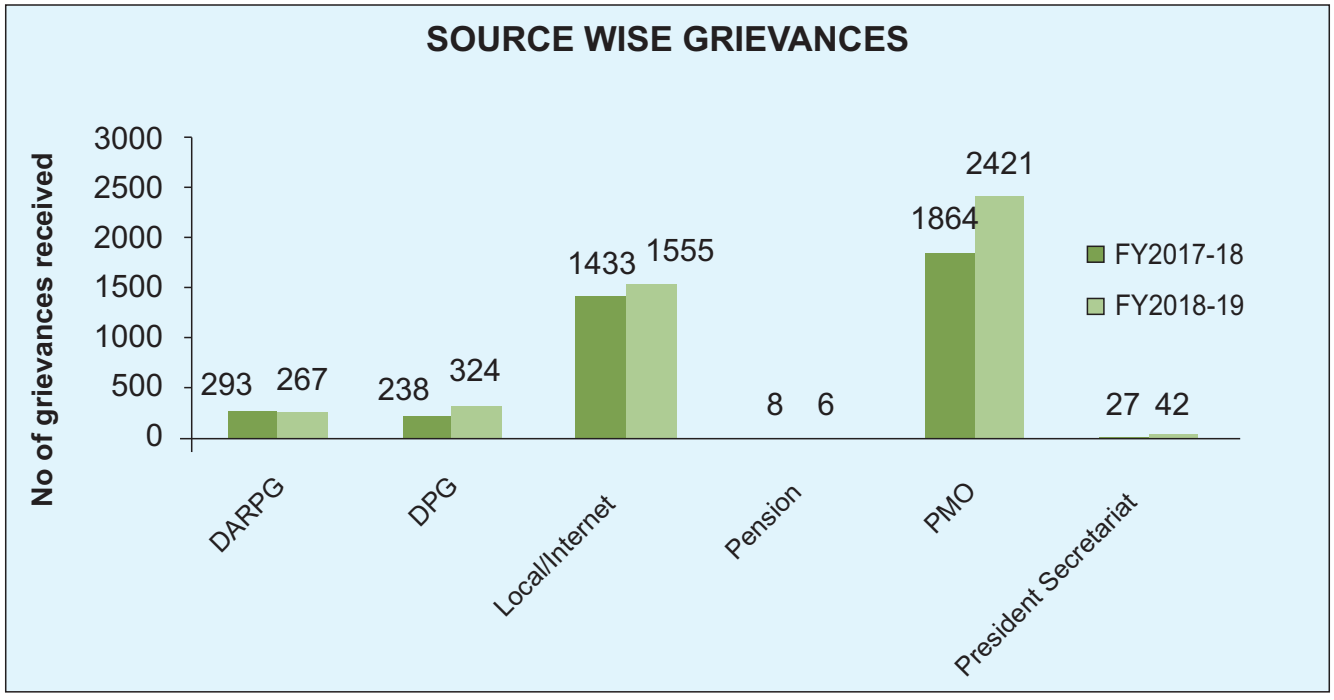
No. of Grievances received during financial year 2018-19 in CPGRAMS portal is 4615 as compared to the grievances receipt in FY2017-18 which was 3863.

STATUS OF GRIEVANCES RECEIVED AT IRDAI THROUGH CPGRAMS						
	Brought forward (a)	Received (b)	Disposed (C).	% disposed (d=c/(a+b))	TAT (e)	Pending as at end of period (f)
FY2017-18	160	3863	3873	96.27%	16	150
FY2018-19	*157(150+7)	4615	4619	96.79%	20	153

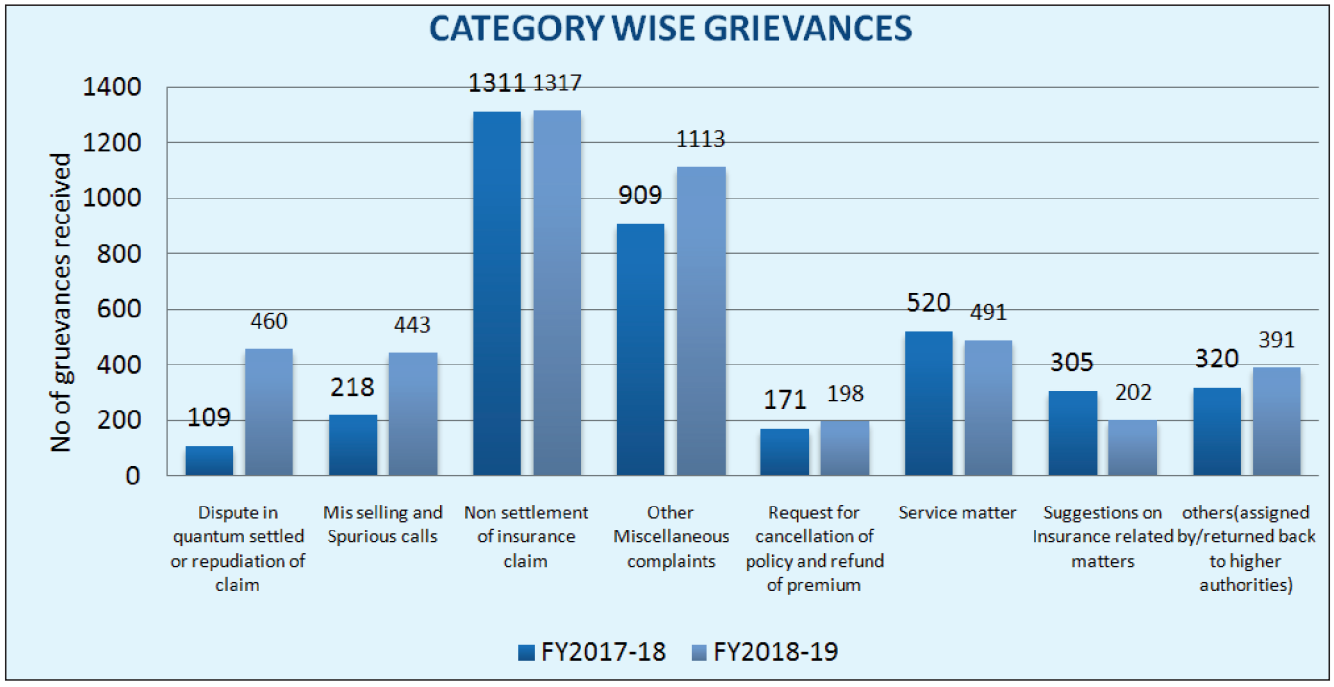
*Grievances pertaining to FY 2017-18 is escalated through portal in FY2018-19 and added to opening balance

SOURCE WISE GRIEVANCES BREAKUP FOR FY2017-18 & FY2018-19

It could be observed from the chart below that Majority of the grievances received from public are through PMO office and DFS- Finance ministry (referred as local/internet in graph) both of which constitute 85.34% & 86% of total grievances received in portal in FY2017-18 and FY2018-19 respectively.



CATEGORY WISE GRIEVANCES BREAKUP FOR FY2017-18 & FY2018-19



It could be observed from the chart above that the highest number of grievances is from "Non settlement of insurance claim" category as majority of grievances received in portal are from PMO office on claim related issues of PMFBY crop insurance. Also numerous complaints are received on claim related issues in health insurance.

Receipt and Disposal of Grievances registered in DARPG Portal and referred to IRDAI (During the period from 1.4.2018 to 31.3.2019)

Grievance Source	B/F Balance	Receipt During the Period	Total Receipts	Cases Disposed of During the Period	Closing Balance as on 31/03/2019
DARPG	15	267	282	272	10
DPG	21	324	345	342	3
Local/Internet	51	1555	1606	1554	52
Pension	0	6	6	6	0
PMO	70	2421	2491	2404	87
President Secretariat	0	42	42	41	1
Total	**157**	**4615**	**4772**	**4619**	**153**

During the Year 4615 grievances have been referred to IRDAI of the grievances registered in DARPG Portal. A total of 4619 grievances have been disposed of during the year. 153 grievances were pending as at 31.3.2019.

Grievances referred to IRDAI - Pending as at 31.3.2019

Name of Organisation	B/F as on 01/04/2018	Grievances Received	Grievances Disposed	Pending as on 31/03/2019	Pending 0 to15 days	Pending 16 to 30 days	Pending 31 to 60 days	Pending more than 60 days
IRDAI	157	4615	4619	153	96	41	14	3

Out of 153 grievances pending as at 31.3.2019, 3 grievances were pending resolution beyond 60 days.

PRAGATI (Pro Active Governance and Timely Implementation).

Under PRAGATI initiative by government of India to ensure effective redress of public grievances, the CEOs of all Insurance Companies were advised to examine 20 grievances every week personally to assess the timeliness and quality of resolutions given. A Monthly Statement under PRAGATI is being submitted by insurers for review every month since June 2016.

Summary of Grievances 2017-18 & 2018-19

(Summary of Complaints, Disposal & Resolutions)

1. Industry (Life & General)
2. Life Insurance Industry
3. General Insurance Industry

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & General)
1-Apr-2017 to 31-Mar-2018

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1033	
Received during the period	202433	
Duplicate during the period	4071	
Actual during the period	198362	
Attended to during the period	197548	99.07%
Pending as at the end of the period	1847	0.93%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No. of Complaints**	**%**
Less than 15 days	595	32.21%
16 - 30 days	104	5.63%
More than 30 days	1148	62.15%
Total Pending	**1847**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	54229	27.34%
Policy Servicing	39573	19.95%
Others	26863	13.54%
Survival Claims	17994	9.07%
Proposal Processing	11039	5.57%
Death Claims	3218	1.62%
ULIP Related	1451	0.73%
Claim	25401	12.81%
Policy Related	8750	4.41%
Others	5892	2.97%
Premium	1590	0.80%
Refund	1114	0.56%
Proposal Related	432	0.22%
Product	380	0.19%
Coverage	327	0.16%
Cover Note Related	109	0.05%
TOTAL	**198362**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.99

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR (Complaint Type wise)*			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	16657	3336	34095
Policy Servicing	33719	3321	2526
Others	23033	1761	2060
Survival Claims	14235	1533	2208
Proposal Processing	8568	994	1467
Death Claims	1726	394	1089
ULIP Related	739	230	479
Claim	11114	3645	10174
Policy Related	6727	813	1111
Others	4009	483	1322
Premium	899	140	534
Refund	786	179	125
Proposal Related	200	21	196
Product	117	44	202
Coverage	166	26	129
Cover Note Related	86	8	15
TOTAL	**122781**	**16928**	**57732**

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**30597**	**15.42%**
• Registered by IRDAI	21680	10.93%
• Email	11683	
• Letter	4674	
• Telephone	5323	
• Registered by Policy Holder	8917	4.50%
Complaints Registered in Insurer's portal	**167765**	**84.58%**
TOTAL COMPLAINTS	**198362**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)

Complaint Description Type	Complaints Type	No. of Complaints	%
Malpractices or unfair business practices	Unfair Business Practices	24765	12.48%
Complaint raised with Insurer not addressed	Others	20646	10.41%
Insurer not disposed of the claim	Claim	11425	5.76%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	7436	3.75%
Survival Benefit is not paid	Survival Claims	6785	3.42%
Policy bond not received	Proposal Processing	5886	2.97%
Non-receipt of Premium receipt	Policy Servicing	5356	2.70%
Illegitimate inducements offered	Unfair Business Practices	5031	2.54%
Product differs from what was requested or disclosed	Unfair Business Practices	4831	2.44%
Tampering, Corrections, forgery of proposal or related papers	Unfair Business Practices	4286	2.16%

POLICY TYPE CLASSIFICATION

Policy Type	No. of Complaints	%
Conventional Life Insurance Policy	121032	61.02%
Unit Linked Insurance Policy	18118	9.13%
Others	9160	4.62%
Pension Policy (other than Unit Linked)	3889	1.96%
Health Insurance Policy	2168	1.09%
Health Insurance	25516	12.86%
Motor Insurance	13227	6.67%
Others	4073	2.05%
Fire	768	0.39%
Marine Cargo	205	0.10%
Crop	105	0.05%
Engineering	67	0.03%
Credit	26	0.01%
Marine Hull	8	0.00%
TOTAL	**198362**	

RECEIPT OF COMPLAINTS

Top 5 companies	No. of Complaints	%
Life Insurance Corporation of India	67491	34.02%
United India Insurance Company Limited	8697	4.38%
ICICI Prudential Life Insurance Company Ltd	6858	3.46%
SBI Life Insurance Co. Ltd.	6729	3.39%
HDFC Standard Life Insurance Co. Ltd	6615	3.33%
TOTAL	**96390**	**48.59%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *

In favour	122781	62.19%
Partially in favour	16928	8.57%
Reject	57732	29.24%

*Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer
1-Apr-2017 to 31-Mar-2018

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	247	
Received during the period	157673	
Duplicate during the period	3306	
Actual during the period	154367	
Attended to during the period	154413	99.87%
Pending as at the end of the period	201	0.13%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	54229	35.13%
Policy Servicing	39573	25.64%
Others	26863	17.40%
Survival Claims	17994	11.66%
Proposal Processing	11039	7.15%
Death Claims	3218	2.08%
ULIP Related	1451	0.94%
TOTAL	**154367**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.33

RECEIPT OF COMPLAINTS		
Top 5 companies	**No. of Complaints**	**%**
Life Insurance Corporation of India	77184	50.00%
ICICI Prudential Life Insurance Co. Ltd	7700	4.99%
SBI Life Insurance Co. Ltd.	7640	4.95%
HDFC Standard Life Insurance Co. Ltd	7257	4.70%
Birla SunLife Insurance Company Limited	6793	4.40%
TOTAL	**106574**	**69.04%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	98677	64.01%
Partially in favour	11569	7.50%
Reject	43924	28.49%

"RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)"			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	16657	3336	34095
Policy Servicing	33719	3321	2526
Others	23033	1761	2060
Survival Claims	14235	1533	2208
Proposal Processing	8568	994	1467
Death Claims	1726	394	1089
ULIP Related	739	230	479
TOTAL	**98677**	**11569**	**43924**

* Out of the total complaints registered during the year

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No. of Complaints**	**%**
Less than 15 days	178	88.56%
16 – 30 days	5	2.49%
More than 30 days	18	8.96%
Total Pending	**201**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaints Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	Unfair Business Practices	24765	16.04%
Complaint raised with Insurer not addressed	Others	20646	13.37%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	7436	4.82%
Survival Benefit is not paid	Survival Claims	6785	4.40%
Policy bond not received	Proposal Processing	5886	3.81%
Non-receipt of Premium receipt	Policy Servicing	5356	3.47%
Illegitimate inducements offered	Unfair Business Practices	5031	3.26%
Product differs from what was requested or disclosed	Unfair Business Practices	4831	3.13%
Tampering, Corrections, forgery of proposal or related papers	Unfair Business Practices	4286	2.78%
Alteration in policy not effected	Policy Servicing	4171	2.70%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	121032	78.41%
Unit Linked Insurance Policy	18118	11.74%
Others	9160	5.93%
Pension Policy (other than Unit Linked)	3889	2.52%
Health Insurance Policy	2168	1.40%
TOTAL	**154367**	

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**14773**	**9.57%**
♦ Registered by IRDAI	10744	6.96%
♦ Email	5572	
♦ Letter	2445	
♦ Telephone	2727	
♦ Registered by Policy Holder	4029	2.61%
Complaints Registered in Insurer's portal	**139594**	**90.43%**
TOTAL COMPLAINTS	**154367**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - General Insurer
01-Apr-2017 to 31-Mar-2018

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	786	
Received during the period	44760	
Duplicate during the period	765	
Actual during the period	43995	
Attended to during the period	43135	96.32%
Pending as at the end of the period	1646	3.68%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	25401	57.74%
Policy Related	8750	19.89%
Others	5892	13.39%
Premium	1590	3.61%
Refund	1114	2.53%
Proposal Related	432	0.98%
Product	380	0.86%
Coverage	327	0.74%
Cover Note Related	109	0.25%
TOTAL	**43995**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	17.48

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	24104	55.70%
Partially in favour	5359	12.38%
Reject	13808	31.91%

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**15824**	**35.97%**
• Registered by IRDAI	10936	24.86%
• Email	6111	
• Letter	2229	
• Telephone	2596	
• Registered by Policy Holder	4888	11.11%
Complaints Registered in Insurer's portal	**28171**	**64.03%**
TOTAL COMPLAINTS	**43995**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	11114	3645	10174
Policy Related	6727	813	1111
Others	4009	483	1322
Premium	899	140	534
Refund	786	179	125
Proposal Related	200	21	196
Product	117	44	202
Coverage	166	26	129
Cover Note Related	86	8	15
TOTAL	**24104**	**5359**	**13808**

* Out of the total complaints registered during the year

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No. of Complaints**	**%**
Less than 15 days	417	25.33%
16 – 30 days	99	6.01%
More than 30 days	1130	68.65%
Total Pending	**1646**	

RECEIPT OF COMPLAINTS		
Top 5 companies	**No. of Complaints**	**%**
United India Insurance Company Limited	9425	21.42%
National Insurance Company Limited	5571	12.66%
The New India Assurance Co. Ltd.	4820	10.96%
Star Health And Allied Insurance Company Limited	4496	10.22%
ICICI Lombard General Insurance Company Limited	3037	6.90%
TOTAL	**27349**	**62.16%**

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaints Type**	**No.of Complaints**	**%**
Insurer not disposed of the claim	Claim	11425	25.97%
Certificate of Insurance / Policy not received by the Insured	Policy Related	3149	7.16%
Insurer failed to clarify the queries raised by Insured	Others	2472	5.62%
Difference between assessed loss and amount settled by Insurer	Claim	2042	4.64%
Insurer reduced the Quantum of claim for reasons not indicated in the policy	Claim	2034	4.62%
Insurer repudiated the claim due to alleged breach of policy condition / warranty	Claim	1810	4.11%
Details shown in policy or Add-on are incorrect	Policy Related	1335	3.03%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	1120	2.55%
Insurer not issued claim cheque inspite of offer of settlement	Claim	1104	2.51%
Insurer failed to make offer of settlement to Insured after receipt of survey report	Claim	1101	2.50%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	25516	58.00%
Motor Insurance	13227	30.06%
Others	4073	9.26%
Fire	768	1.75%
Marine Cargo	205	0.47%
Crop	105	0.24%
Engineering	67	0.15%
Credit	26	0.06%
Marine Hull	8	0.02%
TOTAL	**43995**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & General)
01-Apr-2018 TO 31-Mar-2019

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1847	
Received during the period	208483	
Duplicate during the period	2458	
Actual during the period	206025	
Attended to during the period	207188	99.67%
Pending as at the end of the period	684	0.33%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	49570	24.06%
Policy Servicing	45833	22.25%
Others	31147	15.12%
Survival Claims	24200	11.75%
Proposal Processing	7855	3.81%
Death Claims	3586	1.74%
ULIP Related	1073	0.52%
Claim	26496	12.86%
Policy Related	6840	3.32%
Others	5813	2.82%
Premium	1440	0.70%
Refund	1056	0.51%
Product	414	0.20%
Proposal Related	336	0.16%
Coverage	285	0.14%
Cover Note Related	81	0.04%
TOTAL	**206025**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.39

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No.of Complaints**	**%**
Less than 15 days	508	74.27%
16 – 30 days	49	7.16%
More than 30 days	127	18.57%
Total Pending	**684**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	16730	2902	29884
Policy Servicing	40902	2577	2350
Others	26978	1659	2505
Survival Claims	21183	1258	1752
Proposal Processing	6362	305	1181
Death Claims	2345	400	839
ULIP Related	674	74	324
Claim	11081	3235	11819
Policy Related	5242	522	1006
Others	3728	474	1559
Premium	905	147	385
Refund	751	142	148
Product	199	39	175
Proposal Related	153	23	159
Coverage	123	30	129
Cover Note Related	64	4	13
TOTAL	**137420**	**13791**	**54228**

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**30686**	**14.89%**
• Registered by IRDAI	23596	11.45%
• Email	13194	
• Letter	4482	
• Telephone	5920	
• Registered by Policy Holder	7090	3.44%
Complaints Registered in Insurer's portal	**175339**	**85.11%**
TOTAL COMPLAINTS	**206025**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaints Type**	**No. of Complaints**	**%**
Complaint raised with Insurer not addressed	Others	23761	11.53%
Malpractices or unfair business practices	Unfair Business Practices	21305	10.34%
Insurer not disposed of the claim	Claim	12351	5.99%
Survival Benefit is not paid	Survival Claims	9343	4.53%
No Response for recording Change of address	Policy Servicing	7878	3.82%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	7000	3.40%
Maturity claim is not paid	Survival Claims	6808	3.30%
Non-receipt of Premium receipt	Policy Servicing	6011	2.92%
Illegitimate inducements offered	Unfair Business Practices	5574	2.71%
Product differs from what was requested or disclosed	Unfair Business Practices	4235	2.06%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	132997	64.55%
Unit Linked Insurance Policy	16954	8.23%
Others	5474	2.66%
Pension Policy (other than Unit Linked)	5246	2.55%
Health Insurance Policy	2593	1.26%
Health Insurance	25369	12.31%
Motor Insurance	11809	5.73%
Others	4184	2.03%
Fire	706	0.34%
Crop	402	0.20%
Marine Cargo	187	0.09%
Engineering	53	0.03%
Marine Hull	36	0.02%
Credit	15	0.01%
TOTAL	**206025**	

RECEIPT OF COMPLAINTS		
Top 5 companies	**No. of Complaints**	**%**
Life Insurance Corporation of India	91263	44.30%
United India Insurance Company Limited	7554	3.67%
ICICI Prudential Life Insurance Company Ltd	5896	2.86%
Bharti-Axa Life Insurance Company LTD	5571	2.70%
HDFC Standard Life Insurance Co. Ltd	5562	2.70%
TOTAL	**115846**	**56.23%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	137420	66.89%
Partially in favour	13791	6.71%
Reject	54228	26.40%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer
01-Apr-2018 TO 31-Mar-2019

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	201	
Received during the period	164970	
Duplicate during the period	1706	
Actual during the period	163264	
Attended to during the period	163381	99.95%
Pending as at the end of the period	84	0.05%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	49570	30.36%
Policy Servicing	45833	28.07%
Others	31147	19.08%
Survival Claims	24200	14.82%
Proposal Processing	7855	4.81%
Death Claims	3586	2.20%
ULIP Related	1073	0.66%
TOTAL	**163264**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.83

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**14825**	**9.08%**
• Registered by IRDAI	11559	7.08%
• Email	6167	
• Letter	2326	
• Telephone	3066	
• Registered by Policy Holder	3266	2.00%
Complaints Registered in Insurer's portal	**148439**	**90.92%**
TOTAL COMPLAINTS	**163264**	

RECEIPT OF COMPLAINTS		
Top 5 companies	**No. of Complaints**	**%**
Life Insurance Corporation of India	102127	62.55%
ICICI Prudential Life Insurance Co. Ltd	6393	3.92%
Bharti-Axa Life Insurance Company Ltd	6360	3.90%
HDFC Standard Life Insurance Co. Ltd	6026	3.69%
SBI Life Insurance Co. Ltd.	4649	2.85%
TOTAL	**125555**	**76.90%**

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	132997	81.46%
Unit Linked Insurance Policy	16954	10.38%
Others	5474	3.35%
Pension Policy (other than Unit Linked)	5246	3.21%
Health Insurance Policy	2593	1.59%
TOTAL	**163264**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No.of Complaints**	**%**
Less than 15 days	81	96.43%
16 – 30 days	0	0.00%
More than 30 days	3	3.57%
Total Pending	**84**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaints Type**	**No. of Complaints**	**%**
Complaint raised with Insurer not addressed	Others	23761	14.55%
Malpractices or unfair business practices	Unfair Business Practices	21305	13.05%
Survival Benefit is not paid	Survival Claims	9343	5.72%
No Response for recording Change of address	Policy Servicing	7878	4.83%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	7000	4.29%
Maturity claim is not paid	Survival Claims	6808	4.17%
Non-receipt of Premium receipt	Policy Servicing	6011	3.68%
Illegitimate inducements offered	Unfair Business Practices	5574	3.41%
Product differs from what was requested or disclosed	Unfair Business Practices	4235	2.59%
Tampering, Corrections, forgery of proposal or related papers	Unfair Business Practices	4156	2.55%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	115174	70.58%
Partially in favour	9175	5.62%
Reject	38835	23.80%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	16730	2902	29884
Policy Servicing	40902	2577	2350
Others	26978	1659	2505
Survival Claims	21183	1258	1752
Proposal Processing	6362	305	1181
Death Claims	2345	400	839
ULIP Related	674	74	324
TOTAL	**115174**	**9175**	**38835**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - General Insurer
01-Apr-2018 TO 31-Mar-2019

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1646	
Received during the period	43513	
Duplicate during the period	752	
Actual during the period	42761	
Attended to during the period	43807	98.65%
Pending as at the end of the period	600	1.35%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	26496	61.96%
Policy Related	6840	16.00%
Others	5813	13.59%
Premium	1440	3.37%
Refund	1056	2.47%
Product	414	0.97%
Proposal Related	336	0.79%
Coverage	285	0.67%
Cover Note Related	81	0.19%
TOTAL	**42761**	

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**15861**	**37.09%**
♦ Registered by IRDAI	12037	28.15%
♦ Email	7027	
♦ Letter	2156	
♦ Telephone	2854	
♦ Registered by Policy Holder	3824	8.94%
Complaints Registered in Insurer's portal	**26900**	**62.91%**
TOTAL COMPLAINTS	**42761**	

RECEIPT OF COMPLAINTS		
Top 5 companies	**No. of Complaints**	**%**
United India Insurance Company Limited	8404	19.65%
Star Health And Allied Insurance Co. Ltd	5685	13.29%
The New India Assurance Co. Ltd.	5164	12.08%
National Insurance Company Limited	4739	11.08%
ICICI Lombard General Insurance Co. Ltd	2929	6.85%
TOTAL	**26921**	**62.96%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	11081	3235	11819
Policy Related	5242	522	1006
Others	3728	474	1559
Premium	905	147	385
Refund	751	142	148
Product	199	39	175
Proposal Related	153	23	159
Coverage	123	30	129
Cover Note Related	64	4	13
TOTAL	**22246**	**4616**	**15393**

* Out of the total complaints registered during the year

PERIOD OF PENDENCY		
Complaints pending as at the end of the period	**No.of Complaints**	**%**
Less than 15 days	427	71.17%
16 – 30 days	49	8.17%
More than 30 days	124	20.67%
Total Pending	**600**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaints Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	12351	28.88%
Insurer failed to clarify the queries raised by Insured	Others	2920	6.83%
Insurer reduced the Quantum of claim for reasons not indicated in the policy	Claim	2339	5.47%
Difference between assessed loss and amount settled by Insurer	Claim	2304	5.39%
Certificate of Insurance/Policy not received by the Insured	Policy Related	2269	5.31%
Insurer repudiated the claim due to alleged breach of policy condition / warranty	Claim	2183	5.11%
Details shown in policy or Add-on are incorrect	Policy Related	1214	2.84%
Claim repudiated without giving reasons	Claim	1091	2.55%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	1063	2.49%
Insurer failed to make offer of settlement to Insured after receipt of survey report	Claim	991	2.32%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	17.25

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	25369	59.33%
Motor Insurance	11809	27.62%
Others	4184	9.78%
Fire	706	1.65%
Crop	402	0.94%
Marine Cargo	187	0.44%
Engineering	53	0.12%
Marine Hull	36	0.08%
Credit	15	0.04%
TOTAL	**42761**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	22246	52.65%
Partially in favour	4616	10.92%
Reject	15393	36.43%

Analysis of the Grievances Reported against Life insurers

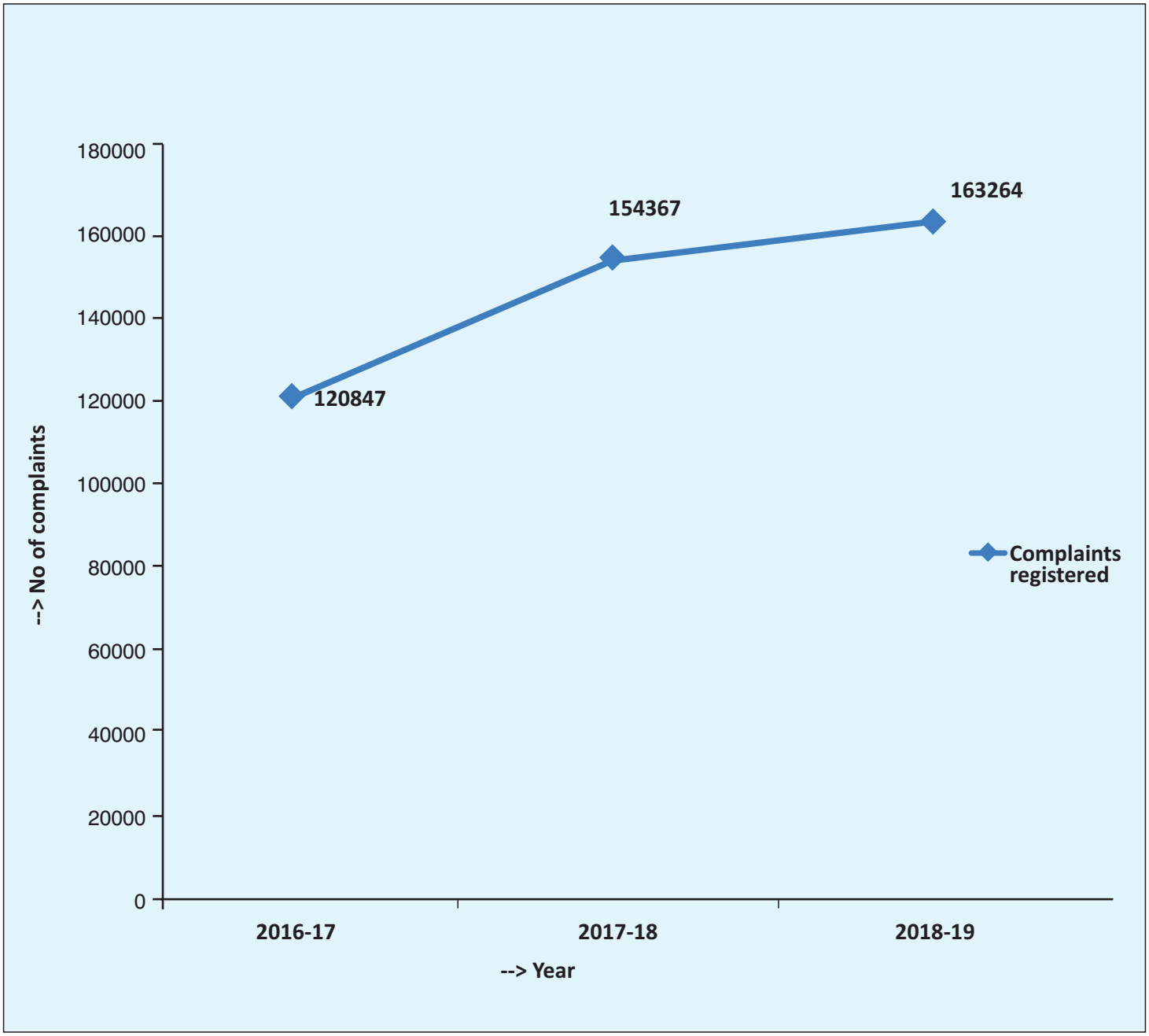
1. Cursory glance of complaints registered & 'attended to' by Life Insurers
2. Complaints registered against Life Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of Life Complaints registered – 2017-18
5. Analysis of Life Complaints registered – 2018-19
6. Classification of Life Complaints - Graphical Presentation
7. ULIP Complaints - Graphical Presentation
8. Analysis of Unfair Business Practice Complaints – Policy type wise
9. State-wise Distribution of Complaints – 2017-18
10 State-wise Distribution of Complaints – 2018-19

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY LIFE INSURERS

S.No.	Description	2018-19		2017-18		2016-17	
		Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly in IGMS	3266	3259	4029	4016	2836	2817
2	Complaints of the Policyholders registered by IRDAI in IGMS	11559	11539	10744	10711	14411	14356
3	Compliants of the Policyholders registered by Life Insurers	148439	148382	139594	139439	103600	103379
	Total:	**163264**	**163180**	**154367**	**154166**	**120847**	**120552**

* Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to, which relates to earlier year.

TREND OF COMPLAINTS REGISTERED AGAINST LIFE INSURERS FOR THE LAST THREE YEARS



MOVEMENT OF COMPLAINTS - LIFE INSURERS

S.No	Insurer	2017-18			2018-19					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints	Attended to during the year	Pending at the end of the year
1	LIC	77184	77184	0	0	102255	128	102127	102127	0
(i)	**Public total:**	**77184**	**77184**	**0**	**0**	**102255**	**128**	**102127**	**102127**	**0**
1	Aegon Life	1764	1764	0	0	1084	35	1049	1049	0
2	Aviva	2282	2282	0	0	2182	106	2076	2076	0
3	Bajaj Allianz	3439	3421	18	18	2299	30	2269	2285	2
4	Bharti Axa	4148	4156	0	0	6397	37	6360	6360	0
5	Birla Sun Life	6793	6786	17	17	2963	0	2963	2978	2
6	Canara HSBC	665	663	2	2	717	0	717	716	3
7	DHFL Pramerica	1592	1589	4	4	992	20	972	976	0
8	Edleweiss Tokio	329	329	0	0	446	5	441	441	0
9	Exide Life	4201	4201	0	0	3624	154	3470	3470	0
10	Future Generali	4447	4462	0	0	4134	2	4132	4132	0
11	HDFC Standard	7257	7256	11	11	6030	4	6026	6035	2
12	ICICI Prudential	7700	7701	2	2	6437	44	6393	6393	2
13	IDBI Federal	742	742	0	0	818	30	788	788	0
14	India First	3219	3201	37	37	3179	99	3080	3097	20
15	Kotak Mahindra	3400	3480	25	25	945	19	926	940	11
16	Max Life	5544	5544	0	0	4038	0	4038	4038	0
17	PNB MetLife	4228	4226	72	72	3702	144	3558	3591	39
18	Reliance	1615	1614	1	1	2316	264	2052	2053	0
19	Sahara	82	74	11	11	110	0	110	120	1
20	SBI Life	7640	7642	0	0	5166	517	4649	4649	0
21	Shri Ram	406	406	1	1	577	0	577	576	2
22	Star Union Daichi	2556	2556	0	0	2050	5	2045	2045	0
23	Tata AIA	3134	3134	0	0	2509	63	2446	2446	0
(ii)	**Private Total:**	**77183**	**77229**	**201**	**201**	**62715**	**1578**	**61137**	**61254**	**84**
Grand total: (i+ii)		**154367**	**154413**	**201**	**201**	**164970**	**1706**	**163264**	**163381**	**84**

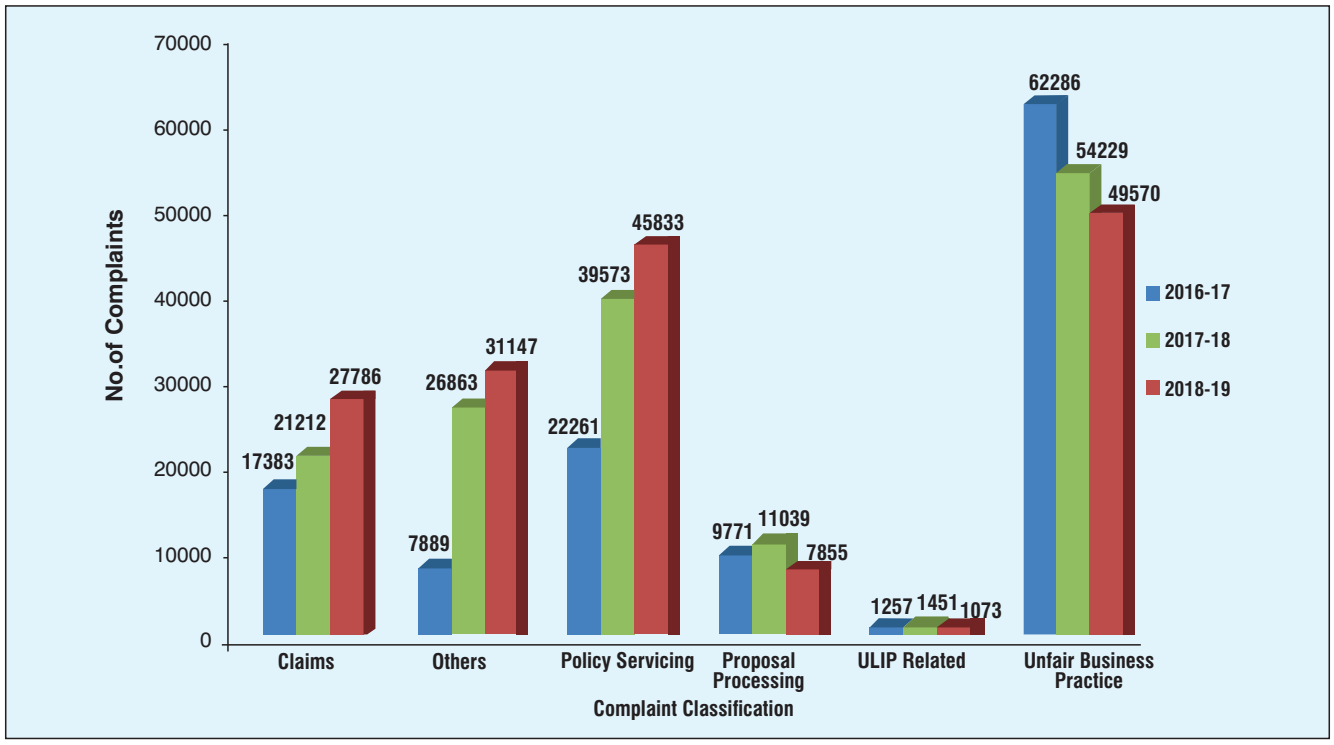
ANALYSIS OF LIFE COMPLAINTS REGISTERED (2017-18)

S.No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non-Linked (A)	ULIP (B)	Total (A+B)
1	LIC	1765	27	22540	1027	31627	951	3002	84	12179	654	420	2733	175	73846	3338	77184
(i)	**Public total:**	**1765**	**27**	**22540**	**1027**	**31627**	**951**	**3002**	**84**	**12179**	**654**	**420**	**2733**	**175**	**73846**	**3338**	**77184**
1	Aegon Life	6	0	47	2	169	0	69	0	18	1	2	1449	1	1758	6	1764
2	Aviva	7	1	42	2	902	25	64	11	86	8	32	1095	7	2196	86	2282
3	Bajaj Allianz	51	2	216	48	83	12	56	16	229	26	40	2633	27	3268	171	3439
4	Bharti AXA	27	0	164	3	109	1	60	0	28	1	73	1281	2401	1669	2479	4148
5	Birla Sunlife	151	33	314	266	1042	677	737	315	329	739	297	1492	401	4065	2728	6793
6	Canara HSBC	6	15	25	1	11	30	13	15	7	20	6	237	279	299	366	665
7	DHFL Pramerica	15	0	48	2	63	5	183	13	40	4	6	1152	61	1501	91	1592
8	Edleweiss Tokio	0	0	10	0	14	0	13	0	3	0	6	281	2	321	8	329
9	Exide Life	21	0	131	4	41	1	59	0	69	7	2	3854	12	4175	26	4201
10	Future Generali	24	2	91	17	40	6	161	17	72	39	7	3825	146	4213	234	4447
11	HDFC Standard	150	45	128	28	186	57	309	53	564	296	72	4765	604	6102	1155	7257
12	ICICI Prudential	85	6	462	44	156	28	189	22	185	104	281	5685	453	6762	938	7700
13	IDBI Federal	18	0	29	0	12	1	49	8	26	8	6	490	95	624	118	742
14	IndiaFirst	132	9	24	0	167	50	56	9	70	32	37	2378	255	2827	392	3219
15	Kotak Mahindra	38	2	231	12	444	61	300	38	48	36	30	1880	280	2941	459	3400
16	Max Life	149	10	267	30	170	59	110	13	98	44	3	3933	658	4727	817	5544
17	PNB MetLife	75	4	48	2	276	81	591	17	202	38	23	2507	364	3699	529	4228
18	Reliance	38	2	121	6	18	0	354	26	71	14	2	944	19	1546	69	1615
19	Sahara	4	0	9	1	10	1	2	0	33	17	2	3	0	61	21	82
20	SBI Life	155	16	202	60	685	259	1838	1498	579	208	51	1443	646	4902	2738	7640
21	Shri Ram	27	1	42	0	17	0	21	1	12	4	0	274	7	393	13	406
22	Star Union Daichi	44	7	38	11	207	56	284	66	157	194	4	1258	230	1988	568	2556
23	Tata AIA	33	15	51	17	600	163	276	21	237	158	49	1169	345	2366	768	3134
(ii)	**Private Total:**	**1256**	**170**	**2740**	**556**	**5422**	**1573**	**5794**	**2159**	**3163**	**1998**	**1031**	**44028**	**7293**	**62403**	**14780**	**77183**
	Total [(i)+ (ii)]	**3021**	**197**	**25280**	**1583**	**37049**	**2524**	**8796**	**2243**	**15342**	**2652**	**1451**	**46761**	**7468**	**136249**	**18118**	**154367**
	Grand Total	**3218**		**26863**		**39573**		**11039**		**17994**		**1451**	**54229**		**154367**		

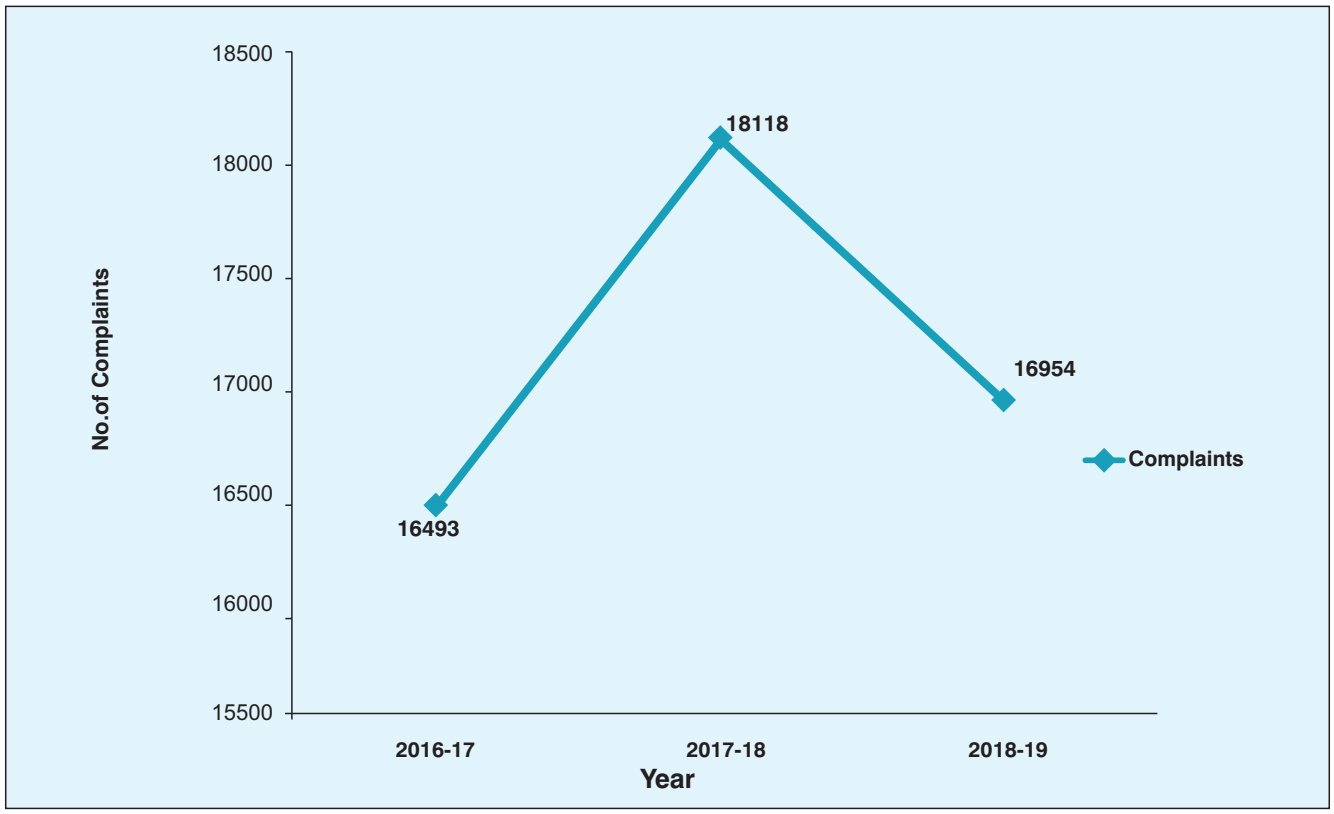
ANALYSIS OF LIFE COMPLAINTS REGISTERED (2018-19)

S.No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non-Linked (A)	ULIP (B)	Total (A+B)
1	LIC	2507	40	26490	1386	40693	1250	3174	118	19844	1749	600	3937	339	96645	5482	102127
(i)	**Public total:**	**2507**	**40**	**26490**	**1386**	**40693**	**1250**	**3174**	**118**	**19844**	**1749**	**600**	**3937**	**339**	**96645**	**5482**	**102127**
1	Aegon Life	4	0	66	0	115	0	40	0	18	1	1	801	3	1044	5	1049
2	Aviva	9	0	35	4	778	16	62	9	71	9	18	1061	4	2016	60	2076
3	Bajaj Allianz	102	2	244	33	42	8	45	4	145	9	11	1615	9	2193	76	2269
4	Bharti AXA	16	1	226	4	101	2	65	0	49	4	81	1954	3857	2411	3949	6360
5	Birla Sunlife	62	8	191	39	231	113	251	76	145	151	75	1247	374	2127	836	2963
6	Canara HSBC	14	15	30	1	22	22	30	12	10	21	15	312	213	418	299	717
7	DHFL Pramerica	9	0	72	0	27	2	98	8	15	0	0	712	29	933	39	972
8	Edleweiss Tokio	5	0	8	0	21	0	41	0	10	1	3	351	1	436	5	441
9	Exide Life	20	0	78	0	30	0	42	0	40	1	2	3248	9	3458	12	3470
10	Future Generali	30	3	90	14	33	13	74	10	24	16	1	3643	181	3894	238	4132
11	HDFC Standard	92	23	173	47	76	34	149	37	232	88	7	4346	722	5068	958	6026
12	ICICI Prudential	61	6	471	26	164	39	128	97	164	37	181	4869	150	5857	536	6393
13	IDBI Federal	16	0	23	1	16	4	43	4	17	0	9	548	107	663	125	788
14	IndiaFirst	48	1	32	5	121	21	45	2	66	16	9	2540	174	2852	228	3080
15	Kotak Mahindra	18	0	155	3	38	5	23	3	28	2	7	439	205	701	225	926
16	Max Life	188	10	321	14	91	17	89	17	94	24	2	2579	592	3362	676	4038
17	PNB MetLife	51	3	93	1	232	37	544	3	102	14	3	2144	331	3166	392	3558
18	Reliance	23	0	107	7	19	1	583	51	101	9	1	1136	14	1969	83	2052
19	Sahara	5	0	13	0	16	5	0	0	34	35	1	1	0	69	41	110
20	SBI Life	101	12	342	134	337	170	858	578	357	133	35	954	638	2949	1700	4649
21	Shri Ram	27	0	59	1	7	0	13	1	23	2	2	417	25	546	31	577
22	Star Union Daichi	36	3	37	7	180	50	101	28	82	89	0	1163	269	1599	446	2045
23	Tata AIA	11	4	56	8	504	130	273	26	84	34	9	1006	301	1934	512	2446
(ii)	**Private Total:**	**948**	**91**	**2922**	**349**	**3201**	**689**	**3597**	**966**	**1911**	**696**	**473**	**37086**	**8208**	**49665**	**11472**	**61137**
Total [(i)+(ii)]		**3455**	**131**	**29412**	**1735**	**43894**	**1939**	**6771**	**1084**	**21755**	**2445**	**1073**	**41023**	**8547**	**146310**	**16954**	**163264**
Grand Total		**3586**		**31147**		**45833**		**7855**		**24200**		**1073**	**49570**		**163264**		

CLASSIFICATION OF LIFE COMPLAINTS FOR THE LAST THREE YEARS



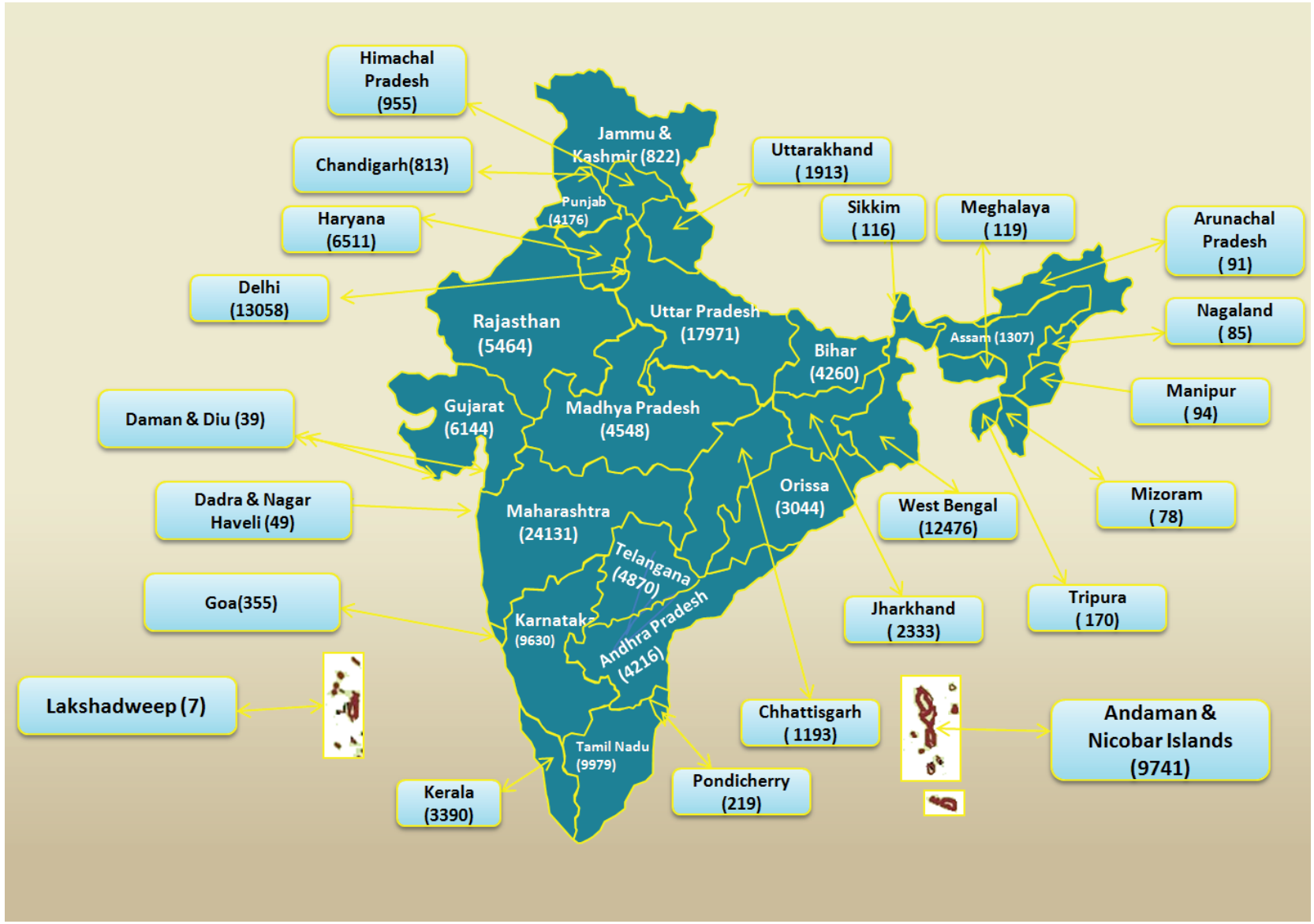
ULIP COMPLAINTS FOR THE LAST 3 YEARS



ANALYSIS OF 'UNFAIR BUSINESS PRACTICE' COMPLAINTS FOR THE LAST 3 YEARS - POLICY TYPE WISE

S.No	Complaint Description	Conventional			Health			Pension			ULIP			Others			Total		
		2018-19	2017-18	2016-17	2018-19	2017-18	2016-17	2018-19	2017-18	2016-17	2018-19	2017-18	2016-17	2018-19	2017-18	2016-17	2018-19	2017-18	2016-17
1	Advice concerning Exclusions/ limitations of cover not communicated	101	89	90	4	4	5	6	4	0	19	41	48	0	3	17	130	141	160
2	Annuity/Commutation/Cash Option/ Rider/other Options not included as requested	135	91	49	2	2	4	65	25	18	14	10	3	2	4	12	218	132	86
3	Credit/Debit card debited without consent of Consumer	855	490	292	9	22	38	18	10	3	163	83	38	10	18	36	1055	623	407
4	Do Not Call Registry	45	32	28	1	0	0	0	1	1	17	12	48	19	39	83	82	84	160
5	Free-look refund not paid	1200	1694	1624	12	17	27	30	23	14	214	264	217	70	83	160	1526	2081	2042
6	Illegitimate inducements offered	3574	3882	2682	7	18	12	8	13	15	1783	844	687	202	274	292	5574	5031	3688
7	Intermediary did not provide material information concerning proposed cover	2265	1882	1424	5	24	30	35	32	48	708	443	355	153	95	390	3166	2476	2247
8	Malpractices or unfair business practices	15216	16858	20619	82	85	163	190	174	266	3693	3739	4682	2124	3909	6870	21305	24765	32600
9	Misappropriation of premiums	824	953	1127	15	13	11	17	15	16	148	241	456	44	63	190	1048	1285	1800
10	Mode of premium payment differs from requested or disclosed	273	279	238	7	9	5	9	4	3	34	32	40	5	18	29	328	342	315
11	Premium paying period projected is different from actual	711	744	982	3	9	7	7	9	11	92	122	213	13	21	73	826	905	1286
12	Product differs from what was requested or disclosed	3624	4059	3409	31	23	20	47	41	53	463	436	413	70	272	338	4235	4831	4233
13	Proposed Insurance not in the interest of proposer	1176	1421	1636	7	52	85	29	24	27	286	234	240	52	42	58	1550	1773	2046
14	Single premium Policy issued as Annual premium policy	1955	2214	1904	1	1	6	7	8	27	384	392	350	49	190	162	2396	2805	2449
15	Spurious calls or Hoax Calls													1202	1888	2946	1202	1888	2946
16	Surrender value projected is different from actual	320	294	305	3	4	4	14	9	16	68	59	59	14	24	46	419	390	430
17	Tampering, Corrections, forgery of proposal or related papers	3537	3533	4049	7	18	16	38	33	40	425	463	570	149	239	362	4156	4286	5037
18	Term(Period) of the policy is different/altered without consent	304	316	271	3	4	7	4	8	5	36	53	35	7	10	36	354	391	354
	Total	**36115**	**38831**	**40729**	**199**	**305**	**440**	**524**	**433**	**563**	**8547**	**7468**	**8454**	**4185**	**7192**	**12100**	**49570**	**54229**	**62286**

STATE/UT WISE DISTRIBUTION OF COMPLAINTS - LIFE – 2017-18



STATE/UT WISE DISTRIBUTION OF COMPLAINTS - LIFE – 2018-19

Analysis of the Grievances Reported against General Insurers

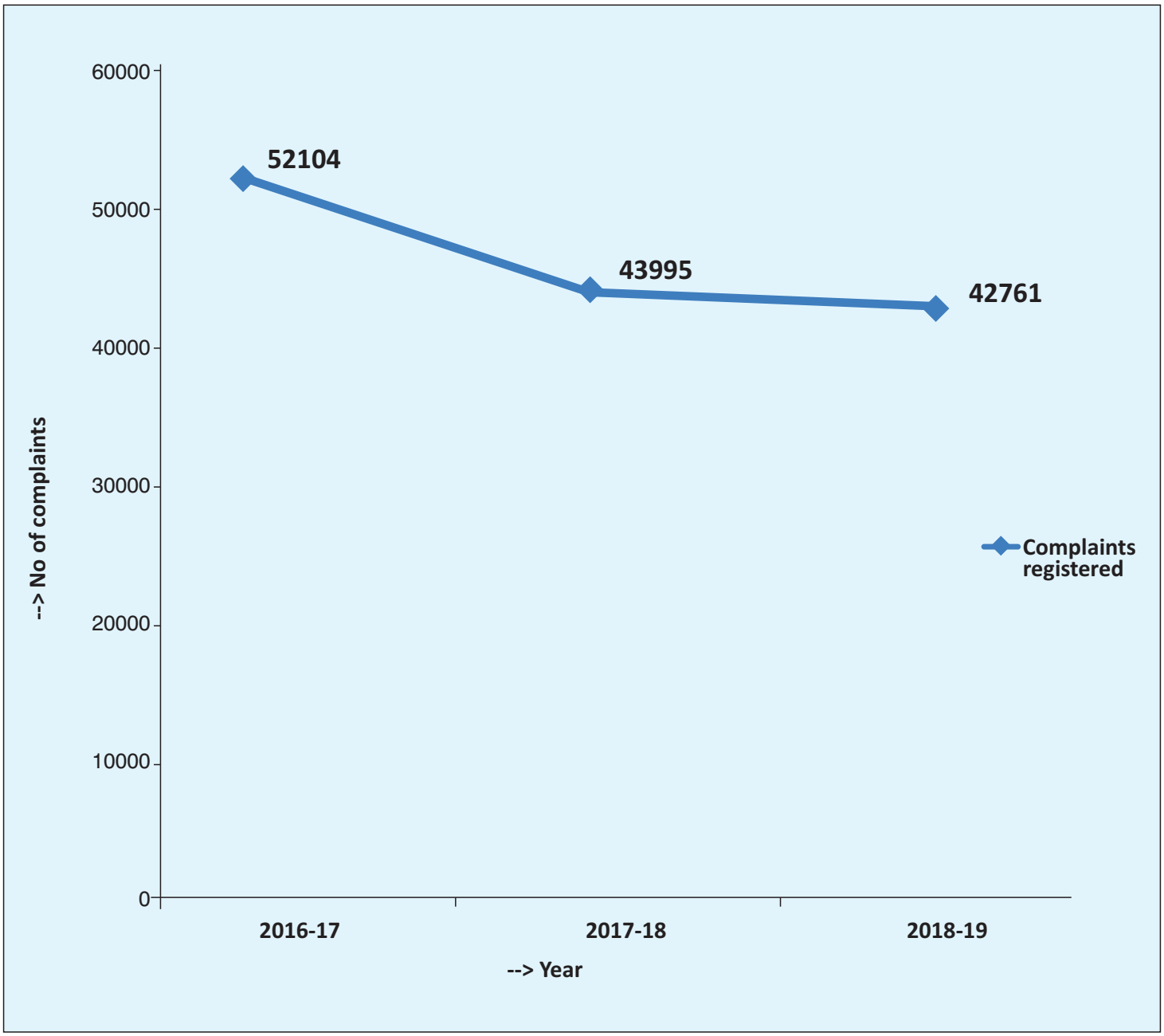
1. Cursory glance of complaints registered & 'attended to' by General Insurers
2. Complaints registered against General Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of Complaints registered against General Insurers
5. Classification of General Insurance Complaints - Graphical Presentation
6. Policy Type wise General Insurance Industry Complaints
7. Policy Type wise General Insurance Complaints - Graphical Presentation
8. Analysis of Health Insurance Complaints
9. Analysis of Motor Insurance Complaints
10. State-wise Distribution of Complaints – 2017-18
11. State-wise Distribution of Complaints – 2018-19

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY GENERAL INSURERS

S.No.	Description	2018-19		2017-18		2016-17	
		Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly in IGMS	3824	3723	4888	4189	3173	3008
2	Complaints of the Policyholders registered by IRDAI in IGMS	12037	11833	10936	10385	12474	12194
3	Complaints of the Policyholders registered by Life Insurers	26900	26605	28171	27775	36457	36225
	Total:	**42761**	**42161**	**43995**	**42349**	**52104**	**51427**

* Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to , which relates to earlier year.

TREND OF COMPLAINTS REGISTERED AGAINST GENERAL INSURERS FOR THE LAST 3 YEARS



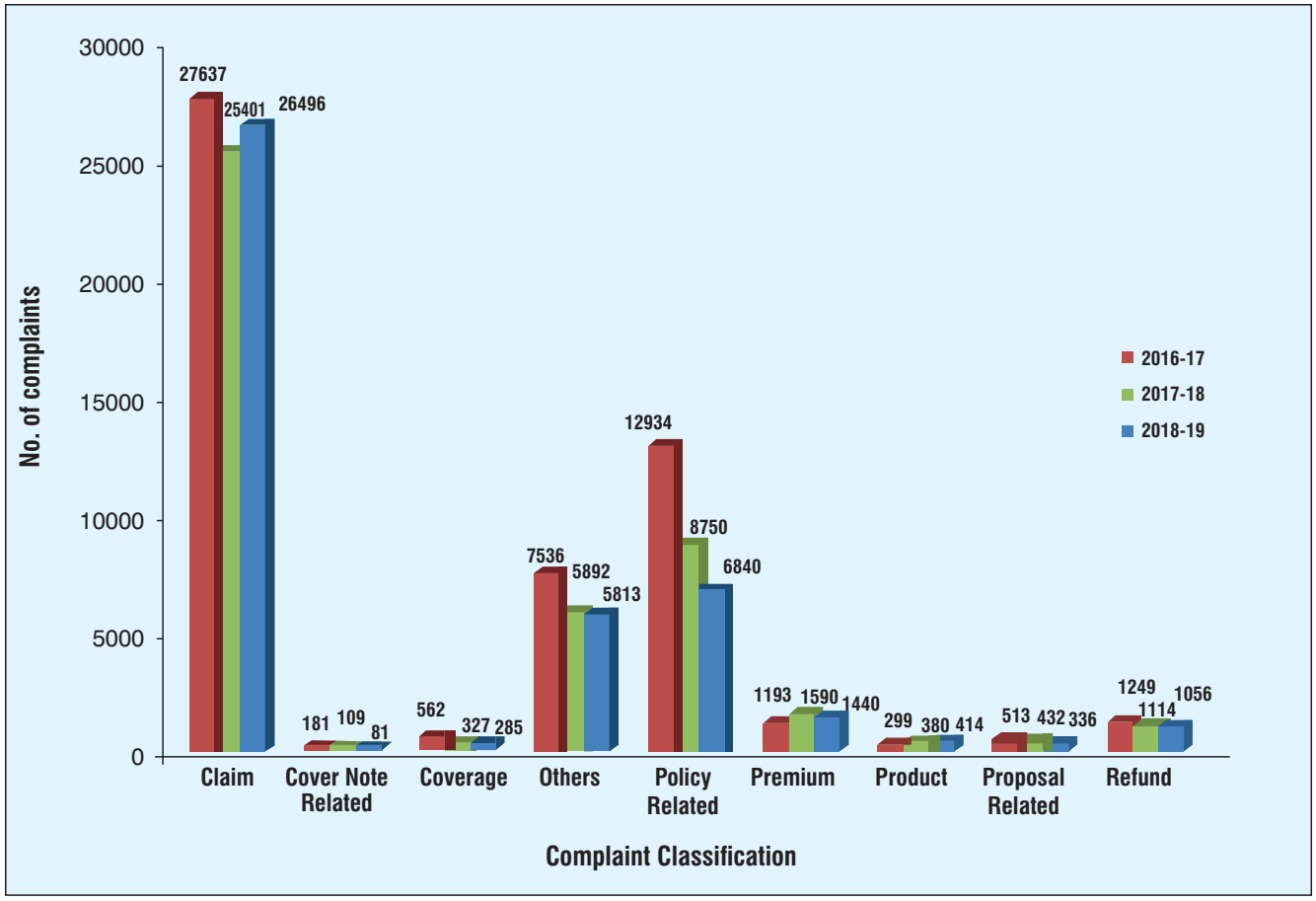
MOVEMENT OF COMPLAINTS - LIFE INSURERS

S. No	Name of the Insurer	2017-18			2018-19					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints	Attended to during the year	Pending at the end of the year
1	Agriculture Insurance*	-	-	-	0	12	0	12	12	0
2	ECGC of India	9	8	53	53	15	0	15	68	0
3	National Insurance	5571	5591	169	169	4739	0	4739	4891	17
4	The New India Assurance	4820	4852	3	3	5178	14	5164	5137	30
5	The Oriental Insurance	2743	2121	752	752	2733	99	2634	3359	27
6	United India Insurance	9425	9212	325	325	8404	0	8404	8464	265
(i)	**Total - PSU insurers**	**22568**	**21784**	**1302**	**1302**	**21081**	**113**	**20968**	**21931**	**339**
1	Acko General				0	11	0	11	11	0
2	Aditya Birla Health	251	145	107	107	599	4	595	702	0
3	Apollo Munich Health	929	918	31	31	1278	67	1211	1230	12
4	Bajaj Allianz General	914	919	2	2	1113	61	1052	1052	2
5	Bharati Axa General	1943	1944	6	6	1423	73	1350	1352	4
6	Cholamandalam MS General	439	440	2	2	237	4	233	235	0
7	CignaTTK Health	702	707	3	3	739	30	709	709	3
8	DHFL General				0	12	0	12	12	0
9	Edelweiss General				0	4	1	3	3	0
10	Future Generali India	1113	1113	3	3	622	20	602	605	0
11	Go Digit General				0	117	0	117	117	0
12	HDFC ERGO General	1037	1037	0	0	1093	23	1070	1070	0
13	ICICI Lombard General	3037	3091	34	34	2976	47	2929	2889	74
14	IFFCO Tokio General	1044	1029	16	16	722	15	707	722	1
15	Kotak General	63	65	0	0	73	2	71	69	2
16	L&T General.	137	137	0	0	5	0	5	5	0
17	Liberty Genral	257	260	0	0	291	0	291	291	0
18	Magma HDI General	94	62	49	49	82	2	80	129	0
19	Max Bupa Health	772	772	0	0	921	29	892	892	0
20	Raheja QBE	1	0	1	1	1	0	1	2	0
21	Reliance General	454	456	7	7	600	0	600	607	0
22	Reliance Health				0	6	0	6	6	0
23	Religare Health	573	569	4	4	690	46	644	645	3
24	Royal Sundaram Alliance	778	782	2	2	566	28	538	530	10
25	SBI General	671	697	29	29	481	10	471	489	11
26	Shriram General	218	218	0	0	234	3	231	231	0
27	Star Health and Allied	4496	4486	47	47	5713	28	5685	5597	135
28	Tata- AIG General	1050	1050	1	1	1365	134	1231	1228	4
29	Universal Sompo General	454	454	0	0	458	12	446	446	0
(ii)	**Total Private Insurers**	**21427**	**21351**	**344**	**344**	**22432**	**639**	**21793**	**21876**	**261**
Grand Total [(i)+(ii)]		**43995**	**43135**	**1646**	**1646**	**43513**	**752**	**42761**	**43807**	**600**

ANALYSIS OF THE REGISTERED GENERAL INSURANCE COMPLAINTS

S. No	Name of the Insurer	Claim		Cover Note Related		Coverage		Others		Policy Related		Premium		Product		Proposal Related		Refund		Total	
		2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18	2018-19	2017-18
1	Agriculture Insurance	9	-	0	-	0	-	3	-	0	-	0	-	0	-	0	-	0	-	12	-
2	ECGC of India	2	9	0	0	0	0	2	0	1	0	0	0	0	0	10	0	0	0	15	9
3	National Insurance	3005	3363	20	36	19	18	1113	1373	427	590	91	108	17	12	7	11	40	60	4739	5571
4	The New India Assurance	3401	2833	6	16	32	39	577	392	751	1089	294	348	22	14	5	4	76	85	5164	4820
5	The Oriental Insurance	1440	1909	9	9	23	17	397	319	488	374	222	87	7	6	6	3	42	19	2634	2743
6	United India Insurance	6250	6323	17	33	50	76	791	1176	856	1270	167	278	15	11	23	44	235	214	8404	9425
(i)	**Total - PSU insurers**	**14107**	**14437**	**52**	**94**	**124**	**150**	**2883**	**3260**	**2523**	**3323**	**774**	**821**	**61**	**43**	**51**	**62**	**393**	**378**	**20968**	**22568**
1	Acko General	5		0		0		4		2		0		0		0		0		11	
2	Aditya Birla Health	189	44	0	0	9	7	100	21	171	73	4	3	57	38	25	38	40	27	595	251
3	Apollo MUNICH Health	412	319	0	0	30	19	209	92	354	348	121	94	17	10	43	20	25	27	1211	929
4	Bajaj Allianz General	498	488	3	0	7	5	222	155	255	197	21	29	22	20	9	5	15	15	1052	914
5	Bharati Axa General	444	900	11	5	6	14	156	110	606	766	40	29	21	41	11	15	55	63	1350	1943
6	Cholamandalam MS Gen	145	244	0	0	0	1	26	32	42	147	10	3	7	3	1	3	2	6	233	439
7	CignaTTK Health	257	222	0	0	0	0	299	242	85	113	6	2	23	65	2	21	37	37	709	702
8	DHFL General	0		0		0		3		3		0		5		0		1		12	
9	Edelweiss general	0		0		0		1		1		0		0		1		0		3	
10	Future Generali India Ins.	243	404	5	6	0	0	93	138	121	322	5	8	44	63	81	166	10	6	602	1113
11	Go Didit General	53		1		1		26		31		0		1		0		4		117	
12	HDFC ERGO General	758	634	0	1	1	4	119	137	133	223	10	8	11	4	9	10	29	16	1070	1037
13	ICICI Lombard General	1006	1075	2	1	1	8	768	743	835	946	238	178	33	11	6	23	40	52	2929	3037
14	IFFCO Tokio General	529	881	0	2	2	1	82	64	57	70	31	6	2	6	3	0	1	14	707	1044
15	Kotak General	32	40	0	0	0	1	20	10	15	6	0	1	4	2	0	0	0	3	71	63
16	L&T General.	3	82	0	0	0	1	2	4	0	44	0	1	0	0	0	0	0	5	5	137
17	Liberty Videocon General	186	157	0	0	0	0	19	19	80	62	1	2	2	5	0	2	3	10	291	257
18	Magma HDI General	49	64	0	0	0	0	16	13	13	13	1	2	0	0	1	2	0	0	80	94
19	Max Bupa Health	541	268	0	0	21	34	111	138	81	64	78	222	17	12	36	17	7	17	892	772
20	Raheja QBE	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1
21	Reliance General	463	327	4	0	2	2	61	51	37	54	17	8	13	8	1	3	2	1	600	454
22	Reliance Health	2		0		0		1		1		0		0		1		1		6	
23	Religare Health	422	361	0	0	0	1	58	70	85	74	24	32	2	2	20	7	33	26	644	573
24	Royal Sundaram Alliance	334	401	0	0	7	12	49	149	118	153	11	39	1	5	7	8	11	11	538	778
25	SBI General	186	366	1	0	0	4	95	117	146	154	3	5	18	7	15	11	7	7	471	671
26	Shriram General	182	178	1	0	0	0	15	19	29	14	1	1	1	3	0	3	2	0	231	218
27	Star Health and Allied	4514	2637	0	0	4	1	195	162	621	1247	31	81	37	25	10	8	273	335	5685	4496
28	Tata- AIG General	538	476	1	0	70	61	163	133	371	297	9	15	14	4	2	6	63	58	1231	1050
29	Universal Sompo General	397	396	0	0	0	1	17	13	24	39	4	0	1	3	1	2	2	0	446	454
(ii)	**Total Private Insurers**	**12389**	**10964**	**29**	**15**	**161**	**177**	**2930**	**2632**	**4317**	**5427**	**666**	**769**	**353**	**337**	**285**	**370**	**663**	**736**	**21793**	**21427**
Grand Total [(i)+(ii)]		**26496**	**25401**	**81**	**109**	**285**	**327**	**5813**	**5892**	**6840**	**8750**	**1440**	**1590**	**414**	**380**	**336**	**432**	**1056**	**1114**	**42761**	**43995**

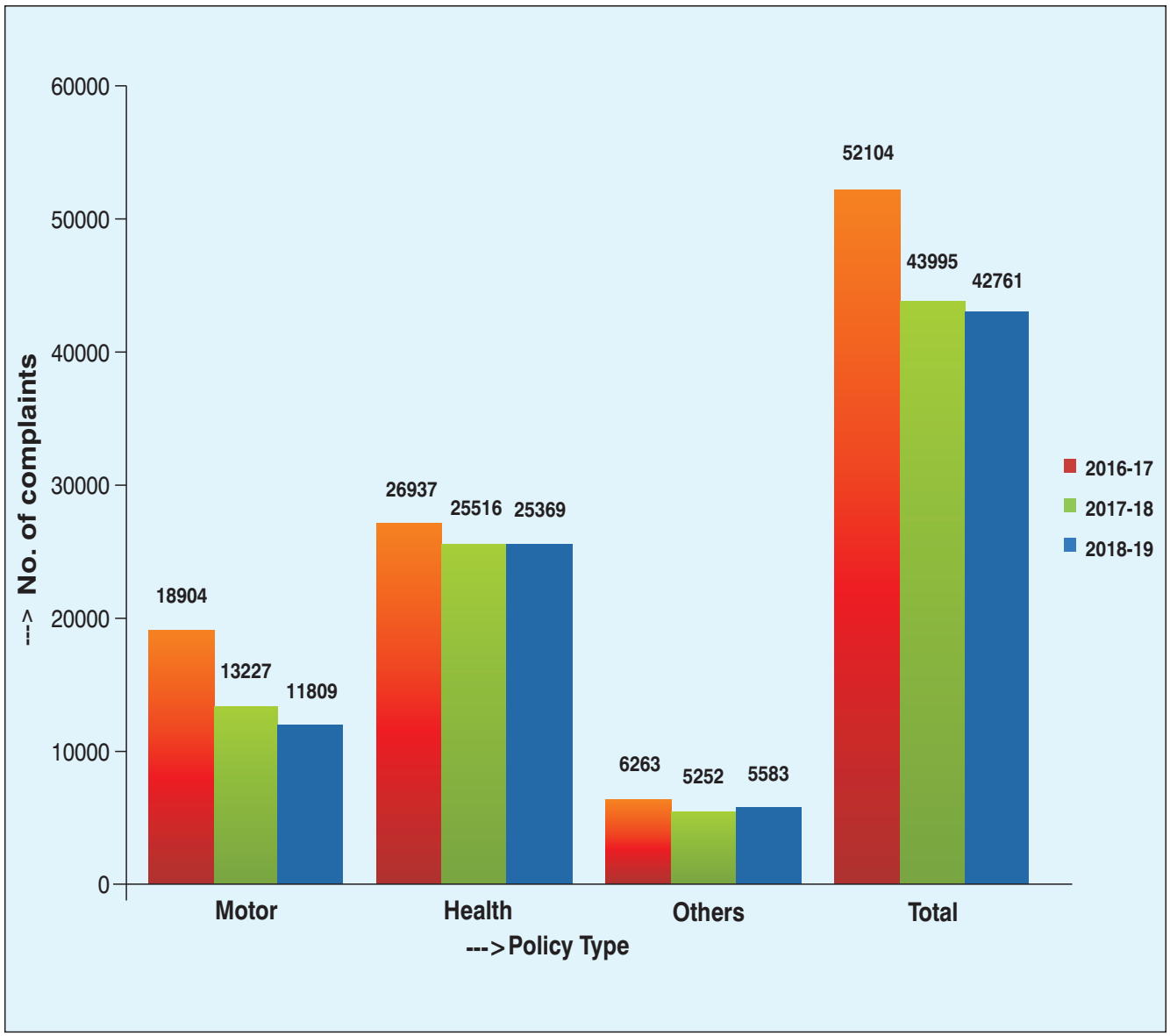
CLASSIFICATION OF GENERAL INSURANCE COMPLAINTS FOR THE LAST 3 YEARS



POLICY TYPE WISE GENERAL INSURANCE INDUSTRY COMPLAINTS FOR THE LAST THREE YEARS

S.No.	Sector of Insurance	2016-17	2017-18	2018-19
1	Motor	18904	13227	11809
2	Health	26937	25516	25369
3	Others	6263	5252	5583
	Total	**52104**	**43995**	**42761**

POLICY TYPE WISE GENERAL INSURANCE COMPLAINTS - TRENDS FOR 3 YEARS



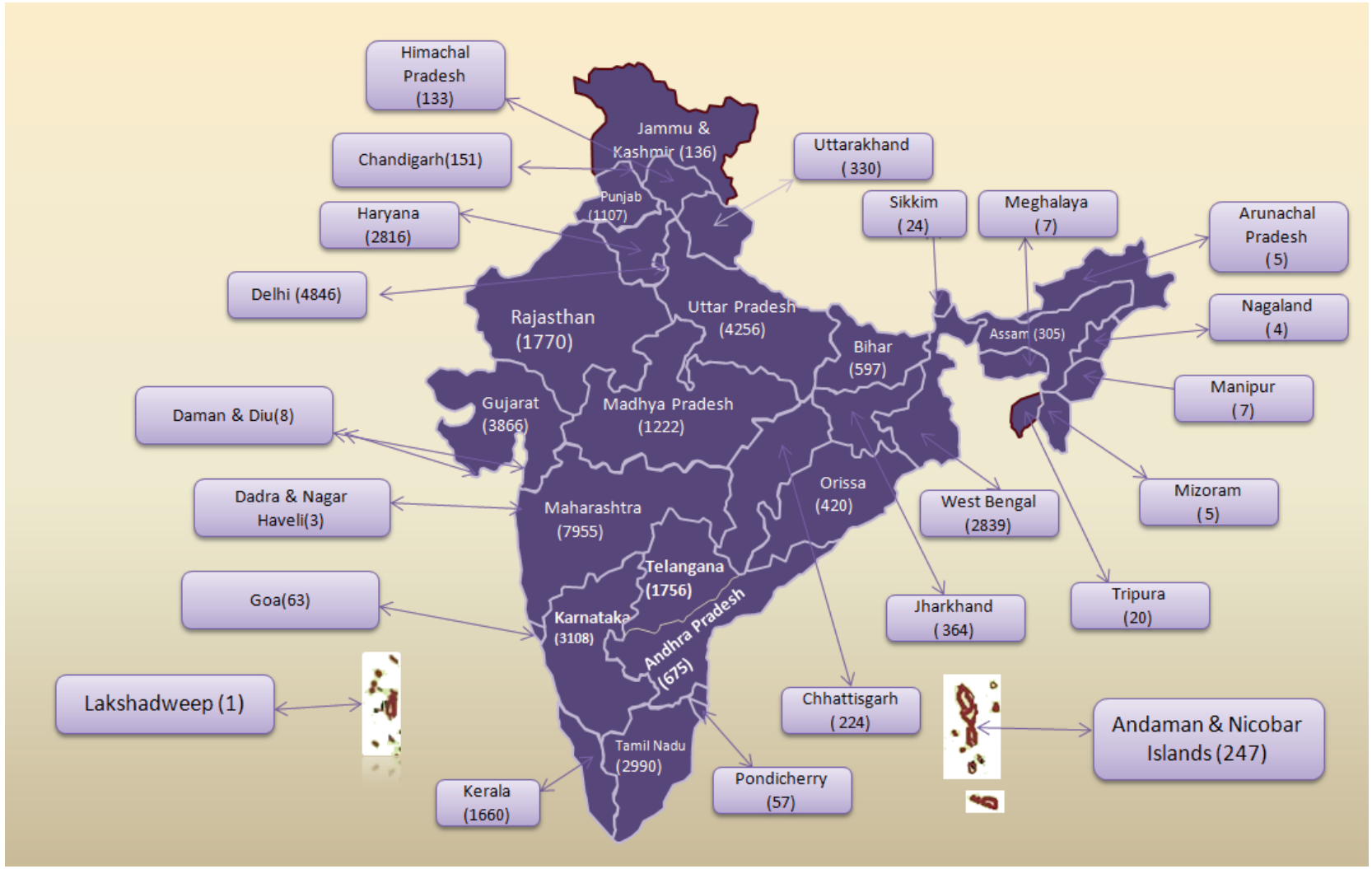
ANALYSIS OF HEALTH INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS

S.No	Complaint Type	2018-19	2017-18	2016-17
1	Claim	16275	14969	14500
2	Coverage	197	234	386
3	Others	3317	3482	4274
4	Policy Related	3539	4608	6042
5	Premium	995	1131	695
6	Product	227	204	130
7	Proposal Related	201	201	182
8	Refund	618	687	728
	Total	**25369**	**25516**	**26937**

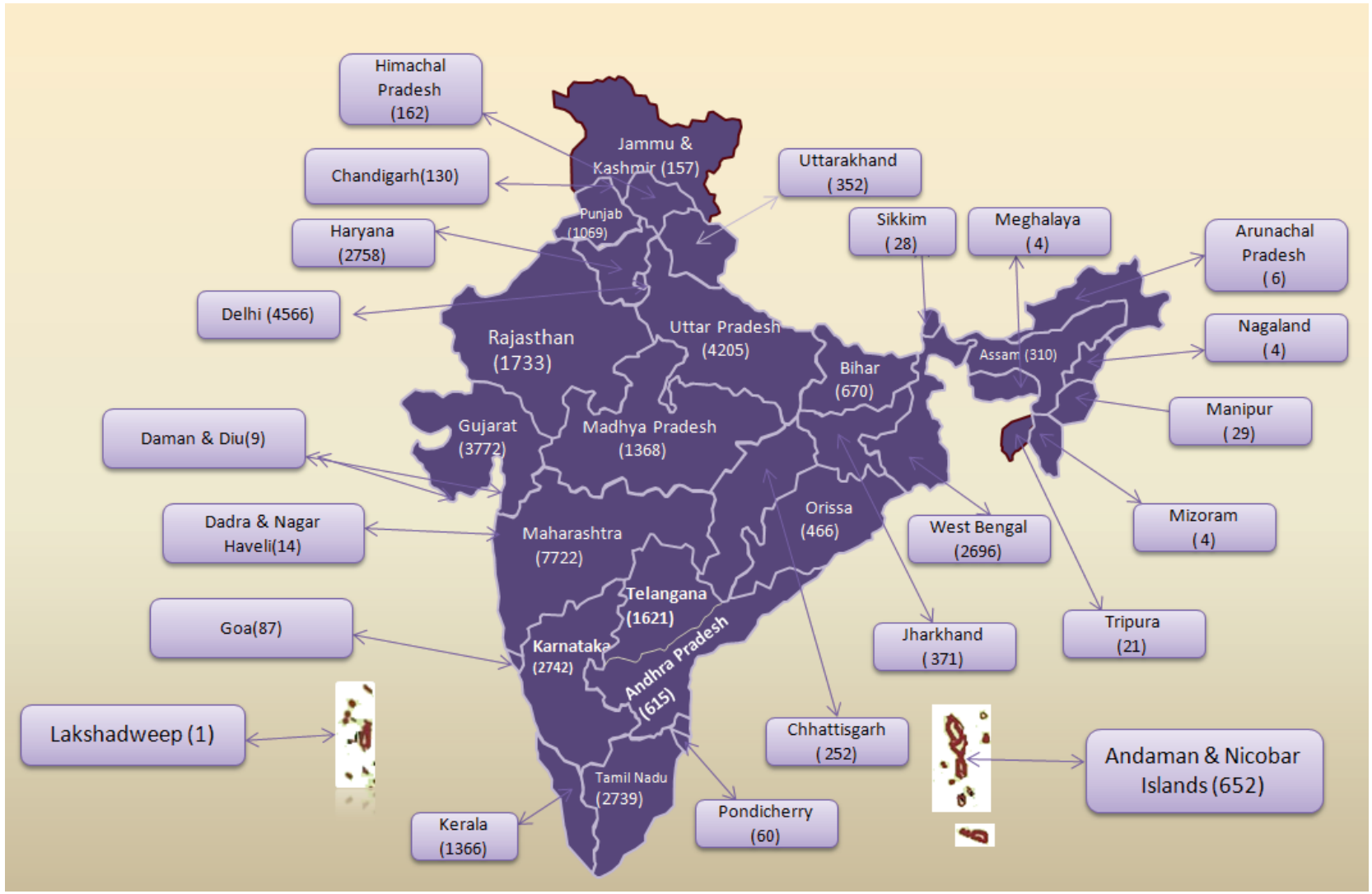
ANALYSIS OF MOTOR INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS

S.No	Complaint Type	2018-19	2017-18	2016-17
1	Claim	7173	7511	9800
2	Cover Note Related	71	90	159
3	Coverage	61	59	105
4	Others	1571	1735	2428
5	Policy Related	2207	2923	5343
6	Premium	257	353	364
7	Product	60	94	127
8	Proposal Related	97	185	269
9	Refund	312	277	309
	Total	**11809**	**13227**	**18904**

STATE/UT WISE DISTRIBUTION OF COMPLAINTS – GENERAL(2017-18)



STATE/UT WISE DISTRIBUTION OF COMPLAINTS – GENERAL(2018-19)



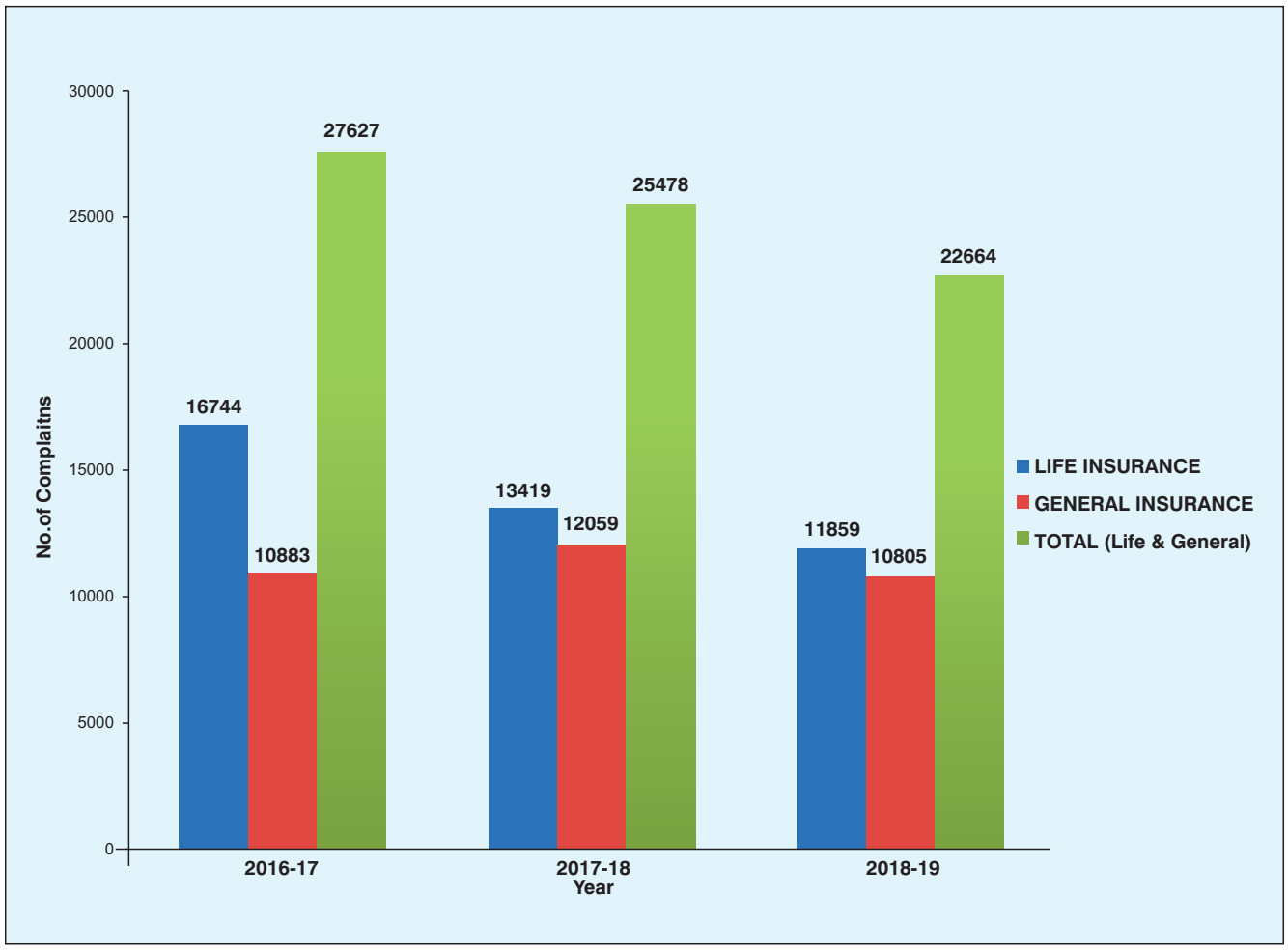
Analysis of the Grievances Reported to Insurance Ombudsmen

1. Cursory glance of Complaints received during the last 3 financial years
2. Complaints received during the last 3 financial years - Graphical Presentation
3. Disposal of Complaints during 2017-18 & 2018-19
4. Classification of Complaints received during 2017-8 & 2018-19
5. Performance of Ombudsmen at Different Centers (LIFE INSURANCE)
6. Performance of Ombudsmen at Different Centers (GENERAL INSURANCE)
7. Performance of Ombudsmen at Different Centers (INDUSTRY)

COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN - CURSORY GLANCE

Insurace Type	2016-17	2017-18	2018-19
LIFE INSURANCE	16744	13419	11859
GENERAL INSURANCE	10883	12059	10805
TOTAL (Life& General)	**27627**	**25478**	**22664**

COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN



DISPOSAL OF COMPLAINTS BY THE INSURANCE OMBUDSMEN

S. No.	Particulars	2017-18				2018-19			
		O/S as on 01.04.2017	Received	Disposed	O/s as on 31.03.2018	O/S as on 01.04.2018	Received	Disposed	O/s as on 31.03.2019
1.	Against Life Insurers	1376	13419	9475	5320	5320	11859	12103	5076
2.	Against General Insurers	954	12059	7750	5263	5263	10805	9864	6204
3.	**Against Life & General Insurers**	**2330**	**25478**	**17225**	**10583**	**10583**	**22664**	**21967**	**11280**

CLASSIFICATION OF COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN

(Life & General Insurers)

Classification Type	2017-18	2018-19
Complaints which are not entertainable	12778	10894
Partial or total repudiation of claim	7481	6863
Dispute in regard to premiums paid or payable in terms of policy	3533	1871
Disupute on the legal construction of the policies so far as such dispute relates to claim	99	46
Delay in settlement of claims	630	879
Non issuance of document to customer after receipt of premium	56	47
Misrepresentation of policy terms and conditions at any time in the policy document or policy contract.	778	1584
Policy servicing related grievances against insurers and their agents and intermediaries.	86	239
Issuance of policies which is not in conformity with the proposal form submitted by the proposer	20	22
Any other matter resulting from the violation of provisions	17	219
Total	**25478**	**22664**

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (LIFE INSURANCE)

Name of Centre	Total No. of Complaints			No. of Complaints disposed by way of							Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2018	Received during 2018-19	Total	(I)	(II)	(III)	(IV)	(V)	(VI)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	411	693	1104	0	2	86	0	2	296	386	309	33	44	386	75	308	335	718
Bengaluru	229	648	877	35	217	43	0	108	348	751	377	294	80	751	68	58	0	126
Bhopal	218	620	838	128	46	35	0	201	322	732	343	319	70	732	74	32	0	106
Bubaneshwar	149	619	768	3	106	4	0	22	458	593	465	9	119	593	48	103	24	175
Chandigarh	1709	1475	3184	0	1010	10	0	486	746	2252	765	91	1396	2252	184	497	251	932
Chennai	89	901	990	0	69	19	0	93	767	948	778	147	23	948	35	7	0	42
Delhi	348	814	1162	181	397	17	0	1	331	927	340	331	256	927	150	85	0	235
Guwahati	56	311	367	8	99	26	0	45	189	367	320	47	0	367	0	0	0	0
Hyderabad	130	655	785	0	215	40	0	62	397	714	488	209	17	714	59	11	1	71
Jaipur	154	374	528	48	200	54	0	49	177	528	336	189	3	528	0	0	0	0
Kochi	134	382	516	0	40	20	0	74	174	308	181	14	113	308	70	124	14	208
Kolkata	718	1082	1800	0	262	200	0	90	337	889	359	139	391	889	161	468	282	911
Lucknow	330	659	989	36	3	35	0	52	355	481	368	12	101	481	63	224	221	508
Mumbai	112	844	956	30	92	17	0	32	643	814	682	121	11	814	121	14	7	142
Noida	134	583	717	24	103	74	0	36	316	553	327	182	44	553	127	37	0	164
Patna	74	389	463	0	76	26	0	24	270	396	278	72	46	396	44	20	3	67
Pune	325	810	1135	8	43	38	0	15	360	464	366	18	80	464	142	292	237	671
Total	**5320**	**11859**	**17179**	**501**	**2980**	**744**	**0**	**1392**	**6486**	**12103**	**7082**	**2227**	**2794**	**12103**	**1421**	**2280**	**1375**	**5076**

Note:

O/S : Outstanding

(I) Recommendations
(II) Awards
(III) Withdrawal
(IV) Non-acceptance
(V) Dismissal awards fvg. Ins. Co.
(VI) Not-entertainable

(A) Within 3 months
(B) 3 months to 1 Year
(C) Above 1 Year

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (GENERAL INSURANCE)

Name of Centre	Total No. of Complaints			No. of Complaints disposed by way of							Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2018	Received during 2018-19	Total	(I)	(II)	(III)	(IV)	(V)	(VI)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	927	1632	2559	0	67	131	0	23	721	942	761	50	131	942	215	645	757	1617
Bengaluru	261	635	896	62	223	50	0	130	304	769	339	389	41	769	88	39	0	127
Bhopal	174	334	508	5	23	27	0	76	175	306	181	28	97	306	44	101	57	202
Bubaneshwar	55	182	237	0	7	3	0	1	176	187	179	1	7	187	2	0	48	50
Chandigarh	430	928	1358	0	263	1	0	172	540	976	564	41	371	976	116	232	34	382
Chennai	314	754	1068	6	325	92	0	150	351	924	396	414	114	924	100	44	0	144
Delhi	326	695	1021	192	167	34	0	2	321	716	334	113	269	716	112	193	0	305
Guwahati	44	161	205	3	71	19	0	39	73	205	136	62	7	205	0	0	0	0
Hyderabad	147	449	596	0	186	22	0	81	200	489	216	260	13	489	63	44	0	107
Jaipur	122	402	524	15	193	53	0	72	191	524	371	150	3	524	0	0	0	0
Kochi	366	600	966	0	173	36	0	123	191	523	203	25	295	523	153	232	58	443
Kolkata	478	698	1176	0	67	119	0	33	104	323	128	74	121	323	145	374	334	853
Lucknow	100	188	288	0	0	30	0	3	64	97	68	20	9	97	26	83	82	191
Mumbai	1116	1670	2786	25	930	177	0	362	469	1963	495	1144	324	1963	339	474	10	823
Noida	81	518	599	8	84	75	0	52	218	437	236	180	21	437	110	52	0	162
Patna	40	254	294	12	36	15	0	0	76	139	85	29	25	139	25	130	0	155
Pune	282	705	987	0	30	61	0	19	234	344	246	39	59	344	146	307	190	643
Total	**5263**	**10805**	**16068**	**328**	**2845**	**945**	**0**	**1338**	**4408**	**9864**	**4938**	**3019**	**1907**	**9864**	**1684**	**2950**	**1570**	**6204**

Note:

O/S : Outstanding

(I) Recommendations
(II) Awards
(III) Withdrawal
(IV) Non-acceptance
(V) Dismissal awards fvg. Ins. Co.
(VI) Not-entertainable

(A) Within 3 months
(B) 3 months to 1 Year
(C) Above 1 Year

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (LIFE & GENERAL COMBINED)

Name of the Centre	Total Number of Complaints			Number of Complaints disposed by way of							Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2018	Received during 2018-19	Total	(I)	(II)	(III)	(IV)	(V)	(VI)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	1338	2325	3663	0	69	217	0	25	1017	1328	1070	83	175	1328	290	953	1092	2335
Bengaluru	490	1283	1773	97	440	93	0	238	652	1520	716	683	121	1520	156	97	0	253
Bhopal	392	954	1346	133	69	62	0	277	497	1038	524	347	167	1038	118	133	57	308
Bubaneshwar	204	801	1005	3	113	7	0	23	634	780	644	10	126	780	50	103	72	225
Chandigarh	2139	2403	4542	0	1273	11	0	658	1286	3228	1329	132	1767	3228	300	729	285	1314
Chennai	403	1655	2058	6	394	111	0	243	1118	1872	1174	561	137	1872	135	51	0	186
Delhi	674	1509	2183	373	564	51	0	3	652	1643	674	444	525	1643	262	278	0	540
Guwahati	100	472	572	11	170	45	0	84	262	572	456	109	7	572	0	0	0	0
Hyderabad	277	1104	1381	0	401	62	0	143	597	1203	704	469	30	1203	122	55	1	178
Jaipur	276	776	1052	63	393	107	0	121	368	1052	707	339	6	1052	0	0	0	0
Kochi	500	982	1482	0	213	56	0	197	365	831	384	39	408	831	223	356	72	651
Kolkata	1196	1780	2976	0	329	319	0	123	441	1212	487	213	512	1212	306	842	616	1764
Lucknow	430	847	1277	36	3	65	0	55	419	578	436	32	110	578	89	307	303	699
Mumbai	1228	2514	3742	55	1022	194	0	394	1112	2777	1177	1265	335	2777	460	488	17	965
Noida	215	1101	1316	32	187	149	0	88	534	990	563	362	65	990	237	89	0	326
Patna	114	643	757	12	112	41	0	24	346	535	363	101	71	535	69	150	3	222
Pune	607	1515	2122	8	73	99	0	34	594	808	612	57	139	808	288	599	427	1314
Total	**10583**	**22664**	**33247**	**829**	**5825**	**1689**	**0**	**2730**	**10894**	**21967**	**12020**	**5246**	**4701**	**21967**	**3105**	**5230**	**2945**	**11280**

Note:

O/S : Outstanding

(I) Recommendations
(II) Awards
(III) Withdrawal
(IV) Non-acceptance
(V) Dismissal awards fvg. Ins. Co.
(VI) Not-entertainable

(A) Within 3 months
(B) 3 months to 1 Year
(C) Above 1 Year

CLAIMS

A brief on Claim Handling by Insurance Companies

CLAIM HANDLING BY INSURANCE COMPANIES

I. INTRODUCTION

Claim is a moment of truth as far as an Insurance policy is concerned. The expectation of the policyholder is whenever the claim amount has fallen due, the insurer honors the claim and makes the payment of the insured amount at the earliest and with least possible inconvenience where as the insurer would want to pay the claims only after due satisfactory compliance of all the requirements for making the payment in accordance with the policy terms and conditions. Paying claims without proper examination can result in a situation where fraudulent claims also get entertained and paid. This could severely impact the financials of the company putting in jeopardy the very solvency of the insurance company.

Therefore, the claim handling is a critical function of an insurer which has to be carried out with diligence and prudence without adversely affecting the customer service.

II. Root cause of claim settlement related complaints

Based on consolidation of submissions made by Insurers and our own analysis, the following issues have been identified as root cause of claim settlement related complaints:

A. In respect of Life Insurance Companies

- Non- submission or delay in submission of documents like KYC, hospital/medical records or payment mandate details by the claimant.
- Delay in processing of claim due to Incorrect or incomplete contact details given by the claimant, as it become difficult to establish contact with the claimant for any requirement or clarifications.
- Non-availability of complete Police records such as Final Police Investigation Report, Chemical Analysis/ Viscera Report, etc which could take time.
- Claims coming from Tier 3 or rural areas take longer time as records are either not properly maintained or are maintained in manual registers
- Operational constraints in terms of geographies and climactic conditions i.e. customers based in remote locations, heavy rainfall / snowfall etc.
- In the absence of any law / guidelines, hospitals sometimes refuse to share information or provide the required information / documents causing significant delays in claim settlement.
- Absence of credible identity of customers like social security number etc. restricts ability at times to identify and establish the right identity of the customer at hospitals and from treatment records and this becomes a constraint in settling claims
- Non co-operation from Employers –when asked for pay slips, leave records.
- Authorities when hand in glove with fraudsters, especially Gram Panchayat and Aanganwadi workers
- Cases where title is not clear or pending in court for decision with respect to right beneficiary to whom payment is to be made, causes delay in settlement of such claims even

though the decision has been taken to pay the claim.

B. In respect of General Insurance Companies

- Non-submission and non-cooperation in providing required document or information by insured or insured's representative.
- Non-submission of complete information in one go by the customer, majorly financial documents, KYC and NEFT details etc.
- Delayed submission of requirements by customer post communication of deficiency
- Some cases require further investigation to rule out suspected fraud / Abuse which requires additional time
- Dependency on leaders for Co-insurance & Re-insurance claims
- Delay in receipt of premium subsidy from Government for Govt. sponsored scheme
- Delay in reporting of claim by insured for survey
- Dispute between insured and financier resulting in delays in the claim settlement process
- Delay in responding to the queries raised by Surveyor/ Insurance Company.

The following issues were observed to be concentrated to specific line of business:

1. In respect of health Insurance:

a. Non-utilization of cashless facility by the customer even in case of network adequacy leading to higher requests for reimbursement

b. Non-standardized hospital documents leading to the need of verification to avoid any abuse scenario

c. Transition from one Third Party Administrator to another

d. Dependency on receipt of documents from hospitals causes delay

e. Non-disclosure of personal medical information at the time of buying of policy (which require verification at claim stage).

f. Verification of pre-existing conditions and/or ailments

g. Lack of previous claims history in case of ported policy

h. Detailed verification is done in case of claims from suspicious hospitals.

2. In respect of Motor Insurance:

a. Delay in repair of vehicles in the workshop due to non-availability of spare parts, delayed clarification from customer on queries raised etc.

b. Delay in cancellation of Registration Certificate of vehicle in respect of total loss claims.

c. Delay in receiving the untraced report from police authorities in respect of theft claims

d. Verification of Driving License with Road Transport Authorities in cases where details are not available online.

e. Repair invoices are not handed over to the company / surveyors by the garages which results in delay of settlement of the claims.

f. Vehicle produced with delay for inspection/ survey due to vehicle being placed in police station, involvement of death in accident etc.

3. In respect of Fire and Marine Policies:

a. Reinstatement of property consumes significant time

4. In respect of Agriculture Insurance:

a. Issues of mapping of Villages with Notified units in Ministry of Agriculture, Government of India portal.

b. Issues of non-uploading of farmers' data by some banks in Ministry of Agriculture, Government of India portal.

The above list is an illustrative one- not exhaustive.

III. INITIATIVES BEING UNDERTAKEN BY GENERAL INSURERS TO ENSURE EXPEDITIOUS SETTLEMENT OF CLAIMS:

Based on consolidation of submissions made by Insurers, various Initiatives being undertaken by the Insurers to ensure expeditious settlement of claims are reproduced below:

Cashless facility Awareness:

- Continuous communication with customer informing of availability and promotion of seamless claim experience using cashless facility.

Communications:

- Proactive communication- Emails, SMS and outbound calling to explain the documents requirement, computation of quantum of claim to be settled and reason for deductions if any through customer service executives.
- System triggered SMS to insured at various stages of the claim like – surveyor assignment (with surveyor details), post survey completion, post payment etc.
- Focus on the personal touch base with the customer via Outbound calling at each event, these are in other words customized assistance which help in understanding /answering the queries at first interaction.

Documents related:

- Claim form with checklist to assist the customer in submission of all information/ documents in one go.
- Separate calling to insured to explain a complicated query (if any) raised in the claim
- Meetings with the Insured and/or Intermediary to ensure the documentation is completed in time for settlement.
- For Personal Accident claims a document collection agency is hired to reach the nominees in rural areas, to help in understanding the document requirement and to help in procuring the same, post which the documents available with the nominee will be shared with Insurer. This enable to process claims at the earliest
- Where the admissibility of the claim is otherwise established, requirement of submission of medical information (in Part B of the claim form) is waived off to expedite claim settlement. (Health)
- Wherever Registration certificate and driving license original is not available, the same is validated in the online government portals by the Company.
- Where the customer is unable to produce hospital records, Insurer contacts the hospital directly with the consent of the customer and obtains the relevant records.
- Explore / discuss and offer market value settlement as & when Insured is unable toProvide reinstatement documents. (Commercial claims)

Monitoring of Intermediaries (Surveyors, TPAs, garages etc.):

- Periodic peer to peer review of claims.
- Frequent review of Surveyors for submission of survey reports ensuring strict surveyor management.

Monitoring and Review of claims:

- Monitoring of claims on a regular basis by a dedicated team at Corporate level.
- Robust monitoring system with daily, weekly and monthly frequencies for Review and Speedy settlement of claims

On account payment:

- "On Account" Payment: Pending final assessment of a claim, an "on account" payment is considered subject to confirmation of Loss due to Occurrence of a peril covered by the policy, Establishment of liability, The minimum liability that might arise under the policy.

Self survey:

- With a view to provide seamless claims journey to the customer, the Insurer provides the customers an option to undertake self-survey in case of claims up to Rs. 50,000/-.

Travel claims:

- Direct initiation of claim based on delay information garnered by the Insurer for common carrier delay claims in domestic travel. Customer is only required to upload the boarding pass to receive claim amount.

Repair related:

- In case insured finds it difficult to comply with the requirement Insurer probes possibilities with the surveyor of arriving at the loss assessment for settlement of the claim
- Spot settlement facility to our customers where immediate disbursement is made as per assessment without even waiting for the repairs to be completed

Website/Application/portal facility:

- The surveyors are equipped with Tab based application for end to end claim processing which improves the turn around time for settlement. An Application for conducting survey through live streaming is introduced to speed up the claim survey and settlement
- Hospital portal developed where network hospitals can upload the documents on the portal and get authorization approval within 30 minutes.
- Garage mobile app where workshops can also upload the documents in the event of the customer leaving the vehicle and the documents at the cashless workshops.
- Access to Claims module provided to Investigators for seamless submission of reports
- Launched Mobile app to enable customers to access all services over the phone.Tracking system, accessible by the insured to find out the status of his claim
- Quick claim settlement module developed where Health claims UptoRs 25,000/- would be settled on submission of copy of documents through mobile app.

Motor Third Party Claims:

- For Third Party claims wherever the claims are prima facie admissible, we approach the claimant for compromised settlements.

Decentralisation of authority:

- Decentralized claim approval to ensure quick settlement of claims within the respective zone

- We have given Field settlement authority from the range of 10K to 50K to the surveyors for speedy settlement of claim.

Tieups with garages:

- Tied-ups with repair centers to convenience claim settlement for its customers. They are also given an option to get vehicles repaired at a garage of their choice and get the agreed claim amount settled. In the latter, the Company also offers to make advance payment of a certain amount of the claim to the customer to enable claim servicing in case of admissible claims.

Crop Insurance:

- Co-observance of Crop cutting experiments along with use of mobile app for fast assessment of claims.

Miscellaneous:

- Concurrent processing of claims while the survey and assessment is still in progress.
- Joint Meeting are held with insured, surveyors and intermediaries to resolve disputes and other differences to take the claim forward for completion of survey report.
- In-house team of Claims surveyor for expeditious survey of claims
- Annual Functional Trainings in all Lines of Business

IV. INTERMEDIARIES IN HANDLING OF CLAIMS

Surveyors and loss assessors in non-life and third party administrators in health insurance are the most important intermediaries who have a significant role in claim handling. Ensuring that these intermediaries function properly is the most critical to the discharge of claim related functions by insurers.

Surveyors and loss assessors are appointed by the insurer for surveying and assessing the loss caused when a claim is reported. The report is required to be furnished to the insurer. The insurer would decide upon the claim and may use the report of the surveyors and loss assessors but are not bound by it. The timeliness in appointment and conduct of survey and furnishing a report, the professionalism displayed in their functioning and the quality of the report determines the speed and quality of settlement of claims by insurers.

In case of health insurance, Third party administrators are the most important intermediaries handling policyholder servicing issues. Providing of cashless facility and settlement of reimbursement claims is facilitated by TPAs. The professionalism in conducting both these functions determines the smoothness of claim handling by insurers.

V. COMPLAINTS RELATED TO CLAIMS

Once a claim has been unduly delayed or repudiated by the insurer, there is a cause for complaint. The claimant takes up the matter first with the insurer. All the insurers have put in place internal mechanism to deal with such grievances and resolve them. The resolution of claim related complaints also generally includes review of the decision on claims by a Committee. After review, the decision on the claim is conveyed to the complainant.

Once the complaint is not internally redressed, the claimant is forced to seek adjudication of the dispute. For this purpose, he may approach an insurance ombudsman, consumer forum or a civil court and later take it through the appellate channels if redress is not to his satisfaction.

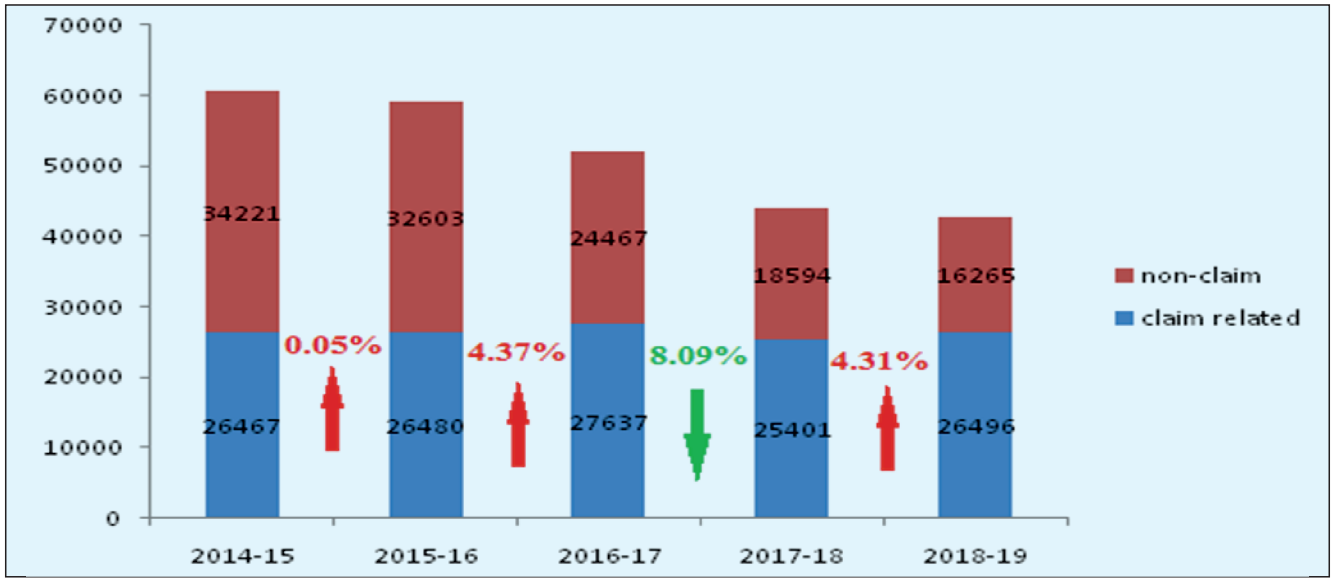
The statistics on claim related grievances indicate that in the Non-Life Sector, claim related complaints constitute a major proportion to the total complaints as compared to the life insurance sector.

The data relating to claim related complaints as obtained from the Integrated Grievance Management System, is as follows:

Year	No. of Claim complaints	% increase / decrease compared to last year	Total complaints	% of Claim related complaints to total complaints
NON-LIFE COMPLAINTS				
2014-15	26467		60688	43.61%
2015-16	26480	0.05%	59083	44.82%
2016-17	27637	4.37%	52104	53.04%
2017-18	25401	-8.09%	43995	57.74%
2018-19	26496	4.31%	42761	61.96%
LIFE COMPLAINTS				
2014-15	31076		278992	11.14%
2015-16	24749	-20.36%	204701	12.09%
2016-17	17383	-29.76%	120847	14.38%
2017-18	21212	22.03%	154367	13.74%
2018-19	27786	30.99%	163264	17.02%

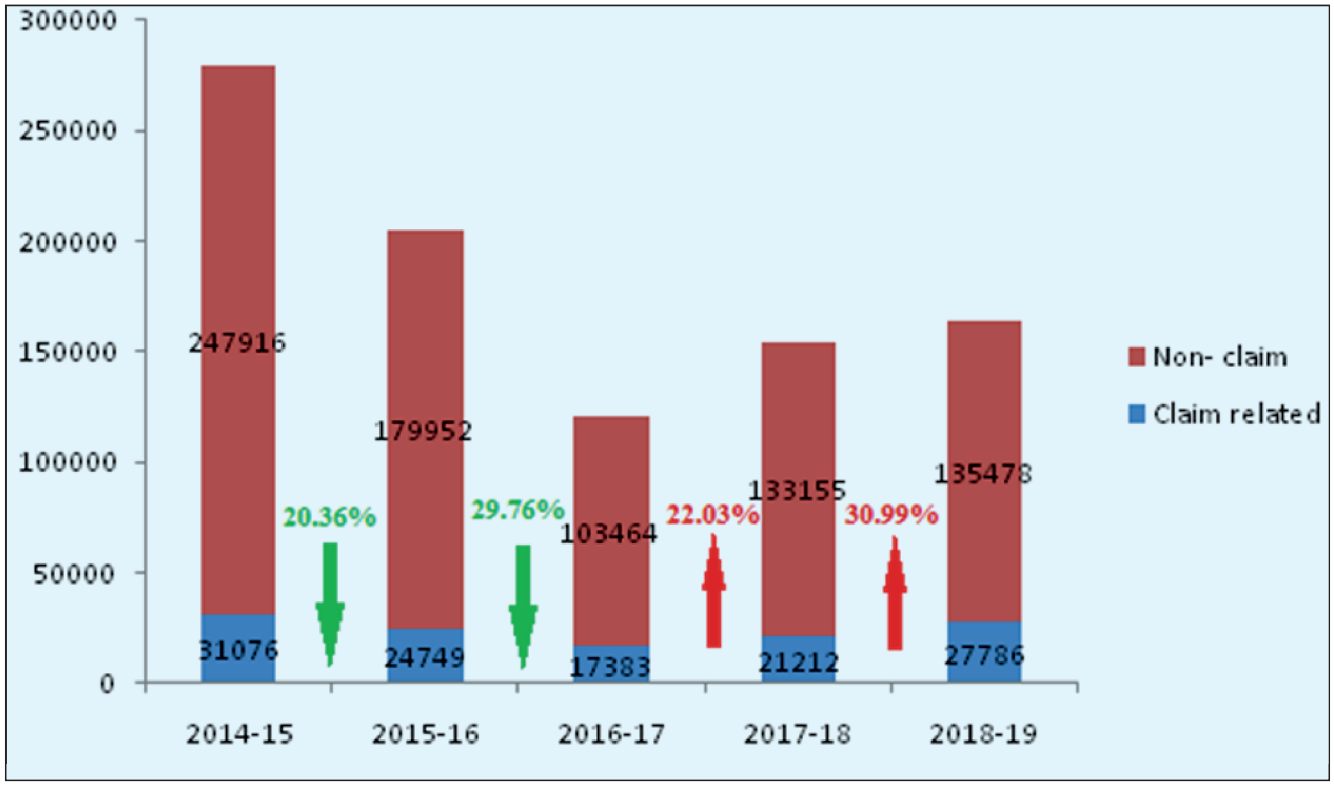
Source: IGMS OF IRDAI

Trends in claim related complaints under Non- Life Insurance:



% change indicates change in no. of claim related complaints over the past year

Trends in claim related complaints under Life Insurance:



-% change indicates change in no. of claim related complaints over the past year.

Claim related complaints as % of total complaints has been increasing over the years in respect of general Insurance complaints. Claims related complaints constitute less than 20% of total complaints against Life Insurance companies whereas they are more than 50% in respect of General Insurance companies. This clearly shows that claim handling is a serious customer service issue in general insurance industry.

There has been an overall decrease in no. of claim related complaints in life insuranceover the past 5 financial years with the rate of decrease being close to 10 % and in respect of general Insuranceit has remained relatively unchanged. While the volume of complaints in relation to total number of claims is very small, the problems faced by the complainants cannot be wished away given the inconvenience caused to them.

The major claim related complaints as per IGMS are as follows:

1. Insurer not disposing of the claim.

2. Difference between the amount claimed and the amount settled by the Insurer

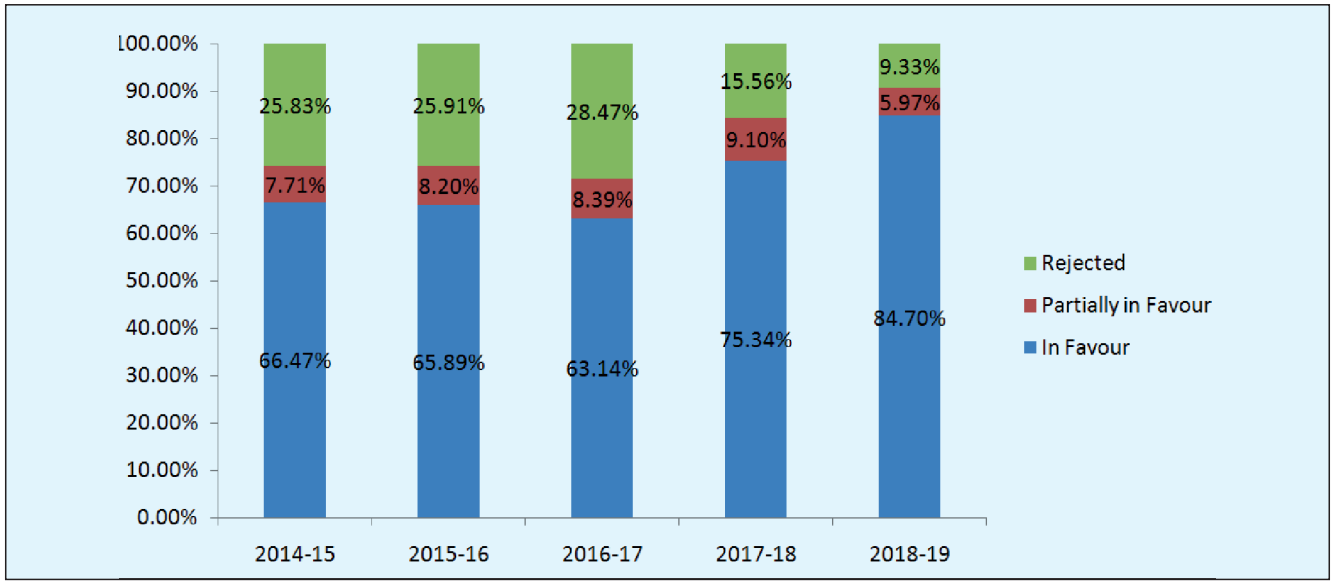
3. Insurer reduced the quantum of claim without providing proper reasons.

4. Insurer failing to offer settlement of claim after receipt of survey report.

5. Delay on the part of TPA to arrange claim reimbursement

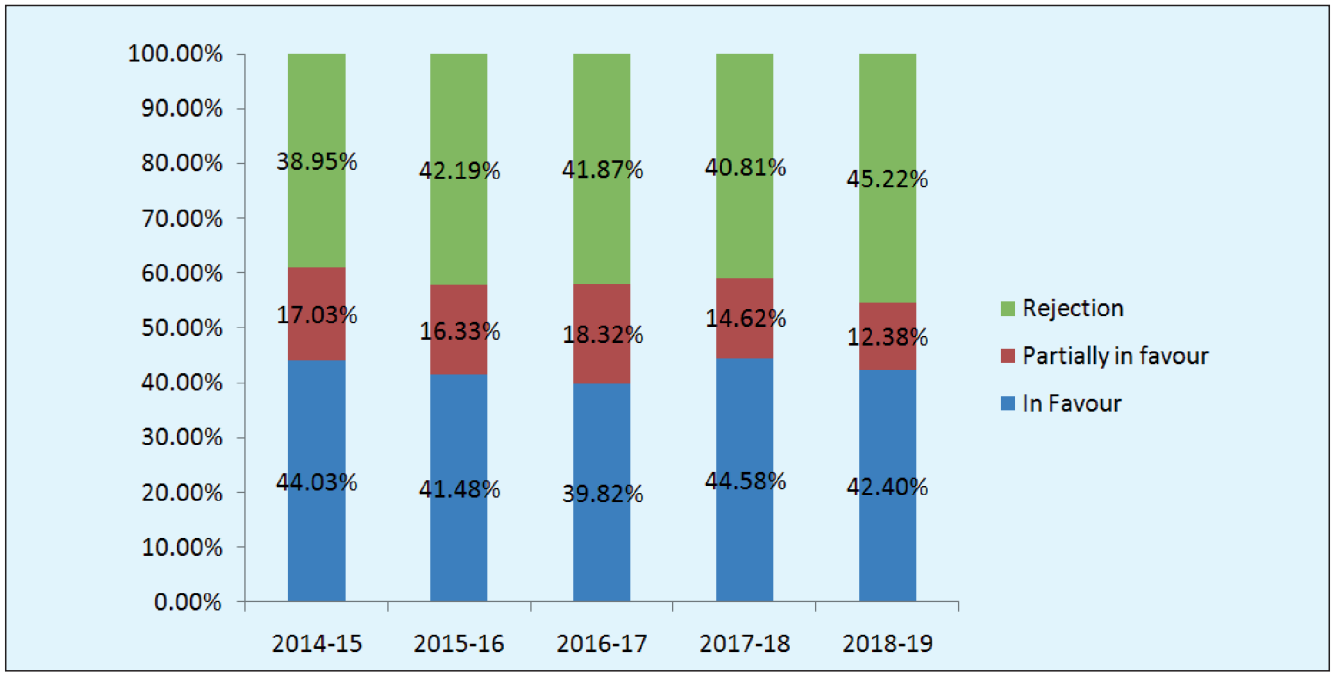
VI. DISPOSAL CLASSIFICATION OF CLAIM RELATED COMPLAINTS IN IGMS

In respect of Life Insurers (including survival and death claims):



No. of complaints being disposed in favour of the complainant has shown a good increase over the years.(from 66.47% in 2014-15 to 84.7% in 2018-19).

In respect of General Insurers:



Percentage of complaints being disposed in favour of the complainant has reduced over the years (from 44.03% in 2014-15 to 42.4% in 2018-19). However, percentage of complaints disposed against the complainant has increased over the years. (from 38.95% in 2014-15 to 45.22% in 2018-19).Percentage of complaints being disposed in favour of the complainant is very less in General Insurance as compared to Life Insurance.

VII. LEGAL AND REGULATORY FRAMEWORK

The regulatory framework and institutional arrangement for processing claims expeditiously and resolving grievances relating to claims is discussed below in brief:

Section 45 of Insurance Act, 1938:

Section 45 offers protection to policyholders of Life Insurance by holding that a policy cannot be questioned by the Insurer after 3 years from the date of issue of policy (or date of revival or date of rider) saying that there was a fraud or misrepresentation by the policyholder while taking the policy or revival.

A. Regulations:

- IRDA (Protection of Policyholders' Interest) Regulations, 2017 constitutes the regulatory framework for the protection of policyholders' interests. In terms of Regulation 17 of the above mentioned regulations, every insurer should have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed. Regulation 14, 15 and 16 deals with claims procedure in respect of life insurance, general insurance, and health insurance policy respectively.

The Turn Around Time (TAT) for claims related services as per the Regulations are as follows:

	CLAIM SERVICE	Turn Around Time
	LIFE INSURANCE CLAIM	
1.	Maturity claim / survival benefit / penal interest not paid	On/Before due date
2.	Raising claim requirements after lodging the claim	15 days
3.	Death claim settlement/ Repudiation (without investigation requirement)	30 days
4.	Death claim settlement / Repudiation (with investigation requirement)	4 months
	NON-LIFE INSURANCE CLAIM	
1.	Surveyor appointment	72 hours
2.	Survey report submission (except commercial and large claims)	30 days
3.	Insurer seeking addendum report	15 days
4.	Additional report submission	3 weeks
5.	Offer of settlement / Rejection of claim after receiving 1st / addendum survey report	30 days
	HEALTH INSURANCE CLAIM	
1.	Health claim settlement/ Repudiation(without investigation)	30 days
2.	Health claim settlement/ Repudiation(with investigation)	45 days

- In terms of Regulation 14(2)(iv), Regulation 15(10) and Regulation 16(2)(i) where there is a delay on the part of the insurer in payment of life insurance claims or non-life insurance claims or health insurance claims respectively, the insurer is required to pay interest @ bank rate plus two per cent for the delay.
- IRDAI (Appointment of Insurance Agents) Regulations, 2016, IRDAI (Registration of Corporate Agents) Regulations, 2015, IRDA (Insurance Brokers) Regulations, 2018, IRDAI (Third Party Administrators – Health Services) Regulations, 2016 and IRDAI(Insurance Surveyors and Loss Assessors)Regulations, 2015 stipulate Code of conduct for insurance agents, corporate agents, Brokers, TPAs and Surveyors respectively wherein aspects relating to claims are also specified.
- IRDAI has issued CircularsRef No IRDA/HLTH/MISC/CIR/216/09/2011 dated 20-9-2011, Ref. No: IRDA/NL/CIR/MISC/149/06/2017 dated 28-06-2017 in respect of delay in claim intimation/document submission with respect to all life insurance contracts and non-life individual and group insurance contracts. IRDAI advised all companies not to repudiate delayed claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.

B. Grievance Redressal System

- To enable timely resolution of grievances, IRDAI has issued Guidelines for Grievance Redressal by insurance companies on 27 July 2010 according to which every insurance company is required to acknowledge grievances within 3 days and resolve complaints within two weeks.
- Grievance cell in the Consumer Affairs Department of IRDAI also receives complaints from policyholders which include those relating to claims. The complaints are registered and forwarded to the insurers for resolution under advice to the complainants. The insurers are required to examine the complaints and resolve the same within two weeks.
- Where the complaints are not resolved to the satisfaction of the complainant, the complainant can take up the matter with the Insurance Ombudsman or any other appropriate forum.

C. Insurance Ombudsmen in Mediation and Adjudication of Claim related grievances

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 17 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction
- The basic framework for functioning of Insurance Ombudsman is outlined in Insurance Ombudsman Rules, 2017.
- The grounds relating to claims for which a complaint can be made to the Insurance Ombudsman are prescribed under Rule 13(1) of Insurance Ombudsman rules, 2017. Grounds under which a claim related

complaint can be made with Ombudsman is as follows:

(a) Any partial or total repudiation of claims by an insurer.

(b)Any dispute on the legal construction of the policies in so far as such disputes relate to claims.

(c) Delay in settlement of claims.

- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the compensation amount sought is less than Rs.30 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 30 days of the receipt of the award from the Ombudsman and it shall intimate the compliance to the Ombudsman.
- IRDAI in order to monitor the non compliance of the award of Insurance Ombudsman has issued Circulars Ref: CAD/Insu.Omb/10-11 dated 23-11-2010, Ref: IRDAI/Cir/Misc/194/11/2015 dated 03-11-2015, Ref No. IRDAI/CAD/CIR/MISC/063/03/2016 dated 01-04-2016 and Ref No.IRDAI/CAD/CIR/MISC/038/03/2019 dated 05-03-2019. In the recent circular dt.05-03-2019 issued by IRDAI Insurers have been cautioned to comply with the awards passed by Insurance Ombudsman within the prescribed timelines under Insurance Ombudsman Rules, 2017.In cases where the Insurer prefers an appeal against the order of the Judicial/Quasi Judicial body, such appeal against the order should be preferred with the stipulated time limit as per the rules applicable.

D. Supervision and Regulatory action

- IRDAI monitors the claims payment position of the insurance companies by collecting the claims payment data quarterly.
- IRDAI monitors the claim handling systems based on the complaints registered in the IGMS.
- IRDAI regularly inspects the books of the insurance companies which includes the examination of systems and procedures relating to handling of claims, practices of making payment as well as compliance with various regulatory requirements relating to claim handling. Whenever any deviations are noticed regulatory action is initiated.

VIII. INITIATIVES BY INSURERS

Insurers themselves also take several steps for better claims handling. The steps include giving the claim related documents and the list of documents to be submitted along with the policy document itself, having a claim review committee headed by independent persons of repute from the industry / judiciary. The monitoring, supervision and constant interaction with the intermediaries like surveyors/loss assessors, TPAs etc. also enables these intermediaries to perform their responsibilities in accordance with regulations issued by IRDA and the Code of Conduct specified for them.

IX. CLAIMS AND LITIGATION

The basic principle on which insurance operates is 'uberrima fides' i.e. principle of utmost good faith. The good faith is applicable equally to insured as well as the insurer. The insured gives all the information required in the proposal form and the insurer has to give the information about the products like terms, conditions, warranties and exclusions in documents of offer like prospectus,

brochure, advertisement etc. and also make them part of the policy document. The Insurer designs policy and the policy terms and conditions are prepared which could at times put customer to disadvantage. Since the insurer knows only those things about the insured and the risk as is disclosed by him in the proposal, any failure to disclose renders the position of insurer difficult. The insured has chosen to buy the insurance product and is presumed to have satisfied himself about the product as the principle of 'caveat emptor' or 'buyer beware' applies to insurance as well. Protection to an extent is provided to the insured through the 'contra proferentem' rule. As the decision to underwrite a policy is supposed to be taken by the insurer after obtaining all information necessary for understanding the risk and the policy terms and conditions being standard forms drafted by the insurer, while interpreting the clauses of contract, any unclear term is interpreted in favour of the insured and against the insurer. The interplay of these principles, provides reason for disputes in insurance.

Disputes in insurance are basically disputes in contract and have to be taken up in a civil court. To provide scope for settling the disputes through alternate dispute resolution mechanisms, the institution of Insurance Ombudsmen has been created by Government of India under the Redressal of Public Grievances Rules, 1998. However, only disputes on personal lines of insurance and where compensation sought is less than Rs. 30 lakhs can be taken up with Insurance Ombudsman. Absence of mechanisms of appeal against Awards or for enforcement of Awards make the legal recourse the only alternative for persons or insurers aggrieved by unsatisfactory Awards.

In case of commercial lines of insurance, while resolution through Arbitration and Conciliation is provided for, the Arbitration Awards do not provide finality leaving room for litigation even after arbitration. Further arbitration clause is provided in general for partial repudiation cases of claim and not in cases of denial of claim.

With the increasing publicity about the recourse to Consumer Fora under the Consumer Protection Act, 1986 (now superseded by The Consumer Protection Act, 2019), the volume of cases before Consumer Fora on matters of insurance has also been increasing with more and more people taking recourse to Consumer Fora alleging deficiency of service. The delay in resolving a case before the District Forum and the several years taken in disposal of appeals by State Forum and National Forum because of the huge volume of cases pending before these fora have rendered the recourse to Consumer Fora ineffective in the expeditious resolution of insurance related disputes.

In order to provide a separate forum for dealing with cases relating to third party claims in case of motor accidents, the Motor Accident Claims Tribunals have been set up under the Motor Vehicles Act. Several of these Tribunals are in operation across the country. The number of cases pending before these Tribunals is huge and the time taken for disposal owing to the involved processes, is also substantial. There is no finality to the decisions as cases where the claimants feel that the compensation ordered is too low, they go for Appeal to the High Court and where the insurer feels that the compensation ordered is too high, the insurer goes on an Appeal leading to increased number of appeals before High Court

and if further appealed against, before the Supreme Court. The difficulty in resolving disputes about motor accidents arise of the onerous task of assessing the value of human life lost in the accident and there can always be divergence of views of either party leading to litigation and escalations in the form of appeals. A straight jacketed formula is difficult to implement. However, there is sufficient scope of settlement of disputes at the earliest to save the financial burden in the form of absence of any earning of the deceased, cost of filing a case and pursuing it and the consequent time value of the money ordered at some remote time after the loss occurred.

In addition to these, disputes regarding claims in other non-life insurance policies which are not on personal lines are taken up before Civil Courts, where long time is taken in deciding the matter, owing to the involved processes. Even after decision of the Court is received, there is the option of Appeal leading to delay in finality of the decision.

X. VOLUME OF LITIGATION

The volume of cases pending before various fora / courts as on 31-03-2019 is given below:

COURT / FORUM		LIFE No. of Cases	NON-LIFE No. of Cases
Consumer Forum	District Level	13784	56793
	State Level	6320	21758
	National Level	552	3617
Civil		7900	1768
High Court		2098	1811
Supreme Court		125	1201
MACT Related	MACT	NA	620582
	State Level	NA	159923
	National Level	NA	554

(Source-Consolidation of Information furnished by the Insurers)

It is clear from the above that the number of cases relating to life insurance is much less when compared to non-life insurance.

While delays in litigation and large pendency of cases are a common problem in India, the impact of the delay in decision in matters relating to insurance on the insurers and the insured is significant calling for a new approach for dealing with the problem. Since the liability to honour the decision of the Court which has ordered payment has to be maintained, the cost of engaging counsel and pursuing the matter across different fora is definitely something which affects the financial strength of insurance companies. The occurrence of peril for which insurance was intended to provide cover for puts the claimants in a very difficult position where they have to not only battle the loss / tragedy caused as a consequence

of the occurrence of the peril but also spend substantial amounts of money, time and effort to pursue the legal battle with an institution.

XI. INSURANCE AWARENESS

Insurance awareness can help persons taking insurance to be more aware about the nuances of insurance, what to disclose and what to look for in an insurance product, how to understand the insurance product and comprehend the terms, conditions, exclusions and warranties in the insurance policy. When this meeting of minds of insurer and the policyholder/claimant about mutual rights and obligations is there, disputes warranting litigation would not arise. In non-life insurance, underwriting includes risk assessment. Therefore, suggesting the suitable insurance policy and also mechanisms of mitigating risks can be an important service provided by the insurer to the policyholder. Building insurance awareness and bringing in more transparency in policy terms and conditions through simplification of language can help in interpretational problems in claim handling, avoiding an important reason for a lot of litigation in claims.

XII. CONCLUSION

Insurers should have proper systems in place for quick and proper handling of claims. Providing a reasoned and timely decision about the claim can help mitigate the agony of the claimant in approaching various channels only to understand why there is a delay and what is the reason for repudiation of claim in full or in part. A suitable mechanism at insurer's level to ensure that this information would be provided promptly would reduce the number of complaints relating to claims.

MIS-SELLING & SPURIOUS CALLS

A brief on Mis-Selling and Spurious call complaints in the Life Insurance Sector

MIS-SELLING COMPLAINTS IN LIFE INSURANCE SECTOR

I. INTRODUCTION

Mis-selling in common parlance refers to unfair or fraudulent practices adopted at the time of soliciting and selling insurance and generally includes selling policies which have not been sought by the customer or which are different from what the customer wanted or was promised or where the product offered for sale is not suitable to the needs of the customer. Therefore, misselling in insurance could be described as selling a product/service to a customer in a manner which is detrimental to his/her interest.

II. CAUSES OF MISSELLING COMPLAINTS

The following issues have been observed as causes of mis-selling complaints:

a) Incorrect explanation of product features and benefits by Sales person sourcing the business.

b) Regular premium paying product is sold as single premium product.

c) Policy is sold to prospects assuring Loan / Bonus / Medical Benefits/ Gold coins/Mobile towers/other benefits upon purchase of insurance policy.

d) Tampering, forgery of proposal/ other related documents.

e) High attrition rate amongst Sales team wherein the sales person move from one Insurer/Intermediary to another and instigate policyholder to surrender the existing policy and to take a new policy

f) Inducements such as rebate (commission are offered while sourcing the policy)

g) Undue pressure on the sales person to meet sales target.

h) Free look cancellation requests are rejected by Sales personnel who are not authorized to take such decisions.

i) Splitting of policies wherein multiple policies are issued to the same proposer at the same time.

j) Life Insurance policies are sold as Tax saving/ Investment plans.

k) Sales personnel are inadequately trained, thereby recommending unsuitable products to prospects.

l) Improper/Incorrect financial needs assessment of Prospect is done while sourcing the policy by the sales personnel.

m) Charges under the policy and lock in period are not properly explained while sale of Unit Linked Insurance Policies.

n) Lack of awareness on insurance on the policyholder's part thus being misled into buying the insurance policy.

o) Policyholders not reading policy terms and conditions at point of sale

p) Policyholders failing to cross-check details

q) Financial Problems/incapacity of the policyholder to pay future premiums

r) Insurance made a condition to avail loan/locker facility etc. at bank

s) Debit of bank accounts with Insurance Premium without explicit consent

III. IMPACT OF MIS-SELLING

Sales related complaints affect the sentiment about the insurance sector. This in turn may impact the initiatives aimed at enhancing the level of insurance inclusion as measured by indicators such as insurance penetration (measured as ratio of premium to GDP) and insurance density (measured as ratio of premium in USD to population). Increased incidence of mis-selling can adversely impact growth in the insurance industry which in turn would impact the availability of long term funds for economic development from the insurance sector. Hence, while there is need to assess and eradicate mis-selling from insurance industry, there is also a need to reassure general public that the regulatory framework of life insurance business is sound enough to protect policyholders' interests and grievances, if any, are capable of being resolved by insurers or settled / adjudicated by insurance ombudsmen or consumer fora.

IV. COMPLAINTS OF MIS-SELLING

A. AS PER IGMS STATISTICS

Integrated Grievance Management System (IGMS) introduced by IRDAI in 2011 is a computerized industry-wide grievance repository for the insurance sector. In IGMS, the complaints relating to misselling are included under the broad category of "Unfair Business Practices".

The complaints relating to broad head of 'unfair business practices' consist of complaints falling within the following complaint descriptions:

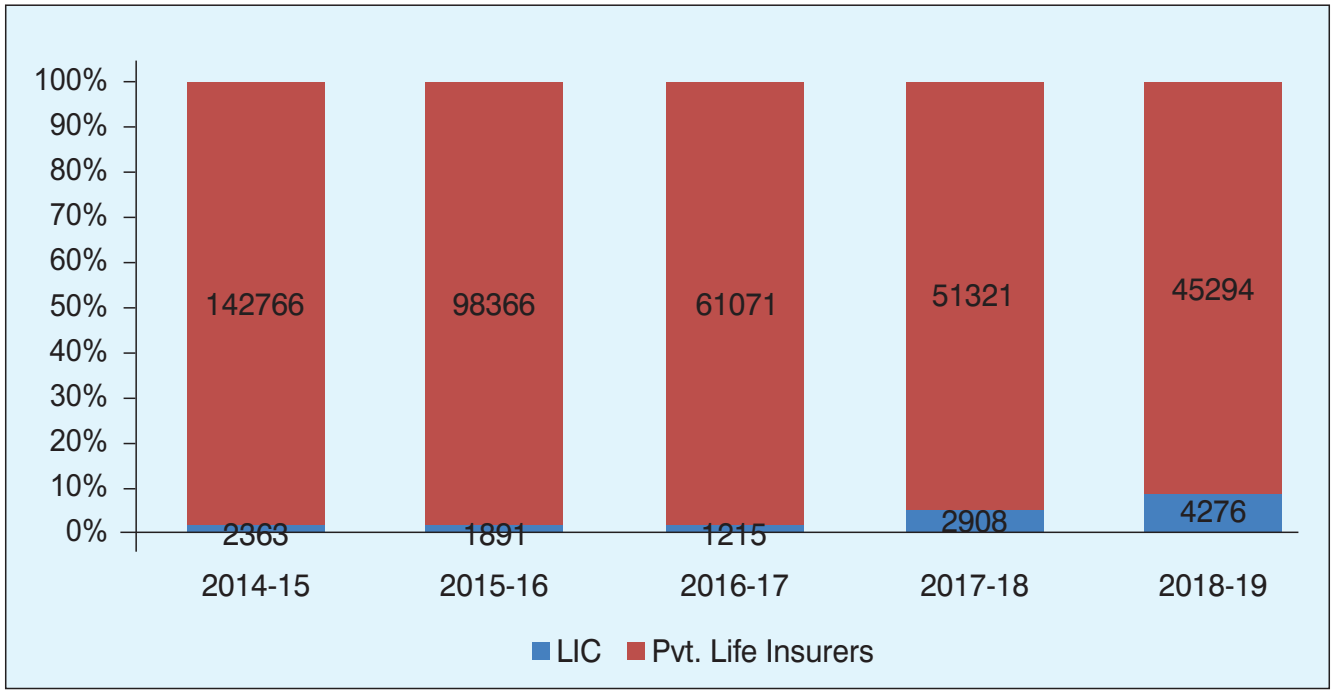
1. Product differs from what was requested or disclosed.
2. Term(Period) of the policy is different/ altered without consent
3. Mode of premium payment differs from requested or disclosed
4. Annuity/Commutation/Cash Option /Rider/ other Options not included as requested
5. Proposed Insurance not in the interest of proposer
6. Intermediary did not provide material information concerning proposed cover
7. Single premium Policy issued as Annual premium policy
8. Tampering, Corrections, forgery of proposal or related papers
9. Credit/Debit card debited without consent of Consumer
10. Premium paying period projected is different from actual
11. Surrender value projected is different from Actual
12. Free-look refund not paid
13. Spurious calls or Hoax calls
14. Advice concerning Exclusions/limitations of cover not communicated
15. Illegitimate inducements offered
16. Misappropriation of premiums
17. Malpractices or unfair business practices

The number of complaints relating to misselling in life insurance business as well as the percentage of such complaints to total complaints has reduced over the years. The details are provided in the table below:

Year	Insurer	No. of UFBP complaints	% change over last year	Total Life complaints	% of UFBP complaints	No. of new policies sold	% of UFBP complaints to new policies sold
2014-15	LIC	2363		80944	2.92%	20171063	0.40%
	Pvt. Life Insurers	142766		198048	72.09%	5738812	3.45%
2015-16	LIC	1891	-19.97%	64750	2.92%	20546749	0.32%
	Pvt. Life Insurers	98366	-31.10%	139951	70.29%	6193339	2.26%
2016-17	LIC	1215	-35.75%	30784	3.95%	20131500	0.15%
	Pvt. Life Insurers	61071	-37.91%	90063	67.81%	6325145	1.42%
2017-18	LIC	2908	139.34%	77184	3.77%	21338176	0.36%
	Pvt. Life Insurers	51321	-15.97%	77183	66.49%	6860602	1.13%
2018-19	LIC	4276	47.04%	102127	4.19%	21433256	0.48%
	Pvt. Life Insurers	45294	-11.74%	61137	74.09%	7254556	0.84%

Source: Integrated Grievance Management System and Business Figures-Life of IRDAI

Unfair Business Practices complaints- LIC vis-a-vis Pvt Life Insurers



The number of complaints on unfair business practices has been on a declining trend over the past years. In the current year also, there has been 8.59% drop in the number of Unfair business practices complaints over previous year which can be attributed largely to the review made by IRDAI of the grievance redressal machineries of all life insurers and to the subsequent follow up measures taken up by IRDAI. This apart, based on the inputs provided during the review meetings with the GROs effective monitoring mechanism has been put in place by the Life Insurers towards arresting misselling. On the other hand the multi-pronged insurance awareness campaign by IRDAI towards educating the general public has also resulted into creating awareness on the misselling and consequent reduction in such instances.

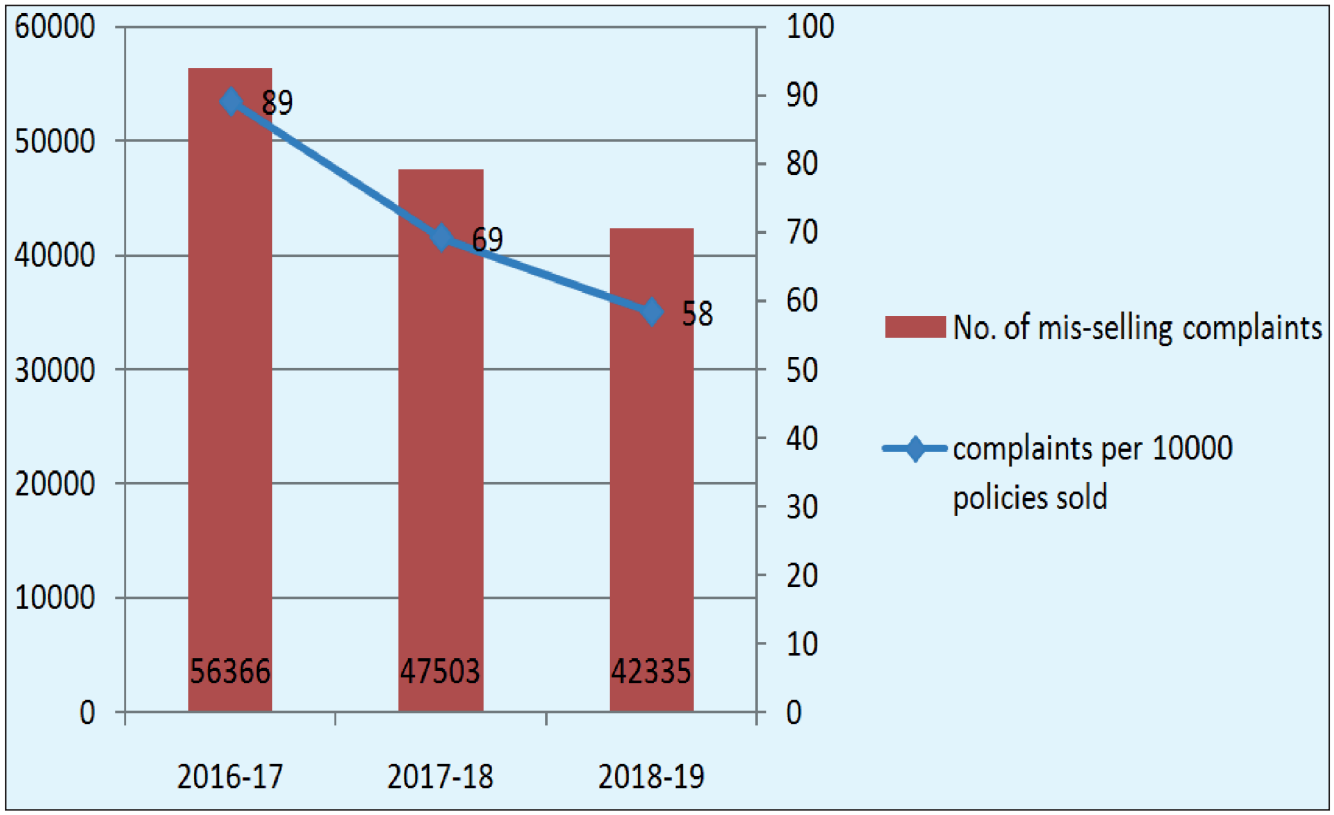
The proportion of complaints relating to unfair business practices to total life complaints has been on a declining trend over the past 5 years except for FY 2016-17.

The proportion of the complaints on mis-selling to new policies has also been on a declining trend over the past 5 years.

B. AS PER DATA SUBMITTED BY INSURERS

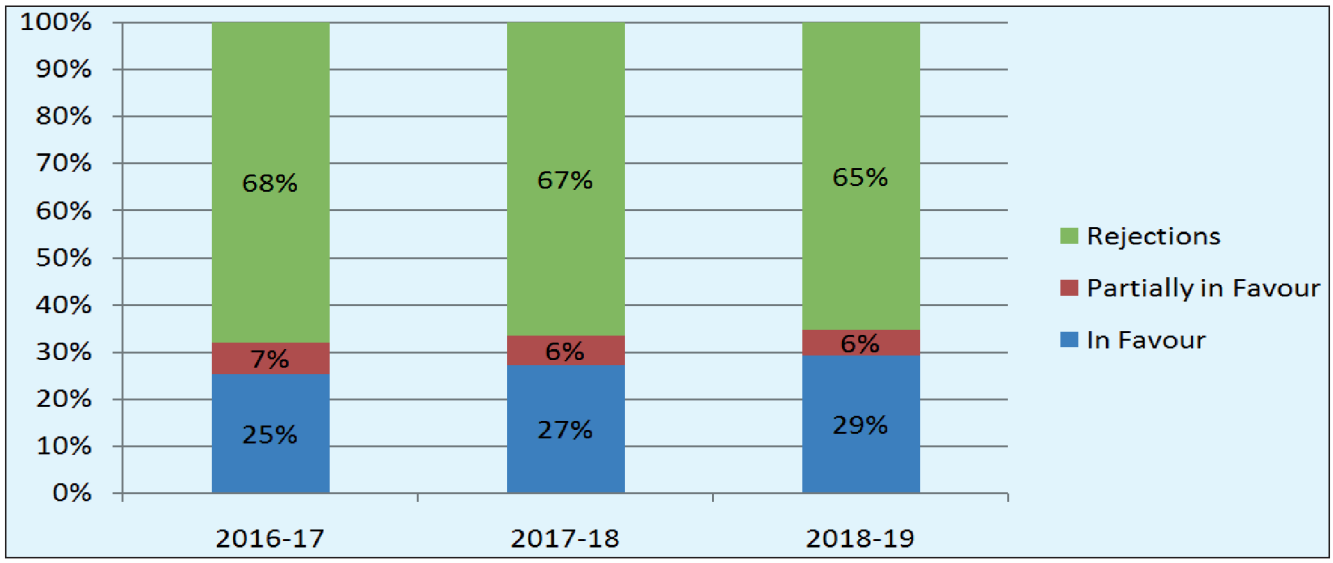
Based on consolidation of data submitted by Private Life Insurers, statistics pertaining to mis-selling complaints are reproduced below:

1.Incidence of mis-selling complaints per 10,000 policies sold



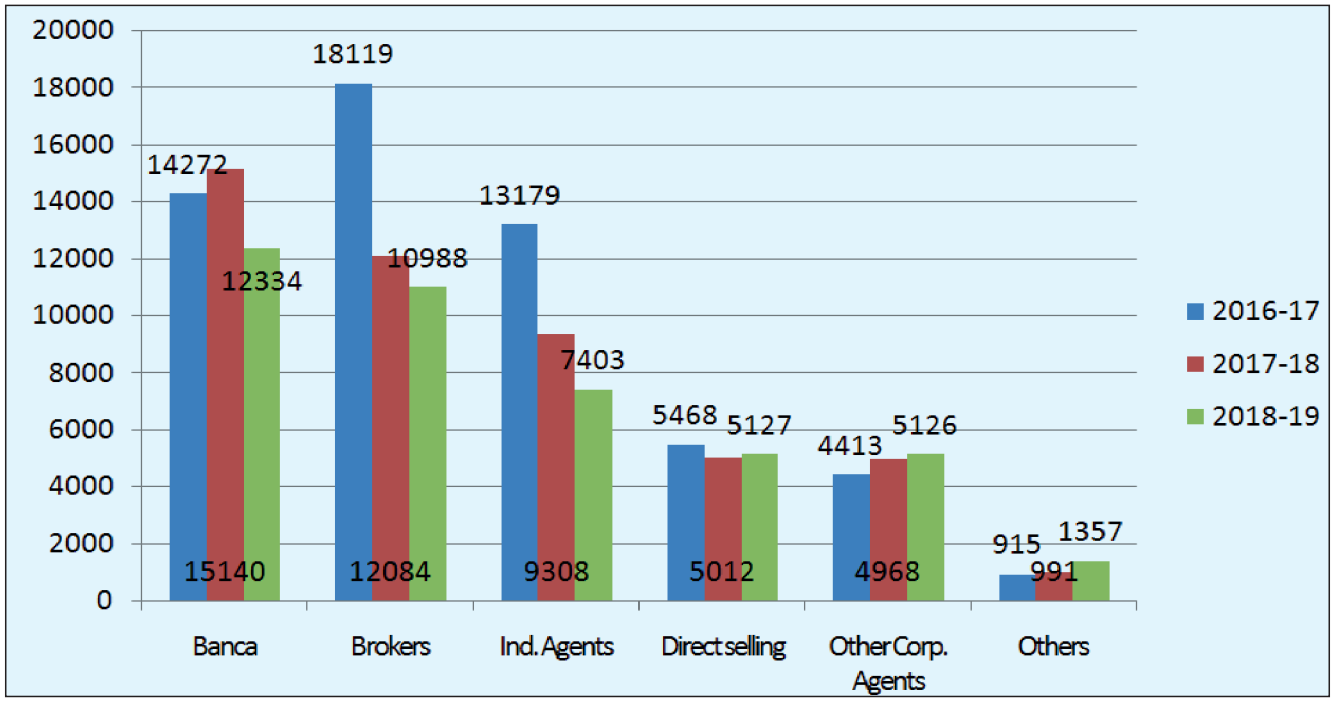
No. of mis-selling complaints have reduced from 56366 in 2016-17 to 42335 in 2018-19 in respect of Private Life Insurers. Incidence of mis-selling complaints per 10,000 policies sold has also reduced over the years.

2.Acceptance status of mis-selling complaints



Percentage of complaints being disposed in favour of complainant has increased slightly from 25% in 2016-17 to 29% in 2018-19.

3.Channel wise Mis-selling complaints:



V. REGULATORY FRAMEWORK

The regulatory framework for preventing mis-selling and to ensure right selling is discussed in brief.

A. Regulations issued by the Authority:

a. IRDA (Protection of Policyholders' Interests) Regulations, 2017

The basic framework for policyholder protection is contained in these regulations.

The regulations mandate insurer to have in place a Board approved policy for protection of policyholder's which shall at the minimum include steps to be taken for enhancing insurance awareness, Turnaround Time (TAT) for various services rendered, procedure for expeditious resolution of complaints, steps to be taken to prevent mis-selling and unfair business practices, steps to ensure that prospects are fully informed and made aware of the benefits of product being sold.

Insurers are required to display the service parameters and turnaround times as approved by the Board in its website.

Procedure to be followed at the 'point of sale', requirements to be complied with at the proposal stage and disclosures to be made in the life insurance policy are clearly stated in these Regulations.

These Regulations contain a **provision for free-look cancellation within 15 days of receipt of policy (30 days in case of electronic policies and policies obtained through distance mode)**.

Every life insurer,while forwarding the policy to the insured, should inform by the letter forwarding the policy that he has a **period of 15 days from the date of receipt of the policy document to review the terms and conditions** of the policy and where the insured disagrees to any of those terms or conditions, he has the **option to return the policy stating the reasons for his objection**. On availing of the free-look cancellation, the insured would be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period of cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In case of ULIPs, the insurer would also be entitled to repurchase the units at the price of the units on the date of cancellation.

In respect of Individual health insurance policies there is a provision for free look cancellation within 15 days of receipt of policy except those with tenure of less than a year in accordance with Regulation 14 of **IRDAI (Health Insurance) Regulations, 2016**.

The Regulations clearly indicate that the requirements of **disclosure of "material information" regarding a proposal or policy apply both to the insurer and the insured**. Further, every insurer is required to have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed.

Therefore, the regulations ensure that the prospective policyholder is given a thorough understanding of the specific requirements and

details required for taking an insurance policy. The insurer, agent or intermediary should enable the prospect to take the best cover that would be in his or her interest.

b. The IRDAI (Insurance Advertisements and Disclosure) Regulations, 2000

These regulations require the insurers, agents or intermediaries not to issue "unfair or misleading advertisements" and follow the procedures laid down therein with respect to advertisements (including those on the internet) so that any communication directly or indirectly related to a policy and intended to result in the eventual sale or solicitation of a policy is not misleading or unfair. The Master Circular Ref: IRDAI/LIFE/CIR/MISC/147/08/2015 dated 19-08-2015 issued on Insurance Advertisements, clearly prescribes the details to be made available in the advertisements, and also indicates the do's and don'ts amongst other requirements.

c. IRDAI (Appointment of Insurance Agents) Regulations, 2016

d. IRDAI (Registration of Corporate Agents) Regulations, 2015

e. IRDA (Insurance Brokers) Regulations, 2018

f. IRDA (Web Aggregators) Regulations, 2017

g. IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015

These regulations prescribe code of conduct to ensure that the persons soliciting insurance business should be eligible persons and they disseminate the requisite information in respect of insurance products offered for sale, understand the policy being sold and should be capable of making suitable advice based on the customer needs so that the policy offered / sold meets the requirements of the prospect. Responsibilities are cast upon the agents and other intermediaries in terms of code of conduct, which are mainly aimed at curbing the mis-selling and to promote best practices during solicitation of the business.

The training curriculum of these intermediaries is also updated to ensure that the sales force is up to date with all the changes and is capable of providing necessary advice at the time of sale to the prospects.

h. Guidelines on Distance Marketing of Insurance Products, 2011

With the increasing recourse taken by insurers, corporate agents and brokers to solicit policies including lead generation through telecalling, SMS, email, internet, DTH, postal mail and other modes which do not involve communication in person as well as requests from clients seeking information and sale of insurance products in distance mode, IRDAI issued Distance Marketing Guidelines. These guidelines cover not only measures for policyholder protection at the time of offer, negotiation and conclusion of sale but also about preparation of standardized script, training of telecallers, monitoring of calls, preservation of call recordings etc.

i IRDAI Regulations on Linked and Non-Linked Life Insurance Products

In order to standardize the minimum elements and attributes in the life insurance products with a view to protect the interests of policyholders, these regulations were initially notified in 2013. After taking into account the feedback received from various stakeholders, they were reviewed and Product Regulations 2019 have been issued.

These regulations ensured that the commission rates are consistent with the premium payment term. The customized benefit illustration requirements have been made applicable. The Regulations prohibited highest NAV guarantee products. They also dealt with splitting of policies, accepting advance premium, mis-leading names. The regulations also bring in transparency in terms of benefit payouts and enable the customers to choose the right policy.

In case of linked products the regulations make it mandatory for separate training to all the insurance agents/intermediaries before they are authorized to sell linked insurance products, recommending a suitable product and collecting sufficient information about the potential policyholder, inform the upfront charges and indicate how premium paid is appropriated towards various charges from the unit fund and the balance of the fund at the end of the first year and subsequent years.

The customized benefit illustration shall be signed by the Agent/Intermediary as well as prospect signifying his consent after understanding the applicable charges and the risks in the investment.

j. Grievance Redressal Guidelines for Insurance Sector, 2010

In addition to the above regulations, IRDAI has also issued Grievance Redressal Guidelines for insurance sector specifying the timelines for acknowledging, resolving and closure of grievances reported by the prospect and policyholders.. IRDAI has also provided channels for customers to raise grievances with insurers in the form of Integrated Grievance Management System, IRDA Grievance Call Centre and postal, fax and email channels, wherein IRDAI facilitates resolution of grievances by insurers.

Complainants who are not satisfied with the resolution provided by the insurer can take up with the Insurance Ombudsman or approach Consumer Fora or Courts.

k. Corporate Governance Guidelines – Policyholder Protection Committee

With a view to addressing the various compliance issues relating to protection of the interests ofpolicyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer has been directed to set up a Policyholder Protection Committee which shall directly report to the Board. The responsibilities of the Policyholder Protection Committee include putting in place proper procedures and effective mechanism to address complaints and grievancesof policyholders including mis-selling by intermediaries and reviewing the mechanism as well as status of complaints at periodic intervals.

The Committee is also responsible for ensuring compliance with the statutory requirements as laid down in the regulatory framework and adequacy of disclosure of "material information" to the policyholders.

From the foregoing it can be seen that elaborate regulatory framework has been put in place to ensure that insurers, agents or intermediaries do not resort to mis-selling.

B. Insurance Ombudsmen in Mediation and Adjudication of MIs-selling complaints:

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 17 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction.

- The basic framework for functioning of Insurance Ombudsman is outlined in Insurance Ombudsman Rules, 2017.

- The grounds relating to mis-sellingfor which a complaint can be made to the Insurance Ombudsman is as follows:

(a) Misrepresentation of policy terms and conditions at any time in the policy document or policy contract;

- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the compensation amount sought is less than Rs.30 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 30 days of the receipt of the award from the Ombudsman and it shall intimate the compliance to the Ombudsman.

C. Insurance Act, 1938 as amended by Insurance Laws(Amendment) Act, 2015

The amendments to the Insurance Act, 1938 have been made through the enactment of Insurance Laws (Amendment) Act, 2015. In terms of section 42 (A)(2) of the insurance act 1938, no person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy through multilevel marketing scheme. Further, section 42 (A)(3) of the insurance act 1938 prescribes that the Authority may through an officer authorised in this behalf, make a complaint to the appropriate police authorities against the entity or persons involved in the multilevel marketing scheme. This Amendment Act vide section 42(5) of the insurance act 1938 also prescribes that the insurers shall be responsible for all the acts and omissions of its agents including violation of code of conduct and liable to a penalty which may extend to one crore rupees. These changes will enable the interests of consumers to be better served through provisions like those enabling penalties on intermediaries / insurance companies for misconduct and

disallowing multilevel marketing of insurance products in order to curtail the practice of mis-selling.

VI. MONITORING COMPLIANCE AND REGULATORY ACTION

The compliance with the regulatory framework can be ascertained by way of on-site inspection or off-site monitoring through tools such as complaints, press reports, etc. IRDAI conducts on-site inspection of insurance companies, corporate agents and other intermediaries periodically to verify the books of accounts, examine the systems and procedures, compliance to the regulatory framework, etc. IRDAI also monitors the market conduct of the insurers, agents and intermediaries through complaints, their frequency and severity, press reports etc. Wherever it is found that the entities have not complied with the regulatory framework, IRDAI takes up regulatory action.

VII. CONSUMER EDUCATION

The definitive way of reducing mis-selling is to make the members of public aware of the concept of insurance, kinds of insurance policies, risks covered, benefits offered, exclusions, and conditions etc. This is sought to be achieved through various efforts of financial education to improve financial literacy

- BimaBemisal campaign through print and electronic media,
- Cautioning public against fictitious offers and spurious calls
- Consumer education website www.policyholder.gov.in
- Devising various films, comics, games, handbooks and FAQs relating to insurance and initiatives of IRDAI and publicizing them
- Conducting regular seminars involving customer groups addressing policyholder concerns and policyholder education.

Considering the fact that several complaints were received from members of public relating to spurious calls and fictitious offers involving insurance products, IRDAI launched a multi-pronged campaign to caution members of public through print, electronic and mass media including Internet and by way of specific directions to insurers to incorporate the caution in their publicity material in policy related advertisements as well as advertisements in print, electronic media and TV.

VIII. ACTION BY INSURERS

Insurers have also been taking the issue of mis-selling seriously by doing a root cause analysis of mis-selling complaints to identify the major causes and have taken steps to prevent or reduce mis-selling through steps to ascertain suitability of product, place controls on the various channels, tuning it based on the vulnerability of the channel and have a strategy on dealing with complaints of mis-selling. Some Insurers are now conducting sales audit of the proposals that satisfy certain vulnerability criteria like First time ulip customers, Proposals from Senior Citizens , Premia payable not commensurate to the declared sources of

income etc. to ensure right selling.

Further, every insurer has a Board approved policy to enhance insurance awareness; steps to prevent mis-selling and unfair business practices at point of sale and service; and to ensure that prospects are fully informed and made aware of benefits of product being sold at various stages of sale.

In addition to the action taken by IRDAI based on the examination of complaints by the insurers, Insurers also take up action against the agents or intermediaries in the form of issuing warning letters, terminating employees, filing police complaints and most commonly resorting to claw-back of commission wherever the policies have been cancelled as a consequence of proven mis-selling.

IX. CONCLUSION

To summarize, the problem of missellingin life insurance is a major hindrance in expansion of life insurance business. The regulatory framework is adequate to prevent misselling. However, greater compliance with the relevant regulations, increased insurance awareness, simpler policy terms and conditions, greater adherence to code of conduct by agents and intermediaries, and self-disciplineamong insurance intermediaries &insurance companies can significantly reduce the mis-selling complaints without affecting the volume of new business. Since mis-selling impacts the trust and confidence in insurance companies, it is time the insurance companies wake up to the challenge and not only take initiatives in educating and empowering consumers leaving them the freedom to exercise an informed choice but also to rein in unscrupulous agents and intermediaries who are bringing business by resorting to false promises. Putting in place systems to examine complaints from the underwriting perspective and expeditiously redressing them where the policy appears inappropriate can help build trust in the public.

SPURIOUS CALLS – PROBLEM, IMPACT AND EFFORTS OF IRDAI TO CAUTION PUBLIC

I. INTRODUCTION

Spurious calls in the name of regulatory organizations and government or quasi government authorities has been a problem which has been in prevalence for quite sometime now. The calls contain offers of benefits of huge amounts to be released by authorities. As a pre-requisite for such payment, the callers insist upon payment of money for purchase of new policies or fulfilling certain regulatory requirements. The payments are made mostly in cash or sometimes through cheque or net banking. The persons who respond to such calls and who are lured by such offers lose their money and trust in the financial system.

II. OFFERS MADE BY SPURIOUS CALLERS

The general nature of fictitious offers made through such spurious calls, as discerned from the complaints received by IRDAI, are as follows:

- Claiming to be representatives of IRDAI/IGMS and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDAI is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDAI.
- Claiming that the policyholder would receive bonuses being distributed by IRDAI if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDAI.
- Advising existing policyholders that money in respect of their policy has been fraudulently transferred to someone else and for receiving that money back from IRDA, they have to fulfil certain formalities including payment of money
- Claiming that they are from the Grievance Cell or IGMS Department of IRDAI making a call in continuation with a complaint made against an insurer and for resolving the grievance and release of benefit, they have to fulfill certain formalities including payment of money.
- Advising customers to subscribe to a fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

The above list is indicative but not exhaustive.

III. IMPACT OF SPURIOUS CALLS

Spurious calls of the nature indicated above could dent the reputation to IRDAI and other agencies and also financial loss to the gullible public who pay money based on such calls in lure of the offers made. Considering the fact that the mission of Government as well as IRDAI is in promoting financial inclusion by improving access to

insurance related services in both life and non-life segments, such spurious calls would adversely affect the general sentiment of general public in relation to insurance. Given the fact that insurance is a complex financial product and is a subject matter of solicitation, the trust deficit caused due to such spurious calls can dissuade those who are apprehensive but interested in buying insurance because of the benefits of insurance. Since insurance is a product of risk protection, this can impact the general risk coverage of members of public rendering them more vulnerable to risks to their life and property. The premiums received from insured public forms the corpus for insurance companies to make long term investments in instruments such as Government securities and other securities. The money so invested serves as the investment for nation building. As a result, spurious calls are also indirectly hindering not only growth in the insurance sector but also development of the country through the premium funds available for development.

IV. IRDAI'S CAUTION TO PUBLIC

Considering the extent of the problem and the impact of such calls on IRDAI's efforts in protectingthe interests of policy holders and ensuring the orderly growth of the insurance sector, IRDAI has taken up a campaign to caution members of public. The emphasis is more on dissuading people from believing such spurious calls and acting upon them so that the problem does not manifest into a financial loss to members of public who make payment believing in the veracity of the calls and offers.

Through the caution, IRDAI has been informing the members of public that:

- IRDAI does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDAI does not invest the premium received by insurance companies.
- IRDAI does not announce any bonus for policyholders or insurers.
- IRDAI has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDAI Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.
- IRDAI or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDAI as IRDAI plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person receiving such spurious calls may inform police.

V. CAUTION AGAINST FRAUDULENT ENTITIES

IRDAI has been receiving complaints against entities which are un-authorized in selling insurance policies and are involved in other insurance related activities without a license. It is observed that general public is falling prey to such unscrupulous entities losing their hard earned money.

IRDAI advises general public to be cautious and not to fall prey to such entities.

Few illustrations of modus operandi followed by such entities along with recommended precautions (indicative) to be taken to counter such entities are given below.

1. Sale of fraudulent Insurance policies:

Modus operandi: Representative of fraudulent entity approaches general public promising huge discounts compared to other Insurance Companies, higher coverage etc. and lure public to buy policies. Prospects believing such information to be true purchases such policy and realizes at a later stage that he/she has been cheated.

Precautions to be taken:

In India only an Insurance company licensed by IRDAI can solicit Insurance Business. Before purchasing any Insurance Policy general public/prospects are hereby advised to visit our website www.irdai.gov.in for list of Insurers authorized to sell Insurance Policies. However, in few cases it is observed that fake policies are issued on the letter head of genuine insurance companies. All Insurance Companies have website facility and pan India presence. Prospects may verify the details provided in the policy by visiting the Website of Insurance Company or by visiting their branch or contacting their customer care.

In case you have been sold fraudulent Insurance Policy, you are advised to file a police complaint immediately against the entity and bring it to the notice of IRDAI.

2. Sale of Insurance Policies by unlicensed entities:

Modus operandi: Representative of such entity claiming to be licensed by IRDAI approaches general public promising to help in purchasing/ renewing Insurance policy. These people will purchase/renew policy from a genuine Insurer during the first year so as to gain trust. However, when premium for subsequent renewalsare paid to representatives of such entity, fake premium receipt/policy document is issued and the premium amount is siphoned off by the fraudsters which will be noticed only at the time of maturity/claim.

Precautions to be taken:

Proposal form is the most important document based on which the Insurer issues an Insurance Policy. PPHI Regulations prescribes the Insurer to send a copy of proposal form within 30 days of acceptance of proposal (except in marine policies). You should ensure that the details mentioned in the proposal are correct. Recently IRDAI has issued a circular to all Insurers directing them to send all communication relating to issuance and servicing of insurance policies either in the form of a letter, e-mail, SMS or any other electronic from approved by the Authority. Therefore, it is of utmost importance that your contact details are properly updated with your Insurer.

Great care has to be exercised while remitting premium amount. While issuing the cheque you should ensure to write name of the Insurer. In case of suspicion, verify the details of person soliciting the policywith the Insurer.

Further PPHI Regulations prescribe that the Insurance policy document should contain Name, Code number and contact details of the person involved in sales process. You should ensure that details of person with whom you are dealing have been mentioned in the policy

document.

3. Enrolment in Multi-Level marketing (MLM) schemes:

Modus operandi: We have been receiving complaints against websites inviting individuals to become 'partner insurance consultants' with them promising bright prospects and huge remuneration. The prospects are made to purchase insurance and are induced to bring in new members to the group promising commission upon joining of new members (especially senior citizens/unemployed people). The prospect could even be paid some commission on the policy purchased by him so as to gain confidence. In few cases it is observed that prospect is even made an agent of genuine Insurance Company.

Precautions:

It has to be noted that soliciting insurance without being licensed by IRDAI is illegal and in violation of Insurance Act, 1938. Rebate (commission to purchase a policy) is also outlawed in the Insurance Act, 1938.

The maximum commission rate that can be earned by a person soliciting insurance is prescribed in the regulations issued by IRDAI. Therefore, whenever someone approaches promising huge incentives on soliciting insurance policies then the prospect should suspect a foul play.

In this regard, please also refer the Public Notice issued on 09-09-2019 videRef. No: IRDA/CAD/MISC/PRE//08/2019 available at our website https://www.irdai.gov.in

VI. EFFORTS BY IRDAI TO CAUTION PUBLIC

IRDAI has taken various initiatives to spread awareness among the members of the general Publicparticularly against the spurious calls through a multi-pronged strategy. The modes of campaign used by IRDAI directly for cautioning public about such offers are public notices, press releases, advertisements in newspapers, radio spots, television advertisements, caution on the Internet websites of IRDAI and its consumer education website etc.

IRDAI has already issued directions to all the life insurers to incorporate caution against such spurious calls in their publicity material – print, internet and electronic – as well as through SMS to their policy holders. Insurers themselves have also been independently taking up steps for cautioning public through print, electronic and internet media.

The following are the various efforts taken in the direction of cautioning public from spurious calls and fictitious offers

- A massive campaign cautioning general public against spurious callers and fictitious offers was carried out through television in 12 regional languages including Hindi.
- IRDAI has been spreading the awareness against the spurious calls by placing the relevant material i.e. radio jingles, TV Advertisements, press release etc. on IRDAI's Consumer Education Website (www.policyholder.gov.in), which is available both in Hindi as well as in English.
- The information sought by the visitors of IRDAI's Consumer Education Website as part of feedback w.r.t. spurious calls, IRDAI guidesthem to deal with it during the

monthly review of the feedback.

- IRDAI would continue with the initiatives for protecting policyholders' interests and for promoting insurance awareness.

VII. RECOURSE FOR PERSONS WHO PAID MONEY BASED ON SPURIOUS CALLS

In spite of the best efforts in cautioning public there are several persons who complain about making payment to spurious callers. The various categories in cases where payment is made based on spurious calls and the recourse available are briefly indicated below:

i. The amount is paid to an individual

Being a fraud by an individual, the only recourse available is to take up the matter with police for necessary action.

ii. The amount is paid to a non-insurance related service provider or agency

In such cases, depending on whether the services promised by the agency have been provided or not, the individual has to take up the matter with such agency or the police for necessary action. IRDAI would not be in a position to intervene as the institution does not fall within its regulatory purview.

iii. The amount is paid to an insurance company and a policy is issued

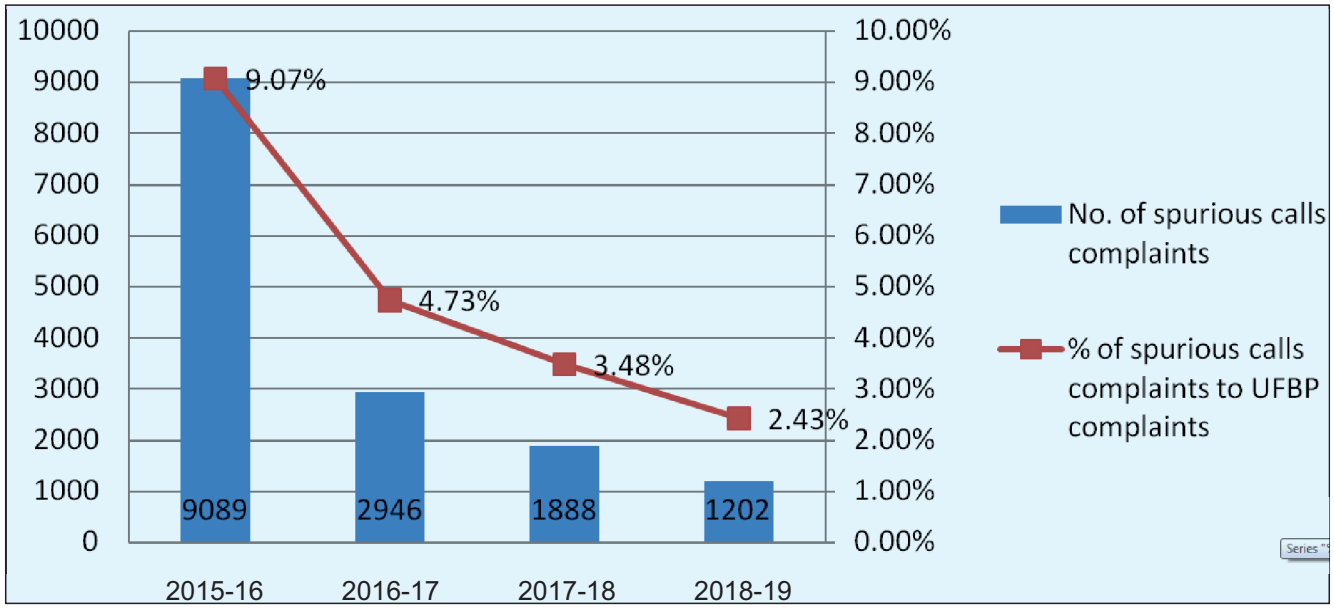
Being a case of fraud, a complaint can be filed with police for necessary action against the telecallers as well as the insurance company whom they represent. However, as an insurance policy is issued by an insurance company, the person may make a complaint of mis-selling with the insurance company bringing to the notice unfair business practice adopted by the telecaller/agent/intermediary in selling the policy and seek changes in the policy or cancellation of the policy. The other channels of making a complaint offered by IRDAI can also be used for registering a complaint against the insurer such as writing to Consumer Affairs Department of IRDAI, sending an email to complaints@irda.gov.in, making a call to toll free numbers (155255 or 1800 425 4732)of the IRDAI Grievance call centre or online on the Integrated Grievance Management System (IGMS) (www.igms.irda.gov.in).

VIII. COMPLAINTS ON SPURIOUS CALLS

The complaints relating to spurious calls are included under the broader complaint category of unfair business practices in the Integrated Grievance Management System of IRDAI which is the industry-wide repository of insurance grievance related information. The number of complaints of this nature as per IGMS is as follows:

Sl. No.	Year	Number of complaints	% -variation over previous year	% of complaints on spurious calls to the total complaints under UFBP
1	2015-16	9089		9.066%
2	2016-17	2946	-67.59%	4.730%
3	2017-18	1888	-35.91%	3.482%
4	2018-19	1202	-36.33%	2.425%

Spurious calls complaints over the past 4 financial years



It can be seen that there has been a reduction of no. of spurious calls complaints over the past 4 years from 9089 in 2015-16 to 1202 in 2018-19(overall reduction of 86% in the past 4 financial years). In terms of % share to the total UFBP complaints it has shown reduction of from 9.066% in 2015-16 to 2.425% in 2018-19. This indicates that the extensive campaign for building awareness amongst public and cautioning them from falling prey to spurious calls taken up by both IRDAI as well by the Insurers have shown positive results

IX. ACTION BY IRDAI ON COMPLAINTS

On receipt of complaints under spurious calls made in the name of Insurance Companies, IRDAI forwards the complaint to the named insurer to investigate the complaint vis-à-vis the telephone numbers/Mobile numbers/Names of persons mentioned in the complaint for taking appropriate action under intimation to IRDAI.

Wherever the spurious calling has resulted into issuance of an insurance policy IRDAI takes up the complaint with the insurer concerned for resolution, which is updated by the insurer in IGMS. In case the complainant is not satisfied with the resolution provided by the insurer, he may take up the matter with insurance ombudsmen (for details visit www.ecoi.co.in) for amicable resolution or adjudication under the Insurance Ombudsman Rules, 2017- Alternately, the complainant can file a complaint with Consumer Forum for deficiency of service; or take up before a criminal court for cheating or fraud; or file a suit in a civil court for breach of trust. -

However, through the volume of complaints, IRDAI monitors the market conduct of insurers, agents and intermediaries. Further, during the course of on-site inspection and off-site monitoring of regulated entities like insurance companies, insurance agents, corporate agents and insurance intermediaries (brokers) for

examining the compliance of these entities with the extant regulatory framework, IRDAI focuses on the process of soliciting, offering and selling insurance. Based on the findings, IRDAI initiates regulatory action against the insurers or intermediaries as per the provisions of the Insurance Act and Regulations.

CONCLUSION

The realization of the fact that insurance is for risk protection and not for windfall gains can bring about caution in the members of public. So, there is a need for greater insurance awareness apart from the specific efforts taken by IRDAI in cautioning public against spurious calls. IRDAI on its part has been proactive in devising and implementing a multi-pronged strategy for spreading caution so that people do not fall prey to offers made by spurious callers.

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