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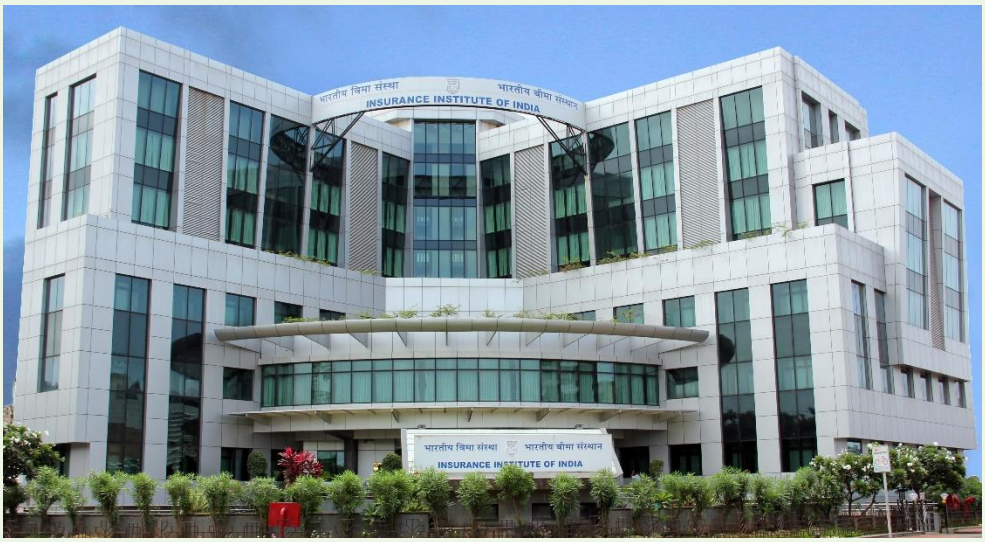


QUOTE OF THE WEEK

"Acceptance of what has happened is the first step to overcoming the consequences of any misfortune."

William James

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Hail Insurance

Hail insurance refers to a policy bought by farmers that covers damage to crops because of hail and other natural disasters. It is usually provided by the government in the US as a way of protecting agriculture in the country. Hail insurance usually falls under the more general term crop insurance. The latter term suggests that crops are not just protected from hail but from other natural disasters as well, like fire and storms.

The government, through the Federal Crop Insurance Corporation, provides this policy for farmers. This is not just to protect the farmers but the agricultural industry as well. It is a recognition that agriculture provides so much for the economy of a state. Private insurance companies sell crop-hail insurance. This type of insurance covers damage from hail alone. Private insurance for farmers tend have policies designed for a specific peril.

LIFE INSURANCE

Life insurers see impressive 22% YoY growth in new business premium in Sept - Business Standard – 8th October 2021

With the ill-effects of the second wave of the pandemic behind and urgency among consumers to buy insurance before the premium hike, life insurers showed impressive growth in new business premiums (NBP) in September over the same period last year. The NBP of life companies was up more than 22 percent year-on-year (Y-o-Y) in September to Rs 31,001 crore. While private insurers, 23 in total, saw their NBP go up more than 42 percent, state-owned insurance behemoth Life Insurance Corporation (LIC) saw a 12 percent rise. The top three private insurers--SBI Life, HDFC Life, and ICICI Prudential Life--recorded a NBP growth of 30.5 percent, 37.5 percent, and 20.8 percent in the same period. NBP is the premium acquired from new policies in a particular year. Rushabh Gandhi, Deputy CEO, Indiafirst Life Insurance said, "Life insurance industry's Y-o-Y growth has picked up admirably in the recent months.

LIFE INSURANCE SECTOR NEW BUSINESS PREMIUM GROWTH (in ₹cr)

	Private Insurers	LIC	Industry Total
September, 2021	12,480.96	18,520.21	**31,001.17**
YoY growth (%)	42.42	11.55	**22.21**
Q2FY22	29,744.72	49,511.91	**79,256.63**
YoY growth (%)	24.43	-3.84	**5.12**
QoQ growth (%)	73.60	39.07	**37.3**

Source: Life Insurance Council

The economy has been faring well with the gradual receding of Covid-19. Increasing interest and awareness about insurance amongst people is also aiding growth. The growth can also be partially attributed to the base effect of H1 last year which was marred by the lockdown. Also, there is speculation around an increase in mortality premiums and this is causing customers to fast track their decision to buy". Experts have also pointed out that typically the quarter-ending month sees higher premiums because bancassurance partners of life companies push the sale of insurance products aggressively to shore up their fee income.

In Q2FY22, the industry recorded a 5 percent YoY growth in NBP over the same period last year, with private insurers growing at 24 percent and LIC recording a 4 percent contraction in premium. However, on a sequential basis, the industry recorded 37 percent growth in NBP as private insurers grew by 73.6

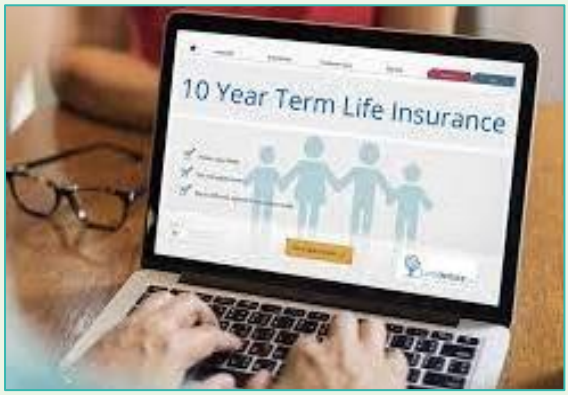
percent and LIC grew by 39 percent. Growth in Q1FY22 was muted due to the second wave of the pandemic and also because the first quarter of any financial year is generally slow for the industry.

To add to the misery, the sector witnessed significant claims because of the devastating second wave, and profitability suffered as companies shore up their reserves to alleviate the impact of the claims. But, the sector has seen green shoots since August with a focus on annuity, non-par, and ULIP products. And, Q2FY22 has ended somewhat better than Q1FY22. Given the increasing share of digital channels, the demographics, and market under penetration, continued easing of restrictions, and opening of the economy, the life insurance premiums are expected to witness improvement in FY22, said Care Ratings in a note. As far as H1FY22 is concerned, the life insurance industry has recorded 5.8 percent Y-o-Y growth in NBP to Rs 1.31 trillion, with LIC recording a 3.3 percent drop and private insurers growing by 28 percent.

(The writer is Subrata Panda.)

TOP

Buying term insurance will be costlier by 30 percent – Hindustan Times – 2nd October 2021



Buying term insurance can be expensive once again. Insurance companies are preparing to increase the premium of term insurance by 25 percent to 30 percent. Sources related to insurance companies have given this information. According to the information received, eight to 10 companies have planned to increase the premium of term insurance from the end of this year. This time the premium can be increased by 30 percent.

At the same time, companies have increased the premium of the already taken term plan by 30 percent to 40 percent. It is worth noting that even before this, insurance companies had charged four to five percent more premium on renewal of policy in March. In this way, for the second time in a year, insurance companies are going to increase the premium of term insurance.

Why is term insurance getting expensive?

Regarding the cost of term insurance, insurers say that they are under a lot of pressure from re-insurance companies. This is the reason why insurance companies have to increase the premium money. It is also being said that the underwriting of re-insurance has been tightened, which is making insurance costlier. Some of the other changes that can happen are insurance companies can demand income proof, bank statement from their customers. Till now such documents were not being asked for. Companies can also tighten the conditions for medical check-ups.

Increased risk due to corona

Insurance companies fix premium on the basis of insurance underwriting. The higher the risk involved in underwriting, the more expensive the premium can be. The risk has increased due to the corona pandemic. Hence the companies say that they have no other option but to increase the premium. Significantly, due to the sudden death of lakhs of people due to corona, the financial burden on insurance companies has increased. In view of this, the insurance companies have decided to increase the premium.

TOP

GENERAL INSURANCE

Cargo insurance premiums up 33%; second fastest after personal accident biz - Business Standard – 7th October 2021

The sudden jump in the volume of oil, gas and coal being transported across the seas is pushing up cargo insurance premiums for India's general insurance companies. This is significant as the cargo insurance market had declined by close to 8 percent in FY21. However, in the current financial year (till August), the total premium for the sector has jumped by 33.6 percent, making it the second fastest after personal accident business, eclipsing heavyweights, motor and health insurance. "The market is very competitive, but the tenders are now coming at a rapid pace," said a senior marine insurance specialist at one of the state-owned insurers. The energy trade is fraught with the risks of spillage and natural catastrophes like hurricanes.

Despite that, insurance companies are offering almost the same premium rates, banking on high volumes to make up for them. In September, almost all the refineries floated three-month tenders for insurance rates to which all the major underwriters have responded. The low rates are significant as there has been a hardening of premium for global cargo insurance, especially in the latter half of calendar year 2020, a trend which has continued into 2021. Global marine underwriting premiums for 2020 grew by 6.1 percent to $30 billion year-on-year. Offshore energy insurance accounts for 12.1 percent of the total marine cargo business as per figures released by International Union of Marine Insurance (IUMI), the global organisation which tracks the sector. While Europe remained the biggest contributor, accounting for 47.7 percent of the premiums, Asia has become the next largest, with a share of 29.3 percent.

In India, the top five insurance companies are ICICI Lombard, followed by New India Assurance, Tata AIG, United India and Oriental Insurance. To back the low rates, the insurance companies are confident that they will be able to bargain for higher reinsurance support from the global underwriters, despite the perceived high risks of the sector. IUMI has, however, warned that with economies recovering and shipping and offshore activity increasing, "it can be expected that both claims frequency and severity will also rise again." IUMI has also warned that the shipping business in the energy sector is particularly susceptible to natural catastrophic events. "Although there appears to be a strengthening of the offshore energy market, the long-term outlook remains uncertain at this point," it said. In the pecking order of the non-life insurance business in India, health tops the list, followed by motor. Cargo insurance comes way down the chart, accounting for less than 2 percent of the total premium (figures for FY22, Upto August). The underwriters are hopeful this can change rapidly this year. The large premiums and the larger risks for the business both come from seaborne cargo like ores and fuel.

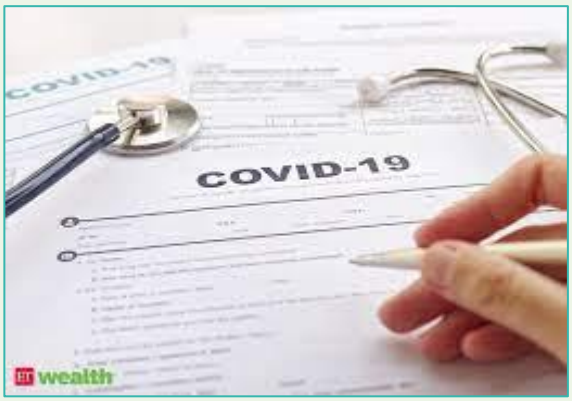
(The writer is Subhomoy Bhattacharjee.)

TOP

Evolution of health insurance policies during the COVID pandemic – The New Indian Express – 4th October 2021

The Covid-19 pandemic has changed not only individuals' approaches towards health insurance but also various health insurance policies. The severity of the Covid-19 pandemic, especially the second wave, and post-Covid complications have made people realise the importance of having a health insurance cover, that too, a large enough coverage to fund hospitalisation and other medical costs.

And while people are inquiring more about health policies, health insurance companies have also improved their offerings by adding more features and relaxing some rules to make the claims easier.



Changing customer behaviour

The pandemic has forced people to shed their reluctance to buy health insurance policies. They are more aware about the benefits and features of health policies. People are also enquiring more about ways to increase their insurance coverage.

We have seen customers looking for innovative products offering coverages to cater to specified diseases and higher sum insured, says Subrata Mondal, executive vice-president, underwriting, IFFCO Tokio General Insurance Company.

Sanjay Datta, head of underwriting and claims, ICICI Lombard, says customers are now asking specifically about benefits and exclusions/ non-payables alike. While people are now more aware of health insurance and their features, the way they buy insurance is also changing.

According to an Emkay Global Research report on the General Insurance Industry, Covid-19 has accelerated the adoption of digital technology in most aspects of the general insurance business. “This has also increased the focus of insurers on reaching customers using digital means,” says the report. With the accelerated adoption of the digital mode of buying insurances, health insurers are also seeing a growth in offering innovative and cost-effective insurance solutions to customers.

Changes in health policies

For health insurers, the Covid-19 pandemic came as an opportunity to expand their customer base as well as product portfolio. With people enquiring more about health insurance, its features, etc., health insurance companies had to make the most of the opportunity and so they decided to change, both on their own account as well as due to the nudge from the regulators.

Whether it is the launch of Covid-specific products, short-term covers, home care covers, health insurers were quick to expand their product portfolio and product features to suit the customer needs. Datta of ICICI Lombard says they have been proactive in providing extremely relevant features at no extra costs to customers. “Since last year, we have reduced the initial waiting period for Covid-related hospitalisations to 15 days (from earlier 30 days). We are also offering home treatment for all ailments where customers can avail treatment from the safe confines of their home, thereby, reducing the risk of exposure to Coronavirus,” says Datta.

Mondal of IFFCo Tokio says that they have added some features like Introduction of cover for telemedicine, short-term policies, Covid-specific products keeping in view the pandemic situation. IFFCO has also started the facility to pay a premium in instalments, virtual signature/online consent of proposal forms.

Jitendra Singh, Vice president, Swastika Insurance Broking Services, says some health insurers have started covering Covid from day one in the existing health policy, consumables, home treatment, etc. The Insurance Regulatory and Development Authority of India (IRDAI) has played a proactive role in nudging and directing insurance companies to wake up to the challenges faced by people due to the pandemic.

It had taken numerous steps like recognition of make-shift hospitals for Covid claims, standardized Covid policies, the inclusion of home treatment and coverage of telemedicine etc. The regulator has also allowed the launch of vector-borne disease products.

Increased compliances

While Covid-19 has forced many changes at the policy and distribution level, do these changes come at a cost - increased compliance or premium? While insurance companies claim that there has been little or

no additional compliance burden on policyholders post the Covid pandemic, insurance brokers and experts say insurers have been more vigilant while offering new policies. "We do not ask for any additional information during the renewal of any policy with us. However, during the first purchase of the health insurance policy, customers must declare all health conditions/ treatments taken/hospitalisations as detailed above," says Datta.

Mondal says in order to encourage and promote vaccination, they are going to offer additional discounts on health products to those who have taken both the doses and hence they are enquiring about vaccination status. However, he says, any member who has suffered from Covid-19 is being treated at par with other ailments.

"Only the basic information which are enquired for any kind of medical history is being sought in such cases," he says. Jitendra Singh of Swastika Insurance Broking Services says, to avoid misuse of new features and benefits added in their policies, insurance companies have set a basic minimum benchmark for compliance to ensure that the policy is not misused.

After the breakout of the Covid pandemic, health insurance products have changed for the better. However, prospective buyers and existing policyholders must be aware of all the features and benefits and their relevance to ensure they get the maximum out of their policies.

Major changes in health insurance products

- Launch and standardization of Covid-specific policies.
- Recognition of make-shift hospitals for Covid claims.
- Inclusion of home treatment under health policies.
- The advent of short-term policies with tenure less than a year.
- Coverage for tele-medicines and consumables.

(The Writer is Dipak Mondal.)

TOP

HEALTH INSURANCE

Benefits offered by OPD cover should be in line with your family's needs – Business Standard – 8th October 2021

Since the onset of the pandemic, demand is up - not just for comprehensive health insurance covers but also for outpatient department (OPD) covers. Reliance General Insurance has recently launched Reliance-Digital Care Management, a policy that covers OPD expenses with sum insurance ranging between Rs 1,000 and Rs 5,000. OPD policies are available in three formats. "It sometimes comes as a built-in benefit within a comprehensive health policy. It is also available as a rider," says Indraneel Chatterjee, co-founder, Renew Buy. Standalone policies with sum insured up to Rs 1 lakh are also available. The majority of health insurance plans do not offer OPD benefits. "The bulk of out-of-pocket expenses on health care, however, arise due to OPD expenses," says S Prakash, managing director, Star Health and Allied Insurance. Adds Amit Chhabra, head-health insurance, PolicyBazaar: "Almost everyone, irrespective of age, incurs OPD expenses." These plans usually cover costs like doctor's consultation fee,

CHECK IF OPD COVERAGE LIMIT IS ADEQUATE

Insurer	Plan	OPD coverage limit (₹)	Premium (₹) 30-year-old	Premium (₹) 35-year-old
Star Health	Star Comprehensive	2,100	11,476	11,476
Manipal Cigna	Prohealth - plus	2,000	10,625	11,942
Universal Sompo	Activ Health Platinum Enhanced (Diabetes)	7,500 after 3 years coverage	12,241	12,241
Max BUPA	Go Active	1,500	11,747	12,721
Aditya Birla Health	Activ Health Platinum Enhanced (Diabetes)	2,250 for diabetes	17,912	18,279

These policies offer OPD as in-built feature. Premiums are for ₹10 lakh sum insured, for healthy individual

Source: Policybazaar.com

annual health check-up, pharmacy bills, diagnostic tests, and dental and ophthalmic treatment. Some also cover costs incurred on physiotherapy, vaccination, AYUSH treatment, etc.

A standalone OPD cover will have its own sum insured. If OPD coverage is built into a policy, or is offered as a rider, the limit will be specified. Check whether the sum insured for OPD coverage is adequate. "Estimate your household's annual OPD expenditure and then decide on the sum insured you should buy," says Nayan Goswami, head-general insurance, Sana Insurance Brokers. Prakash says that in this age of investigative medicine, when costs incurred on diagnostic tests can be high, one should have OPD coverage of Rs 50,000-1 lakh for the family. "If the total OPD coverage is for, say, Rs 10,000 in a year, there could be sub-limits for consultancy, diagnostics, and medicines. Make sure these are adequate," says Jitendra Singh, vice-president, Swastika Insurance Broking. Sometimes there is a sub-limit on each consultation. "If your plan pays only Rs 350 or Rs 500 for each consultation, that may suffice in a small town, but not in a metro," says Goswami. Some plans impose restrictions on consultations with specialists, like two in a year. "Such low limits could be inadequate for families that have children and senior citizens," says Goswami.

If you have a pre-existing disease, you are likely to face a waiting period. Go with a plan where it is low. Check whether the OPD facility is available within a closed or open network of hospitals and doctors. Both options have their pros and cons. "When an insurer offers this facility only at network hospitals, it is able to maintain tighter control over costs and is able to offer more attractive pricing," says Chhabra. However, this can at times be inconvenient. "It means your options will get restricted to the insurer's panel of doctors," says Singh. The cashless facility is usually available only at network hospitals. Some insurers even impose co-payment if you consult outside the network. Purchase a comprehensive health insurance plan first. Remember that although hospitalisation is rare, the cost incurred on each incident is high. "Buy a high-quality base policy that offers good OPD coverage as a built-in feature. Several recently launched plans offer this," says Chhabra. If your base cover does not offer OPD as a built-in feature, but the company offers a good rider, go for it. If not (or if you want a large sum insured), buy a standalone cover. Prakash suggests going with an insurer with a reputation for offering quality service, including easy cashless claims, on OPD expenses. These policies are usually issued on the basis of self-declaration, so be truthful. Finally, you can avail of Section 80D deduction on a standalone cover too.

(The Writer is Sanjay Kumar Singh.)

TOP

Ayushman Bharat to cover sex change of transgenders - The Economic Times (Delhi edition) – 6th October 2021

Ayushman Bharat, the Centre's flagship health insurance scheme for the poorest of the poor, will now provide medical cover to transgenders and support medical intervention like sex change operations. Pradhan Mantri Jan Arogya Yojana (PM-JAY) provides a medical cover of Rs 5 lakh per family per year for free treatment at all public and empanelled private hospitals. This benefit will now be extended to transgenders under the government's new scheme, Support for Marginalised Individuals for Livelihood and Enterprise (SMILE). The health cover will include medical support and medical intervention.

Secretary (social justice and empowerment) R Subrahmanyam told ET, "There are five components of the new scheme - education, health, skill development, rehabilitation and economic linkages. For health, packages are being worked out under Ayushman Bharat for transgenders. This will cover surgeries and medical support required by transgender persons."

The ministry of social justice and empowerment will roll out SMILE on October 12. The scheme has two sub schemes - Central Sector Scheme for Comprehensive Rehabilitation for Welfare of Transgender Persons and Central Sector Scheme for Comprehensive Rehabilitation of Persons engaged in the act of begging. The umbrella scheme will cover several measures, including welfare measures for both transgender persons and persons who are engaged in the act of begging, with focus extensively on rehabilitation, provision of medical facilities, counselling, education, skill development, economic linkages with the support of state governments and non-governmental organisations (NGOs). The Centre has earmarked Rs 500 crore for a five-year welfare plan for transgender persons.

(The writer is Nidhi Sharma.)

TOP

Should you opt for long-term health insurance? – Live Mint – 6th October 2021

With the cost of quality healthcare going through the roof, even a single instance of hospitalization can dent your finances hugely. The one-stop solution to such problems is a comprehensive health insurance policy. A health insurance plan financially secures your family and yourself from hefty medical expenses.

"Despite the numerous advantages of health insurance, the task of getting your health insurance renewed every year can be cumbersome. To make this process hassle-free and to reduce the burden of yearly renewal, many insurance companies offer long-term health insurance policies," said Amit Chhabra, head - health insurance, Policybazaar.com.

"Long-term health insurance policies basically offer you coverage for more than one year. In India, there are policies which offer you the choice of continuous coverage for two or three years," said Gurdeep Singh Batra, head - retail underwriting, Bajaj Allianz General Insurance.

Let us now look at the advantages of buying long-term health insurance.

No renewal worries: Renewing your health insurance policy every year is an important financial task you need to do. "Once you buy long-term insurance, you are freed of the worry of policy renewal for two to three years. In the case of a usual health insurance policy, you would have to set aside some money for yearly renewal; also default of payment would result in cancellation of policy," said Chhabra. A long-term health insurance policy thus comes with more peace of mind.

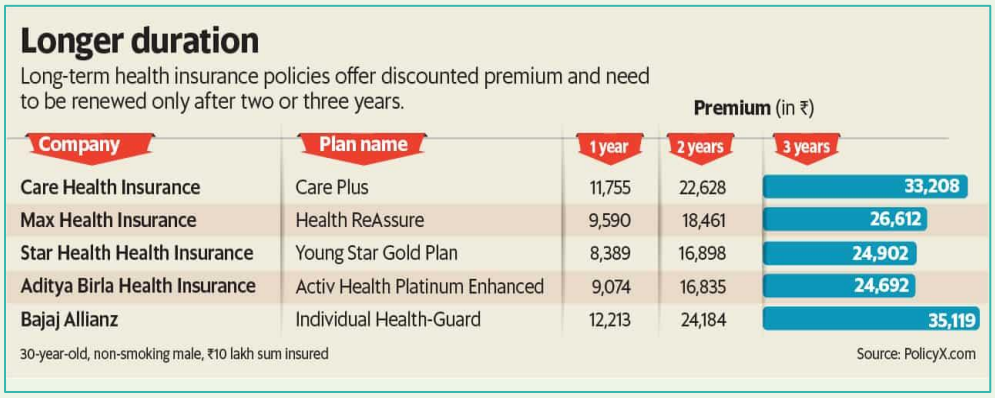
Discounted premium: Long-term policies are cheaper than annual policies as long-term discount is applied on premium paid for multiple years together.

"Depending on the company you plan to go for, the premium for a two-year policy can range from 1.8x to 1.9x of single year premium. Similarly for a three-year policy, the premium range could be between 2.7x and 2.8x of single-year premium," said Harshad Chetanwala, co-founder MyWeathGrowth and a Sebi-registered investment adviser.

Also, under long-term health insurance plans, your premium gets locked for two to three years and becomes immune to revision in prices. "The constant increase in medical inflation is one of the most important reasons why people these days are looking for long-term health insurance plans," said Chhabra.

Let us take the example of Health Guard Policy offered by Bajaj Allianz General Insurance. In case of a Platinum Plan for one individual from Zone A, with inception of policy at 32 years, and a sum insured of ₹5 lakh, the premium for a one-year plan is ₹10,600; for a two-year plan (age 33 years), it is ₹20,352 and for a three-year plan (age 34 years), it is ₹29,256. Thus, a long-term policy discount of 4% is applicable if a policy is opted for two years and of 8% if a policy is opted for three years.

Long-term health insurance plans can also make sense for you in certain situations. “Usually, health insurance premium rates are set as per age range, where the premium will increase when you move from one age range to another, say, from 36-45 to 46-50. Here, if you opt for a two-year or three-year policy at the age of 45, there is reasonable savings in long-term plans," said Chetanwala.



However, even with discounted premiums, when you opt for a long-term health insurance plan, you have to fork out a larger one-time amount. A similar higher amount needs to be planned for every two to three years. Hence, you need to plan accordingly.

“Additionally, insurers offer the option of payment of health insurance premium in instalments," said Batra.

Tax matters: Health insurance premiums are eligible for deductions under Section 80D of the Income Tax Act. “As per government guidelines, where health insurance premium is paid for multiple years in one year, the deduction shall be allowed proportionately over the years for which the benefit of health insurance is available, subject to the limits of deduction as prescribed by Section 80D," said Batra. So, you cannot claim the entire premium paid under Section 80D but only a proportional amount every financial year.

Coverage given by a long-term policy is not very different from what an annual policy gives. The differentiating factors will be the tenure of the policy and the long-term discount offered on total premium. “My advice for buying any health insurance policy is that you should check the policy terms and conditions, understand what is covered and what is not. Opt for a policy based on your requirement and healthcare needs," said Batra.

(The Writer is Anagh Pal.)

TOP

Ayushman package to cover black fungus treatment, rates of 400 procedures revised – The Tribune – 5th October 2021

The National Health Authority implementing Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on Tuesday revised the rates of 400 health benefit packages offered under the cashless hospitalisation plan and included black fungus treatment.

In the revised version rates of some packages have been increased by 20 per cent to 400 per cent. Around 400 procedure rates have been revised and one additional medical management package on black fungus added, said the government.

Mansukh Mandaviya, Minister of Health, said, “The revised version will strengthen the empanelled hospitals to provide better healthcare services to the beneficiaries under Ayushman Bharat PM-JAY. The revised packages for oncology will enhance cancer care for the beneficiaries.”

Revision has happened in the following categories—radiation oncology; medical management procedures like dengue, acute febrile illness; surgical package treatment for black fungus, right/left heart catheterisation, among others.

Under medical management procedures, rates for ICU with ventilator has been revised by 100 per cent, rates for ICU without ventilator by 136 per cent, rates for HDU by 22 per cent while prices for routine ward has been revised by 17 per cent.

Currently, Ayushman Bharat offers 1669 treatment procedures out of which 1080 are surgical, 588 medical and one unspecified package. The plan provides free and cashless hospital cover up to Rs 5 lakh annually to over 60 crore people listed as poor and vulnerable in the socio economic caste census.

TOP

Centre extends Rs 50 lakh Covid insurance cover to anganwadi workers – The Tribune – 5th October 2021

The government on Tuesday expanded the scope of Pradhan Mantri Garib Kalyan Yojana to cover Anganwadi workers (AWWs) and Anganwari helpers with Rs 50 lakh insurance cover each in case they have succumbed to Covid in the line of duty.

The Women and Child Development Ministry's proposal in this regard—to bring health workers and frontline anganwadi workers on par in respect of Covid suress—has been accepted by the government and Ministry of Finance.

So far, such insurance was available only for health workers on Covid duties. Now AWWs and helpers who died while performing any range of Covid related duties from community and fever surveillance to vaccination or care of Covid infected pregnant will get the insurance cover. India has 13,29,000 AWWs and 12,79,000 anganwadi helpers.

TOP

Health insurance premium stable in Jul-Sep, says report – Live Mint – 4th October 2021

Premium for health insurance was largely stable during July-September, despite reports suggesting a rise in premium amid the pandemic, according to Insurance Price Index data for the third quarter of 2021, compiled by PolicyX.com, an insurance web aggregator.

"The Health Insurance Price Index maintained tranquillity with no change in the index value in Quarter 3, 2021. The Health Insurance Price Index has been persistent at Rs25,124 since Quarter 4, 2020. This is the result of no price hike in the 5 health insurance companies forming the part of the index," the report said.

Naval Goel, founder and CEO, PolicyX.com, said, "It is great to see that the prices have not increased despite the fact that the insurance industry was hit by record Covid-19 claims and losses. Although the pandemic has resulted in a higher incidence of claims, there is an increased awareness of the need for insurance amongst the Indian population which should provide the impetus to help the industry grow faster."

The average payable premium by a 26-year-old across categories was Rs16,695 for Rs10 lakh sum insured, and Rs13,140 for a Rs5 lakh sum insured, highlighting the fact that premium does not increase proportionately with sum insured. From Rs5 lakh to Rs10 lakh sum insured, the premium rose 27% compared to a 100% increase in sum insured.

Also, adding members to the family floater policy does not increase the premium proportionately. In fact, there is a 50% increase of premium on an average on adding 1 more adult of the same age or lower age in

the same policy. The increase is lower--11.9% and 13.7%--on adding first child and second child to the policy.

Of the five companies, comprising the index, the variance observed in premiums among health companies was quite high, ranging from 59-76% for different age groups compared to variance observed among term insurance companies. This is primarily because coverage, features, and benefits differ significantly for health insurance and term insurance.

Premiums reported were average compiled from five health insurance companies for all age groups - 26 years, 36 years, 46 years, and 56 years and all coverage types i.e, 1 adult, 2 adults, 2 adults plus 1 child, and 2 adults plus 2 children.

TOP

How your health insurance will help if taking treatment at a non-network hospital – Financial Express – 4th October 2021

People buy health insurance policies for cashless mediclaim. And before buying it, they also check its network hospitals list to ensure one of them is in their vicinity. However, there are times when one has to take treatment at a non-network hospital. Does the health insurance policy help in such a situation, and how?

The answer is yes, the health insurance policy does help but not completely if taking treatment at a non-network hospital. Also, the experience is not as smooth as one may experience at a network hospital.

It is believed that the longer the list of network hospitals of the health insurance company, the easier it would be to find a hospital near you for making cashless mediclaim. Health insurance companies on board a number of hospitals, clinics on their network. These networked medical facilities provide services to policyholders at a lower fee. In return, these hospitals and clinics get a regular inflow of patients who are the policyholders of the insurance companies.

However, when a person is admitted to a non-network hospital, he/she has to pay the full cost of treatment. They can submit all the treatment-related documents to the insurance provider to claim reimbursement. If the claims are found to be genuine by the insurance company then refunds are provided to the policyholder in 10-12 days.

According to Aatur Thakkar, Co-founder and Director of Alliance Insurance Brokers, if a patient gets treated in a non-network hospital, it is difficult for him to avail the complete benefits of his health insurance policy.

Documents required

"The policyholder can file a claim for reimbursement after the entire medical treatment and after bearing medical expenditure out of the pocket. However, it is necessary to submit all the original supporting documents like medical reports, medical bills, etc," Thakkar told FE Online.

"After checking all the documents and according to the underwritten policy, the total amount is refunded to the policyholder as per the claim settlement TAT of the insurer. Also, the Cashless facility provided in the network hospital will not be available," he added.

Health insurance covers treatment in non-network hospitals also. But to make the claim, Ramchandra Pandit, head of the insurance business at Navi General Insurance, said, "The policyholder needs to submit his claim form with the medical records, relevant bills, and KYC document."

(The writer is Rajeev Kumar.)

TOP

Things to know before switching your health insurance policy – Live Mint – 4th October 2021

Health insurance portability is a facility using which a policyholder can switch from his or her current health insurance company to another to avail better services.

Ankit Agrawal, chief executive officer and co-founder, InsuranceDekho.com, said, "Porting health insurance policies offers the policyholders flexibility. One may look for better cover, premium or services with another insurer ready to offer the benefits you are looking for from your health insurance policy."

Portability also helps transfer the insured's credit for pre-existing conditions and time-bound exclusions, provided the previous policy has been maintained without a break.

How it works: Once you decide to port your health policy, you are required to notify your new insurer at least 45-60 days before the existing policy expires. The new insurance company will ask you to fill a proposal for portability and to provide copies of the policy from the previous year. The new insurer will then connect with the existing insurer to enquire about your health and claims history. After gaining a thorough understanding, and considering the underwriting guidelines, the new insurer will accept or reject the proposal.

It generally takes 15 days, failing which it will become mandatory for a new insurer to accept the portability application made by the insured.

Sheenu Sehgal, vice-president and national head GI, Bajaj Capital Ltd, said, "A policyholder could face challenges in porting health policies if the expiring policy has a claim, documents presented are insufficient or the policyholder has a critical pre-existing medical condition." Besides, you should know that switching insurers has its own set of pros and cons. Let us look at some of the pros first.

Customization: You get an option to make necessary changes to your health insurance policy that suit your requirements at the time of porting.

Accumulated benefits: Portability allows you to transfer accumulated benefits such as no-claim bonus to the new policy. This means you will not be required to earn most of the rewards all over again.

Premium: Porting to a new insurance policy may help you gain financially as you may choose a policy with a more affordable premium than your existing health insurance policy.

Now, let us look at some disadvantages of health insurance portability.

Time-based: Health insurance portability is time-based, and you can only port to a new health insurance policy close to its time of renewal.

Change in policy not allowed: You may be able to switch from one health insurance policy to a similar policy or make some specific changes according to your requirement, but changing the entire policy is not allowed. For instance, you would not be able to switch to a critical illness policy from an individual health insurance policy.

Extra premium: You will be required to pay a higher premium if you choose a health insurance policy with greater benefits.

"You should thoroughly analyse your requirements before deciding to switch. Also, you must not forget to go through the coverage features, benefits, premiums, and compare similar plans online to make the best decision," said Agrawal.

When to port: You must first analyse the reason why you want to port. The reasons can be many. For instance, compared with your existing insurer, another can have a broader network of hospitals or offer more affordable premiums with similar coverage benefits.

What you should do: Porting to new health insurance is better and helpful because health products nowadays are improving rapidly. The policy you purchased a decade ago is in all likelihood overpriced and outdated today. But you must also know that porting of a policy only adjusts waiting periods. You will still be bound by the premiums, benefits, exclusions and contracts offered by the new insurer.

There are different health insurance providers, and one can always choose the best policy suitable for his/her needs. Portability comes into play when consumers want to avail of additional benefits and to maximize them. Besides, poor service can also be one of the biggest reasons for policyholders looking for alternatives with better quality and accessibility.

“In case the current health insurance policy is not providing add-on covers, it is advisable to opt for an add-on cover. This will enhance coverage and improve benefits of the policy," said Aatur Thakkar, co-founder and director at Alliance Insurance Brokers. “Sometimes, hidden clauses in policies cause havoc during emergencies. These clauses are not clearly stated, or the consumer might not even be aware of its existence while buying the policy. Therefore, one should choose to shift to an insurer which is transparent in its policy documents," said Thakkar.

(The Writer is Navneet Dubey.)

TOP

Centre extends Atal Beemit Vyakti Kalyan Yojana till 2022 – India Today – 2nd October 2021

The Central government has extended Atal Beemit Vyakti Kalyan Yojana (ABVKY) under the Employees' State Insurance Corporation (ESIC) till June 30, 2022. ABVKY was launched in 2018 to provide employment opportunities to people who lost their jobs during the novel coronavirus pandemic, including industrial workers.

ABVKY was launched on a pilot basis for two years with an aim to provide relief to those who were left unemployed during the Covid-19 pandemic and now the scheme has been extended till June, 2022. Under this scheme, insured people are paid unemployment allowance at 50 per cent of wages for three months who lost their jobs for various reasons. People whose interests are protected by an insurance policy come under the category of insured.

Benefits available to employees covered under ESI scheme:
Employees who are covered under the ESI scheme can avail the benefits of ABVKY. Every month, the ESI contribution is deducted from the salary of the employee. An insured person can directly make the claim to the ESIC branch without involving his last employer in the process. Ever since the pandemic, at least 50,000 people have benefitted from the scheme, as per reports.

The decision to announce the extension of the scheme was taken at the 185th meeting of the ESIC held in Uttarakhand's Rishikesh and the announcement was made by Union Minister for Labour and Employment, Bhupendar Yadav.

Here's how you can apply for Atal Beemit Vyakti Kalyan Yojana:
Step 1: If you want to apply for ABVKY, then you must download the ABVKY form from the official website. You can go to the website by clicking on this link: https://www.esic.nic.in/
Step 2: Fill all the required details in the form and submit it to the nearest ESIC branch.
Step 3: You also need to attach a notary's affidavit on a non-judicial stamp. You have to submit forms AB-1 to AB-4 to apply for this scheme.

Documents needed for Atal Beemit Vyakti Kalyan Yojana:
Applicants have to submit the physical claim with an affidavit, Aadhaar card's photocopy, details of the bank account at any ESIC Branch Office. The payment will be directly credited to the bank account of the insured person.

Eligibility criteria for Atal Beemit Vyakti Kalyan Yojana:
-Employees working with private companies, factories and industries can avail the benefits of ABVKY. Either an ESI card has to be made or benefits can be claimed with the help of documents given by the company.

-Only those people can avail the benefits of ABVKY whose monthly salary is less than Rs 21,000 and in the case of specially disabled people, the limit is Rs 25,000.

-The insured person must have insurable employment for a minimum time period of two years before his/her employment.

-The insured person should also have contributed to ESI not less than 78 days in the contribution period immediately preceding unemployment to avail the benefits of the scheme. As per the government notification, the contribution should have been paid or payable by the employer.

-If the person has lost his/her job due to punishment, misconduct, superannuation or voluntary retirement, then the benefits of ABVKY cannot be availed.

-The Aadhaar and bank account of the insured person must be linked with the data base and the claims can be filed only by workers.

-The claim will be due 30 days after the date of unemployment. Earlier, the limit was 90 days.

TOP

What is a Third-Party Administrator (TPA) and its relevance in Health Insurance? – Financial Express – 2nd October 2021

As people realized that health emergencies could arise at any time, the insurance companies started developing improved policies, various health products, etc. Too many service offerings made it difficult for the insurance companies to give out quality service delivery alone, eventually leading to the advent of Third-Party intermediaries by the Insurance Regulatory and Development Authority of India (IRDAI).

What is a Third-Party Administrator?
According to IRDAI, a Third-Party Administrator (TPA) is defined as a company registered with the Authority and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services. A TPA may render the following services to an insurer under the agreement in connection with health insurance business:
Insurance processing services delivered
To process health insurance claims.

What are the various roles of a TPA?
A TPA plays an indispensable role in the complete processing of a health insurance claim. The part of the TPA is massive when it comes to the health insurance sector, some of which include –

1. Smooth and holistic claim processing and settlements
A TPA is responsible for expediting a health insurance claim as soon as the policyholder intimates them. TPAs can choose to come up with their services to ensure seamless service delivery. Their job is also to

check all the documents submitted by the policyholder responsibly and thoroughly and ask for as much information from them to do the same.

These claims could either be cashless or reimbursement. In the former's case, the TPA can collect the documents from the hospital directly. In the latter's case, the TPA asks for supporting documents and bills from the policyholder.

2. Extend value-added services, or improvise the existent for the policyholder
Other than claim processing, a TPA is also responsible for sharing knowledge about health insurance to policyholders and improve their services to ensure seamless service delivery. Moreover, they arrange for other services that a customer might need, like – ambulance, emergency assistance, well-being programs, etc.

3. Issue health cards/ecards to the policyholder and their dependents
For every policy that a TPA issues to the policyholder, they need to validate the same. The procedure is accomplished by issuing health cards/ecards that hold the policyholder's details, dependents, the TPA responsible for claim processing, and policy number. A policyholder can show these cards at the time of their admission to the hospital's insurance desk, ensuring intimation to the TPA or the insurer about the same so they can be prepared.

4. Provide dedicated helplines for policyholders to reach out to
All policyholders should have access to information and assistance regarding their claims. A TPA is responsible for setting up helplines so that policyholders can reach out to them by calling them/emailing them. This facility should be available 24X7 for customers and needs to be Pan India.

5. Have a large network of hospitals and nurture existing providers
The TPA will have a list of network providers and on an ongoing basis, they will further try to enlist more hospitals across the country that can quickly arrange for cashless at negotiated rates, benefiting the policyholder.

For the reasons listed above and more, a TPA is central to a policyholder, the hospital, and the insurance company to work in tandem. Respective TPAs have many of their services and features that further enhance their service delivery systems and make the lives of insurers, agents, policyholders, and hospitals easier. Check them before you enroll a TPA to process your claims, and if you are a corporate employee with a TPA onboarded already, read the terms and conditions to set the right expectations for your group medical coverage.

(The writer is Satish Gidugu.)

TOP

9 Common Mistakes to Avoid While Purchasing Health Insurance – Forbes – 2nd October 2021

In this era of high cost-of-living and rising medical costs, having a comprehensive health insurance plan is a much-needed investment for individuals across socio-economic classes. It's an effective tool to safeguard against unforeseen medical emergencies and maintain financial stability.

The widespread consequences of the pandemic hurt the savings of many households as they scrambled to meet mounting medical expenses of hospitalized family members. Such circumstances reinforced the importance of securing health and financial well-being via adequate health insurance plans.

Without a proper understanding of the consequences of a health insurance policy and its clauses, hasty decisions could lead individuals to choose an ineffective plan that may not serve the purpose of opting for them. Here are the top nine common mistakes you should avoid when buying a health insurance policy in India.

1. Lack of sufficient research.
Many individuals buy a health insurance policy in a hurry without a thorough understanding of the policy terms and conditions. People also don't always remember to compare different policies and rather buy the first policy that comes their way.

It is recommended that individuals undertake rigorous research before choosing a health insurance policy. For instance, families with two or more children should choose a family floater plan rather than an individual plan. Or, if grandparents are in the family, buying a senior health insurance policy with higher tax benefits could be more viable.

Individuals must take the time to understand their probable medical expenditures in the coming years and find a suitable policy that fulfils them.

2. Insufficient policy coverage.
The premium cost is of prime consideration to decide from a wide range of health insurance policies. However, many individuals choose sub-optimal coverage plans to have an economic premium outgo and select plans with restricted insurance coverage. The restricted insurance coverage may leave an individual to pay out-of-pocket at the time of a medical emergency.

The yearly cost of the premium is significant but not the only factor to consider when buying a health insurance policy. It is essential to consider the family size, medical history, expected medical expenses, hospitalization expenses, and flexibility before making the final decision. Adequate coverage will ensure financial security and save extra financial burden of medical expenses at the time of medical emergency.

What defines adequate coverage?
A few aspects must be checked in every health insurance policy to determine if the coverage is adequate:
Hospitalization expenses: It is important to note whether the health insurance policies cover the hospitalization cost. The expenses covered must include the hospital's room rent, intensive care unit (ICU) charges, surgery charges, doctors' fees and diagnostic test costs.

Pre and post-hospitalization expenses: A good health insurance plan must reimburse any expenses incurred 15 to 60 days before hospitalization. This clause should cover doctor visits, diagnostic tests, and any other pre-hospitalization treatment. Similarly, the policy must cover medical expenses incurred for follow up post-discharge from the hospital. Ideally, insurance companies specify a window ranging between 30 to 90 days after the discharge for costs to be considered post-hospitalization.

Health Check-ups: Good health insurance plans offer yearly preventive health check-ups to make policy beneficiaries cautious of their lifestyle and promote good health. It is essential to understand this clause and access yearly medical check-ups timely.

Waiting period: There are certain diseases for which insurance plans specify a waiting period of 1 to 4 years. It is prudent to know about this clause and you must look at buying a health insurance policy at an early life stage.

3. Hiding accurate medical history.
Individuals commit the mistake of concealing their medical history while applying for health insurance policies fearing rejection or high premiums. Hiding medical history or lifestyle habits such as smoking can act against the insured at the time of claims. This could be detrimental as insurance claims can be denied on knowledge of undisclosed medical information.

Health insurance policy contracts are built on utmost good faith based on the information shared by the insured at the time of policy purchase. Disclosure of medical history might attract a slightly higher premium but will remove the possibility of claim rejection in the future.

4. Not taking a personal insurance cover.
A salaried employee gets several benefits from their employer and health insurance is one of the attractive perks of employment. But this quantum of coverage may not be sufficient for the entire family and is a contract that will terminate the moment an individual decides to quit their job. Therefore, it is crucial to have a separate health insurance plan unaffected by the terms and conditions of the current employment.

It is advisable to buy a low premium personal insurance cover to assure financial security and sufficient insurance coverage regardless of employment status. This could be handled in two ways: either have a parallel base insurance coverage for self and family or top it up with super top-up plans for additional coverage.

5. Overlooking the small print.
While an insurance company must explain the inclusions and the exclusions in a policy document, it is also the responsibility of customers to understand the policy thoroughly. Often, buyers pay attention to what is included in the policy and forget to understand the exclusions. Neglecting the exclusion list when buying an insurance policy will cost dearly during claim settlement. Having a thorough understanding of a health insurance plan is mandatory to know the inclusions and exclusions specified. This clarity is crucial to avoid unpleasant surprises at the time of settlement, and it also aids in making an informed decision when buying a health insurance policy.

Every health insurance plan comes with an option of a free-look period of 15 days. This period provides an opportunity for the insured to review the policy after buying and understand the minute details of the policy. The insured has the benefit to cancel the contract in case of some unacceptable clauses, and the insurance company shall refund any amount paid if the policy is cancelled in the free look period subject to no claims being made in the policy.

6. Misreading the Co-Pay Clause.
Most buyers don't account for inflation and lower purchasing power of money in the future when agreeing to a co-pay clause. With the co-pay clause, the insured is responsible for covering a specific portion of the claim and the insurer covers the amount over and above the co-pay limit. The clause is usually for expensive medical treatments, for senior citizens and treatment in metro cities. Under this clause, the insured shares the claim amount up to the co-pay limit, which could range from 10% to 20% of the claim amount.

The policies with the co-pay clause tend to have low premium outgo as compared to the other policies. Understanding this clause is essential to buy a cost-effective health insurance policy that is viable in the long run. The co-pay clause is beneficial at an early stage of life wherein probability of a medical emergency is fairly low.

7. Purchasing insurance only to save taxes.
Although health insurance premiums reduce taxable income, it cannot be the basis to decide the health insurance policy. The primary purpose of getting health insurance is to have comprehensive coverage of health issues and be financially secure during medical difficulties. Buying a health insurance policy with a singular focus on tax saving will lead a customer to invest in policies with inadequate coverage.

The health insurance premiums paid by an individual is subject to tax deduction under Section 80D of the Income Tax Act, 1961. It is recommended policy's tax benefits are fully understood but evaluating an insurance policy solely based on the tax quotient isn't prudent. An individual must purchase an insurance cover worthy of meeting their family's health requirements during a medical emergency.

8. Investing in health insurance only during old age.
Many people believe that health insurance plans are for the elderly or are needed only during old age and make the mistake of not investing in the health insurance policy at an early stage of life. No one can predict medical emergencies and not having adequate coverage at a young age could lead to wealth erosion at the time of an unforeseen medical emergency or making high premium outflows for coverage

later. To avoid either scenario, individuals must consider investing in health insurance plans at an early stage of life.

There is a wide range of policies for individuals below 45 years, and these policies are easy to obtain and usually involve a lower premium payment. The additional benefit of buying health insurance at an early age is that one can easily cover up the waiting period in the times when the probability of triggering a health insurance is minimal and hence can enjoy maximum coverage at an early age.

9. Overlooking the sub-limits.
It is common for individuals to overlook the sub-limits clause while evaluating and choosing health insurance plans, only to regret it at the time of claim where the expense is beyond the sub limit as stipulated in the policy coverage.

The insurance companies specify threshold limits on their liability in specific circumstances by including sub-limits. They are defined as a maximum value for a particular illness/expense or as a percentage of the sum insured. Health insurance plans with sub-limits are cheaper in comparison to the other plans. Sub-limits can be imposed on a hospital room rent, ambulance charges, doctor's consultation fees, or any major medical treatment such as knee replacements, kidney transplants, etc. It is advisable to review the sub-limit clause before finalizing a health insurance policy.

Bottom Line
Health Insurance is an essential investment to navigate unscathed through unforeseen medical emergencies. With the high-stress, hustle and bustle lifestyle we lead today, buying a health insurance plan with comprehensive coverage and benefits is no longer a luxury but a necessity. However, given the number of insurance products available in the market today, individuals need to be well informed to make a wise choice. Avoid making the mistakes as mentioned above and secure the future and wellbeing of yourself and your family with the right health insurance.

(The writer is Pankaj Arora.)

TOP

Buying health insurance for senior citizens? Consider these important factors first – Financial Express – 2nd October 2021

Health insurance is necessary now – not only for oneself but for the entire family, especially for elderly parents and grandparents. There has been a constant rise in medical costs, and with the ongoing worldwide pandemic, it is evident that your savings might not always be sufficient to meet your medical expenses adequately.

Shreeraj Deshpande, Chief Operating Officer, Future Generali India Insurance, says, "As one's parents age, the hospital visits and ailments increase. In the backdrop of such a landscape, the best decision you can make for your elderly parents and grandparents is to purchase a health insurance policy for them."

He further adds, "This will ensure that their medical costs are adequately covered, and they can live a financially stress-free life." At the same time, there are a few things that you must consider before buying a health insurance policy for senior citizens in your family.

Check the waiting period – It is vital to check the waiting period of the chosen policy. As the hospitalization needs of senior citizens are generally more imminent, it is advisable to opt for a health insurance policy with a minimum waiting period. Examine the exclusions and sub-limits- Always opt for a policy that has no or minimum exclusion.

Deshpande says, “Read the policy documents carefully to understand the exclusions from the policy since many senior citizen health policies come with sub-limits and co-payment.” Additionally, understand the procedures and treatments that have sub-limit or co-payment clauses.

Terms and conditions regarding pre-existing illnesses – Choosing the right health insurance policy for senior citizens can be tricky; check the terms and conditions regarding pre-existing illnesses – For instance, whether certain pre-existing illnesses or treatments are covered in the policy or not, the waiting period of each co-payment clause, etc.

Look for high sum insured – Medical cost of surgery/treatments of aged individuals are usually high. Hence, to bridge that disparity in costs, look for high sum insurance value. Deshpande adds, “One should compare various plans and premiums from multiple insurers and opt for an ideal plan for their parents and grandparents.” Avail tax benefits – You can also get an exemption of up to Rs 50,000 for the premium paid for senior citizen insurance policies under Section 80D of the Income Tax Act 1961.

(The writer is Priyadarshini Maji.)

TOP

CROP INSURANCE

Tenant farmers worst hit as many lack insurance cover – The Hindu – 5th October 2021

Thousands of marginal farmers will continue to be in a debt trap following the huge damage caused to the standing crops in Vizianagaram and Srikakulam districts by Cyclone Gulab and the consequent floods. Many farmers and tenant farmers invested around ₹15,000 per acre depending on the crop and were hoping to get a bumper yielding within a few weeks when the storm has put paid to their hopes. Their combined investment of nearly ₹165 crore was drained by the crop damage in nearly 1.10 lakh acres. Paddy, maize, groundnut, banana and vegetable crops were badly hit in the two districts.

Though e-crop insurance facility is available, many farmers were unable to upload the details of their crops due to illiteracy and lack of communication. Moreover, the farmers who lease out their lands to tenants are not allowing the latter to opt for e-crop insurance due to the fear of losing their right over the land. Around 1.63 lakh farmers in Srikakulam district opted for the insurance facility while nearly 1.09 lakh farmers could not upload their details on the website. The same is the case with Vizianagaram where 40,000 farmers could not utilise the facility.

According to TDP senior leader Kalisetti Appala Naidu many farmers are not interested in going for the e-crop facility due to the inordinate delay in assessment of damage. "Agriculture department takes many months to complete the damage assessment process. The small compensation paid thereafter only disillusions farmers. At least now, the government should form special teams quickly and assess the damage, taking each village as a unit. Then only, farmers will get financial assistance quickly," he opines.

The government should take up immediate steps for payment of compensation to save farmers from falling into a debt trap, says Bharatiya Janata Party senior leader Birlangi Umamaheswara Rao. "Many tenant farmers invest in agriculture by borrowing money at high interest rates. However, in many cases, financial assistance and other benefits are paid to landowners. As tenant farmers are the actual victims of floods and cyclones their interests need to be protected. Their details must be enrolled in e-crop insurance scheme," he says.

(The Writer is K. Srinivasa Rao.)

TOP

Crop insurance scheme may cover 25 lakh farmers – The Hindu – 2nd October 2021

Status of coverage under the Crop Insurance Scheme during 2021-22*

Crop	Kharif season		Special season		Total	
	Area insured (acres)	Farmers enrolled	Area insured (acres)	Farmers enrolled	Area insured (acres)	Farmers enrolled
Agricultural	1,08,950	90,772	3,794	3,772	1,12,744	94,544
Horticultural	3,875	3,371	Nil	Nil	3875	3,371
Grand Total	**1,12,825**	**94,143**	**3,794**	**3,772**	**1,16,619**	**97,915**

*AS ON SEPTEMBER 29, 2021

The Tamil Nadu government hopes to maintain the enrolment of 25 lakh farmers and the coverage of 42 lakh acres this year, too, under the Prime Minister's crop insurance scheme (Pradhan Mantri Fasal Bima Yojana), despite a late start.

Though only about one lakh farmers have been brought under the scheme this time, officials of the Agriculture Department hope the enrolment drive will gather pace in the weeks to come as the farmers intensify their operations during the current 'samba', 'thaladi' and 'pishanam' cultivation season.

Special season

As far as insurance coverage is concerned, the crops raised during the 'samba' season fall under the special season, given the uniqueness of the situation in the State.

Otherwise, for the purpose of insurance, it is either kharif or rabi season.

Last year, 25.77 lakh farmers were enrolled for an area of about 42.77 lakh acres. During the 2020-21 special season, about 12.4 lakh farmers alone had enrolled themselves.

The importance of the ongoing 'samba' season can be gauged from the fact that the season accounts for nearly two-thirds of the annual rice production.

This time, there is one more reason for the authorities to ensure a very good coverage. During the kharif season this year, the coverage was hardly one-fourth of what the State had achieved last year. This was due to a variety of reasons such as the enforcement of the model code of conduct for the Assembly election and the consequent delay in the selection of insurance companies.

By the time Agriculture Insurance Company of India Limited and Iffco-Tokio General Insurance Company were chosen in late August, the harvest of paddy raised during the 'kuruvai' season had begun. This was why paddy alone could not be covered this year, explain the officials.

Enrolment period

Normally, the enrolment of farmers during the special season ends on December 15. But, in the case of paddy, it gets over by the middle of November in most of the districts. Other crops that can be covered are maize, cotton and onion.

As for rabi, the registration process is expected to begin in the third week of October, and will go on till February. However, there will be district-wise and crop-wise cut-off dates.

(The Writer is Ramakrishnan.)

TOP

SURVEY & REPORTS

Term Insurance Prices climbed up by 1 percent, while health prices remained stable in Q3: Shows PolicyX.com's Insurance Price Index – Business Standard – 2th October 2021

A leading online insurance aggregator, PolicyX.com releases 'Insurance Price Index' data for Quarter 3, 2021. The latest data, comprising July, August, and September 2021, depicts a marginal shift in the Insurance Price Index Value of Term Insurance whereas health insurance prices have remained stable during the same period.

Term Insurance Price Index value has escalated by 1%, taking the index price to INR 22,750 in Quarter 3, 2021. In Quarter 2, 2021, the Term Insurance index value was INR 22,526. As per the Term Insurance Price Index trend, the total index value for Term Insurance has increased by 3.8% in the span of 9 months. The average annual premium payable for a sum assured of INR 1 Crore has gone up to INR 29,127 in the third quarter, 2021 compared to INR 29,010 in Quarter 2, 2021.

In the last 3 months, out of the 10 insurers that are part of the index computation, 4 insurers have hiked premiums, wherein two of them exhibited a significant increase between 10.6% to 12.6%. Contrary to this trend, 1 insurer has even reduced their premium by approximately 10% for term plans in the last 3 months. While other term insurance companies remained stagnant in this duration.

The escalated index value of Term Insurance has impacted uniquely across all age groups as the highest impact of increased prices were felt by the age group of 35 & above Male category with a 3.9% increase in the index value. On the contrary, the Female category of 55 years & above experienced relaxation with a 1.6% reduction in premium prices in Quarter 3, 2021.

Further talking about gender difference, the Term Insurance Price Index Quarter 3, 2021 observed the premium variation of 20.7%, where the male audience paid a higher premium than the female audience. The data also showed that delay in purchase of Term Insurance plan by 10 years could cost on an average 47% dearer for a 25-year-old, 72% dearer for a 35-year-old, and 78% dearer for a 45-year-old.

The mentioned premium prices are averaged from 10 leading insurance companies for various age groups i.e. 25 years, 35 years, 45 years and 55 years for both genders and smokers & non-smokers category and for a sum assured of INR 50 lacs and INR 1 crore.

For a detailed report on Term Insurance Price Index click here:
(https://www.policyx.com/term-insurance/price-index.php)

The Health Insurance Price Index maintained tranquillity with no change in the index value in Quarter 3, 2021. The Health Insurance Price Index has been persistent at INR 25,124 since Quarter 4, 2020. This is the result of no price hike in the 5 health insurance companies forming the part of the index. Although there were numerous media reports suggesting an imminent hike in health insurance premium prices due to the catastrophic pandemic, the data seems to suggest that none of the 5 companies have changed their prices.

The average payable premium by a 26-year-old across categories was INR 16,695 for INR 10 Lakh sum insured amount and INR 13,140 for an INR 5 lac sum insured highlighting the fact that premium does not increase proportionately with sum insured. From 5 lac to 10 lac sum insured, there is a hike of only 27% in premium compared to a 100% increase in sum insured.

The data highlights the fact that adding members to the family floater policy does not increase the premium proportionately. In fact, there is an increase of premium of 50% on an average on adding 1 more adult of the same age or lower age in the same policy. The increase is meagre (11.9% and 13.7% on adding 1st child and 2nd child respectively) on adding children to the policy.

Of the 5 companies, forming the index, the variance observed in premiums among the health companies is quite high (ranging from 59% to 76% for different age groups) as compared to variance observed in term insurance companies. This is primarily because of the fact that coverage, features, and benefits differ significantly for health insurance whereas term insurance is usually simple with similar benefits in case of death.

The premium prices for Health Insurance are average prices taken from the leading 5 health insurance companies for all age groups i.e., 26 years, 36 years, 46 years, and 56 years & all coverage types i.e., 1 adult, 2 adults, 2 adults + 1 child, and 2 adults + 2 children.

For a detailed report on Health Insurance Price Index click here:
(https://www.policyx.com/health-insurance/health-insurance-price-index.php)

Naval Goel, Founder & CEO of PolicyX.com says: "It is great to see that the prices have not increased despite the fact that the insurance industry was hit by record Covid19 claims and losses. Although the pandemic has resulted in a higher incidence of claims, there is an increased awareness of the need for insurance amongst the Indian population which should provide the impetus to help the industry grow faster."

TOP

INSURANCE CASES

SC upholds hike in pay-out from 10 lakh to 2 crore for accident victim – The Times of India – 4th October 2021

A Supreme Court bench of Justices R Subhash Reddy and Hrishikesh Roy has dismissed an appeal filed by the National Insurance Company Limited against an order of the Madras HC that enhanced the compensation paid to the family of an accident victim by 1,700 percent from 10.4 lakh to 1.85 crore based on Form-16, salary slip and other tax papers filed by the victim's family.

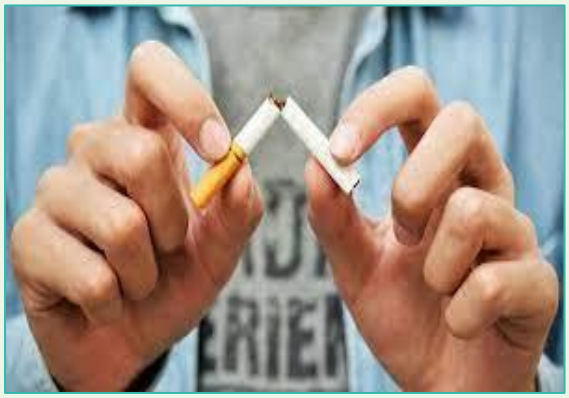
On October 14, 2013, Subash Babu, a 35-year-old manager of a private firm, was killed in an accident while driving a car from Perumanallur to Erode. His wife and other family members who were travelling with him escaped with injuries. His wife, an eyewitness, told Tiruppur motor accident claims tribunal that a van which was going in front of their car turned right without showing any signal and their car rammed against the van and her husband died in the impact. The tribunal, however, fixed 75 percent contributory negligence on the victim based on police FIR, which blamed Babu for negligent driving, and awarded Rs 10.4 lakh as compensation by fixing Babu's monthly income at Rs 20,000 per month.

Aggrieved by the order, the family moved the HC. In August 2018, Justice N Kirubakaran and Justice Krishnan Ramasamy of the Madras HC quashed the order of the tribunal and held that since there was no rebuttal witness provided by the insurance company, the accident happened only due to the negligence of the van driver. Taking into consideration the victim's tax records and pay slip, the court fixed the victim's annual income at 12.3 lakh and computed the compensation to be paid by the insurance company as 1.85 crore.

Agreeing with the HC ruling, the Supreme Court bench said, "In view of such evidence on record, there is no reason to give weightage to the contents of the FIR. If any evidence before the tribunal runs contrary to the contrary to the contents in the FIR, the evidence which is recorded before the tribunal has to be given weightage."

TOP

Non-smokers get cancer too, insurer can't stub claim: Gujarat court – The Times of India – Ahmedabad – 2nd October 2021



A consumer court here has ordered an insurance company to reimburse the expenditure on medical treatment for lung cancer after the company refused mediclaim on the grounds that the patient was a chain smoker and contracted cancer due to his smoking. The consumer court said there was no proof that the cancer had been caused by the patient's smoking habit.

The case involved one Alok Kumar Banerjee from Thaltej, who underwent treatment for adenocarcinoma of the lung from Vedanta Institute of Medical Science in July 2014 and incurred a medical bill of Rs 93,297. He had medical insurance cover. But his claim was rejected by the insurer.

After Banerjee passed away, his widow Smita sued the insurer in 2016 in the Consumer Dispute Redressal Commission, Ahmedabad (additional), where the insurance company took the defence that Banerjee was treated in different hospitals for his illness, which had a direct nexus with his smoking habit, and that this was reflected in his case papers.

The consumer commission did not agree. It cited a higher forum's order and said that a discharge summary itself cannot be treated as primary or conclusive evidence in the absence of any independent proof. There was no evidence in this case to show that the patient got cancer because of smoking.

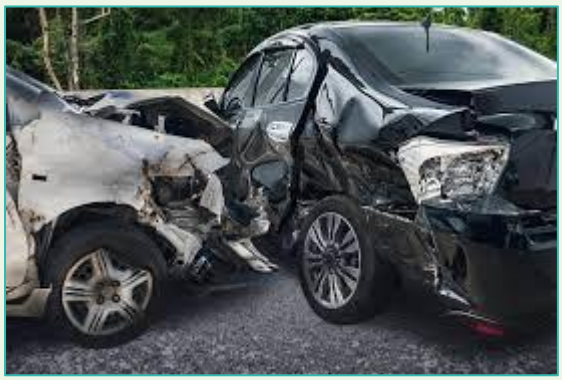
The insurance company's doctor gave a medical opinion that those who smoke have a 26 times higher risk of getting cancer. To this, the commission said that merely on the basis of this opinion it cannot be concluded that the patient got cancer due to his smoking habit. Those who do not smoke also get lung cancer and it cannot be believed that all those who smoke have lung cancer. It cannot be accepted that the complainant's husband got cancer because of his smoking habit and the insurer had wrongly rejected the claim, the commission added.

Besides ordering the insurer to refund the medical expense, the commission has asked it to pay Rs 5,000 extra to the complainant towards compensation for mental harassment and legal expenditure.

(The writer is Saeed Khan.)

TOP

Supreme Court restores compensation awarded by tribunal to accident victim – India Legal – 2nd October 2021



The Supreme Court has recently allowed an appeal by a road accident victim and restored the compensation awarded to him by the motor accidents tribunal, setting aside a judgment of the Allahabad High Court which had reduced the compensation amount.

The Division Bench of Justice D.Y. Chandrachud and Justice B.V. Nagarathna has heard the appeal filed by Satya Prakash Dwivedi, who was injured in a road accident. He has filed the appeal, being aggrieved by the award dated 28.01.2021 passed by the Allahabad High Court by which the High Court dismissed his appeal filed by him and reduced the compensation amount from Rs 5,42,633 to Rs 3,26,833 on the premise that the Motor Accident Claims Tribunal had arbitrarily construed functional disability at the rate of 50% without any

evidence to that effect. The High Court deemed it appropriate to assess 20% functional disability inasmuch as it was nowhere mentioned that the disability was permanent in nature and was irreversible.

The facts are that the appellant-claimant while riding on his motorcycle met with an accident on 30.10.2002 when a truck came on the wrong side of the road and collided against the appellant-claimant, as a result of which he sustained grievous injuries. Although the appellant-claimant underwent treatment for about 470 days, he was rendered disabled. He was 32 years of age at the time of the accident and was running a canteen and said to be earning Rs 10,000 per month. Appellant filed a claim petition seeking compensation of Rs 17 lakh along with interest at the rate of 17% per annum from the date of filing of claim petition till the date of actual payment on account of grievous injuries sustained by him in the accident.

The Tribunal initially awarded compensation of Rs 6,03,000 along with 7% interest per annum from the date of judgment till actual payment vide its Award dated 30.10.2006. Being aggrieved by the said Award, the respondent insurance Company approached the High Court. By order dated 03.12.2015, the High Court set aside the Award dated 30.10.2006, except the finding recorded by the Tribunal that the accident had actually taken place, allowed the said appeal, and remanded the matter to the Tribunal for decision afresh in the light of the observations made in the said order.

On remand, the Tribunal passed the judgment and order dated 01.07.2017 awarding compensation of Rs 5,42,633 along with interest at the rate of 7% per annum from the date of filing the petition till the date of actual payment by accepting the permanent disability to the extent of 50% to that particular part of the body and taking into account his income as Rs 54,000 per annum. The Tribunal also applied a multiplier of 15 in calculating the future loss and also awarded compensation on other heads. Not being satisfied with the said Award, the appellant-claimant filed an appeal.

By the judgment dated 28.01.2021, the High Court construed functional disability at the rate of 20% rather than 50% as assessed by the Tribunal, assessed the age of claimant to be above 35 years, and by applying the multiplier of 15, computed the total compensation under the Head of loss of income at Rs 1,51,200. The High Court also awarded compensation under the other heads i.e. Rs 53,633 under the Head of medical treatment; Rs 25,000 under the head of mental and physical pain; Rs 36,000 under the Head of loss of income; Rs 18,000 under the head of nutritious diet; and Rs 5,000 as conveyance.

The High Court noted that the Tribunal had not awarded any compensation under the head of attendant charges and future treatment, it awarded compensation for a sum of Rs.18,000/- and Rs.20,000/- respectively under those heads, even though the High Court reduced the overall compensation from Rs.5,42,633/- to Rs.3,26,833 resulting in a total reduction of compensation to Rs.2,15,800/-. This was on account of construing functional disability at the rate of 20% rather than 50% as assessed by the Tribunal. The age of the claimant was also assessed as being above 35 years and taken the same in the bracket of 36 to 40 years. A multiplier of 15 was applied rather than 17 as applied by the Tribunal. Hence the appellant –claimant approached the Supreme Court.

Vipin Kumar, Counsel for the appellant-claimant, contended that the High Court was not right in reducing the quantum of compensation awarded to the appellant, in an appeal filed by him seeking enhancement of the same. The main grievance of the appellant is that the High Court ought not to have exercised power under Order XLI Rule 33 of the CPC to reduce the compensation awarded by the Tribunal in an appeal filed by the appellant-claimant. It was submitted that while on the one hand, the High Court reduced the quantum of compensation by reducing the percentage of functional disability from 50% to 20%, at the same time the High Court granted compensation under the heads of 'attendant charges' and 'future medical treatment charges' in a sum of Rs.18,000/- and Rs.20,000/- respectively.

The Court observed that upon a plain reading of Order XLI Rule 33 of the CPC, it reveals that the Appellate Court has the power to pass any decree or order which ought to have been passed, and to pass such other decree or order as the case may require. Notwithstanding that the appeal is against a part of the decree, this power may be exercised by the court in favour of all or any of the respondents although such respondent may not have filed any appeal or objection. However, the said power must be exercised

with caution or circumspection, particularly, in the absence there being any cross objection or appeal filed by the respondents. Such a power has to be exercised in exceptional cases when its non-exercise will lead to difficulties in the adjustment of rights of the parties.

Order XLI Rule 33 of the CPC does not confer unrestricted rights to interfere with decrees which are not assailed merely because the appellate court does not agree with the opinion of the court appealed from. It is the duty of the appellate court to decide the appeal in accordance with law. The appellate court must apply its judicial mind to the evidence as a whole while deciding a case and a judgment on merits should not be lightly interfered with or reversed purely on technical grounds unless it has resulted in failure of justice, the Court further observed.

"Instead of considering that contention on merits, the High Court ignored the same and instead give weightage to the contentions of the respondent insurance Company which was to the effect that the computation of functional disability at the rate of 50% was on the higher side and the same had to be toned down and therefore, the power under Order XLI Rule 33 of CPC could be exercised to do complete justice to the parties. We find that the High Court was not right in its approach in the matter for the reason that the respondent – Insurance Company had not filed any appeal seeking reduction in the compensation amount awarded by the Tribunal and consequently, in the appeal filed by the injured appellant-claimant, the contention of the Insurance Company ought not have been allowed by ignoring the plea of the appellant-claimant seeking enhancement in the compensation. The appellant-claimant could not have been worse off than what had been granted to him by the Tribunal, in an appeal filed by him seeking enhancement of compensation."

Therefore the Top Court is of the view that the High Court was not justified in exercising its power under Order XLI Rule 33 of the CPC in the instant case and reducing the compensation from Rs 5,42,633 as awarded by the Tribunal to Rs 3,26,833 i.e. a total reduction of Rs 2,15,800 in the compensation amount. At the same time, the High Court awarded an additional compensation under the heads of 'attendant' and 'future treatment' charges.

TOP

PENSION

General Provident Fund (GPF) interest rate for Q3FY22 declared. Check details – Live Mint – 5th October 2021

The central government has announced interest rate for General Provident Fund (GPF) and other similar kinds of funds for October to December 2021 quarter. The GPF and other similar fund subscribers, who are central government employees, will continue to get 7.1 per cent return in Q3FY22, as central government has left GPF interest rate unchanged at 7.1 per cent for the third quarter of FY 2021-22. The central government had left GPF interest rate unchanged in previous quarter as well. The Budget Division of the Department of Economic Affairs at Ministry of Finance today issued notification in this regard.

The Budget Division notification said, "It is announced for general information that during the year 2021-22, accumulation at the credit of subscribers of General Provident Fund and other similar funds shall carry interest rate of 7.1% (seven point one percent) w.e.f. 1st October 2021."

Earlier, the central government had left interest rate of Public Provident Fund (PPF), NSC (National Saving Certificate), Sukanya Samridhi Yojana (SSY) and other small saving schemes for October to

December 2021 unchanged. The PPF interest rate for current quarter is 7.1 per cent, which is compounded annually.

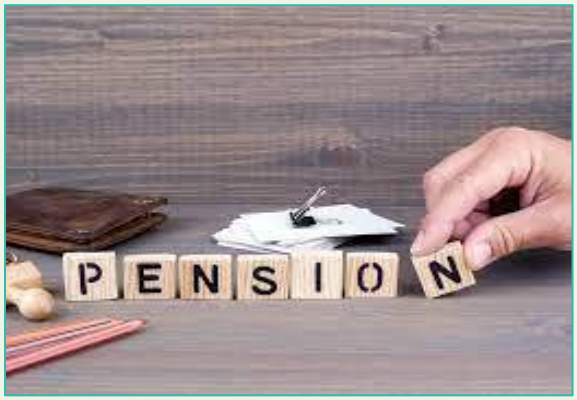
The 7.1 per cent interest rate for October to December 2021 quarter, effective from 1st October 2021, will apply to all the following funds:
1] The General Provident Fund (Central Services);
2] The Contributory Provident Fund (India);
3] The All India Services Provident Fund;
4] The State Railway Provident Fund;
5] The General Provident Fund (Defence Services);
6] The Indian Ordnance Department Provident Fund;
7] The Indian Ordnance Factories Workmen's Provident Fund;
8] The Indian Naval Dockyard Workmen's Provident Fund;
9] The Defence Services Officers Provident Fund; and
10] The Armed Forces Personnel Provident Fund.

According to the official website of The Ministry of Personnel, Public Grievances and Pensions, the General Provident Fund (Central Services) Rules 1960 applies to all temporary government employees after a continuous service of one year, all re-employed pensioners (other than those eligible for admission to the Contributory Provident Fund) and all permanent government employees. Contributory, Provident Fund Rules (India), 1962 is applicable to every non-pensioner government servant belonging to any of the services under the control of the President. The Rules provide for the withdrawal of advances or withdrawals from the CPF for specific purposes. As in GPF Rules, the CPF Rules also provide for Deposit Linked Insurance Revised Scheme.

(The Writer is Asit Manohar.)

TOP

PFRDA extends online exit process option to government sector subscribers – Live Mint – 5th October 2021



The Pension Fund Regulatory and Development Authority (PFRDA) has extended the option of online, paperless process of exit to subscribers in the government sector. Earlier, only non-government sector subscribers enjoyed the end-to-end facility of the online exit process. National Pension Scheme (NPS) subscribers in non-government sectors are currently empowered with comprehensive end-to-end digitally enabled solutions to fulfil their evolving needs.

PFRDA in a release said, "The online exit would be integrated with Instant Bank Account Verification as per the existing guidelines as part of enhanced due diligence in the interest of Subscribers. The facility would also be available to the employees of Autonomous Bodies of Central/State Government who are covered in NPS." Further, the Central Record Keeping Agencies (CRAs) would have to enable the required technical functionalities before 30 October, 2021.

"Nodal Officers of Government Sector will play a larger role to educate their employees about the process of online exit which not only benefit Subscribers but also the nodal officers by freeing them from handling paper-based documents and dispatching those papers to the associated CRA for record keeping," it said. NPS subscribers are encouraged to utilize the option of online exit which ensures timely process of exit and seamless issue of annuity-by-Annuity Service Providers (ASP).

(The Writer is Navneet Dubey.)

TOP

E-Pension payment order gets integrated with Digi Locker; to benefit 23 lakh pensioners – Live Mint – 5th October 2021

The Centre on Tuesday announced that it has integrated the Electronic Pension Payment Order (EPPO) with Digi Locker. This will benefit over 23 lakhs defence pensioners.

The official release said. department of ex-servicemen welfare, Ministry of Defence has integrated the Electronic Pension Payment Order (EPPO) generated by Principal Controller of Defence Accounts (PCDA) Pension, Allahabad with Digi Locker, in order to enhance 'Ease of Living' of Defence Pensioners.

This will enable all Defence Pensioners to obtain instantly a copy of the latest copy of the PPO from Digi Locker. This initiative will create a permanent record of PPO in Digi Locker and at the same time eliminate delays in reaching the PPO to new pensioners as well as the necessity of handing over a physical copy, he said.

Accordingly, the PCDA(Pension), Allahabad has been registered as a Service Provider for providing EPPOs of over 23 lakhs Defence Pensioners through Digi Locker platform, enabling the Defence Pensioners to access their EPPO from anywhere in the world, it also said.

TOP

PFRDA expects addition of 1 crore new subscribers to APY in FY22 – The Hindu Business Line – 5th October 2021

Pension Fund Regulatory and Development Authority (PFRDA) expects to add about one crore new subscribers to the government's Atal Pension Yojana (APY) pension scheme this fiscal.

The Atal Pension Yojana, a guaranteed pension scheme of the Government of India and administered by PFRDA, continues to attract new enrolments supported by aggressive canvassing by intermediaries such as public sector banks, private sector banks, regional rural banks, small finance banks and co-operative banks among others on the back of growing awareness about future financial planning among the people.

"Total enrolments have crossed more than 30 million. In this fiscal alone, we have added a little over 4 million new customers to the APY scheme. Every day we see the numbers go up. On an average, we add 30,000–35,000 subscribers on a daily basis. Looking at the kind of growth we are getting, we feel we can add 10 million new customers under APY in 2021-22," Supratim Bandyopadhyay, Chairperson, PFRDA, told *Business Line*.

Changing mindsets

The APY scheme has seen a growth of about 27 per cent as of September. Last year was also good and this year it was even better. In NPS, the growth is significantly higher at about 60 per cent, Bandyopadhyay said.

"Over the years, the mindset of people has changed positively towards pension schemes. Now people are really thinking about post-retirement and financial plans. I think the Covid-19 pandemic has also been a trigger for people to think seriously about the need to save for a rainy day. In the past couple of years, including the worst pandemic phase, our on-boarding rate didn't drop. There was no negative rate in any month," he added.

Unorganised sector

To a question on coverage for the unorganised sector, he said that with the APY scheme, which allows people in the age group of 18–40 years to join through the bank or post office branches through a savings bank account, a decent progress has been made to cover workers in the unorganised segment.

"It is an ongoing process. Because the number of people in the unorganised sector is so huge — about 45 crore. I think we have reached a little over 3 crore people. It may be low. But what gives us hope is that intermediaries such as banks, RRBs, SFBs have taken it as a mission to bring more people under APY coverage. They are doing a great job," he added.

Different strategies

He pointed out that while RRBs in Kerala were following different strategies to reach more people, Airtel Payment has done impressive work and has enrolled more than 1 million subscribers. Banks have engaged self-help groups and banking correspondents to reach out to more people.

On the Amendment Bill, PFRDA was hoping that it would be considered during the winter session of the Parliament. It is with the Cabinet as discussions with all stakeholders are over and inputs have been incorporated. We hope it will be taken up during the winter session, added Bandyopadhyay.

(The Writer is G. Balachandar.)

TOP

NPS corpus seen rising 30% to Rs 7.5 lakh crore by end-FY22: PFRDA – Financial Express – 2nd October 2021

With the corporate sector and individuals showing greater interest in the national pension system (NPS), the NPS assets under management will likely rise 30% on year to Rs 7.5 lakh crore by end-FY22, the Pension Fund Regulatory and Development Authority (PFRDA) chairman Supratim Bandyopadhyay said on Friday.

"Total NPS corpus was at Rs 6.67 lakh crore as on September 25, 2021, up from Rs 5.78 lakh crore as on March 31. Our internal assessment is that by the year end, we will reach Rs 7.5 lakh crore," Bandyopadhyay said.

Private individual enrolments (excluding Atal Pension Yojana) grew 35% on year to 18.28 lakh as on September 25, 2021, while corporate sector subscribers has shown 20% growth to 12.59 lakh during the period. The Central government employee subscribers grew 4.4% on year 22.24 lakh as on September 25, 2021, while state governments subscribers grew 10% to 53.79 lakh during the period. Total number of subscribers as of September 25, 2021, was 4.6 crore, up 24% from a year ago and 8.5% since March 31, 2021.

To foster greater competition in fund management, PFRDA has recently given its nod to two new entrants into NPS fund management — Tata Asset Management and Max Life Insurance. Axis Mutual Fund is also in the process of joining as a fund manager, Bandyopadhyay said.

Currently, there are seven fund managers, namely, HDFC Pension Management, ICICI Prudential Pension Funds Management Company, Kotak Mahindra Pension Fund, LIC Pension Fund, SBI Pension Funds, UTI Retirement Solutions and Aditya Birla Sun Life Pension Management.

In June, the PFRDA has permitted engagement of individuals who are working as business correspondents or agents within their existing business structure for facilitating the distribution of pension schemes.

Bandyopadhyay said individual distributors would play a key role expansion of NPS among the masses. The regulator is also examining if the fees paid to distributors could be enhanced from the current rate of 0.25% of the contribution by a subscriber.

With longevity of life and working life going well beyond 60 years, the regulator has enhanced the entry

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IRDAI CIRCULARS

Title	*Reference*
GROSS DIRECT PREMIUM UNDERWRITTEN FOR AND UPTO THE MONTH OF SEPTEMBER, 2021	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4585&flag=1
New Business Statement of Life Insurers for the Period ended 30th September	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4584&flag=1
Maintenance of Current Accounts in multiple banks by Insurers	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4582&flag=1
List of Third-Party Administrators as on 05th October 2021	https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3649&flag=1

TOP

GLOBAL NEWS

Japan: Life insurance underwriting income remains resilient – Fitch - Asia Insurance Review

Earnings from underwriting in the life insurance sector in Japan remain resilient due to the seasoned and stable in-force policies, noted Fitch Ratings in its "2021 Fitch on Japan" webinar yesterday. In a commentary titled “Outlook on Japan Insurance”, which was released as part of the webinar, Dr Teruki Morinaga, director, Asia-Pacific Insurance, at Fitch Ratings, highlighted several other aspects of the Japanese insurance market:

Life: New businesses were weak on the whole due to the COVID-19 pandemic, but steadily recovering due partly to insurers’ efforts at DX (digital transformation) strategies.

Non-Life: Domestic results improved, but COVID-19 related losses suffered in US/London.

Life and Non-Life: Favourable financial markets continue to support investment results.

Life and Non-Life: Capital adequacy continues to improve, to cope with the new solvency regime from around 2025.

TOP

Global: More than 35% of insurers' invested assets exposed to risks from climate change – IAIS – Asia Insurance Review

Quantitative data analysis shows that "climate-relevant" assets within equities, corporate bonds, loans and mortgages, sovereign bonds and real estate represent more than 35% of insurers' total assets, says the International Association of Insurance Supervisors (IAIS).

Within equities, corporate bonds and loans and mortgages, most climate-relevant assets relate to the housing and energy-intensive sectors.

These findings are in the 2021 special topic edition of the IAIS Global Insurance Market Report (GIMAR). This year, the report assesses how insurance sector investments are exposed to climate change, reflecting the findings of the first such global quantitative study.

Type of transition

Scenario analysis assessing the forward-looking impact of climate change shows that the magnitude of the impact is highly dependent on the type of climate transition considered. Compared to an orderly transition towards internationally agreed climate targets, a disorderly transition, or a scenario whereby climate targets are not met, would have a two to six times greater adverse effect on sector-wide solvency. For example, under a "disorderly transition" scenario, results show an absolute drop in insurers' solvency ratio of more than 14%, increasing to almost 50% under a "too little, too late" scenario.

Nevertheless, considering the solid overall solvency position of the global insurance sector, the sector as a whole appears to be able to absorb investment losses from all scenarios tested, GIMAR says. "This report underscores the importance for supervisors of assessing how climate change may affect the insurance sector and individual insurers and of developing an appropriate supervisory response," said Jonathan Dixon, IAIS secretary-general.

"The IAIS is committed to deepening the breadth and scope of our contributions to helping insurance supervisors mitigate the effects of climate change." "Climate change is the defining challenge for this generation. The GIMAR uses data from our wide membership in combination with analytical tools to understand how the insurance sector is exposed to climate risk," said Vicky Saporta, IAIS executive committee chair.

Drawing on unique quantitative and qualitative data gathered from 32 IAIS members covering 75% of the global insurance sector, this report represents the first global deep-dive analysis on insurers' investment exposures and supervisors' views on climate-related risks. The report identifies key risks and vulnerabilities for the sector. The IAIS is a global standard-setting body whose objectives are to promote effective and globally consistent supervision of the insurance industry. Its membership includes insurance supervisors from more than 200 jurisdictions.

TOP

Indonesia: Sales of protection insurance products outpaced those of investment-linked plans in 1H - Asia Insurance Review

Sales of traditional life insurance products (pure protection plans) increased at a faster pace in the first half of 2021 compared to those of unit-linked or investment-related plans, according to data from the Indonesian Life Insurance Association (AAJI).

Traditional insurance premiums increased by 18.5% year-on-year IDR40.27tn ($2.8bn) in the first six months of this year, while unit-linked insurance premiums grew slightly at below 17% year-on-year to IDR64.44tn, reported CNBC Indonesia citing the AAJI data.

Mr Budi Tampubolon, AAJI chairman, explains that the faster growth of traditional life insurance premiums was due to the development of alternative distribution channels, such as digital channels, as well as marketing and collaboration with business entities.

In addition, the growth of traditional life insurance has been backed by higher demand for health insurance. This is because of the COVID-19 pandemic that has heightened public awareness of the importance of insurance.

Nevertheless, Mr Budi said at an AAJI media conference, "I think the difference is too narrow to indicate a shift in interest from unit-linked to traditional products. Indeed, the proportion of unit-linked products in the total portfolio is already above 60%."

Unit-linked products accounted for 62% of the total life insurance premiums premium with the remaining 38% being from traditional life insurance plans.

The proportion of unit-linked insurance business could have been higher but for the fact that the number of unit-linked insurance policyholders plunged by 40% or almost 2.8m last year from 7m at the end of 2019. This means there were around 4.2m policyholders as of 31 December 2020.

The head of the OJK 2A Non-Bank Financial Industry Supervision Department, Mr Ahmad Nasrullah, said the fall was due to conditions brought about by the COVID-19 pandemic, as many policyholders did not continue their policies. Furthermore, there were not many additional new customers, he said.

TOP

Australia: Insurers ready for regulatory changes - Asia Insurance Review

The Insurance Council of Australia (ICA) says insurers have made sweeping changes to their systems and processes in readiness for the implementation in coming days of wide-ranging reforms intended to improve consumer outcomes.

The raft of regulatory changes being implemented from 1 October 2021 are part of the federal government's response to the Financial Services Royal Commission.

Since the Royal Commission report and its recommendations were released, the ICA and its members have worked closely with the government and stakeholders to ensure the intentions of the reforms are realised. In facilitating collaboration between industry, consumer groups and regulators the ICA has advocated for a regulatory regime that allows insurers to deliver services that meet customers' expectations with no unintended consequences.

The ICA says it will be working closely with its members monitoring the implementation of the regulations as they are rolled out, and stands ready to engage with ASIC, APRA and Treasury should any implementation issues arise. Additionally, the General Insurance Code of Practice will be updated from 5 October 2021 to align with ASIC's Regulatory Guide on internal dispute resolution.

Updates include a reduction from 45 to 30 days to resolve a complaint, as well as an updated definition of a complaint. Changes also include a new commitment to improved customer awareness through information on Code subscriber websites about the availability of financial hardship support.

The Code changes have been developed by ICA members following consultation with key stakeholders, including representatives of the ICA's Consumer Advisory Committee, ASIC, and AFCA. Mr Andrew Hall, ICA CEO, said, "The Insurance Council supports the intention of these once-in-a-generation regulatory reforms to improve consumer outcomes. Insurers have worked hard to ensure the necessary changes to processes have been made and staff are appropriately trained.

"Pleasingly, the Government and its agencies have taken on board much of our feedback and have been open to changes that avoid unintended consequences from aspects of the new regulatory regime. "We look forward to continuing that dialogue as the new arrangements are bedded down and better understood in practice. At the same time we welcome updates to the Code of Practice to further strengthen provisions and information for consumers."

Reforms

The ICA summarises the reforms and insurers' response to them as follows:

Deferred Sales Model (DSM)

The deferred sales model for add-on insurance introduces a four-day pause between the sale of a primary product and the sale of an add-on insurance product, to help individual customers make informed decisions when purchasing insurance.

Supported by advocacy from insurers and recognising practicalities of applying these new rules to certain purchases, the government has exempted from the deferred sales model the following classes of insurance products: compulsory third party (CTP) insurance for motor vehicles; travel; third party property damage, fire and theft insurance for motor vehicles; comprehensive insurance for boats, motorcycles, motorhomes, caravans, and trucks; insurance sold within superannuation (including group life insurance); postage and delivery of consumer goods insurance; home building insurance; home and contents insurance; and landlord insurance.

Relief from the DSM provisions will also be provided for wholesale style insurances available to businesses.

Anti-Hawking
Working in conjunction with the deferred sales model, the anti-hawking restrictions put certain prohibitions on insurers offering products to consumers while selling other products. Insurers support the policy intent of the legislative ban on hawking, and the ICA supported ASIC's product intervention in relation to unsolicited telephone sales of consumer credit insurance.

The ICA supports monitoring the reforms to ensure there are no detrimental consequences for consumers who may wish to take advantage of discounts and other efficiencies offered by insurance companies when products such as home and motor cover are bundled together. ASIC's regulatory guidance on anti-hawking provides further guidance on consumer consent in consumer-initiated calls to insurers.

Product Design and Distribution Obligations
Under these obligations insurers must design financial products that are likely to be consistent with the likely objectives, financial situation, and needs of the consumers for whom they are intended.

Insurers support the obligation for products to be appropriately designed and distributed so that consumers receive the insurance which is suitable to their needs.

Duty not to make a misrepresentation
A duty to take reasonable care not to make a misrepresentation to an insurer places the burden on an insurer to elicit the information that it needs in order to assess whether it will insure a risk and at what price.

Insurers are supportive of the new duty which will mean a simpler application process for customers as it replaces a lengthy prescribed notice under the existing duty of disclosure.

Breach Reporting Obligations
Financial services firms including insurers are required to report to ASIC any significant breaches of their obligations as Australian Financial Services Licensees. The new regime aims to address concerns of uncertainty about when breaches are significant enough to report, and to improve the consistency of information provided by licensees in their breach reports.

Insurers support the government's breach reporting reforms, however consider there is a further opportunity to reduce uncertainty for the industry and will be working through these issues with regulators and Treasury. Most specifically, insurers are concerned that very minor technical breaches will need to be reported, for example call centre staff accidentally providing inaccurate information which does not have any real consequences but could be interpreted as "misleading or deceptive".

Unfair Contract Terms
These enforceable provisions have applied to insurance contracts since April 2021 and mean contracts with consumers or small business may be void if the term is unfair, the term is a standard contract, or the contract is a financial product.

Insurers note ASIC's statement that insurers have proactively made important changes to insurance policies in light of the new changes. Insurers have either removed, reworded or qualified any identified terms to make it fairer for consumers.

Claims Handling as a Financial Service

Claims handling as a financial service will not come into effect until 1 January 2022, given the 12 months transitional period that began from 1 January 2021. A claims handling and settling service includes assisting someone with making a claim, and a range of other prescribed engagements between insurers and the insured or their representative.

Claims handling is an integral part of the insurance process that enables policyholders to get on with rebuilding their lives and businesses after the shock of an unforeseen event, and the ICA supports claims handling being treated as a financial service.

The industry is focused on meeting the policy intent of the cash settlement fact sheets – to help customers make an informed decision when choosing between cash pay-outs and other options like repairs.

At the same time, insurers do not want the new requirement to issue these statements to slow down insurers' ability to make quick (often instant) payments to customers when they urgently need the cash, particularly during natural disaster scenarios.

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