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QUOTE OF THE WEEK

"The distance between insanity and genius is measured only by success."

Bruce Feirstein

INSIDE THE ISSUE

Insurance Industry	2
Insurance Regulation	4
Life Insurance	7
General Insurance	15
Health Insurance	24
Crop Insurance	34
Insurance cases	35
Pension	38
IRDAI Circular	41
Global News	41

INSURANCE TERM FOR THE WEEK

Restore

'Restore' is an option (usually built-in) in a health policy by certain insurers such as Apollo Munich, HDFC Ergo and Max Bupa.

Restore feature ensures that a policyholder has adequate coverage even after his/her sum insured is exhausted.

That is, if you utilise your sum insured, fully or partially, it will be restored back to your policy.

For instance, if you have a health policy with restore feature for ₹7 lakh and you happen to utilise the entire amount, the entire sum insured of ₹7 lakh will be restored. In case of partial exhaustion, the sum insured will be restored to the extent of incurred claims.

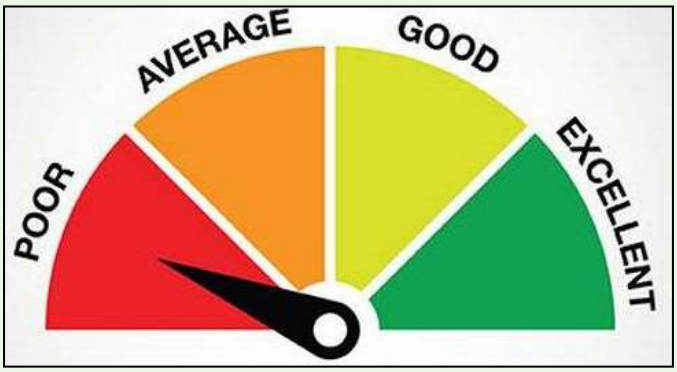
Note that, you can use the restore feature for future claims and not against any claim for an illness for which a claim has been paid in the current policy year. Generally, the restore option is available only once a (policy) year.

In general, policies with restore features are priced little higher than the other health insurance products.

Source

INSURANCE INDUSTRY

Insurers find it hard to offload downgraded paper of NBFCs - The Hindu Business Line – 15th May 2019



Faced with a spate of rating downgrades of non-banking financial companies (NBFCs), insurers seem to be in for difficult times.

Downgraded paper

Insurers are finding it difficult to offload downgraded paper of NBFCs and said it is unlikely the Insurance Regulatory and Development Authority of India (IRDAI) will give a special exemption for holding on to it.

"It's bad news. Insurance companies are big buyers of such paper. Everyone wants to exit but no one wants to buy it," said the CEO of an insurance company, adding that the IRDAI is very clear about its investment norms.

"If the rating does not meet the norms, then it does not qualify. So, insurers have to basically exit them and make provisions," he said.

An executive with another insurance company said that as of now many insurers are still holding on to the downgraded paper. "There is no market for the paper. Insurers may have to hold them to maturity," he said, pointing out that even in the case of Tata Sons, which turned into a private firm, many insurers are still holding on to the company's paper as they find it difficult to sell it.

"But how much provision can we make," he noted. IRDAI norms stipulate that insurers must invest at least 95 per cent of the funds in A+ rated instrument.

For ULIP funds, at least 75 per cent has to be invested in AAA-rated papers. Rating agency ICRA had said the aggregate volume of debt it downgraded last fiscal stood at ₹3.2-lakh crore in 2018-19.

Turmoil in sector

This has been followed by further downgrades of Reliance Home Finance, Reliance Commercial Finance, and PNB Housing Finance in recent weeks. Rating agencies have also warned of continuing turmoil in the sector.

However, while insurers have been closely monitoring their investments in NBFCs, there have been only a few cases of defaults. "Even in cases where the ratings of NBFCs have been downgraded such as DHFL, redemptions have been happening on time," noted the first executive.

IL&FS defaults

IRDAI has already asked insurers to make provisions for defaults by debt-ridden Infrastructure Leasing and Financial Services and its entities, as well as the two Reliance Capital arms that were downgraded recently.

IRDAI Chairman Subhash Chandra Khuntia had, in March this year, urged insurers to use their judgment while making investments and not go by ratings alone. He had also asked them to keep in mind the interest of policyholders and not pull out of investments because of a change in ratings.

TOP

Source

'Insurers slow to invest in safety' – The Hindu – 14th May 2019

Policyholders are increasingly concerned that their insurance coverage has become insufficient for emerging risks from cybersecurity to environmental threats, according to the World Insurance Report 2019 published by Capgemini and Efma.

The report identified five macro trends — disruptive environmental patterns, technological advancements, evolving social and demographic trends, new medical and health concerns, and business environment changes — that are creating emerging risks for insurance customers and their businesses. Yet, most insurers have been slow to respond to these trends and equip customers for them, stated the report, which studied 28 markets, including India.

Under 25% of business customers across all geographies, and less than 15% of personal policyholders, feel they have sufficient coverage to insure against any one of the emerging risks driven by these macro trends. Fewer than 40% of life and health insurers said they have built a pipeline of new products to cover emerging risks comprehensively.

As per the report, 83% of personal insurance customers have medium or high exposure to cyberattacks and to outliving their savings, yet just 3% and 5% respectively are comprehensively covered against these eventualities.

Staff healthcare cost

Among business customers, 81% are exposed to escalating employee healthcare costs against which just 17% are well covered; 87% are at risk of cyberattacks with less than 18% comprehensively insured; and almost 75% are threatened by rising natural catastrophes, for which just 22% are effectively covered, found the study.

The report further said, as the insurance landscape shifts, customers were showing greater readiness for change than their insurance providers.

Over half (55%) of customers said they are ready to explore new insurance models, but barely a quarter (26%) of insurers are investing in them.

While 37% of customers said they are highly willing to share additional data in return for improved risk control and prevention services, only 27% of insurers have the capability to tap real-time data for risk modelling purposes.

Risk assessment capabilities can be significantly enhanced through deployment of machine learning, artificial intelligence and advanced analytics, and effective collaboration with tech providers. However, progress in these areas has been mixed: a majority (57%) have leveraged AI, machine learning and advanced analytics, but only 29% have implemented automated risk assessment, and just 20% real-time insight generation from IoT devices, it explained.

Anirban Bose, CEO, financial services, Capgemini and member of the group executive board said, "Technological progress also needs to be matched by a shift in attitudes. Where insurers have traditionally seen themselves as a payer, they need to evolve into the parallel roles of partner and preventer, working more closely with customers to mitigate risks and provide on-demand services."

The report covered all the three broad insurance segments: life, non-life, and health insurance and gathered insights from 28 global markets including India.

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Source

INSURANCE REGULATION

Genetic diseases, mental illness cannot be excluded from health insurance coverage: IRDAI – Moneycontrol – 16th May 2019

The insurance regulator has said genetic disorders, menopause, mental illnesses among several such health issues cannot be excluded from health insurance coverage. As part of an exposure draft on the standardisation of exclusions, Insurance Regulatory and Development Authority of India (IRDAI) said any disease contracted after taking the policy also have to be mandatorily covered.

All existing health insurance products that are not in compliance with these rules have to be withdrawn by April 1, 2020.

Puberty and menopause-related disorders including menopausal bleeding or flushing will be covered by health insurance plans.

Legally, insurance companies were required to provide covers to individuals battling mental illnesses. However, insurers were still very selective in offering such covers. Now, IRDAI has said the treatment of mental illness, stress or psychological disorders and neurodegenerative disorders will have to be covered.

Among other things, the use of drugs/anti-depressants prescribed by a medical practitioner would also be part of health insurance coverage. Similarly, failure to seek or follow medical advice or failure to follow treatment cannot be used as a clause to deny medical insurance.

In case of artificial life maintenance, including the use of life support machines, IRDAI said that expenses up to the date of confirmation by the treating doctor that the patient is in a vegetative state will be covered. Also, oral chemotherapy and robotic surgeries will be covered by insurance.

However, among the things that will continue to be excluded are pre-existing diseases (with a maximum waiting period of two years before a claim is filed), diagnostic tests, infertility treatment, weight control surgeries or plastic surgery.

The waiting period for lifestyle conditions like hypertension, diabetes and cardiac conditions is not allowed for more than 30 days except if these diseases are pre-existing and disclosed while buying a policy.

Similarly, expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, like rock climbing, mountaineering, scuba diving among others, will not be covered.

IRDAI has also identified a set of illnesses that can be permanently excluded from coverage. Some of these include Epilepsy, Hepatitis B, Alzheimer's disease and Parkinson's disease, chronic liver and kidney diseases and HIV/AIDS among others.

After completion of eight continuous years under the policy, no insurance policy claim can be contested except if there is a proven case of fraud.

TOP

Source

Government should allow Aadhaar for insurance KYC: IRDAI chairman – Mint – 16th May 2019

The Insurance Regulatory and Development Authority of India (IRDAI) plans to lobby the government to allow use of Aadhaar to make online know-your-customer (KYC) process simple and quick for insurers and policyholders, said IRDAI chairman Subhash Chandra Khuntia on the sidelines of *Mint Insurance Conclave* in Mumbai.

"KYC is one area we are taking up with the government, to use Aadhaar as a kind of KYC for the insurance sector," said Khuntia. "The insurance companies and the insurtech companies need to use simple KYC so they do not spend too much time. Customers also do not have to wait for too long before they get the product. This is something which will help in doing that," he said.

Presently, all private companies, including insurers, are barred by the Supreme Court from seeking a person's Aadhaar number to complete the e-KYC process. The apex court judgement, which came last year, had hit banks and online payment platforms which were using the Aadhaar number as a single step, low-cost model for furnishing KYC details of their customers.

Along with steps to ease the KYC process, Khuntia also urged insurers to collectively focus on loss reduction by use of technology for data collection and better risk underwriting. "That way, the premium for policyholders can also go down and we will live in a better society," he said.

But the process of gathering details of customer behaviour for better underwriting, he said, should not happen on an individual basis. The insurance regulator discourages companies from having differential pricing for health and life insurance products based on each individual's data, as this goes against the idea of risk pooling in insurance, which allows risk to be spread across a group of people to insure those who suffer loss, damage, illness, or death.

"If the information about every individual is known completely from all aspects, then finally it will not be resulting in any insurance because the risk of each individual will be known. Then the individual with the highest risk will have to pay high premium and insurance will become unaffordable to that individual," he

said. The segregation of policyholders on this basis should stop at some point, otherwise the purpose of insurance will be lost, he said.

IRDAI also plans to implement risk-based supervision for insurers which means that insurers with lower risk will be regulated less. "We would like to intensify supervision where the risk is more and reduce it where the risk is low," he said. The insurance regulator also plans to implement risk based capital regime, which would allow insurers to maintain solvency capital relative to their risks. Presently, all insurers are required to maintain a compulsory solvency margin of 1.5 times their liabilities.

In the aftermath of cyclone Fani, which claimed 34 lives and damaged 5 lakh houses, the regulator asked companies to brace for insuring climate change. Besides that, insurers need to adapt quickly to changes and develop new processes for assessing emerging risks such as cyber-security, liability and driverless cars, he said.

(The writer is Ridhima Saxena.)

TOP

Source

After three-year hiatus, IRDAI to again nudge insurers towards listing – Moneycontrol – 15th May 2019

After a three-year hiatus, the insurance regulator is planning to nudge companies in the sector to be listed on the stock exchanges. Sources said that the regulator will engage in discussions with companies over the next few months to bring out necessary guidelines for the process.

While the proposal was first mooted in September 2015, it was later withdrawn after stiff opposition from insurance companies.

"Listing of insurance companies with 10-12 years of business experience will be beneficial and also help to bring additional capital to the sector," said an official. It is likely that it could start off with life insurers and then move to general insurers.

According to Insurance Regulatory and Development Authority of India (IRDAI) norms, a company has to be in the insurance business for 10 years to be eligible to list on the equity market. The regulator considers the financial performance, capital structure after offer and solvency margin, among other factors, to give its approval.

Sources also said that insurance companies with assets under management (AUMs) of above Rs 50,000 crore could be nudged to go to the IPO path. Aditya Birla Sun Life, Max Life, SBI General and IDBI Federal Life are some of the companies who will be eligible to go for a listing.

The 2015 proposal

In the 2015, exposure draft 'Issuance of Capital by Indian Insurance Companies transacting Life Insurance Business', IRDAI had said that it had powers to push insurers to list. Such a company has to, within a period of one year from the date of such direction, comply with the direction issued.

"The authority might direct an Indian insurance company transacting in the life insurance business to go for a public issue if the circumstance so warrants," IRDAI had said in the exposure draft.

Following this, there were a series of discussions between the insurance companies and the regulator. Insurers expressed concerns about being forced to list. Hence, the proposal was sent to cold storage.

The regulator now plans to restart the process, and will have meetings over the next few weeks and then an exposure draft will be drafted by July.

Parity with banks

Banks are required to list within three years of starting operations. In insurance, however, the gestation period is longer. Insurers companies, on an average, take seven to eight years to break-even and achieve profitability.

While the idea here is to ensure that financial institutions have similar rules when it comes to listing on the exchanges, insurers will be given a much longer period to go for an initial public offering.

(The writer is M Saraswathy.)

TOP

Source

IRDAI directs insurers to settle claims fast in Cyclone Fani-affected areas – Financial Express – 10th May 2019

The Insurance Regulatory and Development Authority of India (IRDAI), the insurance sector regulator, has issued guidelines to make the claim process easier for the policyholders, in the aftermath of Cyclone Fani. The regulator has directed insurers to take additional steps for ensuring registration of all claims and also provide quick settlement of eligible cases, especially in the cyclone-hit areas of Odisha and neighboring states.

IRDAI has directed all the life insurers to extend every possible facilitation in quick and timely settlement of life insurance claims, has advised taking immediate actions. The insurance companies have been asked to initiate immediate action to ensure that all the reported claims are registered and eligible claims are settled expeditiously. The insurers should have a suitably simplified process, including relaxations in the usual requirements wherever feasible, to expedite the claims settlement.

IRDAI has asked insurers to simplify the registration and claim-settlement procedures and follow the same process as the one used after the Chennai floods in 2015. The regulator said, "With regards to claims involving loss of life, where the difficulty is experienced in obtaining a death certificate due to non-recovery of body, etc., the process followed in the case of 2015 Chennai floods may be considered."

Cyclone Fani has resulted in an immense loss to property and lives. Post the directive by IRDAI, life insurance companies have set up a special helpdesk to service the beneficiaries of policyholders affected by the cyclone Fani in Odisha. Various life insurance companies have already taken initiative towards the same, whereas some are planning to do so. Initiatives among others include special claims helpdesk for claims arising out of Cyclone Fani.

Aalok Bhan, Director and Chief Marketing Officer, Max Life Insurance, said, "We have set up a Special Claims Helpdesk for those customers affected by the devastating cyclone Fani in Orissa and West Bengal. We are expediting the settlement process for death claims arising out of the disaster." He added, "Generally, in times of a crisis, a customer may not know how and where to get in touch with an insurance company for a claims process and hence the dedicated toll-free numbers, as well as email IDs through which a claim can be registered, have been brought in."

For a quick settlement of claims, insurance companies have also simplified claim documentation requirements. "With the set up of special Claims Help Desk, we have also appointed nodal officers for rendering pro-active services to the beneficiaries of the affected policyholders. The process of claim documentation has also been simplified in order to expedite the claim settlements quickly", said Anoop Pabby, MD and CEO, DHFL Pramerica Life Insurance.

Documents required to process a claim faster include Municipal Death Certificate or Death Certified by any competent Government authority like Local Government of Odisha or Armed Forces or Government Hospitals or Police Authority, completely filled Death Claim Form, claimant ID, residence proof and bank account details to ensure claims are paid to correct beneficiary.

(The writer is Priyadarshini Maji.)

TOP

Source

LIFE INSURANCE

Pradhan Mantri Suraksha Bima Yojana: Why to enroll, renew before May 31; Download PMSBY form - Financial Express – 16th May 2019

Risks are omnipresent and its always better to cover them from all corners. In addition to life cover and medical insurance, one may also buy an accidental insurance policy for more exhaustive protection. Among the various schemes offered by the government for social benefits, Pradhan Mantri Suraksha Bima Yojana (PMSBY) is one such scheme offering insurance against accidental death and disability.

PMSBY is an Accident Insurance Scheme offering accidental death and disability cover for death or disability on account of an accident. Death due to natural reasons such as heart attack etc will not be covered. It is a one-year cover and may be renewed each year.

The eligibility conditions are simple as all those between the age of 18 and 70 years with a bank account can enroll in the scheme. In case of multiple bank accounts held by an individual in one or different banks, the person would be eligible to join the scheme through one bank account only.

It is compulsory to give consent to join or enable the auto-debit in the bank account while joining the scheme. The premium of Rs. 12 per annum (including GST) is deducted from the bank account of the insured through 'auto-debit' facility in one installment.

For renewal of the policy, the required premium will be auto-debited generally between May 25 and May 31, unless the account holder has given a cancellation request to the bank for the policy.

The coverage period of PMSBY is from 1st June to 31st May each year. Therefore, if one wants to continue with the scheme, the renewal premium is to be paid in the month of May each year. PMSBY is an annually renewable scheme.

For those who wish to join the scheme now, here is the link to download PMSBY form. (https://www.jansuraksha.gov.in/forms-pmsby.aspx)

The risk coverage under the scheme is Rs.2 lakh for accidental death and full disability and Rs.1 lakh for partial disability. Claim settlement will be made to the bank account of the insured or his nominee in case of death of the account holder.

Death: Rs 2 lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of one hand or one foot: Rs 1 lakh

Total and irrecoverable loss of sight of one eye or loss of use of one hand or one foot: Rs 1 lakh

To avail the benefits of PMSBY, one need to approach any of the public sector general insurance companies and other private general insurance as well which would need to have a tie-up with the banks. One may enroll by filling the prescribed form and submitting in the bank where the account is held. Some banks have also initiated enrollment through net banking or mobile banking.

If you are not holding an accidental and disability cover separately, get one. Additionally, getting PMSBY will help you in enhancing your total coverage.

(The writer is Sunil Dhawan.)

TOP

Source

Critical factors that may get your life insurance claim rejected: Here is how to ensure your nominees get their dues -Financial Express – 16th May 2019

For many years, Aditi saw her husband, Gautam, regularly pay a sizable sum of money as insurance premium for a life insurance policy to ensure his family's financial security in case of his untimely death. Aditi's worst fears came true when Gautam did not return home one night from an office party. While driving back, Gautam had met with an accident leading to his death.

Aditi was yet to come out of her grief when she was dealt with another major shock, this time by the insurance company when she lodged her claim for Rs. 1 crore sums insured under the term policy. The insurer rejected her claim as the police report of the accident said that on the fateful night Gautam was driving 'under the influence of alcohol', an important exclusion in the policy.

Aditi's is not an isolated case. Insurers often deny death benefits to nominees for various reasons. In most cases, however, Indian insurance companies pay the claims. In fact, Indian life insurance companies have a healthy claims settlement ratio (number of claims settled per 100 received), with many showing a ratio in the high 90s. However, policyholders should be aware of the many common reasons that could lead to a rejection of claim, leading to harassment and financial distress to the nominee or beneficiary when they are not around.

Here are some of the reasons:
Lapsation of policy: You must pay your policy premiums on time. Not doing so may lead to your policy lapsing. No claims will be paid against a lapsed policy.

Non-disclosure of facts: You must be honest while disclosing facts when you purchase a policy. Hiding important facts, such as pre-existing diseases like heart ailment, diabetes or cancer, or 'material misrepresentation' of things such as age or smoking habits can lead to claims denial.

Exclusions in play: Claims can be rejected since cause of death wasn't covered in the policy. Thus, death while driving under the influence of alcohol or drugs, death due to the participation in high-risk events (such as car or bike racing), death due to the pre-existing health condition or death due to participation in illegal activities. Death due to suicide is excluded under both individual and group insurance policies. However, in some cases, the insurance company will pay all the premiums paid by the policyholder until the date of death after deducting policy-related expenses.

Inadequate documentation: Death benefits can be rejected if policyholder's family or nominee is unable to provide necessary documentation to support the claim. This could be missing death certificate or original policy documents, ID proof of the beneficiary, discharge form (executed and witnessed), medical certificate (as proof of cause of death), police FIR and post-mortem report (in case of unnatural death), hospital records/certificate (if death is due to illness) or cremation certificate.

Death during contestability period: Insurance policies often include a 'contestability period' stipulating if policyholder dies within two years of purchasing the policy, the insurer can contest or question the claim. During this period, the company can cancel the coverage and return the premium if they believe the policyholder has withheld crucial information or has deliberately lied. So, when you purchase a policy, check whether death during this period will be an issue.

Failure to update nominee details: You should keep your insurer updated on nominee details such like name, age, address and relationship with policyholder and any change should be communicated immediately. If nominee dies during the policy term, change in nominee should be updated immediately. There are no restrictions on the number of times nominee details can be changed.

No beneficiary mentioned: Choosing the beneficiary for your life insurance money is a key step in purchasing a policy. Though nominee and beneficiary can be the same person, the former's duty is to apportion the money received to the beneficiaries mentioned. It may be apportioned as per Will of the person. Your primary beneficiary is first in line to receive the death benefits. If the primary beneficiary dies before you, a secondary or contingent beneficiary is next in line. Some people also designate a final beneficiary in the event the primary and secondary beneficiaries die before they do.

Steps to take if claim is rejected
If you are among the few beneficiaries whose life insurance claim is rejected, you would be wondering what to do now. The money that could have set your life back on track is now slipping out of hand! Here is what you should do now:
Approach the insurer: You should understand the exact reasons for rejection and if necessary lodge a complaint with it.

Escalate, if not satisfied: If response from the company is not satisfactory or no response is received within the set deadline decided by the insurer, you should escalate complaint to the company's grievance redressal head.

Knock at IRDAI doors: If your concerns are not addressed with 15 days, approach the Grievance Redressal Cell of the Consumer Affairs Department of Insurance Regulatory and Development Authority of India (IRDAI) at complaints@irda.gov.in. You can also use of IRDAI's online portal – Integrated Grievance Management System (IGMS) at igms.irda.gov.in to register and monitor your complaint.

Seek Ombudsman intervention: The Insurance Ombudsman is tasked with redressing grievances. In case a customer is not satisfied with the decision/resolution of the company, he or she may approach the Ombudsman if claim has been rejected or there is dispute or delay in claim settlement.

Take legal recourse: If none of the other remedies work, the complainant can approach the relevant Consumer Court under the Consumer Protection Act, 1986. In such a scenario, the consumer can plead in person before the court instead of seeking the services of an advocate.

(By Anshuman Verma is the Chief Marketing & Digital Officer at DHFL Pramerica Life Insurance)

TOP

Source

Pradhan Mantri Jeevan Jyoti BimaYojana: Why to buy, renew before May 31; Download PMJJBY form - Financial Express – 16th May 2019

Pradhan Mantri Jeevan Jyoti BimaYojana (PMJJBY) is a social benefit scheme launched on May 9, 2015, by the government. The PMJJBY scheme is a life cover for a fixed amount of Rs 2 lakh for an annual premium of Rs 330 and is available to people in the age group of 18 to 50 years having a bank account. The life cover will be available until the age of 55 years. The one-time payment towards the scheme has to be automatically debited from one's account. Therefore, one has to enable auto-debit while signing up for the scheme.

The life cover of Rs. 2 lakh shall be for the one year period starting from 1st June to 31st May every year.

The PMJJBY scheme is a yearly renewable scheme and to continue one has to give the consent to the banks in the month of May every year.

PMJJBY comes with risk coverage of Rs. 2 lakh in case of death of the insured, due to any reason. The premium is Rs. 330 per annum which is to be auto-debited in one installment from the subscriber's bank account on or before 31st May of each annual coverage period under the scheme. One, therefore, needs to ensure that the account has sufficient balance on the due date. If the bank account has become inoperative or there are not sufficient funds, the coverage will lapse. Those who exit the scheme may re-join later by furnishing a declaration of good health and paying the annual premium.

If the insurance cover is ceased due to any technical reasons such as the insufficient balance on the due date or due to any administrative issues, the same can be reinstated on receipt of appropriate premium subject, however, to the cover being treated as fresh and the 45 days lien clause being applicable.

The scheme is being offered by Life Insurance Corporation and all other life insurers who are willing to offer the product on similar terms with necessary approvals and tie up with banks for this purpose. For new enrolment, one can apply at the bank using the PMJJBY application form.

For those who wish to join the scheme now, here is the link for PMJJBY form download. (https://www.jansuraksha.gov.in/Forms-PMJJBY.aspx)

For the cover period 1st June 2019 to 31st May 2020, subscribers are required to enrol and give their auto-debit consent by 31st May 2019. As on 23.04.2018, gross enrolment reported by banks subject to verification of eligibility, etc was nearly 5.3382 crore, while the total number of claims received was about 100,881 and the total number of claims disbursed was nearly 92,089.

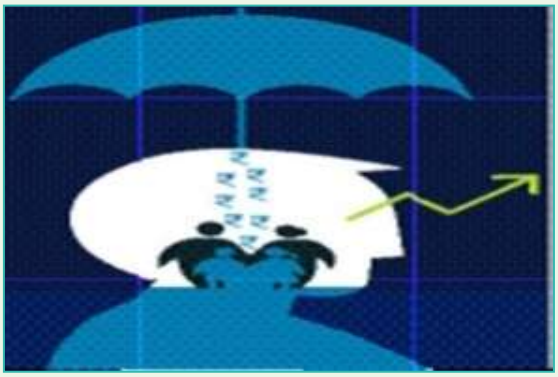
Even though the sum assured is very low, one may get it to supplement existing coverage. Ideally, as a thumb rule, one should have a life cover of at least ten times of one's annual take-home income.

(The writer is Sunil Dhawan.)

TOP

Source

Private sector life insurers see 18% growth in premium collections - Financial Express – 15th May 2019



Individual annual premium equivalent (APE) growth for private sector life insurance companies was up 18%, similar to March 2019. Almost all large players, except ICICI Prudential Life, up 2% year-on-year (y-o-y), reported over 15% YoY growth. HDFC Life, SBI Life and Max Life reported strong growth at 39%, 50% and 28% y-o-y, respectively. Surprisingly, LIC, that was weak for past three months, bounced back with 18% growth.

Private sector individual APE growth strong

Private sector players reported 18% y-o-y growth in individual APE in April 2019, gradually picking pace since November 2018. Overall industry growth and growth of LIC was a notch higher at 19% y-o-y.

HDFC Life reported strong 30% y-o-y increase in individual APE after witnessing muted growth since November 2018. Overall APE was better at 47%, as its group protection remained a segment of focus.

ICICI Prudential Life saw muted growth of 2% y-o-y in April 2019 in individual APE, down from 14% in March 2019. Average ticket size in individual non-single segment saw a marginal dip in April 2019. On considering overall (individual and group) adjusted APE including accrued but not received premium, its APE, according to a company release, was up 9% y-o-y.

SBI Life's individual APE growth was strong at 51% y-o-y in April 2019, on a low base. Notably, SBI Life had reported 11% y-o-y decline in April 2018 due to its focus on productivity and protection business. The overall business momentum picked up since December 2018. Current trends suggest that the company seems to getting back on its 30% plus APE growth trajectory; it would be crucial to see if this momentum can be sustained throughout FY2020E.

Max Life's growth in individual APE was strong at 28% y-o-y, higher than 15% growth in March 2019. The company has increased focus on unit-linked insurance plans (ULIPs) in recent quarters. Its ticket size in individual non-single segment was up 7% y-o-y, unlike other large players who were mostly flat. Additional investment in proprietary channels will further fuel growth.

Birla Sun Life reported 46% y-o-y growth in individual APE, higher than 33% growth in March 2019, as it continued to make inroads in HDFC Bank. Tata AIA was up 1.3 xs, higher than 50% growth observed in 4QFY19. In its earnings call, Birla Sun Life guided that it will continue to grow at a rapid pace within the bank though it may maintain FY2019 growth rates.

Net equity MF inflows dip

Mutual fund inflows to equities declined, with inflows at `20 billion in April 2019 as compared to `95 billion in March 2019, `44 billion-`66 billion in December 2018-February 2019 and `86 billion-`107 billion in the preceding six months. This is the lowest inflow since recent correction in equity markets.

Interestingly, systematic investment plans (SIPs) are broadly stable over the past few months at `80 billion-`82 billion; this meant that the non-SIP flows reported large net outflow. Liquid fund reported strong inflows at `898 billion post recording outflows (`0.2 trillion-`0.5 trillion) in the past two months.

TOP

Source

Should NRIs buy life insurance in India? - Dalal Street Investment Journal – 13th May 2019

Many of you may have started working in a foreign country and many have also settled there. However, when financial security of the family members is concerned, no one wishes to take any chance. Life insurance eases this task and helps you protect your family members financially.

Due to emotional attachment to the motherland, many NRIs wish to have something that connects them to India and insurance is one such thing. However, the question is whether you can buy insurance policies in India? Yes, FEMA (Foreign Exchange Management Act) allows you as an NRI to buy any insurance policy in India that fulfils your requirements.

How can NRI buy life insurance in India? Online would be a better option as you do not need to visit India to buy life insurance. You can directly buy it online after comparing the policies and send across the required documents to the insurance company in India. These days, insurance companies are accepting applications without medical check-ups, subject to certain terms and conditions. Payment of premium depends on the currency denoted in the policy document. If the currency denoted in the policy document is a foreign currency, then you have to make payments in foreign currency using your NRE or FCNR

account. If it is denoted in Indian rupees, then you have to make payment in rupees using your NRO account. The same applies to the payment of claims you would receive.

Is there any possibility of application getting rejected? Yes, if you reside in a high-risk country, then there is a possibility of your application getting rejected or the insurance company demanding higher premium. However, if you reside in a low-risk country, then your application can get accepted easily. High-risk country is a country which is more prone to issues related to civil disturbances or military conflict or has an unstable government with constant violent attacks taking place on its citizens, etc. On the contrary, low-risk country is a country where the civil environment is peaceful with a stable government having proper law and order in place.

Now, after understanding about buying life insurance in India, the question is whether you should buy one? It does not make any sense to buy a life insurance policy in India if you are an NRI. The reason being the premium. If we convert the premium charged from USD to INR by the insurance companies in the US, the premium charged for Rs 1.5 crore sum assured for a 40-year old male who is not a nicotine consumer comes to around Rs 980 per month, whereas all things being constant, the premium charged by the insurance companies in India comes to around Rs 1,500 per month. So, it makes a lot more sense to buy it in the foreign country where you reside. The example, though, considers only the US insurance companies' policies and premiums. However, if you are residing in a country other than the US, then it is recommended you compare the premiums charged by the insurance companies in the country you reside vis-a-vis India to get a better deal.

(The writer is Henil Shah.)

TOP

Source

Life insurance firms must take inputs from youngsters for customised products, here's why – Financial Express – 13th May 2019

So far as providing life insurance cover to more people is concerned, the performance of the industry has been disappointing as it appears from the IRDAI data released recently regarding the performance of the industry for the year 2018-19. The growth of new business premium (NBP) has been mere 10.73%. LIC is responsible for pulling down the industry average as the state-behemoth achieved only 5.68% growth in the NBP income for the whole year.

Elusive target

The reason is not far to trace. The growth in number of policies sold is just 1.7% and the industry has narrowly escaped a negative scenario in this regard. Sometimes I wonder why the untapped potentiality has been eluding the insurers. Unless and until life insurers together achieve 15-20% growth in sale of policies "providing insurance cover to all" will remain an elusive target.

With introduction of so much of technology, there is a need to reach out to a large number of people. Insurers are deciding on business strategies without the consumer involvement. Every year, LIC selling more and more single premium policies is nothing but chasing a mirage. They want to accomplish success through this route but when the year ends they find the success drifting away from them. The growth of total premium of the industry has been just 10.73% and LIC's market share in regular premium business dwindled down to 40%.

Service delivery

The 21st century life insurance market is not unidimensional. Involvement of the consumer in the marketing and service delivery systems is unavoidable. The demography is changing fast and as the prime minister says the challenge for every industry is to satisfy the aspirational generation. Thinking

that technology and the online selling platform would attract more and more young people to buy life insurance from the comfort of their home is causing myopia to the business strategists of the insurance companies.

There is no mutually beneficial connect between the insurers and the potential customers. While discussing the role of consumers in their book The Future of Competition Prahalad and Ramaswami argue that consumer roles are changing. They have said that earlier market was transaction oriented, then it became relationship oriented but the latest trend is to invite the consumers and take their opinion regarding product development and market communications. I think the life insurers are stuck at the first and second stage of marketing. They must bring innovation in developing products and add imagination in distribution of their products to the millenials of new India.

Life insurance is not merely for financial goals as most of the companies communicate with the market while advertising. The essential difference between life insurance and the mutual fund is that while the latter is driven by reason, the former is propelled by emotions. The decision to buy insurance is greatly influenced by emotional factors.

Life insurance is important for peace of mind. But between the consumer and the seller, in respect of this kind of product, technology can't be a motivator; technology can be a facilitator. Strangely, sellers of insurance have started believing that technology will give them business.

Shrinking LIC's market share

Shrinking of LIC's market share may not be a bad news for the industry; but slowing down of growth rate of LIC's new business both of policies and premium is definitely an alarming news. So long the private sector insurers were growing well but LIC had been growing at a much faster rate, neutralizing the impact of the private insurers on market share. But lately LIC's growth rate has suffered a setback.

LIC's strategy to focus on single premium product during last few years has eroded its hold on the market; resulting in slowing down in sales of the traditional and the regular mode products. So long when more and more companies offered the same product people decided to buy the policies from the company having strongest brand reputation. But the ability to reform is the need of the hour because the consumer profile is fast changing in our country.

For the insurance industry to succeed in India it is necessary that LIC succeeds; and for LIC to succeed it is necessary for the current generation of executives to recognise that the business landscapes keep changing and competition keeps unfolding many challenges.

(The writer, Kamalji Sahay is former MD & CEO, Star Union Dai-ichi Life Insurance)

TOP

Source

Decoding unit-linked insurance plans - Decoding unit-linked insurance plans – Mint – 12th May 2019

WHAT IS IT?

Unit-linked insurance plans or Ulips are products sold to you by insurers which area combination of a pure life insurance policy and a market linked investment product. "As the name suggests, Ulips are market linked. A part of the premium you pay to your insurer, certain portion gets allocated to equity or debt funds," said Dheeraj Sehgal, chief institutional business officer, Bajaj Allianz Life Insurance. The product basically provides you with a mix of insurance and investment in the same product. The

product has a five-year lock-in period. “You are allowed to pick from a large-, mid- or small-cap, debt or balanced investment depending on your risk appetite," said Anup Seth, chief retail officer, Edelweiss Tokio Life. You are also allowed to switch between different funds.

TYPES OF ULIPS

There are broadly two kinds of Ulips— pension and endowments. “The pensions Ulips have a fund accumulation part and the matured amount has to be invested in annuities. The endowment Ulip also has fund accumulation, but the fund value can be drawn down freely after five years. This Ulip also has a death benefit. Both have a choice of funds to select from," said Kapil Mehta, co-founder, Secure now. Ulips can also be categorised on the basis of the kind of funds they invest in. Bond funds, where your money will be invested in government, corporate and fixed income bonds; equity funds, where money will be invested in company stocks; and balanced funds, where there will be a mix of both and cash funds, which invest in cash and bank deposits. Ulips can also be classified based on investment strategy.

CHARGES AND TAXES

The charges for investing in Ulips have come a long way since the product was introduced. “Around 15 years back when Ulips were introduced in the Indian market, they were being charged at 40-50% in the industry," said Sehgal.

In 2010, there was both regulatory and industry intervention for the exorbitant charges. “There are four kinds of charges in Ulip—allocation, policy administration, mortality and fund management charges," said Seth. The fund management charges are capped at 1.35%. You can claim tax exemption on Ulips. “Ulips are exempted from LTCG (long term capital gains) taxation that was introduced in last year’s budget. It is an EEE (exempt-exempt-exempt) product and you can also claim tax exemption under section 80C."

SHOULD YOU INVEST?

The decision to invest in Ulips depends on whether you look at the product as an investment vehicle or life cover. “You should have a disciplined long-term savings perspective and should be looking for market-linked products," said Sehgal. However, the many charges and the five-year lock-in period may be a deterrent. “Looking at Ulips solely as a life cover product is not right because the insurance amount is limited to 10-15 times the premium amount. The premium for the ₹1 crore cover in Ulips would be ₹2-3 lakh," said Melvin Joseph, founder of Finvin Financial Planners. For a term life plan of ₹1 crore, the premiums are in the range of ₹7,000-8,000. “When it comes to Ulips as an investment product, the five-year lock-in is an issue as mutual funds have flexibility in exit routes," he said.

(The writer is Revati Krishna.)

TOP

Source

GENERAL INSURANCE

PSU insurance firms cry foul: Private sector insurers taking market with ‘unfair practices’ – Financial Express – 14th May 2019

The public sector insurers claimed that ‘unfair market practices’ by private insurers have resulted in them losing out heavily in the motor business. The state-run insurers including National Insurance Company, New India Assurance, Oriental Insurance Company, and United India Insurance have alleged that their private sector peers are offering higher commission above the limit set by the Insurance Regulatory and Development Authority of India

(IRDAI) to agents and dealers, The Indian Express reported citing unidentified sources. In FY19, the four major government-run insurance firms had together seen deceleration in growth from 45 per cent to 40 per cent in the motor insurance segment.

The private companies have benefited from the latest MISP (motor insurance service providers) rules set by the insurance regulator, limiting percentage of commission which can be paid by the insurance firms to the authorised dealers, the report said. In November 2017, the IRDAI had set a limit on payments by insurers to agents and dealers at 19.5 per cent for cars and 22.5 per cent for two wheelers. The regulator had also brought the companies under its purview as motor insurance service providers.

Meanwhile, the latest data released by the General Insurance Council in April showed that the PSU general insurers are steadily losing market share in collection of premium to their private sector rivals. Against a premium collection of Rs 68,719 crore, up 1.37 per cent, New India Assurance, United India Insurance, National Insurance and Oriental Insurance Company have lost market share to the private sector insurers (except stand alone health insurers) who total recorded a premium collection of Rs 81,600 crore, up nearly 25 per cent, during 2018-19.

The experts had then cited the proposal of merger of three PSU general insurers, the issues around solvency issues as the two main issues other than the alleged unfair practices by private players in the motor business for state-run companies losing out in the market share.

TOP

Source

Look out for travel insurance hacks - Travel Trends Today – 14th May 2019

With summer holiday season just around the corner, travel plans to exciting and exotic destinations are underway for many. From stitching the perfect itinerary to zeroing down on the best hotel and flight bookings, a lot of energy and time has already gone into making the trip a memorable one. So, what next?

In our quest for exploring new experiences, we often tend to miss out on the important aspect of protecting our journey from unforeseen contingencies, and that's where a reliable travel insurance comes in to play. Even though the outbound travel market has surged over the past few years, not many people have recognized the need for a travel cover. While most consumers end up buying travel insurance as a mandatory cover, they often fail to understand the fact that it's the only protection to help them in the event of any eventualities during their trips.

In fact, it is compulsory for travellers visiting Schengen countries to have travel insurance as a part of visa documentation process; even Australia mandates people over a certain age group to apply for travel covers.

For instance, while on a trip, if you lose your passport, a travel insurance policy will be your best guard to take care of the reimbursement expenses of acquiring a duplicate passport or getting a new one.

Similarly, in case of Baggage delay / Baggage loss, the insurance cover will compensate for your loss up to a certain permissible limit; while for baggage delay, you can get the expense of buying new personal properties reimbursed.

Medical emergencies or a serious injury, during a trip could get anyone on their feet and that is when travel insurance comes as a savior to ensure that medical emergencies are adequately met including cashless hospitalization or having a close family member flown to the location and taking care of other related expenses as well.

The most common hiccup nowadays could be an airline's fault or a sudden medical evacuation. Many such unplanned perils may further blemish a planned trip at the eleventh hour, which can arrive in many ways –what do you do about your prior hotel or airline bookings if your trip gets suddenly cancelled due to natural calamity at the location destination? In such cases, a travel policy recompenses for the expenses incurred for accommodation and ticket bookings. In case of a delayed flight, a travel policy will cover additional expenses such as an unplanned night stay at a hotel.

Theft is a common occurrence during trips. An insurance policy takes care of fraudulent charges like loss of credit/debit cards. However, before investing, it is prudent to know the fine prints of a travel policy to secure your journey better.

Given below are some elements you must look out for before buying a travel insurance policy.

• Confirm if you have travel insurance already

You could have travel coverage already and not even know about it! Some Credit card policies or home insurances provide travel too; hence it's well worth checking from the existing accounts before buying a new policy.

• Get your medical cover checked

If you have a medical condition make sure to carry your vaccinations and medicines recommended by the doctor for the destination you are travelling to. Some insurance companies may not pay out in case you get struck by a virus in absence of proper precautions.

• Check for your valuables cover

One must understand the difference between baggage and electronics and other valuables. While 'baggage' refers to personal day to day items; electronics and valuables comprise a completely different section of the policy. Many companies do not compensate if you do not carry an invoice copy. Hence, it's essential to carry original bills and vouchers or have digital copies on your phone or mailbox to testify your purchase claim.

• Pay more to get more

Some travel insurance companies distribute levels of covers to choose from. Make sure you check these levels as paying a little more with not too much difference in price can help you avail more fun with your buck.

• Multi-trip policies

Multi-trip policies are more beneficial for frequent travellers. Multi-trip policies cover all trips undertaken in a policy year, keeping in mind the length and limits of each trip. If one undertakes 5-6 trips a year, it is recommended to buy a multi-trip policy rather than a separate policy for each trip. Also multi-trip policies are more economical.

• Check for Cancellation Terms

The most disheartening part of a trip is if you have to cancel at the last moment due to unforeseen snags. Hence, it's advisable to read the policy document carefully as not all insurance companies cover cancellation of accommodations and flights.

Since the Indian insurance market opened up under the Insurance Regulatory and Development Authority Act (IRDA Act), product innovation and consumer options have grown by leaps and bounds. The Pacific Asia Travel Association (PATA) reported a steady increase in the number of outbound travellers from India; in 2014, there were 18 million travellers departing the country, with an estimated year-on-year growth of 11 per cent and a projection of 35 million outbound travellers from India by 2020.

Vacations are supposed to be pleasant and memorable. You do not want it to be tainted by unfortunate incidents. Since you cannot control an incident, precaution is what you can ensure. Travel insurance is a subjective matter and hence all the parameters should be thoroughly checked. You should choose an insurer which is offering you what you are in quest for. What deems for others may not work out for you.

Medical expenses in abroad can cost a lot, so it's vital that everyone going abroad has adequate cover in place for any eventualities.

It is primarily advised by financial experts to read the travel insurance covers and documents before opting for a policy. You must not only chase an inexpensive travel insurance cover but seek your cover from a trusted brand with strong domestic and international networks and a successful claim settlement track record to go by. But most importantly, be clear of your own needs and expectations from a travel plan to adequately take care of your journey.

(The writer is Parag Ved.)

TOP

Source

How to buy home insurance to protect against natural calamities - The Economic Times – 14th May 2019

Natural disasters can strike anytime. While we can do little to prevent such calamities, we can secure ourselves with adequate insurance.

Take cover

No one can say when the next natural disaster will strike. "In India, only life, health and vehicle insurances are common. However, earthquakes and floods can strike any time. We need to protect our assets from such calamities," says Abhishek Mishra, CEO, and Bonanza Insurance. One way of doing so it is to opt for home insurance. Most home insurance policies automatically cover damage due to cyclones, earthquakes and the like.

Household insurance covers the structure and furniture and fittings inside a house. While it is generally suggested that one opt for a comprehensive plan when it comes to car insurance, choosing the right household insurance policy can be trickier.

Buy structure cover only if needed

Before buying a comprehensive home insurance policy, find out if you need to take cover for the structure. Most housing societies insure the building and therefore, individual flat owners don't need to opt for structure cover. "Flat owners need cover for the contents inside the house," says Mishra. However, check if the policy bought by the housing society covers reconstruction costs and not only the depreciated value of the building. Several housing societies settle for depreciated building value to keep premiums low.

Go with the detailed plan for contents

If you want to insure the contents of the house, there are two plans to choose from—standard and detailed. Most insurers offer standard plans that assume a standard set of assets. However, experts bat for the detailed plan. "List every asset and take coverage for them. This offers several advantages. By giving full details at the time of taking the policy, claim settlement is smoother," says Tarun Mathur, Chief Business Officer, General Insurance, Policy bazaar. Standard plans also usually leave out costs related to repairs.

Go for replacement costs for contents

Experts say it makes sense to opt for replacement cost, instead of depreciated value, for household assets. "House owners should note that this will push up insurance costs," says Sanjay Dutta, Chief, Underwriting and Claims, ICICI Lombard General Insurance. However, this will be useful at the time of claim. Assume a television you bought two years ago is damaged by lightning and the repair cost is Rs 8,000. The insurer will not pay the full amount if you do not opt for replacement cost.

Take precautions after insuring
Insurance laws ask you to take every step to protect your assets. Insurance companies usually educate people about this. "Once Cyclone Fani was announced by IMD, we sent out messages about ways to protect your assets like car, house, etc," says Dutta. These measures are standard procedures like sealing any portion of the house where there is a chance of leakage and repairing old and creaky windows.

Protect your documents
Keeping important documents like degree certificates, registration documents of the house, etc in bank lockers is a wise step. Damage of critical documents can create serious problems in future. "Due to their design, bank lockers can withstand flood, fire, etc and therefore, will be safer than the house." says Mishra. Please save insurance related documents also from damage because they would be needed to make a claim after any disaster.

Follow correct steps for claims
Insurers are usually lenient towards claims after natural disasters and therefore, claim settlement may not be difficult. "After any disaster, submit a claim intimation to the insurer. If it is fire related, you need to submit an FIR and the fire brigade's report. Insurers release payment after getting reports from their surveyors," says Mishra. No FIR is needed if damage is due to other reasons like flooding, short circuit or power surge.

(The writer is Narendra Nathan.)

TOP

Source

How to initiate insurance claims after natural disasters wreck your home – The Telegraph – 13th May 2019

An extraordinary cyclone came to pass recently, wreaking havoc along India's eastern coast. Cyclone Fani, a rare April storm, lasted 11 days, making it the longest that any cyclone has lived in the Bay of Bengal. Around 65 casualties have been reported so far, with damages to infrastructure worth thousands of crores.

Insurance claims will reportedly touch Rs 3,500 crore. After such disasters, the IRDAI often instructs insurance companies to settle claims faster by simplifying claims processes and relaxing norms. A vast majority of these claims are reportedly for damaged crops and property.

Insurance can be a life-saver when natural disasters strike. One must ensure adequate coverage not just for life and health risks, but also for one's home, vehicles, and valuables — especially if one lives in an area prone to natural disasters. Cyclonic storms are among the many destructive situations that home insurance protects you against. Even though you may suffer significant damages, your insurance policy safeguards your finances and helps getting your life back on track sooner.

What insurance covers?
A home insurance policy protects you against several perils, including natural disasters such as earthquakes, flood, lightning strike, cyclones and landslides. The insurance covers both your property structure as well as its contents. Man-made perils such as strikes, fire, theft and robbery are also included. You don't have to be a home owner to buy insurance. You can protect the contents of your rented home.

First step
If disaster has struck in some form, you'll need to file a claim. First things first — ensure that you and your family are out of harm's way, safe and dry. You don't want additional harm to come to you or your loved ones in the aftermath of the damage to your home. Next, as soon as you can, intimate your insurance company about the possibility of a claim being made. You can do so by phone, email or fax. Remember that claims need to be made in a timely fashion. Not initiating the claim according to the process laid down by the insurer could lead to the rejection of a belated claim.

It helps to have the insurer's contact details stored in an accessible place such as on your phone or in an online document. This would be useful in case you're unable to access your home or policy document following the damage. Take photographs and recordings of the damage to your home. Also, collect any receipts or bills for expenses incurred that can be reimbursed by your insurer.

Second step
By intimating your insurer, you have initiated the claims process. A surveyor will be assigned by the insurer to assess your damages. You'll be required to fill out a claims form along with all the necessary documents, proof, receipts and bills that may be required to facilitate the claim. Depending on the nature of the claim, additional documents may be asked for. A copy of the FIR, the fire brigade's report, legal or expert opinions may be required. Once the claim is validated, the insurance amount will be paid out.

What insurance won't cover?
As the insurance is all about protecting you against disasters, do take the time out to read the fine print to understand what your policy will and won't cover. We've talked about inclusions above.

There are several situations in which claims may be rejected. For example, if you misinterpret or do not disclose critical information about your property, have pre-existing damages and or have home items with defects, or if the damages were caused because of your negligence, claims may not be covered. Kuccha homes, homes older than 30 years, or damages brought about by regular wear and tear are typically not covered. Damages caused by nuclear war, riots, civil war, enemy invasion and consequential losses are not covered by any policy. Certain damages like riots, strikes, and malicious damage can be covered upon the payment of an additional premium.

How to be prepared
Always keep handy a copy of the policy, policy number, your identity proof and address proof. You can store these online for easy access via your phone. Be it your home insurance policy or other financial knowledge; ensure that key members of your family are equipped with critical information that may be required during a disaster. You may be personally incapacitated, but armed with the knowledge, your family members may be able to act on your behalf and take the decisions necessary for your family's financial well-being.

Adequate car cover
Natural disasters may also damage your vehicles. Therefore, beyond the third-party vehicle insurance that is mandatory by law, always have comprehensive insurance coverage that not only covers third party damages but also own damage.

A comprehensive policy with premium benefits can save you from the steep charges caused by damages during natural disasters such as floods. With add-ons such as zero-depreciation cover and invoice value cover, your vehicles may suffer wear-and-tear or extensive damage, but you'll get full value for your vehicle. This is especially useful in case you live in a flood-prone area.

With climate changing rapidly around the world, natural calamities may intensify in many parts of the globe. The best you can do is be prepared with adequate coverage and financial know-how.

(The writer is Adhil Shetty.)

Source

TOP

Ready to holiday? Get travel cover - The Hindu Business Line – 12th May 2019

It can save you a lot of trouble and money in case of a mishap

"All my bags are packed; I'm ready to go..." Is this John Denver' number on your lips already? Well, then it's time to head out on that much-awaited vacation with your loved ones. But before you leave for that exotic destination, be sure to have your travel insurance tucked inside your prized Jimmy Choo bag. For many of us, the extra cost may seem unnecessary. But it's one travel thingamajig you must have with you.

What it covers

Travel insurance ideally covers travel-related risks. These include flight delays and cancellations, passport or baggage loss, emergency medical expenses, and other losses while travelling. Travel insurance is available for both international and domestic travel.

Taking a cover for your foreign travel is particularly imperative as travel insurance can reduce your financial burden in case of trip cancellation or interruption, trip delay, lost or delayed baggage, medical expenses and personal liability.

In a nutshell, travel insurance saves you a lot of trouble and moolah in case of a mishap. Imagine you've spent a fortune planning your Europe vacation and just a day before the travel, there is a personal emergency preventing you from making the trip. While your airline may refuse to give back your money, a trip cancellation cover can reimburse you for flight costs — but only for specific and unavoidable reasons laid down in the policy.

If you suffer from an illness or injury during your overseas travel, sudden medical expenses can burn a hole in your pocket. A travel plan that covers emergency medical expenses and extends daily allowance in case of hospitalisation can be helpful.

Travel insurance can also ease some of the stress and pain caused due to loss of baggage or passport. Personal accident, covering death or permanent total disablement due to an unfortunate accident, or personal liability compensating for any third-party damage are other important covers offered under travel plans.

Hijack cover and emergency cash benefit are some other covers offered by most insurers.

Hence, travel insurance plans can cover you quite comprehensively from medical-, journey- and baggage-related risks. The premium a 30-year-old has to pay for making multi-trips worldwide, with a $250,000 coverage, is just ₹3,500-4,000.

How to select

But how do you go about choosing a travel plan from the plethora of options?

First, you need to assess the type of travel insurance you may need. Insurance players offer plans for individuals, family, students, senior citizens, and so on. If you are travelling with your family, go for a plan that covers you and your spouse (and generally two children). The next step is to zero in on the type of plan offering different coverages. This is important as it will vary, depending on your destination, duration of the trip, purpose of travel, etc.

All travel insurance plans come with a total coverage or sum assured. The higher the sum assured, the higher the premium. So, be sure to choose a plan that best suits you. For instance, under Bajaj Allianz Travel Prime Plan, you can choose from standard $50,000 coverage or a Silver $1-lakh cover. Select one that is adequate for you.

But remember, this is the maximum cover one can get under the plan. There are caps on specific benefits. For instance, TATA AIG's Travel Guard Gold policy covers medical expenses up to $250,000; accidental death compensation is $5,000, whereas loss of checked baggage is covered up to $1,000. Under Bajaj Allianz's Travel Prime Gold Plan, while medical expenses are covered up to $2,00,000, daily hospitalisation allowance is $25 per day up to a maximum of $125. Under HDFC ERGO's platinum plan, medical expenses are covered up to $200,000, while hospital cash is $15 per day, up to a maximum of $150.

So, compare various plans and look at various benefits before deciding.

Sub-limits and deductibles

You also need to be mindful of sub-limits and deductibles before choosing a plan. Most travel insurance plans offer comprehensive medical coverage (without sub-limits) only up to a certain age. After that, there are sub-limits on hospital room, surgical treatment, physician's fees, diagnostics, etc. Some insurers offer a no sub-limit plan, but with a cost.

Deductibles is the amount that the insured has to bear before the insurance amount can be claimed. Common deductibles under travel insurance plans pertain to medical expenses, loss of passport, personal liability, trip delay, or delay in checked baggage. For example, under HDFC ERGO, most plans have a deductible of $100 for medical expenses, $30 for loss baggage and personal documents, and a maximum of 50 per cent per bag in case of loss of checked baggage. The deductible in case of checked baggage delay is laid down in terms of duration. You are not paid for first few hours of baggage delay, which is generally 12 hours.

(The writer is Radhika Merwin.)

TOP

Source

Good to Know: 10 useful benefits of senior citizen travel insurance plans – Financial Express – 10th May 2019

Many would agree that it's the ability to see the world without much worry that makes post-retirement years truly the golden phase of life! But a pragmatic way to ensure that elderly travellers actually enjoy their trips without much worry is to sign up for a comprehensive travel insurance plan. These plans, tailor-made to address multiple concerns of senior citizens, offer a wide range of meaningful benefits that protect them from a number of inconveniences that they could face during their trips in foreign countries.

However, travel insurance policies differ a lot from one another in terms of benefits offered. Hence it makes a lot of sense to carefully go through the policy document before making the final decision. So, to help you make an informed choice here's a lowdown of some of the common benefits offered by senior citizen travel insurance plans.

1. Travel insurance cover up to the age of 99 years

A number of travel insurance policies can be purchased by senior citizens till as old as 99 years. This is really helpful as basic travel insurance policies usually apply to travellers who're not older than 60 years. Also, a number of insurance providers have specific policies for different senior citizen age brackets (like 60-70 years, 71-80 years and 81 to 99 years) offering customized protection.

2. Cashless hospitalization across the world

This is really useful as the medical costs in a number of countries, like the US, UK and Germany, are extremely expensive. Many travel insurance plans offer cashless treatment at network hospitals (at times

only for hospitalization exceeding 24 hours) across the globe – something that comes to the rescue if policyholders undergo a medical emergency during their trip. There are some plans that cover for dental treatment and out-patient medical checkups too.

3. Cover for pre-existing medical ailments (leading to a life-threatening condition)
It's obvious that many senior citizens will have certain pre-existing medical conditions, and therefore travel insurance plans that cover for these is a major plus! There are many policies that cover for expenses of treatment arising from pre-existing conditions under life threatening conditions. However, make note of the coverage capping, if any, for this specific protection. Also, non-life-threatening conditions arising from any pre-existing ailment are usually not covered.

4. No medical tests required to buy the policy
There are many travel plans out there that do not ask for a medical checkup before buying the policy. This feature can make the policy-buying process quick and hassle-free. That being said, always get clarity on whether the absence of any prior medical tests will have a bearing on the medical protection of the insurance plan. Also, you'll be well-advised to declare all known pre-existing ailments before signing on the dotted line to minimize the scope of any unpleasant surprises later.

5. Personal accident and personal liability protection
Majority of senior citizen travel insurance plans come with personal accident protection to cover for accidental death or dismemberment of policyholders. There are also many policies that give coverage for death, injury or loss of property accidentally caused by the policyholder which is paid to a third party. However, both personal accident and personal liability protection often come with sub-limits.

6. Loss or delay of luggage, loss or theft of money and passport
Almost every major senior citizen travel insurance plan will compensate for the loss or delay of checked-in luggage. A number of policies will also cover for expenses incurred to buy personal belongings (like toiletries, clothes and medication) if the luggage is missing for more than 12 hours. Similarly, most travel insurance plans also cover for costs incurred to obtain a duplicate or new passport following its loss. However, no claim is entertained if the passport is stolen or misplaced when left unattended or if the insurer doesn't lodge a complaint with local police authorities. There are some policies that also provide you with emergency cash if your money is stolen while you're on a trip. Interestingly, there are plans that also compensate for a burglary at your home while you're travelling abroad!

7. Delayed or cancelled trips, delayed or missed flights
Again, most travel insurance plans reimburse for additional expenses incurred if a trip gets delayed by more than 12 hours. Similar coverage is also given if a trip is cancelled or interrupted, or a connecting flight is missed for a delay of more than 3 hours. However, do note about the usual caveats – a trip delay/cancellation/interruption is only covered when it's caused because of a medical problem, a personal employment issue, an airline issue or owing to a natural disaster.

8. Emergency evacuation
Some senior citizen travel insurance policies also compensate for an emergency medical evacuation back to the insured's country of residence. Similar coverage is also given if the insured needs evacuation owing to a catastrophe or a political turmoil in the visited country. At times a distress allowance is also provided if the insured's flight is unfortunately hijacked for more than 12 hours.

9. Compassionate visit
Many senior citizen travel insurance policies reimburse the return airfare of a family member to visit the insured if the latter is hospitalized in a foreign country for more than 7 days.

10. Repatriation of mortal remains
This "benefit" may sound morbid but it's really significant. A number of senior citizen travel insurance plans cover for costs incurred if the insured's mortal remains need to be repatriated following his/her demise in a foreign country.

As such, you'll be well-advised to closely go through all the benefits offered by your travel insurer before taking the plunge. You might have to take add-ons for some of the above-mentioned benefits, which will increase your premium, but guess it will be worth it if you think it's a meaningful feature. Also, be mindful of riders like sub-limits and other restrictions. Compare all your options before making a decision, and don't buy a policy just because it comes with the cheapest premium. Wish you all a very happy journey!

(The writer, Adhil Shetty is CEO, Bankbazaar.com)

TOP

Source

HEALTH INSURANCE

Coveredby group insurance? You still need an individual health plan - Financial Express – 17th May 2019

While many employees may be covered under a group health insurance scheme, one should buy an individual health policy at an early age. That will not only come cheap but will also cover the exclusion period when one is healthy.

A group health plan offers healthcare coverage to the employee, spouse, dependent parents and dependent children up to a certain age. The terms and conditions, inclusions as well as exclusions are same for every individual covered by the policy. As an individual, it is not possible to voluntarily opt for a group health plan.

Exclusions, waiting period

In group health insurance, one does not have to submit any medical reports, there is no waiting period and there is full coverage for any pre-existing conditions. However, an individual health insurance cover will have exclusions and waiting periods which are typically for four years. So, insurers will cover pre-existing ailments after four years of continuous coverage.

A group policy will no longer be valid if the individual resigns from the organisation or retires. As per the insurance regulator's rules, insurers have to give the policyholder the option to migrate from the group policy to an individual or family floater cover after paying an extra premium. If an individual exits his group plan and buys an individual policy, then the waiting period will start afresh. In such a case, he and his family will be at a risk if he does not have the group policy and is still under his new policy's waiting period.

A group health insurance cover can be customised according to the requirement of the group. But in case of an individual policy, customisation is not possible.

Expensive cover

Premium for health insurance increases sharply when an individual is more than 45 years old. So, as a golden rule buy health and life insurance when you are young and healthy. As you grow older, insurers may insist on a medical test. So, if you rely on your group insurance policy till retirement and plan to buy a cover after retirement, it will not only be very expensive but insurers may reject your case on medical grounds.

All group insurance policies have limitations in terms of coverage amount which may be out of sync with rising healthcare costs. In order to provide greater coverage and more benefits under a group plan, your employer may need to pay higher premium costs. So, it is always better to get over these limitations

personally, by taking an individual health insurance policy with adequate coverage and features as per your needs.

Analysts say one must look at a basic product that covers all the members of the family. At present, all health insurance policies provide for entry age of up to 65 years and do not have any exit age once the proposal is accepted, provided the policy is continuously renewed without any breaks. Health insurers cannot load charges on an individual insurance policy at the time of renewal, even if the policyholder has made a claim in the policy year.

Treatment-wise limit

There is no treatment-wise limit in a group health insurance policy but an individual policy will have such limits. If the claim amount exceeds the amount set by the insurer in an individual policy, one has to pay the balance despite having a bigger policy cover. There are health insurance policies that provide daily cash benefit for each day of hospitalisation. One must also note the terms and conditions of pre- and post-hospitalisation offerings, no-claim bonus and waiting period for specified ailments, vary from company to company.

While buying an individual policy, one must ensure that the cumulative bonus is stated explicitly in the prospectus and even in the policy document. In case of any pre-insurance health check-up of the policyholder, half of the cost will have to be paid by the company, provided the proposal is accepted and results in a policy. Policyholders with multiple health covers can claim from multiple insurers if the benefits covered are fixed in nature.

(The writer is Saikat Neogi.)

TOP

Source

Fixed Benefit Vs Indemnity Based Health Insurance: Which is a better option for you? – Financial Express – 16th May 2019

The cost of healthcare in India has witnessed a significant rise in the last two decades, thanks to the ever-growing demand for medical services across the country. In a country like India where the out-of-pocket medical expenses account for over 62% of the entire costs, the massive increase in the cost of healthcare will certainly erode one's financial savings. Another contributing factor for the rise of healthcare cost is that India is home to around 17.5% of the world's population, and roughly accounts for 20% of the global load of diseases. Considering these stats and the strenuous way of life we live, health insurance has become a basic need. However, what many reports state is that even after constant development and increase in awareness around health insurance, less than one-fifth of the country's population is covered under a health cover.

While insurance pundits believe that one must buy a health insurance plan even before starting to invest for life goals, merely buying just about any health insurance plan may not be enough. It is important to buy a health insurance policy that rightly caters to your specific medical needs and requirements. But the truth is that in spite of the customer being relatively aware and conscious of what he wants from his health insurance cover, he is often confused between investing in an indemnity plan, which reimburses the hospitalisation expenses, or in a fixed benefit plan that pays a fixed sum irrespective of the expenses.

However, this dilemma is surely unwarranted as both, indemnity plan and fixed benefit plan, come with their own set of benefits and are entirely different on the coverage they offer. In simpler words, both these plans have their own uses and complement one another.

What are Indemnity Plans?

Going by the name, indemnity-based health plans basically indemnify the policyholder against hospitalisation expenses up to the total sum insured. Under the plan, the insured is reimbursed the actual expense incurred during hospitalisation only up to the total sum insured under the plan. If the insured has opted for cashless hospitalization plan, the insured only needs to pay a certain fixed amount and the rest is taken care by the insurer. However, in case the insured has not opted for the cashless hospitalization plan, the person needs to submit the necessary medical reports, bills paid, and other required documentation based on which the insurer reimburses the expenses.

You must learn that the plan will only pay the money that is spent on the treatment within the limits of sum insured. The regular Individual Health Plans or Family Floater Plans come under indemnity plans.

For instance, Mr Roy has a health policy with a sum insured of Rs 10 lakh. He gets hospitalized and his total expenses come up to Rs 4 lakh. In this scenario, the insurer will reimburse only Rs 4 lakh (subject to policy conditions) and the balance Rs 6 lakh may be used in case of further hospitalization during the policy period.

What are Fixed Benefit Plans?

Under a fixed benefit health plan, the insured is given a fixed and guaranteed amount equivalent to the sum insured in case of an occurrence of an insured event as per the policy terms. All such plans offer the insured a lump sum amount as claim irrespective of the actual or intended expenses incurred during hospitalisation. Fixed benefit plans do not work on the principle of indemnity and it is completely the prerogative of policyholder on how he wants to utilize the claim amount.

For instance, Mr Sharma opted for a Critical Illness Health Insurance plan with a sum insured of Rs 15 lakh. Within the policy term, he was diagnosed with one of the listed critical ailments under your plan. Now, the insurer will pay him a lump sum of Rs 15 lakh as a claim pay-out regardless of the amount of expenses incurred. Once the insurer pays the total sum insured, the policy will get terminated thereafter.

The following is a comparative table of 5 leading insurance companies providing Health Insurance cover of Rs 10 lakh sum assured for a 30-year-old male who earns between Rs 5 and Rs 7 lakh annually and lives in a metro city.

Insurer	Plan Name	Premium (Rs.)
Religare Health Insurance	NCB Super Premium	8,675
MAX Bupa Health Insurance	HEALTH COMPANION	9,862
Star Health and Allied Insurance	Medi Classic	9,204
HDFC ERGO	Health Suraksha - Silver	9,380
Apollo Munich Health Insurance	Optima Restore	11,024

*Source: www.policybazaar.com

State of Critical Illnesses in India

In the last few years, the number of critical illness cases reported in India have seen a huge surge. A majority of these diseases are directly associated with factors such as lifestyle, hereditary, environment, etc. Talking about the numbers, one in three people in India fall prey to lifestyle related diseases, including cardiac ailments, diabetes and high blood pressure. As per a survey, while the number of cancer cases in India in 2017 was 15 lakh, the number is expected to cross 17.3 lakh by the end of 2020. On the other hand, cases related to heart ailments have gone up in almost every Indian state in the last two decades. The deaths due to cardiovascular diseases has grown by 34 per cent in the last few decades.

Need for Fixed Benefit Plans

It is not always important that a hospitalisation may only be for general treatment or a minor ailment that demands a stay for few days. There even can be some kind of medical emergency that apart from requiring extended stay at the hospital needs great amount of funds to cope with the loss of income during the recovery stage. This is quite common when someone is diagnosed with a life-threatening disease such as cancer, paralysis or kidney failure.

Now, while the average cost of treatment of cancer may range between Rs 10 and Rs 20 lakh based on the stage of cancer, the treatment of heart-related ailments in India can cost you anywhere between Rs 4 lakh and Rs 10 lakh or even more in case of a heart transplant surgery. Spending such a massive amount in one go can be really difficult for an average middle-class household, and especially for a family with only one bread winner. For most people, getting this expensive treatment without being backed by a well-planned financial arrangement is beyond their financial capacity. In a quest to combat such massive costs of treatment and at the same time keep pace with the inflation rate, insurers came up with the concept of 'Fixed Benefit Plans.'

Prominent Features

Apart from paying a fixed lump sum amount to the insured on the occurrence of an insured event, fixed benefit plans even help the insured to get rid of such sub limits. Most importantly, a fixed benefit plan also caters to non-medical expenses which arise due to loss of earnings or livelihood during the treatment and recovery time. The lump sum amount received can be used to take care of expenses like frequent travel, household expenses, kid's educational expenses, etc. All such plans are highly cost-effective and the premiums paid towards the purchase of all such plans is tax-free under section 80D of the Income Tax Act.

Available Options

Here is a competitive analysis of the yearly premium for a CI cover of Rs 10 lakh for a 30-year-old non-smoker male residing in a metropolitan city.

Insurer	Plan	Premium (Rs.)
Apollo Munich Health Insurance	Optima Vital	3835
Max Bupa Health Insurance	CritiCare	2368
HDFC Ergo	Critical Illness Plan	2950
Reliance General Insurance	Critical Illness Insurance	3231

*Source: www.policybazaar.com

Conclusion

The basic concept behind investing in a health insurance is to get adequate coverage and in order to make your health insurance cover much more comprehensive, it is very important to maintain a balance between Indemnity Plan and Fixed Benefit Plan. As both these plans have their individual advantages, choosing them must be correlated as per your specific medical needs.

For instance, in case your family has a history of some specific critical illness, a fixed benefit plan (covering the illness) along with a regular health cover plan makes for a great choice. Moreover, considering the current style of lifestyle we all tend to follow, critical illness can happen to anyone at any age. Find out about your individual medical needs and take an informed decision while buying a specific health insurance cover.

(By Amit Chhabra, Head-Health Insurance, Policy bazaar.com)

Source

TOP

Ayushman Bharat: More schemes to be integrated - The Economic Times - 14th May 2019

After integrating all the health insurance schemes of the state and central governments, now Ayushman Bharat is planning to integrate the comprehensive health scheme (CHS), central government health service scheme (CGHS) and employee state insurance (ESI) under it in the next phase.

"Convergence of these three central government schemes, which are now being offered to government and retired employees, under Ayushman Bharat is our next mission. Our aim is that all government schemes should have same rates for treatment and same package offered to all the beneficiaries," said Ayushman Bharat chief executive officer Dr Indu Bhushan.

The Ayushman Bharat scheme has been successfully implemented in almost all the states with a few exceptions. "Many states have come forward with universal coverage under the scheme without any class divide. This is what we were also targeting at. Quality treatment should be made available to all in the country under this scheme,'' said Bhushan, who was in the state capital to review the implementation of the scheme in Kerala.

On Kerala not using the name Ayushman Bharat while rolling out the scheme from June, the CEO said: "We are not concerned over this. Our aim is to provide the best health insurance cover to all and if in Kerala it is going to benefit more people, then they are free to do so," he said.

He also made it clear that the concern of private hospitals that many of the rates fixed for various treatment packages are not affordable can be addressed. "The main intention of the scheme is to ensure best specialty treatment offered by the private hospitals to the poor. Hence, all the fears expressed by hospitals can be discussed. We intend to include all the leading private hospitals with NABH accreditation under the scheme," he said. He added that Kerala has a strong public health network unlike many other northern states. Hence, implementing the scheme here will be a smooth affair.

(The writer is Rajiv G.)

TOP

Source

Give your health insurance a top-up boost for an additional cover - Telagana Today – 12th May 2019

Cost of healthcare in India is rising every year. This significantly raises the need to enhance the health cover as the regular health insurance cover with a sum insured of Rs 3 – 4 Lakh is no more sufficient.

While it is not always possible to buy a new health insurance cover with a high sum insured, one can look at top-ups to boost their health cover relatively for a small price. A top-up plan offers an additional sum insured to cover medical emergency when the existing sum insured is exhausted. Top-up plans act as alternative to an additional health policy and compensates for all expenses exceeding the base cover for one-time hospitalisation. They are regular indemnity plans that can be renewed annually, according to Amit Chhabra, Head- Health Insurance, Policybazaar.com.

However, top-up plan comes into play once the deductible limit is crossed. Under a health insurance, a deductible is the limit up to which the healthcare costs are borne by the insurer or the policyholder depending upon the type of the policy.

For instance, a person buys a top-up health plan worth Rs 10 Lakh and has a regular health insurance cover with Rs 3 Lakh sum insured. After two months, he meets with an accident and gets admitted to a hospital where the hospital bill reaches Rs 5 lakh. With top-up plan in place, his regular health insurance policy will pay Rs lakh while the remaining Rs 2 Lakh will be paid through the top-up health plan. However, if the bill does not cross Rs 3 Lakh, the entire amount will be paid by the regular health cover policy.

Who must buy top-ups

Anyone who has a basic health insurance with low sum insured must always go for a top-up plan. A top-up plan apart from increasing the sum insured for a health cover, gives the policyholder utter peace of mind. The plan is equally important for those who do not have an individual health cover and rather rely on health insurance provided by the employer. Policyholders must also buy top-up plan along with their regular health cover as during old age the chances of getting ill and facing medical emergencies increase significantly.

Cost

The average premium for a top-up plan for a 30-year-old man, his wife and two children (family floater) with sum insured of Rs 10 Lakh and a deductible of Rs 5 lakh will be between Rs 3,500 – 7,600. The premium varies from insurer to insurer. There are numerous popular insures that offer super top-up plans along with regular health insurance at affordable premiums. Some of the top-up options include Religare's Enhance, ICICI Lombard's Health Booster, Apollo Munich's Optima Super, Bajaj Allianz's Extra Care Plus and HDFC ERGO's My Health Medisure, said Chhabra.

(The writer is B. Krishna Mohan.)

TOP

Source

The benefits women are entitled to and the rights they can claim under maternity – Mint – 12th May 2019

In order to protect the rights of women employees during pregnancy and after childbirth, Indian law makes it mandatory for most establishments to offer maternity benefits to women employees. Maternity benefit in India is mainly governed by the Maternity Benefit Act, 1961 that applies to all shops and establishments with 10 or more employees. Those women who work in factories with 10 or more workers are given maternity benefits as available under the Employees' State Insurance Act, 1948.

Remember that employers are required to inform women in writing and electronically about the maternity benefits available under the Maternity Benefit Act upon their joining the workforce.

Given that women often feel left out or face biases during pregnancy or after childbirth in their workplace, it is important for them to know the benefits they can avail of and the rights under the law. We take you through the maternity benefits available to women and the rights they can lay claim to.

Wages and leaves

The Maternity Benefit Act provides that a woman will be paid maternity benefit at the rate of her average daily wage in the three months preceding her maternity leave. However, the woman needs to have

worked for the employer for at least 80 days in the 12 months preceding the date of her expected delivery.

The Maternity Benefit Act originally provided maternity benefit of 12 weeks, out of which up to six weeks could be claimed before delivery. In 2017, the law was amended to extend the period to 26 weeks. Out of the 26 weeks, up to eight weeks can be claimed before delivery. However, you need not structure your leaves in this manner—you can instead take the entire 26 weeks of leave after the delivery. Also, these are maximum periods of claim and you can claim the benefit for a smaller period as well.

If the woman has more than two surviving children, the maternity benefit is for 12 weeks only. The law was also amended to extend maternity benefits to commissioning and adoptive mothers who are now entitled to 12 weeks of leave from the date the mother receives the child.

Women undergoing a tubectomy operation (a medical procedure to stop future pregnancies) also get a paid leave of two weeks following the operation. In case of miscarriage or medical termination of pregnancy, the law permits women six weeks' leave after the procedure. In case of an illness after delivery, miscarriage, medical termination of pregnancy or tubectomy, a woman can claim a leave with wages for a further period of one month, over and above what is allowed.

Other benefits

The law also allows employers to permit women employees to work from home in addition to the maternity benefit period if the nature of work allows that.

The law was further amended in 2017 to make it mandatory for establishments with more than 50 workers to establish creches. Mothers are entitled to visit the creches up to four times a day and to two nursing breaks per day in addition to any other breaks that are available as a matter of course, until the child attains the age of 15 months.

Employee rights

An employer cannot dismiss a woman for taking maternity leave and cannot serve a termination notice to a woman on maternity leave which expires before the maternity leave ends. Also, an employer can't change the terms of service to the woman's disadvantage during her maternity leave.

Further, maternity benefit and medical bonus will have to be paid to a woman who is discharged or dismissed during pregnancy unless it is for gross misconduct.

TOP

Source

Health insurance for women is need of the hour - Deccan Herald- 12th May 2019

A few years ago mainstream media started recognising this growing breed of superwomen. These were your everyday women, seen in every house who juggled different roles and responsibilities with efficiency and panache. She is at the same time a mother, wife, daughter, daughter-in-law, friend, employee, colleague, home-maker, commuter, earner, and consumer. Juggling these multiple roles is a daily routine and a delicate balancing act that leaves her with very little time to focus on the most important role of all - herself. And one of the biggest setbacks in not being able to focus on herself is that everything about her takes a backseat to the demands of the rest of the world, including her own health and well-being.

But what is this superwoman avatar doing to the normal woman? According to a study conducted by industry body ASSOCHAM, 80% working women in India are suffering from lifestyle, chronic or acute ailments like cardiovascular diseases, diabetes, hypertension, depression, obesity and backache. The pressure of having to balance personal and professional lives has been identified as the primary culprit

for this alarming state of her health. Minor wellbeing concerns, if overlooked, can snowball into significant wellbeing challenges later.

Apart from lifestyle diseases that afflict everyone, women also have to grapple with illnesses like breast cancer, spine ailments, anemia and calcium deficiency-fuelled bone disorders that are either women-specific diseases or show a high level of occurrence in women. Pregnancy and post-natal care, as well, call for extraordinary care and alertness as they can lead to more complications.

Women-centric solutions The world is now slowly waking up to the need for women-centric solutions and we are finding more and more options in the market that cater to her and her health needs. However, as the pressures of balancing personal and professional lives continue to be inescapable, most women will continue to be vulnerable to ill health and critical illnesses.

As a result, apart from taking care of their health through physical exercise, regular medical check-ups and prompt treatment, Indian women need to recognise the need to acquire a critical tool that can safeguard and restore their health without burning a hole in their purse. That tool is health insurance. Not only can health insurance reimburse hospitalisation costs should you be struck by a medical emergency, certain variants can also shoulder planned maternity expenses. They also reward you for leading a healthy lifestyle. Despite being aware of the many benefits of health insurance, many women tend to ignore buying health cover for themselves. They either prefer to rely entirely on the group cover provided by their employer or leave the decision to their spouse or elders in the family, which could prove costly later.

If you make the wise decision to procure a policy for yourself, there are certain additional points you need to bear in mind. Firstly, remember, it is best to buy a policy at the earliest - those who are young and healthy have an upper hand over their older counterparts in terms of premium as it is linked to age and health condition. However, at the time of buying the policy, do not evaluate the products solely on the basis of premiums charged. While it is undoubtedly an important factor, do study the terms and conditions of products you have shortlisted.

Go with a product that is not weighed down by exclusions - i.e. expenses that are not payable under the policy - and restrictions on how the sum insured can be used. Avoid the ones burdened with too many sub-limits, high co-pay ratio and an inefficient cashless hospital network. It is always advisable to choose the cashless facility over the reimbursement option, as it facilitates hassle-free and quick claim settlement. Also, understand the various exclusions in your policy, especially the one related to pre-existing diseases.

Some new-age insurers have gone beyond regular health insurance. Their offerings motivate and support you with an ecosystem to live an active life. Further, incentivise you with cash equivalent rewards or discounts on premiums in the subsequent policy year for staying healthy. Those who are young and healthy might find such products useful. Lastly, do your homework on the company's track record on service quality and claim settlement before zeroing in on the suitable health cover.

(The writer is Mayank Bathwal.)

TOP

Source

'Modicare' significant step towards universal health coverage in India: US think tank - The Economic Times – 11th May 2019

India's ambitious health insurance scheme, Ayushman Bharat, marks a significant step towards universal health coverage but the government should ensure that it is sustainable and delivers the high-quality care that Indians need, a top American think-tank said Friday.

Based on the analysis of the first year of Pradhan Mantri - Jan ArogyaYojana (PM-JAY), popularly known as "Modicare", researchers at the Washington DC-based Centre for Global Development (CGD) said the

overall effort has been positive but they also highlighted challenges and several potential pitfalls related to cost and quality that could derail the scheme's progress.

"Modicare has put healthcare within reach for hundreds of millions, significantly increasing the number of people who have government-funded health insurance and far exceeding the initial estimates," Amanda Glassman, chief operating officer at CGD and one of the authors of the study, told PTI.

"We found that more than 500 million people are now eligible for coverage by Modicare or state-funded expansions of the programme. That's an impressive number, but there's still lots of work to do to bring down costs and bring up quality," Glassman said ahead of the release of the report.

Additionally, the researchers explain that embracing and improving access to primary care and linking it with the hospitalisation plan, rather than only providing hospitalisation, would go a long way toward promoting better health.

The focus in the first year of Modicare has been on expanding access to health insurance, but at some point, the government needs to take steps to tackle the costs of the programme, the researchers said.

These steps would include better purchasing policies for medical supplies and drugs and an increased focus on providing preventative health services like vaccines that could contain high costs of later treatment, they note.

"India has done an impressive job expanding healthcare to hundreds of millions more people, but there's still a lot of work to do. The next big step is making sure that that Modicare is sustainable and that it delivers the high-quality care that Indians need," Kalipso Chalkidou, a senior fellow at CGD and an author of the study, said.

"In a country of almost 1.4 billion people that is home to one-third of global maternal deaths, where public spending for health accounts for roughly one percent of GDP and where 60 million people fall into poverty every year because of healthcare bills, fixing healthcare is a daunting task that will determine the world's performance against the Sustainable Development Goals over the coming decade," said the report, a copy of which was made available exclusively to PTI.

Noting that the scheme is by design pro-poor as it automatically provides entitlement to poor and vulnerable families identified based on Socio Economic Caste Census data, the report said PM-JAY is both benefiting from and triggering significant technological innovation, including the de novo development of a sophisticated IT system building on and improving existing platforms, such as the Transaction Management System of Telangana.

The scheme is also developing a strong anti-fraud approach based on data analytics, the report said, adding that PM-JAY has developed real time dashboards to monitor the scheme. Centre for Global Development notes that massive data generated by PM-JAY can be used for not only improving implementation but also for policy inputs.

The scheme's dashboard can potentially offer a wealth of information to drive strategic purchasing and provider payment reform; inform clinical audit, thereby improving clinical governance and quality; and demonstrate impact on health and on spending, it said. "After the first six months, a priority would be to launch a process for developing world-class methods and standard operating procedures to carry out a series of critical analytical tasks," it said.

India, it said, has kicked off a major tax-funded UHC reform with impressive early gains in covering the poor, providing hospital-based treatment, and generating efficiencies in claims processing that has enabled private participation in provision.

"Post-election, it will be vital to move quickly on a set of rules of the game and administrative adjustments that will assure that PM-JAY delivers on its promise to enhance access, reduce catastrophic out-of-pocket spend, and enhance value-for-money in its own expenditure, while serving as a force to leverage improved health with transparency and accountability," the report said.

Linking of PM-JAY with primary healthcare through Health and Wellness Centres and other mechanisms will be critical to create a continuum-of-care approach, it said.

TOP

Source

5 restrictions in health insurance plans: Know them before you buy one – Financial Express – 10th May 2019

Buying health insurance is considered to be the first step in the financial planning process. But, with several different features across different plans of various general insurance or standalone health insurance companies, it could be difficult to choose the right one. Also, there are certain specific restrictions in almost all health insurance plans and one needs to be aware of them for a smooth settlement of the claims. Being unaware of these restrictions can result in an unhealthy claim experience and can even turn costly for the policyholder.

Here are five such restrictions that every buyer or a policyholder needs to know for avoiding any unpleasant surprises during claims settlement or during hospitalisation.

1. Sub-Limits

When it comes to making a claim, health insurance plans have a restriction in the form of sub-limit which basically is the maximum limit to which the insurer will pay up the claim amount under each expense head. A hospital bill will carry medical expenses under different heads such as doctor fee, room rent etc. No matter what the sum insured of the policy is, most health insurance plans restrict the re-reimbursement limit of each such expense head to a certain percentage of the sum insured. For example, if the sum insured is Rs 5 lakh, the room-rent is capped at 1 per cent i.e. Rs 5,000. If a policyholder chooses a room with rent higher than that amount, the claim will be restricted to Rs 5,000 only. Similarly, the caps could be there for other expense head.

When the insurer doesn't pay any amount above the mandated limit, the expense has to be borne by the policyholder. In some health insurance plans, there may not be any such sub-limits while in others it may be waived off by paying an extra premium. Sub-limits also plays a role in the settlement of total claims. If a policyholder takes a room with rent higher than the upper limit, the other claim for other expense heads is proportionally reduced.

2. Network Hospital

When it comes to a medical emergency requiring hospitalisation, the hospital that is nearest to one's residence is preferred by most. However, as a health insurance policy holder, knowing whether the hospital is on the insurer's list of network hospitals is important. All insurers have a tie-up with specific hospitals in different locations which they call them as a part of the network list. Insurers prefer policyholders to take hospitalisation in the network hospitals and not in a hospital outside the list.

It doesn't matter if you hold a cashless card; the claim process in a non-network hospital may be subject to re-reimbursement and may result in partial claims too. Insurers share the list of network hospitals, also check with them before one has to make a planned hospitalisation.

3. Waiting Periods

After buying a health insurance policy, it's not that the coverage starts from day one. Other than accidental hospitalization, some diseases have a waiting period of 30 days, some others of 24 months or 36 months or even 48 months. The pre-existing ailments after proper disclosure at the time of buying insurance are generally covered after 48 months. It is important that one keeps renewing the policy so that the benefit of the waiting period is not lost. Also, on porting the policy, the advantage of the waiting period is not lost.

4. Co-Payments

Sometimes, even if one holds a cashless policy, not the entire bill amount is paid by the insurer. A portion of the bill is to be borne by the insured. Co-payment or co-pay is that portion of the bill that the policyholder has to bear as an out-of-pocket expense. Such co-pay could be 10 or 20 per cent of the hospital bill.

For example, if a policy has a 20 per cent co-pay, and the bill comes to Rs 30,000, then the insured will have to pay Rs 6,000 while the balance of Rs 24,000 will be paid by the insurer. Co-payments are generally found in health insurance plans for senior citizens. Plans with co-pay come at a lesser premium than the ones without this feature.

5. Cashless or reimbursement claims

The claims settlement in a health insurance policy can be either on a cashless basis or on the basis reimbursement. In a cashless policy, one need not pay anything up to the sum insured amount, to the hospital if it is there on the network list. The insurer's in-house claims settlement team or the insurer's third-party administrator settles the bill on behalf of the insured. In case of reimbursement claims, which generally happens in a non-network hospital, the insured has to pay the hospital before getting discharged and then submit the bills to the insurer for reimbursement.

(The writer is Sunil Dhawan.)

TOP

Source

CROP INSURANCE

Centre to sweeten insurance policy for farmers - The New Indian Express – 10th May 2019

With the Union ministries already been instructed to work on the new government's agenda for 100 days, the agriculture ministry is trying to make the farm insurance scheme more "farmer-friendly".

"We have already started preparing the 100-day agenda for the new government and are working on reforms that were stuck due to the model code of conduct. One major agenda is to work on the agriculture insurance scheme, to make it more farmer-friendly," a senior official from the Ministry of Agriculture told TNIE.

Launched on August 5, 2016, the farm insurance scheme was aimed at providing farmers with an inexpensive option of sustaining agriculture even if the yield is poor or damaged.

According to officials, the general consensus is to widen the coverage under the insurance scheme and to also include damage and loss to cattle and property in case of a natural disaster. Such damages are currently being covered by the National Disaster Response Fund.

To make the scheme more attractive, the ministry is also planning to further lower the premium. The idea is not new though. The Committee on Estimates (2018-19), in its 30th report on performance of the National Action Plan on Climate Change (NAPCC), had also pointed out some loopholes in the scheme.

"The scheme suffers from several problems such as delay in crop-cutting experiments and its associated high costs, delayed/non-payment of insurance claims to farmers, and lack of transparency. As a result, farmers lose interest in the crop insurance scheme. Another problem relating to crop insurance schemes in India is coverage," the panel had said in the report.

The committee had recommended that adequate financial allocation should be made, so that crop insurance schemes attract participation from a greater number of farmers, which was not the case currently.

(The writer is Anuradha Shukla.)

TOP

Source

INSURANCE CASES

Insurance firms told to pay Rs 27k for failing to provide cashless treatment – The Times of India – 16th May 2019

The district consumer disputes redressal forum directed theNew India Assurance Company and Vidal Health Insurance TPA to pay Rs 15,000 as compensation for failing to providecashless treatment despite promise and not paying the full claim to the complainant. They were also directed to pay the remaining claim of Rs 12, 042 along with 9% interest per annum from the date of making the first payment i.e. December 4, 2017, till realization.

Sunita Bhalla, a resident of Sector 4, Panchkula, stated in her complaint that her husband had purchased New India Flexi Floater Group Mediclaim Policy from the company. She got unwell and was admitted to a private hospital in Mohalion October 6, 2017, and was discharged the next day.

The hospital had raised a bill of Rs 1.29 lakh which was paid by them as the insurance company did not accord approval for cashless treatment, though the policy of cashless treatment was taken.

The bill was submitted to Vidal and an amount of Rs 99,632 was only transferred to her account and when she sent a legal notice to the New India Insurance Company, further amount of Rs 15,025 was transferred to her account without any reference, but the remaining amount of Rs 15, 292 was not transferred from the total amount of Rs 1.29 lakh. Despite cashless policy, approval was not accorded. Since no approval was received, the complainant was put to humiliation.

In its reply, the insurance company stated that deductions were made as per terms and conditions. There was capping in the room rent and was limited to boarding and nursing expenses actually incurred or 1% of the sum insured per day whichever was less, Rs 1,500 as against admission charges, Rs 168 deducted

against consultation charges, Rs 350 deducted as against consumables and disposables, Rs 1,836 deducted being non-medical expenses, Rs 492 deducted against laboratory investigations, Rs 1,275 deducted against miscellaneous charges, Rs.500 deducted being excess amount and Rs 19,960 was deducted against charges of surgeons. Vidal did not reply to the notice.

The forum after hearing both the sides held: "Perusal of the record shows that the first installment of Rs 99,632 was deposited in the account of the complainant and thereafter another amount of Rs 15,025 was deposited in her account. How this was released in piecemeal is not understandable and no clarification on this score has been given by the companies.

It was further pointed by the forum, headed by president Rattan Singh Thakur, that "The insurance company has not denied the claim that it was a cashless facility. If it was so, then why approval was not accorded for cashless facility, is not understandable."

The forum observed that: "Even the evidence led by the complainant shows when the assurance of approval for cashless facility was given by them, the hospital had calculated the patient's share of Rs 3,250 and the rest wascashless. There is no explanation on this point of fact why the approval for cashless facility was not accorded particularly when the policy was such. The insurers themselves did not follow the terms and conditions of cashless facility. At the most, Rs 3,250 as patient's share could have been deducted and no other amount."

They were then directed to pay up for causing mental agony and harassment to her.

(The writer is Kamini Mehta.)

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Source

Insurance firm asked to pay Rs 50k compensation – The Times of India – 15th May 2019

The Visakhapatnam district consumer redressal forum-II has held HDFC Life Insurance company guilty of deficiency in service and has directed the company to pay a compensation of Rs 50,000 to a complainant and settle an insurance claim of Rs 4.5 lakh.

The company had refused to pay the insurance claim amount to a Maganti Raju, citing that the policy holder Maganti Venkata Swamy had misrepresented his profile and health conditions. 40-year-old Maganti Venkata Swamy got himself an HDFC endowment assurance policy on November 29, 2013 for a policy term of 20 years for an assured sum of Rs 4.5 lakh. Venkata Swamy's son Maganti Raju is the nominee of the policy. The policy holder, Venkata Swamy died of cardiac arrest on November 11, 2014.

Raju approached the insurance firm for the claim amount and submitted all necessary documents on February 8, 2016. However, the insurance firm refused to pay the claim, claiming that the policy has been cancelled owing to misrepresentation.

The insurance firm claimed that Venkata Swamy was an agricultural labourer, but had mentioned his profession as a farmer in the insurance policy. Moreover, the company also claimed that Venkata Swamy had tested HIV positive and had died of HIV.

After repeated visits, Maganti Raju filed a petition with the consumer forum, citing deficiency of service on the part of the insurance firm. The forum observed that the firm's investigator had failed to submit documentary evidence to substantiate the claims that Venkata Swamy had died of HIV and had misrepresented himself.

The forum directed the insurance company to pay a compensation of Rs 50,000 and pay Rs 4.5 lakh as the insurance claim and also pay Rs 2,500 as legal cost to the complainant.

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Source

Multi-crore insurance scam busted in Sangrur – The Times of India – 11th May 2019

The Sangrur police on Friday busted a multi-crore insurancescam in which an interstate gang of conmen were collecting data from insurance companies and then misleading the policy holders into investing money in Ponzi scheme while promising them waivers on insurance premiums.

SSP Sangrur Sandeep Garg said the special police team, investigating the matter after a complaint filed with the Dhuri Police station, has so far dug out details which shows a 14-member gang, including a woman, have duped a number of policyholders of around Rs 8 crore.

Garg said police arrested seven persons including the woman while the remaining seven members of the gang were still atlarge. "Police teams have been dispatched to nab them."

He said gang members operated in various parts of Punjab and Haryana and collected data from insurance companies about policyholders. They would then scrutinize this data and identify people who had missed their payment of annual premiums. The gang members would then approach these individuals posing as investment agents and entice them to invest money in ponzy schemes. They would promise them of a good return on their investments and a waiver on annual premium.

Those arrested include mastermind Arun Kumar and Dushyant, both residents of Manimajra near Panchkula, Ekta Sharma of Panchkula, Jugraj Singh of Amritsar, Shagunpreet Singh of Zirakpur, Gagandeep Singh of Chandigarh and Jagraj Singh of Amritsar.

The other seven members of the gang who are yet to be captured include, Kailash Soni, Sharad Pawar, Abhishek Jain, Aditya Pandir, Vikas Kumar, Mohammad Ramzan Ansari and Bharat Sharma.

The police have so far made a recovery of Rs 13.76 lakh from them along with 113 grams of gold, a car and some mobile phones. The SSP said, "During interrogation, they have admitted to collect a total of Rs 2.68 crores from unsuspecting policyholders. They also managed to dupe a Ludhiana based businessman of Rs 4 crores and an another businessman from Haryana of Rs 1.5 crores." The SSP said following the busting of this gang, the policehave started receiving more complaints from Punjab and Haryana which were being verified. He said the total fraud could run into several crores of rupees.

(The writer is Manish Sirhindi.)

TOP

Source

CCI dismisses complaint against Oriental Insurance Company – Financial Express – 10th May 2019

The Competition Commission Friday dismissed complaint against Oriental Insurance Company over alleged abuse of dominant position. The complaint was filed by Anil Rathi, partner of Bahadurgarh-based Laxmi Polymers, who had taken fire insurance policy from Oriental Insurance for the firm. Owing to storage of volatile material and use of high tension wires at the premises, a "Standard Fire and Special Perils Policy" was availed for the firm to cover the risk in case of any adversity, the complainant said.

As per the complainant, on the intervening night of 20/21 December 2016, a fire broke out on the premises of the firm and pursuant to the loss occurred on account of fire, an insurance claim was lodged with Oriental Insurance. However, the insurance company rejected the claim on the ground that the firm was in breach of certain conditions mentioned in the policy. Besides, while rejecting the insurance claim, no objection certificate given by the fire department of Bahadurgarh was completely ignored, the complainant alleged. Moreover, the complainant alleged that the survey report done by the insurance company to assess the loss was also not shared with him.

The manner in which the insurance claim was rejected shows that Oriental Insurance abused its dominant position under Section 4 of the Competiton Act, the complainant alleged. For the case, the Competition Commission of India (CCI) considered "market for provision of fire insurance services in India," as relevant one. The fair-trade regulator said that with 25 general insurers offering fire insurance policies, the market for non-life insurance is competitive.

Considering that Oriental Insurance enjoyed only 8.6 per cent market share during 2017-18, the company cannot be said to be in a dominant position, the CCI noted. Since the company is not dominant in the relevant market, "the Commission does not propose to examine the allegations against it of having abused such position". Accordingly, the matter is disposed of as there is no contravention of Section 4 of the Competition Act, it said.

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Source

PENSION

Do new EPFO norms mean more pensions? - Deccan Chronicle – 17th May 2019

In a recent move, upholding the judgment of the Kerala High Court, the Supreme Court directed the Employees' Provident Fund Organisation (EPFO) to allow the pension to the employees based on their full salary. Before we dive into the impact of the apex court's decision on the employees, let's check out the EPFO rule that was applicable before the judgment.

EPFO RULE BEFORE THE JUDGMENT

As per earlier the EPFO rule, all employees who qualified for EPF deduction were required to contribute at least 12 per cent of their salary, i.e. basic plus dearness allowance (DA). The employer was also required to make an equal contribution to EPS at the rate of 8.33 per cent of the salary or Rs 1,250 whichever was higher and rest to the employee's EPF account. Employers considered a maximum salary up to `15,000 for calculating the EPS amount. So the employer's contribution to EPS was restricted to a maximum of Rs 1,250.

WHAT HAS CHANGED NOW?

After the court's ruling, 8.33 per cent of your last drawn salary will go to EPS, if you choose the higher pension option. The pension is calculated as the number of years in service multiplied by last drawn salary and divided by 70. The salary in this context is basic plus DA. Earlier the salary was capped at `15,000 but now the last actual drawn salary will be considered for employee's contribution.

Let's understand this with the help of an example. Suppose a person 'A' was getting a monthly salary (basic + DA alone) of `8,000 in the year 2001-02 and the salary increased at a rate of 12 per cent every year, leading to a current monthly salary of `54,938. According to the earlier EPFO rule, 'A' would have received a pension of `3,857 (as per salary of `15,000/month). But if if 'A' opted for EPS based on the

higher salary amount of `54,938, the pension would be `14,127. Employees who want to get a higher pension amount would be required to transfer an additional amount from their EPF account to their EPS account. Therefore, the EPF corpus will be eroded due to the transfer from EPF to EPS. To exercise this option, a person needs to have sufficient balance in the EPF account. The deduction from his EPF account would be 8.33 per cent of his salary and interest thereof with retrospective effect.

ADVANTAGES TO EMPLOYEES

The employees who received heavy salary increments in the last stages of their career will benefit more in comparison to employees who get periodic increments, or low increments later in their careers.

Under the new rule, the portion of contribution to EPF from the employer's contribution will go down, and the amount allocated to EPS will go up.

If you are looking to manage your pension income in retirement, then having a bigger corpus in the EPF would be more beneficial for you. However, if you are not skilled at money management, or think that your retirement corpus would be mismanaged if you receive it all at once, then it's better to transfer fund to EPS and get an increased pension income after retirement.

There are many cases of mis-selling in which retired/retiring people are convinced against their interests to invest in low-quality investment products. But by investing in the new EPS such individuals can ensure a higher pension and protect their retirement fund from unscrupulous people.

But on the flip side, pension income is taxed. So if you fall in a higher tax bracket, you may want to avoid a higher pension option and look to invest the retirement corpus in other avenues like debt funds with a Systematic Withdrawal Plan, or small savings schemes such as the Senior Citizens' Savings Scheme. If you fall in a low tax bracket, you can explore the option of investing in EPS for a higher pension amount.

STEPS TO USE OPPORTUNITY

Further clarity is required on issues like eligibility for availing new EPS rule by the recently retired employees. If you want to avail the benefit of the new rule and want to increase your pension corpus, you have to submit an application to the EPFO. The application must be submitted through your employer allowing EPFO to deduct 8.33 per cent of your salary and transfer it to EPS along with interest thereof retrospectively till date while adjusting the due from the PF corpus.

(The writer is Adhil Shetty.)

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Source

How NPS has secured retirement of govt staff better than EPFO - The Hindu Business Line – 13th May 2019

Central and State government employees, who were made to subscribe to the National Pension Scheme (NPS), do not have too much to complain about. For, these schemes have delivered far higher returns than the Employees' Provident Fund Organisation (EPFO) despite following a rather conservative investment strategy.

Since April 1, the Pension Fund Regulatory and Development Authority (PFRDA) has given more investment options under the NPS to Central government employees, making the product more attractive.

The Centre made NPS available to new entrants in its services, with the exception of the armed forces, with effect from January 1, 2004. Most State governments, too, followed suit.

The pension savings of government subscribers are split and invested equally in the funds managed by three pension fund managers — SBI, LIC and UTI.

They manage separate funds for Central (Scheme-CG) and State government (Scheme-SG) staff. Currently, these funds jointly manage a corpus of around Rs. 1.1-lakh crore and Rs. 1.6- lakh crore of Scheme-CG and Scheme-SG, respectively.

The funds allocate up to 15 per cent in equities and the rest in government securities and corporate bonds.

Cautious approach

Despite such a cautious investment mandate, Scheme-CG and Scheme-SG have delivered average annual returns of 9.1 and 9.5 per cent, respectively, over the past 10 years.

This is higher than the average 10-year EPFO return of 8.7 per cent (without considering the tax aspect).

The two NPS schemes have also outperformed conservative hybrid mutual funds that invest up to 25 per cent in equities, in the last five- and 10-year timeframe (see table).

Greater flexibility

Following a gazette notification issued by the Finance Ministry on January 31 this year, the PFRDA issued a circular on May 8, allowing Central government subscribers to select any of the eight pension managers to handle their funds.

The investment choices have also been expanded. They can choose from four options under Tier-I — Scheme-G, where investment is primarily in G-Secs; conservative lifecycle funds that park up to 25 per cent in equity and the rest in corporate bonds and G-Secs; moderate lifecycle funds that invest up to 50 per cent in equity; and the existing scheme that had managed the corpus thus far.

While government employees can now increase their equity allocation by opting for the lifecycle funds, these funds restrict the equity allocation based on the age of the subscribers. Since transferring the existing Rs. 1.1-lakh-crore corpus of Central government subscribers can impact the market, changing the investment pattern of the legacy corpus may not be possible immediately.

Therefore, the change in pension funds or investment pattern is allowed for incremental flows only. The PFRDA plans to come up with a scheme for the transfer of the accumulated corpus to match the new choices over five years.

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Source

EPFO offers online facility to withdraw PF balance – Mint – 11th May 2019

The Employees' Provident Fund Organisation (EPFO) is offering an online service to withdraw your provident fund (PF) account balance. To make the withdrawal process quicker and easier, the provident fund body has introduced a one-page composite form for those EPF subscribers who have linked their Universal Account Number (UAN) with Aadhaar.

The single page composite claim form replaces multiple other claim forms like Form 19, Form 10C, Form 31, etc that were in use earlier.

These claim forms are accepted and processed on self-attestation basis without the need for attestation by the employer. The EPFO earlier had three withdrawal forms - Form 19 for final PF settlement, Form 10C for pension withdrawal and Form 31 for non-refundable PF advance.

Now the composite form asks you the nature of the withdrawal. You can withdraw your PF balance for buying a house, land or even for setting off home loan. Other reasons under which withdrawal is allowed include medical expenditure or marriage in the family, child's higher education, etc. You are also allowed to withdraw your PF balance a year before retirement.

In most withdrawal cases, only your Aadhaar, bank account details and PAN card number is required, and no other document is needed to make the claim. According to PF rules, if an amount is withdrawn before five years of continuous employment, it will be taxable as "income from salary".

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IRDAI CIRCULARS

List of Non Life Products of 2018-19 is available on IRDAI website.

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First Year Premium of Life Insurers for the Period ended 30th April, 2019 available on IRDAI website.

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IRDAI issued exposure draft on IRDAI (Minimum Information for Inspection or Investigation) Regulations, 2019.

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IRDAI issued exposure draft on Guidelines on Standardization of Exclusions in Health Insurance Contracts and Modification Guidelines on Product Filing in Health Insurance.

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Source

GLOBAL NEWS

China: Govt to combine rural and urban medical insurance schemes – Asia Insurance Review

China is looking to establish its 'unified national medical insurance service' for both urban and rural citizens across all regions by the end of this year, reported state press agency Xinhua citing a circular issued by the National Healthcare Security Administration and the Ministry of Finance. The circular has urged seven provincial-level regions which have yet to fully integrate their medical insurance schemes to speed up their processes. To date, 24 provincial-level regions in China have combined rural and urban medical insurance schemes into one.

Offering both urban and rural residents equal benefits, the new insurance service was first introduced by the newly-formed state medical insurance administration in July last year.

The state medical insurance administration is responsible for developing and implementing policies, plans and standards on healthcare systems in terms of medical insurance, maternity insurance and medical assistance. It was officially set up in May 2018.

Few years back, Chinese citizens residing in rural areas used to have a medical insurance scheme which offered a mediocre range of benefits in comparison to urban citizens. In 2017, the government started to standardise insurance schemes for both urban and rural citizens.

The circular also announced that the average minimum amount of medical insurance subsidy for each citizen will increase by CNY30 ($4.4) to CNY520 in 2019. Currently, the government provides each citizen with CNY490 yearly in his or her medical insurance account.

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Source

New Zealand: Regulator urges life insurers to conduct themselves better – Asia Insurance Review

The Financial Markets Authority (FMA) has raised concerns about issues within the local life insurance sector especially regarding conduct and culture. Speaking at the IFSO Conference 2019, director of regulation Liam Mason said that the FMA's recent review of the sector revealed that there was inadequate leadership as well as a lack of oversight of advisers and intermediaries as two main areas which led to poor customer experience.

Established about 8 years ago, the FMA is the first conduct regulator of New Zealand's financial markets and its principal legislation is the Financial Markets Conduct Act.

FMA's review of the life insurance sector was undertaken in collaboration with the Reserve Bank. It examined conduct and culture maturity in major areas such as customer outcomes, governance, risk management and issue identification and remediation.

The review noted that there was good customer focus in frontline claims teams, complaints handling teams and some call centres. However, this customer focus was not always reflected across the insurance companies as a whole.

In particular, FMA found it disappointing that most life insurers were not asking questions about conduct within their firms, and boards have not been demanding information regarding customer outcomes and treatment.

Mr Mason said there was limited evidence to suggest that life insurers had looked at FMA's conduct guide or were assessing their businesses against the themes and issues that had emerged from the Australian Royal Commission.

"Not enough is being asked to let insurers gauge the standards of conduct occurring in their names," he said.

According to FMA, life insurers are unwilling to accept responsibility for what is being done in the insurer's name and with the insurer's products. He reiterated that the insurer is ultimately accountable for customer outcomes.

FMA found the following breaches of conduct among life insurers:
- The selling to foreign customers who were ineligible for cover as they were not New Zealand residents.
- Sending out information to customers the insurer knew was incorrect.

• A system error that resulted in an excessive inflation increase of up to 30 times, with matching increases in the premiums. When discovered, the insurer did not proactively contact customers, and three years on remediation had not been completed for just under half of the customers involved.

Life insurers urged to monitor complaints

FMA also observed that complaints are helping to highlight issues to insurers, and not their own monitoring processes which was found to be often poorly embedded, inconsistently used and under-invested in. Therefore, FMA urged insurers to employ appropriate systems and processes to record and resolve complaints.

The regulator found inadequate monitoring of outcomes particularly in products such as:

- Accidental death cover
- Specified injury cover
- Funeral cover
- 'guaranteed acceptance' products
- Loan or credit card repayment protection insurance (payment protection).

FMA felt that these products were highly unlikely to be of real value to consumers given its performance in terms of loss ratio or declinature rates.

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Source

Thailand: Health insurance now mandatory for long-staying foreigners aged 50 and above - Asia Insurance Review

According to a new rule approved in the cabinet, health insurance is now mandatory for foreigners aged 50 years and above who are seeking to stay long-term in Thailand. This seeks to reduce the financial burden placed by some foreigners who have not paid for their treatment in state hospitals, reported The Nation.

According to Health Service Support Department director-general Nattawuth Prasert-siripong, the new rule applies to both new applicants for the non-immigrant visa (O-A), which offers a stay of up to one year and those wishing to renew their visa. He also said that health insurance is beneficial for foreigners.

Foreigners can purchase their compulsory insurance policies either locally from longstay.tgia.org or overseas as long as it offers up to THB40,000 ($1269.73) coverage for outpatient treatment and up to THB400,000 for inpatient treatment. "We are going to discuss with relevant authorities on to how to check the validity of health insurance bought from overseas," said Mr Nattawuth.

For foreigners who have considerably high health risks and are thus unable to purchase health insurance, relevant authorities might require them to have sufficient funds in their bank accounts to ensure they are able to pay for their living and medical expenses in Thailand.

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Source

Australia: Insurance costs to rise due to climate change - Asia Insurance Review

The annual average risk costs of extreme weather and climate change to properties is projected to rise to A$91bn ($63.48bn) per year in 2050 and A$117bn per year in 2100, revealed findings from the Climate Council of Australia's report on the domestic costs of climate change. These costs will be reflected through higher insurance premiums and will primarily impact the same households that will experience the steepest losses in property values due to events caused by climate change.

The Climate Council of Australia is an independent and crowd-funded organisation seeking to provide information on climate change to the Australian public. Its latest report, titled 'Compound Costs: How Climate Change is Damaging Australia's Economy', presents findings on how climate change is a major threat to Australia's financial stability and poses substantial systemic economic risks.

The report also warns that delays in taking swift and decisive action against climate change will cost the Australian economy dearly.

According to the report, certain Nat CAT events may not be covered by commercial insurance even though the frequency of these events is set to rise due to climate change.

While hazards such as bushfires, riverine flooding and storm damage are generally covered, events such as coastal inundation, erosion, landslip and subsidence are all generally excluded. This means that people and businesses are effectively self-insured against these hazards or insured by the taxpayer.

New modelling reveals exorbitant costs to property and agriculture

Based on the Australian Federal Government's current approach to climate change, detailed new modelling commissioned by the Climate Council for the report have disclosed that the economic damage to Australia's property and agricultural sectors will be very significant with possible sharp adjustments in residential property values in some areas.

The modelling was conducted in two parts. Firstly, damages from climate change to agricultural productivity and labour productivity were modelled using the Global Trade Analysis Project Computable General Equilibrium Model.

Next, a separate analysis was undertaken by the Cross Dependency Initiative (XDI) which included each property being tested against six extreme weather hazards – flood, coastal inundation, bushfire, wind storms, heatwaves and soil subsidence. This assessment is said to be one of the largest climate change risk assessments of property in Australia.

Results from the modelling disclosed that the total estimated damage related loss of property value – excluding any disruptions to productivity – is expected to rise to A$571bn by 2030, A$611bn by 2050 and A$770bn by 2100.

These costs are likely to be highly concentrated on about 5-6% of properties and could lead to insurance premiums possibly being effectively unaffordable by 2030 for one in every 19 property owners in Australia as premiums would cost 1% or more of the property value per year.

Recommendations to tackle risk costs

Considering the increasing prevalence of Nat CAT events, the report has called for an in-depth study on this topic which will present a more comprehensive view of the likely economic costs resulting from climate change.

It has also put forth recommendations that the government can adopt to avoid certain losses and damages involving activities such as:

- Reducing emissions to net zero by 2050 or earlier, through clear and coordinated policy leadership
- Strengthening building codes to increase the thermal efficiency and energy efficiency of buildings as well as ensuring building designs are fit-for-purpose to cope with increasingly frequent and severe climate-influenced hazards
- Adopting risk-appropriate national land-use planning guidelines that prevent new buildings and infrastructure being constructed in areas that are, or will be, highly exposed to climate change

hazards, and that help facilitate the reduction of emissions across the transport and buildings sectors

- Upgrading and constructing new infrastructure (including infrastructure specifically designed to mitigate disaster risks), informed by a national assessment.

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Source