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QUOTE OF THE WEEK

"Change is the law of life. And those who look only to the past or present are certain to miss the future."

John F. Kennedy

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

First Unpaid Premium

Definition: First time default on premium payments by a policy holder is termed as First Unpaid Premium.

Description: With each premium payment a receipt is issued which indicates the next due date of premium payment. If the premium is not paid, this date becomes the date of first unpaid premium.

Source

LIFE INSURANCE

How to buy a suitable term insurance plan? – Financial Express – 31st October 2019

Before buying a life insurance cover, you should first know whether you need it. Just because someone has it or a relative or a colleague has recommended it to you, should not go for it.

Why is a life insurance cover needed? Life insurance policy safeguards your dependent's — be it your spouse, parents or children – financial needs, if anything unfortunate happens to you or when you are not around. Hence, the first criteria is, if you have dependents such as spouse, parents, and children, then you can opt for a life insurance cover. However, if there is no dependency on you or your income, there is no need to get a life insurance policy.

When you have established that you need life insurance, you will be spoilt for choice. There are generally four types of life insurance policies to choose from: Term insurance plans, Traditional insurance policies, Unit-Linked Insurance Plans (ULIPs), and Pension plans.

If you are looking for the old fashioned, plain vanilla insurance policy, term insurance plan is the one for you. A term insurance plan offers financial protection in the form of a sum assured to the insured family members if something unexpected happens to the policyholder. Even among term insurance plans, a variety of solutions are offered to fit different situations.

Here is how you can identify the right term insurance plan for yourself:
The money that you pay as an insurance premium in a term insurance policy is used to buy an insurance cover only. Note that, you do not get your money back, after the term of the policy expires. This is where most people go wrong. Term plans are pure protection covers. Unlike other life insurance products, it has no return value; hence, it is one of the cheapest options to get a cover.

In the case of term plans, the policyholders get a bigger sum assured for a smaller premium. For instance, for a Rs 1 crore cover a 30-year old needs to pay just Rs 894 monthly, which is Rs 10,148 annually. However, note that the sum assured that the policyholder chooses for the policy should be at least 15-20 times his/her current annual income.

The thumb rule suggested by industry experts for choosing the sum assured should depend on the age you are buying the insurance policy. For instance, if you are buying a term late, at the age of 50, the sum assured should be equal to 10 times the annual income of the policyholder. In case you are buying at the age of 40, the sum assured should be equal to 15 times the annual income, and if you are buying the

policy at the age of 30 years, the sum assured should be equal to 20 times your annual income. Experts suggest policyholders should choose a plan with single premium options that offers his/her family an assured lump sum amount after the policyholder's death.

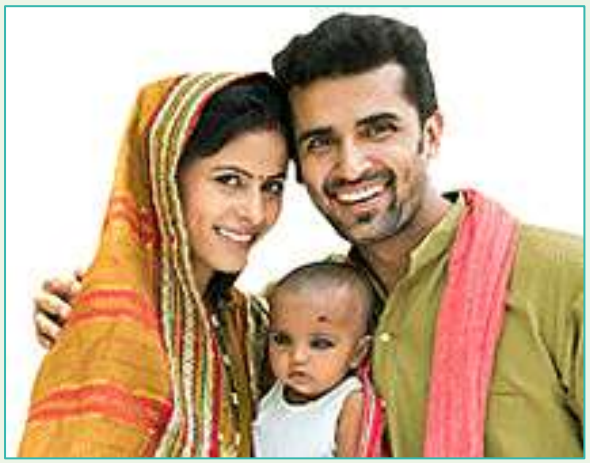
Things you should look at while buying a term plan is the duration of the policy, coverage provided, premium and claim settlement ratio. The premium of the policy should not be the only factor while buying a term plan. The claim settlement ratio of the insurer should be healthy. The claim settlement ratio of an insurance company is the number of claims settled against the number of claims filed by policyholders. The higher the ratio, the better the insurance company. Hence, while choosing the insurance company, policyholders should check the claim settlement ratio. Or else there are chances that the insurer can reject your policy claim if the company has a low claim settlement ratio.

The writer is Priyadarshini Maji.

TOP

Source

Pradhan Mantri Jan Suraksha Yojana enrollments see pickup; 14.7 million enrollments in H1 – Moneycontrol – 31st October 2019

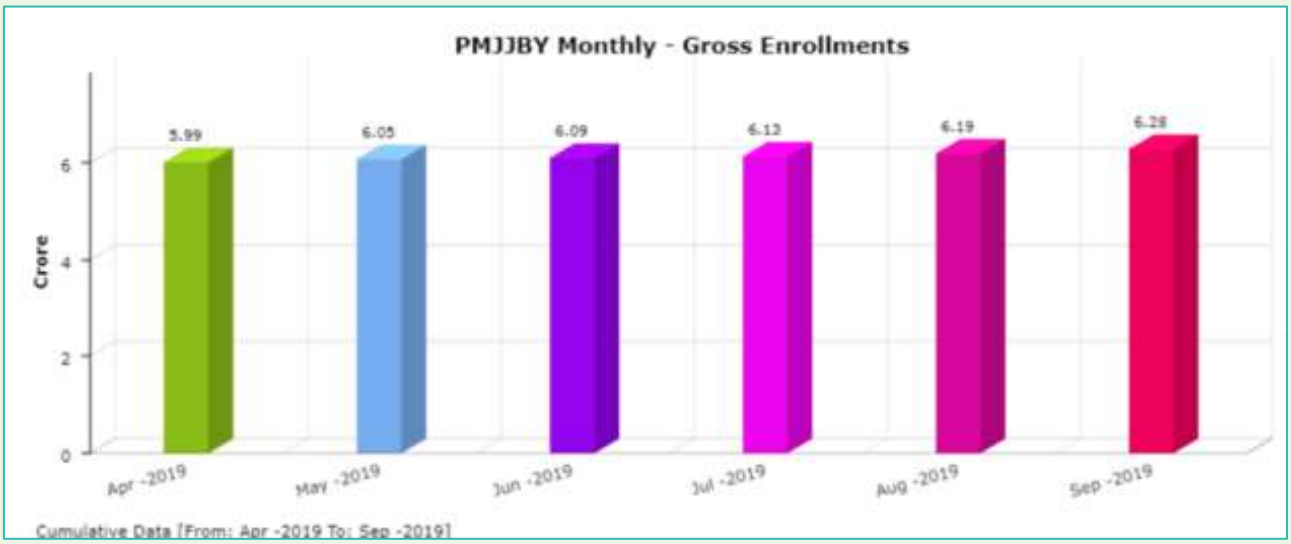


After seeing stagnation in enrollments, PM Jan Suraksha Yojana insurance schemes have got 15 million new enrollments in H1 of the year. This was driven by a government nudge to the banks as well as zero premium increase.

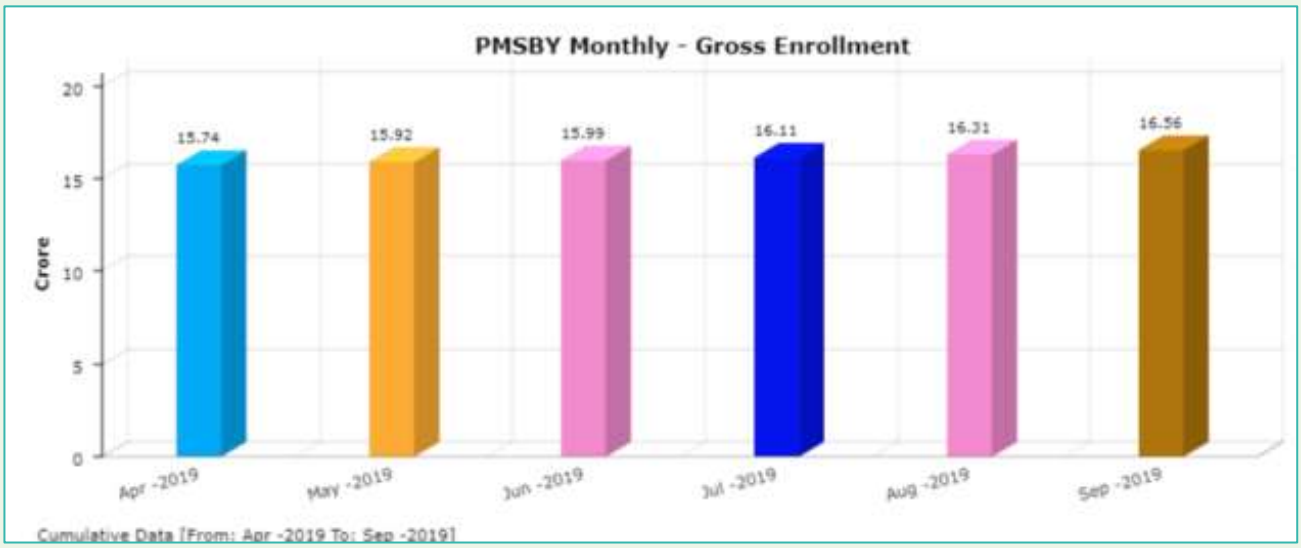
The insurance scheme saw some stagnation in FY18 and FY19 but enrollments picked up again from April 2019 onwards.

The personal accident scheme (Pradhan Mantri Suraksha Bima Yojana/PMSBY) and term insurance scheme (Pradhan Mantri Jeevan Jyoti BimaYojana/PMJJBY) were launched in May 2015. Both policies have a sum assured of Rs 2 lakh each and need to be renewed after one year. But their premiums are low at Rs 12 and Rs 330, respectively.

"During the initial phases of the scheme, banks had strict enrollment targets and hence the numbers saw a positive increase. However, with time they saw a drop in enrollments once the minimum figures were



met. Now a nudge from the Centre has led to movement again," said an official. In the April to September 2019 period, banks sold 10.9 million new personal accident policies under this scheme and 3.7 million term insurance products.



In the period immediately after the launch of these schemes, banks were focusing on enrolling more policyholders aggressively. In the first five months of the schemes' launch, around 120 million policyholders were enrolled.

But then stagnation set in. For PMJJBY, the enrollments remained at around 53-59 million in FY18 and FY19 while for PMSBY it was around 135 million-154 million in the two years. With premiums of Rs 12, PMSBY has seen a faster growth.

Since India does not have a social security initiative, the insurance programmes under PM Jan Suraksha Yojana are positioned as a mass insurance scheme for the country.

Industry sources said that people have also begun to buy the product due to the low premium. While insurance companies had sought a 20-25 percent increase in premium from FY19 on wards, the government wanted to keep the scheme affordable for the general public.

Claims settlement is also happening at a healthy pace. Till September 2019, a total of 34,965 cumulative claims were disbursed out of 45,132 received claims in PMSBY.

Till now in PMJJBy, a total of 1, 49,004 cumulative claims were disbursed out of 1,62,333 received claims.

(The writer is M Saraswathy.)

TOP

Source

Travel Insurance: Quick tips to avoid claim rejection this travel season – Financial Express – 31st October 2019

Travel insurance acts as a saving grace for last-minute changes or some other unexpected circumstances that can arise while on the trip. Even though you get insurance, there are cases when an insurance claim can get rejected. It is the type of situation every insured person dreads.

When you have the policy and have paid that extra money for it but your insurance claim gets rejected from the insurer, it is pretty distressful when that happens. Experts suggest one should ensure properly with the documentation while opting for an insurance policy so that the travel insurance claims do not get rejected.

For instance, accidents during adventurous sports are not covered by most insurance policies. Anurag Rastogi, Chief Actuary, and Chief Underwriting Officer, HDFC ERGO, says, "Do not withhold details of pre-existing conditions.

This should be maintained especially when traveling with elderly parents or traveling against doctors' medical advice."

Here are some tips to avoid your claim rejection:

Claim Exclusions

During international travel insurance claims, this is one of the most common reasons for claims getting rejected.

Every insurance policy has exclusions embedded in, which policyholders should know while buying the policy. With planning for the holiday trips, most people forget to check the list of exclusions in their travel insurance coverage. Hence, make sure to understand the list of exclusions embedded in your insurance policy.

Undeclared Health Conditions

A critical mistake made by most policyholders, they tend to avoid the declaration of existing medical conditions. Even if you don't disclose it completely, you are still at fault. While on your trip if you fall sick or meet with an accident due to an underlying medical condition, there are high chances that your travel insurance claim will get rejected.

Note that, even if the accident is not related to the medical condition, your claim will likely be rejected. Hence, ensure to declare your health condition fully while applying for the travel insurance policy.

Adventurous Activities

Most travel insurance policy does not provide coverage for participation in adventure sports. Adventure sports include bungee jumping, skydiving. Any loss arising due to participating in any such activity is not covered by the travel policies. Policyholders should go through the fine prints, and make sure to go through the exclusion list of adventurous activities to gain more clarity in terms of policy coverage.

Traveling to unsafe locations

There is a consolidated list of locations and places that are deemed risky or unsafe for travel, by the World Health Organization (WHO) and the Foreign and Commonwealth Offices (FCO).

If you are traveling to such places any accident or loss that may result will normally not covered. Experts say, try to avoid such blacklisted areas. Despite the fulfillment of other criteria, the insurance claim will be rejected on the above grounds.

Missing Bills

When you register a claim, make sure to submit the associated bills and paperwork, as they are needed to sustain the claim. This is for reimbursement claims, wherein you have to produce the receipts of every medical service you have received.

(The writer is Priyadarshini Maji.)

TOP

Source

GENERAL INSURANCE

Deposit insurance: How safe is your money in the bank? – Financial Express – 30th October 2019

Each bank customer's deposits in a bank is insured up to a maximum of Rs 1 lakh for both principal and interest amount held by him in the same right and same capacity as on the date of liquidation/cancellation of bank's licence. Deposit Insurance and Credit Guarantee Corporation (DICGC) while registering the banks as insured banks, provides them with leaflets that inform account-holders on the protection given by the corporation to the depositors of the insured banks.

The deposits kept in different branches of a bank are aggregated for the purpose of insurance cover and a maximum amount up to Rs 1 lakh is paid. For example, if an individual had an account with a principal amount of Rs 95,000 plus accrued interest of Rs 4,000, the total amount insured by the DICGC would be Rs 99,000. If, however, the principal amount in that account was Rs 1 lakh, the accrued interest would not be insured, not because it was interest but because that was the amount over the insurance limit.

Type of ownership

All funds held in the same type of ownership at the same bank are added together before deposit insurance is determined. If the funds are in different types of ownership or are deposited in separate banks they would then be separately insured. If a person has deposits with more than one bank, deposit insurance coverage limit is applied separately to the deposits in each bank.

If an individual opens more than one deposit account in one or more branches of a bank, for example, one or more savings/current account and one or more fixed/recurring deposit accounts, all these are considered as accounts held in the same capacity and in the same right. Therefore, the balances in all these accounts are aggregated and insurance cover is available up to Rs 1 lakh.

If the same account-holder also opens other deposit accounts in his capacity as a partner of a firm or guardian of a minor or director of a company or trustee of a trust or a joint account, say with his wife in one or more branches of the bank, then such accounts are considered as held in different capacity and different right. Accordingly, such deposits accounts will also enjoy the insurance cover up to Rs 1 lakh separately.

If more than one deposit account (savings, current, recurring or fixed deposit) are jointly held by individuals in one or more branch of a bank; say, three individuals A, B & C held more than one joint deposit accounts in which their names appear in the same order, then all these accounts are considered as held in the same capacity and in the same right. Accordingly, balances held in all these accounts will be aggregated for the purpose of determining the insured amount within the limit of Rs 1 lakh.

However, if individuals open more than one joint accounts in which their names are not in the same order for example, A, B and C; C, B and A; C, A and B; A, C and B; or group of persons are different; say, A, B and C and A, B and D, etc., then, the deposits held in these joint accounts are considered as held in different capacity and different right. Accordingly, insurance cover will be available separately up to Rs 1 lakh to every such joint account where the names appearing in different order or names are different.

TOP

Source

Insurance relief for waterlogging victims in Patna – The Times of India – 29th October 2019

The insurance companies on Monday agreed with the state government to bring insured vehicles and high-end consumer durables, which were damaged during the unprecedented waterlogging in various localities of Patna, under insurance net.

Three days of heavy rain from September 27 to 29 had triggered massive waterlogging in the city and stagnant water could not be removed from some localities even after a week.

A decision to provide insurance cover to waterlogging victims was taken at a meeting of the representatives of insurance companies with finance department principal secretary S Siddhartha and disaster management department principal secretary Pratyaya Amrit on Monday.

The insurance cover will be provided in 30 days from the day of registration of the claims at the camps to be organised for the purpose. The insurance claims of vehicles up to Rs 25 lakh will be immediately settled.

Technically, the government cannot pay the compensation amount for any damage to property, moveable or immoveable, suffered by people during waterlogging. However, the state government would work as facilitator of all the documents to the insurance companies related to the vehicles as required by them to process the claims. The transport department officials will also help in the assessment of the extent of damage suffered by the vehicles for calculating the matching cost to assist the insurance companies.

"To start with, the camps will be held in the three most affected localities – Rajendra Nagar, Kanker bagh and Pataliputra Colony. The other affected localities will be covered later," Siddhartha said, adding that people will also get insurance amount for the insured consumer durables like expensive refrigerators, television sets and washing machines.

(The writer is Abhay Singh.)

TOP

Source

Safeguard your home this Diwali – Opt for a home insurance policy this Dhanteras – Financial Express – 25th October 2019

Home insurance provides cover for the building, not only the structure but also the contents within the home or the premises against various natural calamities such as fire, storm, flood and other risks like burglary. It is imperative to know what is covered under a home insurance policy and also better understand these covers to be secured financially, in case any unfortunate disaster strikes.

Anurag Rastogi, Chief Actuary & Chief Underwriting Officer, HDFC ERGO General Insurance Company, says "Home insurance has become imperative now because other than the normal building collapse, theft or burglary, fire, unusual yet essential things like portable gadgets, Electrical appliances are also covered under a home insurance policy."

Here are some of the things covered under the policy, which policyholders must be aware of:
1. Burglary and Housebreaking cover – This is an important cover for homeowners, especially during festive seasons and vacations when families choose to travel leaving their home unattended. The contents which can be covered in the policy are cash, securities, and other valuables kept at home. Moreover, the cover will also offer financial security to any damage caused to the home or premises in case of a burglary. Apart from this, homeowners may also cover jewelry and other valuables stored in a Bank Locker. This will safeguard the items stored in the Bank Locker in case a burglary takes place at the Bank.

It must be noted that a Burglary cover is only included under a Home Insurance policy and not as part of a Standard Fire and Special Perils Policy which some customer choose to buy in place of full Home Insurance policy

2. Storm/tempest/flood and inundation cover – This is a built-in cover under a Home Insurance policy or a Standard Fire & Special Perils Policy which will cover the insured property for any damages due to storms, tempest, flooding, and inundation. The recent floods & inundation seen in various parts of the country which resulted in irrevocable damages to residential homes &lives, signify the relevance of this cover.

3. Riots/strike/malicious damages – Another cover that is built-in under a home insurance policy or a Standard Fire and Special Perils Policy, pay for any physical damages to the property and contents due to riots, strikes or incidences of malicious damage to the insured property.

4. Lightning strikes – This is a useful cover, especially for homeowners who reside in high-risk areas that are more prone to climatic changes. It covers the home for any damages caused to the structure or contents due to lightning strikes.

5. Landslide/rockslides – The cover will pay for damages to the property and contents from Landslides/Rockslides.

6. Impact damage by third party vehicles and animals – The cover provides financial security to the homeowner, in case of any damages caused to the property by the impact of third party vehicles or animals. This too is an in-built cover.

(The writer is Priyadarshini Maji.)

TOP

Source

HEALTH INSURANCE

Understanding the importance of health insurance needs – Moneycontrol – 1st November 2019

Rajiv Aggarwal, 32, underwent minor surgery and was hospitalised for three days. When he was being discharged and completing formalities, Aggarwal was staring at a huge hospitalisation bill. With no other option, he had to pay the bill from his savings which derailed his financial planning. That very moment he understood the relevance of health insurance.

Like Aggarwal, many people tend to take health insurance lightly and end up losing all their savings. They underestimate medical costs and wait till something happens to them.

But, one should take health insurance seriously. Due to sedentary lifestyle, health concerns are on the rise.

Moreover, according to a recent study conducted in 2019, there has been a rise in lifestyle diseases since last year among people below the age of 45. As compared to 2018, the percentage of cholesterol among Indians increased to 14.1% from 10.1%.

Meanwhile, the World Health Organisation (WHO) reported that India had the highest number of diabetics at 50.8 million till 2018 and the number was estimated to touch 73.5 million by 2025.

So, life is uncertain and medical emergencies can happen anytime, draining you out physically and financially. Here, you can take charge of the financial part well in advance by taking a health insurance policy.

Health insurance has become important than ever before as it safeguards you from hospitalisation, medicine and ambulance costs and even the doctor's fee. Since the rising medical costs and inflation can burn a hole in your pocket, if you are insured, a health insurance policy can pay for your treatment and offer benefits such as cashless hospitalisation, pre and post hospitalisation expenses and more.

It is better to buy a health insurance when you are young as the health insurance premium is much lesser for a large cover amount when you are in 20s. For instance, at the age of 25, you can have a cover of Rs 3 lakh at a premium of just Rs 5,546. With increasing age, you will end up paying more premium for a greater sum insured.

So, how much health insurance to buy?
Before buying a policy and calculating the sum insured, you should factor in age, rising medical costs, inflation, current health status, nature of job, hereditary diseases, etc., and also the number of dependents. You can calculate the sum insured and premium amount through a health insurance calculator also.

Apart from coverage, health insurance also helps in savings taxes under Section 80D of the Income Tax Act, 1961.

While buying a health insurance policy, always choose a reputed partner such as Reliance Health Insurance so that you don't have to go through any hassles while claim settlement and other benefits that come along with health policies. You can even use the Reliance Selfie App for simplifying your insurance claims & policy renewal process. Reliance Selfi App also provides you with real-time claim status and helps you in finding the nearby hospitals and branches. This app not only makes your renewal and claim process easy but also enables you to track your steps and maintain a healthy life with its integrated pedometer.

A health insurance comes with various advantages and the best investment you can ever make for yourself and family.

TOP

Source

Why you need an indemnity health insurance – Financial Express – 1st November 2019

A health insurance plan must be selected after understanding one's needs and risks. For some, it may be about the final premium outflow while for others it may be getting coverage for a certain high risk disease that may run in the family.

Rising costs of both pre-and post-hospitalisation has meant that many opt for defined benefits plans that cater to these needs, over indemnity-based plans. However, indemnity-based plans have their own set of benefits.

An indemnity-based health insurance plan is one where the health insurance company reimburses the actual amount incurred as expenses during hospitalisation. The amount paid is subject to the maximum sum insured under the policy post the submission of adequate proof and medical bills.

For example, let us assume a policyholder has an indemnity health insurance plan with a sum insured of Rs 5 lakh. Now, if the policyholder gets operated for a hernia surgery costing Rs 2 lakh, the insurance company will pay, post bill submission, for the actual expenses incurred. The remaining amount continues to be left unutilized for any future medical needs. On the downside, any pre- and post-hospitalisation expenses are not covered under indemnity health insurance plans.

Even with the non coverage of post-operative expenses, indemnity insurance plans come with a host of benefits for the policyholder.

Flexibility to choose hospitals
Insurance companies offering indemnity plans have a tie-up with a large network of hospitals and doctors. This means the policyholder is free to choose the desired hospital or health care professional for treatment. Availability of cashless indemnity health insurance plans also mean the policyholder does not have to worry about bill submission, which is done by the networked hospital.

Wide range of protective cover
Unlike defined benefit plans, indemnity-based plans cover a wide range of treatments and illnesses. Also, indemnity-based health plans will cover the actual amount of the hospital bill subject to the maximum sum insured limit. So if a policyholder has opted for adequate coverage, the cost of treatment is never a worry.

Low premium outgo
Health insurance is still considered as a slightly unwanted expense and premium outflow does play a major role. Most indemnity health plans come with a deductible whereby the policyholder shares with the insurance company some percentage of the overall cost of medical expenses. As a result, the health insurance company faces lower risk, which it passes on as lower premium to the policyholder.

When it comes to opting between an indemnity health insurance and a defined health benefit plan, the individual medical needs of the policyholder must take center stage. If you are someone with a high risk of a medical ailment running in the family or looking for a lump sum payment for treatment, a defined health plan catering towards that disease is a better option.

However, if you are looking for a health insurance plan that offers optimum protection, covers majority of ailments, caters to majority of the hospitalisation charges with a budget friendly premium, indemnity health insurance plans are your best friend. Ideally, for a comprehensive cover, both indemnity and defined benefit plans should be opted for.

(The writer is Nisary M.)

TOP

Source

Ayushman Bharat Yojana chinks in spotlight - The Telegraph - 31st October 2019

Grievances related to the Ayushman Bharat scheme dominated the state-level consultation on health and education organised by Life Education and Development Support (Leads) and Child in Need Institute (CINI) at a hotel here on Wednesday.

Most of the villagers, who spoke at the event attended by representatives of NGOs and political parties, highlighted how they were not getting the benefits of the much-touted healthcare programme funded by the Narendra Modi-government despite being covered by it.

Amrit Mahto, who came from Petarwar in Bokaro district, alleged that some of the empanelled facilities were charging money for tests and treatments from Ayushman Bharat card holders.

Ranchi's Manika Ekka, also a beneficiary of Ayushman Bharat, supported Mahto. "A hospital in Ranchi asked me to buy medicines from outside despite me showing them my Ayushman Bharat card," Ekka alleged.

A resident of Khunti, Rijwana Parveen, complained of rude behaviour by doctors who kept her in the dark about her four-year-old daughter's treatment.

Highlighting the problems plaguing the education sector in the state, Jogen Kumar, a member of the NGO Chetna Vikas, said the shortage of teachers in schools was a major stumbling block to quality education.

Another NGO worker, who introduced himself as Mithilesh, called attention to the lack of proper infrastructure in schools located in remote areas.

On the basis of the consultations, A.K. Singh of Leads placed a charter of demands in respect of education while Sumantra Mukherjee of Civil Society Network for Child Rights did the same with respect to health.

Health care for all, more resources for health care facilities, a proper review of Ayushman Bharat scheme and its improvement were some of the demands mentioned in the health charter.

The demands listed in the education charter included proper implementation of the provisions of Right to Education Act and widening its ambit to 18-year-old boys and girls.

Avinash Narayan from AAP said his party had worked on these issues in Delhi and would do so in Jharkhand as well if voted to power.

"As always, we will continue our fight to realise people's right to health and education," Md Bashir of CPI-ML said.

Sunita Singh, spokesperson for JVM, said she would discuss these issues with her party for their inclusion in the poll manifesto.

Kanke MLA and BJP leader Jeetu Charan Ram said: "The government has tried to fulfil its commitment and has taken steps for the improvement in education and health care segments. Things are moving in the right direction and will take some time to show results. I'll, however, place these demands before the party for its consideration.

(The writer is Achintya Ganguly.)

TOP

Source

Bariatric surgery under insurance cover a boost for lakhs: Surgeons – The Times of India – 31st October 2019

The Insurance Regulatory and Development Authority of India (IRDAI) has included bariatric or weight loss surgery under the insurance cover from October 1, offering a respite to lakhs of morbidly obese people who can't afford it.

However, gastroenterology surgeons hope that insurance companies do not add many riders or extra clauses to try not covering it and say more clarity is required regarding the move.

On September 29, IRDAI issued guidelines on standardization of exclusions in health insurance contracts. As per the guidelines, surgical treatment of obesity can be excluded only if the surgery is not conducted on advice of the doctor, the surgery is done without clinical protocols, patient is below 18, the

patient's BMI is below 40 or 35 (in case of being accompanied by severe co morbidities like cardiomyopathy, coronary heart disease, severe sleep apnea or uncontrolled type 2 diabetes).

According to secretary of the Obesity Surgery Society of India and head of the bariatric surgery department at Gem Hospital Dr Praveen Raj, every insurance company in the country will have to offer a cover for weight loss surgery to people who take a new insurance policy after October 2019 and to existing policy holders after October 1, 2020 as per the new guideline.

"Many insurance policies would mention bariatric surgery asone of the exclusions or quote an archaic 1970 clause that calls weight loss surgery as a cosmetic procedure to get away from covering it," he said. "Now, it must be covered with the conditions mentioned in the guideline," Dr Praveen Raj said.

In fact, the Tamil Nadu Comprehensive Health Insurance Scheme has been covering bariatric surgery since 2017, recognizing it as a life-saving procedure. "Sometimes, a surgery or an endoscopic procedure is the only long-term weight loss solution for morbidly obese. A significant weight loss sometimes solves all other issues like heart problems, diabetes etc.," Dr V G Mohan Prasath of VGM Hospitals said.

Insurance agents say they are yet to see any company alter their policy wordings since the guidelines were issued. "United India Insurance has always covered bariatric surgeryas long as the doctor certifies it to be a life-saving procedure, links it to a life-threatening ailment in the discharge summary. If there is a change in base condition, we have not been notified yet," said insurance broker, V P Mohan Kumar who runs Link insurance.

Doctors say there should be more clarity on the policy cover like how much of the surgery cost will insurance cover like how much of the surgery cost will insurance cover, whether it will require co-payment of a certain percentage of the cost from the patient and if it will bring about an increase in insurance premium. "Insurance premiums only change as per the size of the sum insured amount and the age, not as per procedures included. However, we will have more clarity when the altered policy reaches us," Mohan Kumar said.

(The writer is Pratiksha Ramkumar.)

TOP

Source

5 factors to consider while buying health insurance for senior citizens – Elets – 30th October 2019

After a life dedicated to a career or caring for the family, during your golden years, you deserve to be indulged. Your life should be all about pursuing a more relaxed daily routine with enjoyable hobbies and rejuvenating vacations from time to time. In the event that you need medical treatment, it should be a comforting, nurturing experience, without any concerns about affordability. Having health insurance makes that possible.

Missed the bus?

In their younger days, a number of people tend to commit the oversight of not purchasing their own health insurance policy since they are insured by their employer. This culminates in a situation where, after they retire, they do not have health insurance cover when they need it the most.

Fortunately, the IRDAI has instructed insurance companies to permit the purchase of a new senior citizen health insurance plan up to the age of at least 65 years. It also insists that if a senior citizen's health

insurance proposal is rejected, the company is bound to offer valid reasons for the rejection in writing.

Further, the insurance sector regulator has advised that an insurance company cannot decline the renewal of any senior citizen health insurance scheme except in on the grounds of misrepresentation, moral hazard or fraud. It has also insisted on certain allowances for senior citizens, such as the option to alter their TPS anywhere feasible.

Making the right choice

Against this backdrop, almost every company in the health insurance industry has a policy crafted for senior citizens. So, how do you decide what policy is best for you?

Here are five factors that you should pay attention to while purchasing senior citizen health insurance…

Coverage: Ideally, the higher the coverage you opt for, the better. However, there is a direct correlation between the premium that you have to pay and the coverage that you receive. However, some companies will offer to cover more than the basic hospitalisation and pre-and post- hospitalisation expenses. They offer you a consumable allowance, allowance for a companion, domiciliary hospitalization, dialysis cover, and other add-ons. So, ensure that you get the best value for your money.

Flexibility: Some policies allow you to recharge the sum insured, up to 100% of the original SI if the amount gets exhausted. At a different level, some companies allow you to purchase a policy for a tenure of 1-3 years. Look for such options that build useful flexibility into your plan.

Co-Payments: Senior Citizen health insurance policies usually have a co-payment clause. This means that the insured has to bare a portion of the claim amount (as specified in the policy). While IRDAI has stipulated that at least 50% of the pre-insurance medical investigation cost must be reimbursed to the senior citizen, look for a policy that gives you the best deal.

Maximum Age to Renew: This differs from issuer to issuer but there are companies that offer 'Lifelong renewal'. When you choose an insurer, look for such options.

Pre-existing illnesses and waiting periods – This may be the most important factor to consider since most companies have a waiting period before they cover pre-existing illnesses and some do not cover them at all. Naturally, the lower the waiting period the better and in case you do have pre-existing illnesses, as defined in the policy, ideally they should be covered, at least eventually.

Simple Claim Process – This factor is relevant, irrespective of what age you are. Make sure you understand how the claim process works, in advance, so that you do not lose time or effort following up on a claim.

(The writer is Anuj Gulati, MD & CEO, Religare Health Insurance.)

TOP

Source

Mental Illness to Finally Be Covered Under Health Insurance, HIV/AIDS Still Excluded - The Wire – 28th October 2019

In a relief to patients with some mental illnesses, speech disorders, drug-related issues and those who are in need of artificial life support, the Insurance Regulatory and Development Authority of India (IRDAI) has come up with new guidelines that say that many of these issues can no longer be excluded from health insurance contracts.

However, people with HIV/AIDS, epilepsy, heart disease and a number of other common health ailments are to be "permanently excluded" from health insurance coverage.

This attempt at standardisation by IRDAI follows years of arbitrariness and variance across insurance contracts from different companies, which claim to cover some illness and not others. In order to streamline this, the IRDAI put together a working group in July 2018, and now has come up with the guidelines. The new guidelines standardise what kind of conditions can be excluded from health insurance contracts.

The new guidelines do four things: They list a number of health issues that cannot be excluded by insurance policies, and includes the standard language that should be used if there is an exclusion. They also list some existing diseases that can be excluded, and modern medical treatments that should be covered under insurance.

Health insurance policies can now no longer exclude the following:

- Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders,
- Treatment of speech and language disorders such as stammering, dyslexia and any other behavioural and neurodevelopment disorders, including in adults,
- Treatment that arises due a patient failing to follow medical advice,
- Injuries and illness associated with any hazardous activities (adventure sports will not be covered),
- Impairment of a person's intellect due to drugs, stimulants or depressants, which are prescribed by a doctor,
- Artificial life support even if the treatment won't result in the recovery of the patient to her previous state of health,
- Treatment for things related to puberty or menopause for women, and
- Treatments of age-related macular degeneration.

However there is still a substantial number of health conditions that are to be "permanently excluded" from health insurance policies, many of which are common:

- Epilepsy,
- HIV/AIDS,
- Hepatitis B,
- Heart ailment, congenital heart disease and valvular heart disease,
- Parkinson's disease,
- Hearing loss, and
- Chronic liver disease and chronic kidney disease, pancreatic disease and inflammatory bowel disease.

Mental illness coverage is being delayed, HIV/AIDS is excluded

Although the guidelines say that mental illness is going to be covered by all health insurance policies, it is only for policies that are filed on or after October 1, 2019. Existing insurance policies will have to include mental illness only from October 1, 2020.

The Mental Healthcare Act was passed in 2017 and was enforced in 2018. So the IRDAI is delaying the implementation of this Act in insurance policies by at least three years.

Also on HIV/AIDS, parliament passed the HIV/AIDS Prevention and Control Act in 2017 and Section 3 of this Act says that "no person shall discriminate against the protected person on any ground including the denial of, or unfair treatment in the provision of insurance unless supported by actuarial studies".

The Act clearly says that patients with HIV/AIDS are not supposed to be denied insurance coverage.

But on this, the IRDAI says that insurance companies are still bound by Section 3 of the Act and if they have actuarial studies that support the claim of denial of health insurance coverage to people with HIV/AIDS, then they can consider extending health insurance coverage to policy holders with HIV/AIDS.

In effect, this leaves people with HIV/AIDS at the mercy of insurance companies who can take a decision to allow or deny their medical coverage.

(The writer is Anoo Bhuyan.)

TOP

Source

Lessons hospitals can learn from health insurance in terms of disclosure – Mint – 28th October 2019

Health insurance and hospitals must both work when you fall ill. Over the years, there has been substantial improvement in health insurance. Minimum product standards have been set, definitions standardized and basic claims information made public. Buyers can make informed choices and switch insurances if they want. Hospitals, though, have not kept pace.

The original Hippocratic Oath and its modern versions that medical practitioners sign up to are the finest documents on professional ethics. Some early versions had the promise of “nil nocere" or “do no harm". All versions speak of treating patients holistically. Yet there are several issues today that need to be addressed.

First, hospital incentives create a conflict of interest with patients. Some weeks ago, I had a backache and visited a doctor who recommended an MRI. He called the imaging centre and made the introduction. My OPD (out-patient department) fees was₹700 and the MRI cost ₹9,000. Diagnostic centres will often pay up to half the diagnostic cost to the referring hospital as a fee. In my case, the MRI was needed but a referral fee in general creates an incentive for expensive tests. Within hospitals, doctors are encouraged to prescribe tests. Diagnostic costs are borne by patients so they will push back when costs are high.

However, there is no such balance when insurance is available. A poor lady I know was insured for ₹1 lakh. She went to the hospital for a cataract surgery that costs about ₹15,000 but was hospitalized because her blood sugar was high and her entire sum insured of ₹1 lakh was used up. This patient was not informed when her insurance got over and ended up paying ₹30,000, her lifetime’s savings, out of her pocket. Many patients do not understand the nuances of insurance and hospitals seek to increase costs when insurance is involved. Getting into a hospital when you have insurance is easy.

But getting out is not. The average discharge time for patients, after being declared fit, is over six hours. A large part of this delay is because hospitals are bad at collating all the documents needed for cashless approval. Once, after waiting many hours for discharge, a friend threatened to walk out of the hospital but could not because the nurse refused to remove the cannula unless the paper work was done.

How can you decide which doctor to visit? Several doctor discovery platforms have been developed but these provide only contact details and, in a few cases, subjective customer ratings. What we need is better quality, publicly available information like public disclosures in insurance. Data such as the doctor’s background, experience and outcomes should be publicly available to help patients make informed choices.

The patient-doctor trust has broken down to such an extent that being a doctor is hazardous. Some days ago, I took someone who had got hurt on the head to the emergency in a Delhi hospital. There was a prominently displayed warning that patients who manhandle doctors could be jailed. I waited as my patient was stitched up for a relatively minor issue, thankfully. The atmosphere was tense. One patient nearly slapped the receptionist because his name was not spelt right. A few minutes later several aggressive family members surrounded a doctor and questioned every step that he had taken.

Hospitals and doctors face many other issues that pertain to ease of doing business. Some of the rules for getting a licence are archaic and cumbersome. For example, getting a pollution certificate in Delhi requires navigating an unnavigable website. Clearing, inspections and securing insurance panels can require bribes. Payments from insurers and panels take inordinately long. The corporatization of hospitals has resulted in a clash between the patient-driven practice of medicine and profit-oriented approach of administration. Treatments are sometimes insurance-driven. The better solution to my backache, which I opted for, was a gradual, conservative physiotherapy but insurance would only pay for surgery.

To resolve these issues, we need to appreciate that doctors also have to earn an income and face many obstacles to their work. The medical fraternity, in turn, would do well to refresh its vows to the Hippocratic Oath, a recent version of which cautions doctors from overtreatment.

(The writer is Kapil Mehta.)

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TOP

CROP INSURANCE

Crop insurance woes to continue as reinsurers tighten rates – Moneycontrol – 29th October 2019

The tightening of the reinsurance covers given out to non-life insurers for crop insurance will impact the premium collections of insurers even in the second half of FY20. Reinsurers have increased rates for offering cover to insurers on one hand while claims continue to pile up on the other.

Globally, rates for crop insurance have hardened (premium increased) because of the rise in crop losses affected by natural catastrophes. India, too, has seen a series of incidents related to floods and cyclones that have led to a rise in crop losses.

"The rates have seen a spike and even with the higher premium reinsurers are going cautious on this business. Hence, several of us in the non-life space are slowing down crop," said the head of underwriting at a mid-size general insurer.

A few companies like ICICI Lombard have now taken a conscious call to not participate in crop insurance business till there is an improvement in rates.

In the post-results earnings call, Bhargav Dasgupta, MD and CEO, ICICI Lombard General Insurance, said that it had not been able to write any new crop business in H1FY20 due to the prevailing rates.

"On the one hand, reinsurers have hardened rates. On the other, the commissions that reinsurers pay is not even sufficient to cover the basic cost of sourcing business. Hence, it does not make economic sense," he added.

Reinsurance is taken by insurance companies as a protection against the risk of the business. An absence of reinsurance means that an insurer is directly exposed to the risk and the subsequent claims.

Despite no major drought-like situation in the country, Dasgupta said that the crop losses had been on the rise. The rise in these underlying losses, he said, has led to the hardening of rates. Here, hardening of rates means that an insurer has to pay more to secure a cover from a reinsurance company.

For general insurance companies, crop insurance has played a major role in the premium collection. Hence those writing crop have been at a clear advantage from a gross premium growth perspective.

Take Bajaj Allianz General Insurance, for example. The insurer had a 57 percent year-on-year (YoY) growth of premium in Q2FY20, largely driven by crop insurance. Excluding crop, the growth was 14 percent YoY in the September quarter.

The gross direct premium income (GDPI) of ICICI Lombard was impacted in Q2 due to a dip in the crop business. The GDPI of ICICI Lombard saw a 16.4 percent Yoy decrease to Rs 2,953 crore in Q2FY20. Excluding the crop segment, the GDPI grew by 14.5 percent YoY in the September quarter to Rs 2,898 crore.

"We want to grow our target segments between 15-20 percent. If we grow these segments (non-crop) slightly above 17 percent, then we will have a small single digit growth in premium in FY20. If they grow slightly below 17 percent, then we will not even have a single digit premium growth this fiscal," added Dasgupta.

(The writer is M Saraswathy.)

Source

TOP

SURVEY & REPORT

Only one allopathic govt doctor for 10,926 people in India: Report - Business Standard – 31st October 2019

There is only one allopathic government doctor for every 10,926 people in India against the WHO have recommended doctor-population ratio of 1:1000, stated a government report.

Compiled by the Central Bureau of Health Intelligence (CBHI), the National Health Profile, 2019, stated that the number of registered allopathic doctors possessing recognised medical qualifications (under the MCI Act) and registered with state medical councils for 2017 and 2018 was 43,581 and 41,371, respectively.

"At present, an average population served by a government allopathic doctor is 10,926," the report said.

The report, however, highlighted that there has been a marked improvement in the number of dentists.

The number of dental surgeons registered with the central/state dental councils up to December 31, 2018, was 2, 54,283.

There has been a steady rise in the number of registered AYUSH doctors in India from 7,73,668 in 2017 to 7,99,879 in 2018.

AYUSH has the maximum number of registered ayurvedic doctors (55.47 per cent) followed by registered homeopathy doctors (36.69 per cent) in India.

There is an increase in the availability of allopathic medical practitioners, dental surgeons and nurses per lakh population over the years.

The report further states that the cost of treatment has been on the rise in India and it has led to inequity in access to health care services.

"India spends only 1.28 per cent of its GDP (2017-18) on health. Per capita public expenditure on health in nominal terms has gone up from Rs 621 in 2009-10 to Rs 1,657 in 2017-18. The Centre-state share in total public expenditure on health was 37:63 in 2017-18," it said.

The report highlighted that health insurance was a growing segment in the country, even as it hasn't taken off fully and several measures are needed to improve and expand the insurance coverage.

The advent of private insurers in India saw the introduction of many innovative products like family floater plans, top-up plans, critical illness plans, hospital cash and top-up policies, it said.

The Ayushman Bharat Mission-National Health Protection Mission or the Pradhan Mantri Jan Arogya Yojana (PMJAY)-- world's largest health scheme announced in the Union Budget 2018-19--is the latest initiative in expanding the health insurance net and targets 10 crore poor and deprived rural population, the report stated.

The mission aims to provide a cover of Rs 5 lakh per family per year for secondary and tertiary care procedures.

Based on the health survey (71st round) conducted by the NSSO, an average medical expenditure incurred during stay at hospital from January 2013 to June 2014 was Rs 14,935 for rural and Rs 24,436 for urban in India.

TOP

Source

Women are 'recklessly cautious' with savings, prefer to park money in FD, PPF - Financial Express – 30th October 2019

Women are 'recklessly cautious' when it comes to saving as nearly 58 per cent prefer to park their money in either fixed deposits, public provident fund (PPF) or letting it lie in their savings account, according to a survey. Besides, 6 per cent respondents said they preferred to buy gold, while 15 per cent of them picked mutual funds to invest their excess income, the survey by Scripbox, which provides online financial services, said.

Scripbox, which undertook this survey in the first two weeks of October 2019 on leading Facebook Communities, received inputs from 400 women. Of these, 54 per cent were millennials, 56 per cent were non-millennials. Three fourths of millennial women overwhelmingly favour saving, the survey noted. Setting aside money for vacations emerged as the goal for one in six millennials.

In contrast, half of non-millennials pursue investment goals such as building up a retirement corpus or setting aside funds for their children's education, according to the survey. While tax saving schemes such as PPF and LIC, and fixed deposits are important for this age group too (33 per cent of respondents), 26 per cent of the respondents clearly realised the role that mutual funds can play in helping them attain their long term financial goals, it added.
Besides, the survey said nearly 44 per cent of the women said easy access to their money is important to them when they save or invest their hard earned money. "Saving and investing are two sides of the same coin and are used interchangeably. However, there's a big difference in what each delivers. Savings is

money set aside for emergencies which offer minimal or no rate of return. "Investments, on the other hand, are a systematic approach to wealth creation. Investing in market-linked financial instruments can actively help to beat inflation, grow your net worth over the years, and prepare you for what lies ahead – college for the kids, taking care of yourself in retirement," Scrip box CEO Ashok Kumar said.

As per the survey, women's risk aversebehaviour to money qualifies this finding as creating an emergency fund topped their agenda with nearly 36 per cent picking this, followed by setting aside money for their children's education (28 per cent) and building a retirement corpus (26 per cent).

Nearly 25 per cent of women polled admitted to not having a financial goal in mind. About 28 per cent of the women said they were confident of their approach to financial planning and meeting their life goals, while 15 per cent preferred leaving financial planning matters in the hands of one of their family members. However, 44 per cent of women polled said they would welcome additional help in financial planning.

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INSURANCE CASES

Over 15 years after mishap, HC asks insurance company to give compensation to victims – The Times of India – 31st October 2019

Over 15 years after they met with a freak accident followed by a bitter legal battle, the Nagpur bench of Bombay High Court has directed United India Insurance Company Limited (UIICL) to pay compensation to a family residing in Hanuman Nagar.

While quashing city-based Motor Vehicles Claim Tribunal's (MACT) verdict, the HC asked the insurance firm to deposit the entire amount with its registry which would be then handed over to the injured victims comprising a couple and their son.

On May 17, 2004, Dr Ajay Hardas, wife Neeta and son Ayur were travelling in a bus owned by North-West Karnataka Road Transport Corporation (NWKRTC) from Belgaum to Saundatti. The vehicle collided with another bus resulting in death of four passengers and grievous injuries to the rest, including the Hardas family.

Some of the claimants, who were residing in Karnataka, had filed their respective claims before the Additional Motor Accident Claims Tribunal in Hukkeri (Karnataka), where the judge ruled that both the buses were equally responsible for the accident and, therefore, both were held liable to pay 50:50 compensation.

The judgment was reversed by the Karnataka high court in an appeal by holding that the other bus owned by Dharwad-based Vijayanand Road Lines (VRL) Limited was being driven rashly which led to the collision and not the NWKRTC bus carrying the claimants. The Karnataka HC fastened the liability of compensation on VRL and ULLCL.

The Hardas family had also filed individual appeals in MACT here for compensation for their injuries. On May 5, 2012, it also ruled on the lines of its Karnataka counterpart by fixing the responsibility to pay compensation on both bus agencies in equal ratio. This verdict was challenged by the Belgaum-based NWKRTC divisional controller in HC's Nagpur bench.

"It's clear from the Karnataka HC's verdict, material documents and evidence adduced by the claimants in all these appeals that the bus owned by VRL and insured by UIICLwas driven in a rash and negligent manner and hit to petitioner's vehicle," justice Murlidhar Giratkar held.

While partly allowing NWKRTC's plea, the judged noted that MACT hadn't verified the record properly and came to the wrong conclusion in fastening 50:50% liability on the petitioner and VRL, along with UIICL.

"The Karnataka HC judgment is in respect of the same accident in which all the claimants in MACT appeals were injured. Therefore, it's very much relevant to decide all these appeals together. Hence, the respondents are liable to pay the compensation amount. The entire liability to pay it is saddled on ULLCL," the judge said.

(The writer is Vaibhav Ganja pure.)

TOP

Source

Insurance firm told to pay Rs 2.4 lakh relief - The Tribune – 29th October 2019

A Permanent LokAdalat (Public Utility Services), Jalandhar, in its recent judgement has directed an insurance company to pay Rs 2, 30,000 along with interest at the rate of 9 per cent per annum, for its negligence in offering health insurance claim to city resident Geeta Bhandari. The company has also been told to pay the litigation cost of Rs 10,000. The case was instituted against the company in the Permanent LokAdalat (PLA) in December last year and the applicant, Surinder Bhandari (59), husband of Geeta, had got a case registered under Section 22-C of the Legal Services Authorities Act, 1987.

As a nominee of National Mediclaim (Health) Insurance, purchased by Geeta from the accused company, Surinder had mentioned in his complaint that even after informing the insurance company about the critical condition of his wife, the company officials refused to release the insured amount.

In his application, he reported that on April 13, 2018, his wife had a severe brain haemorrhage and was rushed to a private hospital where she telephonically informed the insurance company about her health. Later on April 15, she died in the hospital due to brain haemorrhage and the entire treatment expenditure was borne by the applicant. On April 24, after completing all formalities, Surinder informed the company about Geeta's death and submitted the required original document.

However, the company refused to admit the genuine claim of the insured person and denied accepting the documents. Therefore, after repeated attempts, the applicant failed to receive the insured amount from the company and eventually approached the PLA, where he sought the release of the insured amount of Rs 2, 30,000, along with interest and compensation of Rs 1,00,000 for being harassed by the company.

To this, the respondents (company officials) in their written statement objected to the jurisdiction of PLA, to ask them to enter into any conciliation proceedings and that they have no intent to enter into any conciliation proceedings with the applicant as this case was of repudiation and there is existing no element of settlement, hence, no steps be taken to decide the application on merits or on conciliation.
Thereafter, hearing the arguments of both parties, the PLA counsel, consisting Chairman Surinder Singh Sahni and members SS Jhulka and Shusma Handoo, formulated the terms of settlement. Keeping in view the circumstances, the respondents were told to settle the claim of the applicant by making a payment of

Rs 2,30,000 within 30 days, along with interest at the rate of 9 per cent per annum from the date of filing of the application and Rs 10,000 as litigation cost.

Source

TOP

Chandigarh: Insurance firm told to pay woman Rs 47k for denying her repair claim – The Indian Express – 29th October 2019

THE CHANDIGARH Consumer Forum has directed an insurance firm to pay Rs 47,100 to a Chandigarh woman for not paying claim on her repaired car. Mahima Suden of Chandigarh purchased a car (Renault KWID) from PMG Auto Private, a dealership of Renault, on August 12, 2016, and it was insured with the Oriental Insurance Company.

Suden said that on February 10, 2018, her car met with an accident near Amartex Panchkula. She applied brakes to save a dog. In the process, the car hit the road. But after a few minutes, the car stopped and did not start again. Suden said that she made a request at a toll-free number for assistance but no one came on behalf of Renault for rescue. As a result, she had to get her car towed herself to a nearby dealership in Panchkula where she was told that the engine oil tank of the car was damaged. The complainant requested that the same be replaced as it is covered under the insurance policy as well as the warranty. When Sudan's complaint was not addressed, she filed a formal complaint at the consumer forum on August 2, 2018.

Renault India in reply stated that they do not deal with the customer directly; the customer deals with the authorised dealer only. So they are not liable to compensate the customer.

The dealership, PMG Auto, in reply submitted that it has no knowledge of the fact that the customer called the toll-free number for assistance and no one came from Renault for rescue and does not have any details of this and that the car was towed to other dealership/agency in Panchkula.

The Oriental Insurance Company in reply submitted that the complainant should not have made efforts to cruise further as it would have increased the quantum of damage and this is precisely what had happened in the present case. The replacement can only be done when there is a manufacturing defect or due to accident when the insured vehicle gets damaged and the loss comes in the ambit of terms and conditions of the policy.

After hearing the arguments, the forum held that Renault does not sell the vehicle directly to any of the new customers and thus there is no privity of contract between the complainant and Renault. The forum held that the consequential losses are not covered under the terms and conditions of the insurance policy but in the present case, the incident happened near Amartex Panchkula on February 10, 2018, and after a few minutes, the car did not start again and stopped. The towing of the vehicle is not disputed by any of the dealership or the insurance firm.

The forum opined that the denial of the repair claim pertaining to the replacement of the engine by the insurance company in toto is not justified. Keeping in view the facts and circumstances of the present case, the insurance company should have settled the repair claim amounting to Rs 42,142. The forum thus ordered the insurance company to pay Rs 31,600 for repair, Rs 10,000 as compensation and Rs 5,500 as cost of litigation charges.

TOP

Source

PENSION

National pension system: more people aged 35 plus join NPS; are they going wrong? – Financial Express – 29th October 2019

National Pension System (NPS) Joining: It seems more people aged 35 or above are joining NPS. The latest data released by Pension Fund and Regulatory and Development Authority (PFRDA) shows that as many as 3926 people aged 35 or more joined NPS in the non-government (Corporate) sector in September 2019.

In the Central and State governments, their number was 1045 and 13,187 respectively during the entire month. The number of new joiners in the age group of 22-25 years was just 1733 in the Corporate Sector, 9222 in state government and 2282 in Central government sector. In the 26-28 years age group, the number of new joiners in Corporate Sector was 1593, 2058 in Central government and 7762 in the state government.

The number of new joiners in the 29-25 year's age group was 2334 in the corporate sector, 14,803 in state government and 2070 in the Central government. It is interesting to note the number of new joiners in 29-35 year age group is more than the 35 plus age group in state government.

The NPS subscriber numbers also show that it is not getting very popular in the non-government sector, where most of the new jobs are being created. Here too, the number of new subscribers in the age group of 35plus years is more than double of those joining 18-21 years, 22-25 years and 26-28 years.

Experts attribute the reason for more people joining in the higher age group to increasing popularity of NPS as a tax-saving tool beyond the 1.5 lakh limit of Section 80C of the Income Tax. NPS subscribers get additional tax benefit of Rs 50,000 beyond the Section 80C limit. So, an NPS subscriber can avoid paying tax on income of Rs 2 lakh after exhausting the Section 80C limit.

However, NPS should not be seen just a tax-saving tool. It is a government-backed instrument for retirement planning. One can make the most of it by joining as early as possible as the NPS final returns depend on the total amount deposited by the subscriber over the years and the income generated through its investment. Naturally, early starters will be at an advantage as they will be in a position to accumulate a larger corpus.

"The greater the value of the contributions made, the greater the investments achieved, the longer the term over which the fund accumulates and the lower the charges deducted, the larger would be the eventual benefit of the accumulated pension wealth likely to be," PFRDA says in an official document.

NPS investment is independent of contribution to any other pension fund.

Total NPS subscribers in 35 plus and 29-35 years age groups are 24, 26,523 and 22, 67,966 respectively. In contrast, total subscribers in 26-28 years and 22-25 years age groups are just 7, 10,004 and 3,41,618 respectively.

(The writer is Rajeev Kumar.)

TOP

Source

IRDAI CIRCULARS

IRDAI issued Exposure Draft of IRDAI (Insurance Surveyors and Loss assessors) (Amendment) Regulations 2019.

TOP

Source

GLOBAL NEWS

Philippines: Govt reviews composite insurers' capital requirements – Asia Insurance Review

The government is set to review the minimum capital requirement of companies that offer both life and non-life insurance products, following concerns raised by industry players, according to the Insurance Commission (IC).

On 25 October, Insurance Commissioner Dennis Funa issued a circular which revokes an earlier issuance, Circular Letter 2018-45, that sets the paid-up capital and net worth requirement for composite insurance companies, reported *The Philippine Star*.

Mr Funa said, "In view of the legal issues raised, substantial arguments and valid concerns by stakeholders, and the far-reaching implications to the insurance industry, there is a need to review and revisit the provisions of the CL No 2018-45."

In a phone interview with *The Star,*Ms Joanne Castro, officer-in-charge of the IC's Licensing Division, said that among the main concerns of insurers is the high amount of capital required for composite insurance companies.

Under Circular No. 2018-45, new composite insurance companies must have a paid-up capital of at least PHP2bn ($39.4m). This is double the PHP1bn capital mandated for regular insurance companies, as PHP1bn shall pertain to the life business and the other PHP1bn to non-life operations. Existing composite insurers are to double their minimum net worth to PHP1.8bn by this yearend and to PHP2.6bn by the end of 2022.

Under the Amended Insurance Code, the capital requirement of insurance firms is to increase every three years, starting in 2016. The minimum net worth requirement for insurance companies increased from PHP250m at the end of 2015 to PHP550m at end-2016.

At the end of 2018, only 85 insurance companies were left in the market after 15 direct insurers shut down in the past five years, according to the National Reinsurance Corp of the Philippines.

TOP

Source

Japan: Life insurers cautioned about prolonged low interest rates - Asia Insurance Review

Life insurers have been warned about low interest rates as bond yields sink ever lower, reported Bloomberg.

Ms Miyako Suda, who opposed the Bank of Japan's ultra loose monetary policy while she was a board member, said that the prolonged period of ultra low rates will pressure profits as sovereign debt matures and has to be replaced with lower-yielding bonds. She is now an external board member at Meiji Yasuda Life Insurance.

"As the duration of their JGB holdings shortens, insurers' profitability will worsen if yields stay below zero," the 71-year old said in an interview in Tokyo. "If they don't change direction now, they will become poorer and poorer. The negative impact will become evident."

While Japanese life insurers have sought to diversify away from Japanese government bonds by buying overseas debt, the cost of hedging against foreign exchange volatility and a collapse in global yields have crimped their progress. Domestic sovereign bonds still make up almost 40% of the JPY3.5tn ($32.2bn) of assets they manage, little changed from two years ago.

Insurers are currently in the process of announcing their investment plans for the second half of the fiscal year ending 31 March 2020, with most attention focused on the nation's largest, Nippon Life Insurance.

With the Bank of Japan holding down its policy rate at negative 0.1% and suppressing bond yields through record asset purchases, the coupons on long-term debt have plunged. The most recent sale of 30-year bonds this month carried a coupon of 0.4%, compared with 2.80% for similar-maturity debt maturing in 2029.

Life insurers typically invest in longer-dated securities to match the liabilities on the policies they sell. JGBs with maturities of more-than 10 years make up 74% of their domestic debt holdings, according to Japan's Financial Services Agency.

About JPY40tn of 20-year government bonds will mature in the next 5-6 years, according to data from the Ministry of Finance. "There is a huge gap between the potential risks that await insurers and the sound profitability they are enjoying now," Ms Suda said, likening the life insurer industry to the Titanic.

An evaluation of insurers by the Financial Services Agency (FSA) last year showed the average economic solvency ratio (ESR) would drop to 100%, the minimum required to cover capital needs, if the yield on 20-year Japanese bonds fell to 0.051%.

The ESR averaged 141% for the industry in March 2018, according to the FSA. "The 100% solvency ratio serves as a threshold, a drop below which will severely limit their risk taking," said Ms Suda, who sat on the BOJ board from 2001 to 2011.

The BOJ shouldn't deepen negative rates unless it can also prevent bond yields from sliding, MsSuda said. The decline in benchmark 10-year yields to the brink of a record low last month indicates the challenge for the central bank, she added.

TOP

Source

Thailand: International study proposes mandatory contributions to pension fund - Asia Insurance Review

Thailand is at the bottom of 37 retirement income systems around the world examined in an international study called the Melbourne Mercer Global Pensions Index.

The report suggests that the Thai pension system could be improved by:

- introducing a minimum level of mandatory contributions into a retirement savings fund;
- increasing the coverage of employees in occupational pension schemes thereby increasing the level of contributions and assets;
- increasing the minimum level of support for the poorest aged individuals;

Introducing a requirement that part of the retirement benefit from private pension arrangements must be taken as an income stream.

At present, Thailand's retirement income system provides broad coverage across three pillars, comprising of:
1) a means-tested old-age pension, a Social Security Fund for private sector employees in the formal sectors;

2) Provident Fund, a voluntary-basis employer-sponsored direct contribution plans; and

3) Individual savings products including the Retirement Mutual Fund which provides a tax free lump sum upon retirement and a large market of insurance / endowment products.

In Thailand, 10.5m, or 16.2% of the 65.2m population were aged over 60 in 2015. According to the United Nations, a country with over 10% of its population aged 60 and older is an ageing society. When this group increases to over 20%, the country is classified as an aged society.

The Bangkok Post, in an editorial, notes that Thailand has various pension schemes -- a system for civil servants, a compulsory system for workers under the Social Security Fund (SSF), a voluntary system of the National Savings Fund (NSF) which covers informal workers, and voluntarily annuity insurance for retirement.

Unfortunately, pension incomes likely to be provided by these plans are insufficient, even by today's standard cost of living, says the editorial. For example, the SSF's retirement income is up to THB7, 000 ($232) per month. The NSF pays varying rates depending on the amount and the period of contribution, ranging from THB600 to THB7, 200 a month. Those eligible for the maximum retirement income of THB7, 200 must have contributed to the fund since they were 15 years old.

TOP

Source

Australia: Every bit of the country should be insurable - Asia Insurance Review

No area of Australia should be uninsurable, provided governments invest appropriately in permanent mitigation and resilience measures to protect communities from known and projected risks, including the impact of climate change, says the Insurance Council of Australia (ICA) in a statement on climate change, insurance affordability and accessibility.

Mr Campbell Fuller, ICA head of communications and media relations, says that claims that parts of Australia will inevitably become uninsurable or unaffordable due to climate change fail to recognize that mitigation and adaptation can prevent some of the worst impacts of extreme weather. Australian communities should be encouraged to lower risks and take practical action.

He says that it is important that extreme weather projections based on climate change models are agreed upon and understood by all relevant stakeholders before they are used in a way that may unnecessarily scare householders and businesses, disrupt communities and lead to poor decisions and outcomes.

The ICA supports the need for well-coordinated and prudent action on climate change. It is working with insurers and other stakeholders to integrate its efforts. Achieving a smooth and orderly transition to a low-carbon economy can only be achieved through credible, agreed and understood methodologies. This will help property owners, communities and governments avoid costly mistakes and maladaptation.

Climate change tools

Fee-based commercial climate change tools that aim to provide information about future risks must be based on transparent methods and data. This would allow community members to understand relevant limitations in the projections and make more informed decisions.

The insurance industry is investing in the development of transparent risk tools for climate change, based on centuries of underwriting expertise and extreme weather knowledge. These tools and the methodology upon which they are based will be available for all stakeholders to use. The outputs from the industry's work on climate change may ultimately be useful for commercial ventures.

The statement adds that insurance is risk-rated, and remains competitive in all regions. Sending a price signal to high-risk areas is an important part of insurance. These price signals send a message to property owners, communities and governments about their risks and serve to encourage consideration of mitigation, resilience and improvements to town planning and building codes.

Resilience infrastructure

The ICA notes that earlier this month, the Senate voted to increase the amount of money available for mitigation measures by A$50m ($34m) a year. "This is a positive sign governments are starting to understand the important role they play," the statement says.

At present, only 3% of natural disaster funding is spent on mitigation; 97% is spent on post-disaster recovery. The Productivity Council advocates that prevention is better than cure. In 2014 it recommended the Commonwealth invest at least A$200m a year in mitigation and resilience, to be matched by state and territory governments.

The ICA would like mitigation investments to be treated as nation-building infrastructure. It says that governments must also determine how best to ensure communities can be more resilient to the impacts of climate change.

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