भारतीय बीमा संस्थान
INSURANCE INSTITUTE OF INDIA

INSUNEWS

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QUOTE OF THE WEEK

"The only way to discover the limits of the possible is to go beyond them into the impossible."

- Arthur C. Clarke

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

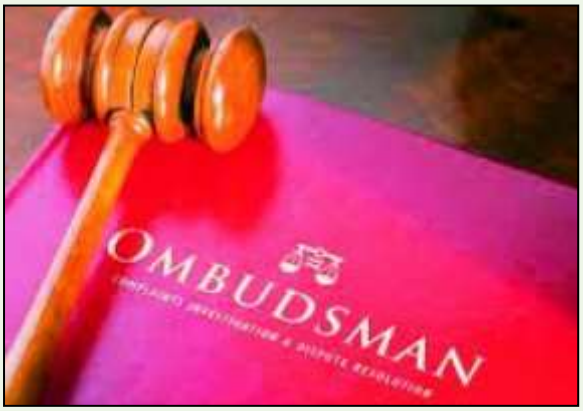
Deductible

A deductible is that portion of any claim which is not covered by the insurance company. It has to be paid by the policyholder from his pocket. In a car insurance policy, there are two types of deductibles — compulsory and voluntary. The compulsory deductible amount is fixed by the insurer and has to be paid necessarily by the policyholder, whenever any claim arises. In a voluntary deductible, the limit is chosen by the policyholder.

Source

INSURANCE INDUSTRY

Now insurers can't ignore insurance ombudsman decision on your policy grievance; Regulator pulls up companies – Financial Express – 6th March 2019



As an insurance policyholder, one is supposed to take up any grievance initially with the company concerned and then subsequently raise the concern with the Insurance Ombudsman. The cases are heard between the insured and the insurer and then either the case is settled in favour of the insurer or the Insurance Ombudsman passes an award against the insurer.

As per the mandate, the insurer is supposed to comply with the awards passed against them by Insurance Ombudsman in an agreed time-frame.

In reality, however, the picture seems to be different.

Insurance regulator IRDAI has pulled up some of the CEOs and MDs of insurance companies for not complying with the directives issued to them in 2016, related to submission of data pertaining to compliance of awards passed against them by the Insurance Ombudsman.

Non-compliance by insurer

On studying the data from all Insurers for the period April, 2018 to December, 2018, IRDAI observed the following:

1. While Insurance Ombudsman Rules, 2017 mandate insurers to comply with the awards passed by Insurance Ombudsman within a period of 30 days of receipt of award, many Insurers are neither complying with the awards nor filing appeals within 60 days of receipt of awards.

2. While submitting the statement, reasons for pendency for each award have to be mentioned separately. However, many Insurers are not mentioning the same.

3. Few Insurers are not even submitting prescribed statements to designated person.

Insurer's response

Upon calling for reasons for non-compliance from the insurers, few insurers are submitting that they have complied with the award post timelines stipulated under the rules.

Back in 2016, the IRDAI had reiterated that their earlier guidelines of 2010 and also of 2015 need to be followed and subsequently stipulated submission of monthly statement by Insurance Companies on the status of Ombudsman cases and compliance of its awards and also the status of court cases by 10th of the

subsequent month. The Insurance Ombudsman scheme was created by the Government of India for individual policyholders to have their complaints settled out of the courts system in a cost-effective, efficient and impartial way.

There are at present 17 Insurance Ombudsman in different locations and any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

IRDAI take

IRDAI strongly feels that non-compliance of these awards within the timelines prescribed would severely undermine the grievance redressal framework laid down and cause undue hardships to the policyholder.

The insurance companies need to pull up their socks and do not leave any stone unturned in bringing back the lost trust of the industry. Incidents such as these where the regulations are not adhered to, will dent the image of the industry in the long run.

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Source

Tax saving: Does GST on insurance premium qualify for tax benefit u/s 80C, 80D? – Financial Express – 5th March 2019

The tax saving season has entered its last month for the financial year 2018-19. Many of you would have submitted the original investment proofs to your employer to avoid deduction of higher taxes from the last month's salary.

Amongst the investment proofs are the insurance premium receipts collected from either life or health insurance companies. The insurance premium paid also includes the GST amount and at times some employers do not accept the full amount and provide tax benefit only for the premium amount excluding the taxes.

GST on insurance premium

In case of life insurance GST rate, for all life insurance policies excluding single premium and term insurance policies, 25 per cent of the premium of the first year and 12.5 per cent of the premium in subsequent years is considered for tax calculation. So, if the premium of an endowment plan is Rs 10000, the GST rate on insurance premium of 18 per cent will be applicable on the 25 per cent of the premium i.e. on Rs 2500, so, Rs 450 will be the GST amount.

However, if the entire premium paid by the policyholder is towards the risk cover in life insurance such as in term insurance plans, the GST of 18 per cent will be calculated on the entire premium. Similarly, in the case of health insurance policy, the calculation of GST is on the entire premium amount.

Will GST be allowed for tax benefit

The concern that most taxpayers have is whether the total amount paid towards insurance (health or life insurance) including the GST, qualifies for tax benefit under section 80C and 80D respectively. "Yes, the total amount paid towards health and life insurance (including the GST paid on such insurance premium) qualifies for deduction under Section 80D and Section 80C respectively. This is due to the fact the income tax legislation mentions that 'any amount paid' for the insurance premium for life as well as medical are eligible for deduction under the respective section," informs Taranpreet Singh, TASS Advisors Partner.

What if employer disallows

Sometimes, the premium receipt does not show the GST amount separately. "In such cases, the employee can obtain an annual statement of policy premium from the insurance company and can provide it to the employer," says Dr Suresh Surana, Founder of RSM Astute.

Also, if the employer disallows the GST amount for the tax benefit, even then, the taxpayer can take benefit for it. "In case an employer disallows the GST amount paid on insurance premium if the same is not reflecting the receipts, the employee may claim the deduction of the same GST amount while filing the Income Tax Return," says Singh.

TOP

Source

Insurers want new capital framework to be pushed to April 2022 – Money control – 4th March 2019

Insurance companies will seek another extension of the risk-based capital (RBC) framework from the regulator. Sources told Money control, insurers will seek an additional 12 months for implementing RBC. The present deadline for the new regime to kick off is April 1, 2021.

"While we have been given time till FY21, it may not be adequate. Hence, we will request the Insurance Regulatory and Development Authority of India (IRDAI) for time till April 2022 to enable the systems to be put into place," said a senior insurance executive.

Under the RBC framework, insurers will not only be required to set aside more funds for their business but also have to re-price their insurance products. For those writing riskier businesses with high claims, the product premium will be increased. Currently, insurers' assets are required to be 1.5X or 150 percent of their liabilities. Once risk-based capital (RBC) framework comes into place, insurance companies will have to hold capital in the proportion of the business they write. Riskier the business, higher is the capital requirement.

This is to ensure that the companies have adequate reserves in case there is a large claim on the books. Further, companies not wanting to maintain large cash reserves will have to rejig their portfolio towards less risky business.

Insurers have asked for an extension since migration to the RBC will involve setting up a separate accounting system for each product category, moving existing products to that segment and product-wise re-pricing based on how risky the business is. In between this migration, a new product regime is also expected to be introduced by IRDAI and insurers are likely to be involved in product refiling to meet those requirements in 2020.

Multiple deadlines

Initially, RBC was to be implemented from April 1, 2019. However, considering the industry did not have the systems in place to implement it, it was pushed to April 2021.

IRDAI has said the RBC will first be introduced for the insurance sector, followed by intermediaries. Once it is introduced, IRDAI will assess each insurer based on its 'risk profile' and focus on entities that have a higher risk compared to others. In the financial sector assessment programme of 2017, IMF and World Bank recommended that IRDAI moved towards an RBC supervisory regime. In Europe, several insurers and reinsurers have adopted the Solvency II regime where the solvency capital is directly proportional to the risks written by them in their books.

India currently follows Solvency I or a factor-based solvency capital model. This means a set factor (3 or 4 percent) is multiplied with the mathematical reserves to arrive at the minimum capital that is to be held by insurance companies.

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Source

Role of artificial intelligence and machine learning in Insurtech startups in India - Deccan Chronicle – 4th March 2019

The world is changing and insurance is changing with it. This change is being driven by customer expectation and technological advancement. To be competitive, insurance companies need more customer insights and ability to turn these insights into actions, which need focused effort and expertise.

Most of the insurance companies struggle in this area which is why Insurtech start-ups play a key role. They are able to move faster and identify these gaps and provide solutions.

The bulk of these solutions are fuelled by use of Artificial Intelligence (AI). In fact it's not wrong to say that AI is playing a key role in enabling Insurtech start-ups to bring "smartness" in insurance.

In order to understand the role of AI, we need to understand what AI is and what it is not. Contrary to general perception, all AI techniques don't automatically learn from the data. AI can be divided into two high level categories:

Machine Learning (ML): Techniques that automatically learn from the data. All predictive models fall in this category. Generally, this is what business users understand when they hear "AI". ML based solutions can add value to insurers - irrespective of the mode of delivery – delivered as a standalone model (standalone AI), or delivered as a part of a process/service/product (embedded AI).

Symbolic AI (SAI): Techniques that don't automatically learn from the data. Human experts are needed to create the business rules. Underwriting or claim rules coded in IT systems are examples of this category. Insurers already have in-house capabilities of creating and implementing complex business rules. Hence, SAI packaged as ML and delivered in standalone AI mode is highly unlikely to survive through the later stages of AI hype cycle. Real value can only be added through embedded AI mode.

So let's categorise the gaps in four high level categories and see how AI is enabling start-ups to address these gaps:
1. Data Gaps: A data gap is created when some data fields are needed for data/analytics based decisions but the insurer is not able to capture them.

Players are attempting to provide external data about the customers. They are leveraging ML based de duplication and linking technologies to identify a unique customer and then provide additional data about him/her from external data sources.

Some players are helping insurers digitise their internal data by improving data capture at each stage of insurance operations. For example, Optical Character Recognition (OCR) and then Natural Language Processing (NLP) are used to capture and logically store data from physical documents.

2. Process Gaps: A process gap is created when new technologies having the potential to transform one/more steps in insurance value chain become available, but the insurer is not able to adopt it.

Building standalone ML based predictive models for different stages of the insurance value chain to predict propensities related to fraud, cross-sell/up-sell, retention, claims, etc. is one of the quickest ways to enter Insurtech space and hence is one of the most crowded areas.

In the last couple of years, embedding AI in processes/services/products to deliver an "intelligent" package has become an area which is attracting a lot of attention and it's expected to continue in 2019 as well.

Robotic Process Automation (RPA) players are using SAI to create a large set of complex rules to improve degree of automation in insurance processes.

Block chain players are primarily relying on a different IT technology (distributed ledger) and aspects related to smart contracts (in reality they are simplified contracts) which are handled through SAI.

There is a growing appetite among insurers to accept automated analytics on claims images/videos, customer voice, claims summary reports, etc. Cloud based predictive services leverage deep learning to train ML models on unstructured data sources like images, texts, videos, and voice. These pre-trained models are then offered to insurers in an off the shelf package.

3. Product Gaps: A product gap is created when new technologies, changing lifestyles and changing business models create new risks or new ways of addressing old risks.

Internet of Things (IoT) start-ups offering usage based insurance (UBI) solutions such as telematics for motor and health insurance leverage a wide range of ML algorithms to normalise and analyse the big data which is generated every second.

Start-ups supporting agricultural insurance operations use weather and crop data collected through satellites, drones and weather monitoring stations. ML algorithms are used to normalise and analyse this data.

4. Customer Interaction Gaps: Emerging technologies have changed customer behaviors and expectations. This creates a gap in customer facing insurance operations such as distribution, policy servicing, and claim settlement.

NLP based ML techniques are enabling chat bots to understand customers' queries. Then, SAI based rules are employed to find appropriate answers to their queries.

SAI is enabling online/app based distribution platforms to recommend the most suitable insurance products quickly by asking an intelligently ordered minimum set of questions. ML based algorithms then predicts the purchase preferences of the given customer and appropriately customizes the insurance offering.

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Source

Poverty to vulnerability: Rethinking social protection – The Indian Express – 4th March 2019

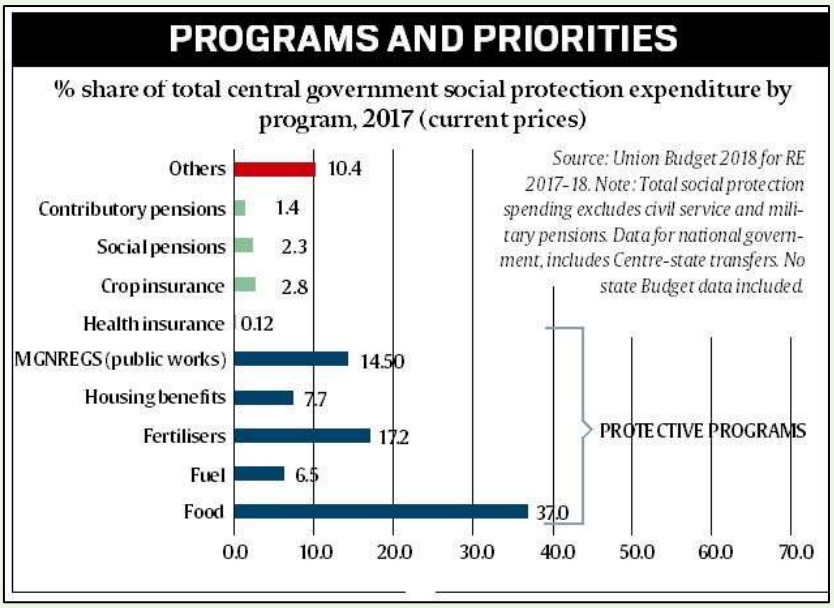
A steady, safe, well-paid job is the best protection against economic hardship. But when this ideal situation is not possible, social protection programs help people become more resilient to risks. Typically, a comprehensive social protection system requires three types of instruments to work together.

* First, promotional instruments invest in the ability of families to survive shocks on their own — by enhancing productivity, access to job opportunities and incomes through human capital infrastructure, wage legislation, labour policies, skills training and livelihood interventions.

* Second, preventive instruments aim to reduce the impacts of shocks before they occur by enabling households to use their savings from good times to tackle losses in tough times. This is mainly done through social insurance programs.

* Third, protective instruments mitigate the impacts of shocks after they have occurred through tax-financed redistribution from the non-poor to the poor. These programs would classically be called anti-poverty measures as they target social assistance or safety net programs to the poor or destitute, whether in kind or cash.

When social protection schemes were created in India after Independence, most of the country was reeling from famine, de-industrialisation and multiple deprivations. Half the population was chronically poor, the country had an aggregate food deficit, financial and banking networks were underdeveloped, growth rates were weak, and technology available for program administration was rudimentary. Therefore, India's policymakers focussed almost exclusively on anti-poverty, protective instruments.



But that India no longer exists, and the country's social protection system needs to evolve and catch up with the needs of its new demography and risk profile. Analysis of the latest available data from 2012 highlight three stylised facts that is important to guide this evolution.

* First, despite the dramatic fall in households below the poverty line to 22%, the challenge of chronic poverty remains. Despite a decline in poverty levels, India shelters pockets of deep poverty and these households are geographically clustered. A significant 15% of households that were poor in 2005 remained poor in 2012. That's 37 million households — the population of Germany.

* Second, inequality across locations and demographic groups has increased. The poverty rate of six of the poorest states in the country is twice that of other states. Seven low-income states — Chhattisgarh, MP, UP, Odisha, Jharkhand, Rajasthan, and Bihar account for 45% of India's population but nearly 62% of its poor — continue to need strong safety nets programs. Within states, poverty and vulnerability remain highest amongst Adivasis. Women are largely missing from the workforce, and face serious risks to their mobility and well-being.

* Third, the majority of India is no longer poor. Instead, half of India is vulnerable. These are households that have recently escaped poverty with consumption levels that are precariously close to the poverty line, and remain vulnerable to slipping back. Programs must ensure that those who've escaped poverty are able to sustain improvements.

As families move out of poverty and the middle class grows, social protection programs can no longer be singularly focused on chronically poor households. In 2016, while traditional safety nets such as the Public Distribution System (PDS) expended $16 billion, the life and accident insurance programs spent less than $16 million together. Programs such as PDS and MGNREGS still constitute half of social protection spending in the country.

It's critical that programs help those vulnerable to poverty to anticipate and manage risks and shocks better, not only attempt to provide aid to relieve deprivations experienced by the poor. Three types of portable tools are needed to prevent the new vulnerable class from falling back into poverty and debt traps — health insurance, social insurance (in case of death, accident and other calamities) and pensions. Portability is key to ensure migrants receive support while they try to build new lives in new places, as state governments often use residency criteria to target benefits.

At present, only 4% of households in India use government social insurance programs. Use of private sources of insurance is higher, particularly for wealthy households. IHDS 2012 data show that 27% households report members using/benefitting from private insurance. Unsurprisingly, the bottom 20% report very low uptake of private options for market-based insurance. Most Indian households — poor

and non-poor — rely on personal savings to deal with health, accidents, or climate shocks. Micro surveys and administrative data also highlight major gaps in pension and health insurance coverage.

Recent policies have taken steps in the right direction. The boost in crop insurance, new pension plans for the elderly, the rise in contributory pensions for those who have the wherewithal to save, and larger coverage of health insurance programs will help India re-balance its social protection architecture to match the needs of the rising numbers of its vulnerable people.

However, the need to re-balance the mix of programs between protection and prevention may not require a dramatic change in the current umbrella social protection budget. Given the huge diversity in the economic profile of India's states, a variety of approaches will be called for.

For instance, the needs of the rising middle class with access to private insurance markets in Delhi and Maharashtra will differ markedly from the needs of poorer states such as UP and Bihar. Delhi should be enabled to spend its centrally allocated social protection resources differently from UP. In states where many poor and vulnerable households are still not able to save enough to insure themselves against crises or times of high prices, social assistance will remain a core intervention. In low income states, anti-poverty programs such as PDS or MGNREGS, if implemented well, can serve twin goals of protection and prevention by ensuring India's vulnerable don't become poor, and that the poor live with dignity during times of drought or food price inflation.

Effective safety nets can dramatically reduce the number of poor and the likelihood that poverty will be transmitted from one generation to the next. Strengthening their delivery systems is key, while allowing state governments to choose the optimal mix of preventive and protective programs to suit their state's needs within an umbrella social protection budget.

If insurance coverage is adequate and expands, many families would not need to rely on safety net transfers in the face of old age or health crises which would otherwise push households into long-term poverty and debt traps. Thus, an increased emphasis on interventions that help anticipate risks should be expected, particularly in medium- and high-growth states.

India is no longer a largely chronically poor country but a more unequal and vulnerable country with pockets of deep poverty. India's future shared prosperity will depend to a large extent on how its social protection system evolves and catches up with its diversity and demography.

TOP

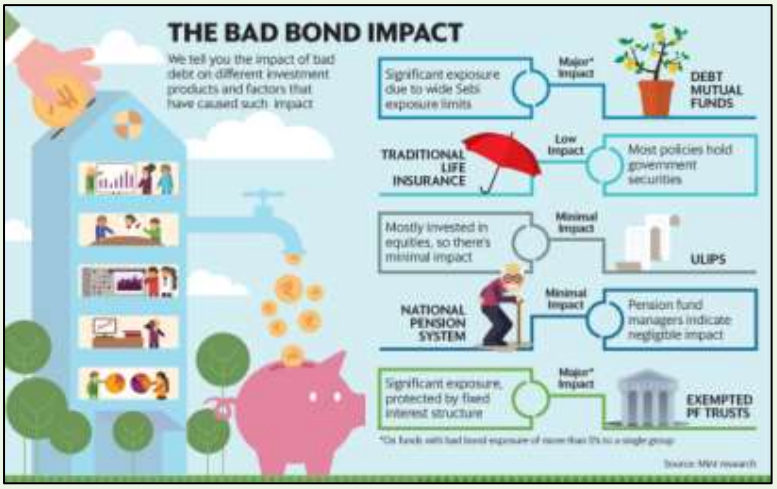
Source

How much of your money is at risk in bad bonds? – Mint – 4th March 2019

orporate India has been hit by a fresh wave of debt defaults and this time the pain has moved beyond bank NPAs (non-performing assets). Your money in mutual funds, insurance policies and pension funds may have been hit by these defaults and you may not even know it.

The latest wave of trouble began with defaults in IL&FS group. IL&FS is an infrastructure builder and financier with Rs 91,000 crore debts on its books. It initially defaulted in September 2018 on some inter-corporate deposits owed to Small Industries Development Bank of India (SIDBI). The series of defaults grew and the IL&FS board was sacked in October 2018. An independent board headed by Uday Kotak was brought in to handle the situation. The bad bond problem spread to Dewan Housing and Finance Ltd. (DHFL) next and then to Essel Group (Zee group of companies), when the promoters announced plans to sell 50% of their stake in Zee Entertainment Enterprises Ltd to reduce their debt. Apollo Hospitals and Emami Ltd

also faced pressure on stock prices, prompting concerns about debt funds that may have lent money to them with equities as collateral.



Contrary to popular belief, the problem of bad bonds may not be just in mutual fund portfolios. It's just that mutual fund losses have been the most widely publicised among affected financial products.

Impact on mutual funds

Debt funds that have invested in companies with equity as collateral have particularly been hit. A drop in stock prices forces the fund to demand more collateral or reduce exposure, precipitating further falls in the borrower's stock prices.

Some fund managers Mint spoke to said, on the condition of anonymity, that three things seem to have gone wrong in the investment approach of AMCs, especially when lending against shares. First, sufficient "margin of safety" was not taken. Margin of safety is the value of the collateral in relation to the sum borrowed. Second, large exposures were taken to single issuers and single groups albeit within regulatory limits. Capital markets regulator Securities and Exchange Board of India (Sebi) restricts exposure to a single issuer at 10% of fund assets (12% with the approval of board of trustees and the AMC board) and exposure to a single group of companies at 20% of fund assets (25% with the approval of the board of trustees). Third, excessive reliance was placed on the ratings issued by credit ratings agencies instead of doing sufficient internal research and analysis.

The problems are worse in case of fixed maturity plans (FMPs) that have taken large concentrated exposures to some of the groups in financial trouble. "FMPs are particularly prone to credit risks due to the limited windows they are given to accumulate papers that matches their tenure. This is why we have been relatively cautious while launching these products." said R. Sivakumar, head, fixed income, at Axis Mutual Fund. Also, FMPs tend to have small sizes in terms of AUM that hampers their ability to diversify because the minimum ticket size of debt papers is large.

In fact, some AMCs have ended up with highly concentrated exposures to their sponsor groups. In case of DHFL Pramerica Mutual Fund, the exposure to the sponsor DHFL group was a huge 34.73% in DHFL Ultra Short Term Bond fund, 20.19% in DHFL Pramerica Medium Term Fund and 17.96%% in DHFL Pramerica Floating Rate Fund in February 2018. Sebi's limit for exposure to sponsor groups is 25% of net assets. A spokesperson for the fund house said in an email comment, "We witnessed some pullback and AUM (assets under management) withdrawal by investors, which led to some of the funds shrinking in size. The increase in issuer concentration in the highlighted schemes is purely the result of AUM declining in these funds and not from an active breach of investment limits in these funds." Reports have emerged that DHFL is in the process of exiting the DHFL Pramerica AMC by selling its stake to its joint venture partner Pramerica.

The total exposure in mutual funds to IL&FS group debt as of 21 January 2019 was Rs 2,042 crore, according to Kotak Wealth Management, just about 0.16% of the approximately Rs 13 trillion managed by debt funds. However, what does not matter at the industry level begins to really matter at an individual scheme level when investors see their returns or capital fall.

Impact on insurance

But the risk goes beyond mutual funds. Your insurance policies that bundle investment with a risk cover too have some of these bad bonds in their portfolios. However, an investment manager with an insurance company, who did not want to be named, said in the case of unit-linked insurance plans or Ulips,

investors largely prefer equity funds, whereas in the case of traditional plans, insurers generally take on long dated papers to match liabilities. This has prevented large exposure to the troubled debt in question (which was of short to medium term duration).

"Customers primarily invest in equity funds of Ulips. Talking about traditional plans, insurers have to invest at least 50% in government securities and insurers typically have a higher exposure than that. Even in traditional plans in the private sector, insurers are unlikely to invest in corporate bonds in a big way so recent credit events have no or minimal impact for the life insurance industry," said A.K. Sridhar, director and chief investment officer, India first Life Insurance Co. Ltd.

Impact on pension products

These bonds have showed up in portfolios of PF trusts making subscribers nervous about their retirement money. A January report in *The Economic Times* said PF trusts had Rs 15,000-20,000 crore invested into IL&FS group debt papers. However, PF trust subscribers are typically assured an interest rate declared by the EPFO for all subscribers every year.

"Big corporate trusts definitely have exposure to IL&FS and are worried. But for the employees there is nothing to worry as even exempted trusts have to match the same interest rate that the EPFO declares and if the trusts can't make this return from their investments, the employer has to make good. Although we haven't come across any trust looking at a dire situation, there are queries on how trusts can be part of the recovery process," said Madhu Damodaran, head-legal operations, Simpliance.com, a labour law compliance firm.

The National Pension System (NPS) has a tiny exposure to these bonds. Kumar Shardindu, CEO, SBI Pension Funds Pvt. Ltd, said, "Given the AUM size, I don't think any pension fund manager would get impacted by more than 1% of their AUM in case IL&FS investment turns non-performing. So the hit in NAV will be marginal compared to debt mutual funds. Also, NPS is a long-term product, as more corpus comes in, even the marginal impact will diminish over time. So pension fund subscribers don't have much to worry about."

Another pension fund manager, who did not want to be named, said the industry exposure is just Rs 500 crore, or just 0.001% of the total industry AUM, in bad bonds that are currently identified.

So yes, there is risk at the moment, but not that much. It is true that the ongoing credit problems in corporate India affect your money in multiple ways. But as of now the problem is not going to dent your money or pension kitty. It will take a much larger spread of the problem before it begins to bite. The uproar over IL&FS is actually good because it is forcing regulators, fund managers and investment professionals to wake up to the problem and strengthening internal processes.

TOP

Source

IRDAI REGULATION

Working group submits new norms for insurance surveyors to IRDAI – The Times of India – 8th March 2019

Around six months after insurance regulator, the Insurance Regulatory and Development Authority of India (IRDAI), constituted a working group (WG) to update the norms for insurance surveyors, the WG has submitted its report that has suggested doing away with training and has instead one of its main recommendations include doing away with training for surveyors and instead has proposed a two-level examination system.

The WG members were also of the opinion that as there are not many takers for the profession of survey and loss assessment, final year students of recognized qualifications should be allowed to take the

Surveyor and Loss Assessor exams and such individuals would fall under the classification of 'Students'.

The working group has stated that under the new regulations, surveyors will not be categorised as licentiate, associate or fellow but as individual surveyors, corporate surveyors, employee surveyors and students. As far as individual surveyors and corporate surveyors are concerned, there is already a definition provided for in the current framework but an employee surveyor may be defined as an individual, who is an employee of an insurance company and holds a valid licence to act as surveyor.

In terms of qualification, the WG recommended that in respect of crop insurance, the recognized qualifications may be expanded to include graduation with at least one subject being agricultural science from a recognized university. "However, government schemes may be exempted from this and they shall follow the provisions as notified by the government," it added. It has also recommended specific qualifications for dealing with aviation sector as well as cyber risk cases.

The report added that the licensing system may be replaced by registration with a provision of payment of annual fee. "Registration does not involve 'renewal' and therefore issuance of fresh certificates does not arise," it added.

TOP

Source

IRDAI Complaint Website: How to register, download format, check status and file insurance grievance – Financial Express – 7th March 2019

As a policyholder, if you have a problem with your insurance company or feel that there was negligence on the part of the insurer either in servicing a policy, processing a proposal, or processing claims, you can register a complaint with the Insurance Regulatory and Development Authority (IRDAI) Grievance cell. You can register a complaint through the online service for registering customer complaints launched by IRDAI. You can also follow up on the same through there. Thus, now you don't have to worry about whom to approach with your grievance if you have a complaint against an insurance company. A complaint can be raised against both life and non-life insurance.

Policyholders first need to raise a complaint with their insurance companies. The cell also provides mail IDs of the Grievance Redressal Officers of the insurers. If you are having a problem with your insurance company, you can raise a complaint with them first. If policyholders do not receive a response from the insurer within the allotted days, one can approach the Grievance Redressal Cell in the Consumer Affairs Department of the IRDAI. Also, if you are unsatisfied with the responses from the insurance company, even then you can register a complaint against them to the Grievance cell of IRDAI. The Grievance cell is open to both the insured and the claimants for sharing their complaints.

The Grievance Redressal Cell in the Consumer Affairs Department of the Insurance Regulatory and Development Authority of India looks into complaints/grievances from policyholders. This Cell takes up the grievances with the respective insurers for redressal. Complaints from the insured or the

policyholder are considered by the Redressal Cell. They do not entertain complaints written by advocates or agents or by any third party on behalf of policyholders.

Find out how to file a complaint;

- To register a complaint with the IRDAI, as a policyholder you can use of the Integrated Grievance Management System (IGMS), IRDAI portal (https://igms.irda.gov.in/) for registering a complaint and monitoring the status of the complaint themselves.
- You can also send the complaint through e-mail at complaints@irda.gov.in. or call their toll free number 1800 4254 732.
- You can visit this link to download the Complaint Registration Form. (https://www.policyholder.gov.in/Report.aspx#)
- Your complaint should also be submitted with complete details of the complaint as required in the complaint registration form.
- Without the required information needed in the registration Form, IRDAI will not register your complaint.
- You then need to fill and send the Complaint Registration Form along with any letter or enclosures, by post or courier to the below address;

Address:
General Manager, Consumer Affairs Department- Grievance Redressal Cell,
Insurance Regulatory and Development Authority of India(IRDAI),
Sy.No.115/1,Financial District, Nanakramguda,
Gachibowli, Hyderabad-500032

TOP

Source

Do not depend only on ratings; use your own judgment too: Irdai to insurers - Business Standard – 6th March 2019

The insurance companies have to use their own judgment and cannot simply rely on the credit rating assigned to their investment by the rating agencies, the insurance regulator said in an advisory to the insurance companies.

"Our requirements are that investment should be in highly rated instruments. In case there is a change in the ratings, they will have to take appropriate action", Irdai chairman Shubash Chandra Khuntia said.

"We have told insurance companies besides rating they should also apply their own judgment. We are making them aware that they will have to be proactive so that policyholders' interest is protected", he further added.

Many insurance companies have exposures to the beleaguered IL&FS group as part of their investment portfolio. Now, the regulator has made it clear that these companies have to make provisions for their exposures as write-off is not an option for them. IL&FS was rated very highly by the credit rating agencies but it defaulted on its debt obligations that resulted in a liquidity crunch situation in the entire financial sector.

"We have not asked insurance companies to pull out of any investment because of change in ratings as that may damage it further so they have to time their judgment appropriately. There cannot be a cut and paste solution", Khuntia said.

On the issue of insurance companies not disclosing the embedded value of their company, the chairman said," During listing the companies have to declare. We are encouraging the companies to go for listing. We have not made it compulsory because the industry has to develop more. We have many new companies but we will encourage them to disclose their embedded value".

On private equity firms buying stakes in insurance companies, Khuntia said," They are permitted to buy but we apply a lock-in period so that there are no frequent changes. So, the first five years there will be stability and after that they are free to either remain or sell it to someone else".

The regulator also made it clear that state owned life insurance behemoth, LIC, has to bring down its stake in IDBI to 15 per cent which is the norm. Although the Irdai has not communicated a timeline to LIC to bring down their stake in the bank but the regulator said that LIC is preparing a road-map in that direction and as soon as it is ready, they will communicate it to the regulator and the regulator will then fix a timeline, accordingly.

LIC has acquired 51 per cent stake in IDBI Bank after it infused Rs 21, 624 crore in the bank. Also, as IDBI Bank is the majority shareholder in IDBI Federal Life Insurance, and now that LIC owns 51 per cent stake in IDBI Bank, that makes LIC the indirect owner of IDBI Federal Life Insurance.

Moreover, on the conflict of interest situation of LIC in IDBI Federal Life Insurance, Irdai chairman said, "There are various method to sort it out. Suppose they sell it then there will be no conflict of interest. It will take some time to resolve it. But it needs to be sorted out. There should be any conflict of interest".

TOP

Source

India: Regulator calls for more homegrown actuaries – Asia Insurance Review

The Indian insurance regulator, the IRDAI, has called for a collective effort by various stakeholders in India to increase the number of homegrown actuaries from the present 60 to a minimum of 1,000 per annum.

India is seeing high economic growth that is also benefitting the financial services sector and there is increasing demand for actuaries in the country.

"We need to produce many more actuaries every year and for this there needs to be tie-ups with universities and colleges around the country to attract young people to this profession," said Dr Subhash Khuntia, IRDAI chairman.

Speaking at the 20th Global Conference of Actuaries in Mumbai yesterday, he asked the industry to start a campaign to popularise the actuarial profession among young people with a mathematical bent of mind. "Actuaries play a critical role in the investment, pension fund and insurance segment, and with the advent of digital tech, the role of actuaries will continue to grow," said Dr Khuntia.

Speaking of the role of appointed actuaries in insurance companies, he mentioned that they have a responsibility to be professionally and technically correct, which was an important aspect of the profession. "Actuaries need to maintain a fine balance between policyholders' funds and the company's interests, so that the insurance industry remains sustainable" he said.

India emerging as a global hub for actuarial services

In an earlier address to conference delegates, Mr. Sunil Sharma, president of the Institute of Actuaries of India (IAI) spoke of how the actuarial profession in India is undergoing a sea change through improved member services and implementation of professional standards. "India is emerging as a global hub for actuarial services and over 1,000 actuarial professionals provide support across the globe," he said.

Actuaries are today contributing in various fields including data science and analytics. The IAI currently has a mutual recognition agreement with the Institute and Faculty of Actuaries (IfoA) of the UK and most of the existing systems in India are adopted from the UK.

The two-day event, with the theme, "Expanding the horizon, strengthening the core" is being attended by 750 delegates from 15 countries and will conclude today.

TOP

Source

LIFE INSURANCE

Life insurance companies to seek nod for health indemnity – The Times of India – 6th March 2019

Life Insurance Council, the representative body of life insurance companies, will request the Insurance Regulatory and Development Authority of India (IRDAI) to allow them to offer indemnity health cover again. The regulator had barred life insurance companies from offering indemnity health products from July 2016. Currently, life insurers can only offer fixed-benefit health products.

HDFC Life MD & CEO Vibha Padalkar pointed out that the council has formed a committee headed by her to deal with the issue. "In two-three weeks, we shall submit a proposal to IRDAI for resuming health indemnity cover for life companies." According to her, insurance remains a logical growth path for a life insurance company as the underlying risk remains the same.

Being risk managers for a longer term, life insurers are at a natural vantage position to offer better value proposition to meet the healthcare needs of their customers.

TOP

Source

Check your health status before buying insurance – DNA – 5th March 2019

Most insurance buyers are reluctant to undergo a medical test before buying an insurance policy. It may be the fear that the premium will increase after the test. But it is in the customer's interests to undergo a medical test, say experts. It can ensure better premiums and ensure hassle-free claim payout, since you have disclosed all details at the time of buying the policy. Let us understand how exactly a medical check-up will help.

When do insurers ask for medical test?

For insurance companies, a medical test is a risk assessment of the customer's profile. If the test is done and the customer's health is fine, then the price that is offered is one of the best offered in that pool, says Vineet Arora, MD and CEO, Aegon Life Insurance.

"From a customer's angle, it makes sense to go in for a medical test and prove he is healthy, and hence, he should be given the price as per medical underwriting. It proves that the customer has been transparent while entering into the policy contract based on the medical test results and declarations in the application form,'' he explains.

In case of a life insurance policy, the insurer is trying to assess the current health of the consumer who may be buying a policy for, say 50 years. The pricing is based on the buyer's current health. "If someone is applying for a Rs 1 crore cover and paying a premium of Rs 10,000, the medical test will asses if the health is good enough to last out the policy term or if the customer will make a claim in the next five to six years. If the medical shows some anomaly, pre-existing disease or some disease that could become terminal, the insurer may either reject the policy altogether or charge a higher premium,'' says Tarun Mathur, chief business officer-general insurance, Policybazaar.com.

Medical tests may or may not be mandatory while purchasing a health insurance policy. "It depends on multiple factors like the customer's age, health declaration, including pre-existing medical condition and sum insured amount. Based on these conditions, the company may or may not choose to carry out the medical test,'' says Mayank Bathwal, CEO, Aditya Birla Health Insurance. The sum assured is one parameter which determines if medical test is required. The higher the sum assured, higher are the chances of a medical test; lower the sum assured, lesser are the chances for a test.

It also depends on the physical condition disclosed to the company while buying the policy. In case the physical conditions are clearly mentioned in the proposal form and if the applicant falls under the age group of 45 or 50 years (this could vary from company to company), then the policy is processed (first level of underwriting). If not, the applicant has to go to either of the medical process, says Rakesh Goyal, Director, Probus Insurance.

"The first medical process includes the telemedical process which is a preset format that undergoes wherein questions are asked related to you and your family. After that, if the insurance company still has any concerns, it would ask the applicant to go for the proper physical test,'' he adds.

Who pays for the medical test?

In order to provide a smooth application and buying process, insurance companies have started conducting medical tests at the applicant's home, at a time of his convenience. In case it is not possible, the applicant is required to visit the network hospital of the insurer near his residence. Whether the policy is purchased online or through an intermediary or broker, the criteria for medical test still apply.

In the case of life insurance plans, the cost of medical tests is borne by the insurance company. Under a health insurance plan, the cost is shared by the applicant and insurance company equally. However, there are some insurance companies that bear the entire cost of medical tests, hence check the same before applying for a plan.

Benefits of a medical test

The benefit of undergoing a medical test is that it establishes transparency from the customer. "This means that anytime during the claim, all the information was correctly provided to the insurance company so it will be a seamless process thereafter,'' says Arora, referring to the claim settlement.

There could be two policies in the market, one could be offering no medical test and another may ask for one. The one that asks for medical is better because the price for that product is better price because it is a less risk pool for the insurance company. Hence, it is in the interests of the customer to choose a plan that asks for medical test, Arora adds.

"When the insurer has all the required information about the applicant, they are able to issue a policy quickly. This information also helps in settling claims without any hassle and also at the earliest possible,'' says Mahavir Chopra, director - health, life and strategic initiatives - Coverfox.com. If the medical test results show that the applicant is in good health, the insurer will charge standard premiums or can even lower it, Chopra adds.

If medical test is adverse or not done

If a customer undergoes pre policy medical check-up and certain health conditions are observed, the insurance company notifies the customer of such adverse conditions along with details of what medical conditions would be covered as per policy conditions. Before issuance of the policy the customer is notified of the coverage in the light of his/her medical condition and if the customer accepts the same, a

policy is issued, says Bathwal. In case a customer is suffering from a known or unknown ailment or condition, which he fails to declare at the time of policy application and has also not undergone any medical tests, then this would increase the chance of claim being declined by the insurer, says Biresh Giri, appointed actuary and CRO, Acko General Insurance.

In case a customer is diagnosed with an existing ailment or medical condition during a medical test, the insurer might offer to insure the customer at the same premium with specific terms, higher premium with standard terms, higher premium with specific terms, or may decline the policy.

PAYS TO KNOW HOW HEALTHY YOU ARE

- If medical test shows customer is healthy, then the price offered is one of the best offered in that pool
- Medical test establishes transparency on the customer's part, so claim process will be seamless
- If test results show the applicant is in good health, the insurer may charge standard premium, or even lower it

TOP

Source

India: Life insurers to lobby for indemnity health insurance business – Asia Insurance Review

The Life Insurance Council, which represents life insurance companies in India, will request the IRDAI to allow them to offer indemnity health cover again. The regulator has barred life insurance companies from offering indemnity health products since July 2016. Indemnity-based plans are those where the policyholder can claim reimbursement after visiting a doctor.

Currently, life insurers can only offer fixed-benefit health products, reported *The Times of India.* The council has formed a committee led by HDFC Life managing director & CEO Vibha Padalkar to handle the issue. She said, "In two to three weeks, we shall submit a proposal to IRDAI about resuming health indemnity cover for life companies." The insurance regulator in 2016 banned life insurers from offering indemnity based health products, which at that time constituted 90% of the health insurance market.

TOP

Source

GENERAL INSURANCE

Love your dog, birds, and other pets? Go for pet insurance – Financial Express – 6th March 2019

Pets are members of your family. And just like everyone else in your family, they have healthcare needs too. And to cater to this rather new-age need, some insurance companies have started offering pet insurance policies in India. While cattle insurance has been there for a while now, pet insurance is emerging in India.

What is pet insurance?

Pet insurance, like any other insurance, is a risk-mitigating product that covers unexpected expenses related to pets. From covering for veterinary bills for treatment/accidents–in–transit to loss or theft and death of pets, pet insurance takes care of all these expenses. It also covers the risk related to third-party liabilities in the event of damages caused to other people.

Which are the animals covered under pet insurance?
In India, pet insurance is available for dogs, cats, birds, sheep, goats, horses, rabbits, elephants etc. The list may vary from company to company. Some companies offer insurance specifically to a particular type of pet. For example, a company offering dog insurance.

What is the process of taking insurance?
Like any other insurance policy, there's an age limit applicable for taking pet insurance. For example: for dogs and cats, the age bracket for buying insurance is between eight weeks and eight years. For cows, it is two and ten years, for goats/sheep, it's between one and seven years.

You may have to provide a veterinary certificate for identification of a pet while taking insurance. It includes declaring identification mark, colour, sex, breed, age and other details pertaining to the pet.

What should be the ideal insurance premium size?
Typically the insurance premium size ranges between 3% and 5% of the sum assured, but it may vary depending upon factors such as the age of the pet, size of the sum assured, breed, third-party liability coverage, accidental rider, death rider, accidental-death rider, disability rider, etc. When it comes to livestock insurance, the government provides subsidy of up to 50% on the premium price.

The thumb rule to minimise the premium size for any insurance product is to start early, at a stage when the pre-existing diseases are low in number.

Things to keep in mind
A few things that you must keep in mind are whether the plan is IRDA approved or not, the sum assured, and the capping for specific risks. Check whether third-party liabilities risk is covered or not. Verify the list of ailments covered; the inclusions and exclusions associated. Most insurance companies may not include injuries/ diseases due to mal-handling/poor upkeep of pets or pre-existing illnesses for that matter. Loss or theft of pets due to conditions such as war, military attacks are excluded as well. Death due to rabies, Hepatitis, Enteritis, Leptospirosis are often left outside the ambit of pet insurance.

TOP

Source

Insurers see 'strong potential for revival of pet insurance market' - The Hindu Business Line – 4th March 2019

Insurance companies are looking to tap into the steadily growing pet market in India by either reviving existing cover or designing new products to suit consumers.

According to data available on the India International Pet Trade Fair (IIPTF) website, the pet population in India has grown from 70 lakh in 2006 to one crore in 2011. On average, six lakh pets are adopted every year.

The Indian pet market is estimated at more than $800 million, and is expected to register strong double-digit retail value growth in the coming years.

Higher disposable incomes, smaller families, sensitivity to animals, and social-media craze are the key contributors to the rise in pet ownership, studies point out. This, coupled with an increase in awareness about pet health, is driving people to look for pet insurance cover.

A number of public sector insurance companies, including National Insurance Company (NIC) and United India Insurance Company, have pet insurance products, and offer cover against death due to accident or disease, and third-party liability.

However, these products have not been able to make a mark due to the lack of awareness and poor inclination among agents to sell these products, as well as the absence of a proper distribution model, said a senior official at one of the public sector insurance companies. Hence, the number of policies sold and premium collected is very small.

NIC sold close to 25 dog insurance policies, and collected a total premium of around Rs 4.8 lakh in 2016-17 (collecting an average of Rs 19,700 per policy). The state-owned insurer sold around 31 policies in 2017-18; however, the premium figures were not readily available.

"There is a strong potential for revival of pet insurance. If marketed well, it can be a good product," KB Vijay Srinivas, former director, United India Insurance, told *BusinessLine*.

Online customers

Online insurance marketplace Coverfox.com is in talks with a few insurance companies to come up with a pet insurance product aimed at online customers in the next six months.

According to Premanshu Singh, CEO, Coverfox.com, the plan is to customise some existing products offered by a public sector insurer to suit the needs of online customers.

"Currently, insurance companies cover death due to accident or disease. But owners are emotionally attached to their pets and look for health insurance plan. Once the supply is created, then the demand will automatically follow," said Singh.

The medical cost involved in maintaining a pet is quite high, and is almost similar to what is spent on human healthcare. Hence, there is a need for pet insurance. However, just having a product may not solve the problem. It would call for proper distribution, said Sanjay Datta, Chief – Underwriting and Claims at ICICI Lombard General Insurance.

"You need pet insurance, but there has to be a good number of people who will pay the premium for the same, otherwise it is unsustainable. I do think it will evolve," he said.

TOP

Source

Title insurance for realty sector fails to pick up despite made mandatory – The Indian Express – 3rd March 2019

The concept of 'Title Insurance' aimed at protecting the promoters and customers of the real estate projects against many risks, has failed to take off due to high pricing and lack of clarity on a host of technical issues despite being made mandatory for real estate projects.

Advertising

The Real Estate Regulation and Development Act 2016 (RERA) mandates the purchase of Title Insurance for all new and ongoing property developments registered with the regulatory body.

Though IRDA has already approved seven products of the seven general insurers including, New India Assurance, National Insurance Company, ICICI Lombard General Insurance, Bajaj Allianz General Insurance, HDFC Ergo General Insurance, Tata AIG General Insurance and Liberty General Insurance, there are hardly any transactions for the Title Insurance products with many of them seeing only two or three deals, said an industry official.

"We are keen that market for the title insurance picks up as the government wants to promote housing for all in the country. How much premium the insurance companies can charge is left to them,'' said an IRDAI official.

Title insurance, which is common in the US, is a form of indemnity insurance which insures builders and customers against financial loss from defects in title to real property and from the invalidity or unenforceability of mortgage loans.

The premium would vary between 0.5 to 3 per cent of the sum insured for a seven year policy which can be extended further. Though such a product is already made mandatory in the Act, the state governments will have to notify the mandatory feature of the product separately. "The state governments are in the process of enacting Land Titling Bill and may consider notifying the mandatory feature of the Title Insurance," said an official source.

Once, the state government makes it mandatory, the state real estate regulatory body can enforce it amomg the promoters of the real estate projects. However, sources said the governments in states like Maharashtra are not in a hurry to notify the product as premiums for such products seem to be expensive and ultimately have to be recovered from the buyers of the real estate projects.

This could push up the final cost of the property. The Maharashtra government is now currently evaluating its role in controlling the premiums, which are fixed by the insurance companies, after making Title Insurance mandatory. The title Insurance can cover the gross asset value, consisting of land cost, construction cost and profitability, of a real estate project, said an official.

Moreover, defence and legal costs incurred are also covered under the policy.

TOP

Source

HEALTH INSURANCE

Why women in India need to buy health insurance – Financial Express – 8th March 2019

Women in India are making strides in every sphere. From handling their jobs, to managing homes, women are maintaining a fine balance through highly stressful situations. Various trends show that lifestyle changes do cost them their health, with a rise in lifestyle-led diseases such as hypertension and heart diseases.

Moreover, medical emergencies can hit anyone and absence of adequate planning can lead to financial distress. So, having a comprehensive health insurance cover can help in managing such situations. Despite contributing to their family's financial welfare, women account for less than a quarter of the total number of health insurance policyholders.

Group insurance scheme

As a working woman, you may be covered under your employer's group medical cover or as a spouse/daughter you may be covered under a family floater policy. However, the adequacy of these covers in case of a medical exigency should be ensured by you.

Given the rising medical costs, it would be ideal to get a health insurance that offers a cover of at least Rs 5 lakh. Starting early has an advantage since not only is the premium low for younger age groups, but also, any forms of pre-existing medical conditions get covered within two or three years as per the policy one selects.

Health insurance products also cover maternity and new-born related expenses, and their coverage extent should be considered before you buy a product. Also, every health insurance policy has a waiting period ranging from one to four years. It is advisable to get your health insured at a young age so that you can avail complete policy benefits when required.

Critical illness plans

While 25% of all women related claims are because of infections/fevers, with changes in lifestyle, we are seeing an increase in the number of women facing various critical illnesses. To address this issue, there are women-specific critical illness plans. Such policies cover different critical illnesses that women may suffer from like, breast cancer, cervical cancer, vaginal cancer, congenital disabilities that affect newborns, etc. To ensure higher coverage you can also seek super top-up policies that act as top-up covers to your base policy of Rs 5 lakh. These policies not only increase your coverage phenomenally but also come at a nominal premium.

Lack of financial awareness, dependency on family for financial decisions and a lack of consideration for the self, lead women to not participate in this financial protection tool which can ensure them better and hassle-free medical services. A woman who is protected with adequate health cover is not only well-equipped to face any sort of a health exigency but is also financially independent and self-reliant. Health insurance should hence be a preferred investment by all women since they empower them to face any medical exigency, head on.

TOP

Source

Are medical reimbursements eligible for tax deductions? See the changes made in income tax rules – Financial Express – 6th March 2019

Income tax jargon makes many people confused. One of such confusion is with Medical Reimbursement and Medical Allowance. While Medical Reimbursement on any disease was tax free up to Rs 15,000 u/s 17(2) of the Income Tax Act till last year, Medical Allowance was fully taxable. However, may people used to claim the full benefit without any actual expenditure or even on Medical Allowance?

From this financial year (2018-19), the Medical Reimbursement u/s 17(2), along with Conveyance Allowance, has been replaced with Standard Deduction. For the current financial year, the amount of Standard Deduction is Rs 40,000.

So, even if there is some reimbursement of medical expenses on normal treatment and medicines, you will not be able to get any tax benefit as the reimbursed amount will be treated as perquisite and will be taxed accordingly. However, apart from Section 17(2), tax benefits on account of medical expenditures may be availed as per other sections or income-tax rules.

Tax exemption u/s 17

Tax benefit will be available on any sum paid by an employer in respect of any expenditure actually incurred by an employee on his/her medical treatment or any other member of his/her family in hospitals approved by the Chief Commissioner in respect of following diseases or ailments, as these will not be treated as perquisite:

(a) cancer;
(b) tuberculosis;
(c) acquired immunity deficiency syndrome;
(d) disease or ailment of the heart, blood, lymph glands, bone marrow, respiratory system, central nervous system, urinary system, liver, gall bladder, digestive system, endocrine glands or the skin, requiring surgical operation;

(e) ailment or disease of the eye, ear, nose or throat, requiring surgical operation;
(f) fracture in any part of the skeletal system or dislocation of vertebrae requiring surgical operation or orthopedic treatment;
(g) gynecological or obstetric ailment or disease requiring surgical operation, caesarean operation or laparoscopic intervention;
(h) ailment or disease of the organs mentioned at (d), requiring medical treatment in a hospital for at least three continuous days;
(i) gynecological or obstetric ailment or disease requiring medical treatment in a hospital for at least three continuous days;
(j) burn injuries requiring medical treatment in a hospital for at least three continuous days;
(k) mental disorder – neurotic or psychotic – requiring medical treatment in a hospital for at least three continuous days;
(l) drug addiction requiring medical treatment in a hospital for at least seven continuous days;
(m) anaphylactic shocks including insulin shocks, drug reactions and other allergic manifestations

Loans for medical treatment of above diseases specified in Rule 3A are also exempt, provided the amount of loan for medical reimbursement is not reimbursed under any medical insurance scheme.

Tax exemption u/s 80D
Tax benefits will also be available on medical expenditure for treatment of senior citizens provided no health insurance is taken. Any assessee may get tax benefit on medical expenditures up to Rs 50,000 u/s 80D, if he/she or any member of his/her family is a senior citizen. Such an assessee may also avail additional tax benefit up to Rs 50,000 on medical expenditure of his/her parents, provided they are also not covered by any health insurance. So, maximum benefits available u/s 80D on medical expenditure is Rs 1 lakh in a financial year.

Tax exemption u/s 80DD
Resident employees may avail tax deductions up to Rs 75,000 from his/her gross total income on expenditures incurred for medical treatment (including nursing), training and rehabilitation of a dependent, who is a person with disability. In case of severe disability, the deduction limit is up to Rs 1, 25,000 in a financial year. Deductions u/s 80DD will also be available if the amount is paid or deposited under a scheme framed for the maintenance of such a dependent by the Life Insurance Corporation or any other insurer or the Administrator or the specified company, subject to the conditions specified in this regard and approved by the Board in this behalf.

Tax exemption u/s 80U
Tax deductions u/s 80U is available to an assessee, if he/she is a person with disability. The benefits will be identical to that of Section 80DD of the Income Tax Act as mentioned above.

Tax exemption u/s 80DDB
An assessee may avail tax deductions up to Rs 40,000 u/s 80DDB on the basis of a prescription from an oncologist, a urologist, nephrologists, a haematologist, an immunologist or such other specialist, as mentioned in Rule 11DD specifying that the assessee or his/her dependent is/are suffering from any of the following diseases or ailments as specified in the rules 11DD (1):
(i) Neurological Diseases where the disability level has been certified to be of 40 per cent and above,—
(a) Dementia; (b) Dystonia Musculorum Deformans; (c) Motor Neuron Disease; (d) Ataxia; (e) Chorea; (f) Hemiballismus; (g) Aphasia; (h) Parkinsons Disease;
(ii) Malignant Cancers;
(iii) Full Blown Acquired Immuno-Deficiency Syndrome (AIDS);
(iv) Chronic Renal failure;
(v) Hematological disorders — (a) Hemophilia and (b) Thalassaemia.

Further, deduction up to Rs 1 lakh is allowed u/s 80DDB; in case of the person against whom such claim is made is a senior citizen.

TOP

Source

Ayushman Bharat on way to become world's largest free healthcare scheme, says Arun Jaitley – Financial express – 6th March 2019

Finance Minister Arun Jaitley Wednesday said the Pradhan Mantri Jan Arogya Yojana (Ayushman Bharat) is on its way to become the world's largest free healthcare scheme in just over five months of launch. Billed as the world's largest government healthcare programme, Ayushman Bharat is funded with 60 per cent contribution coming from the Centre and remaining from the states. The central government aims to cover around 50 crore poor people. "In just over five months of its launch #Ayushman Bharat #PMJAY is well on its way to become the world's largest free healthcare scheme with – 2.2 crore people issued e-cards and over 14 lakh people treated," Jaitley said in a tweet.

In another tweet, the Finance Minister said over 9.23 crore toilets have been constructed under the Swachh Bharat Mission, taking the coverage of toilets from 39 per cent in October 2014 to 98.9 per cent in 30 states and Union Territories have become open defecation free.

"A national survey, conducted by an independent agency under the World Bank support to Swachh Bharat Mission, has found that 93.4 per cent of households in rural India who have access to toilet use it, showing that construction is also matched by a behavioural change in the usage of toilets," he added. Swachh Bharat Abhiyan, a cleanliness campaign, was launched by Prime Minister Narendra Modi on October 2, 2014.

TOP

Source

A visit to a medical lab or diagnostic centre can help you save tax; here's how – The Economic Times – 6th March 2019

This is a yearly phenomenon that happens at the end of every financial year. All kinds of financial service providers - right from banks to insurers to fund houses and now the likes of Paytm - start taking up space not just in our inboxes and messages but also hoardings all over the city pushing one thing: how you and me can save on tax by using their products.

Now, jumping on board the 'milk the tax saving season' bandwagon are medical diagnostic laboratories. Many renowned diagnostic centres have been sending SMSs and printing ads in newspapers telling people how they can save tax by undergoing a preventive health check-up from their centres. 'Save tax and your health' is the message these medical labs are spreading.

Sample this: a message from Thyrocare read: "Don't tax your health, don't tax your wealth, preventive care check-ups save you and your tax. Book now," with a hyperlink to its website. SRL Diagnostics has Bollywood actress, Shilpa Shetty, giving website visitors a thumbs up and coaxing them to save tax under section 80D with preventive health check-ups.

Now that we have piqued your interest, we will get these three questions answered in this story: how you can save tax, how much tax can be saved and what you need to do to make sure your claim is eligible for deduction.

How can you save tax?

The medical labs and diagnostic centres are taking advantage of the fact that up to Rs 5,000 spent on 'preventive health check-up' can be claimed as a deduction from income before levy of tax as per Section 80D of the Income Tax Act. Using this as a USP, these labs are trying to get people to go for medical tests before the financial year end. As per the law, an individual is allowed to claim tax deduction on the expenses incurred to undergo the preventive health check-up, irrespective of whether he is covered under a medical health insurance policy or not.

Abhishek Soni, CEO, tax2win.in, a tax-filing website says, "It is not necessary that the preventive health check-up must be done only on the individual himself/herself. If the preventive health check-up has been undertaken for family members, then, too, he is eligible to claim the deduction. Family member is defined as individual himself, spouse and dependent children as per the income tax law. If the individual has incurred some expenses on his/her parents for preventive health check-up, then also he/she can claim the deduction."

What you need to do to make sure your claim is eligible for deduction?

"The Income Tax Act allows maximum deduction of Rs 5,000 for the amount spent on health check-ups. Do keep in mind that the deduction amount for preventive health-checkups comes under the overall ceiling of the health insurance premium paid", says Soni .

Deduction on preventive health check-up and health insurance premium

	Amount (In Rs)	Amount (In Rs)	Amount (In Rs)
Health insurance premium paid	20,000	23,000	25,000
Preventive Health Check-up **deduction available**	5,000	5000	5,000
Preventive Health Check-up **deduction allowed**	5,000	2,000	-
Maximum deduction under Section 80D	25,000	25,000	25,000

(For individuals below 60 years of age)

An individual below the age of 60 years can claim the deduction of Rs 25,000 in a financial year for the health insurance premium paid for self, spouse and dependent children. For someone who is 60 years and above, the deduction amount of Rs 50,000 will be applicable. Additional deduction can be claimed for health insurance premiums paid for parents of Rs 25,000 or Rs 50,000 depending on their age.

Therefore, if you have paid health insurance premium of Rs 20,000, then you can claim deduction on preventive health check up to the maximum amount available. However, if the health insurance premium paid is Rs 23,000, then, deduction on preventive health check-up can be claimed for only Rs 2,000.

Payment for preventive health check-up can be done in cash as well. This is unlike from the premium paid on health insurance policy. Under section 80D, the premium paid on health insurance policy has to be done through banking channels only.

Preventive health check-up for family members and parents

Income Tax Rates	Tax-savings (Rs)
5 per cent tax rate	250
20 per cent tax rate	1000
30 per cent tax rate	1500

Tax-savings are exclusive of cess

How much tax can you save?

Though the amount of deduction available is for Rs 5,000, the amount of tax that you can save depends on the tax rate applicable to your income after claiming all the eligible deductions.

Here's the amount of tax that you can save by simply claiming deduction on preventive health check-ups.

It is important to remember that one must keep the documentary evidences such as doctor's prescription, receipt of medical tests undergone and other documentary evidence in case the income tax department asks for proof.

TOP

Source

Delhi's plan to launch own insurance scheme delayed – The Times of India – 6th March 2019

Of the three states that are yet to sign up for Ayushman Bharat, Telangana and Odisha have their own insurance schemes which, they claim, is better than Pradhan Mantri Jan Aarogya Yojana (PMJAY) — the national health protection scheme.

Delhi, too, wanted to implement a universal health insurance plan for the state by last December. But the status report of the outcome budget presented by the Delhi government recently shows that the project is yet to take off. "The modality of the insurance scheme has not been finalised yet," it noted.

The government had, in its budget for 2018-19, had proposed an outlay of Rs 100 crore for the state health insurance scheme to cover treatment of citizens in empanelled private hospitals and government hospitals. A source said a committee constituted to prepare detailed guidelines recommended adopting the Ayushman Bharat scheme but that didn't happen over naming of the scheme.

Also, some officials in the health department argued, the poor and vulnerable who are the intended beneficiaries of PMJAY were already getting free treatment in Delhi's state-run hospitals as well as some of the top private hospitals under various schemes.

"Our government has ensured 100% availability of free medicines and consumables at state-run hospitals," said an official. In case diagnostic services such as MRI and CT scan aren't available readily in government hospitals, officials have been authorised to refer the patient to empanelled private facilities where the tests can be done for free and the government will bear the cost, he added.

The official said 1,116 free surgeries were conducted in empanelled private hospitals on patients referred from 24 Delhi government hospitals because the waiting period in the government hospitals was too long under the free surgery scheme.

"Also, more than 40 big private hospitals that got land on concessional rates have to provide free treatment to 25% out-patient department and 10% in-patient department patient belonging to economically weaker sections," he pointed out.

Telangana's Aarogyasri universal health scheme covers around 80 lakh families in the state and the insurance coverage to each family varies between Rs 2 lakh and Rs 13 lakh per annum. In some specialised therapies, there is no limit. Odisha's Biju Swasthya Kalyan Yojana, a health-for-all scheme, provides health assurance coverage to around 70 lakh families.

TOP

Source

'Ayushman Mitra' can be brought under national health agency payroll: Think tank associated with BJP - The Economic Times- 5th March 2019

Volunteers appointed to assist patients under the Ayushman Bharat scheme could be brought under its payroll to fix a direct accountability, according to recommendations of a think tank associated with the BJP.

The Public Policy Research Centre conducted an assessment of first phase of implementation of the Pradhan Mantri Jan Arogya Yojana and suggested that instead of reporting to individual hospitals, Ayushman Mitra can be brought under the purview of the national health agency to fix their responsibility.

The other recommendations given by the report included to consider making an Ayushman council, which would be on the lines of GST council to improve coordination between the beneficiaries and the government.

The recommendations have been submitted to NITI Aayog. The report said the assessment was conducted from November last year till this January in eight districts across four states -- Himachal Pradesh, Haryana, Uttar Pradesh and Uttarakhand.

The team, that led the study, interviewed over 600 patients, relatives and other stakeholders, including government stakeholders, grassroots workers - ASHA workers, ANM, pharmacists, common service centres, among others.

The report claimed that beneficiary interviews revealed people are now tending to health care problems on priority; they are departing from a common practice of overlooking or putting off doctor visits due to financial concerns leading to worsening of illnesses.

Several case studies pointed out the trend that people are now visiting doctors for their health care issues, lingering for decades, the report said.

TOP

Source

How will a standard health insurance plan help customers? – Mint – 5th March 2019

The Insurance Regulatory and Development Authority of India (Irdai) has issued draft guidelines for a standardised health insurance product. The rationale behind a standard policy is to give customers access to basic health insurance that doesn't come with bells and whistles.

A standardised product will make it easy for customers to understand and compare health insurance. Some experts feel it may also make porting health insurance policies between different insurers possible. Deepti Bhaskaran asks experts if a standardised product will indeed make all this possible:

Success of basic health product will depend on awareness level

Mahavir Chopra, Director, health, life and travel insurance, Coverfox.com

While there is still further refinement required in the guidelines with respect to standardised capping on room rents, treatment costs, the effort on standardisation of benefits and conditions is welcome, and should in the long run make it easy for customers to compare and buy plans. It will also become easy for intermediaries to advise on plans.

However, remember that health insurance is a push product in India. The success of these standardised plans will depend on how well aware customers are about these products—how well they are marketed by insurers. While as per the Irdai mandate, every non-life insurer has to offer this standard product, the existing flagship health insurance plans from all insurers will continue to have differential benefits and hence remain "non-standard". Customers may now, in fact, have to compare the standard product with the non-standard product of the same insurance company too.

These flagship plans are likely to continue as top-of-the-shelf products from insurers and their entire distribution machinery, except maybe in the case of PoSP channels (point of sales persons that are

mandated to sell over-the-counter products and hence the products need to be simple) where Irdai could mandate only this standardised product to be sold.

It will help increase health insurance penetration

Prasun Sikdar, Managing director and CEO, Cigna TTK Health Insurance

Irdai's proposed move for standardisation of health insurance product will definitely improve access to healthcare without having to go through a complex decision-making process around the choice of products. Currently, many consumers may find it difficult to understand what services different health insurance products cover, and what they don't. This will allow consumers to focus on provider network, premiums, benefits and quality, and not have to make complex trade-offs among product features across a large number of plans.

This initiative may, however, result in a downward spiral of cost undercutting across the industry and impact innovation. The guidelines state it will have the basic mandatory cover and will be uniform across the market. It also emphasizes on incentivizing early entry which will benefit the customers. But in the long run, the same standard basic cover may not offer comprehensive risk protection to the customer.

Due to standardised coverage, it will be simple for a consumer to port a policy without having to worry if the benefits would change, but we do not see this causing a huge impact versus the portability experience since the process is very simple even today. The industry will indeed witness increased penetration with a simple standard product and enable scale.

Minimum sum insured of Rs 50,000 could be reviewed

Mayank Bathwal, Chief executive officer, Aditya Birla Health Insurance

Product complexity has been a constant rejoinder of customers and standardisation is a step in the right direction to build further trust, simplify underwriting, claims, operational and grievance processes in the health insurance industry for both insurers and consumers.

The Irdai product standardisation draft should serve to expand the market base. If the industry and the regulator can work together on the lines of how the mutual fund industry has created broader awareness and clarity, then this intent would be well served. Hence, a clear strategy to create awareness is critical.

With rising medical costs, the minimum sum insured of Rs 50,000 could be reviewed taking into perspective parity with the cover of Rs 5 lakh provided by Ayushman Bharat and genuine customer need for adequate protection. As per the Irdai draft, the standard product will be required to cover standard co-pay, wellness incentives, hospitalisation (pre and post) expenses, Ayush treatment and cumulative bonus which may attract a new set of consumers.

The policy will also offer outpatient department (OPD) coverage but the draft is yet to define whether the total OPD component will be part of the sum insured or will be over and above the sum insured. We await clarity on standardisation of policy exclusions, and other terms and conditions.

Creating rules for outpatient treatment will be a challenge

Nayan C. Shah, Managing director, Paramount Health Services (TPA)

Standardisation of the individual health product is a progressive step. The salient features include outpatient consultation treatment which most retail products don't offer currently. The premium would definitely be different than that of a pure hospitalisation product and the network will need to be expanded to include outpatient facilities. Managing this network and creating the rules for outpatient treatment is going to be a challenge. The rules should specify the caps for outpatient treatment; otherwise it can be a nightmare for underwriting. There will also be other challenges like collection of data for outpatient treatment and it would have been better if a standardised data format is prescribed at the earliest so that the industry can have better analytics.

The fraud and abuse are always more wherever outpatient benefits are available and controlling this is going to be a challenge in the Indian market. In countries where outpatient is covered, insurers pay between 15% and 25% claims towards fraud and abuse. We will have to wait and see what innovations

these technology and service providers will bring in to control these. By and large, covering outpatient and wellness are progressive steps but it has its own challenges.

TOP

Source

1.4 lakh Ayushman Bharat health cards issued – The Hindu – 4th March 2019

Pralhad Joshi, MP, Dharwad, said that already 1.4 lakh health cards under the Union government-sponsored Ayushman Bharat scheme were issued and appealed to the people to make use of the scheme.

TOP

Source

A standard health cover explained – Mint – 2nd March 2019

Do you find it difficult to choose a health insurance plan? In a relief for customers, the Insurance Regulatory and Development Authority of India (IRDAI) have issued draft guidelines to offer a standard health plan by all general and health insurers. Once the guidelines come into effect, all general and health insurance companies have to offer a standard health cover. Here is what you can expect:

The proposal

According to the IRDAI circular, in order to enable customers to choose appropriate health insurance coverage of their choice, all general and health insurers should offer standard individual health insurance products apart from personal accident and travel covers. Once the guidelines are effective, the customer will be able to identify the product as a standard mediclaim policy along with the name of the company.

Issued under the provisions of section 34 (1) (a) of Insurance Act, 1938, this standard product will have basic mandatory covers which will be uniform across the market. There will be no additional addons or optional covers. Only the basic cover under the standard product is standardised. The regulator has left the decision of the premium to the insurer.

Its proposal is to offer on indemnity basis only. The standard product will have standard exclusions and offer mandatory covers such as hospitalisation expenses. Expenses incurred for treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines will be covered, but will come with fixed standard sublimits.

Under this cover, periodic consultation of at least once in a policy year will be included. It will also have an option to provide incentive for fitness. Sum insured will be increased by 5% for each claim-free policy period (where no claims are reported), provided the policy is continuously renewed without a break, subject to maximum 50% of the sum insured (excluding CB accrued) under the current policy period. No deductible features are permitted under the base cover.

The standard plan will come with standard co-pay. Co-pay means you will have to pay a certain amount too. Add-ons or optional covers are not allowed to be attached to the base cover.

Is it worth it?

Currently, a majority of health and general insurance companies offer health insurance policies along similar guidelines. However, it is not standardised yet. "There are probably around 30 insurers offering health insurance policies. I think 25 of them will have a product already similar to the guidelines issued in the circular.

They may just have to modify a bit and change the name. There will be some insurers who will not have certain variants. For instance, it may not have a co-pay feature. Hence, I don't think this is a major change, but is a step to create a market benchmark," said Kapil Mehta, co-founder, Securenow.com, an online insurance broking firm.

Though it is an attempt to standardise the plans available in the market, there is still enough flexibility. "Right now, there is a lot of flexibility given to insurers. Ideally, those should also be standardised. For instance, the number of years for preexisting diseases that are excluded could be a standard three or four years. Right now there is no guideline on it," said Mehta.

There is also an inclusion for 5% co-pay which experts think is a good way to avoid frauds. "It is one of the best ways to ensure that there is no fraud. If you have evidence of customer paying money then the chances of fraud comes down," said Mehta.

The basic sum insured amount is set in the range of Rs 50,000- Rs 10 lakh. Right now, most insurers offer policies starting from Rs 3 lakh sum insured. Hence, the Rs 50,000 sum insured will cater to a new category of individuals.

In the current form there is no mention of the cap on room rent. It requires clarification on basic parameters which can be followed by the insurance companies. The regulator is seeking suggestions till 6 March.

TOP

Source

Will rise in claims bump up insurance premium under Ayushman Bharat? - The Hindu Business Line – 1st March 2019

Tamil Nadu, which has integrated the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) with the Centre's Ayushman Bharat scheme, has submitted 1.25 lakh claims so far totalling Rs 274 crore.

United India Insurance, the State's insurance partner for the earlier CMCHIS, currently charges a premium of Rs 699 per cover, which is borne by the State (under Ayushman, it is split between the Centre and the State in 60:40 ratio for 77 lakh beneficiaries).

The existing tender comes up for renewal in 2022. The fact that the State's health scheme has been in operation for over seven years, and claims have more or less stabilised, lends comfort on the premium front. But integration of Ayushman with CMCHIS is likely to increase awareness and also lead to substantial rise in claims over the next two to three years. This could bump up premium costs significantly when the tender comes up for renewal.

A wider coverage

Tamil Nadu's CMCHIS offered coverage of Rs 1 lakh to Rs 2 lakh per year for specified procedures for those with an annual income of less than Rs 72,000. Under Ayushman (PMJAY-CMCHIS), while about 77 lakh beneficiaries must be covered as per SECC data, the State covers close to 1.47 crore families for up to Rs 5 lakh according to the income criteria.

Health check

Top 5 hospitals (amount wise)	Claims (numbers)	Claims amount (₹ cr)
Government		
Madras Medical College, Chennai	13,761	22.82
Govt. Rajaji Hospital, Madurai	6,964	12.00
Govt. Stanley Medical College Hospital,Chennai	4,989	9.17
Tirunelveli Medical College Hosp, Tirunelveli	5,685	7.52
Coimbatore Govt Medical College, Coimbatore	3,788	7.00
Private		
Jipmer Hospital, Pondicherry	3,568	9.09
VMC Speciality Hospital, Madurai	811	6.21
Sri Ramakrishna Hospital, Coimbatore	2,531	5.99
Meenakshi Mission Hosp and Rsrch Centre, Madurai	1,102	4.66
Sri Ramachandra Medical Center, Kancheepuram	2,106	4.50

From the period Sept 23, 2018 to Feb 25, 2019

According to the existing tender, which is up to 2022, the insurance company will take care of specified procedures up to the sum insured of Rs 1 lakh or Rs 2 lakh. For uncovered procedures beyond the sum insured, reimbursement will be done by the State.

As awareness increases and claims shoot up, premium costs could go up over the next two to three years. Currently, the overall utilisation has been 3-4 per cent over the past few years – that is, of the 1.4 crore families – about six lakh have been availing benefits under the CMCHIS every year. If utilisation moves up to 5-6 per cent, premiums could go up substantially.

Mitigating factors

However, there are some factors that lend comfort. Ayushman covers 1,393 procedures, while CMCHIS covered 1,027 packages.

About 335 packages fall under both schemes, while 635 are covered in one and not the other. All three types – totalling 970 – are clubbed and covered under the new integrated health scheme called PMJAY-CMCHIS.

"The remaining 423 packages (1,393 less 970) have been reserved only for government hospitals. These are mainly low-end procedures. The re-jigging of the packages in such a way ensures minimal burden on the insurer as the procedures reserved for government hospitals are zero packages," explains Selvavinayagam.

This implies that these procedures will be free for a patient, but the government hospital will not get reimbursed for this. "With the high-volume low-end procedures pushed to government hospitals, the misuse is also reduced," adds Selvavinayagam.

High-end specialised procedures that were already covered under CMCHIS continue under Ayushman, hence, capping the extent of revision in premium. The top claims in the State have been related to high-end procedures such as cardiology and renal. The State agreeing to bear the burden of excess claims also helps cap the premium, adds Prema Mukilan, Chief Manager, United India Insurance.

TOP

Source

MOTOR INSURANCE

IRDAI chief rules out dismantling of third party motor tariff system – The Indian Express – 7th March 2019

IRDAI had, way back in 2007, deregulated the pricing of the entire range of insurance products except the third party motor premium. Every year by March 1, the IRDAI unveils the new third party motor pricing for the year.

The Insurance Regulatory and Development Authority of India (IRDAI) has ruled out dismantling the third party motor tariff system, which is still regulated by the insurance regulator in the post detariffication period.

IRDAI had, way back in 2007, deregulated the pricing of the entire range of insurance products except the third party motor premium. Every year by March 1, the IRDAI unveils the new third party motor pricing for the year.

When asked about any possibility of removing the third party motor segment from tariff regime, S C Khuntia, chairman, IRDAI, said, "Often general insurers complain us that tariff was not adequate and they are bleeding due to the loss making portfolio. However, if it is detariffed, a cut-throat competition will begin." "We are looking at various options on the issue," he said on the sidelines of the 20th Global Conference of Actuaries.

In fact, some years back, IRDAI had mooted a proposal to dismantle the tariff system in the third party motor segment but called it off after PSU general insurers opposed the proposal. On the insurers' exposure to the financially battered IL&FS, Khuntia said that each insurer has got different kinds of exposure in the company.

"We have said that insurers should do adequate provisioning and can't write them off,'' Khuntia said. Insurers are advised to invest in high rated companies only and in case the rating comes down in due course of time, then the insurers should apply their own judgment to respond to the situation. "It is not possible for IRDAI to tell them what to do exactly. The only thing that we have to do is protect policyholders' interest,'' he said.

On the 51 per cent investment by LIC in IDBI Bank, the IRDAI chief said the regulator has to give a timeline to LIC by when it should bring down its stake in the bank to 15 per cent. "But we are yet to do so," he said. On the possibility of launching a long-term health insurance policy similar to the long-term motor policy, Khuntia said unlike life insurance where there is a life table available, the general insurance industry did not have such facility. "So, we can make long-term health insurance policy for two or three years,'' Khuntia said.

TOP

Source

Car Insurance: How to protect your vehicle from monetary depreciation – Financial Express – 5th March 2019

Purchasing a new car is one of the most important investments in an individual's life. So, it becomes important to protect your car with a comprehensive motor insurance policy and adequate add-ons. While a regular car insurance policy is instrumental in safeguarding your car against possible threats, the add-ons make the policy much more comprehensive. Failing to enhance your cover with necessary add-ons can prove to be troublesome at times.

Let's try and understand this with an example. Assume that you bought a car worth Rs 30 lakh (IDV – 26, 00,000) in the year 2017. Now, a few months back the car got stolen and as per the norms you filed an FIR, but there was no report of its recovery. You get worried if your insurer will cover the loss of the car and, if yes, how much money would you actually get back? When you contacted the insurer, you were told that your motor insurance policy will cover theft and disappearance. Moreover, you had done the right thing by filing an FIR as under any such circumstances, it is quite difficult for the insurer to establish whether the car got really stolen. You were requested by the insurer

to submit both sets of the car keys as it was important to establish that the car was not taken away due to your own negligence.

Regarding the claim amount, you were advised that the car qualifies for total loss wherein the insurer would reimburse the total sum assured of the policy, that is, the insured declared value (IDV). Not to forget, IDV is reset every year after deducting depreciation which is based on the vehicle's age. As your car was 2 years old, it qualified for 30% depreciation and the total amount that the insurer is liable to pay is somewhere between Rs 18,00,000 and Rs 18,50,000, i.e. the IDV of the car after 2 years.

However, you were further informed by your friend that had you bought the exclusive add-on cover named 'Return to Invoice' along with your car insurance policy, the total loss claims would have been settled on the original cost of the vehicle instead of the IDV.

What is 'Return to Invoice' Add-On?

Return to Invoice (RTI) is a popular add-on which provides adequate coverage and it basically covers the gap between the insured declared value and the invoice value of the car. Under RTI add-on, you get the entire amount of loss (the total on-road price paid for the car) that you incurred from losing the vehicle. The RTI generally costs around 10% more than the normal comprehensive insurance policy. However, one must know that if the same model and variant is available at a lower than the original purchase price, the former is considered.

When is RTI Applicable?

Approximate Annual Premium for RTI	
Cost of the Car (Rs.)	Price of RTI (Rs.)
Up to 5 Lakh	1,000
Up to 10 Lakh	2,000
Up to 10 -15 Lakh	3,000

It is a common misconception amongst the people that RTI can be availed to compensate for the bill of small dents and repair. The fact is that Return to Invoice only helps you in retrieving financial loss of a stolen car or a car that has been damaged beyond repair. Considering the depreciation that is applied on new vehicles at 5% for the first 6 months from Day 0 of purchase, and 10% for each year going forward, you could lose a lot of money even if your insurance company compensates you for total damage of your vehicle. The RTI add-on plays a great role in bridging this gap. An important thing to know is that RTI is only applicable for cars that are up to 3 years old. RTI will not be offered to you after a couple of years of policy renewal i.e., when your car gets more than 3 years old.

TOP

Source

Return to invoice add-on can get you original cost of car from insurer if insured car is stolen – The Economic Times – 4th March 2019

What if your new car gets stolen within the first one or two years of you buying it? Delhi-based Rajneesh Malhotra met with a similar incident recently. His three-month-old car was stolen while he was shopping in one of the upscale markets of South Delhi.

As soon as he realised that his car was stolen, Malhotra filed an FIR (First Information Report) at the nearest police station and informed the insurance company about the theft.

"My insurance claim got accepted and I thought I will receive the full amount (on road price) as I have taken a standard motor insurance policy when I purchased my new car. However, the insurer told me that even if a new car is stolen within a year from it is purchase date; they cannot pay back the original or full cost of the car. Instead, they could only pay the amount that equals to the IDV (Insured Declared Value) of the car as

mentioned in the policy document. In effect, it meant that the insurance claim I would get would lesser than the actual cost of the car," he said.

This left the policyholder unhappy.

How much insurance reimbursement you get in case of car theft?

When you buy a standard motor insurance policy at the time of new car purchase. The insurer fixes the IDV of a new car by deducting depreciation from the invoice value. It is basically the current market value of a car and it is the maximum amount your motor insurance policy pays you when your car gets stolen.

Sanjay Saxena, Head - Motor Claims & Underwriting, Bajaj Allianz General Insurance said that Indian motor tariff gives a schedule of depreciation for arriving at IDV of the vehicle. This IDV represents the market value of the vehicle and remains unchanged during the policy period. This removes any dispute at the time of claim in case the vehicle is reported stolen. "Thus, if the age of your vehicle is not more than 6 months, 5 percent depreciation is deducted when fixing IDV. However, if the age of your vehicle is more than 6 months but not exceeding 1 year, in that case, 15 percent depreciation is deducted when fixing IDV," he said.

For example, let us say you bought a car worth Rs 8 lakh (ex-showroom price) and got it insured at the time of purchase. At the time of insurance of a new car the IDV is fixed at 5 percent less than the invoice value (i.e., Rs 7.6 lakh) because 5 percent is the depreciation of car once it goes out of the showroom. Let us say the car gets stolen within the first six months of the policy term, the insurer will pay you Rs 7.6 lakh and your policy will end. The IDV value for the first policy term remains the same across all the insurers when you buy a brand-new motor vehicle. However, later on, it can be changed year after year.

Here is what industry expert says on how to get the original cost of the car reimbursed via insurance claim when a car gets stolen.

How you can get complete claim?

For someone like Malhotra, if he would have taken a 'Return to invoice' adds on with his car insurance policy at the time of purchase, he would have got back the full amount, i.e., the on-road price of the car.

Saxena says, "Return to invoice add-on with comprehensive insurance policy, in case of total loss, theft or constructive total loss of the vehicle, you will get replacement of insured vehicle with a new vehicle of same make, model, specifications and colour subject to availability in the open market. In addition, you will get basic insurance on the new vehicle, cost of its registration, road tax including octroi if any."

Tarun Mathur, Chief Business Officer- General Insurance, Policybazaar.com said that while buying a car one should take an invoice price add-on when buying insurance for new car to be able to get the invoice value reimbursed from insurer in case of theft of car. It is also referred to as 'Return to Invoice' or 'Gap cover'. It is useful in case of car theft because this cover offsets the depreciation incurred on the car.

"If you have the insurance price add-on cover then you are eligible for the payout as per the invoice value of your car. For say, you have made the claim against the theft of your car which was valued at Rs 10 lakh (on road price) at the time of purchase. But the IDV mentioned in your policy is supposed Rs 9, 00,000. Then in case of normal motor insurance policy, you will receive the payout based on your IDV. This way, this add-on bridges the gap of Rs 1 lakh which you paid towards registration charges and road tax as well. However, the important thing you should know that you can avail such add-on only for a new motor vehicle which is not older than 2 years," he said.

Generally, while taking this add-on, some companies give you full on-road price and some may not give you the full on-road price which means they exclude the insurance premium cost while making final payments.

Mathur says insurance companies like ICICI Lombard General Insurance, Bajaj Allianz General Insurance, Reliance General Insurance provide the on-road price to the insured which includes ex-showroom price, road tax, registration charge, and insurance premium. But there are companies like HDFC Ergo, National India Assurance, and The Oriental Insurance Company, which may not include the price of insurance premium while evaluating the on-road price when providing final reimbursement to the insured. In such

a case, the price of the add-on also varies from insurer to insurer. "Basically, it all depends upon insurance companies how they have filed their product with the regulator (including add-ons)," he added.

Therefore, in case you wish to buy this add-on, carefully check what it covers at the time of purchase.

TOP

Source

SURVEY & REPORTS

Patients spend double of what the govt does on them – The Hindu Business Line- 6th March 2019

What patients shell out from their pockets is close to double of what the Centre and State governments spend on public healthcare in India.

According to the latest National Health Accounts (NHA) estimates released on Wednesday, patients bear a big chunk of health expenses — as high as 61 per cent of the total health expenditure — by themselves.

The total expenses incurred on healthcare stood at Rs 5,28, 484 crore in FY16, while household Out Of Pocket Expenditure (OOPE) on health totalled Rs 3,20,211 crore (60.6 per cent of the total health spend).

On the other hand, the government's health expenditure (GHE) stood at Rs 1, 61,863 crore (30.6 per cent of the total health expenditure).

Patients end up spending out of their pockets on medicines, doctors' fees, bed charges, diagnostic tests, drugs and products such as vitamin supplements at public and private hospitals and pharmacies despite various public healthcare schemes.

Changing dynamics

Over the years, the share of GHE has increased, from 22.5 per cent in FY05 to 30.6 per cent in FY16, while that of OOPE has decreased from 69.4 per cent in to 60.6 per cent. But the latter still accounts for a massive chunk of health expenses.

While GHE was 1.18 per cent of the total GDP (Rs 1, 37,64,037 crore in FY16), OOPE was 2.33 per cent of the GDP that year, showed NHA estimates. The Centre, through the National Health Policy — 2017, committed to increase health allocation to 2.5 per cent of GDP till 2025. However, in FY19, there was no such increase.

In per capita terms, while the Central and State governments spend Rs 1,261 on each citizen over healthcare, the individual OOPE stands at Rs 2,494.

NHA estimates also suggest that the penetration of private health insurance has risen from 1.6 per cent in FY05 to 4.2 per cent in FY16. Private health insurance expenditure is pegged at Rs 22,013 crore.

Of the total healthcare expenditure, the amount spent to buy medicines at pharmacies (Rs 1,38,061 crore, or 27.9 per cent), and on expenses at private general hospitals (Rs 1,28,011 crore, or 25.9 per cent), comprised a major chunk, compared to expenditure for treatment in government general hospitals (Rs 64,585 crore, or 13 per cent).

State-wise spends

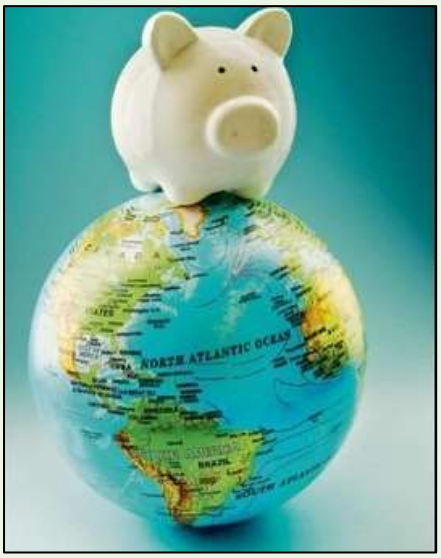
Among States, the share of OOPE against the overall expenditure was the highest in Bihar, at 79.9 per cent, against the national average of 60.6 per cent. The Central and State governments spent Rs 4,756 crore on healthcare in Bihar, where OOPE stood at Rs 19,890 crore. OOPE was the lowest in Gujarat, at 50.4 per cent. However, that still came to Rs 10,589 crore, against government spending of Rs 7,808 crore.

TOP

Source

PENSION

What happens to your EPF account when you are relocating abroad – Mint – 6th March 2019



So you've got that dream opportunity and are jet-setting off to a new country. But as you tie up all the loose ends and sign off on the paperwork, don't forget your Employees' Provident Fund (EPF) account. If your employment in India ceases, so will your eligibility to continue contributing to EPF; so you can withdraw the amount and close the account.

According to the EPF Act, in order to claim the final PF settlement, you have to be 58 years of age and retire from your job. The rules also allow you to withdraw money in case of unemployment for more than two months. The total PF balance you can claim includes your contribution as well as that of your employer, along with the interest accrued. However, if you're settling abroad, you can apply for withdrawal at any age. In fact, when you are relocating, you can withdraw the money immediately.

To apply for withdrawal, you need to get an EPF withdrawal form from your employer. You can also download it from the EPFO (Employees' Provident Fund Organisation) portal. If your Universal Account Number (UAN) is linked to your Aadhaar, you can use the Aadhaar-based withdrawal form and approach the EPFO office directly, without the intervention of your former employer. You can also apply for the withdrawal online through UAN's portal. Fill in the form stating the reason for withdrawal as moving abroad, and submit it along with the necessary documents.

If you are planning to go abroad only temporarily, it makes sense to retain your EPF account. While an EPF account that hasn't received any contributions for three years is considered inoperative, the amount deposited in it continues to earn interest till you turn 58. When you live and work in a foreign country, you might be required to contribute to the pension or social security scheme there, even if you are employed with an Indian company. If you have only gone abroad for a short duration and still work for an Indian employer, it might not be beneficial for you to contribute to such a programme because chances are that you will not be able to reap the benefits.

The Indian government has social security agreements with several countries, including Australia, Canada and Germany. If you are going to one of these countries, you can apply for a certificate of coverage issued by EPFO, which will exempt you from making contributions to the local social security scheme. But for this to work, you need to be employed in an Indian company and your employer must keep depositing EPF contribution on your behalf, during your foreign stint.

Handle your EPF account depending on your long-term plans, but complete the paperwork on time.

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Source

EPF deduction may increase soon, but not for everyone – Mint – 5th March 2019

Soon, you may be investing a much larger share of your salary in your Employees' Provident Fund (EPF) account. Last week, the Supreme Court ruled that all allowances, such as special allowance and dearness allowance, should be included while computing EPF deduction. Only allowances that are variable and linked to the employee's efforts, such as overtime allowance, can be excluded, the court said.

EPF deduction

According to the Employees' Provident Fund (EPF) Act, 1952, 12% of an employee's basic salary and dearness allowance has to be invested into EPF and the employer needs to invest an equal sum. For example, if your basic salary and dearness allowance add up to Rs 12,000, your employer has to deduct Rs 1,440 towards PF every month and match it with Rs 1,440 from its own pocket. Both these amounts are, typically, a part of the cost to company (CTC).

If you earn more than Rs 15,000 per month in basic salary plus dearness allowance, employers can limit the PF deduction to 12% of Rs 15,000 (Rs 1,800) under the proviso to Para 26A of the Employees Provident Fund Scheme, 1952. This also brings down their matching contribution to 12% of Rs 15,000. Many companies choose not to take the benefit of this proviso and contribute 12% of the actual basic salary plus dearness allowance, even if the sum is higher than Rs 15,000.

Employers, however, often exclude special allowance, travel allowance or canteen allowance while computing PF deduction. For example, if your basic salary and dearness allowance add up to Rs 30,000 and you get Rs 10,000 as special allowance another Rs 10,000 as conveyance allowance; your employer may only deduct 12% of Rs 30,000 or Rs 3,600. This keeps the "in-hand" salary high and reduces the CTC for the company.

The ruling

In Regional Provident Fund Commissioner (II) West Bengal vs. Vivekananda Vidya Mandir and Others, the Supreme Court heard a batch of petitions from employees who had challenged the exclusion of a special allowance given as an incentive to teaching and non-teaching staff pursuant to an agreement between the employer and employees. This batch of petitions was clubbed with several other petitions in which allowances like house rent allowance (HRA), canteen allowance, travel allowance, management allowance, conveyance allowance, education allowance, medical allowance and others were excluded by different employers while deducting PF contributions.

The court ruled that allowances which are paid to all employees and are not variable or linked to any production incentive should not be excluded. Such allowances should be counted in the salary limit for PF deduction.

The impact

Experts have noted four implications of this ruling. First, the employees earning more than Rs 15,000 in basic wages plus dearness allowance will not be affected. This is because employers of these types of workers are exempted from making PF contributions on amounts higher than Rs 15,000 by the Proviso to Para 26A of the Employees' Provident Fund Scheme, 1952. According to Madhu Damodaran, director, HR business services, Co Achieve Solutions Pvt. Ltd, this interpretation was reaffirmed by the Supreme Court in 2011 in Marathwada Gramin Bank Karmachari Sanghatana and Anr v Management of Maratha Gramin Bank and Ors.

Even employers who were voluntarily deducting PF contributions on wages above Rs 15,000 per month would not be hit by the latest Supreme Court decision. Second, HRA is excluded by the definition of basic wages under Section 2(b) of the EPF Act, 1952 and hence will not be affected by the judgment.

Third, employees earning basic wages plus dearness allowance less than Rs 15,000 per month may have to contribute a higher share of their CTC to the EPF but this will depend on the facts of each case. According to Puneet Gupta, director, EY, “The court has ruled that in each case the facts and evidence on record will have to be looked at in order to determine whether the allowance in question was truly variable and discretionary or it was fixed in nature."

Fourth, international workers posted in India may see a higher amount being deducted towards PF. Such workers are not exempted by the proviso exempting domestic workers earning more than Rs 15,000 per month.

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Source

Serving, retired employees of public sector insurers to get pension option – Mint – 4th March 2019

Retired and serving employees of government-owned insurance companies are happy at the Centre's decision to offer another chance to opt for pension scheme.

"I am happy with the interest rates on bank deposits sliding down; getting a steady pension income is good. I am going to opt for pension," Y. Sivam, a retired employee of National Insurance Company Ltd.

A serving employee in the same company on the condition of anonymity, said: "Earlier I didn't opt for the pension scheme as the situation was different. But now the circumstances have changed. And I am going to retire in a couple of years down the line, it is better to have pension."

According to the employee, the amount that a retired employee has to refund as the company's share of provident fund can be recovered through monthly pension in couple of years time.

On a poll year, the welfare measure is expected to benefit 42,720 employees (serving and retired) of which 24,595 are of Life Insurance Corporation of India (LIC) and 18,125 of public sector general insurers.

The Central government recently decided to allow one more opportunity to employees of government-owned general insurers who had joined on or before June 28, 1995, to opt for pension as retirement benefit.

In April 1997, employees of LIC and public sector general insurance companies namely-General Insurance Corporation of India, National Insurance, Oriental Insurance Company and New India Assurance Company, who joined service on or before June 28, 1995, were given another opportunity to opt for pension, as a retirement benefit.

The scheme was introduced after the insurers had hired large number of freshers in 1990. But, many eligible employees could not exercise the option and there has been a long standing demand from them to be given another option.

In order to mitigate the hardship of such employees of whom many have retired, government has decided as a welfare measure, to allow one more opportunity to employees of general insurers to opt for pension scheme in lieu of contributory provident fund.

The pension option is not available for those who had resigned from the company, said an official of an public sector insurance company.

The Government of India has decided to allow one more opportunity to employees of Public Sector Insurance Companies (PSICs) who joined on or before 28th June 1995, to opt for pension, as a retirement benefit.

Pension was introduced as a retirement benefit in PSICs with effect from 28th June 1995. In April 1997, employees of LIC and Public Sector General Insurance Companies namely, GIC, NICL, OICL, UIICL and NIACL, who joined service on or before 28th June 1995, were given another opportunity to opt for Pension, as a retirement benefit.

However, many eligible employees could not exercise the option and there has been a long standing demand from them to be given another option.

In order to mitigate the hardship of such employees of whom many have retired, Government has decided as a welfare measure, to allow one more opportunity to employees of PSICs who joined service on or before 28th June 1995, to opt for the Pension scheme of their respective organizations, in lieu of Contributory Provident Fund.

This decision is expected to benefit 42,720 employees (serving and retired) of which 24,595 are of LIC and 18,125 of PSGICs.

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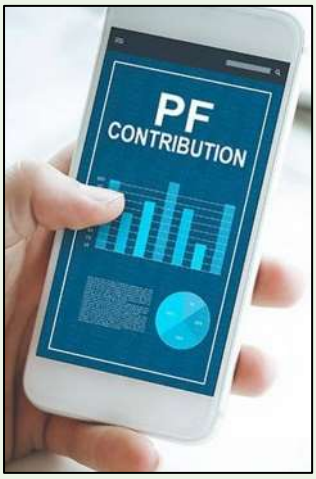
Earning less than Rs 15,000/month? SC ruling on PF contribution may dent your take-home pay - The Hindu Business Line – 3rd March 2019



Employees whose monthly pay is less than Rs 15,000 may have to brace for a lower take-home salary, going by the recent Supreme Court judgment on the sums to be considered for provident fund (PF) contribution. Monthly pay here comprises basic wages, dearness allowance, cash value of food concession and retaining allowance, if any.

The Supreme Court has recently ruled that almost all allowances (except HRA) should be considered when calculating the PF contribution by both employers and employees.

However, by taking away more towards long-term savings, the judgment helps in boosting the retirement kitty of such employees.

As per the Employees' Provident Funds and Miscellaneous Provisions Act, 1952, both employer and employee have to mandatorily contribute 12 per cent of the monthly pay towards provident fund, if the monthly pay do not exceed Rs 15,000. PF contribution in cases where monthly pay is more than Rs 15,000 is only voluntary, although many employers and employees continue their contributions even beyond the limit.

So far, the definition of basic wages has been a contentious issue. As per law, basic wages includes all payments excluding DA, House Rent Allowance (HRA), overtime allowance, bonus, commission and any gifts made by the employer.

But over the years, the Employees' Provident Fund Organisation has contended that employers provide various allowances such as special allowance, conveyance allowance, canteen allowance, education allowance and medical allowance, which are in the nature of basic wages but are shown separately to avoid contribution to the PF account. The latest judgment seeks to address this issue.

Addressing the gap

As per SC's judgment on February 28, basic wages include components of salary that are universally, necessarily and ordinarily paid to all across the board. That is, an allowance goes beyond basic wages if it

can be shown that the workman concerned had become eligible to get the extra amount for doing beyond the normal work which he was otherwise required to put in.

If the employer is able to prove that the allowance so provided to certain employees is not common or linked to his/her performance, that allowance will not become part of basic wages. Therefore, the order implies that the allowances discussed above now become part of the basic wages and the PF should be deducted on the total sum of the basic pay, including these allowances and the DA.

The implication

If your monthly pay is more than Rs 15,000, this judgment may not be binding. Kuldip Kumar, Partner at PwC India, says, "As per an SC order in the Marathwada Gramin Bank case, employers cannot be compelled to contribute beyond their statutory liability unless they voluntarily agree to contribute PF on the wages higher than Rs 15,000 per month."

If your monthly pay is less than Rs 15,000, as almost all allowances now come under the definition of basic wages, there could be higher deduction of PF. This will reduce your take-home salary. But the good news is that the contribution (both employer and employee) to your retirement fund goes up.

Experts though are divided on whether the changed definition of basic wages will be applicable only for PF contribution or will also apply to the calculation of the Rs 15,000 ceiling. Chirag Nangia, Director, Nangia Advisors, says that it will help if the employers keep a simple compensation structure clearly defining 'basic wages' to avoid litigations on this front.

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IRDAI CIRCULAR

Exposure draft on Insurance Regulatory and Development Authority of India (Conflict of Interest) Guidelines, 2019 is available on IRDAI website.

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Terms and conditions of life products for F.Y. 2018-19 is available on IRDAI website.

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Report of Working Group for Revisiting the Surveyor Regulations is available on IRDAI website.

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GLOBAL NEWS

Australia: Call for superannuation scheme to be improved to help women – Asia Insurance Review

The superannuation system in Australia is stacked against women because it fails to pay any attention to their working lives, according to two professors at the University of Sydney Business School.

Professor Marian Baird, Discipline of Work and Organisational Studies, and Professor Susan Thorp, Discipline of Finance, in an article in *The Sydney Morning Herald*, say that the Royal Commission into Banking, Superannuation and Financial Services that released its final report last month, did not address how the scheme could work better for women.

Australian women have a distinctive work pattern over the course of their lives, one that is quite different to men's. Whether by choice or constraint, women in Australia manage their care responsibilities with part-time work.

In fact, levels of full-time work for women have not increased at all over the past 40 years, despite the surge of women entering the labour market.

Nearly half (46%) of women work part-time compared to 17% of men. Two-thirds of women move to part-time work after the birth of their first child and one third are likely to move to jobs requiring different skill levels. This inevitably leads to less pay, and therefore less superannuation. As a result, on average, women retire with about 40% less superannuation than men.

The academics also point out:
Default life and temporary and permanent disability insurance is set up for full-time workers. Premiums are set by age not income, and people who work part-time pay premiums as if they worked full-time.

Furthermore, premiums are deducted for a period of time after members stop contributing. Women who take time out of the workforce continue to pay premiums. The Productivity Commission estimates that a retirement balance could be eroded by 14% by inappropriate insurance premiums.

In a defined contribution scheme like Australia's, lower earnings at younger ages means less funds to benefit from compounding of investment returns. For every dollar that women do not contribute in their 30s, their child-bearing years, they need to contribute A$3 in their 50s to achieve the same balance.

Improvements to the performance and efficiency of superannuation funds will make the early dollars contributed by women count more. However, the system should facilitate women contributing to their superannuation in their 20s or early 30s, before they have children.

The annual and lifetime limitations on concessional contributions mean that women who reach their peak earnings in their 40s or 50s cannot get the advantages of tax concessions in the same way as if they had smoothed work hours over their lives. Concessional contribution caps should accommodate the uneven workforce participation that many women experience.

The current catch-up windows around parental leave, for example, are too short. The regulations should allow people to catch up in their 50s and 60s when they have more money to save, without imposing higher tax rates.

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Source

Japan: Pension system deters women from working full time – Asia Insurance Review

Japan's pension system is seen as one of several hurdles to more women being employed full time in the country.

If a wife makes over a certain amount of money and no longer qualifies as a dependent, she would have to pay into the national pension system. Dependent spouses enjoy what is called Category III status, entitling them to their own pensions even if they never work and pay premiums.

But once they enter the workforce and earn above a certain amount, they have to start paying, and if they look at the matter

in the long term, they might conclude that they will get a better pension as a dependent than they would as a non-regular worker, according to a report in *The Japan Times.*

Japan has one of the highest rates of working women in the developed world, but according to the Internal Affairs and Communications Ministry, 56% of all women who worked in Japan in 2018 had non-regular jobs, meaning part-time, temp or contract work that usually lacks benefits. The corresponding rate for men was 22%.

In a February report on employment statistics by the Ministry, the workforce in 2018 consisted of 34.76m people in regular positions and 21.2m in non-regular positions.

The breakdown by gender for regular employees was 23.39m men and 11.37m women. More significantly, there were 6.69m men and 14.51m women in non-regular jobs.

Other deterrents to women working more include cultural norms such as the idea that homemaking is the responsibility of women; the tax deduction system; and the company allowance system that favours households where the woman is a full-time homemaker.

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Source

Premiums in emerging Asian markets to grow 3 times faster than world average – Asia Insurance Review

Premiums in emerging Asia are projected to grow three times faster than the world average over the next two years and China will become the world's largest insurance market by the mid-2030s, according to a sigma report released by Swiss Re Institute.

In terms of economic output, China alone will count for more than 25% of the global total in the next decade, the report says.

Emerging markets around the world

Indeed, China together with six other largest emerging markets in the world are forecast to contribute around 40% of global economic growth over the next 10 years. The other six biggest emerging economies in terms of gross domestic product are India, Brazil, Russia, Mexico, Indonesia and Turkey.

Over the next 10 years, emerging market premiums are forecast to more than double, outpacing growth in advanced markets by four times.

The sigma report forecasts that the emerging market share of global premiums will increase by about 50% over the next decade, with the long-term premium growth rate for emerging markets five percentage points higher than that for the advanced markets. The growth rate in emerging Asia is forecast to be three times the world average over the next two years.

"Emerging markets will continue to outperform advanced markets in terms of growth in the next 10 years," said Swiss Re Group Chief Economist Jerome Jean Haegeli. "The shift in economic power from west to east will continue. As this happens, the quality rather than speed of growth becomes the differentiating factor in emerging markets."

Challenges

Emerging markets currently face cyclical and structural challenges, but they remain an attractive growth proposition relative to the advanced markets. A key finding that the shift to relatively slower growth will be accompanied by more stable economic growth, a shift from quantity to quality.

"Prior to the global financial crisis, the five-years-ahead expected growth differential between emerging and advanced markets was 4.5%. It is now 3.5% and this is still a comfortable growth uptick, especially in light of the lower growth levels in advanced markets", Mr. Haegeli said.

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Brokers lead the way in new Asian economic era – Asia Insurance Review

Indonesian Financial Services Authority (OJK) reaffirmed their support for the insurance industry and the many insurance brokers that operate in Indonesia.

Executive head of non-bank financial institutions supervision Mr Riswinandi said with Indonesia an important part of the ASEAN Economic Community and at the forefront of the new era of Asian economic opportunities, brokers can create success through clever market positioning and use of all the tools at their disposal, including technology and human resources.

He said that it was not an easy period for insurers, due to the volatile global economy. He cited the trade war between the US and China and the uncertainty in the EU as the main drivers for this volatility, which has negatively affected Indonesia.

However, the insurance industry is more than capable of capitalizing on their opportunities, especially by employing fourth industrial revolution technologies, he said, during his keynote address at the 7th Asia Insurance Brokers' Summit in Jakarta yesterday morning.

The digital insurance era is bringing change to the industry, whether they want it or not, said Association of Indonesian Insurance and Reinsurance Brokers (APPARINDO) chairman, Harry Purwanto during his address at the conference. "Those that welcome this collaborative new economy have an opportunity to embrace, enable and monetize disruption, placing them on a path of higher growth."

Leaders who respond positively to this new era and technology, he said, will not just transform insurance, but also reshape entire markets and change the way people work and live.

"Innovative risk management is not just allowing businesses to take more risk in a responsible way, but it is about strengthening our defences from new and emerging risks. In my opinion, advancing innovation will provide the confidence and economic freedom for businesses to grow and evolve," he said.

The conference was organised by *Asia Insurance Review* and sponsored by Steadfast Group.

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Singapore: Motor business turns around to post underwriting gains in 2018 – Asia Insurance Review

Underwriting profits for the motor business picked up in the second half of 2018, after three consecutive quarters of incurring losses, to record underwriting profit amounting to S$9.96m ($7.35m) for the 2018 financial year. This reverses the S$27.2 million underwriting loss recorded in 2017.

This turnaround is primarily attributed to a 1.5% decrease in incurred claims, reflecting efforts of effective fraud management initiatives by the sector as well as a decline in the number of road traffic accidents in 2018, said the General Insurance Association of Singapore (GIA)

yesterday as it released the 2018 results for the industry.

However, significant increases in claims costs for work injury compensation (WIC) insurance and health insurance segments contributed to the sector's 64.8% decline in underwriting profit for 2018 totalling S$37.7m. Underwriting losses surged by 57.6% to S$44.17m in health insurance while WIC insurance saw an underwriting loss of S$3.61m, from a gain of S$30.71m in 2017.

Overall, the general insurance sector saw stable growth of a 3.4% year-on-year increase in total gross premiums, totalling S$3.81bn for 2018. Motor premiums dipped by 0.5% to S$1,105m in 2018.

2019

GIA President, Mr. Karl Hamann, said, "We will continue to focus on driving progress and building resilience as we adapt to the global economic uncertainties in 2019 where global growth is expected to moderate. Our key priorities for the year include investing in digital technologies to manage claims cost inflation, developing our human capital, and addressing climate change challenges."

GIA Insurance Fraud Tip-off (GIFT) reward scheme

GIA also launched the GIA Insurance Fraud Tip-off (GIFT) reward scheme yesterday, where a reward of up to S$10,000 will be given to individuals for reporting insurance fraud cases with evidence that leads to prosecution and conviction of offenders. Reports are to be submitted online at: https://gia.org.sg/consumers/contact.html, with evidence proving the wrongdoing.

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