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QUOTE OF THE WEEK

“The turning point in the process of growing up is when you discover the core of strength within you that survives all hurt.”

Max Lerner

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INSURANCE TERM FOR THE WEEK

Business Insurance

Business insurance coverage protects businesses from losses due to events that may occur during the normal course of business. There are many types of insurance for businesses including coverage for property damage, legal liability and employee-related risks. Companies evaluate their insurance needs based on potential risks, which can vary depending on the type of environment in which the company operates.

Business insurance refers broadly to a class of insurance coverage intended for purchase by businesses rather than individuals. Businesses seek insurance to cover potential damage to property, to protect from lawsuit, or contract disputes. Business insurance accounts for about half of the U.S. property casualty insurance industry, and includes many insurance products known as "commercial lines".

INSURANCE INDUSTRY

Challenges the insurance industry is facing during the second wave – ELETS - 15th June 2021



The novel corona virus is proving to be a bigger problem than one ever anticipated. The pandemic shows low signs of containment, and it seems like there isn't going to be a sigh of relief anytime soon. Industries and businesses worldwide have been hugely impacted since the spread, and now the virus is known to be mutating and spreading even further.

We have experienced something known as the second wave of this infamous disease, proving to be far more lethal and devastating. Steps taken to contain the second wave and the measures taken to limit the spread of the disease have significantly disrupted and created a huge impact on different industries, including insurance.

Since Covid-19 was recognized, insurers worldwide began providing protection and offering coverage with minimum clauses to all the people. Since the impact was devastating, risk mitigation was not completely taken into account by the insurance industry as a business. Due to this, the insurance industry as a whole seems to have dug a deeper hole. Here are some of the factors that are making the second wave challenging for the insurers:

Coverage and immunity:

Insurance companies have offered coverage against the coronavirus and its immediate aftermath. Various benefits, coverage plans, standard products, dedicated covers and schemes, etc were immediately developed for the general masses to help them fight the battle with Covid-19. The IRDAI has also given out several notifications in order to make the process easy for the policyholders to deal better with the second wave; however, these instant changes have created some degree of pressure on the insurers. In spite of this situation, insurers have been trying their level best to cope up with the situation and ensure that their customers are well-supported.

Claims and settlements:

Covid-19 has proved to be not only fatal but also financially expensive in terms of medical treatments and other recovery measures. Insurance companies have been rigorously settling claims for one and all who

have been insured against the virus, thereby increasing the outgoing cash flow. As the number of cases increased, more and more people were compelled to seek coverage benefits.

Until the mid of last month, it was observed that there were approx 11.40 lakh cases which were received by the general insurers in India. Out of which, around ~15.8% of the cases were pending cases with unsettled claims. Talking about the state of Maharashtra, around 5.35 lakh number of claims were raised out of which ~16.15% of claims remained unsettled. This clearly implies that the second wave has been really hard on the insurers owing to the excessive increase in the number of claims.

Flexible terms and conditions:

Insurers have been tirelessly working to quickly come up with coverage plans that would make the most sense for people who are seeking immunity. This enforced the insurance companies to quickly incorporate coverage plans with flexible terms and conditions. Low premiums and basic eligibility criteria have been a key base for the Covid-19 protection plans as it was the need of the hour. This has created increased penetration but at the same time additional pressure on the insurers.

Addressing overwhelming queries:

Considering the fact that the second wave has been more threatening and difficult to handle, there has been an overwhelming flow of queries from the customers for different issues pertaining to the plans, claims, renewals etc. Although the insurance companies had to face similar issues during the first wave, there has been considerable increase due to the spiking cases during the second wave. As the second wave progresses, insurance companies will need to focus on settling claims, make efforts to increase sales for policies, and fight a monetary pressure that might continue to grow exponentially if not looked upon.

(The writer is Rakesh Goyal.)

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DPIIT notifies 74% FDI cap in insurance sector under automatic route - Business Standard - 15th June 2021

The Department for Promotion of Industry and Internal Trade (DPIIT) has notified the government's decision to increase the foreign direct investment (FDI) limit in the insurance sector under the automatic route to 75 per cent from 49 per cent earlier. According to a press note issued by the department, the decision will take effect from the date of FEMA (Foreign Exchange Management Act) notification.

The Insurance (Amendment) Bill, 2021, was passed by Parliament in March. The Bill amended the Insurance Act, 1938. FDI in the insurance sector was increased from 26 per cent to 49 per cent in 2015. The announcement for hiking the FDI limit was made in the Union Budget 2021-22 on February 1. The new arrangement is expected to benefit 23 private life insurers, 21 private non-life insurers and seven specialised private health insurance companies.

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Insurance sector reform in the digital age - Outlook - 12th June 2021



Technological disruption has caused a shift in the way businesses communicate and engage with their consumers. It has heralded an era of customisation that allows businesses to get up close and personal with their customers. Today, in the wake of the pandemic, risk assessment and mitigation have come under the spotlight. Insurance, being one of the best risk protection tools available to people, is inevitably going to gain traction. However, the insurance industry can optimally leverage upon this opportunity only if it is focused on meeting the nuanced needs of its customers.

The Catalyst for the Insurance Industry

People's attitude towards risk management has changed from being reactive to proactive. They are more demanding in terms of being selective in the type of insurance coverage they purchase and a "one size fits all" approach is no longer an option for insurance companies. Personalised insurance can effectively cater to the changing demands of new-age customers. Here are three key reasons why personalised insurances are likely to prove popular in 2021.

1. Awareness: Today's consumer is highly evolved – with many following either the Research Online Buy Offline (ROBO) model or its reverse, i.e., Research Offline Buy Online. In either case, online is an integral part of the buyers' journey. This is because the consumers' digital interactions generate a significant amount of data that can be further harnessed to create personalised solutions. As consumers are receiving personalised solutions and services in most aspects of their lives, it is only inevitable that they expect the same level of personalisation from their insurance companies as well.

2. Option to Pick and Choose: Insurance also requires customised solutions basis individual/business risks. This is especially true for health insurance. Every individual has different levels of health and fitness. At the same time, there is a whole range of insurance products that are available to meet your specific needs. Thus, you can choose to purchase an insurance product that meets your requirements, whether it is a preventive cover or a cover for critical disease. Further, you can also choose add-ons to improve the extent of coverage of your chosen policy. As a result, you can customise the insurance policy to suit your unique needs. Similarly, personalised car insurance based on factors such as customer's driving record, annual mileage, etc is also possible by the use of telematics devices that can be fitted in cars.

3. Personalised Marketing: Customer-centric marketing is still at an early stage in the Indian insurance industry. However, the experience abroad suggests that insurers who are willing to offer tailor-made solutions for their clients after understanding their requirements are likely to see better revenues as well as higher customer retention. While data privacy issues remain a concern, research suggests that customers are willing to share data provided it results in a solution that is cheaper and more suited to their needs.

Many insurance companies are embracing this opportunity to improve the value proposition for their customers. For example, a health insurance policy where a menu card approach has been adopted, offering customers the option to choose the cover that best suits their requirements. Personalisation has already orchestrated change in several industries. Insurance is next.

(The writer is Subramanyam Brahmajosyula.)

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INSURANCE REGULATION

Irdai looking for an agency to manage its grievance redressal centre – Live Mint – 13th June 2021



Regulator Irdai is looking for an agency to manage its multi-media grievance redressal centre with a view to address complaints of insured public against insurance companies. The Insurance Regulatory and Development Authority of India (Irdai) had set up a consumer affairs department (CAD) to oversee compliance of insurers and intermediaries with respect to Protection of Policyholders' Interests Regulations. It will also empower consumers by educating them on grievance redressal mechanisms. To provide alternative channels to receive complaints against insurers, it has set up the Irdai

Grievance Call Centre (IGCC) that receives complaints through a toll-free telephone number and by e-mail. It also registers complaints apart from furnishing the status of the resolution. The agency will be required to manage its IGCC by providing the state-of-the-art call centre solution based on IP Multimedia platform for seamless handling of channels (telephone calls, e-mails and letters) with unified administration and reporting as well as having the integrated components in a single platform, said the request for proposal (RFP) for IGCC Services.

The entity, the RFP said, should be able to take over the operations from the current service provider. According to the RFP document, the duration of the contract will be initial for three years and further extendable for two years on a year-on-year basis. The regulator said the IGCC is envisaged to be a true alternative channel for the insured public consumers by offering comprehensive tele-functionalities (both manual and IVR) to all insurance consumer segments. It serves as a 12 hours X 6 days' service platform, offering multiple languages and integrating channels.

"It is envisaged that the IGCC would not only attend to phone calls and e-mails but also complaints forwarded by the consumer affairs department of the authority, subject to internal procedures, complaint registration process and other process requirements," it added. The regulator has also put in place the Integrated Grievance Management System (IGMS) as an online system for grievance management. IGCC has an interface with IGMS; and through IGMS, Irdai has an interface with grievance systems of all insurers. The Irdai receives complaints on insurers from prospects and policyholders, and takes up these grievances with insurers for resolution.

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IRDAI issues guidelines on professional indemnity policy for insurance intermediaries – Financial Express – 12th June 2021

Regulator IRDAI has come out with guidelines on standard professional indemnity policy for insurance intermediaries, including brokers, corporate agents and web aggregators. The guidelines issued by the Insurance Regulatory and Development Authority of India (IRDAI) will come into effect from July 1.

Professionals and professional entities may be sued by their clients for errors or negligence during the course of their professional duties, as per the guidelines. A professional indemnity policy is a liability insurance product that protects individuals giving professional advice and professional entities against negligence claims by their clients for errors and omissions. It covers financial loss suffered by the clients resulting from breach of professional duty.

As per the guidelines, every general insurer should endeavour to offer the standard professional indemnity for insurance brokers, corporate agents, web aggregators and insurance marketing firms. On policy period, the guidelines said: "An insurer shall issue an annual policy to the insurance intermediary. The insurer shall endeavour to issue long-term policy valid for the period of certificate of registration." The premium rates will be determined by the insurers depending upon various risk factors and its board approved underwriting policy. Insurance intermediaries engaged in solicitation and distribution of insurance products are required to take professional indemnity insurance policies.

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LIFE INSURANCE

Insurers want more people under social welfare cover – The Times of India – 18th June 2021

With claims under the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) exceeding premium collections, insurers are calling for expanding the insured population. At the end of FY21, the cumulative enrolments under the scheme were 10.3 crore, against which 2, 50,351 claims were reported. With claims outstripping premium, insurers have to find ways to bridge the gap. This is becoming tougher at a time when reinsurers are hardening their stance on term insurance in India and some even pulling away

from the Indian market. “The current experience is that claims are 160 percent of risk premium. One of the options to increase the sustainability of the scheme is by reducing the solvency margin and mandatorily increasing the participation under the scheme as the principle of insurance is based on the



law of large numbers,” said IndiaFirst Life Insurance MD & CEO R M Vishaka. According to her, life insurance can be made mandatory for accountholders or at least those who avail of loans and, to reduce the burden, the premium can be collected each month so that the instalment is less than Rs 30. “Just like wearing a helmet is mandatory for driving a two-wheeler, life cover should be mandatory for breadwinners,” she said.

Insurers also said that, while they have for long been calling for an increase in the premium under the social welfare schemes, they also feel that it may not be the right

time for higher rates given the fall in incomes. At the same time, the relatively low premium and absence of margins make it difficult to spend on increasing awareness through promotions. The Confederation of Indian Industry had also called for making this cover universal. However, the cover cannot be provided without the consent of the deposit holder. The PMJJBY scheme was launched in 2015 and it provides insurance cover of Rs 2 lakh to every bank accountholder for a premium of Rs 330. To ensure universal coverage, all adults up to 50 were covered without any exclusion and consent could be given through a form, through text or online. The pricing was devised calculating the mortality in the age group assuming around 1.2 deaths per 1,000 + 0.2 percent stamp duty. However, the experienced rate is over 2. So far under PMJJBY, about 4.7 lakh claims have been paid Rs 9,307 crore. Since the beginning of the pandemic, that is, April 1, 2020 onwards till date, 1.2 lakh claims have been paid amounting to Rs 2,403 crore. Last week, the government indicated that it wants to streamline the process of claim settlement. The idea is to integrate systems so that when family members come in for closure of accounts following the death of the account holder, the process is automatically initiated.

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How does a regular income plan pay-out work in life insurance? – DNA – 17th June 2021

Today's youth are much more 'woke' than their parents and older family members. They have social and political consciousness, are self-aware, and are more open to learning. So no wonder when the COVID-19 pandemic began, a lot of young Indians, more than 82% in fact, took little to no time to reshape their beliefs on life insurance or **term insurance**. Now, several believe that life insurance is essential to secure them in the face of a crisis. Once you figure this golden rule beforehand, all that remains is to get a plan that suits your lifestyle and needs. But the buying bit is where it can get tricky, and questions about whether you should invest in a market-linked plan or a non-linked plan can arise.

Now, as vital it is to diversify your financial investments with both kinds of plans, knowing how volatile the current scenario is, it is wise to have at least one non-linked plan that gives you fixed and guaranteed returns.

What are regular income plans? How do they work?

Generally, life insurance plans give the breadwinner's (called the insured or policyholder in insurance lingo) family a lump-sum payout in case of his/ her death. While this can seem like a boon at the start, it can soon turn into a bane if a family prefers managing their expenses through monthly incomes and does not know how to manage a huge lump-sum amount. To ease the stress of money management, regular income plans can be of immense help. These are life insurance plans that give a fixed and guaranteed income throughout the tenure of the insurance policy along with life insurance protection. This means that the family members of an insured not only receive a death benefit payout in case of the insured's death but also receive regular periodic payments from a year after paying the premium for the plan. Under such plans, one can secure their family even during their lifetime. This is a great financial resource for those who wish to secure their loved ones in their presence and absence.

What are the premium payment and payout options in regular income plans?

Paying the premium of a regular income plan is very flexible and convenient for the policyholder. For instance, policyholders have the option to choose between monthly, quarterly, half-yearly or yearly terms for paying premiums. They also have the liberty to choose premium paying terms ranging between 5, 8, 10 and 12 years. Moreover, they can even decide when and which type of regular income returns they want to receive. One is where they will receive the same amount of guaranteed income every month. The other is where they will receive a guaranteed income that increases at a fixed percentage every year.

Who should opt for a regular income plan?

A regular income plan is best for those who are averse to taking market risks and want to ensure a fixed stream of income. Such a plan helps one avoid the chances of losses and stay safe from the effects of inflation as well. This is all the more essential in today's COVID-19 stricken times. Moreover, policyholders get the added benefits of choosing to add extra riders. These riders cover demises and injuries caused due to critical illnesses and accidents and waive the payment of premiums in such situations and until the policyholder is fit to pay them again.

Those who want to ensure that their loved ones remain secure at all times should go for the regular income plan. By guaranteeing payment during the breadwinner's presence and absence, a family can get round-the-clock protection. Furthermore, apart from receiving a death benefit payout in unfortunate cases of the policyholder's death, families also receive a maturity benefit in case the policyholder survives the term of the regular income plan, so one doesn't have to lose the effort of their invested income. So in all ways, this plan is a win-win!

To sum it up:

It is better to start small and early with a regular income plan than procrastinate. Let the magic of compounding work wonders for you.

As business tycoon Warren Buffett once said, "Someone's sitting in the shade today because someone planted a tree a long time ago."

Let yourself be the one to plant that tree of security. And let your loved ones receive the shade of financial freedom irrespective of what is going on in the world.

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Shocked by COVID deaths, young Indians rush for life insurance - Financial Express - 16th June 2021



Like many other twenty-somethings in India, Beverly Coutinho kept postponing buying a life insurance policy, until a surge in COVID-19 cases and deaths made her confront her own mortality. "I saw people my own age dying, which prompted me to get life insurance immediately," says Coutinho, a 24-year-old senior executive at a public relations agency in Mumbai.

"I wouldn't want my family to be in situation where they have to scramble for funds if something happens to me." The official count puts the number of deaths due to COVID-19 at 380,000, the third highest after the United

States and Brazil, though experts say India's numbers are grossly underestimated due to the low levels of testing for the virus and more people have probably died in India than anywhere else in the world.

When a devastating second wave of the pandemic peaked in India during April and May, the numbers of people aged between 25 and 35 buying term insurance was 30% higher than in the previous three months combined, said PolicyBazaar, India's largest online insurance aggregator.

Term insurance purchases via online insurance aggregator InsuranceDekho's website rose 70% in May compared with March. Insurers did not reveal how many plans they sold citing business confidentiality, but many said it was in the "high thousands". "The current pandemic has led to higher awareness around the need for financial protection and the inadequacy of the current insurance coverage," Niraj Shah, chief financial officer of HDFC Life Insurance, said.

Shah's firm said it had seen more demand for protection products by the under-35 age group since the pandemic first struck India, around 15 months ago. Industry executives say enquiries about insurance plans have rocketed despite the second wave of infections subsiding, probably due to strong prospects of a third wave given the slow start India made to the mammoth task of vaccinating its people.

BEHAVIOUR CHANGING

Stock market investors still appear uncertain whether buying shares in life insurers is a good bet during a pandemic. Since the start of the year the benchmark NSE Nifty 50 index has gained 13.5%, while shares in HDFC Life Insurance are up just over 2%, SBI Life Insurance has risen around 10% and ICICI Prudential Life Insurance has climbed nearly 18%.

"In the longer term, investment in insurers make sense as the awareness has risen about insurance," said Saurabh Jain, assistant vice president research at SMC Global Securities in New Delhi. But he added that high valuations and a rise in number of claims due to the first and second wave were a concern. Despite the lack of firm numbers on growth in the life insurance market, industry analysts see behaviour changing among middle class families in a country that has traditionally seen poor levels of coverage.

"After clothes, food and home, insurance has now become the fourth pillar for a middle class family," Ankit Agrawal, InsuranceDekho's founder and chief executive, said. Life insurance penetration among India's population stood at 2.82% in 2019, compared with 2.15% in 2001, the latest annual report from the Insurance Regulatory and Development Authority showed. That is still well down from a global average of 3.35% in 2019, but then a large section of India's 1.35 billion people lack disposable income to set aside for insurance, a situation made even more acute by the economic fallout from the pandemic.

Term insurance plans are popular in India because they are often cheaper and pay the family if the insured dies within the policy's payment period, though there is no maturity benefit if they outlive the plan. Demand for other kinds of insurance, including various medical cover, has also risen. "If someone was thinking about buying insurance, they are actually doing it now," said Avneesh Sukhija, a senior financial analyst at BNP Paribas India.

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Life Insurance: How nominees can easily process Death Claim Settlement – Financial Express – 15th June 2021



Death Claim settlement is one of the most important responsibilities that an insurance company has to fulfil towards its policyholders and claimants. This service has assumed greater importance in the wake of COVID-19 for all life insurance companies. Life insurance companies have an obligation to decide and settle claims promptly.

While insurance companies offer various options to the claimants of bereaved life assured to file a death claim, especially in times like these, where mobility itself is a significant constraint and risk, insurance companies offer various digital options for easy claim intimation by the

claimant. Generally, life insurance company websites offer the provision to file the death intimations digitally and also have the death claim intimation form which if required by the claimant can be printed and completed and couriered to the insurance company.

It may also be noted that life insurance falls under 'essential services' and most of the life insurance companies have their branch offices open (based on local conditions) to provide all kinds of policyholder service, including claim registration by claimants.

For an insurance company to promptly assess the death claim and quickly initiate the process, the claimant must intimate the death claim at the earliest with the required documentation/ information. The details required on the digital claim intimation form should be accurately filled, and it should contain basic information such as policy number, name of the life assured, date of death, cause and place of death, and name of the claimant. The claimant can complete the claim intimation digitally through the company website, obtain the form from the nearest local branch office of the insurance company or through their insurance advisor/ agent.

Along with the claim intimation form, the claimant also needs to provide original policy document, death certificate, police FIR and post mortem report (for accidental death), certification/records from the treating doctor/hospital (for death due to illness), KYC and bank details of the nominee, and claimant's statement. If the death has occurred due to COVID-19, you need to provide relevant proof confirming the same along with the mentioned documents.

Settlement of Claim: As per the regulatory requirements, the insurer must settle a claim within 30 days of receipt of all documents, including clarification sought by the insurer. If the claim requires further investigation, the insurer has to complete its procedures expeditiously, in any case not later than 90 days from the date of receipt of claim intimation, and the claim must be settled within 30 days thereafter.

Claim services during COVID times: All life insurance companies are regularly monitoring the intimations received, especially those where the cause of death is due to COVID, and ensuring that such claims are assessed and decided expeditiously and as a good governance practice, the status of all COVID-related death claims are shared daily by life insurance companies with IRDAI also.

To maintain customers' safety, insurance companies under the direction of the IRDAI have communicated and published on their website about all digital options available at their fingertips to access their insurers and avail of services, including claims. Besides, if any more clarifications are required, the claimants should contact the insurance company contact centre/ helpline; write an e-mail to the customer care team, or avail of any customer service touch point offered by the insurance company.

(The writer is S Mahesh.)

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Three ways to reduce life insurance premiums – Live Mint – 15th June 2021



The cost of insurance premiums should be seen as an investment, which enables your and your family's safety during uncertain times. Hence, you should be smart enough to choose the right policy, one which not only helps you save on premium cost but also provides adequate coverage.

If the cost of insurance premiums has ever influenced your decision to purchase a life insurance policy, here are different ways which can help reduce your insurance premiums and not burn a hole in your pocket.

Begin when you are young

Your age has a direct bearing on the premium amount, the younger you are, the lower your life insurance premium will be. Starting young is the key to low life insurance premium. Sajja Praveen Chowdary, head-term life insurance, Policybazaar.com said, "Simply put, if you purchase your policy as soon as possible, you will be eligible for lower premiums than if you wait until you are older because there is less risk

associated with a young policyholder. The higher your age, the higher your premiums will be. It is highly recommended that you purchase a policy in your early 20s to save money on your premiums."

"For instance, if you purchase a term insurance policy at the age of 25, it will cost you between Rs600 and Rs800 per month. Alternatively, if you buy the same policy at a later age, say at the age of 40, it will cost you around Rs1300-1400 per month. As a result, don't wait any longer; simply purchase the appropriate policy at the appropriate age," Chowdary explained.

Select the premium payment mode option astutely

When purchasing a life insurance policy, you have the option of paying premiums in a variety of ways - annually, half-yearly, or monthly. Premiums can also be paid at one go if desired. Your policy will most likely lapse if you choose monthly premiums as your payment method and do not pay them on time. As said earlier, some insurance companies allow policyholders to pay a lump sum premium, which could result in a discount.

For a 30-year-old male, non-smoker living in a metro, there are price comparisons of term Insurance offered by four major insurers. The total sum assured is Rs1 crore, with a 60-year coverage period. The idea is to compare all premium payment options on one platform, which can be monthly, annually, or even a single premium paid all at once.

Maintain a healthy lifestyle

If you maintain a healthy lifestyle, your premium payout will be lower. Insurers pay special attention to the medical history of the policyholder. Lifestyle ailments like blood pressure and hypertension can increase the premium amount. Hence, it is important to maintain a healthy lifestyle.

"The irony is that when you most need life insurance—right after you've had health problems—you're least likely to get it or your premiums will be higher. Before issuing you a policy, insurance companies conduct a medical examination to learn about your medical history. The basis on which insurance companies set premium rates. This is due to the fact that insurers are well aware of life-threatening habits and will charge a higher premium as a result," said Chowdary.

(The writer is Navneet Dubey.)

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Life Insurance and Health Insurance: Why to get insured and which cover is essential? - Financial Express - 12th June 2021



The aim of taking insurance is getting financial protection against a risk, where uncertainty is there about timing and/or occurrence of an insurable event. For example, death is certain, but no one knows when. This uncertainty causes two types of risks – the risk of dying early and the risk of living too long. The risk of dying early would put the financially dependent persons in great financial difficulty and make their life miserable.

On the other hand, the risk of living too long may result in a person ending up using all the retirement corpus resulting again in financial difficulty for the person himself/herself.

Life Insurance

While the risk of living too long may be managed by buying a life-long pension plan and other plans for best utilisation of the retirement corpus, the risk of dying early poses a greater uncertainty. This is because a person can't accumulate enough corpus to replace his/her entire future earnings. Moreover, with the uncertainty of how early a person would die, it is also uncertain how long would be the remaining earning life to start accumulating a corpus. As insurance companies are in a better financial

position to manage such risks, by taking insurance, a person transfers the risk to the insurer. To accept the risks, insurance companies charge premiums from the insured persons. So, for every individual having financially dependents, it's very important to take life insurance cover. As term life insurance products cover only pure risk of death, it's the cheapest life insurance product. So, it's advised to take term insurance to solely cover the risk of dying early.

Health Insurance

People fall ill with communicable diseases – like common cold, viral fever, lose motion, malaria, etc – as well as with non-communicable diseases – like diabetes, hypertension etc. However, there are uncertainties over how frequent a person may get sick and how seriously ill a person may become. The uncertainties over getting ill, coupled with the rising cost of treatment in private hospitals, make it a necessity to take health insurance cover.

With the rising cost of hospitalisation, the uncertainty of getting ill poses a great risk of running out entire savings due to some serious illness resulting in repeated hospitalisation. The purpose of taking health insurance is transferring the risk of cost of hospitalisation – which is uncertain – by paying premium – which is certain. So, unless covered under a health scheme that covers entire life, everybody should take adequate health insurance cover to protect their savings in case of hospitalisation.

Life vs Health Insurance

Compared to life insurance, taking health insurance cover is necessary for every individual, while a life insurance cover is necessary for those having financially dependents.

(The writer is Amitava Chakrabarty.)

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GENERAL INSURANCE

Directors' and officers' covers become costlier as their liabilities rise - The Economic Times - 18th June 2021

Indian companies are paying up to a fifth more on average toward insurance covers for their directors and top executives against liabilities from potential claims related to either bankruptcy, fraud, security lapses or perceived breach of fiduciary duties. Tariffs on directors' and officers' (D&O) liability policies have risen in line with the demand for such coverage, insurance companies said, with lenders taking more borrowers to bankruptcy courts over bad debt. Fiduciary claims on staff benefit plans or security related claims from shareholders have also raised the demand for D&O policies that seek to compensate key executives against legal action. The premium charged on D&O insurance has increased in some cases up to even ₹3 crore, from ₹1.5 crore on average, for sums assured in the region of ₹5 crore to ₹30 crore, an official at Iffco-Tokio General Insurance said, requesting anonymity. Anup Dhingra, managing director, Marsh India Insurance Brokers Pvt Ltd, said premium tariffs have already climbed up to a fifth for large D&O buyers having tie-ups with global reinsurers and could rise further as the financial ecosystem assesses the impact of the pandemic.

(The writers are Kala Vijayraghavan & Joel Rebello.)

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HEALTH INSURANCE

Should NRIs buy health insurance in India? - The Economic Times - 17th June 2021

Health insurance premiums in India are considerably lower than what you would pay in other countries. That is because the cost of medical treatment in many developed countries, especially the US, is simply too high. Covering that amount requires a very high premium. According to insurance research firm

Kaiser Family Foundation, the average annual premium for family coverage in the US was \$20,576 (more than Rs 14 lakh) in 2019. In UAE, premiums for comprehensive health insurance for a family of four can get a cover of Rs 20 lakh for about Rs 70,000-80,000 per year.



However, the low premium rates do not mean NRIs must always buy health insurance in India. A health plan bought in India is meant to cover expenses on medical treatment in India. Almost all health insurance policies have geographical restrictions, which mandates that expenses incurred outside India will not be covered.

This clause on geographical restrictions is buried in the fine print of the terms and conditions so you may not notice it when you apply for a policy. But it will render the policy useless if you are not in India. This is also why Indians going for studies abroad are encouraged to not rely on the health insurance plans bought in India but buy a policy in the destination country. Some premium policies do cover life-threatening emergencies if they occur in a foreign country, but even they require a very high co-payment by the insured person. There are also policies that cover medical expenses incurred abroad if that treatment and the required medical infrastructure do not exist in India.

Buying health insurance in India makes sense if the NRI is returning to the home country or intends to do so in a couple of years. It's advisable to buy the insurance well in advance because most policies have a cooling period of 1-2 months before some illnesses are covered. That way you will not have to rush to buy health insurance immediately after landing in India.

If the NRI family has a history of diabetes or a heart condition or there is a new born baby in the family, it might be cost effective to buy the insurance much before you intend to come to India. Certain pre-existing ailments such as diabetes and cardiac ailments are not covered by insurance for the first four years. For certain other ailments, such as ENT disorders, hernia and osteoporosis, the waiting period can be 1-2 years. There is also a 90-day waiting period for infants. So even though you will have to shell out a premium for 2-4 years without enjoying any benefit, it still works out cheaper than not buying insurance.

Interestingly, even though a health insurance policy might not give them coverage in India, the tax department still offers tax benefits to NRI buyers of health insurance plans. The premium paid for health insurance is deductible under Section 80D of the Income Tax Act. The limit is Rs 25,000 for self and family and Rs 25,000 for parents. If anyone is a senior citizen above 60, the deduction increases to Rs 50,000. Keep in mind that this can be availed as a deduction only if the NRI is filing returns in India.

While it does not make sense for NRIs to buy health insurance in India, it makes eminent sense to buy medical insurance while traveling to India for holiday or business. It might just be a 5-6 day trip, but don't travel without medical insurance. General insurance companies now offer customized plans that can fit your pocket. For less than Rs 1,600 one can buy a cover for Rs 15-20 lakh. Do watch out for a co-payment clause when you buy such a plan.

[TOP](#)

Soon, Indians won't be able to afford hospitalisation without insurance like in the US - The Economic Times - 16th June 2021

While Covid cases are slowing down, insurance companies are busy settling health claims. According to the recent data, insurance companies have got the majority of the claims in the last two months itself. They received 7.9 lakh claims between April 10 and June 11. They have settled 81% claims, for which the pay-out is over Rs 14,000 crore.

But insurers are very unhappy with the hospitals. The reason is huge bills charged by hospitals to patients. With rising Covid cases hospitals have raised rates, which the insurers are unable to pay. "On one hand, hospitals say there is no standard treatment available for Covid. But on the other hand,

they are charging high rates and bills are so high,” said M N Sharma, Secretary General of General Insurance Council (GIC), a body formed by regulator IRDAI to communicate with the regulator and government on behalf of the general insurance industry. Sharma adds, “There is no exact proof to understand the charges of the hospitals.”



Manipulation charges

While the debate between hospitals and insurance companies is more than a decade old, Covid has aggravated it since the claims are in huge numbers. Insurance companies have often blamed hospitals for the manipulation of bills.

“We look at many factors before arriving at rates. Such as the location (specifically city) of the hospital as there could be differences between metro and non-metros. The rates could be varying from the multi-specialty and super-specialty hospitals. Also, the number of beds and people working in the hospitals are considered while evaluating the hospitals,” Sharma explains. “But big hospitals are not agreeing with the rates. They are in fact asking for double the rates. We can’t agree on that. If we do, even small hospitals will follow the same,” he adds.

Patients pay

But ultimately, the cost is being borne by the patient. In many cases insurance companies have asked policyholders to make partial payments, citing the higher rates charged by the hospitals. Sharma says hospitals are encashing in a big way and patients will have to pay. “Treatment costs are going out of reach of the common man. And very soon like America, the situation is developing in India where without health insurance nobody can bear the hospitals. This is where it has reached,” he says.

Citing an example, Sharma says the rates charged by hospitals for appendix surgery are different for those with and without insurance. He says that the government should look into it. “We have written to the finance ministry regarding the issue.”

Insurance companies have been recommending the government to set up a health regulator for the hospitals. The Economic Survey of the year 2020-21 has also proposed a standardized system for quality reporting on healthcare for hospitals, physicians and insurance companies. But there has been no update so far.

(The writer is Amol Dethle.)

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Smart tips for buying a comprehensive health insurance plan amid pandemic – Financial Express – 15th June 2021

The entire world is still struggling with the massive impact of the pandemic. Vaccines developed by many countries, including India, appeared like a ray of hope; however, the second wave of the pandemic overwhelmed the available healthcare infrastructure and also put immense financial burden on the patients and their families. It became difficult for many to access appropriate care in these dire circumstances.

With the prevalence of the contagion for over a year now, consumers are starting to realise the significance of health insurance; however, most of them opt for only COVID related policies that may not be adequate. Managing healthcare emergencies in times like these can be difficult. Apart from the illness, the financial burden could prove to be a nightmare for those inflicted by life-threatening diseases. It is in the best interest of individuals to buy comprehensive health insurance policies to save themselves from catch-22 situations like these.

There was a significant increase in the adoption of health insurance purchases over the last year. As per reports by General Insurance Council, health insurance achieved a market share of 29.5 per cent with a growth rate of 13.3 per cent till March. Market experts believe that the upward trend would continue as speculations are rife that the pandemic would not abate shortly. While it is heartening to witness this piqued interest, it is pertinent to note that the buyers must make an informed decision. They must not rush to buy inappropriate plans with inadequate cover.



Important elements that must be ascertained

Purchasing an insurance plan is always advisable. While old age is not a barrier, it is always better to buy an insurance plan early in life for it can prove to be of great help in old age. Certain elements must be ascertained while deciding to buy an insurance plan.

Analyse coverage options: Insurance schemes have various benefits and each may have its own limits and terms of coverage. Buyers must understand the offerings and be fully aware of what is covered and what isn't. While buying disease specific policies, one should also be prepared in case of occurrence of other diseases which

may place a financial burden on the customer. **Hospital Network:** Health insurance plans provide information on enlisted/network hospitals where the insurance cover is applicable on a cashless basis. It is in the best interest of the buyer to understand which nearby hospital would provide treatment on a cashless basis as provided by their insurance company.

Claim settlement ratio: Claim settlement ratio is among the decisive factors that must be enquired into. The buyer must also try to understand the average time taken by the insurance company to settle claims, whether cashless or reimbursement; as it is an important service parameter.

Compare plans: Buyers must compare plans provided by different service providers to select the best-suited plan. Insurance aggregators have made the job easier for consumers; however, they must exercise discretion while taking the final decision.

Room rent restrictions or any other pre-conditions: Understanding pre-conditions or clauses that may affect services availed are pertinent before making a choice. The buyer must know if there is a cap on the room rent or a sub-limit on procedures.

Selecting the policy that suits you

Once the buyer is sure of the requirement from an insurance policy, the next step is to choose the policy that fits in their scheme of things. Knowing whether the policy would cater to the individual and family needs can help to decide the next step.

Individual Health Plan: 'Individual Health Plans' are people specific; consumers should buy them after considering the requirements of each individual. Old age individuals may require a different plan while a youngster can opt for a different plan. Individual plans have to be bought in the name of each beneficiary with a different premium requirement for different individual.

Family floater plan: These plans cover more than one family members without any additional insurance premium requirement i.e. at one pre-defined composite premium. Parents, spouse and children can be covered under these plans.

Critical illness plans: Diseases that require longer healing time and expensive treatment cost fall under 'Critical Illness Plans'. Such policies help the buyer meet long term financial assistance as they are paid a fixed amount on the diagnosis of such diseases. **Covid-19 insurance plans:** Ever since the pandemic outbreak, insurance providers are providing standard indemnity policy to cover COVID-19 treatment costs. Known as Corona Kavach, these are short term plans that do not cover other illnesses.

Comprehensive plans: Comprehensive health insurance policy provide for hospitalisation expenses in acute or chronic illnesses. They cover accidental cases and provide insurance cover on viral infections like COVID after the expiry of 30 days of policy purchase.

Top-up plans: Plans that provide additional assistance if hospitalisation expenses cross a certain limit are known as ‘Top-up Plans’. It is advisable to make an informed decision while opting for insurance policies. While seeking cover from particular diseases might appear to be a cost-effective idea one must choose to invest in comprehensive policies as these Policies can also be of use in case of other unforeseen diseases or conditions.

(The writer is Ajay Shah.)

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Examining reasons behind market failure in health insurance - Observer Research Foundation - 13th June 2021



For the second most populous country in the world, the health expenditure in India is amongst the lowest at 3.54 percent of the Gross Domestic Product (GDP). Of this, the share of public expenditure is about 1.28 percent of the GDP, indicating that healthcare in India is largely privately owned. In such a market, health financing tools become an important social security measure. It not only enables access, but also generates demand for improved healthcare and ensures financial risk protection. An efficient health insurance market, therefore, reduces the ‘out of pocket’ healthcare expense burden on individuals, which can otherwise push households into poverty. But, in

India, the ‘out-of-pocket’ expense on healthcare is a high 62 percent, which is indicative of the fact that health insurance in India is producing sub-optimal outcomes.

Building a robust health insurance market to enable access to healthcare was one of the drivers for the government to open up the insurance sector to private participation in 2000. The Insurance Regulatory and Development Authority of India (IRDAI), which came into existence as a result of privatisation, was handed the dual role of developing as well as regulating the insurance sector.

Ailing private health insurance sector

But two decades later, the report card for commercial health insurance ranks poor. Commercial health insurance is headlined not only by under-penetration—only 137 million lives were covered in FY20—but also market failure. The growing instances of market failure can be evidenced through health risk selection (cream skimming), shallow coverage, high administrative costs and low burning ratios.

A huge part of the problem is the unmet need to build and strengthen a regulatory structure in the healthcare sector, the lack of which is currently impeding the way the private insurance market is working in the country. This is one of the reasons why despite increasing medical costs, health insurance has seen fewer clients. This is also why health insurance cover continues to focus narrowly on hospitalisation expenses (in-patient care) instead of the broader spectrum that includes preventive healthcare and out-patient costs which is essential for long-term sustainability of health financing.

Even within this narrow scope of coverage, and despite important reforms to make health insurance more comprehensive, health insurance products come with complex constructs laced with waiting period exclusions, exclusions in terms of non-payable items, and other contractual disallowances compounding information asymmetry further leading to market failure. This is also why health insurance sees the highest bucket of complaints after life insurance policies. In fact, a huge number of the complaints in health insurance originate while making a claim, pointing to a lack of understanding on the part of the insured.

Figure 9: Complaints by policy type

Total complains in 2019-20	215,205
Policy type	Share of complaints (percent)
Conventional life insurance policy	63.36
Health insurance policy*	1.18
Others	1.89
Pension policy (other than unit linked)	2.31
Unit linked insurance policy	8.03
Health insurance policy	14.32
Motor insurance	5.73
Others	2.36
Fire	0.44
Crop	0.23
Marine cargo	0.1
Engineering	0.02
Marine hull	0.02
Credit	0.01
*Health insurance policies sold by life insurance	
Source CAB FY20	

Figure 12: Breakup of health insurance complaints

	2016-17	2017-18	2018-19	2019-2020
Total complaints	26,937	25,516	25,369	30,825
Type (percent)				
Claim	53.83	58.67	64.15	70.55
Policy	22.43	18.06	13.95	12.44
Premium	2.58	4.43	3.92	2.57
Refund	2.7	2.69	2.44	1.95
Product	0.48	0.8	0.89	0.72
Proposal	0.68	0.79	0.79	0.42
Coverage	1.43	0.92	0.78	0.67
Others	15.87	13.65	13.08	10.69

The Insurance Ombudsman too, in its annual report for FY19, has pointed out unhealthy selling practices and the casual approach to filling up proposal forms and non-disclosure of terms and conditions as the genesis of most complaints. While the point of sale may see a casual approach towards non-disclosure of personal medical information, verification of pre-existing conditions or

previous claims history in case of ported policy, point of claim is followed by thorough scrutiny by the insurer. Front-ending underwriting at policy issuance instead of a claim can reduce customer grievance to a large extent.

Sour claims experience can push customers towards lapsing their policies and it's important to study the impact of market failure on lapsation; but there exists no data in the public realm. Persistency of health

insurance policies, acceptance rate of the insured (percentage of applied customers that were actually insured), claims settlement rate (segregated into retail and group buckets) are some of the important markers to assess the performance of an insurance company, but public disclosure documents mandated by the insurance regulator don't have such customer facing data sets yet.

Looking at persistency across age groups is also important from a pricing standpoint. Health insurance pricing for retail still remains in the clutches of legacy lethargy and high embedded cost of distribution. Retail health insurance has always followed an 'age-band pricing' approach where policyholders in a particular age band pay an identical premium and see their premium jump as they move bands, especially amongst higher age groups. Adding to this is the premium revision by insurers, usually in a block of two-four years to keep pace with medical inflation. These factors together can see premiums jump to as high as 50 percent on renewal leading to large risks of selective lapsing. It's important to insulate the older cohorts from pricing shocks and at the same time encourage younger people to buy health insurance, yet despite regulatory nudges insurers have not adopted differential pricing where customers who have been with the insurer for long benefit cost-wise.

In addition, the high cost of acquisition in retail health insurance that further reduces the risk premium (cost of insurance) for insurers, necessitating regular premium hikes. Regulations allow a 15 percent payout to insurance intermediaries. This is, however, not a one-time payout but a recurring one and that too on a premium that increases overtime. High administrative cost is one of the reasons why insurers don't pass on the benefits of a low claims ratio in the retail bucket to the customers.

Urgent need to resuscitate

Even after 20 years of privatisation, the health insurance market in India is fairly nascent going by the number of people covered. It is, therefore, important to address issues of market failure early on. Health insurance reforms need a two-pronged approach. There needs to be a more collaborative effort on the part of the government to fix the larger healthcare ecosystem in terms of some regulatory oversight the will give insurance industry the confidence to step out of their comfort zone. But, even within the health insurance sector, there is enough scope for improvement. For example, while the product construct remains largely focused on in-patient coverage, care set-up or the route of administration or manner of hospitalisation still form the basis of eligibility for insurance claims. Insurance needs to evolve towards 'episode of care', especially in critical illnesses where if an ailment is insured, coverage should be extended to all treatment modalities for it.

Hence, it is important to have a health committee that can identify indications of right drugs and procedures to enable avoidance of unnecessary lines of treatment or excesses. On similar lines, the insurance regulator did propose setting up a health technology assessment committee, but it's yet to see the light of day. Pricing of health insurance policies too needs immediate attention for a healthy long-term persistency. This again needs regulatory intervention in terms of reviewing intermediary costs and pushing the industry towards a more dynamic pricing structure. Work is also required on a transparent benchmark that captures medical inflation, facilitating regulatory monitoring of pricing, and making price hikes more predictable and transparent.

Improving public disclosures is again important and perhaps the easiest to implement. This will not only supply information to the market but will also increase competition. There is huge scope for improvement in the health insurance market, and the work needs to begin with the insurance regulator. There is a growing need for the regulator to review and expand capacities for proactive regulations and enforcement.

(The writer is Deepti Bhaskaran.)

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Health insurance policies covering domiciliary covid treatment in demand – Live Mint – 12th June 2021



The pandemic has indeed brought health insurance products to the forefront and with lockdowns in effect, customers have been steadily discovering the ease of digital purchase.

In an interview with *Mint*, Tarun Mathur, CBO, Policybazaar.com, said rising covid cases have led to increased interest for health insurance plans with high sum insured. Besides, enquiries and sales are up twice compared year-ago levels.

What type of insurance policy is the must-have to stay safeguarded from the pandemic?

Health insurance and term insurance are rightfully the most sought after products in this pandemic. Medical expenses for covid treatment are very high and family members are typically at high risk of contracting the disease. Hence, any sum insured less than ₹10 lakh can be highly inadequate for treating a family.

Therefore, it is advisable to get at least ₹10 lakh sum insured per person. Apart from that, there are now plans in which coverage starts from day 7 instead of the usual 30 days period, which the customers are keen to buy. In addition, domiciliary treatment of covid is covered in a handful plans which are now finding favour with customers.

As directed by the Insurance Regulatory and Development Authority of India (Irdai), insurers have also launched the Saral Jeevan Bima cover. With the new Standard Term life covers Saral Jeevan Bima in the market, we are seeing a new category of customers emerging for this segment where protection cover is meant for all.

Saral Jeevan Bima has made it easier for people who are less educated or have a low-income profile to buy a term insurance plan. The average income of people investing in Saral Jeevan Bima is ₹3.3 lakh. This plan provides a higher issuance rate for the lower-income segment groups compared with the other term plans available.

Last year, covid was at its peak around this time, and so many people bought health insurance in a rush. What are the trends you are witnessing now as it's the time for renewal?

In the last 12 months, health insurance has successfully transformed from being a good-to-have product to a must-have commodity – all because of rising covid-19 cases across the country. More and more customers have been renewing their health insurance policies compared to last year. Renewal rates are as high as 94%, up from approximately 88%.

Another notable change is that a lot of customers who have low sum insured plans are opting to go for a higher cover i.e. ₹1 crore in case of an emergency. Out of all the family floater policies bought last year, 78% of customers renewed their policy while for individuals the number is 71%.

What is the average claim amount range due to covid?

Reports vary (different from location to location and company to company) and claims are still pouring in but we are already seeing claims as high as ₹15 lakh with an average already sitting at upwards of ₹1 Lakh per individual.

(The writer is Navneet Dubey.)

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TPA vs in-house health insurance claim settlement process: Differences to know – Live Mint - 12th June 2021



The health insurance claim settlement process is one of the most important aspects of a policy. You can get your health insurance claim settled by the insurer in two ways -- in-house claim processing department and a TPA or third party administrator.

"While buying a policy, a buyer should understand that TPAs associated with the insurers are available for processing the health insurance claims only. They cannot accept or reject the claims, the authority for acceptance or rejection lies with insurers only. Besides, there are no TPAs for other kinds of insurance such as life insurance or motor insurance," said Ankit Agrawal, CEO and co-founder, InsuranceDekho.

A TPA acts as an intermediary between the insurer and the claimant, who facilitates the settlement/processing of health insurance claims. A TPA is appointed by the insurance company.

The in-house claim processing department, which is also known as Health Administration Team (HAT), is set up by insurers within their own company.

Both methods help in the claim settlement process and have some pros and cons. In this piece, we take a look at five major differences between them.

Better services than TPAs

To stand in the competition, the insurance companies provide unique facilities to the policyholders. Building an in-house claim process allows the insurance company to provide special offerings including ease on the claims handling front, lower Turnaround Time (TAT), etc. to policyholders from time to time.

The process is smooth and faster than TPA

Since the policyholder can directly deal with the insurer via the in-house claims settlement, it takes less time to process the claim compared to a TPA that acts as the middleman between the insurer and the policyholder.

"Sometimes, a TPA can be incompetent in handling a cluster of cases and rely on the insurer for decision," said Agrawal.

TPAs are reliant on insurers

TPAs are dependent on the insurers for settling health claims, which is not the case in the in-house claim settlement process as ultimately, the insurers are the ones to take care of health claims directly. This can be another benefit of choosing an in-house claim settlement process.

TPAs have a greater hospital network

TPAs have their list of network hospitals, which is mostly longer than that of the in-house claim settlement department of any insurer. Hence, it can be said that the extent of coverage for cashless treatment in-network hospitals of TPAs is greater than most of the insurance companies in India.

TPAs provide better claim settlement facilities

Agrawal said, "TPAs can provide better facilities to the policyholders to make claims under their health insurance policies by making the process easily understandable. While, in the case of the in-house claim settlement department, you have to go through the customer care route, which may take more time."

Mint takeaway

Both in-house claim department and TPA provide effective processes for health insurance claim settlement. While the mentioned differences can help you decide to choose rightly between health

insurance companies offering TPA or an in-house claim settlement department, you must not take policy buying decisions solely based on these factors. Instead, you should consider other factors as well, such as coverage benefits offered under the health policy, exclusions, claim settlement ratio of the insurers, waiting period, etc.

(The writer is Navneet Dubey.)

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MOTOR INSURANCE

When can insurers reject monsoon-damaged cars? - Live Mint - 17th June 2021



Insurance companies are flooded with claims of engine failure every year during monsoons. Most claims during the monsoon season are similar in nature - engine damage due to water or hydrostatic lock. Insurers mostly outright reject these claims as such damages are caused due to negligence of the car owners.

Engine damage due to water can, typically, happen in two scenarios. One, the car was submerged in water. The owner tried to start it after the water receded, and the engine got seized. Second, the car owner drove through a flooded area, and the water entered the engine causing

damage to it. If you want to avoid rejection, here are a few steps you can take.

If your car is submerged in water, call up the insurance company. Explain the situation and ask what you can do. The insurer could suggest you take the vehicle to the nearest authorised garage for inspection. The idea here is to show that you took adequate precaution. If the engine still gets damaged, it would be considered an accident, not negligence. Engine damage when driving through a waterlogged area is disputable. But the insurer would still reject it as there's no way to know whether the drive took adequate precaution or not. The only option in such a case is to avoid starting the car if it shuts off in a flooded area. Once the water level recedes, call the insurer and ask for guidance.

To avoid such disputes, you could buy an engine protection add-on cover. The add-on will cover all kinds of damages to the engine and is not expensive. However, you cannot purchase it once the insurer issues the policy. You will need to wait until renewal. Do note that if the water enters the cabin and damages parts like speakers, sensors, or electric equipment, the insurer will only pay for factory-fitted parts. Whatever you purchased separately will not be covered unless you have an add-on covering such fittings.

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Electric Car Insurance: Is it cheaper compared to regular car insurance policies? - Financial Express - 16th June 2021

There has been a pick-up in the sales of electric vehicles (EV) in India in the last few years. Even in global markets, EVs have been in range and in the years to come, a large number of people will shift from conventional cars (petrol and diesel) towards EV. Currently, premiums rates for EV are less by 10-15% compared to diesel and petrol, but rates are going to be hardened going forward. Just like any other vehicle, even an EV needs insurance as it offers financial protection against damages to your vehicle caused by accidents. The insurance also covers you against liabilities arising from any property damage, fatality, or injury caused to another person in accidents involving your car.

Currently, a vehicle exceeding 65-kilowatt capacity (KW) costs insurance premiums of around 6,700. While for 30-65 KW it costs Rs 2,700. On other hand, third party premiums come in the range of Rs 3,211 for a 100-1500 cc vehicle. In developed markets, EVs are becoming more attractive to consumers as their

cost declines and new models are released. However, climate change is the biggest single driver behind the push for EV sales going forward.

There are three main types like battery electric vehicles (BEVs), plug-in hybrid electric vehicles (PHEVs), and hybrid electric vehicles (HEVs). BEVs, also known as all-electric vehicles, rely 100% on battery power, while PHEVs and HEVs supplement electric power with conventional combustion engines. In Indian like other vehicle insurance, citizens are legally bound to hold at least a third-party vehicle insurance to be able to drive on public roads. This stipulation is under the Motor Vehicle Act, 1988. Driving without insurance is a violation of the law.

Having a car insurance policy can offer much-needed financial help when a vehicle is met with an accident. The insurance covers you against damages caused by accidents, natural calamities, acts of violence, and more. A comprehensive insurance policy also safeguards you from losses due to theft.

With your electric car insurance policy, just like with all regular car insurance policies, you get third-party insurance, which is mandated by law in India. However, still, EV insurance is on the nascent stage in India. But as the sales improve, the premiums might go up going forward as value and spare parts prices go up. As we have seen certain spare parts of EV are costlier when compared to traditional cars and repair work for electric cars is also costly. Repair work for electric cars can only be done by technical experts.

Even now there are a lack of skilled technicians in India and if an accident happens and the components of your electric car require repair, there is a possibility that policyholders may not get the parts easily or skilled technicians may not be easily available. All these factors can lead to higher premiums for EV going forward. Finally, a car insurance policy is a must, whether one buys petrol, diesel, or electric car. By paying a small premium, a policyholder can buy protection against unforeseen events in the future.

(The writer is Rakesh Goyal.)

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SURVEY & REPORTS

Only 19% elderly have health insurance and can't bear costs: IIT study - WION News - 14th June 2021



A study by the Indian Institute of Technology Madras (IIT-M) has urged greater government investment in public healthcare to mitigate the impact of COVID-19 on the elderly. The study suggests that the elderly are even bound to be adversely affected by COVID-19 norms such as physical distancing and isolation, which can lead to depression and other issues. According to the study, diabetes, blood pressure and cardiovascular diseases are common in the elderly and those in the lower socio-economic strata suffer more. Mobility issues, dependence on younger generation amid lockdown etc. affect their access to routine primary healthcare and essential care for other ailments.

"Only 18.9% of the elderly had health insurance and therefore may not be able to bear large expenditures on health. 27.5% of people aged 80 years or above are immobile and 70% of elders are partially or wholly financially dependent on others," the study revealed, based on the 75th round of the National Sample Survey (NSS) 2017-18.

Undertaken by Prof. V.R. Muraleedharan, Dept of Humanities & Social Sciences, IIT Madras, and Dr Alok Ranjan, Assistant Prof, Dept of Humanities & Social Sciences at IIT Jodhpur, the NSS survey covered

113,823 households and 555,115 individuals. The surveyed were randomly selected from 8077 villages and 6181 urban areas. The results of this study, published in the International journal Globalization and Health, showed that disparities exist in health status as well as healthcare access of elderly people across the country. Factors such place of residence, gender, social group (caste), marital status, living arrangements, surviving children, and economic dependence are said to impact healthcare access among the elderly. Missed treatments and unavailability of drugs also pose a major health challenge.

Dr Alok Ranjan is of the opinion that lessons from the current pandemic are learnt to ensure that future adversities are less detrimental to the physical and mental well-being of the elderly. The researchers want to extend the result of this study to a policy. They plan to carry out detailed surveys among the elderly population particularly in Tamil Nadu, especially to design effective rehabilitative care which is almost absent in India's public healthcare system.

(The writer is Sidharth MP.)

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INSURANCE CASES

National consumer commission orders Tata AIG to pay up life insurance sum plus Rs 1 lakh cost to family of man run over by train - India Legal Live - 12th June 2021



The National Consumer Disputes Redressal Commission has held that in a case of unnatural death, where a DD entry is duly made, an Inquest is duly carried out, a Post Mortem is duly conducted, a private agency providing “medico legal services” does not wholly substitute for and replace investigation by police.

The Court said this while allowing a plea filed challenging the order of State Commission by a widow and a son of the deceased who had died more than a decade ago when he was run over by a train. The State Commission had denied the claim based upon insurance policy while relying on a report of a private agency which had termed

the said incident was suicide and not accidental. Due to an exclusion clause of the policy, that it was not a case of accidental death, the insurance claim over the policy was denied to the family of deceased.

The NCDRC overruled the said order of the State Commission and has noted that as per the facts there were three more policies were taken by the deceased from the same insurance company/Tata AIG Life Insurance Corporation Ltd and the objection was raised by insurance company in respect of the fourth policy only. It was also the claim of the insurance company that the deceased didn't inform the insurance company about his three policies. But the said issue was already settled by the State Commission and the State Commission had said “in the instant case of non-disclosure of the previous policies by the life assured is not fatal to the claim,” which was also endorsed by the NCDRC.

The NCDRC dealt in depth with the findings of the State Commission which had relied on the medico legal opinion dated 19/01/2011 from one Adroit Consultancy Medico Legal Services and had held that death of the deceased was due to suicide and not accidental. NCDRC's Presiding Member Dinesh Singh said, “There is no evidence on record that the life assured was under pecuniary difficulty debts etc., or was having family problems etc., or was having psychological disorders etc.”

He said, “there is no evidence on record that the Insurance Co. made a police complaint or filed a complaint before the competent judicial magistrate that a false case of accidental death has been made out for wrongful gain when the death was by suicide, or that any remedial action in case of the other

three policies settled earlier was subsequently undertaken, or any disciplinary action against its functionaries responsible for settling the earlier three policies was taken.”

“Weighing the evidence in its totality, the eventuality of the death being accidental cannot be ruled out. In the facts of the given case, the benefit of preponderance of probability goes to the Complainants,” it added. Further it stated that the State Commission erred in placing reliance principally on the report of a private agency engaged by the Insurance Co. and ignoring the complete spectrum of evidence in the matter, especially the DD entry, Inquest, Post Mortem Report and Police Inquiry Report.

Furthermore, it held that the Insurance Co. has wrongly withheld the claim in respect of the subject policy. It is also clear that there has been inconsistency and arbitrariness in decision-making by the Insurance Co., in identical facts and same points of law a different decision has been taken in respect of the first three policies and a different decision has been taken in respect of the fourth subject policy.

The NCDRC has directed the Insurance Co. through its chief executive to settle the claim of the subject policy with interest at the rate of 9% per annum from the date of filing of the Complaint before the State Commission till realization within a period of four weeks from today, failing which the State Commission shall undertake execution against the Insurance Co. through its chief executive (by name and by designation) as per the law. The matter was filed and argued by Adv Praveen Kumar Aggarwal.

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PENSION

Now, individuals too can work as distributor of pension products: PFRDA - The Hindu Business Line - 17th June 2021



Pension regulator PFRDA has now enabled even individuals to work as distributor of pension products. Earlier only institutions were given the licences for distribution and the regulator had allowed entities such as banks, NBFCs and certain non-bank entities categorized as points-of-presence (PoP) to work as distributors. “If we are to expand NPS in big way among retail segment then we thought individuals too must be allowed to distribute pension products. The individuals will be recruited as sub-entities. Whether these are insurance agents or mutual fund distributors, we will bring them also as our distributors,” Supratim Bandyopadhyay, Chairman, PFRDA, said. Changes have

been brought to the PoP regulations to enable this, he added. Bandyopadhyay said that PFRDA will not give licences directly to individuals, but ask PoPs to allow them as sub-entities and monitor their functioning and behavioral part. He said that PFRDA will roll out some broad guidelines under which the individuals can be recruited. PoPs will be directly responsible for the actions and inactions of the individuals (basically business correspondent or agents registered with them), he added. Points-of-presence are basically the first points of interaction of the NPS subscriber with the NPS architecture. The authorised branches of a PoP, called Point of Presence Service Providers (PoP-SPS) will act as collection points and extend a number of customer services to NPS subscribers including requests for withdrawal from NPS.

Modifications

Meanwhile, modifications have been made to PoP, Central Record Agency and NPS Trust regulations so as to keep them in alignment with the proposed intent of separating the NPS Trust. “Only those things that NPS Trust is supposed to do, that will find part of their regulations. Other things they are not supposed to do will come back to PFRDA. These changes have been made to bring certain things back to PFRDA. For

instance, in the case of PoPs a lot of things NPS Trust was doing. We found that they are not required. NPS Trust will now only be looking after pension fund managers, Trustee Bank and Custodians. All the PoP related work of NPS Trust will now come to PFRDA supervision department”, he added. It may be recalled that Finance Minister Nirmala Sitharaman had in her 2020-21 Budget speech proposed the separation of the role of PFRDA from that of NPS Trust for government employees and announced that necessary amendment would be carried out in PFRDA Act for this purpose. Indications are that this Bill will be taken up at the upcoming monsoon session of Parliament. PFRDA had also earlier indicated that it would in the coming days look at rationalisation of commission for PoPs on the lines effected for pension fund managers.

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How many times can you extend your PPF after maturity? – Live Mint - 17th June 2021

A Public Provident Fund (PPF) matures in 15 years. But it's not mandatory for the depositor to close the account. You can extend it indefinitely in blocks of five years. One option for the account holder is to withdraw the entire amount, including interest, and close the account on maturity. But if you want to make the best use of the PPF, it's best to extend it until you retire. The longer you stay, the better returns you will get, thanks to compounding.

Here's an example to show how compounding works. Suppose you keep investing ₹1 lakh every year in PPF. The average interest rate is 7.5% for 15 years. You would end up with about ₹31 lakh on maturity. To double this money at the same interest rate, it will take a little less than 10 years. When you opt for an extension, you have the option to either continue with your contribution or without it. For the extension of the PPF account, you will need to inform your bank or post office.

If you don't do it within a year, you cannot make fresh contributions. The balance will continue to earn interest until you withdraw. You can make partial withdrawal once a financial year. If you decide to continue with your contributions, you will need to fill up Form H. Submitting the form is mandatory. Else, your account will be treated as irregular, and no interest will be paid on fresh contributions. You will also not get the tax deduction benefit under Section 80C. In case the account holder decides to continue with fresh contributions, then he can withdraw up to 60% of the account balance at the beginning of each extended period - block of five years.

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NPS subscribers with corpus up to Rs 5 lakh can withdraw entire sum on exit – Financial Express – 16th June 2021



National Pension System (NPS) subscribers with a corpus of up to Rs 5 lakh will now be able to withdraw the entire amount upon superannuation/ exit, instead of investing 40% of the amount in low-yield annuities as for other subscribers, according to a Pension Fund Regulatory and Development Authority (PFRDA) notification. The pension regulator has also enhanced the entry age into NPS from 65 to 70 and exit age from 70 to 75 for all citizen and corporate models. Among other changes, it has permitted individuals to sell NPS products to widen retirement plan coverage.

The full withdrawal facility will benefit a section of government sector and private sector subscribers who have joined NPS late in their lives. Earlier, full withdrawal was allowed if a subscriber's NPS corpus was up to Rs 2 lakh. With returns from annuities around 5-5.5%, if a subscriber invests 40% of his corpus of Rs 2.5 lakh, she will get a paltry `400-450/ month. According to extant norms, at the time of exit from NPS, a subscriber gets 60% lump sum in cash and balance 40% must be used to buy annuities.

Since the defined contributory pension system was rolled out from January 1, 2004, to contain the pension bill, about 21.8 lakh central government employees and 52 lakh state government employees are enrolled in the scheme with 82% share in NPS AUM as on April 30, 2021. About 2.82 crore people are enrolled under the Atal Pension Yojana (APY), a government-backed pension scheme for the masses, as on April 30, 2021. The flow of new entrants from the government sector is slowing down due to saturation, and most new entrants are now from corporate sector and APY. To widen the NPS base, the PFRDA has permitted engagement of individuals who are working as business correspondents or agents within their existing business structure to facilitate the distribution of pension schemes.

“Where the accumulated pension wealth in the Permanent Retirement Account of the subscriber is equal to or less than a sum of five lakh rupees, or a limit as specified by the Authority, the subscriber shall have the option to withdraw the entire accumulated pension wealth without purchasing annuity and upon such exercise of this option, the right of such subscriber to receive any pension or other amount under the National Pension System or from the government or employer, shall extinguish,” the PFRDA notification said.

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Only a portion of employer's contribution goes to EPF – Live Mint – 15th June 2021



Under the Employee Provident Fund (EPF) scheme, employees and employers both contribute equally. However, only a portion of the employers' contribution goes towards the investment fund. According to regulations, employees and employer contribute 12% of the basic monthly salary to the EPF. Women can choose to contribute only 8% of the basic monthly salary for the first three years. For sick companies or establishments with less than 20 employees, the rate can be 10%.

If your basic salary is ₹30,000 a month, you will contribute ₹3,600, and the employer will contribute the same amount. However, the employer's contribution will

not entirely go towards the investment fund. An employer must contribute up to ₹1,250 towards Employee Pension Scheme, depending on the basic pay. The money contributed by an employer goes towards different schemes. Of the basic salary, about 3.67% goes towards EPF or for investments, and 8.33% goes towards Employee Pension Scheme (EPS). The rule applies if the employee is earning up to ₹15,000 basic salary. If your monthly salary is higher, it will be capped at ₹15,000 for calculating EPS contribution.

Let's understand with an example. If your basic salary is ₹30,000, the employer's contribution for EPS will be ₹1,250 a month. The remaining ₹2,350 will go towards EPF. But if your basic salary is, say, ₹14,000, the EPS contribution from the employer will be 8.33%, which is ₹1,166.2.

The calculation of the pension you will receive is tricky. There's a formula – pensionable salary X pensionable service/70. However, there are caps on the pensionable salary and pensionable service in this case. To simplify, under the EPS, the minimum pension amount is ₹1,000 per month, and the maximum amount is ₹7,500 a month. There are some charges as well. You will need to pay 0.5% for Employee's Deposit Link Insurance Scheme (EDLIS), 1.1% for EPF Administration charges and 0.01% administration charges for EDLIS.

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Regulator in talks with government for NPS overhaul – The Times of India – 14th June 2021

The pension regulator is in talks with the government for an overhaul of the National Pension System (NPS) — including changes to the tax regime, allowing insurance agents to hawk the scheme and launching systematic withdrawal plans as well as annuities indexed to inflation to offer higher returns —

PFRDA chairman Supratim Bandyopadhyay said. While implementation of some of the changes has already begun, others such as allowing investors to park their entire corpus into systematic withdrawal



plans (SWPs) will require amendments to the law. Currently, NPS subscribers can withdraw up to 60 percent of the corpus at the time of their retirement and the remaining has to be used to purchase annuities that will fetch them income for the rest of their lives. With annuities offering 5-6 percent return in a falling interest rate regime, many investors do not see it as an attractive proposition, prompting Pension Fund Regulatory & Development Authority (PFRDA) to seek inflation-indexed annuities from the insurance regulator IRDAI. The matter is currently being examined by a committee. In the meanwhile, for those with a corpus of up to Rs 5 lakh, rules will be eased to allow to complete withdrawal

of their money. "The notification will be issued in the next few days. An investment of Rs 2 lakh will not get you much via annuities," Bandyopadhyay said.

Separately, PFRDA has suggested to the government that the annual tax benefit of Rs 50,000 for NPS investment should be doubled. "We are suggesting that the pension coming from annuity should be made tax-free up to a certain level, say, Rs 10 lakh a year. It should be either tax-free or lower tax may be charged... Today, a monthly income of Rs 60,000-70,000 may look decent but 10-15 years down the line, it may not even meet your basic needs. So, indexation and taxation can play a role," he said. The changes come at a time when several individuals are looking to park a part of their provident fund contribution in other long-term saving instruments after the government changed the tax rules to make the interest on employee contribution over Rs 2.5 lakh taxable. While NPS was introduced for the private sector nearly 12 years ago, its assets under management (AUM) are under Rs 1 lakh crore, compared to a Rs 7.5-lakh crore corpus with insurance companies. Bandyopadhyay said PFRDA is also looking to register individuals as points of presence (PoPs) or to be part of the distribution network and is willing to pay a higher commission to expand the base. Currently, banks and institutional entities act as PoPs and are paid Rs 200 to get a new customer and 0.2 percent of the investment as commission. "The effort has been to keep the overall cost structure low. It has helped subscribers, but a time has come to encourage the distribution channel to improve the coverage and expand the corpus. Today, the threat of dying early is slowly going away and it is taken over by the risk of living long... We will try to see what best we can give to our distribution partners but I am not sure if we can manage the kind of returns that the insurance industry gives," the pension regulator said. Already, fund management fees for fund managers have been increased and PFRDA is looking to expand the number from seven to 10 with the process expected to start at the end of the month. Besides, going forward, licences will be available on tap. Bandyopadhyay said the regulator is targeting a million new subscribers from the private sector this year, in addition to nine million under Atal Pension Yojana. "For the first time last year, the number of new customers joining from the non-government sector, which was six lakh, was more than the government sector. This is the trend that we will see in the years to come. Slowly, the non-government sector will not just catch up but the AUM will be higher."

(The writer is Sidhartha.)

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EPFO is planning automatic settlement of non-Covid claims - The Economic Times - 13th June 2021

Retirement fund body the Employees' Provident Fund Organisation (EPFO) is considering automatic settlement of claims to reduce the time taken to process non-Covid claims, currently done manually. Millions of withdrawal claims — both Covid-related and non-Covid — have been pouring in since the

outbreak of the Covid-19 pandemic last year, as EPFO subscribers dug into their retirement savings to meet their financial requirements.

Though the Covid-related claims are largely being settled automatically, the non-Covid claims have to be settled manually. Typically, all Covid-related claims are settled within 72 working hours.



“As an organisation, we have to be prepared for the third wave,” a top EPFO official told ET. The official said several proposals, including automation, are being considered in view of the safety of the workforce.

“One option is to process all claims automatically if the KYCs of the applicant match the EPFO database, as is being done with the Covid claims,” he said, adding that this would hasten the process of settling normal claims, which sometimes take more than a month.

Some 35 million workers in the formal sector, or more than half of the 60 million EPFO subscribers, have dipped into their retirement savings between April 1, 2020 and

May 12 this year to meet their financial needs, causing an outflow of more than ₹1.25 lakh crore.

Of this, nearly 7.2 million subscribers have availed of the non-refundable Covid advance amounting to ₹18,500 crore. Last year, the government had allowed EPFO subscribers to avail 75% of their fund amount, or three months' basic pay, whichever is lower, as a one-time, non-refundable advance to address their financial requirement during the pandemic. Recently, EPFO had notified the benefit of a second withdrawal as well, adding to pressure on its workforce.

(The writer is Yogima Seth Sharma.)

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GLOBAL NEWS

Global: Life insurance sector's outlook revised to stable from negative – Asia Insurance Review

Moody's Investors Service says that it has changed the outlook for the global life insurance sector to stable from negative for 2021.

The change in outlook mirrors a recent shift in outlook to stable from negative for life insurers in the US and Japan, two of the world's largest life insurance markets, says Moody's. It also reflects the sector's improved growth prospects and reduced likelihood of tail events in the near term, as a result of a more

favourable global operating environment, aided by improving individual health as mass vaccinations reduce the virus's spread.



Despite sustained low interest rates, Moody's expects the life insurance sector to remain stable over the next 18 months. Of the remaining countries where we still have a negative outlook, in some, such as the UK, there have been signs of stability, both in the operating environment and at the individual company level, as shown by solid profitability and solvency ratios. In other countries with negative outlooks, such as Germany and the Netherlands, life insurers are faced with structural pressure on profitability and capital adequacy linked to still very low yields.

The following factors underscore the change in outlook to

stable from negative:

1. A rebound in the global economy will support industry growth

Moody's forecasts GDP in G-20 economies to grow by 6.1% in 2021 and by 4.4% in 2022, following a 3.2% contraction last year. A growing economy, supported by the lifting of pandemic restrictions on most economic activity, will boost demand for life insurance products.

2. Solid capital adequacy has helped insurers navigate the pandemic

Globally, insurance companies entered 2020 with strong regulatory capital ratios, which were further bolstered by funds from debt issuances. Solid solvency ratios and strong liquidity helped insurers navigate the pandemic.

3. M&A leads business transformation, prepares insurers for post-COVID

Private capital is playing a key role in this industry transition, particularly in the US, as it seeks to manage a greater share of insurance assets, often through M&A and other partnerships or investments.

4. Pandemic accelerates digitalisation

The pandemic-driven year of contactless, virtual business interaction accelerated the digitalisation of life insurance sales processes that was already underway pre-pandemic. Increased digitalisation will reduce costs for companies as well as policyholders, and in the longer term will make insurance more appealing to new, digitally oriented, younger generations of buyers.

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Indonesia: Life insurance policyholder numbers fall but premiums rise in 1Q - Asia Insurance Review



The COVID-19 pandemic has affected the insurance industry through its economic impact on businesses, with millions of customers redeeming or surrendering their life insurance policies.

The Indonesian Life Insurance Association (AAJI) noted that the number of insured or life insurance customers decreased by 4.7% or around 3.15m people in the first quarter of 2021. This means that the number of life policyholders fell to 63.87m as of end-March 2021 from 67.02m 12 months previously, reported *Kontan*.

The head of AAJI's R&D, Reporting and IT Division, Mr

Edy Tuhirman, explains that the decline in the number of insured occurred in group insurance. In contrast, the number of individual customers increased by 460,000 people. This is in line with the growth in the number of individual policies by 2.7% and the total individual sum insured by 5.2%.

Mr Edy said, "It is possible that many small companies have collapsed in the face of COVID-19."

Higher premium volume

Although the number of customers has decreased, the life insurance industry has managed to pocket a larger volume of premiums. In 1Q2021, life insurance premiums jumped by 28.5% to IDR57.45tn (\$4bn).

"The industry's total premiums have increased because large companies are still able to increase their premiums. They have increased insurance cover for employees despite COVID-19," Mr Edy said.

In detail, premium income from individual customers increased by 31% year-on-year to IDR49.90tn during the first quarter of this year. Group life premiums rose by 13.3% to IDR7.55tn.

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