Ref: IRDAI/E&C/ORD/MISC/14/01/2025

Order in the matter of Royal Sundaram General Insurance Co. Ltd.

1.1. Based on the

1.1.1. Show Cause Notice ("SCN") Ref.No.IRDA/Enforcement & Compliance/ 2022-23/658/SCN/LR/023 dated 25th June, 2024 issued to M/s Royal Sundram General Insurance Co. Ltd. ('Insurer' or 'Company') in connection with the remote inspection conducted by the Authority from 14th September 2020 to 25th September 2020.

1.1.2. Submissions made by the Insurer vide email dated 16th July 2024 in response to the aforesaid SCN.

1.1.3. Submissions were made by the Insurer during the personal hearing held on 22nd October, 2024, chaired by a panel of two whole-time members of the Authority – Shri Rajay Kumar Sinha (Member-F&I) and Shri Deepak Sood (Member-Non-Life).

1.1.4. Further submissions made by the insurer post-hearing vide email dated 30th October 2024.

2.1. Background

2.1.1. The Authority had conducted a remote inspection on M/s. Royal Sundaram General Insurance Co. Ltd. ('Insurer' or 'Company') from 14th September 2020 to 25th September 2020. The inspection report, inter alia, revealed certain violations of provisions of the Insurance Act, 1938 and Regulations, Guidelines and Circulars issued thereunder.

2.1.2. A copy of the inspection report was forwarded to the Insurer on 6th January 2021 seeking their response and the insurer submitted their response vide email dated 5th February 2021.

2.1.3. On examining the submissions of the Insurer, an SCN was issued on 25th June, 2024. The Insurer replied to the SCN vide email dated 16th July,

2024. As requested for by the Insurer, a personal hearing was granted to the Insurer on 22nd October, 2024.

2.1.4. On behalf of the Insurer, Shri Amit Ganorkar (Managing Director), Shri Vaibhav Kabra (Chief Financial Officer) and Shri SR Balachandher (Company Secretary & Chief Compliance Officer) and on behalf of the Authority, Shri Rajay Kumar Sinha, Member (F&I) and Shri Deepak Sood, Member (Non-Life), Shri RK Sharma (Chief General Manager), Shri TV Rao (General Manager), Shri Sanjay Kumar Verma (General Manager), Shri Manoj Asiwal (Deputy General Manager) and Shri Yash Arvind Patil (Assistant Manager) attended the hearing.

2.1.5. The submissions made by the Insurer in its email dated 5th February 2021 and the submissions made after SCN vide email dated 16th July, 2024, submissions during the personal hearing on 22nd October, 2024 and further submissions made post hearing vide email dated 30th October 2024 have been carefully considered by the Authority and are summarized below:

3.1. Charge-1

Violation of

3.1.1. Regulation-27 (v) of IRDA (Health Insurance) Regulations, 2016

3.2. Inspection Observation_C-8

3.2.1 While examining the IBNR calculation sheets for Financial Year (FY) 2019-20, it was observed that the insurer had closed the health insurance claims in previous year/current financial year and re-opened the same in current/next financial year and settling the claims.

3.2.2 It was observed that the insurer re-opened around 53354 claims amounting to Rs.123.43 crore in Personal Accident, Health, Individual and Group Schemes. Similarly, the insurer closed around 6466 claims amounting to Rs.34.99 crore.

3.3. Summary of Insurer's Submissions:

3.3.1. The insurer submitted that 521 claims were re-opened in the FYs based on the submission of fresh documents by claimant after closure of claims and on that basis the rejection of claims was reconsidered.

3.3.2. The insurer further submitted the explanation about the closure of 5 claims highlighted in the observation.

3.3.3. The claims were initially closed due to non-submission of required documents by the claimant, despite multiple reminders. However, they reopen the files and process payments once the documents are received. This approach is detailed in the Standard Operating Procedure for closure/reopening of claims.

3.3.4. Insurer submitted that if they keep the claims indefinitely open, it will also skew the claims disposal ratio. Moreover, as per the terms and conditions of the policy contract, it is clearly mentioned that the customer shall submit all the claim related documents within 30 days (for both retail and group policies). Though this is the criterion for repudiation, they have chosen as a customer friendly approach to temporarily put the claims on hold and settle the claim as and when the customer produces the relevant documents. However, this approach is resorted to only after sending sufficient reminders to the customer to provide the documents.

3.3.5. Insurer also submitted that the reserving methodologies adopted by the company are always on a prudent basis and takes into consideration not only IBNR claims but also the IBNER. Thus, any insufficiencies in outstanding claims either due to closure/repudiation of claims and subsequent reopening or due to outstanding claims being insufficient for payments are considered in the estimation of claims.

3.3.6. During personal hearing, the Insurer reiterated the submissions made in response to the SCN regarding closure of claims in line with Standard Operating Procedure (SOP), which was approved by Chief Operating officer.

3.3.7. The Insurer stated that 521 cases were reopened in FY 2019-20, out of which 445 cases (85%) were already settled earlier and reopened only for subsequent or additional payments related to pre and post expenses and investigator expenses.

3.3.8. However, the Insurer admitted that only 76 claims were initially closed due to missing documents, despite repeated reminders, and were subsequently reopened, paid, and settled as a first payment transaction once the customers submitted the required documents. The Insurer submitted that there were no outright or premature closures.

3.3.9. The Insurer also reiterated that they have chosen this practice in good faith as a fair, customer-friendly approach to temporarily put claims on hold until the customer provides the required documents. This approach is pro-customer, as it gives customers an additional opportunity to submit the documents without facing outright repudiation.

3.3.10. The insurer emphasized that both Form NL-25 (Claim Data), in accordance with earlier Public Disclosure norms, and Form NL-37 (Claim Data), which reflects the current Public Disclosure norms (effective September 2021), recognize closed claims as well.

3.3.11. The Insurer also emphasized that the reserves and solvency position as of 31st March 2020 had remained more than sufficient, even after four years. Therefore, inadequate reserving, solvency, or profitability were not reasons for adopting the above process.

3.3.12. The Insurer stated that repudiation is considered a more severe action in which the Insurer denies the claim outright, often due to fraudulent activities or significant violations of policy terms, with no possibility for reopening. In contrast, the Insurer is willing to reopen claims when the policyholder provides the necessary information.

3.3.13. The Insurer acknowledged that their processes are not fully aligned with the Health Regulations, 2016 in terms of language. They assured that they would streamline their process and make appropriate changes to the final letter communicated to the claimant, after due consultation.

3.4. Decisions on Charge-1:

3.4.1. The submissions of the insurer regarding the closure of claims due to insufficient documentation indicates a lack of due diligence or thoroughness in the initial claims review process. This decision to close claims diminishes the gravity of the policyholders' concerns. The policyholders could feel that their claims were not handled appropriately initially, resulting in dissatisfaction and distrust in the insurer's claims handling process.

3.4.2. Although the insurer asserts that it follows a customer-friendly approach, this seems to be a mere excuse for the delays. A genuinely customer-centric approach would focus on the timely resolution of claims and maintain transparent communication during the entire claims process. The insurer's emphasis on delays in submitting of documentation by policyholders suggests either inadequate communication or engagement including inadequate support mechanisms for claimants or policyholders, which could lead to the prolonged claims process.

3.4.3. The insurer's acknowledgment that processes are not in line with Health Regulations, 2016, points to a serious level of non-compliance. This misalignment erodes trust in their operations. In view of the above, the insurer is warned for the lapse and advised to ensure that the claims are settled either by way of payment of claims or repudiation of claims in accordance with the terms and conditions of the respective Policy and no claims are closed in the books of the insurer. The insurer shall note that any recurrence or similar lapse, in future, shall be viewed sternly and stringent regulatory action, as deemed appropriate, shall be taken by the Authority.

3.4.4. The insurer is also advised to ensure that effective communication, including precise guidance on documentation requirements, is standardised throughout the claims process.

3.4.5. Further, the insurer is advised to prioritize a thorough review and realignment of internal processes in order to comply with the provisions of the extant master circulars/regulations and the action report, to this effect, shall be filed with the Authority.

4.1. Charge-2

Violation of

4.1.1. Regulation-21 of IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017.

4.1.2. Clause 4(a) of Circular No. IRDA/INSP/CIR/157/09/2018 dated 19th September, 2018.

4.2. Inspection Observation_F-33

4.2.1. It was observed that the payments made during 2018-19 and 2019-20 to vendors in excess of Rs.1 crore were not reported in the outsourcing returns filed with Authority.

4.2.2. Insurer failed to submit the explanation / information sought by the inspection team during the inspection period.

4.3. Summary of Insurer's Submissions:

4.3.1. The insurer submitted that the activities carried out by vendors referred in the observation are specialized activities, not expected to be carried out internally and do not fall within the purview of the outsourcing activities as defined in the regulations and hence the same were not included in the outsourcing return. All these vendor arrangements were presented to outsourcing committee for review post which their services were utilized.

4.3.2. During personal hearing, the Insurer stated that they had engaged the said vendors only for conducting the activities for which their services were enlisted and payments were made accordingly. The Insurer also stated

that the pay-outs were genuine and these vendors are neither their related parties nor the related parties to their Intermediaries.

4.3.3. The insurer also explained the profile of each vendor, including GST details, and Memorandum of Association (MoA) related to the vendors, where applicable.

4.3.4. Post hearing, the insurer submitted documents related to constitution of Vendor Management Committee and Vendor onboarding Framework along with vendor onboarding checklist, agreement execution form, copy of MOA (wherever applicable), GST and PAN related to the vendors.

4.4. Decisions on Charges-2

4.4.1. The submissions of the insurer, with respect to the activities such as repairs and maintenance charges of Hardware & Software and Courier Charges, are taken on record.

4.4.2. However, the Authority raised its concerns about activities, such as conducting conferences, training workshops, and advertising expenses, which are normally undertaken by the insurer and do fall under the definition of 'outsourcing' as per Regulation 4(e) of IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017. A bare perusal of outsourcing returns filed by the Insurer indicates that the insurer does not have a clear understanding of the services to be treated as 'outsourcing'. For illustration, as per the Outsourcing returns of FY 2018-19, tele calling services and software maintenance services are indeed shown under 'outsourcing' but telemarketing and software solutions services are precluded from the same though all of these activities do not have any material difference. It is not clear as to why the Insurer chose to report some services under 'outsourcing' and excluded others. Similarly, there is no distinguishing factor between "distribution of publicity material and advertisement material" and "Advertising Expenses"; However, the insurer chose to report the former and avoided reporting the latter. If the insurer's interpretation is allowed, every function can be derived independently as not falling within the meaning of 'outsourcing'. It is essential to note here

that it is not the regulatory intent to force the insurers to carry out all the activities in house and not take assistance of third parties. The regulations only aim to safeguard the insurers from any risks emerging out of dependence on such third parties. Precisely, for this reason the disclosure and reporting requirements are treated as sacrosanct and inalienable and any attempt to deviate from the same is viewed seriously.

4.4.3. In view of the above, it is concluded that the insurer did not properly classify and disclose its activities as outsourcing, which goes against regulations then in force. This shows a lack of responsibility and commitment to following the rules regarding outsourcing.

4.4.4. Going by the submission of the Insurer that these vendor arrangements were presented to outsourcing committee, the Committee failed to identify and manage essential outsourcing activities and the failure led to poor governance of such arrangements. As a result, the Outsourcing Committee failed to implement the outsourcing policy effectively. The lack of strict enforcement of this policy exposed the insurer to inadequate internal controls.

4.4.5. Consequentially, although the insurer made substantial payments to the following vendors for FY 2019-20, they did not report these to the Authority under Regulation 21 of IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017 due to the erroneous classification of such activities as not outsourcing.

S.No.	Name of Vendor	Amount
1	Story Labs	Rs.22.01 crore
2	Dhanalaxmi Marketing	Rs.14.21 crore
3	Aries Solution	Rs. 8.63 crore
4	Cedreto Marketing Pvt. Ltd.	Rs. 2.55 crore
5	Lease Plan India Pvt. Ltd.	Rs. 1.40 crore
6	We can Holidays Tours and Travels	Rs. 1.16 crore
7	Nexus innovative solutions Pvt. Ltd.	Rs. 1.16 crore

4.4.6. The insurer's failure to report the above payments for outsourced financial commitments violates disclosure requirements and may indicate an attempt

to evade regulatory scrutiny. This lack of transparency raises concerns about the governance gaps, while also limiting the Authority's capacity to evaluate outsourcing risks. As a result, this situation increases both operational and reputational risks, indicating that the insurer lacks the necessary systems and controls to meet regulatory standards.

4.4.7. In view of the above, in exercise of the powers vested under Section 102 of the Insurance Act, 1938, the Authority hereby imposes a penalty of Rs.1 Crore (Rupees-One Crore) for the violation of the provisions of Regulation-21 of IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017.

5. **Summary of Decisions:**

Charge No.	Violation of Provisions	Decision
1	**Inspection Observation_C-8** a) Regulation-27 (v) of IRDA (Health Insurance) Regulations, 2016	**Warning & Advisory**
2	**Inspection Observation_F-33** a) Regulation-21 of IRDAI (Outsourcing of Activities by Indian Insurers) Regulations, 2017.	**Penalty of Rs.1 (One) crore**

6. The penalty amount of Rs.1 crore (Rupees-one crore) shall be remitted by the Insurer by debiting Shareholder's Fund within a period of forty-five days from the date of receipt of this order through NEFT/RTGS (details of which will be communicated separately). An intimation of remittance may be sent to Shri T.Venkateswara Rao, General Manager (Enforcement and Compliance Dept.) at the Insurance Regulatory and Development Authority of India, Survey No. 115/1, Financial District, Nanakramguda, Hyderabad 500032, email id enforcement@irdai.gov.in.

7. Further,

a) The Order shall be placed before the Board of the Insurer in the upcoming Board Meeting and the Insurer shall provide a copy of the minutes of the discussion.

b) The Insurer shall submit an Action Taken Report to the Authority on direction given within 90 days from the date of this Order.

8. If the Insurer feels aggrieved by this Order, an appeal may be preferred to the Securities Appellate Tribunal as per the provisions of Section-110 of the Insurance Act, 1938.

Deepak Sood Member (Non-Life)	Rajay Kumar Sinha Member (F&I)

Place: Hyderabad
Dated: 23rd January 2025