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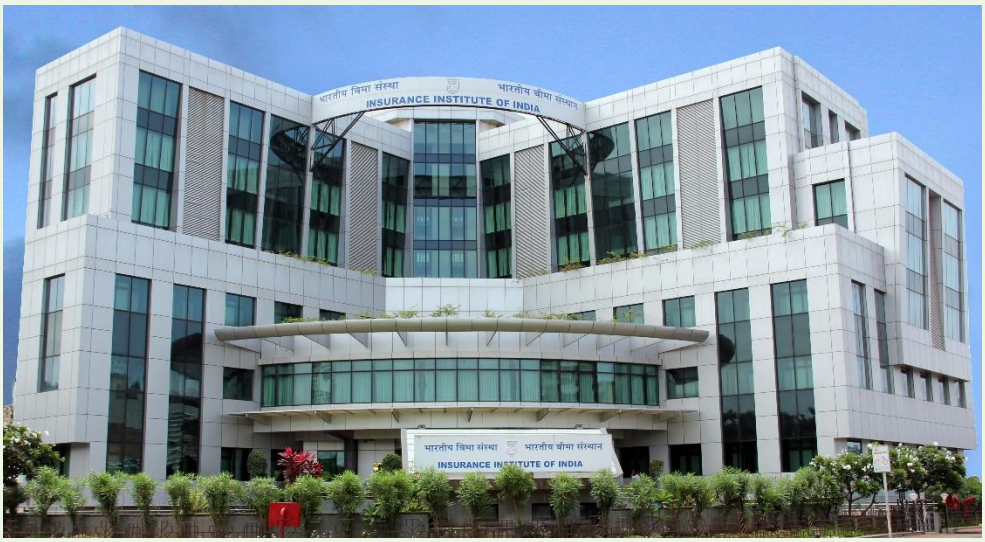

QUOTE OF THE WEEK

"A positive atmosphere nurtures a positive attitude, which is required to take positive action."

Richard M. DeVos

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Bridge Insurance

Bridge insurance is a type of insurance that covers damage to bridges due to flood, fire, explosions, and more. However, it generally does not cover damage as a result of war, inherent defects, or natural wear and tear. As bridges are meant for the public's benefit, nearby government agencies are the ones who purchase bridge insurance. Because bridges are completely exposed and may sustain various types of damage, such policies act a preventative measure against using significant sums of taxpayer dollars on repairs in the event of major bridge damage.

LIFE INSURANCE

Life insurers' claim settlements stable despite Covid - The Economic Times – 16th February 2022

Indian life insurers' claim settlement ratios have remained mostly stable during the Covid-19 period compared with earlier years despite an uptick in claims as the regulator pushed for easier settlements amid a once-in-a-century pandemic. The settlements-to-claims ratios of the country's top life insurers were in the range of 98.3 percent to 99.3 percent in 2020-21. The claim settlement ratio shows the percentage of life insurance claims an insurer settles out of the total number of claims it receives including pending ones during a financial year. It is an important measure to consider before buying a life insurance policy. Among the large life insurers, Life Insurance Corporation of India's (LIC) claims settlement ratio improved to 98.3 percent in 2020-21 from 95.4 percent in FY20 to equal the pre-pandemic FY19 ratio of 98.3 percent, according to the draft red herring prospectus (DRHP) ahead of its much-anticipated initial public offering (IPO).

The top five private-sector insurers, SBI Life, HDFC Life, ICICI Prudential Life, Max Life, and Bajaj Allianz Life, reported a stable 99.3 percent claim settlement ratio on an average in FY19, FY20 and FY21. Among them, SBI Life's settlement ratio dropped from 98 percent in FY19 to 97 percent in FY 20 and 96.4 percent in FY 21, while ICICI Prudential Life Insurance saw the most improvement from 95.4 percent in FY20 to 98 percent in FY21. However, settlement ratios for all life insurers for the first six months of the current fiscal were lower than their ratios for the full FY21.

(The writer is Joel Rebello.)

TOP

Sukanya Samridhi Yojana vs Child Insurance Plan: Which one is better to secure your child's future? – Financial Express – 15th February 2022

Providing good education to children are the prime concern for parents. The high rate of inflation in the education sector adds to the concern, as parents need to keep a corpus ready to ensure that their children don't miss a golden opportunity due to paucity of funds.

Apart from education, marriage, accommodation etc are some other financial goals, for which proper planning and investments are also needed.

To fulfill the dreams, ensuring financial security is also important to ensure that the goals are achieved even in case of unfortunate early demise of the earning parent(s).

Here are the pros and cons of investing in Sukanya Samriddhi Yojana (SSY) and Child Insurance Plans to secure your child's future:

Sukanya Samriddhi Yojana

The parents or legal guardian of a girl child may open a Sukanya Samriddhi Yojana Account till the girl becomes 10 years old.

Benefits:

With sovereign guarantee, SSY is fully risk-free and provides an attractive rate of interest even higher than the rate offered on the Public Provident Fund (PPF).

The maturity period of SSY is 21 years and deposits are to be made for 15 years. Partial withdrawal of 50 per cent of the outstanding account balance is allowed when the girl child attains the age of 18 years, which may be used for study purposes.

Even as the maturity period is 21 years, an SSY account may be closed prematurely and the entire balance may be withdrawn if the beneficiary girl child gets married after attaining 18 years of age. Investments in SSY accounts enjoy tax benefits u/s 80C, while interest and maturity amount are completely tax free.

Limitations:

SSY accounts may only be opened for girls. So, for boys, parents need to select other investment avenues. With rate of interest revised quarterly, the maturity amount may fall short in case of rate cuts. In case of the death of an earning parent, investments in SSY will get stopped, derailing the goals of a beneficiary girl child.

Child Insurance Plans

Like SSY, the Child Insurance Plans are also aimed at fulfilling the financial requirements for higher study, marriage etc of children.

Benefits:

The Child Insurance Plans generally come with the option of Premium Waiver Benefit (PWB), which ensures that a policy continues without paying premium in case of unfortunate demise of the earning parent(s).

Such an insurance plan may be taken for both girls and boys.

Parents have the flexibility of choosing the maturity period and in some cases also money back mode and period.

Like SSY, investments in Child Insurance Plans also enjoy tax benefits u/s 80C and the maturity and money backs are also tax free.

Limitations:

With lower bonus rate, parents need to opt for higher Sum Assured (SA) to meet the financial requirements, leading to high premium payouts.

Which one to opt for?

With sovereign guarantee, attractive rate of return and complete tax benefits, SSY is a good risk-free investment option for girls.

As investments in SSY may get derailed in case of unfortunate early demise of the earning parent(s), taking insurance cover is also necessary.

However, instead of relatively costly Child Insurance Plans, parents may opt for cheaper Term Insurance Plans to insure the life of the earning parent(s) and invest the remaining amount in Mutual Fund (MF) or other investment options giving superior returns.

(The writer is Amitava Chakrabarty.)

TOP

GENERAL INSURANCE

Home insurance policy: Buyers, now get ready for structural audit - Business Standard – 15th February 2022

The recent news of a portion of the sixth floor collapsing all the way to the first floor at Chintels Paradiso society in Gurugram's Sector 109 has left both existing homeowners and prospective buyers alarmed. However, there are a few steps you can take to ameliorate this risk. Before buying, get the structural strength of the building tested if you have any doubts. Today there are home inspection companies that do a thorough check of the flat for all kinds of defects. "We check for defects in doors, windows, electricals, plumbing, walls, ceiling, etc. First, we do a visual inspection of the property. If we notice large cracks and other issues, we bring in structural auditors to evaluate the building's structural stability,"

says Nitin Prabhakar Shingote, founder, PropCheckup. These structural auditors perform a series of tests. "They carry out tests primarily to check the quality of concrete and the quality of steel reinforcement," says Dikshu C Kukreja, managing principal, CP Kukreja Architects. To check the quality of concrete, they carry out tests like RH (rebound hammer), CAPO (cut and pull out), ultrasonic pulse velocity, and so on. They perform half-potential and carbonation tests to check steel reinforcement.

Depending upon the number of tests, the cost can range from Rs 2-5 per square feet or higher. "Once you have entered the building, make sure your society adheres to the national building code norms and those laid down by local authorities. Ensure that periodic lift and fire safety inspections, as well as structural audits, are carried out," says Kukreja. A home insurance policy would not have covered an incident like the recent one in Gurugram, where the structure collapsed on its own. But it would be useful in other catastrophes. "This policy covers named perils, such as fire, lightning, storm, cyclone, landslide, explosion, riot, impact damage, acts of terrorism, and so on. Collapse due to wear and tear, however, is not covered," says Raghavendra Rao, chief distribution officer, Future Generali India Insurance. Buy adequate cover for both the structure and the contents. Most policies cover the replacement cost. "The structure is covered for the amount that will be required to rebuild it. The sum insured for the building is calculated as its carpet area multiplied by the cost of construction per unit," says Parag Ved, president and head-consumer lines, Tata AIG General Insurance.

Be careful while arriving at the per unit construction cost because it can vary by locality, quality of construction, and so on. Bajaj Allianz General Insurance offers sum insured for the building based on the "agreed-upon value" in its My Home insurance policy. "Usually, the claim gets paid once the reinstatement is completed. What we offer the customer in case of a claim is that he takes the sum insured, whatever was agreed at the time of policy issuance, hands over the apartment or building to us, and buys a house anywhere in the country with the insurance money he receives," says T A Ramalingam, chief technical officer, Bajaj Allianz General Insurance. The internal contents are also covered for the amount required to replace them with a similar item at current cost. "In a standard home insurance policy launched by the regulator, the cover for contents allowed is 20 percent of construction cost or Rs 10 lakh, whichever is lower," says Rao.

One can, however, buy additional content cover by paying additional premium. In the case of Bajaj Allianz General Insurance's My Home policy, if the value contents is more than Rs 5 lakh, the company waives the requirement for a list of individual items with their values. One point needs to be kept in mind regarding high-value items. "Valuables like jewellery, curios, art, etc are not included in general home contents. They need to be insured separately under valuable contents," says Ved. Finally, do the due diligence

before buying a policy. Says Abhishek Misra, chief executive officer and principal officer, Bonanza Insurance Broker: "Compare the claim settlement ratios of insurers. Also compare their policies and understand the scope of their coverage and benefits."

(The writer is Sanjay Kumar Singh.)

TOP

HEALTH INSURANCE

Health insurance: Making claims settlement transparen - Financial Express – 18th February 2022

In order to make the claims process for health insurance claims more customer-friendly and improve the functioning of Third Party Administrators (TPAs), the insurance regulator has suggested certain amendments.

Earlier, the Insurance Regulatory and Development Authority of India (Irdai) had asked health insurance companies to be more transparent in their health insurance claim settlement. Claims will have to be processed in a transparent, seamless and efficient manner within the prescribed timelines. "All the insurers shall ensure putting in place systems to enable policyholders track the status of cashless requests/claims filed with the insurer/TPA through the website/portal/app or any other authorized electronic means on an ongoing basis. The status shall cover from the time of receipt of a request to the time of disposal of the claim along with the decision thereon," the regulator has now said.

The regulator has also asked the insurers to ensure that repudiation of the claim is not based on "presumptions and conjectures". If a claim is denied or repudiated, the communication about the denial or the repudiation will have to be made only by the insurance company by specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions.

The insurer will also have to furnish the grievance redressal procedures available with the insurance company and with the insurance Ombudsman along with the detailed addresses of the respective offices. In case TPAs are settling the claims on behalf of the insurance company, policyholders will have to be notified about all the communications as well as location to track the claims.

Streamlining of TPA regulations

In its draft recommendations, Irdai has proposed to relax the requirement that at least one of the directors of the TPA should be an MBBS. As some state governments are allowing AYUSH practitioners to practice in allopathy, the regulator has proposed that the minimum qualification of MBBS for director of TPA will be substituted and linked with the term medical practitioner.

"Taking into consideration the experience gained while reviewing the dynamic needs of the insurance industry, the TPA Regulations 2016 were comprehensively reviewed in order to examine the scope for allowing operational freedom to both insurers and TPAs. The extant regulations are also reviewed from the perspective of allowing further facilitations that can be considered," the regulator's note says.

At present, every TPA has a chief medical officer with a minimum qualification of MBBS and holding a valid registration from the Medical Council of India or Medical Council of any state. The proposed changes will be substituted and linked with the medical practitioner as defined in the guidelines on standardization in health insurance. As on March 31, 2021, there are 23 TPAs registered with Irdai.

The regulator has proposed to do away with the current norms of mandating written bipartite / tripartite agreements between the insurance company and TPAs and instead the insurance company will be accountable to render effective cashless services to the policyholders.

"The insurers shall enter into suitable health services agreement with the TPAs wherever the TPAs are engaged for providing health services to policyholders. The terms of providing health services by a TPA shall be mutually agreed by the contracting parties. Insurers shall be responsible for providing effective cashless services to the policyholders. The Authority may specify guidelines in the matter of health services agreements," the exposure draft underlines.

(The writer is Saikat Neogi.)

TOP

India: IRDAI proposes to allow greater operating freedom in health insurance business – Asia Insurance Review

The insurance regulator IRDAI is proposing several amendments to the IRDAI (Health Insurance) Regulations, 2016 following a review and after taking into consideration the dynamics of the insurance industry.

In a statement issued earlier this week, the IRDAI says that the 2016 Regulations have been comprehensively reviewed in order to examine the scope for allowing operational freedom to both insurers and TPAs while protecting the interests of policyholders. "The extant regulations are also reviewed from the perspective of allowing further facilitations to the Insurers and the TPAs," the IRDAI added.

The draft IRDAI (Health Insurance) (Amendment) Regulations, 2022 is open for feedback by stakeholders until 6 March 2022.

Among other purposes, amendments are proposed to a number of clauses which would:

Encourage life insurers also to incentivise policyholders for early entry, continued renewals (wherever applicable), favourable claims experience, preventive and wellness habits etc, as applicable. The current Regulations already provide for general insurers and health insurers to devise mechanisms or incentives to reward policyholders in the situations outlined.
Encourage insurers to offer discounts where there is an improvement in the risk profile.
Provide for personal accident products to be brought under the ambit of lifelong renewability in the interests of policyholders.
Omits a clause relating to the handling of the costs of pre-insurance medical examinations. Explaining this proposed amendment, the IRDAI says, "These are operational matters, hence considered to be left to the insurers to decide."
omit the definition of "Health Services Agreement" as the IRDAI proposes to remove the requirement for written tripartite/bipartite agreements amongst insurers, TPAs and hospitals.
remove existing rules that mandate that agreements be signed by insurers and cashless facility providers. The IRDAI says that the requirement is highly prescriptive. "While shifting the onus of ensuring the availability of a cashless facility at network providers to insurers, it is proposed to leave it to the insurers the manner of engaging the network providers," the regulator explains.

Ensure that after porting a policy, no subsequent claim related to claims already made with the previous insurer shall be repudiated by the new insurer on grounds of non-disclosure.
Prescribe timelines for calling for claim details from the previous insurer by the policyholder's new insurer after porting a policy.
Mandate the disclosure on insurers' websites of the procedure for porting-in an insurance policy, so as to ensure transparency and provide for policyholder education.

TOP

Still have 80D limit? Avail of deduction on health check-up, say experts - Business Standard – 17th February 2022

Most taxpayers are aware of the deductions they can avail of by investing in a variety of tax-saving instruments. Many, however, may not know that tax deductions are also available on the health care expenses incurred during the fiscal year. The most well-known tax deduction is available under Section 80D on health insurance premiums. Both individuals and Hindu Undivided Families can claim it. The deduction is applicable on a policy bought for spouse and dependent children or parents. Premiums paid for top-up health plans and critical illness plans are also eligible. The maximum deduction allowed in a fiscal year is Rs 25,000 for non-senior citizens and Rs 50,000 for senior citizens. In addition, several other lesser-known tax deductions are available. You can avail of tax deduction on expenses incurred on preventive health check-ups. If you have already got the health check-up done, or have scheduled one before March 31, you can get this deduction.

"The maximum deduction you can claim on preventive health check-ups is Rs 5,000. This falls within the overall limit of Rs 25,000 under Section 80D, which also includes medical insurance premiums and health expenditure on senior citizens," says Pratyusha Miglani, managing partner, Miglani Varma & Co. (Advocates, Solicitors and Consultants). How it works: If your health insurance premium is lower than the Rs 25,000 limit under Section 80D, you can use the expense incurred on a preventive health check-up to avail of the entire benefit. Presume a taxpayer aged 40 pays a medical insurance premium of Rs 22,000. In addition, he incurs an expenditure of Rs 5,000 on preventive health check-up. Although his total expense is Rs 27,000, he will be entitled to a deduction of Rs 25,000. You can claim this deduction, irrespective of whether you have purchased a health insurance policy. You don't even need to pay by credit card or cheque. This benefit can be availed of even if payment was made in cash. However, keep your medical bills and prescriptions handy in case the income-tax (I-T) department asks for proof. You can save up to Rs 1,500 via preventive health check-ups, depending upon your tax slab.

Archit Gupta, founder and chief executive officer, Clear says, "This provision is generally beneficial to younger people who don't exhaust their Section 80D limit with their health insurance premium." A tax deduction under Section 80DDB is available for the treatment of specified ailments. The limit is Rs 40,000 for individuals below 60 years and Rs 1 lakh for senior citizens. This deduction is allowed only for specified illnesses mentioned in Rule 11DD of the I-T Act. These include neurological diseases, malignant cancers, haematological disorders, dementia, Parkinson's disease, thalassaemia, and a few others. Gopal Bohra, partner, NA Shah Associates, says, "Taxpayers can claim deduction under this Section for the treatment of a dependant or for themselves if they are suffering from one of the specified diseases." A certificate stating that a person has the disease must be obtained.

Sameer Jain, managing partner, PSL Advocates & Solicitors, says, "Details that need to be mentioned in the certificate include name, age, ailment, and details of the specialist treating the patient. The 2015 amendment, in fact, has made it easier to claim this deduction since only a certificate is required now." "Only specialists as specified by the I-T department can certify to the disease and treatment under this Section, except in cases where the treatment is being done at a government hospital, where any full-time specialist holding a postgraduate degree in general or internal medicine can issue such certification," adds Miglani.

(The writer is Bindisha Sarang.)

TOP

Here's how you can save income tax up to Rs 1 lakh by buying health insurance plan - Financial Express – 16th February 2022

The last date to save tax for the financial year 2021-22 is March 31, 2022. In order to save tax, if you have already exhausted the limit of Rs 1.5 lakh available under Section 80C, you may consider tax saving under Section 80D. Under section 80D, premium paid towards a health insurance plan, up to a certain limit based on age, will give you the tax benefit, which is over and above Section 80C limit. You may save income tax up to Rs 1 lakh by buying a health insurance plan if you and your parents are above age 60 i.e. senior citizens. There are exclusive senior citizen health insurance plans as well.

The tax benefit that you can avail on the premium paid towards any kind of health insurance policy falls under section 80D of the Income Tax Act, 1961. The maximum tax benefit is capped at Rs 25,000 or Rs 50,000, however, the actual tax benefit will depend on your age. So, if you are above a certain age, the total deduction that you may avail is Rs 1 lakh.

"Health insurance premium can be claimed as tax deduction up to Rs 25,000 for persons under 60 and up to Rs 50,000 for those aged 60 and above. It means, if you are below 60 years and want to buy a health insurance plan for yourself and for your parents (at least 60 years), the total tax benefit can be availed up to Rs 75,000. If both you and your parents are aged 60 years and above, then the maximum deduction that can be availed is up to Rs 1, 00, 000," says Pankaj Arora, MD & CEO, Raheja QBE General Insurance Company. The premium paid will bring your gross total income by an equal amount thus lowering your tax liability.

Even before you start saving for your goals, buying a health insurance plan is suggested by most financial planners. Any major illness or even any casualty requiring hospitalisation of a few days may result in a hospital bill running into lakhs. A health insurance plan comes at a fraction of a cost for a sum insured (coverdage) that the insurer commits to pay to the hospital. Having purchased a health cover for adequate coverage, one may need not dip into existing savings or borrow from friends, relatives.

"The Covid-19 outbreak highlighted the stressful financial burden of treatments, hospitalization and medical expenses that an adequate insurance cover offers in the uncertain times. Not just Covid-19, a health cover ensures you don't have to compromise your savings to meet the rising medical costs because of any illness. A health insurance plan with adequate coverage is, therefore, a must-have for the entire family," says Arora.

The tax advantage of section 80D is available on all health cover plans such as Individual plans or Mediclaim, Family Floater plan, Critical illness plans, health riders of life insurance plans and even other health insurance variants.

Tax benefit is only a fringe benefit that comes along in a health cover. It's always better to buy adequate coverage for self and all family members to take care of hospital bills at the time of hospitalisation.

(The writer is Sunil Dhawan.)

TOP

With milder Covid-19 infections, insurers begin to review cooling-off period for health policies - The Hindu Business Line – 15th February 2022

In a move that will benefit customers, insurance companies have begun to either reduce or completely remove the cooling-off period to purchase health insurance for people who were infected with Covid-19 in the past.

As the name suggests, cooling-off period is the duration when a person infected with Covid-19 cannot purchase health insurance.

With the severity of infections now coming down, insurers have begun to review the cooling-off period, which many of them had introduced during the first and the second waves of the pandemic as there were Covid-related complications in several patients. Insurers such as Niva Bupa and Care Health Insurance have already begun to do so.

Amit Chhabra, Head — Health and Travel insurance, Policybazaar.com, noted that the acceptance of Covid has increased significantly amongst insurers. "Earlier, for a person who had been infected with Covid, the cooling-off period was anywhere between 15 days to six months with the average of 30 days. Now, since the start of February, some insurers have begun to reduce this period and more are expected to follow suit," he said, adding that earlier, insurers were not sure of the long term effects of Covid.

"But in the third wave, the severity of the infection has been much milder with fewer cases of hospitalisation," he said.

While Care Health Insurance plans have only a seven-day waiting period, lans of Niva Bupa no not have a cooling off period for those infected by Covid-19 and who did not require hospitalisation.

'Need more awareness'

Bhabatosh Mishra, Director — Underwriting, Products and Claims, Niva Bupa Health Insurance, said there is a scientific, medical and actuarial basis for the decision to do away with the cooling off period along with a behavourial aspect.

"In the third wave, infections have been much milder and hospitalisation only in fewer cases. Complications like fibrosis of the lungs and black fungus are now not seen. Also, there is much more awareness amongst people about health insurance," he noted.

According to Mishra, the cooling-off period imposed by the company has changed over time, in line with the spread and severity of infections. In case there is a new variant, which is more severe, the insurer would once again review the period. However, there continues to be a cooling-off period for people who require hospitalisation, he said.

(The writer is Surabhi.)

TOP

Covid related health insurance claims remain low in the third wave of the pandemic – The Hindu Business Line – 12th February 2022

With lesser severity of infections and lower hospitalisation rates, the third wave of the pandemic has not led to a significant rise in health insurance claims for the general insurance sector which had seen a deluge of claims after the second wave.

"There have not been too many cases of hospitalisation in the current cycle of Covid-19. Hospitalisation was only in cases where the patient had some other complication; most patients managed under home isolation this time," said Bhaskar Nerukar, Head – Health Claims, Bajaj Allianz General Insurance.

At present, Covid-19 related claims for the insurer are at just 8 per cent of the claims it received in the second wave of the pandemic. "As the infection is milder, the Covid-19 related claim size also came down by 17 -18 per cent while the duration of hospital stay is also lesser. Even in terms of home isolation, just 10 per cent of the overall Covid-19 claims are for home isolation this time, compared to 25 per cent at the peak of the second wave," Nerurkar said.

Fewer other claims as well

However, this time around too, claims for other hospitalisations have come down as people may be postponing elective and non-urgent procedures. These claims have come down by almost nine per cent, he added.

According to Satish Gidugu, CEO and Whole Time Director, MediAssist Healthcare Services, Covid related claims had begun to stabilise in the October to December 2021 quarter and amounted to just three to four per cent of the total claims compared to a peak of 70 to 80 per cent in the second wave.

Milder cases

"In the third wave, we do see volumes with about 11 per cent to 12 per cent of our claims coming from Covid but there is much lesser severity, nor is there a crisis like situation as in the second wave," he said. Both the duration of stay and average claim amount was lower in the third wave for the hospitalisation cases facilitated by MediAssist.

In January 2022, the average claim size for a Covid-related hospitalisation was ₹93,000 and the duration of the stay was six days, according to MediAssist for its cases. In contrast, in May 2021, the average claim size for Covid related cases was ₹1.27 lakh and the duration of hospitalisation was 8.9 days. Average hospital stay rose to 10 days in June and peaked at 10.3 days in July 2021 for the company while the average claim size peaked at ₹1.63 lakh in September 2021.

In all, insurance companies have received health insurance claims of over ₹36,000 crore from the start of the Covid-19 pandemic to the beginning of February this year.

(The writer is Surabhi.)

TOP

Why health insurance is a must for some – The Hindu Business Line – 12th February 2022

Health insurance is purchased to hedge health risks which can affect anyone. But certain groups of individuals, irrespective of their current fitness and health, stand to gain a lot by investing in a suitable health insurance. These include those with a family history of susceptibility to certain ailments, women of childbearing age, individuals residing in zones of frequent communicable diseases, and frequent fliers or those in occupations with a higher propensity for disease exposure. These groups can derive maximum benefit by choosing the right insurance product. And as with any insurance product, the earlier the

purchase the higher the benefits that accrue. The benefit can be further amplified by reaching for the right product or a right add-on, depending on the risk one is looking to hedge against. The list of ailments, chronic or acute, that have a genetic pre-disposition are growing by the day and now include, cardiac ailments, diabetes, and myriad oncological conditions which are the top three killers across countries. Individuals whose family history has evidence of such conditions are now able to financially insure themselves, if health insurance is purchased before the genetic dice is rolled. Pre-existing diseases (PED) are not covered for a period of two to four years across products, and this is the key hurdle for this group which must be overcome. When the policyholder gets affected with any ailment still in the waiting period, he/she misses the prime benefits of insurance.

A few policies offer lower waiting periods of one to two years or others which offer buyback of the waiting period. These can be priced significantly higher (70-80 percent) along with tougher underwriting (pre-issuance medical checkup). Buying insurance earlier to complete the waiting period and get coverage at attractive rates is critical (and not just advantageous) for this group. Plans are also available for cancer and heart ailment survivors providing day one coverage (30 day waiting period) but will cost 4-5 times the regular insurance with four-year PED waiting. The average sum assured in health insurance across products - ₹5 lakh, may be insufficient in some specific risks for instance oncological ones. Increasing the sum assured is not proportionally expensive but will still be on the higher side. Few policies are offering ₹50 lakh – ₹1 crore at 30-40 percent higher premium compared to ₹5 lakh sum insured. Policyholders also have the option of choosing benefits plans. These plans payout the entire sum insured on being diagnosed with specific critical ailments and terminate the policy, allowing for discretionary spending by the policyholder.

Depending on location and season, various regions in India witness sudden surge in diseases, for instance Malaria, Dengue or Chikungunya. Residents of such regions should hold insurance with emphasis on outpatient (OPD) coverage, in addition to in-patient focused health insurance. Hospitalization charges are well covered with most health insurance, but out-patient charges slip through the net, which can be a significant amount in any year. But most insurance providers are now recognizing the gap in service and providing OPD cover as part of the basic policy or as an add-on. ICICI Lombard's BeFit, Reliance General Insurance's Digital Care, or other policies cover OPD charges ranging from ₹1,000 to ₹10,000 per annum at a cost of ₹300 to ₹3,000 for the add-on or with charges included in the basic policy. OPD covers are also being paired with tele-medical consultations and yearly check-ups which further improve the functionality of the cover.

Hazardous occupations find tough underwriting standards and may not be insurable. But occupations which involve significant travel are fortunately insurable, even as the risk of exposure to any disease is on the higher side compared to regular occupations. The ideal policy for such policyholders would be the one with the highest network of cashless hospitals. Procedures in hometowns can be financed out of hand and later reimbursed, the same comfort may not be available for policyholders who are hospitalized while on the go. The problems faced while travelling gets more complex if international destinations are involved. While travel insurance addresses a wide basket of exigencies, health insurance purchased domestically with international cover would be an ideal back-up. ManipalCigna Lifetime Health plan covers 27 critical illnesses when abroad, and Aditya Birla's Activ Health Plan covers 16 major illness, in a cashless manner abroad. Policyholders must opt for higher amount, upwards of ₹1 crore to meaningfully cover health emergencies while abroad.

Most health insurance may not provide maternity cover as part of the basic policy and may need careful reading of terms to ensure the same is covered along with the relevant waiting periods. Group policies offered by employers start coverage very early compared to individual policies. Sub-limits, which limit the compensation to specific procedures, should also be checked for suitability. For instance, for normal

coverage Star Health's Young Star Gold plan, Tata AIG's Medicare premiere plan and Future Generali's ProHealth Plus plans offer maternity cover for ₹30,000-50,000 per instance with waiting period in the range of 2-4 years. Policyholders who desire an extra level of protection including for the new-born can look for such specific policies.

For instance, Bajaj Allianz's maternity specific plans - Health Supreme covers pre & post-natal hospitalization, medical expenses for the treatment of the newborn, and mandatory vaccinations for a period of 90 days. Most family floater plans will include provision to include the newborn on intimations within 90 days of the being born. Depending on an individual's priorities in insuring against health risks, the plethora of product options can be scanned and a suitable product can be arrived at. Group insurance offered by employers provides a wide mix of options and starts from Day-1. But for further customization, an individual health policy may be required.

(The writer is Sai Prabhakar Yadavalli.)

TOP

MOTOR INSURANCE

Top reasons why two-wheeler insurance claims get rejected - The Hindu business line – 16th February 2022

Rejection of motor insurance claims is the follow-on blow after the initial accident. The reasons for rejection can be myriad, some obvious and others hidden under the hood. For instance, a claim can be rejected for failure to transfer the ownership of the vehicle. In the event of an accident or theft, it is important to notify the insurance company at the earliest. Though the actual time duration may vary from company to company, most insurers prefer claims to be notified within 24-48 hours. Delay in doing so may result in a rejection of the claim, as the insurance company may question the claim's legitimacy. Vehicle modifications are illegal in India.

Despite this, many two-wheelers tend to modify their vehicles. Certain modifications can even affect the ride quality and safety of the riders. In such cases, insurance companies are most likely to reject claims. Any vehicle registered as private should never be used for commercial use. In case of an accident f, the insurance firms have the right to reject the claims citing violation of the policy's terms and conditions. A user also must note some obvious conditions for getting the claim.

It is important to pay your renewal premium on time to keep it active. In case of failing to do so, the policy will lapse and loose coverage. The insurance company also has the right to reject the claim if the person does not possess a valid driving license or found drunken while driving. They also have the right to reject the claims for foul play if found during their investigation.

(The writer is Abhishek Misra.)

TOP

CROP INSURANCE

Centre to reach out to 1 crore Fasal Bima policy-holder farmers - The Hindu Business Line – 17th February 2022

In an attempt to create more awareness among farmers about the flagship Pradhan Mantri Fasal Bima Yojana (PMFBY), the Centre has decided to launch a massive drive of reaching out to nearly 1 crore enrolled farmers physically and distributing them the policy papers of current rabi season. The nationwide programme to be launched at a function in Indore, Madhya Pradesh by Union Agriculture Minister Narendra Singh Tomar from February 26, is banking on States' active participation for the success.

The Ministry has written to all the 20 participating States where PMFBY is operational to coordinate with insurance companies for the "door to door" delivery programme, an official said. There are an estimated 98.65 lakh farmers who have been enrolled under PMFBY during current Rabi season in 19 States. Karnataka is yet to submit data. Out of 3.30 crore applications from these farmers, 73.5 percent are loanee and remaining 26.5 percent non-loanee. For the non-loanee farmers, the Centre has left it to the States to decide if they should be covered under the programme or not.

"Non-loanee farmers generally get themselves enrolled through common service centres (CSCs) and get the receipt from there. They may not feel the requirement. Whereas most of the loanee farmers do not possess any documentary proof of their enrollment since it is done through the lending banks," the official said. The Centre has also allowed States to take a call on whether to reach out to places where a handful of enrolled farmers stay after insurance companies raised some logistics issues in arranging the programmes.

The government has published a format of document in which the policy paper should be submitted where a message from Tomar and also a message from chief minister/agriculture minister of State will be placed. The Centre has suggested to the States to invite gram panchayat members, ground level State government officials of related departments, local eminent personalities, farmer producer organisations, Krishi Vigyan Kendras to the meeting where the policy papers will delivered. The Centre also has asked States to disseminate about natural farming and adoption of drone technology in agriculture through these meetings.

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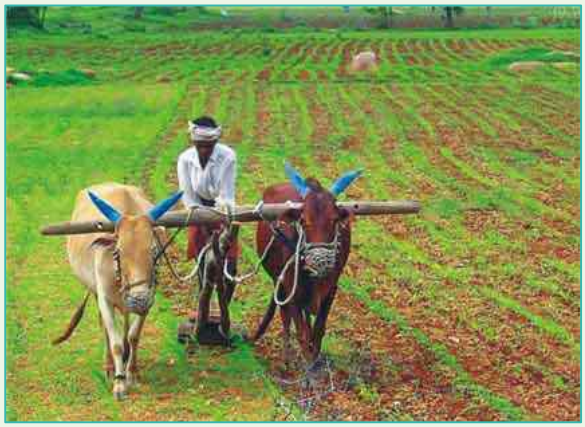
Fixing farm insurance - Business Standard – 17th February 2022



The woes of the government's flagship crop insurance scheme — the Pradhan Mantri Fasal Bima Yojana (PMFBY) — seem to persist despite a slew of modifications in the format since its launch in 2016. Six states have exited from it and now Maharashtra has also indicated that it might do so because the farmers are, by and large, dissatisfied with it.

The leading agricultural state, Punjab, never joined it. Those that tried it and opted to quit include Gujarat and Bihar, both run by the National Democratic Alliance, besides other states like Andhra Pradesh, Telangana, Jharkhand, and West Bengal.

The states generally find the financial burden of running the PMFBY hard to sustain even though the Centre shares 50 percent of it. A sizable part of their agricultural budget goes into paying premium subsidies and meeting other administrative expenses. Insurance companies, on the other hand, find agricultural insurance an inherently unattractive business. The risks involved are too high, thanks to

farming being a wholly outdoor activity, open to all kinds of natural hazards and attacks by diseases, pests, and stray animals. Claims are generally far higher than the premium collected by insurance companies. Besides, the compensation computed by insurers is often disputed by the beneficiaries.

The farmers, too, are not keen to take insurance cover for their crops because they do not deem it financially rewarding. The claims sought by them are most often rejected by the insurers and, if accepted, the payment is usually too meagre and inordinately delayed. Even in the recent event where the Madhya Pradesh chief minister chose to hold a public function to disburse PMFBY claims worth over Rs 7,600 crore, sending the money directly to the farmers' bank accounts, the payment was actually due for over 16 months.

Farm insurance has, indeed, been beset with problems ever since it was first introduced in 1972. None of the dozen-odd schemes and insurance models tried and tested till now has proved successful. The PMFBY is no exception. It underwent a thorough revamp in 2020, when it was made voluntary for the farmers, instead of being mandatory for those taking bank loans.

Trust deficit has been the biggest issue affecting the credibility of insurance as a means of hedging production risks in agriculture. This, in turn, is attributable to lack of transparency and a time lag in undertaking crop-cutting experiments to assess crop damage, the inadequacy of site-specific past data on crop yields to serve as a benchmark for computing losses, delays in paying states' share of premium subsidy to the insurance companies, and procedural complications.

Unsurprisingly, therefore, the area covered under the PMFBY has seldom exceeded 30 percent of the total cropland, against the government's target of extending it to a 50 percent area. Fortunately, the government is not unaware of all this. The parliamentary standing committee on agriculture, which probed the PMFBY, highlighted many of these issues in its report presented in August last year.

The government is now said to have set up a working group to revisit this scheme and suggest the needed changes. But what is really required is to recast the scheme afresh in a manner as to ensure adequate compensation for the losses and timely payment to the farmers. Otherwise, the objective of hedging the farmers' production-related risks would remain unmet.

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INSURANCE CASES

No disowning of claim by insurance company merely on delay in informing of vehicle theft: Supreme Court – Deccan Herald – 11th February 2022

The Supreme Court on Friday declared that the insurance company cannot repudiate the claim merely on the ground that there was a delay in intimating it about theft of a vehicle.

A bench of Justices Sanjiv Khanna and Bela M Trivedi set aside an order by the National Consumer Disputes Redressal Commission passed on a plea by the Oriental Insurance Company Ltd against the direction to pay the insured sum to Jaina Construction Company Limited with regard to theft of Tata Aiwa Truck.

The top court held that the order by the NCDRC was "erroneous".

Irregularity by bank employees should not be dealt leniently: SC

"When the complainant lodged the FIR immediately after the theft, and when the police after the investigation arrested the accused and also filed challan before the concerned Court, and when the claim

of the insured was not found to be not genuine, the insurance company could not have repudiated the claim merely on the ground that there was a delay in intimating it about the theft," the bench said. In the case, the insurance company disowned the liability on the claim, saying there was a breach of condition number one of the policy which mandated immediate notice to the insurer of the accidental loss or damage, and that the complainant had intimated about the theft after the lapse of more than five months.

The district consumer forum allowed the plea by the complainant of the insured amount with Rs 10,000 compensation and Rs 5,000 litigation expenses. The State Commission dismissed the appeal by the insurance company, forcing it to approach the NCDRC.

(The writer is Ashish Tripathi.)

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PENSION

EPFO to take call on interest rate for 2021-22 in March – The Tribune – 13th February 2022

EPFO's apex decision-making body Central Board of Trustee will take a call on interest rate on employees' provident fund deposits for 2021-22 in its meeting next month.

"The Employees' Provident Fund Organisation (EPFO) CBT meeting will be held in Guwahati in March where proposal for interest rate for 2021-22 would be listed as it is end of the fiscal year," Union Labour Minister Bhupender Yadav told PTI when asked about EPF interest rate for 2021-22.

Asked whether EPFO would maintain the 8.5 per cent interest rate for 2021-22 as decided for 2020-21, Yadav, who also heads the CBT, said the decision would be taken on the basis of income projection for the financial year. The 8.5 per cent interest rate on EPF deposits for 2020-21 was decided by the Central Board of Trustees (CBT) in March 2021.

It was ratified by the finance ministry in October 2021 and thereafter, EPFO issued directions to field offices to credit the interest income at 8.5 per cent for 2020-21 into the subscribers' account. Once CBT decides an interest rate on EPF deposits for a fiscal year, it is sent to Ministry of Finance for concurrence.

EPFO provides the rate of interest only after it is ratified by the government through the finance ministry. In March 2020, EPFO had lowered interest rate on provident fund deposits to a seven-year low of 8.5 per cent for 2019-20, from 8.65 per cent provided for 2018-19. The EPF interest rate provided for 2019-20 was the lowest since 2012-13, when it was brought down to 8.5 per cent.

EPFO had provided 8.65 per cent interest rate to its subscribers in 2016-17 and 8.55 per cent in 2017-18. The rate of interest was slightly higher at 8.8 per cent in 2015-16. It had given 8.75 per cent rate of interest in 2013-14 as well as in 2014-15, higher than 8.5 per cent for 2012-13. The rate of interest was 8.25 per cent on provident fund in 2011-12.

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IRDAI CIRCULARS

Topic	*Reference*
Gross premium underwritten by non-life insurers within India (segment wise),January, 2022	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4646&flag=1
Proposed amendments to IRDAI (Health Insurance) Regulations, 2016	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4645&flag=1
Review of Articles of Association (AOA) of Indian Institute of Insurance Surveyors and Loss Assessors (IIISLA)	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4644&flag=1

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GLOBAL NEWS

Indonesia: Regulator orders that charges and fees on investment-linked plans be made clear – Asia Insurance Review

The Financial Services Authority (OJK) yesterday said that fees and charges attached to unit-linked insurance plans (ULIPs) must be included in the illustrations and the insurance policies for such products.

The regulator urged the financial services industry to remind consumers that they have to understand ULIPs, including the costs, before buying such plans. Insurance companies provide a cooling-off period for customers to study the details of the ULIPs before a sale is confirmed. During the period, customers can cancel the insurance agreement.

"Ask the insurance company or marketing agent if there are still things that are not clear," the OJK said on its official Instagram account.

The OJK has been issuing advisories to customers because of disputes between insurance companies and disgruntled policyholders who found they have lost money on ULIPs.

List
The following is a list of fees and charges related to ULIPs as summarised by the OJK:
1. Insurance fee
Charge in connection with the coverage provided by the insurance company. The fee varies depending on age, gender, sum assured, and other risks.

2. Acquisition cost of policy
Medical examination costs, policy procurement and document printing costs, remuneration/commission for employees and agents.

In general, the acquisition cost is charged to the basic premium in the first year to the fifth year of the policy.

3. Administration fee
Fees charged for administration of ULIPs.

4. Fund management fees
Fees charged for the management of investment funds.

5. Cost of switching funds
Fees charged when there is a transfer of investment fund allocation made by the policyholder.

6. Withdrawal fee
Fees charged when consumers make partial withdrawals of funds in the initial year of participation.

7. Top-up fee
Fees charged when consumers make additional premium payments to increase the investment value (also known as top-up premium).

8. Policy termination/redemption fee
The fee charged on the investment value if the consumer terminates/redeems the ULIP before the allowed date.

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