



भारतीय बीमा संस्थान  
INSURANCE INSTITUTE OF INDIA

# INSUNEWS

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## QUOTE OF THE WEEK

**“Always be yourself, express yourself, have faith in yourself, do not go out and look for a successful personality and duplicate it.”**

**Bruce Lee**

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## INSURANCE TERM FOR THE WEEK

### ***New Business Premium***

Definition: New business premium is the premium acquired from new policies for a particular year.

Description: A premium is a regular periodic payment to be made by the policyholder to the insurance provider. The premium earned from the new contracts in a given financial year is referred to as the new business premium for an insurance company.

It incorporates single premium for that year, the first year premium on regular premium policies written in that year and from those written in previous years.

Source

## LIFE INSURANCE

### ***How much can Rs. 1 crore cover? - The Hindu Business Line - 6th December 2019***



It is often observed that for most policy seekers in India, a sum assured of Rs. 1 crore seems substantial, and enough to take care of all expenses. They deem the amount sufficient to sustain their family's requirements in case something untoward happens to the policyholder.

This is where they fail to understand the essential logic and do the basic math. No doubt the eight-digit figure sum assured seems impressive — after all, Rs. 1 crore deposited in

a bank account gives a Rs. 58,333 monthly income at 7 per cent rate of interest. However, there is a flip side to the story.

While the calculation may seem perfect on paper, when it comes to implementation, things change drastically. People often forget to take into account the outstanding loans in the name of the policyholder, the significant inflation and, most importantly, one-time expenses such as children's higher education and marriage and, of course, the retirement needs of the partner.

#### **How to arrive at the figure**

Generally, the value of sum assured must be based entirely on the life stage of the policy seeker. A salaried individual up to the age of 40 must have a cover of approximately 20 times the annual income. Individuals above the age of 40 must buy a cover 10-20 times the annual income while those in their 50s must opt for a cover of 5-10 times their annual income.

Apart from the annual income, your family's annual expenses are also a great way to calculate the right sum assured. A one-size-fits-all approach cannot be followed while taking a policy; a thorough analysis of individual expenses, liabilities, investments and requirements is recommended.

When looking for a comprehensive life insurance plan, do make sure to choose a plan that adequately covers your spouse's future. It must be well equipped to protect your partner's old age requirements so that she/he can live a life of dignity and comfort in your absence. Make sure you consider his/her living, medical and health-related expenses. While a Rs. 1-crore cover is sufficient if the only dependent is the spouse, those with two or more dependent children will require a larger cover.

### Zooming needs

Never forget inflation when calculating your family's future costs and expenses. The needs and requirements of your family will keep rising with time. If your family's total expenses today are Rs. 50,000 a month, they are sure to rise to Rs. 70,000 in five years at an annual inflation rate of 7 per cent.

It is advisable to review the insurance cover every five years and during critical milestones such as marriage, buying a new home and birth of a child. To help policyholders, most insurers have in-built features such as increasing the total sum assured or life stage-linked enhancement. Under these plans, you can easily enhance your policies and the sum assured as required.

Customers can also choose term plans with the option of increasing the sum assured. Under such plans, the sum assured increases every year by a specific amount. While for the first five years the death benefit remains the same, after that period the sum assured increases by 5-10 per cent for the next 15 years, or the end of the policy term, whichever is earlier. All such plans let you increase your term cover by using the increasing sum assured option with the same insurer, thus taking care of the increasing expenses of your family.

*(The writer is Santosh Agarwal.)*

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***New IRDAI norms expected to boost life insurance reach - The Times of India - 4th December 2019***



In a bid to increase the penetration of life insurance products in the country, insurance regulator, Insurance Regulatory and Development Authority of India (IRDAI), on Tuesday issued a circular on 'Point of sales products and persons - life insurance' as part of which it has said that the point of sales person (life insurance) is also allowed to distribute micro insurance products of life insurance.

As per the IRDAI circular, the point of sale product - life insurance would mean plain vanilla type of product wherein each and every benefit is pre-defined and disclosed clearly at the time of sale.

It includes pure term insurance products with or without return of premium, non-linked non-participating endowment product (survival benefit feature also allowed), immediate annuity product and non-linked non-par health insurance with fixed benefits, among others.

The insurance regular said that the turnaround time for issuance of policy/acceptance of risk and communication of acceptance or otherwise to the customer of such policy should not be more than four working days from the date of collection of proposal at the point of sale.

If the proposal is not accepted, the refund of payment should be done to the proposer within seven days from the date of decision.

It said that any life insurer or insurance intermediary that intends to engage point of sales person (life insurance) must conduct 15-hours of training, conduct an examination as well as issue a certificate to the candidate who passes the examination.

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## ***Life insurers want more options to sell health plans – Moneycontrol – 3rd December 2019***



Three years after the Insurance Regulatory and Development Authority of India (IRDAI) asked life insurers to withdraw indemnity or reimbursement-based health plans, the companies are now seeking a revival of a level playing structure. This will offer better product choices to customers.

Sources told Moneycontrol that life insurers had sought permission to start selling reimbursement plans. Here, when an insured is hospitalised, the kin pays the bills. However, this is later reimbursed by the insurance companies on producing the medical bills.

“While general insurers and standalone health companies have more options as far as medical plans are concerned, we

have a limited choice. We are seeking a change in this decision,” said the chief distribution officer of a mid-sized private life insurer.

Currently, life insurers are allowed to sell fixed-benefit health plans. This means that, if an individual is diagnosed with a particular ailment, the insurer will pay out a fixed sum for the treatment.

In 2016, the IRDAI asked to withdraw all indemnity-based health products being sold in the market. This product, popularly referred to as ‘mediclaim’, constituted almost 85-90 percent of the health products being sold by the life insurers.

While the IRDAI did not give any reason for this decision, the idea of the regulator was to let specialised non-life insurers to sell such products. Life insurers are of the view that this has taken away from the level-playing field that existed earlier.

“Globally, life and health come under one category. By not allowing us to sell indemnity plans, the current health plans become restrictive to customers,” said the chief executive of a private life insurer.

The IRDAI has not yet taken a decision on this matter.

If this proposal is approved, customers can choose to buy a product from either a life or a general insurer. After the regulation changed, individuals mostly chose to buy health products from non-life insurers since they provided more coverage, wider benefits at an attractive premium.

For instance, a typical fixed benefit plan of Rs 5 lakh will pay the amount as a lump sum benefit in case of an illness like a heart disease. After this payout, the policy ceases to exist. However, if an individual wants prolonged coverage for critical illnesses and wants to get away from the hassle of paying money at the hospitals for subsequent treatment, having an indemnity-based cover is beneficial since it will pay the exact hospitalisation expenses.

*(The writer is M Saraswathy.)*

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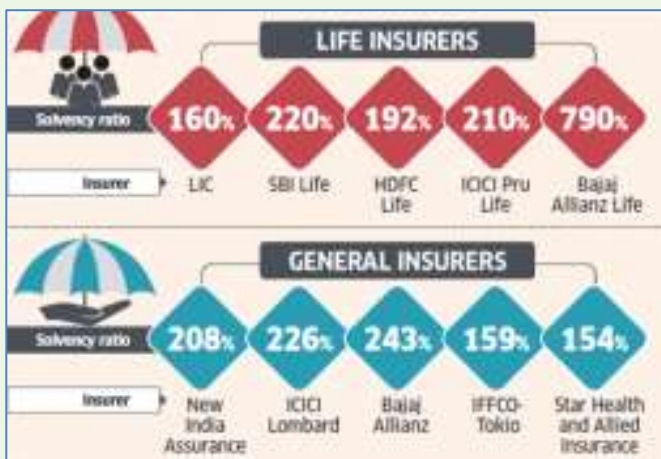
## ***How IRDAI protects policyholders from crises at insurance companies - The Economic Times – 2nd December 2019***

Recently, the Insurance Regulatory and Development Authority of India (Irdai) suspended operations of Reliance Health, a standalone insurer that set up shop only last year. Another insurer, Aviva Life, was dragged to National Companies Law Tribunal (NCLT) by its landlord, Ape jay Group, over payment obligations. Aviva has said the dispute will have no impact on policyholders.

Given the impact of crises at banks and non-banking financial companies (NBFCs) on individual depositors, any adverse news is bound to make policyholders anxious. “These segments require a long-term commitment. Policyholders are bound to be jittery when something happens to the company they have invested in for years. Non-life insurance is mostly an annual affair and thus exposure is limited,” says Jayesh Gadekar, Head, Health and Benefits, Global Insurance Brokers. However, the insurance regulator has adequate powers— and the system requisite checks and balances— to safeguard policyholders’ interests in case insurers run into trouble.

### Solvency margin

The Reliance Health Insurance case is a pointer to powers that Irdai is endowed with to protect policyholders’ interests. It initiated action after the year-old company’s failed to maintain the required solvency margin after June 2019.



Irdai stipulates that all insurers—life, health and general—maintain a minimum solvency ratio of 150%. Solvency margin, captured in this ratio, is the excess of assets over liabilities. “A number higher than the mandatory requirement bodes well for the financial strength of the insurer,” says Mahavir Chopra, Director, Health, Life and Strategic Initiatives, Coverfox.com. It leaves no room for concerns about the insurer going through a financial crisis. “Most Indian insurers today maintain this ratio at much higher levels of 180-220%,” says Ashwin B, COO, Exide Life Insurance.

Source: Irdai, General Insurance Council and company websites; data for top five life insurers by market share in Oct 2019 and top two PSU general insurers, private general insurers and standalone health insurer by premium collected in Oct 2019

However, this number should not be considered in isolation. “For example, the solvency ratio of Life Insurance Corporation of India (LIC) on 30 September was 1.60, but a low number doesn’t mean that LIC is facing a financial crunch. The ratio keeps changing quarterly, so the number can increase in subsequent quarters,” he adds.

In case of Reliance Health, the insurance regulator issued directions in August asking the company to rectify the deficiency in a month, but the insurer failed to comply. “Thereafter, the insurer was issued a show cause notice and given another opportunity to present its case. However, there has been no improvement but further deterioration in the financial position of RHICL,” the Irdai stated, explaining the rationale behind its action. In such cases, the regulator asks the insurer to propose a financial plan to dust off the crisis. More stringent action is considered only if the insurer fails to comply.

### Irdai to the rescue

One of the key objectives of setting up a regulatory authority was to ensure policyholder protection. “The regulator has wide ranging powers to take action if insurers fail to meet their solvency criteria. It keeps close tabs on the solvency levels as they determine the company’s ability to pay claims,” explains Satyendra Srivastava, Partner, and Khaitan Legal Associates.

For instance, Section 52A of the Insurance Act, 1938 empowers the regulator to appoint an administrator for a life insurer if it feels that it is acting in a manner that is prejudicial to the interests of policyholders. “Under Section 52B, this administrator can transfer the business to another insurer or recommend winding up of the business,” says an insurance lawyer who did not wish to be named. In 2017, Irdai followed this path and was instrumental in facilitating the acquisition of the troubled Sahara Life Insurance by ICICI Prudential Life Insurance. Governance related issues were at the heart of this decision by the regulator-appointed administrator. “On the filing of the report with the Irdai, the authority may

take such action as he thinks fit for promoting the interests of the holders of life insurance policies in general,” the amended Insurance Act says.

*(The writer is Preeti Kulkarni.)*

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### **7 reasons why your term insurance claim might get rejected - APN News - 30th November 2019**



Picture this: As a breadwinner of the family, you buy term insurance for your family members to secure their financial needs in your absence. But what would happen if your term insurance claims get rejected during contingencies? Your family would go through financial turmoil due to inadequate funds to maintain their standard of living without your support.

According to the Insurance Research and Development Authority of India (IRDA), many insurers have rejected approximately 12, 769 claims in 2016-17. Since the coverage of term insurance is usually high, many people are unsure about the approval of their claims.

Insurance companies might either approve or reject your claims based on various reasons. As a policyholder, you should hold the responsibility to understand the prime reason behind the rejection of your term insurance claims.

Given below are the top seven reasons that highlight why your term insurance claim might get rejected:

#### **When you provide inaccurate information**

While applying for your claim, you should submit the accurate information to your insurance company. Do not hide any personal details like your age, income, habits, and so on to ensure maximum transparency between you and your insurer. In addition to this, fill the correct policy details for the faster approval of your claims.

#### **When you don't read the policy document**

There is no denying that you might be in the habit of glancing through any essential paperwork. When it comes to a policy document, take your time out and carefully read the terms and conditions of your insurance companies. A policy document includes all the medical conditions covered by your insurer. If you make a claim for uncovered diseases without reading the document, your claim is bound to be rejected.

#### **When you don't reveal the nature of your job**

You might have heard an old adage, 'no job is too big or too small.' As an independent individual, you can choose to either work in construction or an organization. However, working in construction, factories, mines, and so on is life-threatening since it involves high-risk. In such a scenario, you should reveal the nature of your job to your insurance company before buying a term policy.

#### **When you don't make your medical condition clear**

Your health condition is of utmost importance to your insurance providers. Therefore, while filing for a claim, you should specify your and your family's medical history clearly. In addition to this, you should also mention if you have any unhealthy habits like smoking, consumption of alcohol or other harmful drugs.

#### **When you don't renew your term plan**

When you purchase a term policy, you should pay premiums regularly to continue the policy in the long run. In case you fail to make the premium payment due to a financial crunch, your insurer will provide a

grace period (30 days) within which you should compulsorily pay the premium. If you fail to pay the premium within those 30 days, your term policy lapses and you will no longer be eligible to file for claims.

### **When you don't undertake medical tests**

Under a term policy, you might receive a high coverage based on your health risks. Therefore, your insurance company might ask you to undergo medical tests before sanctioning your desired sum assured value. Failure to undergo medical tests can increase the chances of claim rejection.

### **When you don't disclose the number of policy holding**

As a policyholder, you might own multiple life insurance policies. While it's understandable to have several policies in your name, see to it that you disclose the number of your policy holdings. It is compulsory to declare the number of policies you own since many insurance companies have stringent rules and regulations.

In a nutshell, term insurance acts as a financial cushion to support your family in your absence. Therefore, you should carefully select a plan with maximum term insurance benefits for your family's safety. An online term plan is convenient, time-saving, and hassle-free. In addition to this, you should keep these points mentioned above in mind to ensure your claim is approved without creating a mess in times of need.

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***Free-look period in insurance policy: How does it benefit you - Financial Express - 29th November 2019***



Insurance overall is a pushed product in India. This means the insurance product is pushed to policyholders through various channels. Due to this, most people buying a policy lack the proper understanding of the insurance product and end up choosing the wrong policy. There are many policyholders who hold the wrong policy and are still paying a premium for it.

To help policyholders in such situations, insurance regulator IRDAI has brought in a consumer-friendly provision — the free look period – wherein, if a policyholder has bought a policy and then realizes

he does not want it, he can return it and get a refund for it.

Rakesh Goyal, Director, Probus Insurance Broker, says, “This way policyholders with policies that don't meet their needs will not have to worry about being stuck with the policy or the loss of the premium paid for the policy.” This especially helps people who after buying a policy find out that the policy terms and conditions do not suit their needs. However, the cancellation and return of the policy to the insurer have to be done within the free look period, to get a refund from the policy.

### **Here is how the free look period works:**

Even though the free look period was introduced to help policyholders, it comes with certain conditions. For instance, all insurance policies do not have a free look period option. The free look period usually applies to life insurance policies and certain categories of health insurance policies only. Currently, other insurance policies do not have the provision of the free look period.

Goyal of Probus Insurance says, “An insurance policy with a free-look period usually offers 10 to 15 days to review a newly-issued policy. If the terms and conditions aren't acceptable to the policyholder, this

way they can return the policy during the free-look period and the insurance company pays back the premium.”

Some insurance policies bought online offer a free look period of 30 days after receiving the policy document. The policyholder if unsatisfied with his/her policy and wants to return it, needs to inform the insurance company in writing, it should not be communicated orally. Doing so may not be enough.

However, note that the insurance company pays back the premium after deducting certain expenses such as the medical examination expenses if any, tax, and any other charges. As per the IRDAI guidelines, the insurer reserves the right to deduct the expenses incurred, if any, on medical examination.

In the case of ULIP policies, the refund is based on the NAV (unit value). Some insurers also deduct stamp duty charges and then pay the net amount post these deductions to the policyholder’s registered bank account.

To avoid facing such situations, it is better to take an expert’s advice, be it from a financial advisor or an insurance expert, before opting for a policy.

*(The writer is Priyadarshini Maji.)*

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### ***Life insurers get extension till January 2020 to withdraw old products - Moneycontrol - 29th November 2019***



Life insurance companies have been given a two-month extension to withdraw products and riders that are not in tandem with the new product regulations. This is a good news for policyholders as they would have no sudden dearth of products to choose from, while for insurers this means that they have more time to get products out of the market.

The Insurance Regulatory and Development Authority of India (IRDAI) had earlier asked insurers to withdraw products by November 30. But this deadline has now been extended to January 31, 2020.

IRDAI said that they had received representations from Life Insurance Council and various other life insurers, requesting for an extension of the timeline. Insurers had

sought an extension citing reasons like the need to ensure system preparedness and necessary training of personnel.

However, the deadline to refile or modify existing products, which was fixed at February 29, 2020, will continue. This applies to products under the linked and non-linked insurance segment.

IRDAI said that the new guidelines with respect to benefit illustrations, periodic statements, agent training for unit-linked insurance plans will be applicable from February 1, 2020 as against the earlier December 1, 2019 deadline.

The regulator had said that the extension does not apply for products already approved under 'File & Use' under the new regulations. IRDAI has advised all life insurers to file these products as early as possible without waiting for the last date available. It also said that the no further requests for extension will be entertained.

The new guidelines applicable for traditional and ULIP products will change the surrender values and the sum assured of the policies. Hence it was necessary for insurers to seek an extension so that there was no dearth of products in the market.

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## GENERAL INSURANCE

### *How to avoid getting your travel insurance claim rejected - Financial Express - 4th December 2019*



More and more people have started opting for travel insurance policies while travelling, both for domestic and international travel. Travel insurance plans protect the policyholder from some other unexpected circumstance that can arise while on the trip or any last-minute changes.

However, even with a travel insurance policy, your claims can be rejected based on a number of cases. For instance, not disclosing pre-existing diseases/ conditions can lead to claim rejection.

Hence, according to experts policyholders should make necessary disclosures with the documentation while opting for an insurance policy. Withholding important details especially when travelling with elderly parents or travelling against doctors' medical advice, could put the policyholder in a mess.

#### **Here are some points you can keep in mind to avoid claim rejections;**

##### **Withholding medical details**

Policyholders should never withhold details of pre-existing conditions. Especially, if the policyholder is travelling with elderly parents or is travelling against doctors' medical advice. While buying the policy, many people don't disclose existing medical conditions completely or tend to avoid making any declaration. What most don't understand is that this can be the cause of claim rejection.

If you meet with an accident or fall sick during your vacation, due to an underlying medical condition, travel insurance claims can get rejected. Even if the medical condition faced by the policyholder is not related to the pre-existing disease, yet the claim can be rejected. Hence, make sure to declare all health condition when you applying for a travel insurance policy.

##### **Lack of policy cover during adventurous sports**

Travel insurance policies do not extend their policy cover for accidents/injuries due to adventurous sports.

Additionally, any loss arising due to participation in adventure sports are also not included. Adventurous sports such as mountaineering, bungee jumping, hang gliding, scuba diving, trekking, parasailing, and skydiving, are generally not covered by insurers. Even though the list of sports included vary from company to company, the chances of getting injured while engaging in such sports are high, hence, the chances of claim rejection are also high.

##### **Note Claim Exclusions**

All insurance policies come with exclusions, and policyholders not being aware of this gets surprised with claim rejection later. Therefore, it is suggested to check the list of exclusions in travel insurance coverage and understand the list of exclusions thoroughly to avoid any unpleasant surprises down the road.

For instance, events that occur before the start of the policy is not covered. This can be after a policy is bought. As the activation of the policy might be different from the time you buy the policy. Find this out from your insurer while buying a policy.

*(The writer is Priyadarshini Maji.)*

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***'Rs 2,500 cr recap for PSU insurers pre-merger may be insufficient' - The Sentinel - 3rd December 2019***



The Finance Ministry will recapitalize the state-run general insurance companies ahead of taking further steps in their mergers to shore up their balance sheet and solvency ratio but the amount appears to be short of the requirement of the PSUs insurers.

The ministry recently sought approval from the Parliament for an additional requirement of funds for recapitalization of insurance companies of Rs 2,500 crore through demand for grants.

The three firms needed immediate recapitalization of at least Rs 2,000-3,000 crore each to maintain solvency ratios and reduce losses. The total

requirement is up to Rs 12,000 crore.

The public sector general insurance firms had told the department of financial services of the urgency for immediate recapitalization in order to maintain the regulatory solvency ratio and wipe out losses. Though this fund may be insufficient for the urgent needs, still the insurance PSUs will get some recap funds which will slightly improve their vital stats, said official sources.

Recently Finance Minister Nirmala Sitharaman had said government would move forward on the merger of PSU insurance companies. "This was a Budget announcement and I will be moving forward on that", she said in a media interaction about a query on the status of the Budget announcement on the merger of the three general insurance companies", she had said.

The proposed merger of National Insurance Co Ltd, United India Insurance Co Ltd and Oriental Insurance Co Ltd has not been able to move forward due to their weak financial position, official sources said. Since the Budget 2019-20 did not make any provision of funds for insurers, the department of financial services (DFS) will have to seek supplementary demand of Rs 12,000 crore for this purpose, sources said.

But Finance Ministry had made a request for Rs 2,500 crore. General insurers have sought around Rs 2000 crore-Rs 3000 crore each for avoiding falling below solvency ratio, sources said. The three insurers have struggled to maintain the minimum required solvency ratio of 1.5 in recent years.

According to the guidelines of Insurance Regulatory and Development Authority of India, general insurance companies need to maintain a minimum solvency ratio of 1.50. As on March 31, 2019, the solvency ratio of National Insurance Co was 1.04 and for Oriental Insurance Co it was 1.57, while solvency ratio for United India Insurance, as on March 31, 2018, was 1.54.

Oriental Insurance has posted a net loss of about Rs 142 crore in the first quarter of this financial year. At the end of Q4 of the previous financial year, its solvency ratio stood at 1.57. United India Insurance's solvency ratio stood at 1.52 at the end of last financial year, although it was profitable. National Insurance's solvency ratio stood at 1.55, and its net losses touched Rs 2,170 crore. The insurers have appointed management consultant firm E&Y to draw up a roadmap for merger. (IANS)

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***Jammu and Kashmir: 3.5 lakh govt employees get Rs 10 lakh accident insurance cover - Financial Express – 3rd December 2019***



More than 3.5 lakh employees of Jammu and Kashmir government will get aRs 10 lakh personal accidental insurance cover with the administration approving a policy proposal on Tuesday.

The government accorded sanction to the implementation of the Group Personal Accidental Insurance Policy through Oriental Insurance Company Limited for a period of three years commencing from December 2, an order issued by the government said.

According to the order issued by the Finance Department, the policy shall cover an aggregate of more than 3.50 lakh employees of the J&K Government (Gazetted and Non-Gazetted) including employees of PSUs, autonomous bodies,

local bodies and universities, daily rated workers, consolidated, contractual, adhoc employees and contingent paid workers and SPOs.

The sum assured under this policy shall be Rs 10 lakh (Rupees ten lakh only) per employee against payment of a yearly premium of Rs 346 inclusive of GST, it said. The order said all the drawing and disbursing officers (DDOs) of the government shall deduct Rs 346 from all categories of the employees from the salaries of December 2019 on compulsory basis.

Similarly, all the DDOs shall remit an amount of Rs 346 in government treasuries in respect of their employees for being covered under the scheme on or before January 15, 2020, positively and furnish the copy with the list of the employees to the Nodal Officer, Group Personal Accidental Insurance Policy, and Finance Department immediately.

The order reads that inclusion under Group Personal Accidental Insurance Policy shall not confer any rights other than accidental insurance whatsoever as per terms and conditions laid down.

A detailed Memorandum of Understanding (MOU) indicating the terms and conditions and other related details shall be executed between the Government of Jammu and Kashmir and Oriental Insurance Company Ltd.

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***Home safe home here's how to insure it – The Hindu Business Line – 2nd December 2019***

A house is among the most valuable and expensive assets an individual possesses. But like any other investment, property, too, comes with its own risks. Take, for instance, the hundreds of people who lost their houses in the frequent floods the country has been witnessing.

Home insurance, in situations akin to the one mentioned above, protects you — whether you are the home owner or a tenant — from the financial burden of re-building a house or re-purchasing the contents of your home. You can get coverage for your belongings, including domestic appliances, jewellery and furniture.

Home insurance provides coverage against burglary (unauthorized entry or exit or threat by unexpected or forcible means) and theft (misappropriation of contents with intention to deprive the insured permanently), accidental explosion or implosion.

In India, a country prone to frequent floods and other natural calamities, only a few purchase home insurance. Lack of awareness and a general feel that the policies are complicated are some of the reasons for an abysmally low penetration of home insurance.

Here, we decode home insurance policy coverages and products available in the market and how one should choose it.



### **Home insurance basics**

Home insurance acts as a back-up plan if things go wrong with your property. So before you decide to buy a home insurance policy understand the basics.

This form of insurance can be classified into three types. First is a standard fire and peril insurance, which is a basic policy that covers the structure of a house against fire, lightning, explosion, implosion, aircraft damage, riots, strikes and malicious damage, storm, cyclone and earthquake. The second is a content-only policy which covers household contents including appliances, jewellery, other valuables, mobile equipment and third-party liability, and

also provides coverage against terrorism and personal accident. The third is a householder's package policy — a comprehensive cover that protects the structure and contents of the house.

The coverage amount, or sum insured (SI), of a home insurance policy depends on the location of the house, the type of policy and the value of contents. Policyholders have the option to choose from three types of SI.

In the case of structure insurance, policyholders can opt for an SI based on the reinstatement value of the building, in which the value of the building is determined by the reconstruction cost. This cost is usually arrived at based on the surface area of the building (as per the registered sale deed) and the present-day construction cost as per available government data.

Individuals can opt for an SI based on indemnity value, too, where the SI is determined by the reconstruction cost of the building, less depreciation. SI can also be determined on an agreed-value basis (mostly for flats) where it is calculated by multiplying the total square feet area of the building (as per the sale agreement) with the value per square feet (as per the guideline value or the ready reckoner issued by the respective State government). Note that land cost is excluded in the reconstruction cost.

For example, Bajaj Allianz General and SBI General provide all the three policy options. For a structure insurance policy (for an independent house), it is always prudent to consider the cost of construction per square feet as SI, since it will give you the funds required for re-building the house. For a 1,000 sqft house, depending on your location and the market dynamics, if the current construction rate works out to Rs. 3,500 per sqft, you can take an SI of Rs. 35 lakh. If you stay in a flat, you can select the agreed value as SI.

The contents of a house can be covered for their market value (cost minus depreciation) or their reinstatement value (the cost of replacing/reinstating the same kind of content, with or without depreciation).

Insurers also give policyholders an option of factoring in the inflation costs. That is, you can opt for an escalation clause that allows for an increase in the SI every year; but you will have to pay an additional premium. This clause varies with each insurer. Royal Sundaram's Gruh Suraksha, for instance, offers 10 per cent increase in the base SI each year for the entire policy tenure.

## **Know the coverages**

An individual can get a home insurance policy for a period as short as 30 days and up to 20 years. But, in general, insurers offer a policy on an annual basis. Opt for a structure, content or comprehensive home insurance cover based on your requirements. If you are a home owner not residing in the house, it makes sense for you to purchase structure insurance. But if you reside in your own house, you can go for comprehensive insurance. On the other hand, if you are in a rented accommodation or hostel, you can go for content-only insurance plans. Also, in cases where your flat association or your housing colony takes insurance for your structure, you can go for content-only insurance.

Note that some additional covers are also available with home insurance policies, which include keys-and-lock replacement cover, temporary settlement cover, compensation cover for domestic staff if injured during work, and damage to work of art or paintings.

For students and frequent travellers, too, there are some low-ticket home insurance products available in the market. For instance, Digit Insurance's Home Protection plan is available for as low as Rs. 200 for a minimum SI of Rs. 2 lakh. If you are going away on holiday and want to protect only your content, Digit Insurance offers a cover for that as well. The SI and premium amount vary depending on your travel days, type of house (independent house or apartment) and the place of stay (ground floor or top floors).

Here, we look into some common home insurance policies, and explain what a house owner or a tenant can look for.

### **For home owners**

If you are a home owner, you can insure your building with a structure insurance cover. It provides covers against fire, lightening, explosion, implosion, aircraft damage, flood, storm, cyclone, riots and missile-testing operations. Under this cover, a building would mean flats or individual houses used for residential purposes and includes fitted sanitary ware, fittings, piping and similar integral components.

When it comes to cover against earthquake, though it is in-built in most of the structure policies, in some cases you may have to buy it as an add-on cover. Similarly, cover against terrorism is offered as an add-on cover by some insurers. For instance, the Royal Sundaram's Gruh Suraksha plan offers terrorism cover as an optional cover, while earthquake is covered by default in the policy.

Keep in mind that normally, a structure policy does not include compound walls and landscaping, but it can be insured separately by paying an additional premium. For instance, for independent houses, Gruh Suraksha provides a separate SI in addition to the building SI.

Other add-on covers for building insurance (and comprehensive covers) include rental for alternative accommodation if there is damage, hotel stay, loss of rent, expenses in shifting to alternative accommodation, dog insurance, and keys and lock replacement. Insurance companies including HDFC ERGO General, Bajaj Allianz General and Royal Sundaram General offer such optional covers to their policyholders.

Do note that like any other insurance policy, a structure policy also comes with a set of exclusions. It does not cover any damage or defects existing at the time of commencement of the policy or for any damage caused due to lack of maintenance of the property. Damage as a consequence of wear and tear, gradual depreciation or climatic condition are also not covered. It will also not cover for any losses or damage caused due to war, invasion, act of foreign enemy hostilities and revolts.

Under-construction properties are also not covered under structure policies.

Further, a property beyond a certain age (say, 30-40 years) may not be insured by home insurers. For instance, Royal Sundaram General's Gruh Suraksha excludes buildings beyond 30 years old.

### **For tenants**

If you reside in a rented accommodation or are a student in a hostel, you can opt to buy content-only insurance. Content generally means items that are used by you and your family, and not for business purposes. These include household goods such as furniture, fixtures, fittings (includes electrical and

sanitary fittings), home appliances, interior decorations and such similar items. The cover normally excludes jewellery and other valuables, currency and credit/debit cards.

You can choose to calculate the SI either on a reinstatement basis or a market value basis as discussed before. It is better to opt for an SI on a reinstatement basis as the amount received for the damaged or lost item is likely to be higher than the SI on a market-value basis. This is because the market value of a product decreases with the entry of new products over time.

Content insurance provides cover against burglary and theft, and loss and damage of household items. Additionally, you can get covers for jewellery and valuables, crockery glass, baggage, domestic appliances and electronic equipment and personal accident cover (if the insured suffers bodily injury during the policy period).

But many of these covers are in-built in the policy, as in the case of insurers such as SBI General's Simple Home Insurance Policy and Royal Sundaram's Gruh Suraksha. However, in the case of HDFC ERGO's Home Shield Insurance plan, these are offered as add-on covers.

Keep in mind that insurers may have sub-limits (maximum amount to be paid at the time of claim) for some contents covered under the policy. For example, under the content cover of Reliance General Insurance, in the case of burglary/or theft resulting in damage to a house or a safety locker, the coverage for damage to the safe is limited to a maximum of 5 per cent of the SI. Similarly, in the Gruh Suraksha plan by Royal Sudaram, the maximum SI for contents is Rs. 15 lakh (gold plan) with 10 per cent of SI limited to each item.

Content insurance, too, has exclusions, but it varies with each content and insurer. For instance, the Gruh Suraksha policy does not cover appliances such as television, washing machine, etc, for electrical and mechanical breakdown if the appliances are over 10 years old.

Some of the other exclusions in a policy are loss or damage to livestock, motor vehicles, cash, bullion and deeds. It also does not cover any damage caused due to wear and tear. If you are home owner residing in your own house, it is better to opt for a comprehensive cover which includes both content and structure. Additional covers available under both policies are available under a comprehensive cover, too.

### **Your choice**

When you decide to purchase home insurance, you should look for not just the coverages and the SI, but also the insurance premium and the 'excess' clause.

The premium amount on home insurance policies depend on the SI and the type of policy opted. For instance, in Bajaj Allianz General's All Risk Plan, for a structure policy of Rs. 50 lakh, the premium works out to Rs. 2,242 per year (including GST), but for a comprehensive policy, the premium works out to Rs. 8,142 per year (including GST). Similarly, for the same SI in the case of HDFC ERGO's Home Shield plan, the structure policy premium works out to Rs. 1,654 per year (including GST) and a comprehensive cover is available for Rs. 9,088. While Bajaj Allianz's plan is inclusive of covers such as break-down of appliances, loss of rent and alternative accommodation, these are available as add-on covers in HDFC ERGO's plan.

The excess clause allows a policyholder to get a discount on the insurance premium. For this, the policyholder has to agree to pay a part of the claim (known as excess/deductible) to the insurer at the time of the claim.

For instance, in Bajaj Allianz's All Risk policy, policyholders can opt for an excess clause and get a discount on the basic premium for the building's structure. You can choose from an excess of Rs. 5,000-50,000 for a each and every claim; the discount on the base premium varies correspondingly from 5 to 34 per cent. If, for instance, you opt to pay Rs. 10,000 of the claim you get a 10 per cent discount on the premium, and for Rs. 50,000, you get a 34 per cent discount.

Similarly, for insuring the contents in your house, you can get a discount on the base premium, depending on the excess you agree to pay for each and every claim. Further, a policyholder gets to reduce the premium outgo if he/she takes a home cover for a longer tenure (beyond one year). Insurance companies offer discounts of 7-50 per cent on the total premium.

*(The writer is Bavadharini KS.)*

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Source

***General insurers see 16% premium growth in April to October period - Money control - 30th November 2019***



General insurance companies saw a 16 percent growth in gross direct premiums for the April to October period as compared to a year ago. The non-life companies wrote premiums worth Rs 1.11 lakh crore for the period, with standalone health insurers seeing the highest growth rate.

Health insurance companies saw a 34.3 percent year-on-year (Yoy) growth in premium collection to Rs 7,192.17 crore. Among the individual companies, Star Health Insurance was the largest player with 2.95 percent market share and gross

premium of Rs 3,285 crore. The insurer saw a Yoy growth of 33.9 percent.

The other general insurers (except specialist insurers) saw a 15.3 percent Yoy growth to Rs 97,106.3 crore. Here, the public sector insurers held 38.2 percent market share (of 87.12 percent) while the rest was held by private insurers.

New India Assurance continued to be the largest general insurer in the country collecting gross written premiums of Rs 16,054.34 crore for the April to October period and showing a 14.5 percent YoY growth. It had a market share of 14.4 percent at the end of October 2019 on the basis of premiums.

Among the private sector players, ICICI Lombard General Insurance was the largest player with Rs 7,803.7 crore gross written premiums. While the insurer held a market share of 7 percent, for the April to October period ICICI Lombard saw an 8.8 percent de-growth in premium collection.

On the private sector side, new-age insurers saw a large jump in premium collections. Acko General Insurance saw a 279 percent Yoy growth in premiums to Rs 216.2 crore for the April to October period, while Digit Insurance saw a 241.3 percent Yoy growth to Rs 1,216 crore.

With respect to the private sector, DHFL General Insurance, whose parent DHFL is in the midst of a Rs 83,873 crore debt crisis, saw a 43 percent Yoy decline in its gross written premium to Rs 114.6 crore in the seven-month period.

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***IRDAI proposes to reduce sum insured on standard health indemnity insurance to Rs 5 lakh - The Economic Times - 29th November 2019***

The more options you have to choose from, the more difficult it becomes to make the right decision. This is especially true when it comes to financial products like insurance. When it comes to insurance, there is so much information and agents who push products that will get them the most commission. To combat this, the insurance regulator has proposed to "mandate all general and health insurers to offer a standard

indemnity-based health insurance product with a sum insured ranging from Rs 1, 00,000 to Rs 5,00,000 on individual as well as family floater basis."



The Insurance Regulatory Development Authority of India (IRDAI), on Wednesday, stated that it has proposed this to allow the public to choose a suitable health insurance policy which provided coverage to basic hospitalisation charges. The only differential of this standard product, the regulator stated, would be the premium rates that are charged by various insurers.

It seems to be an endeavor of the insurance regulator to standardise health insurance products so that it becomes easier for someone to choose the right policy based on their needs. Back in February of this year, IRDAI, in its Draft Guidelines on Standardization of Individual Health Product, had mandated all general

insurers to offer a standard indemnity-based health insurance product with a basic sum insured ranging from Rs 50,000 to Rs 10 lakh. The proposed standard health product will have to be offered on indemnity basis only.

Kapil Mehta, CEO, Secure Now.in said, "The proposed range of Rs 1 to Rs 5 lakh is fine because the product is meant to cater for entry level health insurance, as lower sum assured means lower premium to pay for the policy. "However, this does not prevent insurers from offering much higher sum assured and, indeed, there are several insurers that offer Rs 50 lakh or higher of sum insured. The standardised product is an addition to the current portfolio of health insurance products," he said.

According to the draft proposal guidelines issued in February, the standard health product shall offer only the following mandatory covers:

**Hospitalisation expenses:** The hospitalisation expenses shall cover the following;

- Room, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home
- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses. (Expenses on Hospitalization for a minimum period of 24 hours only are admissible. However, this time limit will of 24 hours shall not apply when the treatment does not require hospitalization as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)
- Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
- Expenses incurred on treatment of Cataract subject to sub limits, if any, based on sum insured
- Dental treatment necessitated due to an injury
- Plastic surgery necessitated due to disease or injury
- Domiciliary Hospitalization

**AYUSH treatment:** Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines shall be covered subject to fixed and standard sub-limits based on Sum Insured.

**Pre-hospitalisation** medical expenses incurred for a period not less than 30 days prior to the date of hospitalization shall be admissible.

**Post-hospitalisation** medical expenses incurred for a period of not less than 60 days from the date of discharge from the hospital towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever

required and recommended by the Hospital / Medical Practitioner, where the treatment was taken, following an admissible claim shall be included.

**Cumulative Bonus (CB):** Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy period (where no claims are reported), provided the policy is continuously renewed without a break subject to maximum of 50% of the sum insured (excluding CB accrued) under the current policy period.

**Wellness Incentives:** To enable the individuals to lead longer, healthier and more productive lives, the following wellness features shall be made available to all the insured persons by duly complying with the provisions of Regulation 19 of IRDAI (Health Insurance) Regulations, 2016 and the applicable guidelines notified there under.

*Health Check-ups and Consultation services:* Under this cover, the insured person shall be made available an access to the health consultations across the network providers or other empanelled hospitals of the insurer, for getting periodic consultation of at least once in a policy year.

*Disease Management:* Under this cover, every insured person shall be provided an access to the professional medical services for bettering the health profile. As part of post-hospitalization services follow up care shall be made available, as part of Disease Management. Insurers may also provide other suitable services under this programme.

*Fitness Activities:* Under this cover, insurers shall provide parametric indices based on fitness regime being followed by insured person, during the policy tenure and reward mechanism shall be designed so as to incentivize the policyholders to continue with the fitness regime.

*Outpatient consultations or treatments:* Under this programme, insured person shall be provided services of outpatient consultations or treatments periodically or based on the pre-determined triggers contingent upon the health of the insured. No deductible features are permitted under the base cover. A standard Co-Pay shall be offered. Add-ons or optional covers are not allowed to be attached to the base health cover under standard health product policy.

*(The writer is Navneet Dubey.)*

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## HEALTH INSURANCE

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***India's health insurance lacks data for assessing the exact health risks - Express Healthcare - 4th December 2019***



*Dr Kishore Kumar, Founder Chairman and Neonatologist, Cloud nine Group of Hospitals opines on the importance of health insurance and the benefits to the people who have themselves covered with proper knowledge of the scheme*

Healthcare in India is one such sector which is undergoing enormous transition. There is an increased income and health consciousness among the majority of the classes, price liberalisation and the introduction of private healthcare financing that is driving the change. Despite this, most Indians don't have health insurance because many are eternal optimists – always think that the worst doesn't happen to them and God will protect them. While cutting-edge technology has brought tremendous improvements there is a lot of buzz now for inclusion of new set of treatments such as fertility under the purview of medical insurance covers. Currently, both private and public health

insurers do not include fertility procedures and treatments under their cover plans. But is that all? In my view, the condition of health insurance is pitiful as many parts of the population does not use health insurance to finance their medical expenditure.

Over the years the insurance industry in India has grown along with the country's economy with several insurance companies in the country are expanding their operations, across both the public and private sector and offering more specialised covers to patients but it is sad to note that India still needs to take examples from the western world where insurance is 'made compulsory' in many aspects – for example: in Australia – you cannot buy a house without house building insurance whereas in India – majority of houses don't have insurance. Similarly health insurance is compulsory in Australia for people earning more than \$100,000 per annum though the Government provides healthcare free for all, this way to reduce the load on the government hospitals. In India currently, while health insurance is taken by people who are employed or employee provided insurance and it is still in infancy and not more than 15 per cent people have insurance.

### **What is currently lacking in India's health Insurance**

Currently, India chooses to have a healthcare payment system which is somewhere between the American and German systems. The American system of healthcare is a private, for profit system where the owners of insurance companies and the providers are largely privately owned. Premiums are collected from the insured, their employers and, for certain diseases. The amount of premium is based on actuarial risk, and selections and refusals do occur; reimbursement to providers is based on costs and a per procedure basis. The nature of subsidy is from the healthy to the sick; choice of procedures and providers is governed by health management organisations. Co-payments are high, and there is competition between different insurers. Regulation of the schemes is largely governed by good business practice with minimal interference from the government. This system is currently groaning under the weight of progressively high costs and is being subjected to introspection and reform. About 70 per cent of the population is covered by one or the other scheme.

One reason why pricing anomalies prevail is that insurance companies lack the data they need to assess health risks accurately. In addition, today's insurance products work on an indemnity basis i.e. they look at health only as a series of payable events. It covers hospitalisation costs, which could be catastrophic as it gives precedence to tertiary level healthcare and encourages inpatient treatment. This is coupled with the fact that in the absence of any costing mechanisms, there is difficulty in calculating the premium, and the easiest and most illogical way wins viz, the reverse auction system or the lower bid.

### **Need for innovation**

The number of uninsured in India is high. While the amount of government spending on healthcare and health insurance is gaining impetus, there is a need to increase the natural focus of the private sector for developing innovative solutions that encourage more Indians to purchase health insurance and to recognise the value of preventive rather than emergency care. Notable innovations are also occurring in terms of both digital distribution and creating more effective underwriting pools. With increasing healthcare costs, close network products are expected to be more effective in driving wellness and healthcare. This will also be aligned with the government's vision on universal health insurance. Health saving and outpatient department (OPD) are two other opportunities where India has a good opportunity in coming years, considering the rising costs of healthcare. In India's rural areas, however, expanded government coverage will likely be required to care for large numbers of poor citizens, and educational efforts will still be required to explain the benefits of health coverage to those who have never benefited from it.

People who have insurance also don't understand the 'small print' and exclusions – hence this is one of the reasons when claims come, most people would take insurance looking at the premium but not seeing the details. As a general rule, most insurers even in the US and Australia – exclude maternity services for one year from insurance and dental for two years – these are standard exclusions. Here people take insurance to 'claim' expenses just before hospital admissions – hence leading to unnecessary 'fights' with poor understanding.

In India, people have been spoiled by the thought of that a 'life insurance policy' is equivalent to a health insurance. The general principle is if we take insurance, what will we get back? Insurance meaning in westerners is 'peace of mind' – that if something goes wrong, you are 'covered' – so the basic thought process of Indians are different, which makes the number of people taking out insurance will be less. This makes it unsustainable. The principle reason behind this is that people in India lack the knowledge of the simple steps to take to secure our healthcare costs. There is a need to invest in 'counseling' in hospitals than just taking them on their panel. Many hospitals in India are not experienced enough in India to explain the meaning of exclusions and claims to patients before admissions. No one in the industry is taking responsibility to develop knowledge and awareness of health insurance amongst the public; nor is specific expertise in health insurance being developed within the private sector, an expertise that is essential to dealing effectively with providers of healthcare services.

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Source

***PMJAY is way forward to save poor from adverse health effects; here's what govt must do - Financial Express - 4th December 2019***



The National Statistical Office released a report 'Social Consumptions in India: Health' on 23 November 2019 which gives estimates of ailing persons, hospitalizations and expenditure incurred on treatment. The report is based on a sample survey conducted from July 2017 to June 2018 covering about 1.14 lakh households across the country. According to the survey, 7.5 percent of the people suffered from any ailment during 15 days preceding the date of survey. This means that during the said reference period of 15 days, over 10.1 crore people were ailing in India out of the total population of about

135 Crore. The average per ailment treatment cost (as OPD) was estimated at Rs. 636 indicating that an amount of Rs. 6440 Crore was spent on the treatment in a 15 days period or about Rs. 157, 000 crore in a year.

The survey also estimated that 2.9 percent of the people were hospitalized during July 2017-June 2018, meaning that 3.92 crore hospitalizations occurred during this period. The estimated treatment cost per hospitalization estimated by the survey was Rs. 20135 indicating that an amount of about Rs. 79, 000 crore was spent on hospitalized treatments. The annual OPD and hospitalization treatment cost comes to a whopping Rs 2.36 lakh crores, approximately 1.2% of GDP.

There is a large number of poor in India who cannot afford the OPD and the hospitalization treatment costs. It is a known fact that poverty is a major cause of ill health and also a barrier to access to health care. The out of pocket spending not only includes spending on doctors' consultations, diagnostic tests, and medicine, but also the transportation costs and informal payments to providers. The illness causes considerable loss of income to the ailing persons and the family members who may have to stop working to take care of the ill relative. The poor families are forced to sell assets to cover medical expenses and to borrow at high-interest rates leading to their indebtedness.

The country needs a strong health care delivery system to protect the poor from the potentially catastrophic effects of out-of-pocket health care expenditure. Both the public and private sectors need to be involved in the delivery of health services as 70 percent of the OPD treatments and 58 percent hospitalizations occurred in the private sector, according to the survey.

The government has taken many steps to remedy the situation. One such step is to establish 1,50,000 Health and Wellness Centers (HWCs) across the country by 2022. At these HWCs, one mid-level service provider (Community Health Officer) will be positioned along with Multipurpose Female Worker and

ASHAs. These HWCs, mostly in villages or urban slums, will provide OPD and extension services to the population. These HWCs will also encourage people to adopt healthy habits like regular exercise and Yoga.

In order to give protection against the hospitalization expenditure, the government has launched the Pradhan Mantri Jan ArogyaYojna (PMJAY) which will cover about 50 crore rural and urban poor. PMJAY provides cashless and paperless access to hospitalization services and covers medical and hospitalization expenses for almost all secondary and tertiary care procedures.

The scheme is being implemented in 32 States and Union Territories. So far about 21 thousand public and private hospitals have been empanelled and 64 lakh people have got the benefit. Based on the hospitalized cases so far, the treatment cost per hospitalization comes to Rs. 16108 compared to Rs.20135 estimated by the NSO. In order to cover 50 crore targeted poor, it is estimated that an amount of Rs. 23357 crore is required annually by the government, compared to the 2019-20 budget provision of Rs. 6400 crore.

For the success of the PMJAY, it is important that the eligible patients requiring hospitalization get immediate hospitalization approvals and timely payments are made to the empanelled hospitals for the services rendered. The scheme needs to be operationalized fully to cover all the intended beneficiaries. Further, for those not covered under PMJAY (middle class), there is a need to standardize the health insurance premiums so that they can get the insurance coverage at uniform rates. To begin with, the insurance companies and hospitals can be asked to strictly follow the PMJAY empanelled hospital rates.

Other steps to reduce out of pocket expenditure include regulating irrational drug prescriptions, diagnostic and drug prices, opening more PM Jan Aushadi Stores, strengthening referral systems, improving the quality of health providers, providing services closer to the habitations of the poor, etc. The availability of doctors at health facilities, empathy towards patients, availability of drugs and diagnostics requires special attention to enhance the credibility of the public health facilities.

The challenge of malnutrition among the poor also needs to be addressed though the Government has recently launched the National Nutrition Mission to improve nutritional outcomes for children, pregnant women, and lactating mothers. While the government has launched many programmes, there is an urgent need to enhance the credibility and efficiency of delivery systems to save the poor from adverse ill health effects.

*(The writer is Rattan Chand.)*

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Source

***Over 300 hospitals get show-cause notices for submitting forged claims under Ayushman Bharat scheme - The Economic Times - 4th December 2019***

Over 300 hospitals have been served show-cause notices and de-empanelled, and penalties of over Rs 3 crore have been levied on them for submitting forged claims under the Ayushman Bharat Health Insurance Scheme, government told Rajya Sabha on Tuesday. Some instances of creation of fake cards and submission of manipulated/forged claims under the Ayushman Bharat - Pradhan Mantri Jan ArogyaYojna (AB-PMJAY) have come to the notice, Minister of State for Health Ashwini Choubey said.

These instances, he said, have been suitably dealt with by the respective state governments.

"More than 338 hospitals have been served show-cause notice/suspended/de-empanelled in different states and penalties of over Rs 3 crore have been levied on errant hospitals so far," he said.

Also, a close watch is maintained on wrongful enrolments of beneficiaries and 3,785 common service centres and 'Pradhan Mantri Arogya Mitra' IDs have been deactivated in 21 states, he added.



Elaborating the actions taken by the Centre to prevent abuse of the scheme in hospitals, Choubey said a vigil is being maintained on utilisation of data through real time dashboards to identify suspect cases for over utilisation.

Suspect cases and entities are flagged based on different fraud control triggers and results are shared with state agencies for further investigation. Besides, regular joint medical audits along with state anti-fraud units (SAFU) of hospitals, both random and purposive, are conducted to identify any wrongdoing, he said.

All admissions under the AB-PMJAY require pre-authorisations from respective state health agencies and a comprehensive set of anti-fraud guidelines have been issued from the time of launch of the scheme, the minister said.

Regular anti-fraud advisory notes are issued to all states advising them on measures to be adopted to prevent, detect and deter fraud, he said.

Packages prone to fraud and abuse are reserved for public hospitals or need mandatory pre-authorization and require detailed documentation before claims are paid.

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Source

***64 lakh have benefited from Ayushman Bharat so far - The Economic Times - 4th December 2019***

Palliative chemotherapy for cancer implants for hip fractures and angioplasty, in that order, accounted for the highest number of hospital admissions among the top 10 tertiary care procedures under Ayushman Bharat, data up to the end of last month showed. In terms of broad categories, heart-related ailments, including bypass surgery and heart attack management, dominated the list of procedures both in terms of the highest average cost per admission and in the total number of admissions.

They were followed by oncological and orthopedic procedures. Neo-natal packages were the only other category among the top 10, which between them accounted for close to 2.8 lakh admissions. As of November 28, 2019, 63.7 lakh beneficiaries had availed of hospitalisation services and almost 20,000 public and private hospitals across India have been empanelled under the scheme.

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Source

***Ayushman Bharat: UP CM told to treble daily treatments - The Economic Times - 3rd December 2019***

A laggard Uttar Pradesh has been advised “to raise the game” in the implementation of the Ayushman Bharat Yojana and triple the number of daily treatments under the scheme at present in the most populous state of the country.

Ayushman Bharat CEO Indu Bhushan travelled to Lucknow on Monday and met UP Chief Minister Yogi Adityanath and Chief Medical Officers (CMOs) and Chiefs of Medical Colleges from across UP to suggest measures that UP can adopt to increase the penetration of the medical insurance scheme in the state. “UP is reporting about 1,000 treatments under the scheme daily which is less considering there are over a Crore beneficiary families in UP.

We have asked if the level can be raised to 3,000 treatments daily. The public hospitals need to be more actively involved while we will work on early payments to private hospitals to make them more

enthusiastic about the scheme. The CM has promised all cooperation to us and said he will pass instructions to officials for gearing up to the task,” Ayushman Bharat CEO Indu Bhushan told ET.



ET had reported on November 22 that out of claims worth Rs 7,602 Cr raised country-wide under the scheme till November 20, Uttar Pradesh raised claims worth only Rs 247 Cr and reported just 2.3 lakh hospital admissions out of nearly 62 lakh admissions country-wide. This was despite 1.18 Cr potential beneficiary families of the scheme in UP. Bihar fared worse than UP under the scheme.

It was pointed out on Monday to the UP government that some district hospitals in UP had not done even one treatment under the scheme for the last one week and that the public hospitals were not simply doing enough. It has been suggested that public hospitals in each district be

ranked under the scheme to foster competition and do a screening of all patients going to the public hospitals so that they can be given treatment under the scheme. Only 2,312 hospitals in UP are empanelled under the Ayushman Bharat scheme so far including 842 public hospitals and 1,470 private hospitals. About 2,628 Health and Wellness Centres are operational in UP under the scheme so far.

*(The writer is Aman Sharma.)*

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Source

**Settling Health Insurance claim from multiple insurers: Here's some good news for you - Financial Express - 2nd December 2019**



**Health Insurance Regulations 2019:** The Insurance Regulatory and Development Authority of India recently notified the Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019. It has introduced several new provisions, including a call to the insurers to promote wellness amongst the policyholders as per the guidelines of the authority from time to time. “Insurers may Endeavour promoting wellness amongst policyholders of health insurance as per the guidelines as may be specified by the Authority from time to time,” says one of the provisions in the notification.

There are a few more subscriber-friendly changes in the regulations. Here we take a look at two of them and what they mean for the insured persons:

**1. Clause 1 of the notification says:** “For clause (2) of sub-regulation (ii) of regulation 24, the following clause shall be substituted, namely: – “Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy/policies so chosen.”

Explaining the significance of this clause for policyholders, Amit Chhabra, Head- Health Insurance, Policybazaar.com, told FE Online that the above is a good option for the customer as they will have the option of settling the claim from multiple insurers on a certain condition.

“This is a good option for the customer as they have the option of settling the claim from multiple insurers providing the policyholder discloses the existing health insurance covers. This benefit comes in

handy in case of multiple policies like if someone has an employer-provided corporate policy along with an individual policy,” he said.

**2. Clause “k” of the notification says:** “. In sub-regulation (i) of regulation 23, the words “The insured shall be informed in writing of any underwriting loading charged as filed and approved under the Product Filing Guidelines over and above the premium and specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.” shall be omitted.”

Chhabra said, “Loading means an additional premium charged to the customer because of any prevailing conditions as defined by the insurance company. Loading basically provides cover to a ‘risky’ individual.” He further said that the new provision is good for policyholders as it will give the customer “a lot of clarity on how much coverage they will receive and how much loading amount they will be charged as a part of the premium. This is done only with the consent of the customer.”

*(The writer is Rajeev Kumar.)*

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Source

***State-sponsored insurance may not be the best idea - Financial Express - 2nd December 2019***



A new paper by researchers at the National Institute of Public Finance and Policy shows that basic healthcare will suffer after implementation of large government-sponsored health insurance schemes like Ayushman Bharat, especially when the government must contend with a fiscal strain.

The researchers examined health insurance schemes implemented by the governments of undivided Andhra Pradesh, Karnataka, and Tamil Nadu between 2004-2017. In all three states, the schemes started with covering just the poor, and were gradually extended to other sections of society.

Insurance spending cast a shadow on other public health spending, including on primary and secondary healthcare—this increases dependence on private healthcare, which, in turn, pushes up the costs of insurance schemes. The Centre, which is mulling over insurance-based universal healthcare coverage, should take note.

The government must vastly expand its healthcare spend; public spend on healthcare is just 1.13% of the GDP while the total spend is around 4%, indicating, against a backdrop poor health insurance penetration (total health insurance premium, including government, private, and standalone insurance, stood at just Rs 37,000 crore in FY18), massive out-of-pocket expenditure.

But, as the NIPFP study shows, public-funded health insurance schemes may not be the best idea, more so, given the high chances of fraud as Rajasthan’s Bhamashah experience shows. Instead, the government must increase healthcare offerings, from infrastructure to direct spending—Delhi offers a template, having made diagnostics and surgery free at private hospitals (the government will pay the hospitals), it is now making ICU beds free, all subject to referral by a government hospital.

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Source

***Chhattisgarh: A single healthcare scheme to raise efficacy, accountability - The Indian Express - 2nd December 2019***

The Chhattisgarh government recently announced that it was shifting from an “insurance model” to a “trust model” in the field of healthcare and that as many as six insurance schemes run by the state government and the centre would now be subsumed in a single new healthcare scheme, which would be

run by the state government. The idea, the state government said, was to fix accountability on the state health infrastructure itself, and to lessen the amount of public money that was going to the private sector under the insurance model.

On November 15, after a meeting of the state cabinet, a press statement stated that the state was entering a “new phase of healthcare”. Accordingly, a new scheme — Dr Khubchand Baghel Swasth Sahayata Yojana — will provide coverage up to of Rs 5,00,000 per year to not only Pradhan mantri Jan Arogya Yojana families but also to Pradhnikta & Antoyaday Ration cardholders. The new scheme will increase the beneficiary family count from 42 lakhs to 56 lakhs families. “The scheme will be implemented in Trust mode (assurance),” the cabinet release said.



Health Minister TS Singhdeo told The Indian Express that the primary aim is to fix accountability on the healthcare system itself and to increase the financial efficacy of the department. “The job of the minister must be to increase delivery through the pyramid structure

which has mitanins (who are the ground-level health workers) at the base and medical college doctors at the top... We took this up as a challenge on several fronts. One could be the financial aspect. Second is the better use of public funds. And the third is (the) deliverables,” he said. Singhdeo explained that the state had as many as six overlapping schemes where the services were being delivered. “What was being provided by one scheme was also being provided by two-three schemes,” he said, claiming that this has been streamlined.

The minister also said that under the existing “insurance model” there were suspicions of misuse of funds. “In our system, we are fixing accountability on ourselves,” he said.

On the financial benefits the new scheme will accrue, Singhdeo said, “We have not asked for a paisa more than the Rs 845 crore that is the budget for the insurance schemes as well as Rs 277 crore from the Centre. This amount of money, where is it going? As we saw it, straight away 15 per cent of public money was going into the administrative expenses of the insurance company. This was around Rs 100 crore. We want to minimise that. So within the same budget, we make a saving. Take on the responsibility to deliver and have the funds for strengthening your public infrastructure. Part of the 15 per cent will go to the government’s administrative costs but it will not be more than half, so half you will be saving.”

*(The writer is Dipankar Ghose.)*

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***Looking to purchase a diabetes insurance plan? Here are key things to know - Times Now - 1st December 2019***

Diabetes is becoming a lifestyle-related disease. It has been noticed that individuals in the 20-30 years age bracket have increasingly been getting affected by this disease. A business daily citing claims analysed by Bajaj Allianz said that between 2016 and 2019, diabetes-related claims have risen by 120%. The increase is even more at 164% in the 20-30 age brackets.

A diabetic is required to spend between Rs 3,000- Rs 4,000 per month on his medicins, tests, insulin and diet. According to Bajaj Allianz General Insurance. The average claim size for diabetes-related hospitalisation is Rs 80,000. Given the higher cost of treatment of diabetes, one needs to be prepared to deal with the economic impact of the disease. You need to have an insurance plan that covers diabetes-related expenses.

Worth mentioning here is that if you are already diabetic, regular health insurance plans may be denied to you. Even if a company agrees to give you cover, it will charge up to 25% additional premium for the general cover. If you go for a diabetes-specific plan then it will be more expensive. For example, if you are a 40-year-old male person living in a metro city then a general health plan for a cover of Rs 5 lakh will cost you between Rs 6,500-Rs 8,500 whereas a diabetes-specific plan will cost you anywhere between Rs 12,000-Rs 14,500.



Experts say it is better to buy a generic family floater plan, that covers all the members of your family, before you or your family members are diagnosed with this disease rather than buying a diabetes-specific plan after being diagnosed as a diabetic. But if you buy a diabetes health insurance plan, there is no waiting period. These are designed for people

who are already suffering from diabetes. Any diabetes patient between the age of 18 and 65 can buy this plan.

A diabetes policy can be taken on an individual or family floater basis. Some plans come with two options. Under one option, pre-acceptance medical screening is compulsory, while in the other option, there is no pre-acceptance medical screening. While in the first option, there is no waiting period, in the second option, there could be a waiting period of 15 months.

Some diabetes plans also cover out-patient expenses for medical consultations, diagnostic tests, medicine and compensation for the accidental death of the insured person. In India, most of the general insurance companies are now offering diabetes health insurance plans. Some are also offering diabetes add on cover on regular health insurance plans. One can do a comparison of all the available diabetes plan online and choose the one that is best suited for him.

[TOP](#)

Source

## MOTOR INSURANCE

***Six ways your motor insurance policy is set to change. Here's how it could affect you - The Economic Times - 3rd December 2019***



Your motor insurance policy – particularly the own damage component – could soon look very different. The Insurance Regulatory and Development Authority of India (Irdai) has released an exposure draft to revisit the current motor own damage product structure.

Several recommendations of the working group, comprising industry executives, to reexamine the product have been accepted. Here are six key changes you need to be aware of:

### **Customisable premiums**

The most-discussed recommendation, factoring in telematics to compute premiums, has been incorporated in the proposal. “A central repository of telematics data can be created where data from various sources flows to create a common pool. The Insurance Information Bureau of India (IIBI), which acts as data repository for insurance companies, can manage the data and its protection,” the working group recommended.

“Pay as you drive and pay how you drive covers could be offered based on data gathered. Insurers can consider developing products that factor in kilometers and driving behaviour,” says Adarsh Agarwal, Appointed Actuary, Digit General Insurance Ltd. This could mean those exhibiting good driving behaviour— as captured by telematics devices or mobile apps —will be rewarded by way of lower premiums. Conversely, rash drivers will have to shell out more.

**Friendly depreciation rules**

Vehicle age-based depreciation will be introduced for partial loss claims. “Depreciation calculation for various parts and material—glass, fibre, plastic— confuse lay users. The new proposals will make the rules easier to understand,” says Sajja Praveen Chowdary, Business Head, Motor Insurance, Policy bazaar. com. A standard grid has been proposed for depreciation on all parts. “This will remove all ambiguity and subjectivity in claim settlement,” says Saroj Sathpathy, ED-Reinsurance and Weather, Salasar Services (Insurance Brokers).

**New sum insured computation**

The Irdai has outlined new sum insured/insured declared value (IDV) calculation rules for private cars and two-wheelers.

In case of older private cars, the sum insured will now represent the manufacturer’s current listed price, minus adjusted age-wise depreciation under one of the options suggested by the working group. Under another option, for new cars, for the initial three years, the sum insured will cover current day on-road price of the vehicle including invoice value. It will also have to factor in road tax and registration charges as well as value of accessories. You need not buy the return to invoice add-on, it will be built into the base policy.

“At present, if you were to buy a car for Rs 10 lakh, and have paid an additional Rs 1.5 lakh towards road taxes and registration, your IDV will be limited to Rs 10 lakh. Under the proposed regime, the sum insured will be Rs 11.5 lakh in the first three years,” says Chowdary. After three years, the sum insured will take into account the new depreciation table. The depreciation will range from 40% after the third year to to 60% up to the seventh year. Beyond the seventh year, the sum insured shall be arrived at a mutually agreed value between the insured and the insurer.

Calculation of depreciation on parts to be standardized

<b>Age of the Vehicle</b>	<b>Depreciation on all parts (including Glass) (%)</b>
Up to one year	10
1-2 yrs	20
2-3 yrs	30
3-4 yrs	40
4-5 yrs	50
5-6 yrs	55
6-7 yrs	60
Over 7 yrs	65

## Calculate the sum insured for your car

Ex-showroom price ₹10,00,000		Registration charges, taxes etc. ₹1,50,000		Total Invoice value ₹11,50,000	
SUM INSURED					
YEAR	CURRENT*	OPTION A**	OPTION B#		
Brand new vehicle	9,50,000	9,50,000	11,50,000		
1st renewal	8,50,000	9,00,000	11,50,000		
2nd renewal	8,00,000	8,00,000	11,50,000		
3rd renewal	7,00,000	7,00,000	6,90,000		
4th renewal	6,00,000	6,00,000	5,75,000		
5th renewal	5,00,000	5,00,000	5,17,500		
6th renewal	Insurer decides	4,50,000	4,60,000		
7th renewal	Insurer decides	4,00,000	Insurer decides		

Source: Policybazaar.com. Note: Total invoice value assumed to be Rs 11.5 lakh (ex-showroom price Rs 10 lakh, registration charges and taxes Rs 1.5 lakh); sixth renewal onwards, the IDV/SI will depend on insurer. \*Current = Depreciation on ex-showroom price. \*\*Option-A (proposed) = Depreciation on ex-showroom price. #Option B (proposed) = Depreciation on total invoice value

### Better flood damage cover

A base motor policy today does not cover damage to engine due to water ingress. Policyholders have to buy a separate add-on. "If draft norms are finalised in their current form, it will be covered under the base policy. Damage due to oil leakage, however, will continue to be covered under engine protect," says Chowdary.

### No claim bonus slabs

Irdai has proposed a standard grid for no claim bonus. "Right now, each insurance company has its own NCB slabs for long-term policies. This can become a task when a customer wants to move from one insurer to another. A standardised NCB grid will help in resolving this issue," says Agarwal. NCB is linked to the policyholder. The insured can transfer the NCB to the new vehicle he purchases. If the draft norms are implemented, NCB to the new vehicle he purchases. If the draft norms are implemented, NCB can be claimed on the next vehicle if the vehicle is of the same class as the one on which the NCB was earned.

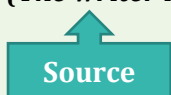
### Standardised deductibles

Current compulsory deductibles – the amount that the policyholder has to bear before the insured processes the claim – will be renamed standard deductibles, and a set of revised deductibles has been proposed. For example, in case of claims, including total loss, 1% of sum insured or Rs 500, whichever is higher, will have to be borne by the two-wheeler policyholder. In case of other vehicles, the deductible will be 1% of sum insured or Rs 2,500. The deductible cannot exceed Rs 35,000.

### Rules for total loss

In cases of total loss and theft claims, the insured will have to get the registration certificate of the vehicle cancelled. The claim will be settled only after the insured surrenders the cancelled RC.

(The writer is Preeti Kulkarni.)



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## ***Soon car owners may have to pay insurance premium for co-passengers - Times Now - 1st December 2019***



If you are a car or other vehicle owner, you could soon be asked to pay insurance premium to provide a medical expenses coverage of up to Rs 25,000 for the co-passengers travelling with you in your car. The Working Group of Insurance Regulatory and Development Authority of India (IRDAI) has recommended that all passengers travelling in a motor vehicle should have Rs 25,000 medical expenses coverage to meet the cost of medical treatment arising out of an accident. The insurer will set the premium accordingly.

“All the occupants travelling in motor vehicles shall have Rs. 25,000/- medical expenses coverage arising out of an accident to the insured vehicle covered

under the basic policy and appropriate premium for this shall be charged by the insurers,” IRDAI’s Working Group on Product Structure for Motor Own Damage Cover has recommended in a draft proposal.

As per the registered seating capacity of each vehicle, the Working Group has proposed to have inbuilt accidental medical expenses coverage (indemnity basis) for all occupants travelling in all motor vehicles.

As per the recommendations, the benefits of the new proposal, if accepted, will not be paid when the actual number of passengers travelling in the insured vehicle is more than the registered capacity at the time of occurrence of such accident. For example, a car has a registered seating capacity of four (including the driver). If the car faces any accident while five passengers were travelling in the car, then this medical expenses claim will not be paid to the claimant.

### **Exclusions**

As per the recommendations of the Working Group, some cases will be excluded from the benefit of the new proposal. Here are they

- Expenses towards psychosomatic disorders of any kind, whether caused or accentuated by accident or otherwise.
- Expenses for any physiotherapy treatment.
- Expenses related to a sickness, pre-existing disease, disease or medical disorder not directly consequential to the accident.
- Expense not supported by an original and valid bill/receipt and related prescription of the attending medical practitioner/hospital/ nursing home.
- Expenses when the treatment is started after 24 hours from the date of the accident
- Expense arising or resulting from or traceable to intentional self-injury, suicide or attempted suicide physical defect or infirmity.
- Expense arising or resulting from or traceable to an accident whilst the insured or any person driving the vehicle with the knowledge and consent of the insured is under the influence of intoxicating liquor or psychotropic or narcotic substances.

The Working Group has also recommended many other amendments to existing insurance rules of both passenger and commercial vehicles. These recommendations have been put in the public domain for comments from stakeholders by December 16, 2019.

Source

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## ***How IRDA's proposal to use telematics for motor insurance may impact your premium - Times Now - 30th November 2019***



Soon, your driving habits will have a bearing on your motor insurance premium. The Insurance Regulatory and Development Authority of India (IRDAI), in a draft proposal has recommended to adopt 'Telematics for Motor Insurance'.

According to the insurance regulator's draft proposal, a central repository of telematics data can be created where data from various sources will flow to create a common pool. Telematics will monitor your vehicle using Global Positioning System (GPS)-enabled devices that will be fitted in your vehicle. This device will monitor and capture data related to your real-time driving habits, the Economic Times said in a report.

Using the data on your driving behaviour, gathered in the central repository, insurance companies will find out chances of accident and fix your car insurance premium accordingly, said experts.

"It helps in customizing the offering as per the customer's driving behavior, rather than just giving a flat insurance price to every driver for the same type of vehicle. Thus, a person driving the same vehicle in a smooth manner might have to pay a lesser amount as opposed to someone driving rash. Collectively, based on a number of metrics, it could ease out the claims process as well, as an insurer can investigate the claims better on the basis of other data points and impact analysis as well, the publication quoted Devendra Rane, Founder and CTO, Coverfox.com as saying.

IRDAI in its draft proposal said that Insurance Information Bureau of India (IIBI) which acts as a data repository for insurance companies can manage the data and its protection.

### **How the new system may benefit you**

Under the existing system premium for your car insurance policy is decided based on parameters such as insured declared value (IDV) of the vehicle, make and model of the vehicle, engine capacity and geographical zone of registration. But after the implementation of telematics, insurers will be able to customise your motor insurance premium based on your driving habit. The better/lesser you drive, the lesser premium you will have to pay for your motor insurance.

Worth mentioning here is that, telematics will also help in roadside assistance and vehicle tracking. Apart from telematics, the insurance regulator has also proposed a change in the depreciation norms for private cars and 23 other changes to the existing structure of motor insurance policies.

IRDAI has recommended that the sum insured for all new private cars will be the current day on-road price of the vehicle. This will include invoice value of the vehicle, road tax and registration charges and value of all accessories fitted by the manufacturer. For 3-4 year old cars, IRDAI has suggested a depreciation rate of 40% and for cars more than four years and less than five years old, 50% depreciation rate has been suggested.

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## ***Two wheeler insurance policy can help curb hefty fines - Financial Chronicle - 29th November 2019***

If you were given a choice between paying Rs 1000 for a product or Rs 4000 for the same product, which would you choose? It would be safe to assume that you would choose to pay the former. Unfortunately, one does not make the same choice when buying insurance. Many people choose to take a chance and pay hefty fines rather than buy two wheeler insurance. Thus, it becomes important for the government to intervene and come up with a solution.

In order to address the menace of road accidents, the central government very recently amended the Motor Vehicles Act with the Motor Vehicles Amendment Bill (2019). Passed in July 2019, the Act intends to levy hefty fines on various violations of traffic rules. Needless to say, the stiff new rules are already grabbing headlines. Under the amended Act, the penalty for driving without a license was increased to Rs 5000 while the penalty for driving without a helmet can lead to a fine of Rs 1000. If the factor of two wheeler insurance is not taken seriously, it will definitely burn a hole in your pocket.

So, can we say that, opting for two wheeler insurance is the solution to paying hefty penalties to the authorities? Well, it is definitely to a great extent.

The Insurance Regulatory and Development Authority of India (IRDAI) have recently set up a working committee to examine the possibility of linking two wheeler insurance with traffic violations. Policyholders with vehicles featuring similar parameters like age, make, model and insured could be charged differential premium based on their track record on roads.

However, opting for a two wheeler insurance on time can ensure a lot of security for the owner and of course exempt him from paying hefty fines. Considering this, we have listed below, three reasons to avail a two wheeler insurance. Here's a look:

### **It pays for damages**

No matter how much security you tend to avail, life will always remain unpredictable. If anything, unanticipated events while driving – like crashing into a wall or a cricket ball crashing into your windshield, will cost you a considerable amount of money in fixing them. However, if you have an insurance in place, you will not have to worry too much about paying hefty bills.

### **It reduces liability substantially**

Opting for two wheeler insurance can help reduce liability to a great extent. Third Party Liability Insurance is mandatory in India, which covers one against the ramifications of accidents caused by an individual. For example, if you happen to cause an accident that damages someone else's property or injures another individual, the insurance will pay for their treatment and you need not worry about the same. Instead of shelling out huge hospital costs, you can always get your two wheeler insurance to take care of these expenses.

Additionally, if you are in an accident, then a third-party insurance can save you from very heavy liabilities.

### **Buying insurance policy online**

With the proliferation of the digital space, opting for insurance policies online has become much easier. Policyholders these days need not undergo tedious paperwork in order to buy a policy. When you purchase two wheeler insurance online, you can compare insurers, choose a policy that meets all your requirements and make the payment directly. Needless to say, these factors bring down the cost of the policy to a substantial extent.

Buying a Two wheeler insurance policy online can also ensure security and convenience as you can compare various options and choose the policy that suits your needs perfectly. Also, you can ensure that the information required can be filled in properly. On the other hand, payment of premium and renewing policies are much easier when done online as compared to in physical form. Availing the online route can also make it easier for you to save documents and chances of misplacing important paperwork are much less.

Of late, there has been a surge in buying two wheeler insurance policies. At Turtle mint, we are seeing a significant surge on the platform for two-wheeler insurance. On an average across cities, our increase in policy issuance has gone up by four times.

On a final note, it can be said that whatever you do or whichever bike you drive, do remember to opt for a Two wheeler insurance policy and secure yourself. It is always better to pay a premium to secure yourself than to pay a hefty fine.

(The writer is Dhirendra Mahyavanshi.)

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Source

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## SURVEY & REPORTS

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### **90% Of India's Poorest Have No Health Insurance - IndiaSpend - 6th December 2019**



Only about 10% of the poorest one-fifth of Indians in rural (10.2%) and urban India (9.8%) had any form of private or government health insurance, show data from India's largest national survey on social consumption, conducted between July 2017 and June 2018.

The poor are routinely forced to dip into their savings, borrow, delay treatment or receive poor quality care, experts said.

Overall, few Indians--14.1% in rural areas and 19.1% in urban areas--had any form of health coverage, found the report by the National Survey

Office (NSO) of the Ministry of Statistics and Programme Implementation. This leaves the vast majority of Indians exposed to health-related financial shocks.

The survey included the Rashtriya Swasthya Bima Yojana (RSBY, National Health Insurance Scheme), which was the precursor of the PMJAY, the Central Government Health Scheme for government employees, the Employee State Insurance Scheme for formal sector employees and state governments' health protection programmes.

Health costs keep people poor, and push those just above the poverty line back into poverty. In 2011-12, out-of-pocket health expenses drove 55 million Indians into poverty--more than the population of South Korea (51.1 million)--as **IndiaSpend** reported in July 2018. Some 38 million Indians were impoverished by expenditure on medicines alone.

India's catastrophic expenditure is high--one sixth (17.33%) of India's population spends more than 10%, and 3.9% of the population spends more than 25% of their income on health costs, found a 2017 World Bank report. Indians are the sixth highest private healthcare spenders among low and middle income countries, **IndiaSpend** reported in May 2017.

Rural poverty grew by 4 percentage points between 2011-12 and 2017-18--pushing 30 million people below the poverty line--according to one estimate based on the same NSO household consumption survey in Livemint on December 3, 2019.

The impact of rising health costs on poverty cannot be estimated because the government has withheld the latest nationwide consumer expenditure report and the raw data due to "quality issues", as per a report in *Business Standard* on November 16, 2019. This consumption survey was India's 75th and was conducted in 113,823 urban and rural households covering every district in the country.

#### **Government health insurance**

In 2017-2018, before the central government's Pradhan Mantri Jan Arogya Yojana (PMJAY, Prime Minister's Health Protection Scheme) was launched, only 12.9% of those in rural and 8.9% in urban areas

were covered under any central government insurance scheme, the NSO report said. Only 9.9% of the poorest (belonging to the 1st quintile) in rural areas and 7.5% in urban areas had any government-sponsored health protection, the survey found.

The coverage is low because this survey was done before the launch of PMJAY, since the performance of services and coverage were poor under RSBY, said ShaktivelSelvaraj, director of health economics, financing and policy at the Public Health Foundation of India, a think-tank based in New Delhi. "This was one of the reasons why PMJAY was launched."

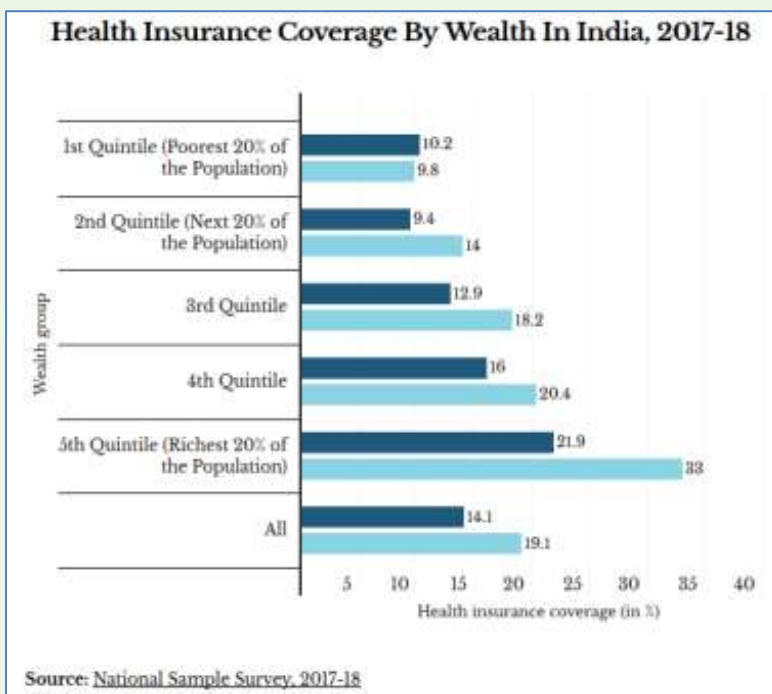
The PMJAY, launched in September 2019, provides health insurance coverage of Rs 5 lakh to 100 million 'poor and vulnerable' families identified by the socio-economic caste census (SECC) of 2011.

By December 1, 2019, about 67 million had been given e-cards qualifying them for free treatment, and the treatment of 6.4 million patients had been paid for by PMJAY, data on its website said. "With PMJAY, the bottom 40% of the population now has health insurance. This is a big leap towards Universal Health Coverage that PMJAY has made," InduBhushan, chief executive officer of PMJAY, told **IndiaSpend**. But "the 2011 [SECC] database is old so we have to ensure that those people [who are left out] are clearly identified and are made a part of the scheme," he said.

The next NSO will show to what extent PMJAY has reduced out-of-pocket expenditure on health, Selvaraj said. Merely increasing insurance coverage is not enough as not all those who are enrolled know about the scheme or its benefits, not all the poor are covered, and not everyone has access to healthcare, he said.

### Persistent low health insurance coverage

Health coverage decreased by 0.7 percentage points for the poorest Indians in rural areas and increased by 1.2 percentage points for the poorest in urban India as compared to 2014, when the previous health consumption survey was conducted.



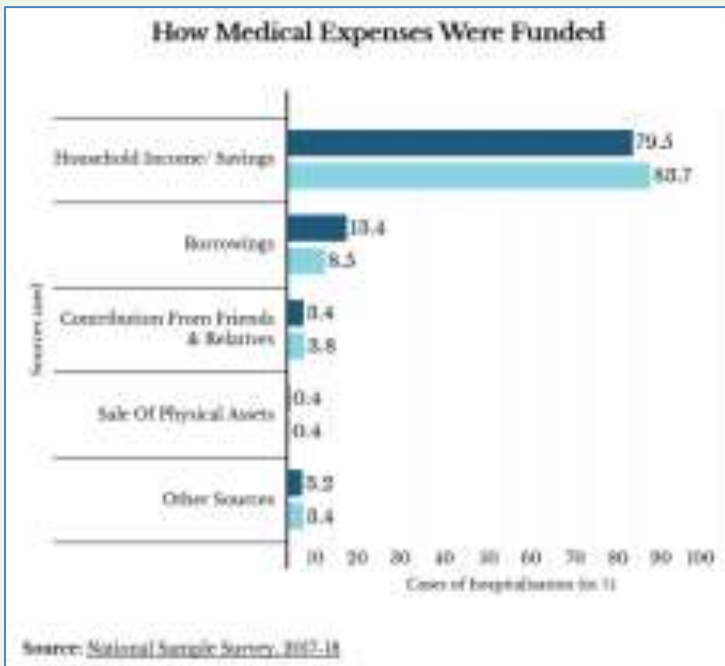
Fewer than a quarter (21.9%) of the richest rural Indians and 33% of the richest urban Indians had health expenditure coverage in 2017-18--the highest proportion of any wealth group--the report said. This is an increase of three percentage points in rural areas and 0.4 percentage points in urban areas between 2014 and 2017.

Health insurance coverage in India is poor because the private health insurance industry is still at a nascent stage in India, the pool of people who are able and willing to pay for insurance is low, and insurance premiums are high, said Amir Ullah Khan, a health economist and professor at the Marri Channa Reddy Institute for Human Resource Development of the Telangana government.

Further because Indians, especially those in rural India, have limited access to healthcare services such as doctors and hospitals, they are less likely to buy health insurance, he said.

**Lack of money impacts health**

As a result of low insurance coverage, in 2016-17, about 79.5% of those in rural areas and 83.7% in urban areas paid for medical expenses from their savings, the NSO report said. This grew from 67.8% in rural areas and 74.9% in urban areas in 2014.



As more people used their savings, borrowing to support medical expenses fell from 24.9% in 2014 to 13.4% in 2017 in rural areas, and from 18.2% to 8.5% in urban areas, data show.

Over half of hospitalisations in India (51.9% in rural and 61.4% in urban) are in private hospitals. The average medical expenditure per hospitalisation in a private hospital (Rs 31,845) is seven times that of a government hospital (Rs 4,452), the NSO report said.

Given this, the poor are less likely to avail of hospitalisation. The wealthiest 20% families formed the highest share of hospitalizations-31.9% in rural and 22.4% in urban areas, the data show. Families in the poorest 20% of the population made up the fewest cases

of hospitalisation (12.9% in rural and 16.2% in urban), which could be because of an inability to fund medical expenses because of low household savings.

Government And Private Health Insurance By Wealth Group							
Sector	Wealth Group	Percentage of persons					
		Not Covered	Covered by				
			Govt-Sponsored Insurance Scheme	Insurance If Employed By Govt./ PSU	Employer Supported Health Protection (Excluding Govt./PSU)	Households' Private Health Insurance	Other
Rural	1st quintile	88.8	8.8	0.2	0.1	0	0
	2nd quintile	90.6	9	0.2	0.1	0	0.1
	3rd quintile	87.1	12.1	0.4	0.1	0.1	0.1
	4th quintile	84	15.1	0.3	0.2	0.2	0.1
	5th quintile	78.1	18.4	1.6	0.8	0.8	0.3
	All	85.9	12.9	0.6	0.3	0.2	0.1
Urban	1st quintile	80.2	7.5	0.6	0.9	0.6	0.1
	2nd quintile	86	10.7	1.2	1.5	0.5	0.2
	3rd quintile	81.8	11.6	2.6	2.1	1.6	0.1
	4th quintile	79.6	9	4.2	3	4	0
	5th quintile	67	5.5	8	7	12	0
	All	80.9	8.9	3.3	3	4	0

The biggest result of paying for healthcare from their own pockets is poverty, said Khan. “Also since they can’t afford to pay for healthcare, the poor postpone seeking treatment which, in case of diseases like tuberculosis, cancer, etc. turn serious and more expensive to treat,” he said.

The rich are also more likely to have health insurance, data show. The rich have greater access to finance and hospitals, and the cost of more than one-fifth of all hospitalizations by the richest group (21.8%) in urban areas are reimbursed, said Selvaraj.

In rural areas, too, the poor remain deprived of access to government health support: The richest 40% of the population used government health programmes more than the poorest 40%, NSO data show.

Source: National Sample Survey, 2017-18

*(The writer is Swagata Yadavar.)*



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## INSURANCE CASES

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### ***Ludhiana: Insurance firm told to pay Rs 34k for failing to settle medical claim - The Economic Times - 2nd December 2019***



The district consumer disputes Redressal forum has penalised a health insurance company for not settling the medical claim of a policy holder. Apart from directing the Religare Health Insurance Company Limited to settle the claim amount of Rs 32,906, the forum — comprising its president G K Dhir and member Jyotsna Thatai — also issued directions to the company to pay Rs 2,000 as composite compensation for mental agony and harassment, as well as litigation expenses to Pankaj, a resident of Hira Nagar on Kakowal Road.

On June 6, Pankaj gave a complaint to the forum stating that he had taken a health insurance from Religare Health Insurance Policy in his name. The firm assured reimbursement of incurred expenses in case of medical emergencies. On February 3 last year, the complainant was admitted in Mohan Dai Oswal Hospital, because he was under the influence of ketamine.

The complainant was discharged from the hospital on February 4 last year. An amount of Rs 31,264 was incurred as medical expenses on his treatment. On submission of the claim, it was rejected through a letter received by Pankaj on March 5 last year. However, earlier in 2017, when he got a similar treatment, then his claim was sanctioned by the insurance company. By claiming that the insurance company failed to perform their part of the contract, and by claiming that deficient services were provided by it, he filed for seeking reimbursement of incurred medical expenses, along with compensation for mental agony and harassment of Rs 50,000, and litigation expenses of Rs 22,000.

The insurance company appeared through a counsel, and without filing a written reply, an offer was given on October 29, to the effect that it was ready to settle the claim by paying the amount of Rs 32,906 as full and final claim settlement within 30 days from the receipt of copy of the order. That offer was accepted by Pankaj on November 7, but with a rider that the amount of compensation and litigation expenses should also be allowed. So, virtually the dispute remained as to whether or not Pankaj was entitled to any amount of compensation and litigation expenses.

The forum observed that without filing a written statement, an offer was made, which was accepted. As such, it showed the anxiety of the insurance company to settle the claim at the earliest by not dragging the complainant Pankaj in further litigation. “In view of that, certainly a lenient view required to be taken in the matter of imposition of costs of litigation and compensation amount for harassment. Rather, the insurance company avoided harassing the complainant, and that is why an offer for settlement given immediately after appearance by the counsel for the insurance company.

The forum observed, “However, had that offer been made before filing of the complaint or claim, then the occasion with the complainant to file the complaint was not there. No copy of the repudiation letter was produced on record by the complainant. In view of this false plea taken in the complaint also, there is need to grant lesser amount of compensation and litigation expenses. The insurance company by giving an offer tried to mitigate the sufferings of complainant, and as such allowing a composite amount of Rs 2,000 as compensation for mental agony and harassment and litigation expenses will be sufficient.”

Source

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***Bus driver, insurer to pay ₹10.5 lakh to Kullu accident victim - Hindustan Times - 2 December 2019***



The Motor Accident Claims Tribunal (MACT) of Mohali has directed a private bus operator, its driver and an insurance firm to pay ₹10.45 lakh as compensation to the family of a Kullu-based mason who died in a road accident in April this year.

The accident claims tribunal presided over by Devinder Kumar Gupta, said the compensation would be paid with 7.5% interest and is to be paid 'jointly and severally' by bus driver Partap Singh and owner Mansa Ram, both hailing from Kullu, and insurance company New India Assurance Company Limited.

The claim seeking compensation was filed by Beena Devi, widow of victim Chove Ram and his two children.

46-year-old Chove Ram was travelling in a bus owned by Thakur Coach from Grammang to Kullu on April 4, 2019. When the bus which was speeding reached near Gaushala Dhara Tin under the jurisdiction of Sadar Kullu police station, its driver lost control following which the vehicle fell into a 70-foot gorge. Chove Ram sustained serious injuries on his head and other parts of the body, and died at regional hospital, Kullu.

A first information report (FIR) was registered against the driver of the bus for rash and negligent driving at Kullu Sadar police station.

Responding to the victim's family's petition, the owner and driver of the bus denied of their vehicle being involved in the accident, while the insurance company claimed that the bus was being driven in violation to the laid conditions. The tribunal overruled their arguments saying, "There is no evidence regarding breach of any condition of the insurance policy."

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## PENSION

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***National Pension System: PFRDA revises norms for valuation of securities - Financial Express - 2nd December 2019***



In order to make investments in National Pension System (NPS) transparent and efficient, Pension Fund Regulatory and Development Authority (PFRDA) has revised the guidelines for valuation of securities under NPS schemes.

Valuation of securities held under the NPS schemes is undertaken by the pension fund regulator to arrive at the scheme-wise net asset value (NAV) at the end of the day at which subscriber transactions such as purchase /redemption /switch of units are done. At present, mark-to-market is done for valuation of NPS securities.

In a circular, the pension fund regulator has underlined that the valuation of investments will be based on the principles of fair valuation, which means that the valuation will reflect the realizable value of the securities or assets. The pension funds will value the assets at fair value at all times by following the valuation guidelines issued by PFRDA and the third-party valuation services facilitated by NPS Trust.

### **Valuation methods**

For equity-related instruments and exchange traded funds, the valuation methods of securities traded on valuation day will be as per the closing price of the principal stock exchange. In case, it is not traded on the principal stock exchange, then the closing price on the secondary stock exchange will be considered.

When a security is not traded on any stock exchange on a particular valuation day, the value at which it was traded on the principal stock exchange or secondary stock exchange at the previous day will be used, provided such date is not more than 30 days prior to valuation date. In case trading is suspended up to 30 days, then the last traded price will be considered for valuation of that security. If an equity security is suspended for more than 30 days, then the valuation may be determined on case-to-case basis in consultation with pension funds, NPS Trust with prior approval of the regulator.

Index funds will be valued at latest NAV available on AMFI website. At present, the previous day's scheme NAVs are being considered as mutual fund houses declare NAV at 9 pm and pension funds cut off time for NAV declaration is 8 pm.

For exchange traded funds, the valuation will be as per the closing price of the day of the respective stock exchange. For valuation of rights, until the right shares are traded, each right share will be valued as ex-rights price minus rights offer price. In case the rights price is higher than the ex-rights price, then the rights will be valued at nil.

In case of demerger, if the shares of all resultant entities are traded immediately on de-merger, they would be valued at respective traded prices at exchange. In case shares of only one company are listed and traded on de-merger, then the traded shares are to be valued at traded price.

In case of a merger, when company A is merged with company B and company B continues to be listed, the proportionate shares allotted of B company against company A will be valued at the closing price of company B on the stock exchange. When company A and company B are merged to form company C, the value of pending listing company C will be the total valuation price of company A and company B before the ex-date till the new entity company C is listed and traded on the stock exchange.

### **Investing in overnight funds**

PFRDA has allowed pension funds to invest in overnight funds and all short duration funds as permitted by Sebi under short-term debt instruments and related instruments. It will be applicable to central and state government schemes, corporate, NPS Lite and Atal Pension Yojana.

*(The writer is Saikat Neogi.)*

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## **IRDAI CIRCULARS**

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Data for calculation of Motor TP Obligations for the FY 2019-20 is available on IRDAI website.

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Brokers updated list as on 30th November, 2019 is available on IRDAI website.

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## GLOBAL NEWS

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### **Thailand: Regulator mulls special licence for digital insurers – Asia Insurance Review**



The Office of the Insurance Commission (OIC) is studying the possibility of issuing a special licence for digital insurance business to encourage traditional insurers to revamp their business model amid disruptive technology.

According to *The Bangkok Post*, OIC secretary-general Suthiphon Thaveechaiyagarn said, "This business model can help traditional insurance businesses revamp their strategy to stay competitive in a market increasingly dominated by technology."

The OIC will study the overall impact and benefits of digital insurance before proposing the idea for the Finance Ministry's consideration and Cabinet approval to issue an operating licence.

Turning to the OIC Gateway development project, Mr Suthiphon said that it is expected to be completed in 2020. The gateway is an IT system that enhances the services of the insurance industry and acts as a channel for linking and exchanging information across the industry, such as claim information and claimants' policy data.

Insurance data collection will initially start with auto insurance, based on both a voluntary and compulsory basis, he said. Data collection will expand into life and health insurances in later stages, said Mr Suthiphon.

Source

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### **Philippines: Regulator proposes list of changes to insurance law – Asia Insurance Review**



The Insurance Commission (IC) is seeking to amend the insurance law, about six years since it was last revamped in 2013, to cater to developments like takaful and catastrophe insurance.

Insurance Commissioner Dennis Funa told the *Inquirer* that the IC would pitch to Congress by the middle or latter part of next year the new amendments.

Based on preliminary documents of an IC technical working group obtained by the *Inquirer*, the proposed amendments include new rules on agri-insurance as well Islamic, catastrophe and parametric insurance.

At present, the Philippines does not have guidelines covering takaful but a number of players have expressed interest to introduce it in the country as soon as rules are in place.

The IC also supports covering risks from contingent events through parametric insurance, extreme or exceptional events through catastrophe insurance, as well as protection of farmers against damages or losses to crops and livestock.

Also, the IC is looking into regulating mandatory insurance such as those covering overseas Filipino workers (OFWs).

The IC also wants to establish an insurance guarantee corporation alongside separate guaranty companies for the life, non-life and takaful sectors.

For the mutual benefit association sector, the IC is eyeing imposing a capital investment requirement, alongside higher capitalisation for those engaged in disaster, marine and suretyship.

The IC will seek immunity from legal action such as temporary restraining orders and other legal proceedings in the conduct of its work as regulator and for its employees, similar to that currently being enjoyed by the Bangko Sentral Pilipinas.

The IC will also pitch the establishment of a separate government entity that will handle the liquidation of distressed insurers.

The proposed amendments include a supervisory framework to enforce and monitor insurance companies' compliance with antifraud regulations; public disclosure requirements for insurers, and development of reinsurance regulations.

In the meantime, industry groups such as the Philippine Life Insurance Association (PLIA), composed of life insurers, and the Philippine Insurers and Reinsurers Association, comprising non-life players, will contribute inputs to amending the insurance code.

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### ***Japan: Major life insurers' core profit fall but capitalisation remains strong - Asia Insurance Review***



Japan's four major life insurers all reported lower core profit for the six months ended September 2019, driven in part by premium rate revisions, but capitalisation remains strong, says Moody's Japan.

The four insurers are Dai-ichi Life Insurance, Meiji Yasuda Life Insurance, Nippon Life Insurance, and Sumitomo Life Insurance.

“Core profit for the four insurers dropped 9.2% from a year ago mainly driven by narrower mortality margins for group insurance policies,

caused in turn by premium rate revisions following the update of the standard mortality table in April 2018,” said Mr Soichiro Makimoto, a Moody's vice president and senior analyst.

“However, the lower core profit will not necessarily impair internal capital generation capability, because the insurers will likely reduce dividend payouts for group insurance policies to offset the decline,” added Mr Makimoto.

At the same time, capitalisation strengthened for all four insurers, providing them with a buffer against the rising risk associated with their overseas assets, which are adding volatility to profit and capital.

The insurers also continue to shift to third-sector products in the first six months of the fiscal year which started on 1 April 2019 (FY2019), which carry higher margins than their traditional mortality products, despite being eroded by rising competition. The higher margins these products offer appeal to insurers that are otherwise under pressure from the prolonged ultra low interest rates and declining working population that constrains demand for mortality protection products. The decline in embedded value in 1H FY2019 highlights the impact on insurers' economic capital from interest rate movements.

Nonetheless, Moody's Japan believes the four insurers' economic capitalisation will remain strong because of increasing internal capital generation and hybrid bond issuance.

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## ***Australia: Regulator reviews capital standards for private health insurance – Asia Insurance Review***



The Australian Prudential Regulation Authority (APRA) has commenced a consultation exercise aimed at updating and strengthening the capital framework for private health insurance (PHI).

APRA's review of the PHI capital framework represents the third and final phase of the PHI Policy Roadmap that APRA released in 2016, after assuming regulatory responsibility for the industry, to outline its approach to a comprehensive review of PHI prudential standards.

Phase 1 (risk management) and Phase 2 (governance) of the Roadmap are now complete.

In a discussion paper released yesterday, APRA set out its proposed structure for the future PHI capital framework including:

- aligning the PHI capital framework with the framework applying to life and general insurers, unless characteristics of the industry warrant a different approach;
- integrating changes stemming from the Australian Accounting Standards Board's new standard AASB 17 Insurance Contracts (AASB 17); and
- applying the capital framework to the insurer's entire business, rather than just the health benefits fund.

The changes are aimed at improving the sensitivity of prudential capital requirements to the risks private health insurers face, and improving the comparability of performance between insurers.

### **Impact on insurers**

APRA executive board member Geoff Summer ayes said, "While it's possible the revised framework may increase some insurers' minimum capital requirements, we don't expect this to be significant.

Importantly, APRA's capital requirements do not have a material impact on premiums so they will not contribute to the affordability problem that has pushed many policyholders to cancel or downgrade their cover."

He added, "While some insurers are evolving their business, innovating and looking at new models to provide services to their members, this is not the case with many.

APRA has expressed concerns about the resilience of the sector and this has informed our approach to a comprehensive review of risk management, governance and now capital standards for PHIs."

The consultation will close on 27 March 2020, with APRA expected to release draft updated prudential standards in the second half of next year for further consultation.

APRA's intent is to implement the finalised PHI capital framework from 1 July 2023 to align with its proposed adoption of AASB 17 for prudential purposes.

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## ***Australia: Regulator acts to stem huge losses in disability income insurance – Asia Insurance Review***

The Australian Prudential Regulation Authority (APRA) has launched an intervention into the life insurance market in response to ongoing heavy losses in respect of individual disability income insurance (DII).

In a letter to the industry yesterday, APRA announced a series of measures, including capital charges, that will require life insurers and friendly societies to address flaws in product design and pricing that are contributing to unsustainable practices.

Life companies have collectively lost around A\$3.4bn (\$2.3bn) over the past five years through the sale of DII to individuals (rather than through superannuation).

APRA wrote to the industry in May requesting urgent action to address the problems. Since then, insurers have reported further losses of A\$1bn, prompting APRA to escalate its response.



With at least one major reinsurer indicating it was no longer prepared to reinsure individual DII, APRA executive board member Geoff Summerhayes said there is now a genuine risk insurers may start withdrawing from the market.

"Disability income insurance plays a vital role in providing replacement income to policyholders when they are unable to work due to illness or injury," Mr Summerhayes said.

"In a drive for market share, life companies have been keeping premiums at unsustainably low levels, and designing policies with excessively generous features and terms that, in some cases, provide a financial disincentive for policyholders to return to work.

"Insurers know what the problems are, but the fear of first-mover disadvantage has proven to be an insurmountable barrier to them making the necessary changes.

By introducing this package of measures, APRA is forcing the industry to better manage the risks associated with DII and to address unsustainable product design features – or face additional financial penalties."

### **Capital requirement**

To underline the urgency of the situation, APRA has decided to impose an upfront capital requirement on all individual DII providers, effective from 31 March 2020.

The capital requirement will remain in place until individual insurers can demonstrate they have taken adequate and timely steps to address APRA's sustainability concerns. In instances where individual insurers continue to fail to meet APRA's expectations, APRA may also issue directions or make changes to licence conditions.

### **Managing risky product features**

- APRA also expects life companies to better manage riskier product features, including by:
- ensuring DII benefits do not exceed the policyholder's income at the time of claim, and ceasing the sale of Agreed Value policies;
- avoiding offering DII policies with fixed terms and conditions of more than five years; and
- ensuring effective controls are in place to manage the risks associated with longer benefit periods.

To further assist life companies gain better insights into market trends and developments, APRA will introduce an individual DII data collection.

This data collection, due to be released mid-next year, will also help APRA to monitor life companies' progress in meeting APRA's expectations.

Mr Summerhayes said: "The ultimate outcome should be more financially resilient life companies and more sustainable products for policyholders. Unless insurers stop losing hundreds of millions of dollars

each year, it's only a matter of time until individual DII – and the protection it provides – is no longer available at all."

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