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QUOTE OF THE WEEK

**"Coming together is a beginning;
keeping together is progress;
working together is success."**

Edward Everett Hale

INSIDE THE ISSUE

INSURANCE TERM FOR THE WEEK

Absolute Assignment

Definition: An absolute assignment is the act of complete transfer of the ownership (all rights, benefits and liabilities) of the policy completely to other party without any terms and condition.

Description: Absolute assignment shifts the ownership of the insurance policy.

For instance, a policy owner X wants to gift his life insurance policy to another person named Y. Hence X is doing absolute assignment. Here X is the assignor and Y is the assignee. Now all benefits, returns and even the liabilities are in the name of Y. If Y wants, he can further use absolute assignment and transfer the policy to other party.

Source

INSURANCE INDUSTRY

Post budget retroaction: the insurance industry – Outlook – 20th February 2020

The budget for FY21 was set in a backdrop of slowing domestic economy and falling tax revenues. This, in a way, made the task difficult as the government had to generate a fiscal stimulus to support growth but at the same time was hand-tied in terms of its revenue growth.

The government revised its fiscal deficit target for FY20 to 3.8per cent of GDP but reverted to Fiscal consolidation for FY21 by announcing a Fiscal deficit target of 3.5per cent. The government has also improved its quality of spending with capital expenditure growth at 18per cent while Revenue expenditure growth at 12per cent. Given revenue constraints and limited resources to fund this expenditure, the Government doubled its Divestment program. The huge asset sales under its Divestment program have provided the fiscal space for the government to stimulate the economy while keeping the headline deficit number in check. I further view this as a positive since the asset sales is being done to fund the higher capital expenditure.

The government seems to be focussed on supporting Investments over consumption. The fall in private Investments has been one of the core reasons for India's growth slowdown. The government had last year announced corporate tax cuts and has now done away with the dividend distribution tax. I think the government has struck the right note here by taking these measures to boost corporate savings, which could be pre-cursor to higher private Investments.

The government, however, has missed the opportunity to increase the availability of risk capital by not removing the long-term capital gains tax on equities. The government is clearly looking at attracting foreign capital and announced many steps in that direction. It has announced issuance of specific securities to Non Resident Investors, which could pave way for listing of some of Indian government bonds on the global bond indices. Such listing would ensure continued passive FPI flows which would help in funding the government fiscal deficit. Also, the government announced increase in foreign portfolio investor (FPI) limits for investments in corporate bonds from 9 per cent currently to 15 per cent of outstanding.

The government did not announce any big measures to boost consumption. This again reinforces the fact that the budget has focussed more on pushing Investments than consumption. No major spending has been announced to boost the rural economy, in fact spending under the guaranteed rural employment scheme (MNREGA) has been reduced by 13 per cent to Rs 616 billion

Given that subdued tax receipts have led to more reliance on non-recurring sources of revenue to bridge the fiscal gap, efforts should be focused on bringing more people under the tax net (currently about three to four per cent of the Indians pay income tax). That will open up fiscal space, on sustainable basis, to spend more on creating infrastructure and promoting economic activities that will generate productive employment.

(The writer is Parimal Heda.)

TOP

Source

Before changing jobs, check insurance policies the employer provides – Mint – 19th February 2020

A candidate who had come for a job interview grilled me for 20 minutes when I asked if he had any questions about our company. This was justified. Changing jobs is such an important decision that you should clarify as much as possible before accepting an offer. Most questions are on company objectives, roles and compensation, but I suggest that job seekers also include insurance in that list. Employer-provided insurance contributes significantly to financial security and many policies, such as group or liability covers, can only be bought by companies.

Ask about health, life, accident and liability insurance. Employers often buy group health insurance, OPD (out-patient department) covers and travel insurance for employees. A group health insurance covers hospitalization costs like an individual mediclaim does. But unlike individual insurance, it covers pre-existing diseases immediately, without the need for proposal forms or medical tests. Group health covers may also allow employees to convert the group insurance into an individual plan if they leave the company. It's also important to ask which family members are covered. While immediate family members are generally insured, some employers insure parents as well. For many senior citizens, this can be the only insurance they have. Find out who will pay the premium. Some employers pick up the cost but many recover this from your salary. When you join a new company, ask for the mediclaim cards. An early claim can get rejected if you have not been endorsed into the insurance.

Some employers provide OPD and wellness benefits. This may be in the form of an annual health check-up or a budget for OPD expenses. These covers are less common but, if offered, indicate a strong employee-orientation.

Employee-provided term insurance will pay your nominee an amount if you die while you are employed by the company. The amount in these covers is generally between one and three times the annual income. Ideally, you should have 10 times your annual income as term cover, which means that you must bridge the gap by buying your own personal term plan. Like group health, group term plans do not need medical tests or disclosures. When you join, do specify your nominee so that, in the event of your death, the benefit is paid quickly.

Some companies provide employees a personal accident insurance instead of a term plan. This covers you for disabilities or accidental death. The advantage of this insurance over a group term life is that it covers disability, but the flip side is that death only due to accidents is insured. Personal accident insurance is cheaper than comprehensive term insurance, which is why it is more common.

If you will travel for work, make sure that you have travel insurance, both international and domestic. Companies can buy this insurance in bulk for all the employees. You should have the insurer's contact details for all the countries to which you travel. If you fall ill overseas, many insurers will guide you to the right medical facilities or step in to handle emergencies.

Senior executives, including directors, are exposed to significant liabilities. These range from allegations of wrongful termination, sexual harassment, misrepresentation and personal guarantees. There are cases where personal guarantees have been enforced on the legal heirs of a director. This is where a directors and officers' (D&O) liability comes in. This insurance pays for defence and settlement costs where an individual is named in litigation. Directors and executives now routinely review the company's D&O insurance before accepting a position. Independent directors, in particular, must ensure that D&O insurance has a sum assured that only non-executive directors can use. In litigious situations, this ensures that the entire sum assured is not used up by the management team, but some cover is set aside for the directors as well.

It can be awkward to ask so many detailed questions when you are joining a new company. However, it is perfectly acceptable to ask for a list of insurance covers that are available and most companies will immediately furnish that. Employer-provided insurance does not substitute but complements personal insurance because you may leave a job or the employer may withdraw the insurance benefit. Having your personal health and term insurance covers is necessary even if your employer provides excellent insurance.

(The writer is Kapil Mehta.)

TOP

Source

GST paid on life, health cover premiums are eligible for tax deduction benefits – Mint – 19th February 2020

The season for submitting proof of investments in tax-saving products has already set in and, in all probability, your employer would have already asked you to furnish them. While it's common knowledge that premiums paid for life as well as health insurance give tax benefits under Sections 80C and 80D, respectively, did you know that you can also claim deduction on the tax paid on these premiums?

When you pay a premium for a life or health policy, you also have to pay goods and services tax (GST), which effectively increases the overall premium. GST is charged on different parts of the premium, depending on the type of policy you buy. This changes the effective rate of GST on different policies. We tell you how GST works for health and life insurance policies.

Health insurance

You have to pay GST at the rate of 18% on health insurance policies. So if your premium is ₹21,000, GST at 18% will come to ₹3,960, and you will end up paying a total premium of ₹24,960.

This will also help you almost completely exhaust your deduction limit of ₹25,000 available under Section 80D for premiums paid for a health policy taken for yourself and your family, including spouse and two dependant children.

Life insurance

In case of life insurance, GST is levied on different parts of the premium, depending on the type of policy you are buying. You are allowed to claim deduction against GST paid on the premium, provided it is within the overall limit of ₹1.5 lakh available under Section 80C.

In case of a term plan, GST is levied at the rate of 18% on the entire premium of the policy, just like in health insurance. Suppose, a 30-year-old male who is a non-smoker pays a premium of ₹9,000 for a sum assured of ₹1 crore over 20 years. GST on this amount will come to ₹1,620. But the total premium paid—₹10,620—will be eligible for tax deduction.

In the case of unit-linked insurance plans, which offer a combination of insurance and investment, GST is only levied on the charges, including premium allocation, policy administration, fund management and mortality charges. No GST is levied on the investment part.

In the case of endowment or traditional plans, which also bundle insurance and investment, GST is levied only on 25% of the total premium in the first year of the policy, which effectively reduces the GST rate to 4.5% of the premium paid in that year. In all subsequent years, GST is levied on 12.5% of the total premium paid, which effectively reduces the GST rate to 2.25% for the rest of the tenure.

So when you fill in the details of the premiums paid for life and health insurance policies in the investment proof form provided by your employer, don't forget to mention the total premium paid, including GST.

(The writer is Renu Yadav.)

TOP

Source

A glimpse into the insurance industry – Silicon India – 17th February 2020

We've all interacted with insurance companies at some point in our life. Whether it's life insurance or home or vehicle insurance, a massive amount of back-office processes inundates the insurance companies. Mundane, manual tasks burden the insurers, which affects the organization's efficiency.

Robotic Process Automation is fast becoming ubiquitous, bringing about enterprise-wide change across industries, and the insurance sector is no exception.

With RPA, time-consuming data entry work is allocated to software bots, relieving the human worker to focus on more value-added tasks, thereby undoubtedly reducing the turnaround time, which increases customer satisfaction.

What is Robotic Process Automation?
In simple terms, RPA is the automation of mundane tasks that are repetitive and follow a set of pre-defined instructions. The insurance industry is overwhelmed with many back-office tasks that take up tremendous time and effort of the employee. With robot-led automation, these tasks are handed to the bots, freeing the human worker to focus on strategic activities.

Insurance companies face a multitude of challenges, from getting rid of legacy applications and disparate systems to maintaining compliance. RPA — the recipe to success streamlines processes end-to-end and removes the burden of the human workers from time-consuming tasks.

RPA can automate sub-processes — pulling data from invoices, moving data from spreadsheets, or scraping information from websites, thus increasing the efficiency of the organization.

Below are a few benefits of implementing automation in insurance companies:
Streamlines claims processing
Claims processing includes gathering data/information from diverse sources such as admin and finance, which is time-consuming and daunting. The data collected is massive, unstructured, affecting customer service. Automation can help direct information to the right people, notifying those responsible for claims handling and integrating information gathered from multiple sources. With RPA, processing claims is faster and easier as it cuts down the processing time by automating manually intensive tasks, thus enhancing customer experiences.

Ensures regulatory compliance
Today, the insurance industry is highly regulated and complex. Maintaining high standards in governance is a top priority Liquidity, foreign exchange risks, and inadequate systems are some of the challenges that threaten the insurers. As compliance standards such as PCI, tax laws, and HIPAA privacy rules change frequently, businesses must realign themselves to the changing policies. This is where RPA comes in — it validates customer information, flags non-compliance by monitoring regulatory compliance daily, sending out reports and processing notifications, thus preventing a regulatory breach.

Helps in expediting the underwriting process
RPA can collate a vast amount of information from diverse sources, update the system, help assess the risks associated with any insurance, and provide recommendations that can assist in decision making and pricing.

Helps in data sorting, data entry, and validation
The insurance industry is replete with manual data entry tasks involving quotations, pricing, and insurance claims. The bots can automate the repetitive tasks in no time, thus reducing human errors and inconsistencies.

Improves customer service and operations
Legacy systems characterize the insurance industry. Robots take over the rules-based tasks, freeing the human worker to focus on creating better customer experiences. Whether it's automating claims processing or handling customer queries, Robotic Process Automation transforms the customer experience.

Synthesizes, analyzes, and digests unstructured data
We understand that the human workforce spends a great deal of time in gathering, collating, updating, validating, and processing data. The digital bots can augment the various insurance processes by:

- Reading and scanning data
- Downloading data from multiple sources
- Flagging errors in data
- Compiling data from various systems

Drives scalability
The insurance sector is slow and highly regulated. The software bots can be scaled up and down as per your business needs, at no extra cost. For instance, if your organization has several claims to be processed during a particular period, the bots can be deployed as per your needs.

Conclusion
Robotic Process Automation is an emerging technology that augments the insurance processes, pushing organizations to embrace digital transformation. Most industries have already implemented software bots in specific business units, reaping the benefits and making better-informed decisions.

With the automation landscape evolving at breakneck speed, organizations are jumping into the technology bandwagon more than ever as they do not want to risk falling behind. Whether it's policy cancellation or compliance management, insurance firms can benefit significantly from RPA.

Have you deployed RPA yet?

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INSURANCE REGULATION

IRDAI wants insurers to weed out low-selling products after annual reviews – Moneycontrol – 20th February 2020

The Insurance Regulatory and Development Authority of India (IRDAI) has asked insurance company CEOs to review their products annually and weed out poor-selling policies.

The idea is to encourage insurers to have products with a high rate of sale, Subhash Khuntia, Chairman, Insurance Regulatory and Development Authority of India (IRDAI), said.

"I would like to encourage insurance companies to weed out products that are not selling and are simply adding to the number. If they do this, they will be able to manage their portfolio well," he added.

The regulator conveyed the message in a recent meeting with CEOs of insurance companies.

A cap in terms of the number of products a company can have was not specified. However, data shows that insurers typically have only four to five popular products on average. The rest merely exist. From the overall list, insurers may now do away with the worst-selling products following a comprehensive review at the end of every fiscal year.

India's life and general insurance companies put together sell more than 1,500 products. To be sure, there are also niche products that may not sell too much but serve a need in the market. Such products, say a cancer cover, would still be made available even if they have low traction, says the chief executive of a mid-sized bank-led insurer.

"Through our actuary, we would be able to explain to the regulator why some products are still being sold," he said. He added that companies would choose products that are the lowermost in the sales portfolio and do not add any significant value to the industry. Having a slew of products leads to additional costs for insurance companies in the form of requisite IT infrastructure and the need for record keeping.

Existing rules state that insurance companies can only file up to five products a year. IRDAI has said if the number of products exceeded five, the insurer should furnish supporting market research, product-wise persistency for the 13th month, 25th month and 37th month as on April 30 of the previous year.

At present, the insurance regulator follows the file-and-use method of application, wherein insurers apply to obtain prior approval of the authority to introduce/modify insurance products.

According to estimates, insurance companies could save up to 30 percent of annual costs if they restrict the number of products being sold in the market. It is likely that policyholders will be given adequate notice before the policy withdrawal from the market.

(The writer is M Saraswathy.)

TOP

Source

Will nudge insurers to go public: IRDAI Chairman Subhash Khuntia – Moneycontrol – 19th February 2020

It may never be mandatory, but the insurance regulator will surely nudge insurers to go public. On this topic, Insurance Regulatory and Development Authority of India (IRDAI) Chairman Subhash Khuntia said there are many benefits.

"Any company that goes public will lead to better corporate governance and better disclosures. Some firms are too small and they need to grow a little more. Ideally in 10 years time, insurance companies should come to a critical size and should be sustainable. But that has unfortunately not happened for several companies," he said.

Khuntia added that because of the economic situation, companies were conscious as far as listing was concerned. "Now I would like to ask other companies who have attained a critical size to go for listing," Khuntia said on the sidelines of the Global Conference of Actuaries.

Among the insurers, Life Insurance Corporation of India is the next big candidate for listing. The government has announced a divestment in LIC through an initial public offering. IRDAI has not yet received an official proposal from LIC.

An earlier IRDAI proposal had talked about mandatory listing of insurance companies after completion of 10 years of operations. However, this was not implemented after opposition from the sector players.

On pricing

Khuntia also pointed that the insurance industry should be sustainable. He said that insurers should neither be unduly profit making or loss making. He added that while companies rely on investment income, this may not sustainable.

"There should not be underwriting loss. This should be done not just through a price increase but through expenditure control and product design efficiency," he said.

However, Khuntia said that as a regulator they would not intervene in individual pricing decisions of the company but will point out any errors.

"We will ask companies for an explanation. It is an open market and we insurers to compete. We don'st want to regulate price since this is not correct in a deregulated economy," he added.

TOP

Source

LIFE INSURANCE

How Ulips can help you grow your money; find out - Financial Express – 17th February 2020

The art of waiting is difficult to master. But, when wealth creation is your objective, waiting is the most crucial factor for its success. While the financial tool you choose is important, what matters equally is how long you stay invested in it. More often than not people believe waiting is detrimental to their investment. However, constantly monitoring, and intervening does not necessarily pay off. In some cases, it can lead to disaster.

In the recent years, new-age Ulips have attempted to change this perception by promoting the mantra of staying invested for wealth creation. The category, especially, has found higher relevance in the e-commerce era. The experience provided by the likes of Uber, Amazon and more has changed customer

expectations. They now expect easy access through a simple, uncomplicated tool. Equipped with the right mix of flexibility, transparency, low-cost structure, and ease of on-boarding, these Ulips are fulfilling every new-age customer wants. No wonder then Ulips have fast become a lucrative investment option for meeting long- or short-term goals.

Another factor that has contributed to their popularity is the dampened risk appetite in light of the volatile market movements. Customers are looking for financial tools that help them keep their wealth insulated from any short-term, and intermittent shocks.

Here are some reasons why Ulips should be your preferred choice for wealth creation:

i) Pure retail focus:
Ulips are an ideal option for retail investors. Most other investment vehicles see commingling of funds from institutional investors, HNIs, and the retail investors (who typically have smaller investments), and are susceptible to large swings in flows and therefore, the fund size. With a focus on acquiring bigger institutional or HNI customer, the investment mandate is focused more on smaller term strategy and assigns higher weightage on short term performance. Moreover, significant volatility in the AUM requires a sizeable allocation to liquid assets. These factors impact the longer term performance and can cause a dent in the returns for the retail investors.

The new-age Ulips do not face this design flaw and require the customer to lock-in their funds mandatorily for a period of 5 years. These 5 years allow the money to grow and fully provide the advantages of compounding.

ii) Flexibility of asset class:
The current tax structure rewards a customer who stays with the same fund or asset class for a longer period. It does not account for the fact that a customer's risk appetite, and expectation of returns can change over the course of time as per market momentum. So, a long-term customer who wants to shift from one security or fund to another has to forego a tax. A Ulip, however, accounts for this flexibility and does not have any tax implication.

A new-age Ulip offers diverse investment options – equity, debt, balanced funds and sub categories within each of these fund classes. It provides freedom to switch between these funds without any cost to generate better returns as many times as the customer chooses without any additional charge or tax implication. In fact, some products offer an option to automatically rebalance asset allocation as you grow older. As the age increases or policy nears maturity, the plan shifts asset allocation from riskier assets to conservative ones to preserve investment value without any tax implication.

iii) Protection throughout your life:
Ulips are designed with inherent benefits of protection and enable you to secure loved ones as per your growing needs. For instance, some Ulip plans allow you to include your spouse, and your children (as you progress through these life events) into your existing policy.

Whole-life option in Ulips is also a suitable tool for those planning their retirement. These products help you build a big corpus, with the much-needed cushion of protection. These instruments allow you to balance your risk appetite as per your growing age. Meaning, some Ulips in the market automatically shift your allocation to funds that carry lower risk.

iv) No tax outgo:
All the benefits of the ULIP investment strategy listed above are sufficient to secure the vote of confidence of retail investors. However, the most impressive benefit of ULIPs is no tax liability at the time of redemption. This benefit is massive as the longer you stay invested, the higher is the wealth creation potential of your corpus.

In contrast, the longer you stay in any other investment vehicle the more your tax increases in tandem with the investment value.

There is no doubt that the new-age Ulips are designed to help investors effectively combine their goals of protection and wealth creation. As customer expectations evolve in the ecommerce era, both from the product itself and the online experience, Ulips will certainly keep the flag flying high for the insurance sector.

(The writer is Anup Seth.)

TOP

Source

Life Insurance: Customised plans for protection needs – Financial Express – 17th February 2020

The investment habits of consumers with respect to life insurance products is changing rapidly. Individuals have their own perception towards various types of investment plans. The most common perception among investors is 'what or how much will I get in return?' And then there are investors who wants to utilise their hard earned money in the most productive way possible.

To better match the needs of their customers, insurance companies are continuously looking for ways to offer more customised products depending on their age, wealth, life stage and more. Addressing the vast variety of protection needs of customers, the plans below are designed to empower customers by helping them to personalise their protection needs and giving them the freedom to decide what works best for them and their loved ones.

Term insurance with return of premium

It is when we are in our 40s and 50s when we start feeling the need to get insured. At this age, even those who were earlier reluctant to buy insurance change their minds. As per data of past two years, those in their 40s comprise the largest fraction (30%) of those buying TROP as a preferred insurance plan. TROP is a variation to the regular term insurance plan and caters to those looking for a life insurance cover that provides some return. In fact, TROP plan offers a full death benefit as well as the prerogative of cash windfall, provided you outlive the term. Considering the need of people of a life insurance product that offers guaranteed return on investment, TROP plans are hard to beat. The product works out for those looking for guaranteed cash value while also having life insurance cover for a defined term. Another advantage is that the guaranteed return is tax-free.

Let's assume you take a term insurance with return of premium plan for a sum assured of Rs 1 crore with a policy term of 30 years by paying an annual premium of Rs 12,000. On completion of the policy term, all premiums paid by you, Rs 3.6 lakh in this case, would be returned to you. In case of an unfortunate incident during policy term, your family will get the sum assured of Rs 1crore.

Limited pay premium

In term insurance plan, limited pay plan took off this year. It was observed that people have shifted towards paying for a shorter period of time and getting coverage for the longer term. Plans that feature pay term till 60 years and give coverage for 80-85 years saw traction from customers since people would want to end their liability by the time they retire.

The idea for this type of pay type was to provide for consumers who do not want to pay premiums throughout the policy term as limited pay premium provides a range of terms options such as single

premium payment or payment for a limited premium of 5, 10, 12 or 15. For instance, if you buy a term plan with a coverage term of 25 years and premium payment term of 10 years, you have to pay premiums only for 10 years while the coverage would continue for 25 years and you also have an effective saving of 28%-32%.

Increasing sum assured

Once you decide on the sum assured in term insurance, you cannot change it during the policy's tenure. With the current term insurance rules in place, young individuals in the low income group are not eligible to buy a term plan with Rs 1.5-3 crore sum assured as one can only buy a term plan up to 20 times of annual income. However, 5-7 years down the line their income would certainly increase and so would their expenses for which they would need a cover with higher sum assured.

To get around this problem, some insurance companies offer plans where the cover increases every year by specified amount. It is perfect for those who have long-term commitments of child education, home loan, marriage of children. In this option, death benefit remains at the same level in the first five years and increases by 5% or 10% of the basic sum assured for the next 15 years or end of policy term, whichever is earlier. Thus as your level of financial stability increases so too does the assurance to stay covered.

(The writer is Santosh Agarwal.)

TOP

Source

How has Budget impacted life insurance companies? – The Hindu Business Line – 17th February 2020

From expectations of a separate investment window for life insurance policies for the purpose of tax benefits to anticipating higher FDI limit, investors and analysts had pinned hopes on the Budget offering a big push to the insurance sector. Instead, the Budget, by way of introducing a new personal tax regime — lower tax rate sans most exemptions and deductions — and abolishing the dividend distribution tax (DDT), making dividends taxable in the hands of recipients, has rattled investors. In a knee-jerk reaction, the stock of listed life insurance companies fell, notably post-Budget announcements.

In India, insurance policies are mostly being sold with a 'tax-saving' pitch. Many taxpayers make a beeline to buy insurance policies in the fag end of the financial year to save on taxes. It is possibly due to this perception that life insurance stocks took a hit when Finance Minister Nirmala Sitharaman announced a lower tax structure, but without most exemptions or deductions (including deduction of up to ₹1.5 lakh on life insurance premium under Section 80C).

(The writer is Radhika Merwin.)

TOP

Source

Want to know if your annual life insurance premium is tax-exempt? – Moneycontrol – 17th February 2020

There is a small detail in the Income Tax (I-T) provisions of Budget 2020 that you might have missed: A life insurance policy without the cover being a certain multiple of the annual premium means you lose out on tax exemptions even if you pay as high as Rs 1.5 lakh for it annually.

The assumption is that the Finance Ministry has allowed policies with a cover which is seven times the annual premium to be tax-exempt. But that is not the case.

While a slew of life insurance products is now available with low ticket sizes, these policies will be eligible for Section 80C tax deduction only if the cover is 10 times the annual premium. So while making a decision, do consider more than the lower premium on offer.

In a bid to improve insurance penetration (as a percentage of GDP) in India, the Insurance Regulatory and Development Authority now allows products, where the sum insured, can be up to seven times the annual premium (compared to 10 times the annual premium earlier).

However, these are not tax-exempt.

For instance, if you pay an annual premium of Rs 20,000, the size of the policy has to be a minimum of Rs 2 lakh to avail Section 80C benefits. Thus, even if you pay the maximum exempt limit of Rs 1.5 lakh as insurance premium yearly, it is not eligible unless the cover is at least Rs 15 lakh.

As per Section 80C of the I-T Act, annual insurance premiums paid are tax-exempt to a maximum limit of Rs 1.5 lakh.

Insurance company officials said that many customers buy smaller covers since the premiums are lower, however, these are not only inadequate but may also increase their overall yearly expenses without underlying benefits.

There was an expectation that the 80C exemption limit would be reduced to seven times the annual premium. However, no such change was made in Budget 2020 by Finance Minister Nirmala Sitharaman.

Not all customers are aware that the income tax exemption is applicable to only a certain category of insurance products. Agents, too, have been unable to spread awareness on the tax provisions.

A few insurers are now considering only offering products with sum assured of 10 times the annual premium and above. This will not only prevent misselling complaints but also ensure that unaware customers do not buy inappropriate products.

Insurers have stated that tax exemption is not the primary reason for people buying a life policy, but the fact remains that it is at least a major consideration while buying a product.

Thus, making it clear that only some products offer tax exemption under 80C is crucial. If the commission structure is changed to offer a higher incentive of selling a 10 times annual premium cover, distributors will also fall in line.

Insurance is primarily an income-replacement tool in case the bread-earner of the family dies. Hence the focus should be on offering covers of a standard size depending on the annual earning capacity of an individual rather than pushing cheap products.

(The writer is M Saraswathy.)

TOP

Source

Do you have enough insurance? Use this thumb rule to find out – The Economic Times – 15th February 2020

The most important question to address while creating a financial plan is that if something untoward was to happen to an earning member of the family what happens to the goals, aspirations of the family and who takes care of the liabilities like home loan? Can an individual create a big enough safety net for their near and dear ones? Leaving this to hope is not the answer; instead the answer to this is having adequate insurance cover.

It is often debated whether one should invest in mutual funds or opt for insurance policies. In my opinion it is not an either or option, both products are required to create a comprehensive financial plan including other asset classes like gold, real estate, and creating a will. What you should know is that

mutual funds are investment vehicles whereas insurance products cover risk and have to be used accordingly.

How much insurance cover should you have?
Like all other aspects of financial planning, the key question is how much insurance is enough?
Some of the factors to consider while arriving at the appropriate insurance cover are:

- Current annual income: Objective is to have an amount of cover adequate enough to help generate income equal to replace the annual income.
- Financial liabilities: This should include current liabilities like home loans, car loans. Any deferred payments also need to be considered.
- Financial goals: Like children's education, marriage etc
- Life stage of the person: A person in the mid stage with liabilities, responsibilities would need a higher cover as opposed to a person at a later stage in the life cycle, whose responsibilities and liabilities have been taken care of.

In arriving at the number, one needs to deduct the corpus one has in the form of investments and savings by way of mutual funds, bank fixed deposits (FDs) etc.

Follow this thumb rule
It may look like a complex mathematical problem to solve, but thankfully thumb rules come in handy here as well. In developed economies, the thumb rule is that one needs to have an insurance cover equivalent of 7 to 10 times of annual income. Experts believe that in an economy like India, where inflation could be higher than developed economies, it is better to have a cover equivalent of 10 to 15 times the annual income plus the outstanding liabilities.

For example, if a person has an annual income of Rs 5 lakh, then the adequate insurance cover would be anywhere between Rs 50 lakh and Rs 75 lakh plus liabilities, if any.

Obviously, the insurance premium has to be paid every year and hence, it is important to give weight age to one's ability to pay the premium year on year, while deciding on the extent of insurance cover.

Thumb rules are just guiding principles, and it is advisable to have a good advisor or financial planner who can customise the financial plan to your goals, aspirations and circumstances. Do keep investing in mutual funds for financial goals but don't forget to buy adequate insurance as well.

(The writer is Ajit Menon.)

TOP

Source

Importance of life insurance in a double-income family and how to find out the right coverage amount – Financial Express – 14th February 2020

With the introduction of the new tax regime from the financial year 2020-21, taxpayers will have the option to pay tax as per the new simplified tax structure or continue with the old tax regime. For those opting for the NTR, among the various income tax deductions that will have to be forgone, the premium paid on life insurance policies will also not be there for tax benefit.

However, the tax benefit is only incidental to a life insurance policy and policies need to be bought purely for saving and protection needs. In today's world, in several households, both the spouses work and thus share the dreams, aspirations and goals equally to a large extent.

In an email interview with FE Online, **Vighnesh Shahane, MD & CEO, IDBI Federal Life Insurance**, talks about the insurance needs for working couples and the implication of the new tax regime on life insurance policies.

Is it true that for someone opting for New Tax Regime from next year, the tax benefit under section 80C for premium paid on existing policies or new policies will not be available? Will section 10(10d) tax benefit still be there?
By opting for the new tax regime as announced in this year's Budget, the taxpayers would have to forego a deduction up to Rs.1.50 lakhs under Section 80C of the Income Tax Act, 1961 in respect of the premium paid for purchase or renewal of life insurance products. So the tax benefit under Section 80C would not be available for premium paid for existing policies if the taxpayer has opted for the new tax regime.

However, the tax exemption under Section 10(10D) would be available for all policies meeting conditions stipulated therein. Tax exemption under Section 10(10D) is not specifically excluded if the taxpayer has opted for the new tax regime.

What is the role of life insurance in a double-income family?
Even in a double-income family, the role of life insurance is crucial. The earnings of both spouses contribute towards meeting the family's financial needs such as groceries, household utility bills, children's school fees, EMIs on outstanding loans and other expenses. In case of the untimely death of either of the spouses, the loss of one income could adversely affect the family's lifestyle in terms of quality of schools, family vacations and repayment of loans.

By both partners investing in life insurance, there is a financial security net for the family in case of any unfortunate circumstance. The payout from the life insurance plan would not only allow the family to maintain its lifestyle in the present but also achieve its milestones over the long-term.

In a family of working spouses, how should the life coverage amount be decided?
To understand the amount of life insurance required, it is important to calculate the individual Human Life Value (HLV) of both the spouses. This is the amount that each individual sets aside for his family's consumption after deducting the cost of his own needs and tax, from his gross salary.

By calculating his economic value to the family and the approximate number of remaining years of service, an individual will be able to decide on the appropriate life cover for himself. It is also necessary to review one's life insurance coverage periodically. As a person's income grows, his life cover would also grow proportionately and he may need to purchase additional coverage.

With rising life expectancy, how important does life insurance become?
As life expectancy increases, Indians will need substantial retirement savings in order to lead comfortable retired lives. Investing in life insurance will help an individual to combat the impact of increasing annual inflation on regular retirement income, as well as provide a sufficient amount of savings for any health emergencies that could dent retirement savings.

There are life insurance plans available that not only provide financial protection to families on the untimely demise of the insured person but also allow investments for future needs like retirement. Thus, on surviving the term of the plan, an individual has adequate savings for his or her retirement.

Additionally, life insurance companies offer various retirement income options called annuities which could provide regular income for a fixed period, coverage of spouse after death, the return of the principal amount, and so on.

(The writer is Sunil Dhawan.)

TOP

Source

GENERAL INSURANCE

Title Insurance: new product for old issues - Governance Now – 20th February 2020

Real estate is among the priciest investments around. More so for the common man who has to live with the burden of monthly EMIs. Yet, it is an art to discover the real owner of any property. Government and revenue records, which are easily accessible to the public, are not properly maintained. Individual plot owners don't even think it necessary to update these records; as such omissions do not attract stringent penalties. The entire process of finding out whether a person's ownership rights are free of any defects depends largely on the co-operation of the purported seller. And the seller may have a vested interest in not making a clean breast of things.

Real estate projects have got stalled on account of various defects in the title of the owner/ developer to the property. Examples of such defects include litigation by a co-owner who was not made a party to the sale; boundary disputes with neighbouring plot owners; non-availability of the requisite approvals.

No takers for title insurance

The Real Estate Regulation & Development Act, 2016 ('Rera'), therefore, made it compulsory for developers/ promoters to obtain insurance against any defect in the title of the land and buildings of their projects. However, there has been no progress on this front. In 2016, it was impossible to obtain insurance coverage against any defect in title since none of the insurers offered this kind of insurance product. This is not the case today. New India Assurance, HDFC Ergo, Tata AIG General Insurance and National Insurance Company have introduced title insurance. Yet, there are no takers for title insurance.

As per recent media reports, only HDFC Ergo has successfully sold title insurance with a humble count of two. This is not good news, neither for the insurance sector nor the common man, for whom the stakes are the highest. Some of the factors responsible for this state of affairs are discussed below. Fixing these loopholes will not only help the common flat purchasers but will also have a direct bearing on ease of doing business in India.

Reasons for non-performance of title insurance

(1) Expensive product

It's an expensive product. The premium is based on the gross developed value (which includes value of land, cost of construction, and profit margin of the developer) and ranges from 0.5% to 3%. Such a high premium is payable for a policy which typically covers a period of 7 to 12 years. Since developers of under construction properties cannot pass on the burden of insurance costs to the customers with whom they have firmed up the prices and executed registered agreements, the title insurance market appears to be a non-starter. To expect a reduction in the premium is unreasonable. The endemic problem of credible data regarding ownership and valuation of the property tells at every step of the way.

In order to hedge their positions, insurers rely on reinsurance. However, given the mystery around the entire issue of title, ownership, valuations, the reinsurers are not confident of doling out the usual terms and condition to insurers at usual prices.

(2) Notable exclusions

In spite of the high premium, title insurance, in its current form, does not cover two vital concerns. (a) Title insurance only covers past defects. One of the biggest fears of land owners or developers is future encroachment of land. Land mafia is as much a truth and reality as day and night. Professional encroachers operate in both, cities and the mofussil. For the high premiums that are being charged, this exclusion from the insurance policy makes it rather unattractive.

(b) Stoppage of work on account of government approvals is also excluded from the ambit of title insurance. Often, government approvals are not forthcoming due to ambiguity and policy paralysis. For example, some years ago, non-availability of environmental clearances under the Environment Protection Act, 1986, and the Environment Impact Notification thereunder, was a major stumbling block in timely completion of projects. In certain cases, projects were pulled back after soft launch. None was to be blamed.

The principal issue that title insurance seeks to cover is litigation costs (including out-of-court settlement) from past defects. However, there is no clarity as to when the costs shall be reimbursed. Given the time taken to have disputes resolved, if the amounts are proposed to be reimbursed when the matter has reached finality, it shall be meaningless.

A committee has been set up to look into standardisation of title insurance policies. Eventually, words and expressions of insurance policies floated by different companies shall be interpreted identically. However, some simple solutions discussed below will also bolster title insurance.

Simple solutions

Linking of departments

All property related documents are compulsorily registrable with the sub-registrar of assurances. These documents are maintained as per the survey numbers assigned to the property. The sub-registrar can be so linked to the revenue department that the name of the buyer in whose favour a sale deed is registered is automatically reflected in the revenue records.

A new webpage of property under litigation reflecting the survey numbers, flat numbers, address of the properties along with names of the parties can be uploaded on the court websites, particularly that of the district and high courts.

Even the extant system is not exploited to the fullest. A notice, notice of *Lis Pendis*, recording basic details of any pending dispute in relation to a property can be registered with the sub-registrar of assurances by the plaintiff. However, hardly anyone goes that extra mile. Registration of *Lis Pendis* effectively puts the world to notice about the dispute. It protects the litigant against any third parties who may have acquired interest in the property pending litigation with their eyes wide open. Creation of third party rights is a common ruse employed by the defendants to frustrate the remedies available to a plaintiff. If a notice of *Lis Pendis* is registered, such a third party cannot claim to be a bona fide purchaser for value.

The Torrens system of title

The Torrens system of title is followed in many developed countries, notably the United States. Here, the government register serves as the ultimate proof of ownership. The title of the owner so reflected in the government records is guaranteed by the government. In other words, the government indemnifies third parties who rely on the government records. The Land Titling Bill drawn on similar lines, in India, is simply languishing. Governance Now had, a year back, carried an article on the Land Titling Bill; precious little has changed ever since.

(2) Creating a market beyond the confines of Rera

Should the pricing be right, there is a huge market for title insurance amongst real estate lenders. Abroad, title insurance is the norm. The seller of an ordinary apartment, more often than not, furnishes title insurance to the buyer. In fact, the common man, without the capacity to appoint a battalion of advisors, may stand to benefit the most form such a product. No product can last unless the market for it is wide and deep. It's myopic to look at title insurance exclusively through the prism of Rera.

Once a market for title insurance is established, the biggest benefit shall come in the form of credible data regarding property valuations. These solutions are desirable for overall good order and transparency.

(The writer is Divya Malcolm.)

TOP

Source

Irdai chief asks general insurers to cut expenses, improve efficiency – Business Standard – 18th February 2020

General insurance companies should focus on cutting expenses, improving efficiency and designing better products to overcome their underwriting losses, rather than increasing prices, said insurance regulator Chairman Subhash Chandra Khuntia on Tuesday.

Most general insurance companies have been reporting underwriting losses for some years now and bank on other sources of income to run their business. Investment income forms a huge chunk of this.

"This is a shortsighted measure and we have to graduate ourselves to ensure that there are no underwriting losses. This doesn't necessarily mean that the insurers increase the prices because improvement in efficiency can also lead to reduction in underwriting losses," said the chairman of the Insurance Regulatory and Development Authority of India (Irdai).

"Similarly, expenses of the company can be controlled."

But, he said, the regulator will not intervene in how insurers price their product. However if it feels the pricing is not right, then at the time of granting approval to the product, the regulator will point it out to the insurer.

"It's an open market and we don't want to regulate prices in a deregulated economy," Khuntia said at the 21st Global Conference of Actuaries hosted by the Institute of Actuaries of India. The chairman also urged insurers to conduct an annual review of their products and "weed out" the ones that are not being accepted by customers.

"Generally in insurance companies, the top three-four products make for 80 per cent of the business. So, is there a need for a large number of complex products that confuse customers and drag the insurers' performance also?"

(The writer is Subrata Panda.)

TOP

Source

Coronavirus: Travel insurance useful, but governments would step in fully – Moneycontrol – 19th February 2020

The thought of being locked up in a room for days – quarantined – till you recover from Corona Virus Disease (COVID-19) can be depressing. For those who are going through it and are covered through a travel insurance policy, there may be a feeling of relief that at least their medical costs would be taken care of. It doesn't quite work that way; you may not actually incur any costs, given that governments would step in.

On Monday, PTI reported that around 17 travellers who had returned to Delhi from China and other affected countries before the screening began in mid-January showed symptoms of the disease and were hospitalised. The number of confirmed cases in India is three, all in Kerala. Despite its geographical proximity to the epicentre of the pandemic Corona Virus Disease (COVID-19), India has, so far, remained relatively unaffected by the global health crisis of Chinese origin. No alarm bells have started ringing in India yet, but central and state governments are taking precautions.

Travel policies during advisories

The Union Ministry of Health and Family Welfare has already issued a travel advisory exhorting people to refrain from visiting China. On cue, general insurance companies that offer overseas travel policies, too,

are exercising caution. “We are not issuing travel policies to China-bound travellers. We have also limited the issuance of travel insurance policies to Hong Kong, Thailand, Malaysia and Singapore. For travellers to other destinations where some cases have been detected, we are asking our customers to follow government advisory and take precautions,” says Sanjay Datta, Chief, Underwriting, Claims and Reinsurance, ICICI Lombard. On paper – and as per travel policy documents – COVID-19 or other such contagious diseases are not exclusions – they are treated like any other ailment, provided they are not ‘pre-existing.’

But when it becomes an epidemic and reaches alarming proportions and where governments get involved, the story changes. “Do not depend on your travel insurance when you travel to countries where advisories have been issued. Insurers can possibly decline the claim under ‘losses that are intentionally caused’ exclusion ,” says Mahavir Chopra, Chief Business Officer, Coverfox.com.

While insurers do pay for the treatment of pandemics, usually, they are completely controlled by the government and regular hospitals rarely enter the picture. “If the treatment necessitates quarantine, including at home, it’s the government’s call to take – travel policies will not come into play,” he adds. Governments tend to take over completely, as symptomatic individuals might need to be placed under quarantine. “Treatment takes place at government-designated hospitals and costs, too, are borne by the governments,” says Nikhil Apte, Chief Product Officer, Product Factory (Health Insurance), Royal Sundaram. The respective countries’ governments need to keep track of such cases to contain the scourge and prevent secondary infection. “Therefore, it is unlikely that insured travellers will file claims with insurers,” he adds.

Settling claims

For Indian health insurance policyholders diagnosed with the disease upon their return, again, similar rules will apply.. If you are, say, evacuated from the epicentre of an epidemic and return to the country, you will be placed under quarantine, as has been the case with Indians airlifted from Wuhan, China. The medical facilities will be controlled and paid for by the government establishments. “So, though any treatment procedure that an insured has to undergo is technically covered by travel and health policies, practically, such situations seldom give rise to claims,” points out Apte.

In case you to travel to regions where no advisory is in place and yet end up contracting the deadly virus, you can turn to your travel or overseas health policy. That is, in the unlikely event that the government of that country does not have a standard protocol in place to deal with COVID-19 patients. “If the government has already picked up your medical tab, you cannot file a claim as you cannot get paid twice. If you are on your own, however, the normal claim settlement process will be applicable,” says Chopra. You will get cashless facilities at network hospitals – the ones that the insurer has tied-up with through global partners, or claim reimbursement later.

A travel policy also covers claims beyond health emergencies – baggage loss, passport loss, third-party liability as also evacuation of mortal remains. “If mortal remains of an insured have to be brought back to India, we will take care of the expenses. However, it is subject to government formalities sanctioning release and insurers cannot play a role here,” explains Datta.

The COVID-19 epidemic, declared ‘Public health emergency of international concern’ by the World Health Organisation (WHO) has led to 1870 deaths in China, while the number of infected has surpassed 72,000. Globally, it has spread its tentacles to 25 countries that have reported 804 laboratory-confirmed cases and three deaths as per WHO figures as on February 18, 2020.

Keep these points in mind when you buy a travel policy while flying abroad.

(The writer is Preeti Kulkarni.)

TOP

Source

Planning to go on vacation? Here's why you should get a travel insurance - The News Mintue – 18th February 2020

Every time you take a trip, you book your flight tickets, make hotel bookings, ensure you read reviews of the place to know what to expect and what to see and experience. But how often do you think of securing a journey with travel insurance?

Travel insurance is an essential part of a vacation as it acts as a safety measure against unforeseen expenses related to travel or medical emergencies that can spoil your trip.

The kind of insurance you choose depends on your travel needs. The insurance covers for a leisure trip and an adventure-filled holiday will be different. For instance, if you are on an adventure-seeking trip to UAE and have planned skydiving in Dubai, the kind of insurance you will need is the one travel covers such leisure activities.

In such a case, the following features in your insurance policy will help you remain stress-free as you have a reliable back up.

24x7 availability
You wouldn't want to be stranded in a foreign destination and wait for it to be working hours in India for support. Thus, your insurer should be always available, any time. You can also opt for insurers who offer a 'Missed Call Facility', wherein when you are on an international trip and need to make an emergency call, they can call you back. It is an added advantage, a convenient option that saves your money and effort to get through to your insurer for help.

Leisure activities cover
This cover is useful if you planned for an adventure activity on your trip. Ensure you compare the details like the premium, duration of the cover, etc., to protect you throughout your plan.

A good medical coverage
This is of utmost important as treatments in a foreign land can get really expensive. So, make sure you have a cover that covers at least 3-4 days of hospitalization and treatment. Every country/region may have a different minimum medical coverage requirement, sometimes also from a visa purpose point of view, but on an average you should look for a coverage of at least $1,00,000 while travelling to US/Canada/Europe and at least $50,000 while travelling within Asia.

On the other hand, if you have planned for a relaxing vacation like going to Bali, and you lose your luggage, or your flight is delayed, it will spoil your vacation. The following features will help you enjoy a hassle-free vacation and protect you throughout the time you are relaxing.

Zero Deductibles
This feature comes in use when you raise a claim as you do not have to pay anything. The insurance company will take care of all the expenses.

Flight delays
Flight delays are common, even on international routes, and always hamper scheduled itineraries. With some travel insurances, you can get immediate compensation for such flight delays.

Baggage claim
Checked-in baggage loss by airlines is a harrowing experience for any traveller. Imagine going to Bali, but your vacation clothes did not arrive as the baggage was lost. According to BBC News, 25 million items of baggage are reportedly mislaid by airlines every year. Few insurance companies also have a flat benefit cash claim option, where you can claim a particular flat-rate amount when your baggage is lost, covering the expenses of the things you lost and can buy afresh on your destination.

Apart from these coverages, irrespective of what kind of trip you are making, there are some coverages that can act like an angel under unexpected circumstances:

Trip Cancellation or Emergency Trip Extension or Trip Abandonment benefit
Right from before the start of your trip to while you are on it, any medical emergency can come up. Of course, while you are on the trip, the medical expenses will be covered by insurance, but even if something happens, make sure your insurance covers trip cancellation costs, the non-refundable ones.

Loss of passport
This can happen anywhere, even in the safest of foreign cities. So, for such circumstances, if your insurance has a loss of passport coverage, you can be cushioned against the emergency certificate needed for you to continue your trip or return to India. And of course, the insurer will help you in this situation as an advisor as well.

And while you're away, apart from a travel policy, you can also opt for a policy like home protection cover. It relieves you from thinking about the safety of your house while you are away. Unexpected situations like fire or burglary are covered under this insurance. People do not have to take a yearlong cover and can opt for a bite-sized two-day cover at a low cost to cover their home contents.

Before you start your trip, it is important first to protect yourself, your loved ones and your beloved assets to avoid unexpected losses and regret.

(The writer is Vivek Chaturvedi.)

TOP

Source

Non-life insurers register 7.2% rise in January premium income at Rs 17,226 crore – Financial Express – 16th February 2020

India's non-life insurance companies registered a 7.2 per cent rise in their combined new premium collection at Rs 17,225.75 crore in January this fiscal, Irdai data showed. The 35 insurers' gross premium collection stood at Rs 16,076.28 crore in the same month a year ago.

Among these, the 25 general insurance providers had a collective premium of Rs 14,643.26 crore during the month, up 2.2 per cent from the same period of 2019, as per the Insurance Regulatory and Development Authority of India's (Irdai) data.

The seven stand-alone private sector non-life insurers registered a 28 per cent jump in their collective premium income at Rs 1,530.75 crore in January.

The rest of the specialised PSU insurers — Agricultural Insurance Company of India and ECGC Ltd — reported 92 per cent spurt in total premium at Rs 1,051.73 crore during the month.

Cumulatively, the premium during April-January of this fiscal for non-life insurance companies rose 14.52 per cent to Rs 1.59 lakh crore.

TOP

Source

Minister hints at FRDI bill in new avatar; UCBs keep fingers crossed – Indian Coperative – 16th February 2020

Financial Resolution and Deposit Insurance (FRDI) Bill, which was once opposed vigorously by the leaders of the cooperative banking sector is again being talked about in the corridors of Finance Ministry.

Soon after the presentation of budget the Union Finance Minister has hinted at the emergence of FRDI bill in a new avatar. "Finance Minister Nirmala Sitharaman said her ministry is working on the controversial

Financial Resolution & Deposit Insurance (FRDI) Bill, but added she is not sure when it will be tabled in the House", quotes PTI.

The new format of the said bill is not known to us yet and thus we cannot react, said NAFCUB President Jyotindra Mehta to Indian Cooperative. "But we are happy that the risk-based premium has not been accepted by government and it's a great relief for UCBs", Mehta added.

"It is a great success for NAFCUB as since last two years we had been representing not to levy premium on differential bases and here it stands accepted", Mehta added.

The original Bill first proposed in 2017 and withdrawn in 2018, had a 'bail-in' clause for resolution of bank failure which was regarded as a step against the savings account holders.

It bears recall that the apex body of urban cooperative banks of India NAFCUB has made a representation before the Joint Parliamentary Committee (JPC) headed by Bhupendra Yadav on the proposed Financial Regulation and Deposit Insurance Bill 2017.

The Bill aims at dealing with bankruptcies in banks, insurance companies, and other financial intermediaries through a 'Resolution Corporation' and a 'Corporation Insurance Fund'.

The bill is a banking version of Insolvency Act currently applicable to companies and corporates. The Insolvency and Bankruptcy Code, 2016 (IBC) is the bankruptcy law of India which seeks to consolidate the existing framework by creating a single law for insolvency and bankruptcy.

The bankruptcy code is a one stop solution for resolving insolvencies which previously was a long process that did not offer an economically viable arrangement. The code aims to protect the interests of small investors.

The finance minister's comments assume importance given the massive five-fold hike in deposit insurance and the recent changes in the insolvency laws to include insolvency provisions for financial institutions, following which leading mortgage player DHLF was sent to NCLT last November, reports PTI.

"We are working on the FRDI Bill; but not sure when it can get through the House," the minister told reporters here without elaborating.

TOP

Source

All you need to know about fidelity insurance – Outlook – 16th February 2020

Amidst a plethora of insurance options we often get confused which one to opt for and which one to avoid. But there are certain insurance policies that you cannot do away with and they are not very talked about. Yes, fidelity insurance is one of those kinds, which is utmost important for industries but very less talked about.

So, let us know what exactly is the fidelity insurance and how should you go about it.
1. What is fidelity Insurance?
See it is very difficult for you to keep everyone honest in your organisation and so you must always think from a different angle that you can't make everyone honest but yes you can be equipped to deal all sorts of problems emanating from the dishonesty of your employee.

So in a nutshell, fidelity insurance is a policy that is going to compensate the company for any financial fraud conducted by any employee. But this policy is going to compensate for a very limited amount of money.

Now, under fidelity insurance there are multiple policies available like individual policy, collective policy, floater policy and blanket policy.

There are multiple things to know before you go out to buy this policy. This policy purely covers financial damage done to an organisation by any unscrupulous element in the company.

How to claim?
Once you get to know that there is a loss reported by your organisation due to the dishonesty of one of your employees then immediately inform the insurer. Disciplinary action must be taken against that employee. The company after this will have to furnish proof to show loss incurred by the organisation. A forensic audit will take place. Sometimes these frauds are very complicated and it is very difficult to know the degree of fraud.

So, this insurance can insulate you from the damages that can be done by your employees.

(The writer is Rajat Mishra.)

TOP

Source

Travel Insurance: Find out if your policy provides coverage due to Coronavirus outbreak – Financial Express – 15th February 2020

The coronavirus outbreak is taking its toll and the virus is known to spread across several other nations outside China. For those who are planning to travel during the coming weeks and months, there are genuine concerns – what if the flight gets cancelled or what if there is a medical emergency abroad owing to coronavirus? In all likelihood, one would have bought a travel insurance policy, but will it cover a cancelled flight due to the coronavirus outbreak? Let's find out from the insurance industry experts.

Typically, a travel insurance policy will cover medical exigencies in addition to your flight-related uncertainties such as loss of baggage, passport etc. "Travel insurance safeguards you from specified uncertain and unexpected situations occurring while you are travelling. It assures that a passenger is able to handle and financially cover medical services in case of accidents, injury, health condition or any sudden event, faced during the travel," says Parag Ved – Executive Vice President & Head – Consumer Lines at Tata AIG General Insurance.

The impact of coronavirus on your travel plans could be financially damaging. There could be cancellation or rescheduling of travel dates, hotel stays etc. "Outbreaks like coronavirus not only result in medical expenditure but may also require the traveller to be evacuated back to his home country which entails a significant cost. These expenses are generally covered under Travel insurance on a cashless basis," says Parag Ved – Executive Vice President & Head – Consumer Lines at Tata AIG General Insurance.

However, at times, not all policies may provide coverage in cases such as the coronavirus outbreak. "Coverage depends on various factors, such as the type of policy, insurer, and policy inception date. There are a few insurers who have announced that policyholders will be covered if they are impacted by the outbreak of the viral disease. However, it will vary on the travel advisories and their respective governments to take a call on this as such cases of epidemics and pandemics are usually excluded," says Rakesh Goyal, Director, Probus Insurance Broker.

If you are travelling abroad, it could be compulsory to get travel insurance before you fly to some specific countries. "Travel insurance policy is a mandatory requirement for travellers who need to apply for a Schengen visa. Also, for passengers travelling to other countries, it is equally important to have the most comprehensive overseas travel insurance to safeguard you from medical and other exigencies.," says Ved. Remember, the cost of hospitalisation in most foreign countries especially in US, UK and Europe is very high.

And, if you are considering to buy travel insurance before taking your family to an international trip, you can either buy a family floater or buy a cover separately for each member. "It is prudent for travellers to buy individual travel insurance as the coverages under a group policy may be restricted or may have a sum insured which are insufficient to meet any exigency," says Ved. For someone going on an official trip, one may want to skip buying a separate cover. "One when travelling internationally for work purposes, it is suggested to have an individual policy too even if you are covered under a group plan. Furthermore, it is crucial to check inclusions and exclusions of a policy from the insurance company, as it may vary from insurer to insurer,' cautions Goyal.

Reading the fine print is very important to make an informed buying decision. It is better to go through the inclusions and list of exclusions in the policy document. One may even contact the insurer and get it in writing about the specific coverage.

(The writer is Sunil Dhawan.)

TOP

Source

HEALTH INSURANCE

How senior citizens aged over 65 years can get optimal health insurance at reasonable cost - The Economic Times – 25th February 2020

On 1st April, India's health insurance landscape will change forever with the Irdai-mandated Arogya Sanjeevani Policy coming into effect. However, the standard health insurance policy has its set of limitations. Not only is the entry age restricted to 65, but the cover is also capped at Rs 5 lakh, way too low for senior citizens living in big cities.

Since this new plan will not serve the purpose of those above 65 years of age or those who need a larger cover, they must look at other options. Before exploring the available options, let us first understand the basic premise of health insurance. Unlike life insurance, the annual premium for a health cover keeps increasing with age. So while choosing an option, you need to calculate the expected premium 10 or 15 years from now in addition to studying policy features and current premium. Though it is difficult to predict what the exact premium would be going forward, someone who is 65 can get a rough idea about how much would need to be paid 10 years down the line by looking at the current premium charged by insurance companies for a 75-year-old.

Medical insurance premium balloons with age

1. Normal or dedicated plans

With more senior citizens realising the benefits of and opting for health insurance, some insurance companies have started offering dedicated plans (see table). So you need to first decide whether to opt for a normal health plan or one specifically meant for senior citizens. As of now, there is little advantage in opting for senior citizen specific plans. If you compare the premiums charged by the dedicated plans and regular plans by the same insurers, you will notice the specific plans charge higher premiums and come with more restrictions. Regular plans work out to be more cost effective for senior citizens because the pool is also supported by young people, who make very few claims.

There is little advantage in opting for dedicated plans

Go for senior specific plans only if you are not eligible for normal plans.

Premium for Rs 10 lakh cover. Source: www.policybazaar.com

Senior citizen-specific plans

INSURER	Religare Health Insurance	Star Health Insurance	Aditya Birla Health Insurance
PLAN	Care Senior	Senior Citizen Red Carpet	Activ Care Standard
ANNUAL PREMIUM 60-YR-OLD	NA	₹26,550	₹23,049
ANNUAL PREMIUM 65-YR-OLD	₹25,828	₹26,550	₹30,888
ANNUAL PREMIUM 70-YR-OLD	₹39,524	₹26,550	₹49,672
ANNUAL PREMIUM 75-YR-OLD	₹50,939	₹26,550	₹64,331
ROOM RENT LIMIT	Up to ₹10,000/ day	Up to ₹6,000/ day	Shared room but can upgrade to single by opting for rider
CO-PAY	Mandatory co-payment of 20%	Mandatory co-payment of 30% and 50% in case of PED	20% mandatory co-payment

General retail plans

INSURER	Religare Health Insurance	Star Health Insurance	Aditya Birla Health Insurance
PLAN	Care	Medi Classic	Active Assure Diamond
ANNUAL PREMIUM 60-YR-OLD	₹25,265	₹26,366	₹24,264
ANNUAL PREMIUM 65-YR-OLD	₹29,564	₹35,330	₹28,392
ANNUAL PREMIUM 70-YR-OLD	₹29,564	NA	₹42,892
ANNUAL PREMIUM 75-YR-OLD	₹58,151	NA	₹55,844
ROOM RENT LIMIT	Up to single private room permissible for hospitalisation	Up to ₹5,000/day	Up to single private room permissible for hospitalisation
CO-PAY	Full claim paid by insurer; 20% co-payment if age>60	Full claim paid by insurer; 10% co-payment if age>60	Full claim paid by insurer; 20% co-payment if age>60

However, one should note that the underwriting standards are higher for normal plans and therefore, chances of senior citizens being allowed to opt for these is lower. However, this should not be a deterrent. “Normal health insurance comes with better features and fewer restrictions. So, senior citizens should try for that first and settle for dedicated senior citizen’s plans only if insurance companies do not allow them to opt for a normal plan,” says Amit Chhabra, Health Business Head, Policy Bazaar.

2. Co-payment or not

High premium costs are a deterrent for senior citizens seeking health insurance. Settling for plans with co-payment option is one way of keeping premiums low. Co-payment provides a win-win situation for the customer as well as the insurer. “Since customers start questioning costs charged by hospitals, co-payment brings in discipline,” says Sanjay Dutta, Chief, Underwriting and Claims, ICICI Lombard General Insurance. The Arogya Sanjeevani Policy comes with 5% co-pay for all age groups.

In an effort to reduce premiums, however, do not ignore your liquidity situation. “If you have enough liquid cash and can handle 20% of the expenses, opt for co-payment option and enjoy the reduced premium,” says Abhishek Mishra, CEO, Bonanza Insurance.

General plans without co-pay can be costly

Opt for co-pay if you can afford it as it will keep the premium down.

INSURER	PLAN	ANNUAL PREMIUM AT 60 YEARS	ANNUAL PREMIUM AT 65 YEARS	ANNUAL PREMIUM AT 70 YEARS	ANNUAL PREMIUM AT 75 YEARS	ROOM RENT LIMIT
Max Bupa Health Insurance	Health Companion	₹33,558	₹46,040	₹59,853	₹74,816	All categories except suite and above
HDFC Ergo Health Insurance	Optima Restore	₹31,802	₹44,860	₹55,577	₹71,132	All categories

Premium for Rs 10 lakh cover. Source: www.policybazaar.com

3. Base or critical illness cover

Does it make sense to reduce the base cover and replace the same with a critical illness rider? After all it's critical illnesses that make a bigger hole in your pocket than common illnesses. A Rs 5 lakh base cover + Rs 10 lakh critical illnesses cover works out to be cheaper than a comprehensive Rs 15 lakh base cover (see chart). However, there is a catch. Critical illnesses are defined and any illness outside that list will not get the additional cover.

Base + critical illness cover works out cheaper
The catch is any illness beyond defined critical illnesses will not be covered.

INSURER	PLAN	₹5 LAKH BASE COVER + ₹10 LAKH CI	GENERAL PLAN (₹15 LAKH)
Religare Health Insurance	Care	₹27,783	₹30,388
Star Health Insurance	Senior Citizen Red Carpet	₹29,637	₹34,462
Max Bupa Health Insurance	Health Companion	₹35,178	₹38,139
HDFC Ergo Health Insurance	Optima Restore	₹31,176	₹38,119

Annual premium for 60-year-old

Another option is to go with an independent critical illness cover. Here the claim payment mechanism is different. The money is paid out in a lump sum on detection of a particular illness and is not based on actual treatment cost. "While health insurance will meet hospitalisation expenses, an independent critical illness cover will help to meet additional expenses triggered by the illness," says Dutta.

4. Base cover or super top up

Another way to reduce premium is to skip the base health insurance cover and try to manage only with super top-up plans. Before explaining the strategy here, let us explain the difference between top-up and super top-up plans. In top-up, the hospital bill should be more than the deductible limit to get paid. In super top-up, on the other hand, the limit is considered on policy year basis. Assume that you have a top-up plan with deductible of Rs 5 lakh and your medical bill for the year is Rs 8 lakh, but the same is split between four hospitalisations— Rs 2 lakh each. Since each hospitalisation cost less than the Rs 5 lakh

limit, you won't get anything from top-up plans. However, the insurance company would have paid you if that plan was a super top-up, as the total expenses incurred was more than Rs 5 lakh in a policy year.

Super top-up plans work fine if you can keep the deductible low (say Rs 1 lakh) and then go for a super top-up plan with a high cover. In this situation, you will be first paying Rs 1 lakh per annum from your own pocket and the insurer will foot the bill only when it goes beyond this limit. The logic here is like that of co-payment. You are ready to bear a part of the medical bill to reduce the overall premium. However, the problem is most insurance companies won't allow a high top-up with low deductible. For example, most companies will offer only up to Rs 5 lakh cover with a deductible of Rs 1 lakh. They will increase the deductible proportionately —you will need to take a Rs 5 lakh deductible to get a super top up cover of Rs 20-25 lakh.

The strategy of taking Rs 5 lakh base cover and Rs 10 lakh as super top-up (with Rs 5 lakh as deductible) works out cheaper (see chart). Legally, customers can take base cover and super top-ups from different insurance companies, thereby keeping costs low. However, experts ask you to take both policies from the same company. "Both policies from same company increases the operational convenience. You don't have to handle documentation from two companies," says Mishra.

Super top-ups work if deductible is low
Base plan + super top-up works out to be cheaper than only base plan.

Large base plan or base plan + super top-up

INSURER	PLAN	₹5 LAKH BASE COVER + ₹10 LAKH SUPER TOP-UP	GENERAL RETAIL PLAN (₹15 LAKH BASE)
Religare Health Insurance	Care	₹28,934	₹30,388
HDFC Ergo Health Insurance	Optima restore	₹25,765	₹29,119

Annual premium for 60-year-old

5. Insurance or corpus

With medical insurance costs rising, some people may think of replacing it with a medical corpus. However, that is not the right thing to do. "Depending only on a medical corpus will be risky because a serious ailment can wipe out the corpus in a year," says Melvin Joseph, Founder, Finvin Financial Planners.

However, even if they have medical insurance, senior citizens should also maintain a reasonable medical corpus. This is because all medical costs are not covered by insurance. For instance, most policies don't cover OPD treatments; you need to be hospitalised for at least 24 hours to make a claim. Secondly, while all hospitalisation expenses may be reimbursed for younger policyholders, senior citizens will have to deal with several exclusions or co-payment restrictions.

Depending on child's cover

It works well if you are covered under a family floater paid for by your child. What about the health cover offered to your children by their employers? While health insurance policies of some companies cover employees, others give options to add parents at a price. Though these are good, depending on these alone may be risky. "One basic criterion to be used is certainty of its continuance. The corporate insurance will stop once your child leaves the company," says Deepak Yohannan, CEO, My Insurance Club. Changing companies or starting new businesses are common among the young today, so senior citizens depending only on their child's corporate cover may be left with nothing at the time of need.

Porting company policy

Consider porting your corporate cover at the time of retirement instead of buying a new plan. Since insurance companies know your claim history, this transfer will be easy if your health is good. However, the transfer may get rejected if you have health issues. "Since most companies insist on medical checkup for this transfer, the chances of them getting rejected is high," says Joseph.

Why you need to take early cover

High medical insurance cost is the first thing that comes to everyone's mind. More importantly, annual premium on health insurance keeps increasing with age. This increase is applicable for everyone, including people who have a running health insurance cover from a young age. However, one must buy a cover as early as possible. "The premium will be similar at a later age but getting a new cover will be difficult. So, purchase a reasonable cover before you get any health issues," says Melvin Joseph, Founder, Finvin Financial Planners.

Will insurance companies play dirty when you start developing health issues? Earlier, insurance companies used to reject renewals or increase premiums to very high levels (forcing customers to withdraw) in case a customer made regular claims. This played havoc with long term policyholders. However, Irdai has stepped in to stop companies from terminating policies of senior citizens who make regular claims. "Health insurance policies can be renewed lifelong and companies can't reject it or jack up premium for specifi c customers," says Amit Chhabra, Health Business Head, Policy Bazaar.

(The writer is Narendra Nathan.)

TOP

Source

National policy on rare diseases is unscientific – The New Indian Express – 20th February 2020

Terming the draft national policy on rare diseases "unscientific", the Organization for Rare Diseases India (ORDI) urged the Centre to make a budgetary allocation of Rs 400-600 crore for the treatment of such diseases and remove the Rs 15-lakh cap on the treatment cost.In its list of 15 recommendations sent to the Ministry of Health and Family Welfare in response to the draft policy which the Union government came out on January 13 inviting inputs from the public, the Bengaluru-based not-for-profit sought disease-specific financial packages, waiver of GST and import duty on essential drugs and medical devices.

"The draft policy does not speak about the central government covering the treatment cost of rare diseases and only depends on crowd funding which is not sustainable when the treatment runs into crores each year per patient. The earlier draft included a cost sharing between the state and the centre in 40:60 ratio which has been removed from the new draft," ORDI co-founder and executive director Prasanna Shirol said.

ORDI urged the ministry to create a rare diseases fund and share the cost of treatment with the state government in 60:40 ratio. There should be centres for treatments in every state and a national treatment centre, it recommended, adding that state and central technical committees should meet annually and take stock of rare diseases, drug price and therapies.

It also demanded a clear definition of rare diseases and called out the policy for its "unscientific and biased way of randomly selecting a few diseases to be covered." The organisation recommended putting orphan drugs (intended for treatment of life-threatening rare diseases) under price control. There must be a healthcare coverage for rare diseases, including recurring supportive treatment which is highly expensive, it advised.

"The lack of insurance coverage must change... It is unclear whether patients can avail assistance of multiple schemes such as Rashtriya Arogya Nidhi or Ayushman Bharat or both. There is no coverage for

outpatient services," it said.The organisation urged that the government encourage research and development for diseases which do not have any approved therapies.

"The policy must include pre-natal screening of high risk pregnancies and new born screenings which can identify rare diseases in the first few days of baby's life and result in life-saving changes," the submission explained, also urging the government to create awareness among clinicians, supportive care personnel and make special medical foods and special wheelchair affordable and available to patients.

(The writer is Ranjani Madhavan.)

TOP

Source

Five health insurance terms you must know before buying policy – Mint – 20th February 2020

Buying a health insurance policy may have been on your mind for a while now but the long list of jargon that you have to decode before zeroing down on a policy might make you lazy.

"Unless a policyholder understands the various terms in a policy and what they mean, he or she won't be able to effectively use it," said Abhishek Bondia, principal officer and managing director, SecureNow.in. To make your purchase easier and help you pick the right policy, we demystify some of the common health insurance terminologies for you. Read on.

WAITING PERIOD

This is the time span during which you cannot file a claim on your health insurance policy. Duration of the waiting period varies from insurer to insurer.

"Waiting period is the duration after which the said ailment gets covered. Until then the ailment is effectively uninsured," said Bondia.

Typically, there are three kinds of waiting period. First is the initial waiting period where in if you get hospitalised within the first 30-90 of buying the policy, your claim will not be accepted, unless the hospitalization is on account of an accident. In case of an ailment, you will be eligible for the claim benefit only once the initial waiting period is over. Second is the waiting period for pre-existing diseases. Typically, you are required to undergo a health check up before buying a health insurance plan. You're also required to declare specific diseases you've been treating for or are undergoing treatment for. Such diseases are known as pre-existing diseases and there's a waiting period before which your insurer will not accept a claim. The waiting period for pre-existing conditions can last from one to four years. The third kind of waiting period is on specific ailments. The insurer specifies the waiting period during which time it won't entertain a claim for specified ailments and this waiting is usually for a year to two years. While these are the common waiting periods, there could be some more like in case of maternity benefits. A few health insurance plans offer maternity benefits only after a waiting period of 9-36 months, depending on the policy and the insurer.

CO-PAYMENT

Certain policies come with a co-payment clause. This means if and when you file a claim, a part of the claim amount will have to be borne by you. This would be your out-of-pocket expense and is usually expressed as a percentage of the claim amount. For example, if you file a claim of ₹10,000 and have a co-payment clause of 10%, you'd have to spend ₹1,000 from your own pocket.

Typically, insurers insert the co-payment clause where the risk is high; for instance, a health insurance policy for a senior citizen.

DEDUCTIBLE

"Deductible is a fixed amount of deduction. Claim amount only exceeding this threshold will become payable," said Bondia. Simply put, deductible is the uninsured part of your claim amount. As a policyholder, you have to pay this amount before your insurer steps in and takes over to cover for damages as per the policy terms and conditions. Deductible amount is usually decided at the time of policy purchase. Say your deductible is ₹10,000 and you make a claim of ₹60,000, then your insurer will cover you for the remaining ₹50,000 after you've paid the ₹10,000.

NO-CLAIM BONUS (NCB)

Insurers give cumulative bonus, also known as NCB, if you don't make any claim. Usually, your insurance cover, or the sum insured, is increased by 5% for the year you don't make a claim up to a maximum of 50%. The type of NCB offered and the discount rate provided vary from one insurer to another. For instance many insurers now bump your sum insured by a 100% instead of 50%. However it's important to understand the impact a claim may have on your accumulated bonuses, so do ask your insurer about it. "In case of a claim, the insurance company will reduce the no-claim bonus at the same rate at which the NCB was increased when it rewarded you for a no claim. However, this does not affect the base sum insured for which you have paid," said Mahavir Chopra, director of health, life and travel insurance, Coverfox.com

FREE-LOOK PERIOD

You may have bought a health insurance policy on somebody's suggestion and might realise a little later that the benefits and terms and conditions don't suit your needs. Here's when the free-look period helps. Free-look period gives you an opportunity to review the policy you've bought and return it in case it doesn't fit the bill.

Almost all health insurance policies come with a free-look period of up to 15 days from the date of receiving the policy documents and can go up to 30 days in case of some insurers. In case you do choose to return the policy, the insurance company will refund the premium paid after deducting a specific amount. Charges such as stamp duty, expenses incurred towards the medical test and so on are deducted from the refund.

(The writer is Disha Sanghvi.)

TOP

Source

Woof! Your pets can get health insurance – Deccan Herald – 19th February 2020

Health insurance for pets is now available, but not many pet parents in Bengaluru are aware of it. New India, United India, and Oriental Insurance are among the companies offering pet health insurance. Policies cover pre- and post-hospitalisation expenses, and cancer and heart ailments.

Premium ranges from Rs 120 to Rs 2,000 a year per pet. Dogs older than eight years are not insured. The basic premium is five per cent of the sum insured. New India Assurance offers dog insurance policies that cover death from accidents and diseases contracted during the period of insurance. Bank Bazaar aggregates policies of many kinds, including those that cover loss or theft of the pet, accidental poisoning and third-party liability.

Death from rabies, distemper, viral hepatitis, viral enteritis and leptospirosis, and loss or injury due to war and foreign hostility are excluded.

Keep in mind
One of the requirements for pet insurance is that the dog must be registered. A certified veterinary doctor will examine the pet as part of the process.

Apart from breed, sex and age, identification markers include tattooing, a nose print and a photograph. The insurance company bears up to 80 per cent of the claim amount.

Welcome move
In 2019, a report by India Pet Food Market Forecast and Opportunities said Bengaluru, besides Mumbai and Delhi, is one of the cities with an exponential rise of pet ownership.

Dr Pawan Kumar, veterinarian, surgical emergency department at Cessna Lifeline Veterinary Hospital, says pet parents claim reimbursement on hospitalisation bills. "Just like health insurance for people, pet insurance is also cashless. I've come across parents who bring along pets for immediate surgeries. It's difficult for many to handle the costs, so insurance comes in handy," he says. Cessna has tied up with Vetina Pet Insurance to help parents who come in for medical emergencies.

Only about two per cent of pet parents are taking health insurance for their pets, according to a rough estimate. Anand Vishwanath, founder of Anvis Inc, a company that provides pet fostering, was speaking to pet insurance agencies but wasn't fully convinced it was for him. "Most policies have schemes specific to the breed of the dog, and we didn't get any clarity on the case for mixed breeds. And while the insurance companies say they provide 'pet health insurance', it's mostly only for dogs. Cows are considered livestock, but what about pets like cats, fish and so on?" he says.

Companies offering pet health insurance
New India: Insures dogs between eight weeks and eight years. Premium charged is 5% of sum insured. The company also insures sheep, goats, cattle, pigs, camels, poultry, duck, rabbit, elephant, and inland fish.

United India: Covers both exotic and indigenous breeds of animals. Policies cover permanent and total disability and accidental death.

Oriental: Policies cover horses, dogs and elephants. Dogs between eight weeks and eight years are insured. Premium ranges from Rs 200 to Rs 10,000 per animal per year.

(The writer is Anila Kurian.)

TOP

Source

Health Insurance: Turning a blind eye towards C-word? Better be prepared for it – Financial Express – 19th February 2020

The C-word brings sweat to our foreheads, there's no doubt about that.

Even more when today we see that celebrities to our next-door neighbour, a new born to an ageing person, a city dweller to a rural dweller, there is no defined pattern which can guarantee that this lifestyle or social status or gender or location will not get the disease. A research report published in the Asian Pacific Journal of Cancer Prevention, 2013, says that around 13 lakh+ people are predicted to report the disease by 2021.

Basically, it can happen to anyone.
Of course, there are lifestyle changes including food habits, exercise routines, preventive care, stress-free mind and more that gets talked about when it comes to avoiding cancer but there is no full-proof method or vaccination that can protect us.

But the silver lining is that if detected and treated at the right time, today even Cancer is treatable. With the development of modern medicines, cancer in some cases, cancer can be completely cured.

Even though new treatments and medical advancements assure you of quick procedures, holistic care and relatively less painful cures for cancer, the protocols are time-consuming and expensive. For instance, the treatment of commonly seen cancer types like breast cancer among women and lung cancer among men cost a minimum of Rs 4-5 lakhs, depending on the severity, putting it under the 'not-affordable' category.

For some families, this could cost half of the savings of their lives. Unfair right?

Yes, it is unfair, and which is why we need to plan in advance for these scenarios with interventions like regular annual screenings and a Health Insurance Policy.

Screening is actually the key in timely cancer treatment, therefore an annual screening after 40 yrs in women (like Mammography, Pap smear, Ultrasound) and 55yrs in men (PSA Ultrasound for men apart from some tumor markers) can be helpful. Also, it just takes Rs 1000 to Rs 1500 a year to get these screenings done, making them totally worth it!

New-age insurance companies provide Critical Illness Cover as a part of the Comprehensive Health Insurance. The coverage will include cost of procedures for diagnosis and the following treatment including chemotherapy, surgery, hospitalisation, radiation therapy, immunotherapy and other expenses, along with several years of follow up.

From a health insurance perspective, when you choose your health insurance, check the following:

Go for a higher sum insured: Don't just take insurance from a tax benefit pov, but also from an actual usage point of view. Here's how you can go about choosing your sum insured:

- One straight through way is to choose a sum insured greater than or equal to your annual salary.
- Another way to look at it is from the medical costs in your city. If you are living in metros, the cost of treatment may be higher vs. if you are living in a smaller town, so choose a sum insured that can cover at 1.25 times of the average cancer treatment.
- Also, the type of cancer dictates the cost. But having a coverage of 5-7 lakhs is the minimum you should have if you are looking at average treatment costs.
- In case you are planning to buy a family floater policy then increase the above-expected coverage by 50% as it is shared between members of the family.

Check for copayments: Copayments is a tool with which the insurance premiums can come down for the customer and the risk becomes lower for the insurer. But if you are looking at the coverage to really protect you against big expenditures then copayment is a bad idea.

Have two separate policies: Some people have comprehensive health insurance without Critical Illness cover, in that case, they can look at a separate Cancer Benefit Addon or Cover, though the suggested one would be a comprehensive cover that covers all Critical Illnesses, beyond cancer as well!

Waiting periods: If there is no pre-existing Cancer Illness then there is generally a waiting period of 30 days before the Critical Illness Cover is active for the insured members. And unfortunately, if there is an existing Cancer condition or history, then getting a new policy becomes difficult, even increasing the sum insured becomes difficult.

In short, if Cancer enters your life, you need both emotional and financial support. So, health insurance with a Critical Illness cover is mandatory and is often ignored by people.

Therefore, to avoid such regret, it is always best to buy health insurance with a decent sum insured when you are young, healthy and disease-free!

(The writer is Dr. Sudha Reddy.)

Source

TOP

Medical policy holders seek higher cover – The Times of India – 19th February 2020

As more Indians turn cautious and protect their life goals from getting derailed, they are writing fatter consequentially the average sum insured for critical illness has risen 20%-30% in the past year.

"On an average, people are trying to take high sum assured policies on indemnity plan, where cashless medical expenses get covered. In those products which are only for critical illness, the sum insured rate has grown by 10%-20%," said Sanjay Datta, head of underwriting at ICICI Lombard General Insurance.

Future Genrali India Insurance said they have seen customers increasing the average sum insured on standalone critical illness covers by 30%-35% on yearly basis. "However, we have not recorded any significant loss claim ratio, as it remains flat at 65%," said Shreeraj Deshpande, chief operating officer of Future Generali India Insurance.

The main reason for people to opt for higher sum insured is the higher incidents and claims made under critical illness.

Amit Chhabra, business head, Health Insurance, Policybazaar.com said, "There is a growing trend where people choose for an indemnity plan with higher value of sum insured as it provides the option to renew the policy for lifelong, unlike the fixed benefit policy, where the insurance money gets settled for once. Meanwhile, more people are increasing their health insurance cover with higher sum insured, instead of buying a basic health policy and an add on of critical insurance policy. In such case, the premium is cheaper by Rs 5,000." Heart ailments, cancer-related illness, kidney problems continue to top the list of major critical illnesses.

According to data shared by Bajaj Allianz General Insurance in the period between FY2016-2019, there has been a 79% increase in the number of claims due to cancer. While, the average claims size is around Rs 75,000 to Rs 80,000, with the highest claims pay out was over Rs 25 lakh in 2019. On an average 40% claimants are males as against 60% female claimants, with the average claiming age group lying between 50-60 years. Parag Ved, senior VP — head of consumer lines of Tata AIG General Insurance Company said, "We have seen about 10%-15% increase in policyholders opting for higher sum insured under indemnity cover to meet expenses related to critical illness." Meanwhile, general insurance companies also expressed, their share of business covering critical illness." Meanwhile, general insurance companies also expressed, their share of business covering critical insurance policies see tough competition from life insurance companies who offer the critical insurance cover as a rider.

(The writer is Mamtha Asokan.)

TOP

Source

Irdai plugs gaps to reduce claim disputes on pre-existing illness – Mint – 18th February 2020

The interpretation of pre-existing diseases has been the biggest bone of contention between policyholders and health insurers, and is also the primary reason behind claim rejection. While the insurers put the responsibility of disclosing pre-existing ailments on the buyers, the ambiguity in its definition and the way health insurance is sold in India leaves a lot of room for confusion. Coupled with the fact that awareness about insurance products is still low in India, the balance is largely tilted in favour of the insurers, in terms of claims.

To remove this ambiguity and to set the balance right, the Insurance Regulatory and Development Authority of India (Irdai) has changed the definition of pre-existing diseases twice—through notifications issued in September 2019, and on 10 February.

Until the first change, they were defined as ailments for which the insured person had “signs" or “symptoms" and had sought medical advice or treatment 48 months before the policy was issued. “As the definition was broad, there were cases where insurers inferred it differently, leading to disputes," said Nikhil Apte, chief product officer, Royal Sundaram General Insurance Co. Ltd. The subsequent changes have narrowed the definition, giving more clarity. We take you through the changes in the definition of pre-existing diseases.

The problem earlier

The broader definition led to disputes in certain cases.

Take the case of an insured person who had a liver-related disease a few months before taking the policy but did not know about it. According to Apte, fatigue is the most common symptom for a liver disease. The patient may have sought treatment for fatigue before taking the policy and the doctor may not have related the symptom to a liver-related problem. However, after taking the policy, the liver-related disorder was finally diagnosed because his condition worsened. Claims for such treatment, typically, led to disputes. An insurer could say that the patients had the signs and symptoms of the disease, and medical treatment was also sought for it, though in reality, the doctor never diagnosed the illness then. Consequently, it could lead to rejection of the claim.

Similar treatment was meted out in cases where the insured person was not aware of an ailment he had.

Experts said this broader definition gave insurers a lot of leeway. “If an insurance company could prove that the policyholder had ‘signs’ and ‘symptoms’ of an illness before taking the policy, it would be considered as pre-existing disease," said Mahavir Chopra, director, health, life and travel insurance, Coverfox.com, an online insurance marketplace.

In fact, insurers were within their rights to exercise this up to four years from issuing a policy, and pre-existing diseases were covered only after this period. A lot of these problems also surfaced in policies that are sold without any medical tests as they are also subject to stricter scrutiny. According to experts, more than half of health insurance policies are sold without medical tests, especially those sold through the banking channel.

The first modification

Irdai first redefined pre-existing diseases in September 2019, as part of a standardization exercise for the health insurance industry. It gave insurers time until 1 October 2020 to implement the changes.

The regulator brought in two separate clauses to define a pre-existing disease. One, where the patient was diagnosed with an ailment for which medical advice or treatment was recommended 48 months prior to policy issuance. Two, where the patient had signs or symptoms of a disease within three months of taking the policy, and was diagnosed later.

The second clause was inserted primarily for diseases related to the heart, hypertension and diabetes, where there could be signs and symptoms but the patient was not aware or delayed medical consultation. “This was inserted as the regulator wanted to put some onus on the policyholders to disclose all information correctly and clearly, failing which, there could be consequences," said Apte.

However, some experts said that the second clause retained the original ambiguity. Insurers could have contended that there were signs and symptoms that the policyholder had not disclosed. For example, a common symptom of diabetes is increased thirst,but that may happen even to those who do not have diabetes.

The latest changes

The regulator has now deleted the second clause. Now, a pre-existing disease is any condition “that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer

or its reinstatement, or for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement."

“The change takes away problems that policyholders could have faced due to existing regulations. If an illness falls under the definition of pre-existing disease, the insurer could reject the claim, hike premium, or even terminate the policy," said Amit Chhabra, head, health insurance, Policybazaar.com, an online insurance marketplace.

The regulator has also relaxed the norms for treatment at hospitals that insurance companies have blacklisted.

Earlier, insurers rejected claims made at a hospital they had blacklisted, unless a person was admitted after an accident that was life- threatening. Now policyholders can get treatment not just after accidents but in any life threatening situation at such hospitals. “Insurers will admit such claims only until the stage when a patient’s condition stabilizes. Expenses after that will not be reimbursed," said Chopra. In most cases, stabilization would mean when an insured is moved out of, say, the intensive care unit (ICU) to a regular room. Chopra added that whether the situation was life- threatening or not would depend on the doctor’s diagnosis.

Mint take
Irdai has tried and plugged most loopholes that left room for ambiguities in how pre-existing diseases are defined. However, as a policyholder, you need to be careful as well. Ensure that you fill out the correct details to the best of your knowledge and don’t rely on the agent completely. Do not hide pre-existing diseases even if the agent tells you to. Non-disclosure can easily lead to termination of a policy.

“Insurers construct the forms in such a way that they ask for all the relevant details from the patient. For example, we even ask the patients whether they’ve consulted a doctor for any disease in the past 12 months. If they say yes, we ask for details. Depending on the information, we ask patients to undergo medical tests for further investigations," said Apte.

Also, remember that most health insurance policies come with a cooling period of one month. During this time, only accident-related claims are accepted.

(The writer is Tinesh Bhasin.)

TOP

Source

Now opt for a comprehensive health insurance policy - Outlook – 18th February 2020

The decision to go for health insurance is usually something most of us are not willing to do until it is too late. Choosing the right insurance to safeguard your health can be challenging and confusing at the same time. Health insurance is still not seen as a priority unless we need the policy to save on taxes.

Even if you and your loved ones are in perfect health, your health insurance should play a critical role in your financial planning. If you were to get sick and in need of treatment and hospitalization, not having an insurance plan, could dent your pocket significantly. A good health insurance plan can reduce the financial blow that is associated with doctor’s visits, tests, medicines, and other procedures.

The escalating cost of healthcare is just one of the reasons why health insurance is important. Your health insurance also covers medical Inflation as healthcare is likely to become more expensive in the future and

ensures cashless treatments, especially in an emergency situation, where you may be strapped for funds or resources.

Another common misconception is that health insurance should be purchased when you are older since the possibility of falling ill is higher. Nothing could be further away from the truth. The regulations in India have ensured an extremely customer friendly construct for the product and therefore buying it young, makes an immense sense. You can not only start your health insurance at a very affordable premium, but you are also guaranteed renewability for life. This means that an insurance company cannot refuse to renew a policy once issued, irrespective of any number of claims made. Further, most policies will have waiting periods for specific types of claims so, if you start early, by the time you really need those facilities, all the wait periods are over.

However, choosing the best health insurance policy for your or your family's health is a decision that cannot be taken lightly or in haste. There are several things you must consider when opting for a comprehensive health insurance policy. Here are some pointers to get you started –

The comprehensiveness of cover – You should choose a policy that covers not just hospitalization but also allied medical costs including outpatient treatments and check-ups. Also, select the amount of coverage or 'Sum Insured' carefully keeping in mind the cost of today's medical treatments or about an average cost of hospitalization.

Consider what is included – When opting for a health insurance policy, remember to check what all are included in the policy, there are many procedures that do not require hospitalization, so the number of daycare procedures included should be important. Depending on your life stage, you may also need some specific benefits as maternity included.

Sub-limits – Some policies will have sub-limits on the room rents, you should consider if these fit your requirements in terms of the type of room and kind of hospital you might go to. Some policies may also have procedure wise sub-limits, it is advisable to be mindful of that. Policies without sub-limits are likely to be more expensive and that is a choice that should be made with careful consideration.

Hospitals network - Check for network of hospitals available under the policy that provide cashless facility and how close they are to your neighbourhood. Global hospital networks in case you travel frequently.

Co-pay - Most health policies have a voluntary co-pay clause. This means that you can choose to reduce your premium at the time of purchasing the policy by offering to pay a fixed percentage of whatever claims have been made throughout the year. If you wish to co-pay, you can select the percentage you would like to commit to the right at the start.

Waiting periods - Different policies have different waiting periods outlined. The waiting period is basically a defined time span during which claims are not entertained. Generally, if the claim is related to a pre-existing illness, the waiting period is likely to be longer. When looking for a policy, try to find one that has the least possible waiting period.

Critical illness cover – It is an unfortunate fact that the incidence of illnesses like cancer is increasing. So it is always advisable to choose a health policy that could help cover easily the areas. However, this comes with a cost and you need to make the decision based on its affordability.

No claim bonus – Most insurance providers will provide you with something known as a cumulative or loyalty benefit. Essentially, if you do not make a claim during a policy year, they will consider a discount on your insurance premium for the following year. Alternatively, they may also offer you a higher sum insured without increasing your premium. Always choose which benefit wisely.

Premium – Generally, the premium that you pay will depend on factors such as the amount of cover you have opted for, your age, your medical history, and the type of plan you have picked. Given the competition in the market, you should be able to find yourself a provider who will offer you exactly what

you are looking for at the best possible rate. However, this should not be the primary decision making factor.

This is a list that should help you do your homework based on what your needs are and then invest in a health insurance plan that is comprehensive and best suited for your family and you. While you may seek recommendations from friends and family, make the choice consciously, keeping in mind, what your needs are and what services you expect.

At the same time, while it is advisable to not make this decision in a hurry, I would recommend that you do not wait too long either. Often, customers wait just a tad bit too long for their perfect health insurance plan and gradually miss out on buying the health insurance. As a thumb rule, any plan that matches around 75 per cent of your requirements is the plan you should go for.

Finally, while health insurance will always act as an effective fall back for medical expenses, it is equally important that we take steps to prevent illness by focusing on nutrition, exercise, and sleep. While the financial expense of a medical emergency can be covered by insurance, emotional expense will still take its toll.

After all, prevention is better than cure!

(The writer is Shanai Ghosh.)

TOP

Source

Your money: Know how a top-up health insurance plan works – Financial Express – 18th February 2020

One of the best ways to be financially equipped against uncertain health risks is by buying health insurance which provides people with financial support in times of medical emergencies. However, when it comes to buying a health insurance cover, tax rebates take precedence over adequate cover. People usually dismiss the significance of an adequate health cover with rather frail arguments that they are healthy enough or the present cover is sufficiently high.

Let us take the case of Sanjay Verma. He had a taken a health cover of Rs 5 lakh sum insured as he believed that this would be sufficient for any medical exigency. He and his family were quite assured even when he was hospitalised last April, as they believed that all the expenses would get covered. But, it came as a shock to them when the medical bills rose up to Rs 8 lakh and the family had to utilise the money that was set aside for their children's higher education.

It is also a fact that a larger health cover, no matter how essential, may not fit into everybody's budget. This doesn't mean that there is no solution for it. This is where top-up plans come in.

What is a top-up plan?

Top-up plans are basically add-on plans which can be purchased in addition to one's regular health insurance policy. Top-up health insurance plans cover hospitalisation costs outside the specified limit.

While regular health insurance policies compensate hospital bills equal to the sum insured, top-up plans cover costs after a certain threshold is attained. They not only cost less but offer high coverage too.

One of the best features of a top-up plan is that it is available with most health insurance companies and one can buy them either from the existing insurer or a different company.

How does it work?
Top-up plans function on a cost-allocation basis where medical expenses up to the threshold limit have to be borne by the policyholder either from his own sources or any base insurance plan.

Sum insured
Top-up plans can offer a sum insured ranging between Rs 50,000 and Rs 15 lakh, with the deductible falling between Rs 30,000 and Rs 5 lakh, respectively. This sum insured of the top-up plan will offer protection over and above the deductible amount which is being borne by another policy or any other source.

One of the biggest advantages of the top-up plan is that it helps in saving money as the premiums of a top-up are much lower than buying an additional insurance cover to make up for the deductible. A top-up plan with Rs 10 lakh cover and Rs 5 lakh as deductible limit can be bought at an annual premium of as low as Rs 3,000. On the other hand, a regular health insurance cover for the same amount is likely to cost more than Rs 7,500. Top-up plans, thus, help the insured save more than 50% on premium.

Benefits
No medical screening: Insurance companies offer top-up plans without requiring any medical screening. This is irrespective of the fact whether the top-up is from the same insurer or from a different one.

Recharge: Nowadays, there are top-up plans that come with recharge benefits too. If the sum insured under the policy is exhausted during the policy period, additional indemnity up to the limits can be availed. Top –up plans do not just cover hospitalisation charges but cover peripheral expenses as well.

(The writer is Anand Roy.)

TOP

Source

All about insurance policies for cancer treatment – The Hindu – 17th February 2020

Cancer has become the most dreaded and least understood medical threat. It also appears much more prevalent than ever before. What is pretty clear is the havoc it plays with lives, lifestyles and finances. Cancer treatment can be prolonged and its high cost warrants proper planning. Cancer insurance can be in the form of benefit policies or indemnity policies. An indemnity policy reimburses hospitalisation and treatment expenses within the policy scope. It can be renewed in the usual course after a claim and will continue to offer coverage.

Examples of indemnity policies covering cancer are fStar Health Insurance Company Limited's pilot product, Star Cancer Care Gold, and HDFC ERGO Health Insurance Company Limited's iCan cancer insurance. The latest in this stable is Cancer Guard launched by The New India Assurance Company Limited. The policy covers expenses related to cancer treatment and is available in sums insured of ₹5, 10, 15, 20, 25 and 50 lakh and anyone from 18 to 65 years of age is eligible for coverage.

(The writer is K. Nitya Kalyani.)

TOP

Source

IRDAI plans to set up common electronic platform to settle health insurance claims – The Hindu Business Line – 15th February 2020

The Insurance Regulatory and Development Authority of India (IRDAI) is looking at setting up a common electronic platform for settling health insurance claims.

Specific time period
The platform, which is expected to come up soon, will help standardise settlements and ensure that they are done within a specific period of time, said TL Alamelu, member (non-life), IRDAI. The regulator has

already formed a committee for this, and the platform will be developed by the Insurance Information Bureau.

"The idea of forming this platform is (to ensure) that all are there on a single platform, that is the insurer, insured, and hospitals – and the claims will be processed on this platform. This will give a rich wealth of data, apart from standardising settlement and ensuring that settlements are done within a specific period in time," she said at a health insurance summit organised by Assocham here on Friday.

The common platform will bring a paradigm shift in the way claims are being settled in health insurance, she observed.

Acknowledging the fact that the health insurance ecosystem in India is distorted primarily due to wide disparity in charges, Alamelu said that IRDAI is looking at the possibility of standardising charges of some of the procedures such as cataract surgery and hysterectomy.

There is a wide disparity in charges for these frequently opted procedures across different hospitals, giving rise to ambiguity. IRDAI is working more "in an informal manner" with the help of General Insurance Council and with all TPAs (third-party administrators) to standardise charges for at least some of the procedures.

As a regulator, IRDAI ensures that insurance companies do not jack up premiums every year or make changes to the policy because they are not able to make profits.

However, it is noticed that hospitals keep making changes to the tariffs of various procedures due to the lack of a regulator. "It is being noticed that hospital inflation is 10 per cent to 15 per cent whereas in premiums there is no inflation impact; it is being maintained at a steady rate.... so, there is a mismatch. This is one issue that we are progressively thinking as to how to handle," she said. IRDAI is also open to the idea of opening a second window for inviting proposals under the sandbox model. Under its regulatory sandbox approach, IRDAI has already received close to 173 proposals.

According to Alamelu, a majority of the proposals received under health insurance were related to wellness, linking premiums to various wellness apps and instruments. "There may be a second window (for sandbox), may be some months or a year later.

"The industry should start thinking of something that is disruptive, covering a huge population yet making it simple by the use of technology," she pointed out.

TOP

Source

Hospitals raising tariffs on regular basis, nobody to check; insurance regulator worried – Financial Express – 15th February 2020

Tariffs are being changed by hospitals across the country on a regular basis and there is no one to check the hike, Insurance Regulatory and Development Authority of India (IRDAI) said. There is a need to standardise charges for some medical procedures amid rising tariffs, news agency PTI reported citing insurance regulator. Even though there is nearly 10-15 per cent inflation in hospital charges currently, the insurance companies are not allowed by the insurance regulator to hike premium every year, IRDAI member (non-life) T L Alamelu was reported as saying by the news agency at an ASSOCHAM event.

"Hospitals keep on changing tariffs on a regular basis. There is no body to check that. The regulator does not allow insurance companies to raise premium every year though there is around 10-15 per cent inflation of hospital charges at present," T L Alamelu said. The General Insurance Council and TPAs

(third-party administrators) are in talks of the same matter so as to standardise charges for some medical procedures such as cataract surgery and hysterectomy, T L Alamelu also said.

Even as IRDAI is working on the matter, it may take some time for results to appear as it is a 'tough challenge", Alamelu added. IRDAI is mulling a plan to introduce a system where people will choose their TPAs directly as against the current scenario where insurance companies select the TPAs, she added. Setting up a health insurance forum for settlement of claims is also being thought of by the insurance regulator, Alamelu said. "All claims will be settled from this forum within a specific period of time," she said.

Speaking further at the event, Alamelu said that the regulator may soon announce a common health policy named 'Arogya Sanjeevani' with standardised terms and conditions. Every insurer would have to offer the scheme, she added. In the last ten years, there has been good growth in the health insurance industry, she said, adding that the collection of health insurance premium has increased to Rs 44,873 crore in FY19 from Rs 3,342 crore in FY07.

TOP

Source

Confinement expenses hiked for pregnant women who can't avail maternity services of ESIC dispensaries - The Economic Times – 14th February 2020

The Employees' State Insurance Corporation (ESIC), under labour ministry, has extended the confinement expenses from Rs 5,000 to Rs 7,500 for pregnant women who are not able to avail maternity services of ESIC dispensaries.

A decision to this effect was taken at the 181 meeting of ESIC boards, chaired by labour minister Santosh Kumar Gangwar, on Thursday.

"Keeping in view the rise in the cost of living index resulting increase in expenditure related to confinement, existing amount of confinement expenses has been increased from Rs 5,000 to Rs 7,500," ESIC said in a statement on Friday.

"This facility is for pregnant ladies who are not able to avail maternity services of ESIC dispensaries or hospitals due to unavoidable reasons and take treatment in other hospitals," it added.

According to the statement, ESI Corporation has also approved the operationalization of economically weaker section (EWS) quota and admissions to ESIC medical institutions from academic year 2020-21. "Besides this, provisional admission Policy-2020 for admission to MBBS/BDS seats under insured persons' (IPs) quota in ESIC Medical Colleges has also been approved," it added.

The Employees' State Insurance Corporation is a social security organization providing comprehensive social security benefits like reasonable medical care and a range of cash benefits in times of need such as employment injury, sickness, death etc.

The ESI Act applies to premises or precincts where 10 or more persons are employed. The employees drawing wages up to Rs 21,000 a month are entitled to health insurance cover and other benefits, under the ESI Act. The Act now applies to over 12.11 lakh factories and establishments across the country, benefiting about 3.49 crore family units of workers. As of now, the total beneficiary population of ESI Scheme stands over 13.56 crore.

(The writer is Yogima Seth Sharma.)

TOP

Source

CROP INSURANCE

In a first, govt rolls out customised crop insurance policy – The Times of India – 24th February 2020

For the first time, the Centre has come out with customised crop insurance (single peril insurance cover) for states by factoring in one specific natural disaster. Such insurance will first be made available to farmers in Punjab, parts of Haryana and western Uttar Pradesh where farmers are not generally hit by droughts or floods but have to suffer due to hailstorms.

This model, having low premium due to risk coverage against single extreme weather event, will be available to other states or Union Territories (UTs) as well under the existing Prime Minister Crop Insurance Scheme (PMFBY).

TOP

Source

Farmers likely to gain from PMFBY revamp – The Tribune – 22nd February 2020

A revamp of the Pradhan Mantri Fasal Bima Yojana (PMFBY) by making it voluntary and bringing in some changes is being touted as a farmer-friendly move though experts fear that this can also lead to hike in premium.

By revamping the PMFBY, the Centre has not only made it voluntary for farmers, but also allowed single-peril insurance. Until now, farmers were required to pay premium for multi-peril insurance.

Sources in the Agriculture and Farmers Welfare Department explained that even in arid areas like Badhra, with no history of floods, farmers had to pay premium for this too, while those in irrigated areas like Sirsa and Fatehabad had to pay premium for drought as well, a rarity in that region.

They said now, farmers would be able to get their crops insured by paying lesser premium on perils like hailstorm, which was actually a bigger risk in states like Haryana.

"The Centre has decided that allocation of business to insurance companies will be done for three years. They were allocated business for a year or even a season earlier. This will cut overhead expenses of insurance companies and hence reduce premium," said the sources.

The sources said while commercial banks were deducting amount of premium from accounts of farmers for the PMFBY, those taking loans from cooperative banks were in a position of advantage as these banks were not forcing farmers into insurance.

They said now, the scheme had been made completely voluntary, whether or not the farmers were taking loans from banks.

The new norms also provided that for estimation of crop loss claims, a two-step process would be adopted, based on weather indicators, satellite indicators, normal range and deviation range. The scheme provided that only areas with deviation range would be subjected to crop cutting experiments for assessment of yield losses.

Hailing the revamp as a welcome step, Sanjeev Kaushal, Additional Chief Secretary, Agriculture and Farmers Welfare Department, said it would address the biggest grievance of farmers that banks were insuring their crops without their wish.

"Even during pre-Budget consultations with the Chief Minister, several MLAs had demanded that the PMFBY should be made optional and should not be mandatory," he stated.

Dharam Sharma, former consultant, PMFBY, Agriculture and Farmers Welfare Department, said the move would see at least 70 per cent dip in the number of those opting for insurance under the scheme.

"Of the 16 lakh farmers in the state, only 9 lakh loanee farmers are being covered under the PMFBY. Of the other 7 lakh farmers, hardly 12,000 are opting for the scheme on their own. The dip in number will also lead to a hike in premium," he said.

He expressed the apprehension that three-year contract would restrict corrective measures and improvement in implementation.

Gurjeet Singh Mann, a progressive farmer, said making the PMFBY optional for farmers was a step in the right direction. He said farmers who opted for the scheme must be provided policy document so that they could approach consumer forums in case of denial of claims.

(The writer is Sushil Manav.)

Source

TOP

Cropped insurance – The Hindu Business Line – 21st February 2020

The Centre has decided not to fork out its share of the premium subsidy (45-49 per cent) if the premium amount on a crop insured in a particular region under PM Fasal Bima Yojana exceeds 25-30 per cent of the sum insured. Its move comes amidst growing allegations that the PMFBY is benefitting insurance companies more than anyone else. The sum insured is calculated on the basis of scale of finance, which is a measure of the loans that can be given per acre per crop.

Hence, a farmer is generally entitled to a loan of Rs. 23,000 per acre for paddy and Rs. 44,000 per acre for sugarcane, and this is likely to be the sum insured. Hence, a higher premium hurts the Centre and the States besides the farmer, who pays 1.5-5 per cent of the premium. It is, however, notable that 40 districts account for 50 per cent of the insurance claims under the PMFBY. If the claims ratio here renders existing levels of premium unsustainable, the Centre and States need to work out a solution. The insurance regulator should look into whether there is genuine price discovery in the premium bids invited from insurers with respect to a particular cluster.

Insurance companies, too, have faced criticism for not meeting claims on time, notably in Maharashtra last kharif, where an estimated 70 lakh hectares were impacted by unseasonal rain. Insurance firms, in turn, complain that the States do not pay up their share. It is just as well that the Centre has decided to make crop insurance voluntary for farmers, rather than link the policies to loans taken. In this way, insurance firms will have to work for their customers and match their products to farmers' needs, rather than get their clientele on a platter.

As a result, insurers are often not aware — because they have not interacted with their customers — of what farmers have grown, and hence are not adequately informed when it comes to meeting claims. The industry, on its part, says that crop-cutting experiments are fudged. It should consider investing its workforce in CCEs. The Centre has decided to shift away from CCEs to other technologies which are expected to improve accuracy.

It has also done well to insist that companies stay the course in a region for two or three years, instead of bidding for one year. The sector enjoyed three relatively stable years from 2016-17 to 2018-19, with the premiums collected being Rs. 9,000 crore more than the claims paid in 2018-19. However, some firms opted out last year, minimising business risk. To escape this messy situation, Bihar and West Bengal have launched their own schemes with no insurance players. The PMFBY covers 5.6 crore farmers and 30 per cent of cropped area. Its modalities need to be improved.

TOP

Source

Farmers see red over tweaks to crop insurance scheme – The Hindu Business Line – 20th February 2020

The Centre's decision to reduce its share in premium subsidy for its flagship crop insurance scheme — PM Fasal Bima Yojana (PMFBY) — to premium rates of 30 per cent in unirrigated areas and 25 per cent in irrigated is criticised by many with some saying the move foretells the impending death of the scheme.

On Wednesday, the government decided to not to pay the Centre's contribution to the PMFBY to farmers in those districts where crops have premium rates more than 30 per cent in unirrigated and 25 per cent in irrigated regions of the country. The Centre also decided to enhance its share in PMFBY premium subsidy to 90 per cent for north-eastern States from the existing 50 per cent. It also made the scheme voluntary to farmers.

There are nearly 40 districts in the country — mainly in Gujarat and Rajasthan — where PMFBY premium rates are beyond 30 per cent. From next kharif season onwards, these districts with higher premium rates will not get the Central subsidy.

Currently, farmers growing notified crops in different parts of the country — barring in a few States like Punjab and Karnataka — pay 1.5 per cent to 5 per cent premium for crop risk cover under PMFBY, with Central and State governments pooling the rest of the premium equally. Among other things, the government decided to make the scheme voluntary as well.

"This is like throwing the baby with bathwater. They implemented the PMFBY scheme barely for three years. We had problems with it since its inception. We wanted the government to extend the coverage to tenant farmers. Now instead of expanding it, the government is trying to shrink its scope further by increasing the burden of State governments," said Vijoo Krishnan, Joint Secretary of the All India Kisan Sabha (AIKS), the CPIM-backed farmer organisation.

Krishnan said it was not clear who may have to shoulder the burden — the State governments or the farmers. Either way, this scheme will not go much far, he observed. If the States refuse to put in the premium subsidy for those whose premium rates are higher than 30 per cent, the premium to be paid by farmers would go up substantially. "The farmers will eventually withdraw from the scheme," he said.

An official from Agriculture Ministry had earlier talked of the need for moving the districts that have higher premium rates from PMFBY to other crop insurance schemes like Restructured Weather-based Crop Insurance Scheme, which have lesser financial implication for the government.

Kavita Kuruganti of Hyderabad-based Alliance for Sustainable and Holistic Agriculture, said instead of improving upon the existing scheme, the government is trying to kill it.

(The writer is T.V. Jayan.)

TOP

Source

Government makes crop insurance schemes voluntary for farmers – Financial Express – 19th February 2020

The government on Wednesday made its flagship crop insurance schemes voluntary for farmers with existing crop loans or those willing to take new ones, as it seeks to address the concerns raised by farmers' body and states in implementation of these programmes.

"The Union Cabinet has approved revamping of 'Pradhan Mantri Fasal Bima Yojana (PMFBY)' and 'Restructured Weather Based Crop Insurance Scheme (RWBCIS)' to address the existing challenges in implementation of crop insurance schemes," an official statement said. Under the PMFBY, which was launched in February 2016 by Prime Minister Narendra Modi, it is mandatory for loanee farmers to take insurance cover under this scheme.

The PMFBY provides comprehensive crop insurance from pre-sowing to post-harvest period against non-preventable natural risks at extremely low premium rate of 2 per cent for kharif crops, 1.5 per cent for rabi crops and 5 per cent for horticulture and commercial crops.

The Cabinet approved modification of certain parameters/provisions of ongoing PMFBY and RWBCIS schemes. "Enrolment under the scheme to be made voluntary for all farmers (both PMFBY/ RWBCIS)," Agriculture Minister Narendra Singh Tomar told reporters here.

He said currently 58 per cent of total farmers are loanee and the remaining 42 per cent are non-loanee. The number of farmers opting for these crop insurance schemes may drop immediately but the enrolment would eventually pick up, Tomar said.

The minister said the government would launch a campaign for creating awareness among farmers about the need to take a crop insurance policy. These modifications will help in addressing the concerns raised about the PMFBY scheme by farmers organisations and states, he said.

Among other modification, Tomar said the allocation of business to insurance firms through tender process would be done for three years as against the current policy of one to three years. "Central share in premium subsidy to be increased to 90 per cent for north eastern states from the existing sharing pattern of 50:50 (Both PMFBY/RWBCIS)," the statement said.

Tomar said States will not be allowed to implement these schemes in subsequent seasons in case of considerable delay in release of requisite premium subsidy to insurance companies beyond a prescribed time limit. Cut-off dates for invoking this provision for Kharif and Rabi seasons will be 31st March and 30th September of successive years, respectively.

The Cabinet also approved provisioning of at least 3 per cent of the total allocation for the scheme to be made by the Centre and implementing state governments for administrative expenses.

For estimation of crop losses/admissible claims in the PMFBY, two-step process will be adopted based on defined deviation matrix using specific triggers like weather indicators, satellite indicators, etc, for each area along with normal ranges and deviation ranges. Only areas with deviations will be subject to crop cutting experiments (CCEs) for assessment of yield loss.

Technology solutions like Smart Sampling Technique (SST) and optimization of number of CCEs would be adopted in conducting CCEs. In case of non-provision of yield data beyond cut-off date by the States to implementing insurance firms, claims will be settled based on yield arrived through use of technology solution.

The central subsidy under PMFBY/RWBCIS to be limited for premium rates up to 30 per cent for un-irrigated areas/crops and 25 per cent for irrigated areas/crops. Districts having 50 per cent or more irrigated area will be considered as irrigated area/district.

States have been given flexibility to implement the schemes with option to select any or many of additional risk covers/features like prevented sowing, localised calamity, mid-season adversity, and post-harvest losses. Further, States/UT can offer specific single peril risk/insurance covers, like hailstorm etc, under PMFBY even with or without opting for base cover (Both PMFBY/RWBCIS).

"As the scheme is being made voluntary for all farmers, therefore, to provide financial support and effective risk mitigation tools through crop insurance especially to 151 districts which are highly water stressed including 29 which are doubly stressed because of low income of farmers and drought, a separate, scheme in this regard would also be prepared," the statement said.

The concerned provisions/parameters of scheme and operational guidelines of the PMFBY and RWBCIS would be modified to incorporate these modifications and made operational from Kharif 2020 season.

"With these changes, it is expected that farmers would be able to manage risk in agriculture production in a better way and will succeed in stabilizing the farm income. These changes will also enable quick and accurate yield estimation leading to faster claims settlement," the statement said.

TOP

Source

How the State Fails to Insure its Farmers – EPW – 19TH February 2020

Crop insurance would be essential in insulating a large proportion of India's farmers against food insecurity in the future. How has the government fared in implementing it till now?

In the the 2020 Union Budget, Finance Minister Nirmala Sitharaman announced that the government had insured 6.11 crore farmers under the Pradhan Mantri Fasal Bima Yojana (PMFBY) and that the centre was committed to the goal of doubling farmer income by 2022. With the budget setting the agricultural credit target at Rs 15 lakh crore going forward, crop insurance now holds the third-largest portfolio in the non-life insurance industry.

However, over the years, its premium outgo has increased from a gross level of ₹22,015 crore (2016–17) to ₹29,065 crore (2018–19). Correspondingly, its gross loss ratio has gone up from 78% to 100% for the same time period. These numbers suggest that the crop insurance industry in India is in a dismal state. Ajay Vir Jakhar, chairman of the Bharat Krishak Samaj commented on the PMFBY, saying, "The government needs to do away with the Pradhan Mantri Fasal Bima Yojana in the budget as it's been a waste of money, no one seems to be benefiting." Moreover, he pointed out that the PMFBY does not take into account landless farm workers. The loss-making enterprise, according to Jakhar, is largely ineffective on-ground and distant from the requirements of all farmers.

The importance of an instrument like crop insurance is underscored in a report by the Federation of Indian Chambers of Commerce and Industry. Examining the agriculture insurance market, the report points to the importance of crop insurance in light of the increasingly "erratic and unpredictable behaviour of monsoon, accentuated by climate change." The changing climate scenario, till now, has not only resulted in extensive financial loss in terms of crop failures and damage to agriculture infrastructure, but also loss of lives due to the numbers dependent on it for livelihood.

Thus, crop insurance is bound to play a significant role in combating any future food insecurity. However, from its inception in 1985 to 2019, crop insurance schemes such as the Comprehensive Crop Insurance Scheme (CCIS) (1985), the National Agricultural Insurance Scheme (NAIS) (1999) and the Modified National Agriculture Insurance Scheme (MNAIS) (2010–11), the Weather Based Crop Insurance (2007) and the Pradhan Mantri Fasal Bima Yojana (2016) have had very limited success. Primary inhibitors of these schemes have been the lack of awareness and access.

Caught between the future importance of crop insurance, and the systemic inefficiencies it is currently entangled in, we explore the EPW archives to get a bird's-eye view of crop insurance in India, why it has not been effective so far, and the fate of the alternatives the government has thus far executed.

Why Is Crop Insurance Required and Why Has It Not Been Effective So Far?

Reshmy Nair notes that the basic risk faced by agriculturalists is that of weather variability and the uncertainty of crop yield. The magnitude and intensity of the same is especially high in India, considering that the overwhelming majority of farmers who excessively depend on the farming sector have extremely limited means and resources to cope with the disastrous consequences of crop failure. Thus, given the significant contribution of the agricultural sector in the Indian economy, coupled with looming "climatic aberrations," crop insurance becomes a necessity to mitigate the risks associated with a majority of the country's farmers. In light of this, pilot projects carried out in the country between 1972 and 1973 gave rise to the CCIS which was implemented from 1985 to 1999. The scheme later evolved into the NAIS. However, crop insurance, particularly yield insurance, by itself, is not the solution. It suffers from drawbacks, such as complex processes, moral hazard, adverse selection, and low penetration.

> … Less than one-third of the farming community avails of institutional credit in India and for the remaining, insurance continues to be voluntary. Insurance in Indian agriculture is more challenging than in the developed countries due to its inherent nature – a large number of small and scattered landholdings, varying climatic and soil conditions, lack of basic data, and variety of agricultural practices, making it practically impossible to implement the scheme on an 'individual basis' on a wide scale. Further, there is widespread lack of knowledge about the nature and functions of crop insurance amongst the farmers, a majority of whom are illiterate and poor.

Subhankar Mukherjee and Parthapratim Pal recount that crop insurance in India dates back to 1920, with the first crop insurance scheme launched in 1972. Observing the difficulty of calculating, and, thus, the paucity of crop insurance data, Mukheree and Pal undertake the responsibility to calculate the same using Agriculture Insurance Company of India's (AICI) Business Profile Data and National Sample Survey Office's (NSSO) Situation Assessment Survey of Agricultural Households. They note that the proportion of farmers that buy prescribed crop insurance without taking any loan is only 15%. This hints at the inability of the farmers to pay the premium for insurance. Low penetration of crop insurance is also due to the fact that demand for crop insurance is highly price-sensitive and depends on prior experience. This is exacerbated by the fact that the crop insurance system is riddled with payment delays due to lengthy and tedious procedures in the calculation of the extent of crop loss. In a 12-year period (that is, 2001 to 2013), average growth rate of crop insurance in terms of farmers has only been 6.5% annually.

> ... Coverage of crop insurance in India is abysmally low both by number of farmers and units of cultivation. Annually, just over 7% farmers subscribe to crop insurance, and only 4% of the units cultivated are insured. These figures are particularly striking because crop insurance in India is mandatory for all farmers taking short-term crop loans. Banks are supposed to deduct the premium amount while advancing crop loans to farmers. Given the disparity between crop loan penetration and crop insurance penetration, it is apparent that this rule is not strictly followed in many states. Crop insurance is also available on [a] voluntary basis for non-loanee farmers. But ... voluntary purchase of crop insurance in India is also extremely low.

Shubhashis Gangopadhyay argues that the major obstacle to commercialisation for a small farmer is the increased uncertainty of the marketplace and the inability to absorb the risk of loss. In such a case, buying insurance does not work, considering that the premium rates to cover the risks are too high. He notes

> The poverty line in rural India for the year 1999-2000 was Rs 328 per person per month. For a family of 5, this implies an annual expenditure of Rs (328*5*12) = Rs 19,680. Now consider a 5-member household with a small plot of land that can yield an annual income of Rs 23,153 if it is a good year (with probability 0.8) and Rs 5,788 if it is a bad year (with probability 0.2).

> In a bad year, the household will be impoverished, while in a good year it will be above the poverty level [...] Applying the solution demonstrated by the example, this hypothetical household can buy insurance coverage of Rs (23,153 – 5,788) = Rs 17,365 at a premium of Rs 3,473. In a good year, it will have Rs (23,153 – 3,473) = Rs 19,680. In a bad year, similarly, it will have Rs (5,788 – 3,473 + 17,365) = Rs 19,680. With this insurance scheme, the household will no longer be impoverished, even if the crop fails. What makes this seemingly workable solution infeasible is the ability of the farmer that makes Rs 23,153 in a good year to come up with an initial amount of Rs 3,473 to pay the premium.

Thus, with poverty levels themselves so high, farmers' obligation to pay the high premium upfront, without resorting to taking a loan, would be a difficult task.

What Are Some Steps Taken by the Government to Encourage Adoption of Crop Insurance?

An alternative to the traditional yield-based crop insurance system is a weather-based crop insurance. Weather-based crop insurance, Reshmy Nair elaborates, pays out indemnities based not on actual losses experienced by the insured, but on the realisation of a weather index, which is, in fact, highly correlated with actual losses. The index itself measures a specific weather variable (such as rainfall, temperature, relative humidity, wind speed, etc.) rather than the extent of loss (in crop yield). Thus, the crop insurance product uses proxies for the loss that farmers face due to adverse weather conditions. Not only is the weather-insurance product easier to administer and significantly reduces cost by eliminating the need for yield estimation and field visits, a weather index product is also transparent, given that weather data can uploaded immediately so the insured is aware of weather performance vis-à-vis the given trigger. Nair provides a brief history of weather-based insurance products in India,

> In India, weather-based insurance was first introduced in 2003 by ICICI Lombard for groundnut and castor farmers of Mahboobnagar district in Andhra Pradesh, followed by the pilot rainfall insurance scheme by IFFCO-Tokio General Insurance (ITGI) in 2004-05 in Andhra Pradesh, Karnataka and Gujarat. The Agricultural Insurance Company of India (AIC), the public sector insurer, also introduced rainfall insurance (Varsha Bima) in 20 rain gauge areas spread over Andhra Pradesh, Karnataka, Rajasthan and Uttar Pradesh in 2004-05, providing five different options suiting varied requirements of the farming community– seasonal rainfall insurance based on aggregate rainfall from June to September, sowing failure insurance, rainfall distribution insurance with the weight assigned to different weeks, agronomic index based on the water requirement of crops at different phenophases, and a catastrophic option, covering extremely adverse deviations in rainfall during the season.

With India becoming one of the world's pioneers in weather-based crop insurance, Kushankur Dey and Debasish Maitra point out that under weather-based crop insurance schemes (WBCIS), the number of farmers increased from 6.79 lakh during 2007–08 to 136.14 lakh during 2012–13. That said, implementation of weather-based crop insurance schemes has not been as systematic as it ought to be. For instance, there is a glaring lack of integral infrastructure, such as automatic weather stations (AWSs), which are crucial in collecting relevant data.

> However, weather-based insurance product in India has not been subscribed to on a large scale as yet. Besides, the high premium costs and complex computational exercise involved in index-based weather products, low density of weather stations seems to be a pressing problem. For example, there is a shortfall of around 24,000 AWS and more than a lakh of rainfall data loggers, although a few private service providers have tried to speed up parametric weather data collection and dissemination. It is evident that since weather-based insurance product in the form of (put) option can be used to manage various on-farm risks affecting all stages of crop cycle, lack of product choice to potential farmers is a limiting factor for the penetration of weather-based product.

Examining the recently implemented PMFBY, Dey and Maitra note that it has been, so far, the most successful crop insurance scheme in India. A multi-peril crop insurance scheme, replacing the NAIS and

the MNAIS since 2016, the PMFBY covers a broad set of risks spanning the various stages of crop development as well as post-harvest losses (for instance, due to natural calamities). They state,

> About 309 lakh farmers in 23 states (34.5% of total farmers) had been covered under PMFBY in kharif 2015, of which 294 lakh farmers were loanee and 15 lakh were non-loanee. During kharif 2016, however, 366.64 lakh farmers (41% of total) have been covered, out of which 264.04 lakh farmers are loanee and 102.60 lakh farmers are non-loanee. PMFBY has been implemented in 21 states during kharif 2016. The achievement of 41% coverage of farmers within a couple of years after the inception of PMFBY appears impressive, particularly as compared to 28% coverage of farmers achieved under three schemes combined (WBCIS, NAIS, and MNAIS) prior to the implementation of PMFBY.

Meenakshi Rajeev and Pranav Nagendran observe that since the introduction of PMFBY, share of cultivated land under crop insurance cover improved from 22% during 2013–14 to 29% by 2016–17. However, this was subsequently followed by a decline, reaching 25.96% in 2017–18. Moreover, while most central and northern states fall under crop insurance to some extent, the same cannot be said of some of the southern states (Tamil Nadu: 21.11%; Karnataka: 19.40%; Kerala: 1.84%), or for Uttar Pradesh (only 14.91% of all crop area falls under insurance cover). Similarly, north-eastern states have barely seen any crop area under the scheme (for example, Assam: 1.06%; Tripura: 0.63%). Taking note of the hindrances met by farmers in gaining access to crop insurance, Rajeev and Nagendran state

> ... there are several difficulties that farmers face while accessing credit. One of the major concerns in this regard is the lack of land records (such as the Record of Rights, Tenancy and Crop Information or RTC certificate) among farmers. Thus, documentation requirements are indirectly one of the barriers to adoption of crop insurance. Landowning farmers face issues owing to a lack of automatic mutations. Updating these records can prove to be a complex bureaucratic process that most farmers are ill-equipped to handle. Resultantly, many farmers who own land do not possess adequate land records. Non-loanee farmers need to exert extra effort to go through the process of enrolling under the insurance scheme, which often may not happen. Tenant farmers are often oral lessees who cannot prove cultivation, as landowners are reluctant to provide formal lease documentation for fear of losing land rights. As a result, these tenant farmers and sharecroppers also find it difficult to access credit and hence, crop insurance.

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Source

Insurers exit government's Fasal Bima scheme to cut losses – Moneycontrol – 17th February 2020

The government's flagship Pradhan Mantri Fasal Bima Yojana (PMFBY), or crop insurance scheme, is likely to see a crunch in insurance capacity as companies as well as re-insurers move away from offering covers.

While on one hand, re-insurers have increased rates for offering cover to insurers, on the other, claims continue to pile up. Firms like ICICI Lombard General Insurance as well as a slew of foreign re-insurers have taken a stand to not write crop insurance till there is an improvement in the rates.

Launched in 2016, PMFBY compensates farmers if any of the notified crops fail due to natural calamities, pests and diseases. The scheme seeks not just to insulate farmers from income shocks, but also encourage them to adopt modern agricultural practices.

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

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

Take ICICI Lombard General Insurance for instance. In Q3FY20, crop insurance underwriting losses dropped to Rs 92 lakh compared to Rs 39.70 crore loss in the year-ago period. This is after the insurer took a conscious call to not write crop business.

Unlike previous schemes, PMFBY is open for both farmers who have taken loans (loanee) as well as those who have not (non-loanee). The scheme covers food crops (cereals, millets and pulses), oilseeds as well as horticultural crops.

Here, farmers pay 2 percent of sum insured as the premium for Kharif crops while it is 1.5 percent of the sum insured for Rabi crops.

While all other general insurance schemes have a policy of hike in premium on an annual basis depending on the past claim, PMFBY does not have this provision. This has made the business unviable.

State-owned General Insurance Corporation of India posted an underwriting loss of Rs 1,398.55 crore in the agriculture portfolio in Q3FY20 compared to Rs 233.93 crore underwriting profit in the year-ago period.

“Even if there is no major natural catastrophic incident, an excess rainfall incident in one district alone can wreak havoc to our balance sheets. Though the idea was to use drone for weather predictions and crop yields, it has not yet been implemented on a larger-scale,” said the chief financial officer of a large general insurance company.

In FY19, gross incurred claims under PMFBY was Rs 27,550 crore while the premium collected was Rs 20,293 crore.

On one hand insurance companies are choosing to stay from bidding for new tenders, on the other global reinsurers have refused to provide coverage unless premiums are revised. Insurance companies need a risk cover as a backing from reinsurers as a protection against large claims.

(The writer is M Saraswathy.)

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Source

Create more awareness about PMFBY: Centre to stakeholders – Business Insiders – 17th February 2020

The Centre on Monday appealed all stakeholders to create awareness among farmers about central scheme Pradhan Mantri Fasal Bima Yojana (PMFBY).

The PMFBY was launched in January 2016 replacing the older schemes to ensure farmers pay less premium and get full and early settlement of the claims.

"The current format of the scheme requires active participation of three different sectors -- the state governments, banking sector and insurance sector," Agriculture Secretary Sanjay Agarwal said at a conference organised in Udaipur, Rajasthan for reviewing implementation of the PMFBY.

Therefore, there is a need to ensure effective consultation amongst all the stakeholders for the smooth implementation of the scheme that benefits farmers, a statement quoted him as saying.

The two-day long national conference saw participation of around 140 members representing different states, banks, insurance companies, RBI, NABARD, among others.

PMFBY CEO and Joint Secretary in Union Agriculture Ministry Ashish Kumar Bhutani said there's a need to make a joint effort by all the stakeholders to formulate communication strategy to build trust among farmers.

"Insurance companies need to address grievances raised by the farmers on social media within a stipulated time frame," he said, and emphasised the need to prioritise specific issues of the North-Eastern States about this scheme.

Due to the improved features of PMFBY, the coverage under the scheme has increased to 30 per cent of the gross cropped area from 23 per cent in 2015-16 under erstwhile schemes, according to the official data.

Participation of non-loanee farmers, for whom the scheme is voluntary, have also increased from 5 per cent under erstwhile schemes to 42 per cent (kharif 2019) under PMFBY showing the voluntary acceptability of the scheme, it added.

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Source

Pradhan Mantri Fasal Bima Yojana to Give More Flexibility to Farmers and States – Krishi Jagran – 17th February 2020

Centre is all set to make some positive changes in its flagship crop insurance scheme, Pradhan Mantri Fasal Bima Yojana (PMFBY). After the revamp, states as well as farmers will get more freedom to select insurance products for risk hedging according to the proneness of that particular state to the specific weather vagary. At present, farmers across India do not have any option. There is just one single comprehensive insurance product that covers risks - from pre-sowing to post harvesting.

A senior agriculture ministry official said that “Every farmer who wants crop insurance will have to take this comprehensive product without any customization. This will lead to payment of a higher premium. So we want to break up this single product & give farmers several options in a bouquet of insurance products so that they can take their pick based on their requirement”.

The official also said that in the existing scheme, suppose a grower in Bihar does not want to take risk coverage for drought or a cultivator in Rajasthan wants to avoid from flood coverage then there is no provision.

The official further told that “We are planning to roll out separate products for pre sowing losses, post-harvest losses because of cyclonic rains & losses due to unseasonal rainfall. State government in consultation with farmers can decide on products they want to buy & the risk they want to cover”.

Pradhan Mantri Fasal Bima Yojana has replaced the existing 2 crop insurance schemes i.e. National Agricultural Insurance Scheme (NAIS) as well as the Modified NAIS. It offers comprehensive crop insurance right from pre-sowing to post-harvest period against non-preventable natural risks at very low premium rates a farmer has to give – 2 percent for kharif crops, 1.5 percent for rabi crops and 5 percent for horticulture & commercial crops. And the balance amount of premium is shared equally by Centre and respective state governments.

The penetration of crop insurance scheme has increased to 30 percent of gross cropped area in India from 23 percent in previous crop insurance schemes in 2015-16. Coverage of non-loanee cultivators, for whom the coverage is voluntary, has gone up from 5 percent in 2015-16 to 42 percent during Kharif 2019 that shows the acceptability as well as progress of the scheme on voluntary basis.

The official further told that "We are also considering making this insurance voluntary for loanee farmers also for whom this is compulsory now. We expect that after knowing the significance of this scheme, farmers will voluntarily participate in this scheme".

Centre is also planning to involve compulsorily use of technology & mobile applications to check crop health & Crop Cutting Experiments (CCEs) in coordination with concerned states.

(The writer is Abha Toppo.)

TOP

Source

MOTOR INSURANCE

Pay as you go: Irdai initiave aims to attract low-mileage car user – Business Standard – 21st February 2020

Under the Insurance Regulatory and Development Authority of India's sandbox initiative, general insurance companies have started launching usage-based motor insurance policies.

Companies like Liberty General Insurance, Bharti Axa General Insurance, ICICI Lombard and some others have started giving these innovative features under their existing private car package policies. "Usage-based motor insurance is based on the 'pay as you go' model — different from the traditional motor insurance. Through this offering, we expect increased penetration of motor insurance by covering the customers who drive less and generally may not have a preference for own damage covers (OD)," says Sanjeev Srinivasan, MD and CEO, Bharti AXA General Insurance. When you come to the new offering with other existing products out there, you will realise that in the present, duration of the policy is monitored by 'time' (annual/multi-year) as scale. With the new offering, the new scale is 'vehicle mileage during policy'. Roopam Asthana, CEO and whole-time director, Liberty General Insurance, says: "Pay for the distance feature has been developed keeping in mind car owners who use their vehicles less frequently. The new feature gives customers even more control over their insurance costs with similar coverage in terms of perils and claims service."

The idea behind such policies seems to be 'lower the mileage, lower is the probability of an accident'. The new offering is currently applicable only to the OD part of the policy. Most insurers' policies come with a top-up feature wherein you have the option of reinstating the OD coverage by increasing the number of kilometres by paying an additional premium, if your kilometre limit gets exhausted. How is distance measured? It depends on the car you have. Asthana says, "At the time of proposal, the customer has to declare the existing odometer reading, and the same will be available in the policy schedule at the time of claims. The coverage distance can be checked, based on the odometer reading at the time of the accident and the reading collected at the time of proposal. "For newer cars, which means connected vehicles, the data is gathered using technology like telematics.

(The writer is Bindisha Sarang.)

TOP

Source

Car stolen and meets with an accident? Will the owner still have to pay compensation? – Financial Express – 21st February 2020

Vehicle thefts are usually covered by motor insurance, particularly if it includes comprehensive coverage. However, in case a vehicle, say car, gets stolen and gets damaged in an accident caused by the car thief or someone gets injured in the accident, then who will be held liable to pay the compensation in this case – the owner of the car, insurance company or the thief?

Industry experts say liability is on the car thief, though, usually, the insurance company should pay to the owner of the car or the victim who has got injured, and get the subrogation from the car thief. However, there is no standard process for this as it is not a regular case.

"Usually, car insurance claim cases are straightforward. They can be settled easily by looking at the inclusions and exclusions of the policy, the terms and conditions of the policy, and the nature of the incident. Sometimes, there are cases that need to be analysed from multiple perspectives. These are complex cases and there are no standard processes to settle such claims. Therefore, they need detailed scrutiny," says Animesh Das, Head of Product Strategy, Acko General Insurance.

In the above-mentioned case, for instance, the liability should be on the car thief. However, things are not that simple. There will be a thorough investigation of the case. First and foremost, there needs to be a First Information Report (FIR) filed by the car owner and the insurance company needs to be intimated at the earliest.

The insurance company's surveyor will have a detailed look at the FIR and conduct claim verification. Then various questions need to be looked at. For example, was the car owner being negligent in any way while parking the car when it was stolen?

"The crucial documents required will be an FIR, claim application, and the policy document. The case will be analysed from all angles and if all works out well for the car owner, the insurance company will pay the appropriate amount. The insurance company will settle the claim with the car owner and get the subrogation from the car thief. Having said that, there can be multiple points that can come up while the case is being investigated in detail, and the claim will be settled accordingly," informs Das.

Sajja Praveen Chowdary, Head-Motor Insurance, Policybazaar.com, also says that "in the case of accident, the insurer is liable to pay the claim, as the theft claim will be closed. However, a new claim with reference to vehicle damage will be raised by the owner and the insurance company will bear the claim amount as part of the regular policy."

It may, however, be noted that in the case of a theft, the insured or the registered owner is expected to lodge an FIR with the police immediately and inform the insurance company about the same. A claim is registered on the basis of information provided by the insured. However, any insurer pays the claim amount (maximum being the IDV of the vehicle mentioned on the policy during the policy period) against a theft case only when the vehicle remains untraced for a period of time and it receives the NO TRACE REPORT from the police authorities.

"However, in a scenario where the vehicle is recovered by the police, it will be returned to the registered owner. The insurance company must be apprised by the insured/ registered owner/ policyholder about the vehicle recovery wherein the earlier raised claim case is closed. The insurer registers a new claim for any vehicle damages that are found during the theft period with the consent of the policyholder. All such damages are covered under the standard terms and conditions of the policy and the insurer bears the claim amount as part of a regular comprehensive policy," explains Chowdary.

It is, however, important to note that vehicle damage is only covered under a comprehensive plan which includes both OD (Own Damage) + TP (Third Party) component. If the policy is only a TP policy, then vehicle damages are not covered.

(The writer is Sanjeev Sinha.)

TOP

Source

5 reasons your car insurance rates may be rising – Business Insiders – 21st February 2020

Car insurance pricing is elusive - there's no publicly available formula for the way a car insurance company calculates your premium, and each company does it differently. It can feel sometimes like premiums are arbitrary, especially when you see an increase in the amount you pay every month.

While sometimes price changes can be caused by something as simple as an adjustment to the company's underwriting policy, they might be in reaction to factors beyond an insurance company's control. Everything from a natural disaster to a sudden change in state law could spell increased costs for insurance companies, and eventually, increased costs for drivers, too.

It's worth noting that insurance companies are regulated by state agencies, and in order to change premiums, each car insurance company has to go through approvals and regulatory processes. That change could be slow - it may take insurance companies months to get their changes approved and on drivers' quotes.

While you may be notified about rate changes, you may not be - each state has different laws on when consumers need to be notified of rate changes before renewing their policies, if at all. Some states require no notice, while others only require notices for rate changes over a certain percentage.

1. State laws

Car insurance companies have to comply with state laws. When laws change, insurance rates can, too. Michigan has one of the most stark examples of just how much laws affect premiums. A 1973 law required all drivers in the state to have personal injury protection coverage with no limit as a part of their auto insurance policy. Generally, each type of coverage listed in a policy has a limit that it will cover, generally $25,000, $50,000, or $100,000. In Michigan, however, this coverage, also called PIP, must have no limit to meet the state's minimum coverage.

That's made car insurance in this state incredibly expensive - the Insurance Information Institute ranks it as the fourth-most expensive state in the US for car insurance.

State laws, like Michigan's PIP law, have a big impact on the premium you see listed on your quote. Often, these changes come without warning. If there's been a change to laws in your state, it could be behind your rising car insurance premium.

2. Insurance companies change the way they assess your risk

Insurance companies go through a process called underwriting for every person they insure. Underwriting looks at the likelihood that you'll file a claim and incur a loss. Along with a few other factors, car insurance companies price your policy based on this likelihood.

But that process is constantly changing. Insurance companies sometimes use new technology in their underwriting process, changing the way an insurance company looks at you and the risk you pose. Additionally, when car insurance companies are paying for more accidents, they're spending more money. To recoup those costs, each drivers' cost of coverage rises.

Car insurance companies are constantly changing the way they look at risk and at the drivers they insure, so you might find that the formula isn't in your favor the way it used to be. In this case, shopping around could help you find a company that's more affordable for your history and circumstances.

3. Natural disasters can raise rates

After Hurricane Harvey hit Houston, Texas, about half a million auto insurance claims were filed, according to the New York Times. The Texas Department of Insurance estimated that car insurance

companies faced $2.7 billion in losses. Car insurance costs went up, with Texas indicating hikes of about 8%.

From California wildfires to East Coast hurricane activity, premiums can see spikes after natural disasters. Where there's widespread damage, there will also be an increase in insurance claims. More insurance claims mean greater costs for the insurance companies, and that money has to be made back somehow. Generally, that's in the form of rate increases for drivers.

4. The cost of medical care drives auto insurance increases

The car isn't the only thing covered by car insurance - passengers and drivers are, too. Medical care is a big part of car insurance coverage. As the cost of medical care is rising, car insurance rates have to adapt to include this expense.

Between 2008 and 2017, nonprofit research group Health Care Cost Institute estimates that the cost of an emergency room visit had increased by 176%. Similarly, from November 2006 to November 2016, the US Bureau of Labor Statistics reports that car insurance prices have increased by 50%.

With costs of healthcare on the rise, car insurance companies are struggling to keep up with the increasing costs of care. Raising rates is one way they keep the costs at bay.

5. Car parts are getting more expensive, and cars are becoming more complicated

The safety features designed to keep drivers out of accidents are actually costing insurance companies more. As automotive technology becomes increasingly complex, the costs of fixing vehicles, or purchasing new vehicles after a loss, are on the rise.

While a fender bender used to mean a simple dent repair at the body shop, it can now involve detailed work like repairing delicate sensors. As cars become more complicated and expensive to repair, car insurance rates are climbing steadily as well.

Totaled cars are also more common. Tim Zawacki reports for S&P Global's Market Intelligence, "With the cost of auto parts rising at a faster rate than car prices, companies have observed incremental increases in claims where the vehicle is deemed to be a total loss." As more cars are totaled and car prices rise due to increasing tech features, car insurance companies are funneling more money towards replacing cars than in the past.

What's the best way to avoid rising auto insurance rates?

It's important to remember that car insurance rates are highly individual - not everyone's car insurance rate will follow the trend. Car insurance companies have any number of reasons to raise rates on an individual level, and oftentimes, changes to your driving history, credit score, your car itself, and many other factors can play a role.

If your auto insurance rate is starting to seem high, it's worth shopping around for coverage. Take an hour to gather quotes from a variety of different auto insurance companies, and compare their offerings. For a starting point, see Business Insider's list of the best car insurance companies of 2020.

Look at the coverage types, limits, and the premium to find the best policy for you. You'll want to find the policy with the most types and highest limits of coverage, with a premium that fits your budget.

Sometimes, rate hikes are simply unavoidable. But, there still may be companies that price your policy more affordably than your current policy, and it's worth looking around to see if you can beat your price.

(The writer is Liz Knueven.)

Source

TOP

Why growth in motor own-damage premiums has been flat this year – The Hindu Business Line – 19th February 2020

A spate of regulatory changes over the past two years has impacted the motor insurance business of general insurers in India. The mandatory long-term third-party insurance that kicked in during September 2018 and the Motor Vehicles Act 2019 that came into effect from September 2019, have completely changed the motor segment of the business, according to leading insurers. According to data put out by the General Insurance Council, while the total gross direct premium income (GDPI) for the overall industry (general insurers) has grown by 13.4 per cent year-on-year (y-o-y) in the nine months ended December 2019, motor insurance that constitutes a significant 35 per cent of the overall business has grown in single-digit.

In the first nine months of FY20, total motor GDPI has grown by 8.8 per cent y-o-y. The overall growth in motor premium has been dragged by the flat growth in motor own-damage. Growth of motor own-damage GDPI has been 0.7 per cent y-o-y, while motor third-party GDPI has grown by about 15 per cent.

Motor own damage reports a flat growth

Gross direct premium underwritten %Y-o-Y growth

	Apr-Dec 2019	Apr-Dec 2018
Fire	37.8	7.8
Motor total	8.8	9.4
Motor OD	0.7	1.0
Motor TP	14.7	16.5
Health	12.0	18.2
Total	**13.4**	**13.3**

Intense pricing competition in the own-damage business, post implementation of the mandatory long-term third-party insurance in September 2018, along with relative slowdown in new vehicle sales, have been key reasons for the meagre growth in own-damage premiums this year.

Pricing competition

Motor insurance has two components — a third-party (TP) cover and an own-damage (OD) cover. The former is mandatory and covers the legal liability arising out of damage to third-party or bodily injury or death. OD is optional and protects vehicles against damage or theft.

In September 2018, the mandatory long-term insurance that kicked in, required customers to take mandatory five-year TP cover for new two-wheelers and three-year cover for cars. But the customer had the discretion to either take OD cover also for longer term or just for one year and then subsequently renew it in the coming year. While TP rates are decided by IRDAI, insurers have flexibility to decide on the OD cover premiums.

Insurers vying for the more profitable motor OD business, have been competing intensely on pricing, passing on the benefit of renewal/distribution cost reduction to the customers. This has led to a fall in overall OD premiums in the industry.

"If a customer opted for a one-year OD cover at the time of implementation of the mandatory long-term insurance in September 2018, then he would have had to renew the OD cover in September 2019. Hence, September 2019 onwards, insurers including ICICI Lombard started issuing standalone OD covers. Insurers have been aggressively pricing these policies," said Gopal Balachandran, CFO & Chief Risk Officer at ICICI Lombard General Insurance.

A mixed show by leading players

	Motor total	Motor OD	Motor TP
New India	-2.17	-10.75	2.52
ICICI Lombard	9.53	10.13	8.83
United India	1.07	-7.59	4.49
National	-10.30	-25.38	-0.31
Bajaj Allianz	14.02	4.60	21.41
Oriental	-6.26	-17.57	-0.62
Tata-AIG	10.26	-3.19	23.99
IFFCO-Tokio	9.78	5.39	14.09
Reliance General	12.21	-5.84	27.48
HDFC ERGO	15.41	1.22	33.35
Cholamandalam MS	15.85	11.97	17.96

But the renewal of OD cover has also opened up opportunities for leading insurance players. Over the past fourth months, ICICI Lombard has seen the thrust on renewal of own damage covers pay off and seen an increase in retention of customers. ICICI Lombard has managed to grow higher than the industry in motor OD. In the nine months, ICICI Lombard's motor GDPI has grown by a healthy 10 per cent. On a much smaller base, Cholamandalam MS General Insurance too has seen a 12 per cent growth in motor OD.

Pricing in the motor OD segment may also improve, going ahead. "The intensifying competition in the motor OD has come to a point where it has started to hurt the industry. Hence, pricing competition should ease and sanity should return soon," adds Gopal Balachandran.

Many players such as Tata AIG, Bajaj Allianz and HDFC ERGO have focused on third-party business to drive growth, even as OD premiums have grown at a modest pace. Third-party motor GDPI for these players have grown by 21-33 per cent in the April-December period. The regulator revised the third-party rates effective June 16, 2019. This has also aided in the growth of third-party premiums.

Motor Vehicles Act

Coming out of the interim disruptions owing to mandatory long-term insurance, the prospects of the motor insurance business remain healthy. The Motor Vehicles Act 2019 that came into effect from September 2019 has led to a lot of customer awareness and increase in motor insurance issuance. Aside from increased penalties for driving errors, the law also increased the penalty for driving an uninsured vehicle.

(The writer is Radhika Merwin.)

TOP

Source

Five things to know about motor insurance riders - The Economic Times – 17th February 2020

1. Engine protection cover takes care of the engine seizing or hydrostatic lock due to car starting in a waterlogged area.

2. Roadside assistance and towing rider provides 24x7 varied kinds of assistance including fuel refi lling, lost key recovery, flat tyre change, battery jumpstart and also the cost of towing the car to the nearest repair workshop.

3. Personal accident cover of a paid driver covers permanent disability and death of the driver, in case of road accidents.

4. Vehicle replacement cover ensures that in case of total loss or theft of car, you will get the original invoice value, including registration charges and the road tax.

5. Rental reimbursement covers the rental cost of a substitute car while your car is sent for repairs.
Source –
https://economictimes.indiatimes.com/wealth/insure/motor-insurance/five-things-to-know-about-motor-insurance-riders/articleshow/74146895.cms

TOP

Source

INSURANCE CASES

Andhra vigilance department unearths Rs 404 crore scam in ESIC scheme – The Telegraph – 21st February 2020

The Vigilance and Enforcement Department of Andhra Pradesh has claimed to have unearthed a Rs 404.86 crore scam in the Employees State Insurance Corporation during the period between 2014 and 2019, when the Telugu Desam Party was in power.

Three directors of the Insurance Medical Service (IMS) implementing the ESIC scheme -- B Ravi Kumar, C K Ramesh Kumar and G Vijaya Kumar -- have been found guilty of large-scale irregularities, a report by the vigilance department said.

Besides the three directors, at least five joint directors and several other staff members have been named as culpable in the irregularities, it added. State labour minister G Jayaram said action would be taken against all those involved, based on the vigilance report.

He said former labour minister in the Chandrababu Naidu cabinet, K Atchannaidu, and top officials of the department would be brought to book and the swindled amount would be recovered. "We will not hesitate to send them to jail," Jayaram said in a video statement.

Atchannaidu, who is currently deputy leader of the Telugu Desam Legislature Party, denied any wrongdoing and claimed he merely implemented the directives of Prime Minister Narendra Modi. "In 2016, the Prime Minister convened a meeting of ESIC and wanted the states to introduce tele health services and the Centre wrote a letter to all states in December 2016 on the same.

We had decided to implement that and I asked our officials to follow Telangana model and issued a note," Atchannaidu said in a video message from his village in Srikakulam district. Maintaining that all relevant records were available and could be verified, the former minister said he was ready to face any inquiry.

The vigilance department said that the three directors were the "kingpins of the procurement scam in the ESI, where gross irregularities were committed in purchase of drugs, medicines, lab kits, surgical items and furniture between 2014-15 and 2018-19, causing a loss of over Rs 151 crore to the state exchequer".

Of the total Rs 975.79 crore worth of purchases made during the period, the three directors, along with other staff, violated all procedures and guidelines of the government and ESIC and caused "huge wrongful loss to the exchequer", the vigilance report prepared by Director General K V Rajendranath Reddy said.

While the total budget allocation for the purchase of drugs and medicines during their tenure was Rs 293.51 crore, they made purchases worth Rs 698.36 crore, an excess of Rs 404.86 crore, in violation of procedural guidelines, the report said.

Of this, Rs 51 crore was found to be paid in excess as the drugs were purchased from non-rate contract firms, in clear violation of guidelines, it said. An excess of Rs 85.32 crore was paid to three private firms on purchase of laboratory kits and another Rs 10.43 crore on surgical items, it said.

"The directors purchased furniture worth Rs 6.62 crore without calling for open tenders and, when compared to randomly with the market prices, the purchases were made at 70 per cent excess than market prices. "This caused a loss of Rs 4.63 crore to the government," the Vigilance report noted.

"The above acts of the officers and staff (of ESIC and IMS) and proprietors of various firms attract the provisions of criminal misconduct under Prevention of Corruption Act and cheating, criminal breach of trust, forgery for the purpose of cheating and using forged documents as genuine and other offences under the Indian Penal Code," the vigilance report said and recommended suitable action.

TOP

Source

LIC told to pay Rs 8-lakh claim to deceased's kin – The Tribune – 18th February 2020

The District Consumer Disputes Redressal Forum has directed the Life Insurance Corporation (LIC) of India to pay Rs 8 lakh to legal heirs of a man who died due to ill health.

In a complaint filed by Resham Kaur and Charanjit Singh, the mother and father of the victim, Ravi Pal, it was stated that Ravi took a life insurance policy from the LIC for an assured amount of Rs 8 lakh for the period of 14 months on February 3, 2016. At the time of obtaining the policy, Ravi nominated Charanjit as his legal nominee, in case of any eventuality.

The complainants claimed that Ravi was hale and hearty and was found to be fit at the time of purchasing policy. However in March 2017, he was admitted to SGL Hospital following the complaint of seizures and headache and was diagnosed for left frontal tuberculoma brain tumour. Afterwards, he was taken to the PGI, Chandigarh, on March 4, 2017, for the treatment of diagnosed tuberculoma, but he died on March 16, 2017, at the hospital.

Charanjit said he intimated the insurance firm about the death and the claim was lodged in respect of the policy. He said he submitted relevant documents to the company but it declined the death claim, stating that the insured was not maintaining good health prior to submission of the proposal form and took the insurance after concealing the status of his health and as such, the claim was repudiated.

Meanwhile, the notice of the complaint was sent to the LIC, which in its reply to the forum said the claim was repudiated mainly on the grounds that at the time of making the proposal on February 3, 2016, the policy holder, Ravi Pal, was suffering from some physical problem and this fact was kept concealed from them.

"As per CT scan (head) reports of life insured from SGL Hospital, dated January 1, 2016 and February 20, 2016, there was a bone defect of surgical intervention seen in the left temporo-parietal region of insured. However, the same was never disclosed in the form," the LIC said.

Meanwhile, advocate of the complainant, through valid certificates issued by SGL Hospital proved that the dates mentioned on the CT scan report — i.e. January 1, 2016, and February 20, 2016, were typing errors by the hospital, and the actual dates were January 1, 2017, and February, 20, 2017.

He said the same was also intimated to the LIC, but they were trying to manipulate the facts and denied the claim on baseless grounds.

The forum after verifying documents presented by both parties said: "Human being is a 'putla' of mistakes, and if any mistake is rectified that should be thoroughly verified and investigated. The dates January 1, 2016 and February 20, 2016, were typographical mistakes, whereas the year of the said reports was 2017 instead of 2016. Regarding this, a certificate was also obtained by the complainant from SGL Hospital and the same is signed by Dr Ajay Mahajan as well as by the Medical Superintendent."

"The LIC failed to consider the issued certificate. Thus, the complainants are entitled to get the insurance claim of their son — Rs 8,00,000," the forum said, further directing the LIC to pay the claim with 12 per cent Interest per annum from the date of filing the complaint, i.e. April 22, 2017, till realisation.

(The writer is Avneet Kaur.)

TOP

Source

Pay Rs 20L medical claim to complainant, firm directed – The Tribune – 17th February 2020

The District Consumer Disputes Redressal Forum has directed a private insurance company to pay Rs20 lakh as medical expenses to a city-based resident for repudiating his overseas medical claim.

Ajinder Kaur, a resident of Jalandhar Vihar, had filed a complaint against Religare Health Insurance Company Limited, alleging that she was lured into purchasing an overseas mediclaim insurance policy under a plan, 'Explore Canada +' for a travel period of 179 days as a proposer on the life of Harwant Singh, father-in-law, and Parvinder Kaur, mother-in-law. According to the complainant, the policy covered risk insured against hospital cash and major surgical benefits.

In her complaint, Ajinder said she had purchased the policy in March 2018, for a period of six months from April 4, 2018, to October 7, 2018, for a insured amount of USD 100,000 for each — for her mother-in-law and father-in-law — and paid its premium amount on time.

She said after purchasing the insurance policy, her father-in-law Harwant Singh went to Canada and unfortunately on May 3, 2018, he fell ill and was admitted to Survey Memorial Hospital. He got proper

treatment and was discharged on May 11, 2018. She said they paid Rs Rs 20 lakh for treatment and medicine purchased by them.

According to her, when they approached the insurance company and informed it about the expenses on treatment of Harwant Singh and made claims for the reimbursement of the money, the company rejected the claims. She added that the insurance company said the insured person was suffering with hypertension and hyperlipidemia for long and the same was not disclosed by the family when they had purchased the policy.

However, she said according to medical certificates, Harwant Singh was in the pink of his health at the time of purchasing the policy. She said insurability with no physical impairment and pre-existing disease/ illness were mentioned in the proposal form. He was not afflicted with hypertension and hyperlipidemia.

A notice of the complaint was sent to the opposite party. In its reply to the forum, it said, "There was non-disclosure of material information by the complainant at the time of taking the insurance policy. The expenses in the present case are attributable to, arising out of, traceable to and a complication of pre-existing ailment of the complainant and not payable under the policy terms and conditions."

After going through the facts presented by both parties, Karnail Singh, president of the forum, and member Jyotsna in its judgment held the company liable for rejecting the claim on baseless grounds and directed it to reimburse the medical treatment expenses of Rs20 lakh.

(The writer is Avneet Kaur.)

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Source

SURVEY

Investors prefer savings schemes & pension plans to risky bets: Survey – The Economic Times – 21st February 2020

Investment preference seems to be changing. A survey by UBS Global Research showed that in 2019,ownership has gone up for insurance, post office savings schemes and pension plans compared with equity/debt mutual funds (MFs) and shares, where it has declined.

A survey of investors who have a bank account — either savings or current — by global investment bank UBS showed that 47 per cent of those surveyed held a life insurance policy and 33 per cent had ownership of plain-vanilla bank deposits. "As we have been highlighting, the attractive interest rate offered on government-sponsored small saving schemes versus banks' term deposits is influencing household saving behaviour," said Gautam Chhaochharia, analyst, and Ms Tanvee Gupta Jain, economist, at UBS Securities.

The survey "UBS Evidence Lab", the third urban consumer survey of about 1,064 participants, has other interesting findings. It indicated that a higher proportion of households is saving and 35 per cent of respondents currently save or invest before spending compared to 24 per cent in the 2018 survey.

About 70 per cent of respondents feel their current level of savings has increased compared with the previous year. However, more than half of respondents (58 per cent) still believe their savings are below expectations, that is they would like to save more.

The survey acknowledges the general slowdown in household savings until FY19, for which official data is available.

"Households that contribute 60 per cent of gross savings in India ran into stretched balance sheets, as they were funding consumption by taking higher leverage and dipping into savings amidst muted income growth. This imbalance seems to have started correcting now" it said. Mean income levels of urban households have remained muted over the past year, with the bulk of the decline in tier-1cities. "We believe this could be on account of potentially weaker job creation trends (quantity, quality or both) and the automation overhang" the report said.

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Source

PENSION

New Central Government Employees NPS to OPS transfer option: Don't miss this last date! - Financial Express – 20th February 2020

Central Government Employee National Pension System (NPS) to OPS transfer: The Union government has accepted a long-pending demand of scores of central government employees by giving them an option to switch over to the Central Civil Services (Pension) Rules, or continue to be covered under the National Pension System (NPS). This option can be exercised by those employees of the Government of India whose recruitment was finalised before 01/01/2004 but who had joined service on or after 01/01/2004.

Last Date For NPS to OPS switch: To exercise the new option, eligible central government employees need to apply by 31/05/2020. If an employee fails to exercise this option before the last date, they would continue to be covered by the National Pension System.

The decision to provide the new option to Central Government Employees comes months after the Central Administrative Tribunal (CAT) ruled in a case that the benefit of the Old Pension Scheme cannot be denied to a central government employee if the delay in joining the service before 01/01/2004 was not because of a reason attributable to him. FE Online had reported the order in November.

O1/01/2004 was the cut-off date for employees to be covered under the Old Pension Scheme. The NPS to OPS switch option has rectified a long-standing grievance of a large number of employees whose recruitment (including written examination, interview and declaration of result) was finalized but whose joining was delayed on account of administrative reasons and such delay was beyond the control of such candidates.

Who will benefit from new option

- The Ministry of Personnel, Public Grievances & Pensions has shared some of the instances in which eligible employees will benefit from the new option:
- *The recruitment result was declared before 01.01.2004 but the offer of appointment and actual joining of the Government servant was delayed because of police verification, medical examination etc.;*
- *Some candidates selected through a common selection process were issued offers of appointments and were also appointed before 01.01.2004 whereas the offers of appointments to other selected candidates were issued on or after 1.1.2004 due to administrative reasons/constraints including pending Court/CAT cases.*

Candidates selected before 01.01.2004 through a common competitive examination were allocated to different Departments/organization. While recruitment process was completed by some Department(s)/organizations on or before 31.12.2003 in respect of one or more candidates, the offers of appointment to the candidates allocated to the other Departments /Organization were issued on or after 01.01.2004.

Offers of appointment to selected candidates were made before 01.01.2004 with a direction to join on or after 01.01.2004.

Offers of appointment were issued to selected candidates before 01.01.2004, and many/most candidates joined service before 01.01.2004. However, some candidate(s) were allowed extension of joining time and they joined service on or after 01.01.2004. However, their seniority was either unaffected or was depressed in the same batch or to a subsequent batch, the result for which subsequent batch was declared before 01.01.2004.

The result for recruitment was declared before 01.01.2004 but one or more candidates were declared disqualified on the grounds of medical fitness or verification of character and antecedents, caste or income certificates. Subsequently, on review, they were found fit for appointment and were issued offers of appointment on or after 01.01.2004.

The ministry said in a statement that since the result for recruitment was declared before 01.01.2004 in all the above cases, "the denial of the benefit of pension under CCS (Pension) Rules, 1972 to the affected Government servants is not considered justified."

"It has been decided that in all cases where the results for recruitment were declared before 01.01.2004 against vacancies occurring on or before 31.12.2003, the candidates declared successful for recruitment shall be eligible for coverage under the CCS (Pension) Rules, 1972," the ministry said.

Some more important points to know
For those applying to switch from NPS to OPS, the government will issue the necessary order latest by 30th September 2020 for those found eligible. The NPS account of such Government servants will consequently be closed w.e.f. 01st November 2020.

(The writer is Rajeev Kumar.)

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Source

National Pension System tax benefit: Do you know cut-off dates for NPS contribution? – Financial Express – 19th February 2020

To avail tax benefits through tax-saving investments, a person needs to invest by March 31 of the current financial year. For example, you may avail 80C benefits for the financial year 2019-20, only if you deposit money in your PPF account by March 31, 2020, pay your insurance premium by that date.

The date on the receipt you get for such payments would decide if you are eligible to avail tax benefits or not.

However, to avail the additional tax benefits up to Rs 50,000 on voluntary contribution to NPS Tier 1 Account – over and above the 80C limit of Rs 1.5 lakh, you can't wait till March 31 to make your contribution as it takes some time for the money to get actually credited to the account of NPS fund manager.

So, for the financial year 2019-20, you may avail the additional tax benefit on voluntary contribution to NPS u/s 80CCD(1B) of the Income Tax Act only if the amount contributed gets credited to your account with NPS fund manager by March 31, 2020.

So, what would be the cut-off date to make the voluntary contribution, so that the amount gets credited to the NPS fund account by March 31, 2020?

"It takes 4-5 working days to channelise the funds from POP (Point of Presence) to actual credit to the fund account," said Ankit Agarwal, MD Alankit Ltd, adding, "All the modes of payment are accepted i.e. cash, cheque and all modes of online transfers."

Talking on the cut-off dates, Agarwal said, "Moreover, to get last moment tax benefit u/s 80CCD(1B), it is advisable to pay the contribution by March 25 to avoid any last moment hassle. For cheque payments, March 23 is a good date to pay."

The time gap between paying the contribution amount and getting it credited to the fund account arises due to the structure of the National Pension System (NPS).

POPs are the first points of interaction of the NPS subscriber with the NPS architecture and the authorised branches of a POP, called Point of Presence Service Providers (POPSPs), act as collection points, where contributions are made. Apart from accepting contributions, POPSPs extend a number of customer services to NPS subscribers including requests for withdrawal from NPS.

The POPs transfer the amount collected to the account of the Trustee Bank, from where the fund then channelised to the account of the NPS fund managers, selected by respective subscribers to manage their pension funds.

So, the process of channelising funds from POPs to trustee bank to respective fund managers takes some time and for granting tax benefits, the date on which the amount gets credited in the fund account is taken into account.

You may get the NPS tax receipt delivered at your registered email address by the POP after around 3 working days from the date of transaction or may also log in to the website of POP to download it.

(The writer is Amitava Chakrabarty.)

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Source

PPF account new rules: 5 key things about Public Provident Fund scheme you need to know – Financial Express – 18th February 2020

PPF Account New Rules 2020: The Department of Posts of Ministry of Communication has recently communicated regarding the amendments to procedural rules related to all the small savings schemes, including the Public Provident Fund (PPF) scheme. The changes will largely reflect in the post office savings bank manual governing the rules of PPF and other National Savings Schemes. The gazette notification for the new rules was issued on December 12, 2019.

It may be noted that the government had earlier in December 2019 brought about changes in the way small savings schemes are to be managed. The Public Provident Fund Act, 1968 stands repealed and along with the Government Savings Certificates Act, 1959 both now come under the Government Savings Promotion Act 1873. Along with this change, there were some other procedural changes made in the Provident Funds Scheme Rules 2019.

1. PPF contribution rules

While the minimum and the maximum amount that can be deposited in PPF remains the same, the minimum amount required to open PPF account has changed along with the number of times one can deposit contributions on the PPF account.

Any individual can subscribe to the Public Provident Fund on his own behalf or on behalf of a minor of whom he is a guardian any amount in multiples of Rs. 50 not less than Rs. 500 and not more than Rs. 1.5 lakh in a financial year. Further, the PPF subscriptions can be deposited in a lump sum or in instalments

of even more than one instalment in a month. Earlier, the PPF subscription had to be in multiples of Rs.5 and could be paid into the account in one lump sum or instalments not exceeding twelve in a year.

For opening a PPF account, one needs to fill and submit Form 1 instead of Form A used earlier.

2. PPF extension rules after maturity – With deposits
After 15 years, PPF Account can be extended after maturity with deposits within 1 year of the of date of maturity original PPF Account or it can be extended by submitting the application in Form-4, instead of Form H used earlier.

3. PPF extension rules after maturity – Without deposits
Similarly, PPF Account can also be retained after maturity without further deposits and balance at the time of maturity shall continue to earn interest at the rate notified from time to time. In case PPF Account is retained without deposits, the account holder can make one withdrawal in each financial year.

4. PPF loan interest rate
The principal amount of loan will be repaid by the subscriber through pay-in-slip and it will be credited to the Loan Account of the subscriber. After the principal amount is fully repaid, the subscriber shall pay interest in not more than two monthly instalments at the rate of 1 per cent per annum of the principal for the period commencing from the first day of the month following the month in which the loan is drawn up to the last day of the month in which the last instalment of the loan is repaid. If the loan is not repaid or is repaid only in part, the penal interest will be charged at the rate of 6 per cent per annum.

5. PPF- How interest is calculated
To get interest amount for the entire month, it is suggested to deposit PPF contribution on or before 5th of the month. If you want to use PPF interest rate calculator, remember that the interest on subscriptions will be eligible for a calendar month on the lowest balance at the credit of an account between the close of the 5th day and the end of the month. The interest on the subscriptions made during the financial year and balance in the account will be at rates from time to time by the central Government. It will be credited to the account of the subscriber at the end of each financial year. The interest will be calculated on 31't March day end and credited into the account on April 1.

(The writer is Sunil Dhawan.)

Source

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GLOBAL NEWS

Philippines: Regulator gives insurers ultimatum on minimum capital - Asia Insurance Review

The Insurance Commission (IC) has issued a stern warning to all life and non-life insurance companies that a cease-and-desist order shall be issued against them should they fail to comply with the PHP900m ($17.8m) minimum net worth and minimum capital investment requirement by the regulator's deadline.

The original deadline was 31 December 2019. In an 11 February advisory signed by Commissioner Dennis B. Funa, the IC said that all companies have until 28 February 2020, to comply, reported Business Mirror.

Otherwise, a show-cause order will be served to direct the company to make any shortfall "by cash, to be contributed by all stockholders of record in proportion to their respective interests, and paid to the treasurer of the company, within 15 days from receipt of the letter".

Moreover, the company shall be ordered not to take any new risk of any kind or character unless and until it makes good on any such deficiency. Last month, the IC issued follow-up letters to companies with a net worth below PHP900mn.

In a related development, IC lauded a local non-life insurance company for early compliance with the net worth requirement. SGI Philippines General Insurance (SGI) has already complied with a further requirement to have minimum capital raised to PHP1.3bn which is to take effect on 31 December 2022.

SGI's majority shareholder Indian insurance company Shriram General Insurance, infused fresh capital amounting to PHP624m. As a result, SGI's net worth surged from PHP710m to PHP1.35bn.

"The move on the part of SGI Philippines to comply with the last tranche of capital increase under the Amended Insurance Code is commendable as such action gives us the confidence that SGI Philippines has a solid source of capital to deliver its promises to the insuring public," Mr Funa said in a statement.

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Source

Coronavirus: Outbreak dents optimism just as global economy showed signs of stabilisation-Moody's - Asia Insurance Review

The coronavirus epidemic creates new risks to the prospects of an incipient stabilisation of global growth this year resulting from a truce in the US-China trade war and emerging signs of a pickup in the industrial sector, says Moody's Investors Service.

China

In view of the outbreak, the international rating agency has revised downward the GDP growth forecasts for China to 5.2% in 2020, and maintains expectation of 5.7% growth in 2021.

Moody's vice president Ms Madhavi Bokil said, "The outbreak will first and foremost hurt China's economy by lowering discretionary consumer spending on transportation, retail, tourism and entertainment. There is already evidence?—albeit anecdotal?—that supply chains are being disrupted, including outside China. Furthermore, extended lockdowns in China would have a global impact given the country's importance and interconnectedness in the global economy.

"With the virus continuing to spread within China and to other parts of the world, it is still too early to make a final assessment of the impact on China and the global economy."

Global

Moody's has also revised its global growth forecasts down by two tenths of a percentage point, now expecting G-20 economies to collectively grow at an annual rate of 2.4% in 2020.

The toll on the global economy would be severe if the rate of infections does not abate and the death toll continues to rise.

If the outbreak persists, the domestic and international supply chain disruptions are likely to become significant, amplifying the shock to the global economy. Global companies operating in the affected areas would face output losses as a result of the extended closures of businesses and factories.

Companies that operate outside China but depend on inputs from the affected area would face temporary production delays. In addition, the negative spillover would also affect countries, sectors, and companies that either derive revenue from or produce in China, or rely on Chinese demand.

Apart from China, Moody's has reduced too the growth forecasts of Korea, Japan and Australia on account of the coronavirus outbreak. The negative shock to China's economy has the potential to harm the stabilisation and recovery of other economies through trade and tourism channels.

Growth forecasts for advanced economies are mostly unchanged. Among emerging market countries, Moody's has materially revised downward the growth forecasts for India, Mexico and South Africa, reflecting domestic challenges rather than external factors.

TOP

Source

Malaysia: Insurers urged to change messaging about life insurance - Asia Insurance Review

Life Insurance Association of Malaysia (LIAM) president Loh Guat Lan has suggested that insurers repackage their offerings in terms of financial wellness, rather than just, say, life insurance.

Insurers need to redefine their value propositions so that the working population stops regarding insurance products as expensive and "nice to have" rather than necessary protection, she told The Edge.

To remain relevant, life insurance products need to be dramatically altered so that consumers understand, value and want them, she added.

Ms Loh, who is CEO of Hong Leong Assurance, suggested that insurers change their approach and improve their offerings through microinsurance — coming up with life coverage with bite-sized premiums. Small-ticket insurance coverage, also known as sachet insurance, are non-comprehensive plans that focus on specific needs and come with low premiums and lower cover. Such policies help to boost insurance penetration and, in turn, reduce inequality, she said.

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Source