IC-38
CORPORATE AGENTS
Health

ACKNOWLEDGEMENT

This course is based on revised syllabus prepared by Insurance Institute of India, Mumbai

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CORPORATE AGENTS - HEALTH
IC-38

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This course is purely meant for the purpose of study of the subject by student appearing for the examination of Insurance Institute of India & is based on prevailing best industry practices. It is not intended to give interpretation or solution in case of dispute or matters involving legal argument.

This is only an indicative study material. Please note that the questions in the examination shall not be confined to this study material.

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PREFACE

The Institute has developed the course material for Corporate Agents Health Branch in consultation with the industry. The course material is prepared based on the syllabus approved by IRDAI.

The study course, thus, provides basic knowledge of Life, General and Health insurance that enables agents to understand and appreciate their professional career in the right perspective. Needless to say, insurance business operates in a dynamic environment the agents will have to keep abreast of changes in law and practice, through personal study and participation in in-house training given by insurers.

We thank IRDAI for entrusting this work to III. The Institute wishes all those who study this course and pass the examination.

Insurance Institute of India

CONTENTS

SECTION 1

COMMON CHAPTERS

CHAPTER 1

INTRODUCTION TO INSURANCE

Chapter Introduction

This chapter aims to introduce the basics of insurance, trace its evolution and how it works. You will also learn how insurance provides protection against economic losses arising as a result of unforeseen events and serves as an instrument of risk transfer.

Learning Outcomes

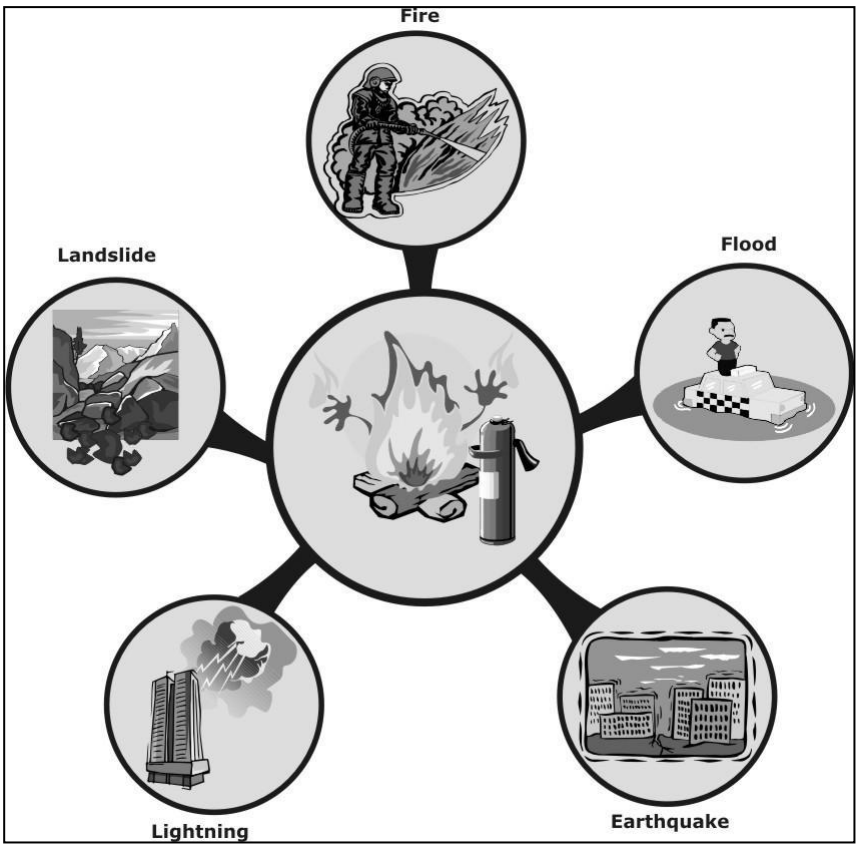
A. Life insurance – History and evolution
B. How insurance works
C. Risk management techniques
D. Insurance as a tool for managing risk
E. Role of insurance in society

A. Life insurance – History and evolution

We live in a world of uncertainty. We hear about:

- ✓ trains colliding;
- ✓ floods destroying entire communities;
- ✓ earthquakes that bring grief;
- ✓ young people dying suddenly pre-maturely

Diagram 1: Events happening around us



Why do these events make us anxious and afraid?

The reason is simple.

i. Firstly these **events are unpredictable.** If we can anticipate and predict an event, we can prepare for it.

ii. Secondly, such unpredictable and untoward events are often a **cause of economic loss and grief**.

A community can come to the aid of individuals who are affected by such events, by having a system of sharing and mutual support.

The idea of insurance took birth thousands of years ago. Yet, the business of insurance, as we know it today, goes back to just two or three centuries.

1. History of insurance

Insurance has been known to exist in some form or other since 3000 BC. Various civilisations, over the years, have practiced the concept of pooling and sharing among themselves, all the losses suffered by some members of the community. Let us take a look at some of the ways in which this concept was applied.

2. Insurance through the ages

Babylonian Traders	The **Babylonian traders** had agreements where they would pay additional sums to lenders, as a price for writing off of their loans, in case a shipment was lost or stolen. These were called 'bottomry loans'. Under these agreements, the loan taken against the security of the ship or its goods had to be repaid only if and when the ship arrived safely, after the voyage, at its destination.
Traders from Bharuch and Surat	Practices similar to Babylonian traders were prevalent among **traders from Bharuch and Surat,** sailing in Indian ships to Sri Lanka, Egypt and Greece.
Greeks	The **Greeks** had started benevolent societies in the late 7th century AD, to take care of the funeral – and families – of members who died. The **Friendly Societies of England** were similarly constituted.
Inhabitants of Rhodes	The **inhabitants of Rhodes** adopted a practice whereby, if some goods were lost due to jettisoning[1] during distress, the owners of goods (even those who lost nothing) would bear the losses in some proportion.
Chinese Traders	**Chinese traders** in ancient days would keep their goods in different boats or ships sailing over the treacherous rivers. They assumed that even if any of the boats suffered such a fate, the loss of goods would be only partial and not total. The loss could be distributed and thereby reduced.

3. Modern concepts of insurance

In India the principle of life insurance was reflected in the institution of the joint-family system in India, which was one of the best forms of life insurance down the ages. Sorrows and losses were shared by various family members in the event of the unfortunate demise of a member, as a result of which each member of the family continued to feel secure.

[1] Jettisoning means throwing away some of the cargo to reduce weight of the ship and restore balance

The break-up of the joint family system and emergence of the nuclear family in the modern era, coupled with the stress of daily life has made it necessary to evolve alternative systems for security. This highlights the importance of life insurance to an individual.

i. **Lloyds**: The origins of modern commercial insurance business as practiced today can be traced to Lloyd's Coffee House in London. Traders, who used to gather there, would agree to share the losses, to their goods being carried by ships, due to perils of the sea. Such losses used to occur because of maritime perils, such as pirates robbing on the high seas, or bad sea weather spoiling the goods or sinking of the ship due to perils of the sea.
ii. **Amicable Society for a Perpetual Assurance** founded in 1706 in London is considered to be the first life insurance company in the world.

4. History of insurance in India

a) **India**: Modern insurance in India began in early 1800 or thereabouts, with agencies of foreign insurers starting marine insurance business.

The Oriental Life Insurance Co. Ltd	The first life insurance company to be set up in India was an English company
Triton Insurance Co. Ltd.	The first non-life insurer to be established in India
Bombay Mutual Assurance Society Ltd.	The first Indian insurance company. It was formed in 1870 in Mumbai
National Insurance Company Ltd.	The oldest insurance company in India. It was founded in 1906 and it is still in business.

Many other Indian companies were set up subsequently as a result of the Swadeshi movement at the turn of the century.

Important

In 1912, the **Life Insurance Companies Act** and the **Provident Fund Act** were passed to regulate the insurance business. The Life Insurance Companies Act, 1912 made it compulsory that premium-rate tables and periodical valuation of companies be certified by an actuary. However, the disparity and discrimination between Indian and foreign companies continued.

The **Insurance Act 1938** was the first legislation enacted to regulate the conduct of insurance companies in India. This Act, as amended from time to time continues to be in force. The Controller of Insurance was appointed by the Government under the provisions of the Insurance Act.

b) **Nationalisation of life insurance**: Life insurance business was nationalised on 1st September 1956 and the **Life Insurance Corporation of India (LIC)** was formed. There were 170 companies and 75 provident fund societies doing life insurance business in India at that time. From 1956 to 1999, the LIC held exclusive rights to do life insurance business in India.

c) **Nationalisation of non-life insurance**: With the enactment of General Insurance Business Nationalisation Act (GIBNA) in 1972, the non-life insurance business was also nationalised and the **General Insurance Corporation of India (GIC) and its four subsidiaries** were set up. At that point of time, 106 insurers in India doing non-life insurance business were amalgamated with the formation of four subsidiaries of the GIC of India.

d) **Malhotra Committee and IRDAI**: In 1993, the Malhotra Committee was setup to explore and recommend changes for development of the industry including the reintroduction of an element of competition. The Committee submitted its report in 1994.In 1997 the Insurance Regulatory Authority (IRA) was established. The passing of the Insurance Regulatory& Development Act, 1999(IRDAI) led to the formation of **Insurance Regulatory and Development Authority of India (IRDAI)** in April 2000 as a statutory regulatory body both for life, non-life **and health** insurance industry. **IRDA has been subsequently renamed as IRDAI in 2014.**

Amending the Insurance Act in 2015, certain stipulations have been added governing the definition and formation of insurance companies in India.

An Indian Insurance company includes a company '***in which the aggregate holdings of equity shares by foreign investors, including portfolio investors, do not exceed forty-nine percent*** of ***the paid up equity capital of such Indian insurance company, which is Indian owned and controlled, in such manner as may be prescribed'.***

Amendment to the Insurance Act also stipulates about foreign companies in India, ***A foreign insurance company can engage in reinsurance through a branch established in India. The term "re-insurance" means the 'insurance of part of one insurer's risk by another insurer who accepts the risk for a mutually acceptable premium'***

5. Life insurance industry today

Currently, there are 24 life insurance companies operating in India as detailed hereunder:

a) Life Insurance Corporation (LIC) of India is a public sector company
b) There are 23 life insurance companies in the private sector

Alphabetical List of **23** Life-Assurance Companies, in the Private-Sector, is as follows:

S.No.	Company
1	AEGON Life Insurance Company Limi ted
2	Aviva Life Insurance Company India Limited
3	Bajaj Allianz Life Insurance Company Limited
4	Bharti AXA Life Insurance Company Limited
5	Birla Sun Life Insurance Company Limited
6	Canara H.S.B.C. Oriental Bank of Commerce Life Insurance Company Limited
7	D.H.F.L. Pramerica Life Insurance Company Limited
8	Edelweiss Tokio Life Insurance Company Limited
9	Exide Life Insurance Company Limited
10	Future Generali India Life Insurance Company Limited
11	H.D.F.C. Standard Life Insurance Company Limited
12	I.C.I.C.I. Prudential Life Insurance Company Limited
13	I.D.B.I. Federal Life Insurance Company Limited
14	IndiaFirst Life Insurance Company Limited
15	Kotak Mahindra Old Mutual Life Insurance Company Limited
16	Max Life Insurance Company Limited
17	P.N.B. Metlife India Insurance Company Limited
18	Reliance Nippon Life Insurance Company Limited
19	Sahara India Life Insurance Company Limited
20	S.B.I. Life Insurance Company Limited
21	Shriram Life Insurance Company Limited
22	Star Union Dai-ichi Life Insurance Company Limited

23	Tata A.I.A. Life Insurance Company Limited

c) The postal department, under the Government of India, also transacts life insurance business via Postal Life Insurance, but is exempt from the purview of the regulator

Test Yourself 1

Which among the following is the regulator for the insurance industry in India?

I. Insurance Authority of India
II. Insurance Regulatory and Development Authority of India
III. Life Insurance Corporation of India
IV. General Insurance Corporation of India

B. How insurance works

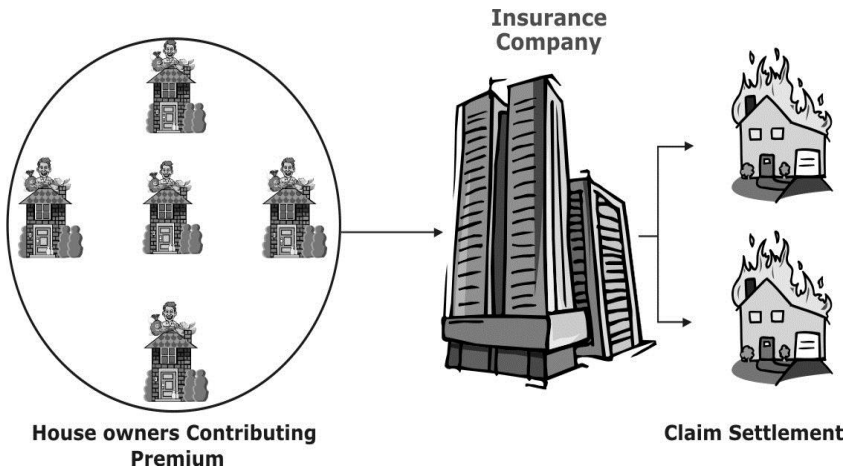
Modern commerce was founded on the principle of ownership of property. When an asset loses value (by loss or destruction) due to a certain event, the owner of the asset suffers an economic loss. However if a common fund is created, which is made up of small contributions from many such owners of similar assets, this amount could be used to compensate the loss suffered by the unfortunate few.

In simple words, the chance of suffering a certain economic loss and its consequence could be transferred from one individual to many through the mechanism of insurance.

Definition

Insurance may thus be considered as a process by which the losses of a few, who are unfortunate to suffer such losses, are shared amongst those exposed to similar uncertain events / situations.

Diagram 2: How insurance works



There is however a catch here.

i. Would people agree to part with their hard earned money, to create such a common fund?

ii. How could they trust that their contributions are actually being used for the desired purpose?

iii. How would they know if they are paying too much or too little?

Obviously someone has to initiate and organise the process and bring members of the community together for this purpose. That 'someone' is known as an 'Insurer' who determines the contribution that each individual must make to the pool and arranges to pay to those who suffer the loss.

The insurer must also win the trust of the individuals and the community.

1. How insurance works

a) Firstly, these must be an asset which has an economic value. The **ASSET**:
   i. May be **physical** (like a car or a building) or
   ii. May be **non-physical** (like name and goodwill) or
   iii. May be **personal** (like one's eyes, limbs and other aspects of one's body)

b) The asset may lose its value if a certain event happens. This chance of loss is called as **risk**. The cause of the risk event is known as **peril**.

c) There is a principle known as **pooling**. This consists of collecting numerous individual contributions (known as premiums) from various persons. These persons have similar assets which are exposed to similar risks.

d) This pool of funds is used to compensate the few who might suffer the losses as caused by a **peril**.

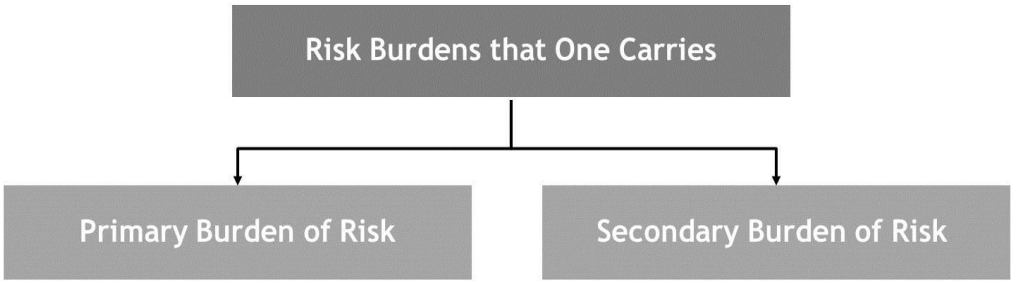
e) This process of pooling funds and compensating the unlucky few is carried out through an institution known as the **insurer.**

f) The insurer enters into an insurance **contract** with each person who seeks to participate in the scheme. Such a participant is known as **insured.**

2. Insurance reduces burdens

Burden of risk refers to the costs, losses and disabilities one has to bear as a result of being exposed to a given loss situation/event.

Diagram 3: Risk burdens that one carries



There are two types of risk burdens that one carries – **primary and secondary**.

a) Primary burden of risk

The **primary burden of risk** consists of losses that are actually suffered by households (and business units), as a result of pure risk events. These losses are often direct and measurable and can be easily compensated for by insurance.

Example

When a factory gets destroyed by fire, the actual value of goods damaged or destroyed can be estimated and the compensation can be paid to the one who suffers such loss.

If an individual undergoes a heart surgery, the medical cost of the same is known and compensated.

In addition there may be some indirect losses.

Example

A fire may interrupt business operations and lead to loss of profits which also can be estimated and the compensation can be paid to the one who suffers such a loss.

b) Secondary burden of risk

Suppose no such event occurs and there is no loss. Does it mean that those who are exposed to the peril carry no burden? The answer is that apart from the primary burden, one also carries a secondary burden of risk.

The **secondary burden of risk** consists of costs and strains that one has to bear merely from the fact that one is exposed to a loss situation. Even if the said event does not occur, these burdens have still to be borne.

Let us understand some of these burdens:

i. Firstly there is **physical and mental strain caused by fear and anxiety**. The anxiety may vary from person to person but it is present and can cause stress and affect a person's wellbeing.

ii. Secondly when one is **uncertain about whether a loss would occur or not**, the prudent thing to do would be to set aside a reserve fund to meet such an eventuality. There is a cost involved in keeping such a fund. For instance, such funds may be held in a liquid form and yield low returns.

By transferring the risk to an insurer, it becomes possible to enjoy peace of mind, invest funds that would otherwise have been set aside as a reserve, and plan one's business more effectively. It is precisely for these reasons that insurance is needed.

Test Yourself 2

Which among the following is a secondary burden of risk?

I. Business interruption cost
II. Goods damaged cost
III. Setting aside reserves as a provision for meeting potential losses in the future
IV. Hospitalisation costs as a result of heart attack

C. Risk management techniques

Another question one may ask is whether insurance is the right solution to all kinds of risk situations. The answer is 'No'.

Insurance is only one of the methods by which individuals may seek to manage their risks. Here they transfer the risks they face to an insurance company. However there are some other methods of dealing with risks, which are explained below:

1. Risk avoidance

Controlling risk by avoiding a loss situation is known as risk avoidance. Thus one may try to avoid any property, person or activity with which an exposure may be associated.

Example

i. One may refuse to bear certain manufacturing risks by contracting out the manufacturing to someone else.

ii. One may not venture outside the house for fear of meeting with an accident or may not travel at all for fear of falling ill when abroad.

But risk avoidance is a negative way to handle risk. Individual and social advancements come from activities that need some risks to be taken. By avoiding such activities, individuals and society would lose the benefits that such risk taking activities can provide.

2. Risk retention

One tries to manage the impact of risk and decides to bear the risk and its effects by oneself. This is known as self-insurance.

Example

A business house may decide, based on experience about its capacity to bear small losses up to a certain limit, to retain the risk with itself.

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3. Risk reduction and control

This is a more practical and relevant approach than risk avoidance. It means taking steps to lower the chance of occurrence of a loss and/or to reduce severity of its impact if such loss should occur.

Important

The measures to reduce chance of occurrence are known as '**Loss Prevention**'. The measures to reduce degree of loss are called '**Loss Reduction**'.

Risk reduction involves reducing the frequency and/or sizes of losses through one or more of:

a) **Education and training**, such as holding regular "fire drills" for employees, or ensuring adequate training of drivers, forklift operators, wearing of helmets and seat belts and so on.

   One example of this can be educating school going children to avoid junk food.

b) **Making Environmental changes**, such as improving "physical" conditions, e.g. better locks on doors, bars or shutters on windows, installing burglar or fire alarms or extinguishers. The State can take measures to curb pollution and noise levels to improve the health status of its people. Regular spraying of Malaria medicine helps in prevention of outbreak of the disease.

c) **Changes made in dangerous or hazardous operations,** while using machinery and equipment or in the performance of other tasks

   For example leading a healthy lifestyle and eating properly at the right time helps in reducing the incidence of falling ill.

d) **Separation**, spreading out various items of property into varied locations rather than concentrating them at one location, is a method to control risks. The idea is, if a mishap were to occur in one location, its impact could be reduced by not keeping everything at that one place.

   For instance one could reduce the loss of inventory by storing it in different warehouses. Even if one of these were to be destroyed, the impact would be reduced considerably.

4. Risk financing

This refers to the provision of funds to meet losses that may occur.

a) **Risk retention through self-financing** involves self-payment for any losses as they occur. In this process the firm assumes and finances its own risk, either through its own or borrowed funds, this is known as **self-insurance**. The firm may also engage in various risk reduction methods to make the loss impact small enough to be retained by the firm.

b) Risk transfer is an alternative to risk retention. Risk transfer involves transferring the responsibility for losses to another party. Here the losses that may arise as a result of a fortuitous event (or peril) are transferred to another entity.

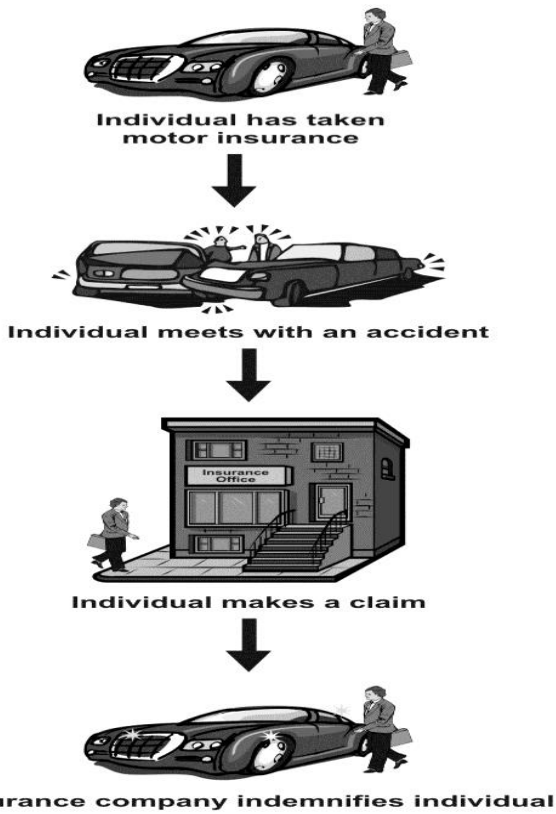
Insurance is one of the major forms of risk transfer, and it permits uncertainty to be replaced by certainty through insurance indemnity.

Insurance vs Assurance

Both insurance and assurance are financial products offered by companies operating commercially. Of late the distinction between the two has increasingly become blurred and the two are taken as somewhat similar. However there are subtle differences between the two as discussed hereunder.

Insurance refers to protection against an event that **might** happen whereas assurance refers to protection against an event that **will** happen. Insurance provides cover against a risk while assurance covers an event that is definite e.g. death, which is certain, only the time of occurrence is uncertain. Assurance policies are associated with life cover.

Diagram 4: How insurance indemnifies the insured



There are other ways to transfer risk. For example when a firm is part of a group, the risk may be transferred to the parent group which would then finance the losses.

Thus, insurance is only one of the methods of risk transfer.

Test Yourself 3

Which among the following is a method of risk transfer?

I. Bank FD
II. Insurance
III. Equity shares
IV. Real estate

D. Insurance as a tool for managing risk

When we speak about a risk, we are not referring to a loss that has actually been suffered but a loss that is likely to occur. It is thus an expected loss. The cost of this expected loss (which is the same as the cost of the risk) is the product of two factors:

i. The **probability** that the peril being insured against may happen, leading to the loss

ii. The **impact** or the amount of loss that may be suffered as a result

The cost of risk would increase in direct proportion with both probability and amount of loss. However, if the amount of loss is very high, and the probability of its occurrence is small, the cost of the risk would be low.

Diagram 5: Considerations before opting for insurance

1. Considerations before opting for Insurance

When deciding whether to insure or not, one needs to weigh the cost of transferring the risk against the cost of bearing the loss, that may arise, oneself. The cost of transferring the risk is the insurance premium – it is given by two factors mentioned in the previous paragraph. The best situations for insurance would be where the probability is very low but the loss impact could be very high. In such instances, the cost of transferring the risk through its insurance (the premium) would be much lower while the cost of bearing it on oneself would be very high.

a) **Don't risk a lot for a little**: A reasonable relationship must be there between the cost of transferring the risk and the value derived.

Example

Would it make sense to insure an ordinary ball pen?

b) **Don't risk more than you can afford to lose**: If the loss that can arise as a result of an event is so large that it can lead to a situation that is near bankruptcy, retention of the risk would not appear to be realistic and appropriate.

Example

What would happen if a large oil refinery were to be destroyed or damaged? Could a company afford to bear the loss?

c) **Consider the likely outcomes of the risk carefully**: It is best to insure those assets for which the probability of occurrence (frequency) of a loss is low but the possible severity (impact), is high.

Example

Could one afford to not insure a space satellite?

Test Yourself 4

Which among the following scenarios warrants insurance?

I. The sole bread winner of a family might die untimely
II. A person may lose his wallet
III. Stock prices may fall drastically
IV. A house may lose value due to natural wear and tear

E. Role of insurance in society

Insurance companies play an important role in a country's economic development. They are contributing in a significant sense to ensuring that the wealth of the country is protected and preserved. Some of their contributions are given below.

a) Their investments benefit the society at large. An insurance company's strength lies in the fact that huge amounts are collected and pooled together in the form of premiums.

b) These funds are collected and held for the benefit of the policyholders. Insurance companies are required to keep this aspect in mind and make all their decisions in dealing with these funds so as to be in ways that benefit the community. This applies also to its investments. That is why successful insurance companies would not be found investing in speculative ventures i.e. stocks and shares.

c) The system of insurance provides numerous direct and indirect benefits to the individual, his family, to industry and commerce and to the community and the nation as a whole. The insured - both individuals and enterprises - are directly benefitted because they are protected from the consequences of the loss that may be caused by an accident or fortuitous event. Insurance, thus, in a sense protects the capital in industry and releases the capital for further expansion and development of business and industry.

d) Insurance removes the fear, worry and anxiety associated with one's future and thus encourages free investment of capital in business enterprises and promotes efficient use of existing resources. Thus insurance encourages commercial and industrial development along with generation of employment opportunities, thereby contributing to a healthy economy and increased national productivity.

e) A bank or financial institution may not advance loans on property unless it is insured against loss or damage by insurable perils. Most of them insist on assigning the policy as collateral security.

f) Before acceptance of a risk, insurers arrange survey and inspection of the property to be insured, by qualified engineers and other experts. They not only assesses the risk for rating purposes but also suggest and recommend to the insured, various improvements in the risk, which will attract lower rates of premium.

g) Insurance ranks with export trade, shipping and banking services as an earner of foreign exchange to the country. Indian insurers operate in more than 30 countries. These operations earn foreign exchange and represent invisible exports.

h) Insurers are closely associated with several agencies and institutions engaged in fire loss prevention, cargo loss prevention, industrial safety and road safety.

Information

Insurance and Social Security

a) It is now recognised that provision of social security is an obligation of the State. Various laws, passed by the State for this purpose involve use of insurance, compulsory or voluntary, as a tool of social security. Central and State Governments contribute premiums under certain social security schemes thus fulfilling their social commitments. The Employees State Insurance Act, 1948 provides for **Employees State Insurance Corporation** to pay for the expenses of sickness, disablement, maternity and death for the benefit of industrial employees and their families, who are insured persons. The scheme operates in certain industrial areas as notified by the Government.

b) Insurers play an important role in social security schemes sponsored by the Government such as
   1. RKBY – Rashtriya Krishi Bima Yojana
   2. RSBY – Rashtriya Swasthya Bima Yojana
   3. PMJBY – Pradhan Mantri Jeevan Jyoti Bima Yojana
   4. PMSBY – Pradhan Mantri Suraksha Bima Yojana

   All these benefit the community in general.

c) All the **rural insurance schemes**, operated on a commercial basis, are designed ultimately to provide social security to the rural families.

d) Apart from this support to Government schemes, the insurance industry itself offers on a commercial basis, insurance covers which have the ultimate objective of social security. Examples are: **Janata Personal Accident, Jan Arogya** etc.

Test Yourself 5

Which of the below insurance scheme is run by an insurer and not sponsored by the Government?

I. Employees State Insurance Corporation
II. Crop Insurance Scheme
III. Jan Arogya
IV. All of the above

Summary

- Insurance is risk transfer through risk pooling.

- The origin of commercial insurance business as practiced today is traced to the Lloyd's Coffee House in London.

- An insurance arrangement involves the following entities like:

  - ✓ Asset,
  - ✓ Risk,
  - ✓ Peril,
  - ✓ Contract,
  - ✓ Insurer and
  - ✓ Insured

- When persons having similar assets exposed to similar risks contribute into a common pool of funds it is known as pooling.

- Apart from insurance, other risk management techniques include:

  - ✓ Risk avoidance,
  - ✓ Risk control,
  - ✓ Risk retention,
  - ✓ Risk financing and
  - ✓ Risk transfer

- The thumb rules of insurance are:

  - ✓ Don't risk more than you can afford to lose,
  - ✓ Consider the likely outcomes of the risk carefully and
  - ✓ Don't risk a lot for a little

Key Terms

1. Risk
2. Pooling
3. Asset
4. Burden of risk
5. Risk avoidance
6. Risk control
7. Risk retention
8. Risk financing
9. Risk transfer

Answers to Test Yourself

Answer 1

The correct option is II.

Insurance Regulatory and Development Authority of India is the regulator for the insurance industry in India.

Answer 2

The correct option is III.

The need for setting aside reserves as a provision for potential losses in the future is a secondary burden of risk.

Answer 3

The correct option is II.

Insurance is a method of risk transfer.

Answer 4

The correct option is I.

The bread winner of a family might die untimely leaving the entire family to fend for itself, such a scenario warrants purchasing of life insurance.

Answer 5

The correct option is III.

The Jan Arogya insurance scheme is run by an insurer and not sponsored by the Government.

Self-Examination Questions

Question 1

Risk transfer through risk pooling is called _____.

I. Savings
II. Investments
III. Insurance
IV. Risk mitigation

Question 2

The measures to reduce chances of occurrence of risk are known as _____.

I. Risk retention
II. Loss prevention
III. Risk transfer
IV. Risk avoidance

Question 3

By transferring risk to insurer, it becomes possible _____.

I. To become careless about our assets
II. To make money from insurance in the event of a loss
III. To ignore the potential risks facing our assets
IV. To enjoy peace of mind and plan one's business more effectively

Question 4

Origins of modern insurance business can be traced to _____.

I. Bottomry
II. Lloyds
III. Rhodes
IV. Malhotra Committee

Question 5

In insurance context 'risk retention' indicates a situation where _____.

I. Possibility of loss or damage is not there
II. Loss producing event has no value
III. Property is covered by insurance
IV. One decides to bear the risk and its effects

Question 6

Which of the following statement is true?

I. Insurance protects the asset
II. Insurance prevents its loss
III. Insurance reduces possibilities of loss
IV. Insurance pays when there is loss of asset

Question 7

Out of 400 houses, each valued at Rs. 20,000, on an average 4 houses get burnt every year resulting in a combined loss of Rs. 80,000. What should be the annual contribution of each house owner to make good this loss?

I. Rs.100/-
II. Rs.200/-
III. Rs.80/-
IV. Rs.400/-

Question 8

Which of the following statements is true?

I. Insurance is a method of sharing the losses of a 'few' by 'many'
II. Insurance is a method of transferring the risk of an individual to another individual
III. Insurance is a method of sharing the losses of a 'many' by a few
IV. Insurance is a method of transferring the gains of a few to the many

Question 9

Why do insurers arrange for survey and inspection of the property before acceptance of a risk?

I. To assess the risk for rating purposes
II. To find out how the insured purchased the property
III. To find out whether other insurers have also inspected the property
IV. To find out whether neighbouring property also can be insured

Question 10

Which of the below option best describes the process of insurance?

I. Sharing the losses of many by a few
II. Sharing the losses of few by many
III. One sharing the losses of few
IV. Sharing of losses through subsidy

Answers to Self-Examination Questions

Answer 1

The correct option is III.

Risk transfer through risk pooling is called insurance.

Answer 2

The correct option is II.

The measures to reduce chances of occurrence of risk are known as loss prevention measures.

Answer 3

The correct option is IV.

By transferring risk to insurer, it becomes possible to enjoy peace of mind and plan one's business more effectively.

Answer 4

The correct option is II.

Origins of modern insurance business can be traced to Lloyd's.

Answer 5

The correct option is IV.

In the insurance context 'risk retention' indicates a situation where one decides to bear the risk and its effects.

Answer 6

The correct option is IV.

Insurance pays when there is loss of asset.

Answer 7

The correct option is II.

Rs. 200 per household should cover the loss.

Answer 8

The correct option is I.

Insurance is a method of sharing the losses of a 'few' by 'many'.

Answer 9

The correct option is I.

Before acceptance of a risk, insurers arrange survey and inspection of the property to assess the risk for rating purposes.

Answer 10

The correct option is II.

Insurance may be considered as a process by which the losses of a few, who are unfortunate to suffer such losses, are shared amongst those exposed to similar uncertain events / situations.

CHAPTER 2

CUSTOMER SERVICE

Chapter Introduction

In this chapter you will learn the importance of customer service. You will learn the role of agents in providing service to customers. You will learn different grievances redressal mechanisms available for Insurance policyholders. You will also learn how to communicate and relate with customer.

Learning Outcomes

A. Customer service – General concepts
B. Insurance agent's role in providing great customer service
C. Grievance redressal
D. Communication process
E. Non-verbal communication
F. Ethical behaviour

After studying this chapter, you should be able to:

1. Illustrate the importance of customer services
2. Describe quality of service
3. Examine importance of service in the insurance industry
4. Discuss the role of an insurance agent in providing good service
5. Review grievance redressal mechanism in insurance
6. Explain the process of communication
7. Demonstrate the importance of non-verbal communication
8. Recommend ethical behaviour

A. Customer service – General concepts

1. Why Customer Service?

Customers provide the bread and butter of a business and no enterprise can afford to treat them indifferently. The role of customer service and relationships is far more critical in the case of insurance than in other products.

This is because insurance is a service and very different from real goods.

Let us examine how buying insurance differs from purchasing a car.

A Car	Insurance of the car
It is a tangible good, that can be seen, test driven and experienced.	It is a contract to compensate against loss or damage to the car due to an unforeseen accident in future. One cannot see or touch or experience the insurance benefit till the unfortunate event occurs.
The buyer of the car has an expectation of some pleasure at the time of purchase. The experience is real and easy to understand.	The purchase of insurance is not based on expectation of immediate pleasure, but fear/anxiety about a possible tragedy. It is unlikely that any insurance customer would look forward to a situation where the benefit becomes payable.
A car is produced in a factory assembly line, sold in a showroom and used on the road. The three processes of making, selling and using take place at three different times and places.	In case of insurance it can be seen that production and consumption happen simultaneously. This simultaneity of *production and consumption* is a distinctive feature of all services.

What the customer really derives is a service experience. If this is less than satisfactory, it causes dissatisfaction. If the service exceeds expectations, the customer would be delighted. The goal of every enterprise should thus be to delight its customers.

2. Quality of service

It is necessary for insurance companies and their personnel, which includes their agents, to render high quality service and delight the customer.

But what is high quality service? What are its attributes?

A well-known model on service quality [named "**SERVQUAL**"] would give us some insights. It highlights five major indicators of service quality:

a) **Reliability**: the ability to perform the promised service dependably and accurately. Most customers regard reliability as being the most important of the five dimensions of service quality. It is the foundation on which trust is built.

b) **Responsiveness**: refers to the willingness and ability of service personnel to help customers and provide prompt response to the customer's needs. It may be measured by indicators like speed, accuracy, and attitude while giving the service.

c) **Assurance**: refers to the knowledge, competence and courtesy of service providers and their ability to convey trust and confidence. It is given by the customer's evaluation of how well the service employee has understood needs and is capable of meeting them.

d) **Empathy**: is described as the human touch. It is reflected in the caring attitude and individualised attention provided to customers.

e) **Tangibles**: represent the physical environmental factors that the customer can see, hear and touch. For instance the location, the layout and cleanliness and the sense of order and professionalism that one gets when visiting an insurance company's office can make a great impression on the customer. The physical ambience becomes especially important because it creates first and lasting impressions, before and after the actual service is experienced.

3. Customer service and insurance

Ask any leading sales producers in the insurance industry about how they managed to reach the top and stay there. You are likely to get a common answer, that it was the patronage and support of their existing clients that helped them build their business.

You would also learn that a large part of their income comes from the commissions for renewal of the contracts. Their clients are also the source for acquiring new customers.

What is the secret of their success?

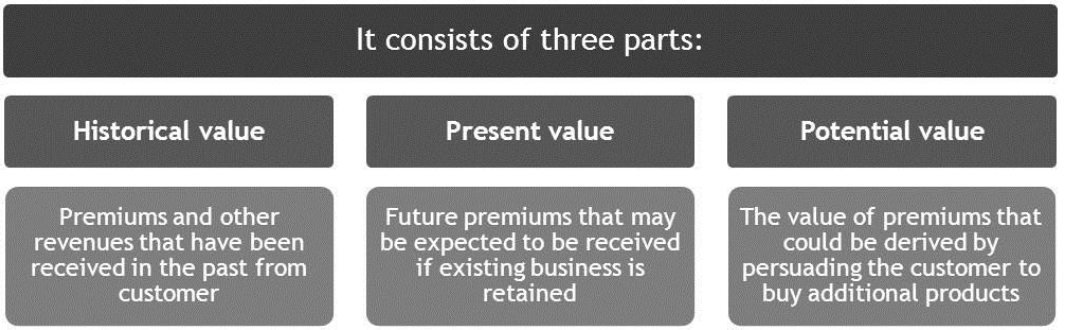
The answer, most likely is, **commitment to serving their customers**.

How does keeping a customer happy benefit the agent and the company?

To answer this question, it would be useful to look at customer's lifetime value.

Customer lifetime value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.

Diagram 1: Customer Lifetime Value



An agent who renders service and builds close relationships with her customers, builds goodwill and brand value, which helps in expanding the business.

Test Yourself 1

What is meant by customer lifetime value?

I. Sum of costs incurred while servicing the customer over his lifetime
II. Rank given to customer based on business generated
III. Sum of economic benefits that can be achieved by building a long term relationship with the customer
IV. Maximum insurance that can be attributed to the customer

B. Insurance agent's role in providing great customer service

Let us now consider how an agent can render great service to the customer. The role begins at the stage of sale and continues through the duration of the contract, and includes the following steps. Let us look at some of the milestones in a contract and the role played at each step.

1. The Point of Sale - Best advice

The first point for service is the point of sale. One of the critical issues involved in purchase of non-life Insurance is to determine the **amount of coverage [Sum Insured] to be bought**.

Here it is important to keep a basic percept in mind - Do not recommend insuring where the risk can be managed otherwise. The insured needs to make sure that the expected loss involved is greater than the cost of insurance.
If the premium payments are high compared to the loss involved, it may be advisable to just bear the risk.

On the other hand, if the occurrence of any contingency would lead to financial burden, it is wise to insure against such contingency.

Whether insurance is needed or not, depends on the circumstances. If the probability of loss or damage to an asset due to a peril is negligible, one may retain the risk rather than insure it. Similarly if an item has insignificant value, one may not insure it.

Example

To a homeowner living in a flood prone area, purchasing cover against floods would prove to be helpful.

On the other hand, if the home owner owns a home at a place where the risk of floods is negligible it may not be necessary to obtain cover.

In India, motor insurance against third party is compulsory under the law. In that case, the debate about whether one needs insurance or not is irrelevant.

One must purchase third party insurance if he owns a vehicle because it is mandatory if one wants to drive on a public road. At the same time it would be prudent to cover the possibility of loss of own damage to the car which is not mandatory.

In case a portion of the possible loss can be borne by oneself, it would be economical for the insured to opt for a **deductible**. A corporate customer may have varied needs, right from the coverage of factory, people, cars, liability exposures etc. She needs the right advice for the coverage and policies to be taken.
Most non-life insurance policies broadly fall in two categories:

- ✓ Named peril policies
- ✓ All risk policies

The latter are costlier as they cover all losses which are specifically not excluded under the policy. Hence opting for 'named peril' policies where the most probable causes of loss are covered by the perils named in the policy may be more beneficial, as such a step could save premiums and provide need based cover to the insured.

The agent really begins to earn her commission when she renders best advice on the matter. It would be worthwhile for the agent to remember that while one may view insurance as the standard approach for dealing with the risk, there are other techniques like risk retention or loss prevention that are available as options for reducing the cost of insurance.

From the standpoint of an insured the relevant questions for instance may be:

- ✓ How much premium will be saved by considering deductibles?
- ✓ How much would a loss prevention activity result in reduction in premiums?

When approaching the customer as a non-life insurance sales person the question an agent needs to ask herself is about her role vis-à-vis the customer. Is she going there just to get a sale or to relate to the customer as a coach and partner who would help him to manage his risks more effectively?

The customer's angle is different. He is not so much concerned with getting maximum insurance per rupee spent, but rather in **reducing the cost of handling risk**. The concern would be thus on identifying those risks which customer cannot retain and hence must be insured.

In other words the role of an insurance agent is more than that of a mere sales person. She also **needs to be a risk assessor, underwriter, risk management counsellor, designer of customised solutions and a relationship builder who thrives on building trust and long-term relationships**, all rolled into one.

2. The proposal stage

The agent has to support the customer in filling out the proposal for insurance. The insured is required to take responsibility for the statements made therein. The salient aspects of a proposal form have been discussed in chapter 5.

It is very important that the agent should explain and clarify to proposer the details to be filled as answer to each of questions in the proposal form. In the event of a claim, a failure to give proper and complete information can jeopardise the customer's claim.
Sometimes there may be additional information that may be required to complete the policy. In such cases the company may inform the customer directly or through the agent / advisor. In either case, it becomes necessary to

help the customer complete all the required formalities and even explain to him or her why these are necessary.

In View of Insurance Regulatory and Development Authority of India (I.R.D.A.I.) (Issuance of e-Insurance Policies) Regulations, 2016, which have come into Force, from **1st October, 2016**:

"Every Insurer, soliciting Insurance-Business through Electronic-Mode, shall create an e-Proposal-Form, Similar to the Physical Proposal-Form, Approved by the Authority; and such Form should enable Capture-of-Information in Electronic-Form, that would enable Easy Processing and Servicing."

"e-Proposal-Form shall have a Provision to Capture the electronic-Insurance-Account (e-I-A) Number of the Prospect, and the Insurer shall facilitate its Creation, whenever the electronic-Insurance-Policy is proposed to be issued through the Insurance Repository System."

"The Prospect should have Own electronic-Signature, while furnishing the Details in e-Proposal-Form."

Here, the Agent can help the Customer to open an e-Insurance Account (e-I-A), if required, through the Registered Insurance Repository.

3. Acceptance stage

a) Cover note

The cover note has been discussed in chapter '5'. It is the agent's responsibility to ensure that the cover note is issued by the company, where applicable, to the insured. Promptness in this regard communicates to the client that his interests are safe in the hands of the agent and the company.

b) Delivery of the policy document

Delivery of the policy is another major opportunity that an agent gets to make contact with the customer. If company rules permit a policy document being delivered in person, it may be a good idea to collect it and present the document to the customer.

If the policy is being sent directly by mail, one must contact the customer, once it is known that the policy document has been sent. This is an opportunity to visit the customer and explain anything that is unclear in the document received. This is also an occasion to clarify various kinds of policy provisions, and the policy holder's rights and privileges that the customer can avail of. This act demonstrates a willingness to provide a level of service beyond the sale.

This meeting is also an occasion to pledge the agent's commitment to serving the customer and communicating full support.

In View of Insurance Regulatory and Development Authority of India (I.R.D.A.I.) (Issuance of e-Insurance Policies) Regulations, 2016, which have come into Force, from **1st October, 2016**:

"Every Insurer shall issue Electronic Insurance-Policies, in Case of: **All** Motor Retail Insurance and Individual Travel (Over-Seas) Insurance, and the Policies that fulfil the Criteria, in Terms of Sum-Assured{**Rupees 10 Lakhs** in Case of Pure Term-Assurance [excluding, Term-Assurance with Return-of-Premium(s)] and All Retail General Insurance except Motor Insurance, and Individual Personal Accident (P.A.) Insurance and Domestic Travel Insurance, and **Rupees 1 Lakh** in Case of Other Than Pure Term-Assurance [including, Term-Assurance with Return-of-Premium(s)], and **Rupees 5 Lakhs** in Case of Individual Health-Insurance}**or** Premium {Single or Annual, Equal To or Exceeding **Rupees 10,000/-** [**Rupees 5,000/-** in Case of All Retail General Insurance Policies except Motor Insurance]}, or, Pension-Per-Annum {**Rupees 10,000/-** in Case of Immediate Annuities}."

Here, the Agent can help the Customer to open an e-Insurance Account (e-I-A), through the Registered Insurance Repository.

The next logical step would be to ask for the names and particulars of other individuals he knows who can possibly benefit from the agent's services. If the client can himself contact these people and introduce the agent to them, it would mean a great breakthrough in business.

c) Policy renewal

Non-life insurance policies have to be renewed each year and the customer has a choice at the time of each renewal, to continue insuring with the same company or switch to another company. This is a critical point where the goodwill and trust created by the agent and the company gets tested.

Although there is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date, yet as a matter of courtesy and decidedly a healthy business practice, insurers issue a **"Renewal Notice"** one month in advance of the date of expiry, inviting renewal of the policy. The agent needs to be in touch with the customer well before the renewal due date to remind the latter about renewal so that he can make provision for the same.

The relationship gets strengthened by keeping in touch with the client from time to time, by greeting him on some occasion like a festival or a family event. Similarly when there is a moment of difficulty or sorrow by to offering assistance.

4. The claim stage

The agent has a crucial role to play at the time of claim settlement. It is her task to ensure that the incident giving rise to the claim is immediately informed to the insurer and that the customer carefully follows all the formalities and assists in all the investigations that may need to be done to assess the loss.

Test Yourself 2

Identify the scenario where a debate on the need for insurance is not required.

I. Property insurance
II. Business liability insurance
III. Motor insurance for third party liability
IV. Fire insurance

C. Grievance redressal

1. Overview

The time for high priority action is when the customer has a complaint. Remember that in the case of a complaint, the issue of service failure [it can range from delay in correcting the records of the insurer to a lack of promptness in settling a claim] which has aggrieved the customer is only a part of the story.

Customers get upset and infuriated a lot more because of their interpretations about such failure. There are two types of feelings and related emotions that arise with each service failure:

- ✓ Firstly there is a sense of unfairness, a feeling of being cheated
- ✓ The second feeling is one of hurt ego – of being made to look and feel small

A complaint is a crucial "**moment of truth**" in the customer relationship; if the company gets it right there is potential to actually improve customer loyalty. The human touch is critical in this; customers want to feel valued.

If you are a professional insurance advisor, you would not allow such a situation to happen in the first place. You would take the matter up with the appropriate officer of the company. **Remember, no one else in the company has ownership of the client's problems as much as you do**.

Complaints / grievances provide us the opportunity to demonstrate how much we care for the customer's interests. They are in fact the solid pillars on which an insurance agent's goodwill and business is built. At the end of every policy document, the insurance companies have detailed the procedure of grievance redressal, which should be brought to the notice of the customers at the time of explaining the document provisions.

Word of mouth publicity (Good/Bad) has significant role in selling and servicing. Remember good service gets rewarded by 5 people being informed, where as bad service is passed on to 20 people.

2. Integrated Grievance Management System (IGMS)

IRDA has launched an Integrated Grievance Management System (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievance redress in the industry.

Policyholders can register on this system with their policy details and lodge their complaints. Complaints are then forwarded to respective insurance company. IGMS tracks complaints and the time taken for redressal. The complaints can be registered at:
http://www.policyholder.gov.in/Integrated_Grievance_Management.aspx

3. The Consumer Protection Act, 1986

This Act was passed "*to provide for better protection of the interest of consumers and to make provision for the establishment of consumer councils and other authorities for the settlement of consumer's disputes.*" The Act has been amended by the Consumer Protection (Amendment) Act, 2002.

a) Definitions under the Act

Some definitions provided in the Act are as follows:

Definition

"Service" means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information. But it does not include the rendering of any service free of charge or under a contract of personal service**.**

Insurance is included as a service

"Consumer" means any person who:

i. Buys any goods for a consideration and includes any user of such goods. But does not include a person who obtains such goods for resale or for any commercial purpose or
ii. Hires or avails of any services for a consideration and includes beneficiary of such services.

'**Defect**' means any fault, imperfection, shortcoming inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

'**Complaint**' means any allegation in writing made by a complainant that:

i. An unfair trade practice or restrictive trade practice has been adopted
ii. The goods bought by him suffer from one or more defects
iii. The services hired or availed of by him suffer from deficiency in any respect
iv. Price charged is in excess of that fixed by law or displayed on package

Goods which will be hazardous to life and safety when used are being offered for sale to the public in contravention of the provisions of any law requiring trader to display information in regard to the contents, manner and effect of use of such goods

'**Consumer dispute**' means a dispute where the person against whom a complaint has been made, denies and disputes the allegations contained in the complaint.

b) Consumer disputes redressal agencies

Consumer disputes redressal agencies are established in each district and state and at national level.

i. **District Forum**: The forum has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs. 20 lakhs The District Forum is empowered to send its order/decree for execution to appropriate Civil Court.

ii. **State Commission**: This redressal authority has original, appellate and supervisory jurisdiction. It entertains appeals from the District Forum. It also has original jurisdiction to entertain complaints where the value of goods/service and compensation, if any claimed exceeds Rs. 20 lakhs but does not exceed Rs. 100 lakhs. Other powers and authority are similar to those of the District Forum.

iii. **National Commission**: The final authority established under the Act is the National Commission. It has original; appellate as well as supervisory jurisdiction. It can hear the appeals from the order passed by the State Commission and in its original jurisdiction it will entertain disputes, where goods/services and the compensation claimed exceeds Rs.100 lakhs. It has supervisory jurisdiction over State Commission.

All the three agencies have powers of a Civil Court.

c) Procedure for filing a complaint

The procedure for filing a complaint for the three redressal agencies mentioned above is very simple. There is no fee for filing a complaint or filing an appeal whether before the State Commission or National Commission.

The complaint can be filed by the complainant himself or by his authorised agent. It can be filed personally or can even be sent by post. It may be noted that no advocate is necessary for the purpose of filing a complaint.

d) Consumer Forum orders

If the forum is satisfied that the goods complained against suffer from any of the defects specified in the complaint or that any of the allegations contained in the complaint about the services are proved, the forum can issue an order directing the opposite party to do one or more of the following namely,

i. To **return** to the complainant **the price**, [or premium in case of insurance], the charges paid by the complainant
ii. To award such amount as **compensation** to the consumers for any loss or injury suffered by the consumer due to negligence of the opposite party
iii. To **remove** the defects or **deficiencies** in the services in question

iv. To **discontinue the unfair trade practice** or the restrictive trade practice or not to repeat them
v. To provide for **adequate costs** to parties

e) Consumer disputes categories

The majority of consumer disputes with the three forums fall in the following main categories, as far as the insurance business is concerned:

i. Delay in settlement of claims
ii. Non-settlement of claims
iii. Repudiation of claims
iv. Quantum of loss
v. Policy terms, conditions etc

4. The Insurance Ombudsman

The Central Government under the powers of the Insurance Act 1938 and Insurance Regulatory and Development Authority Act 1999(41 of 1999), made **Insurance Ombudsman Rules 2017** by a notification published in the official gazette on 25th April,2017. These rules apply to all insurers and their agents and intermediaries in respect of complaints of all personal lines of insurances, that is, insurances taken in an individual capacity.

The objective of these rules is to resolve all complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises on the part of insurance companies and their agents and intermediaries in a cost effective, and impartial manner.

The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

The decision of the Ombudsman, whether to accept or reject the complaint, is final.

a) Complaint to the Ombudsman

Any complaint made to the Ombudsman should be in writing, signed by the insured or his legal heirs, addressed to an Ombudsman within whose jurisdiction, the insurer has a branch / office, supported by documents, if any, along with an estimate of the nature and extent of loss to the complainant and the relief sought.

Complaints can be made to the Ombudsman if:

i. The complainant had made a previous written representation to the insurance company and the insurance company had:

   ✓ Rejected the complaint or

- ✓ The complainant had not received any reply within one month after receipt of the complaint by the insurer
- ✓ The complainant is not satisfied with the reply given by the insurer.

ii. The complaint is made within one year from the date of rejection by the insurance company.

iii. The complaint is not pending in any Court or Consumer Forum or in arbitration.

b) Recommendations by the Ombudsman

There are certain duties/protocols that the Ombudsman is expected to follow:

i. Recommendations should be made within one month of the receipt of such a complaint
ii. The copies should be sent to both the complainant and the insurance company
iii. Recommendations have to be accepted in writing by the complainant within 15 days of receipt of such recommendation
iv. A copy of acceptance letter by the insured should be sent to the insurer and his written confirmation sought within 15 days of his receiving such acceptance letter

If the dispute is not settled by intermediation, the Ombudsman will pass award based on the pleadings and evidence brought on record. It shall be in writing and state the reasons upon which the award is based.

c) Awards by Ombudsman

The awards by Ombudsman are governed by the following rules:

i. The award should not be in excess of the loss suffered by the complainant or should not be more than Rs. 30 lakh (including relevant expenses, if any).
ii. The award should be made within a period of 3 months from the date of receipt of all requirements from the complainant and a copy of the award should be sent to the complainant and the insurer.
iii. The insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance o The complainant shall be entitled to such interest at a rate per annum as specified in the regulations framed under the IRDA Act !999 from the date the claim ought to have been settled under regulations, till the date of payment of the award. The award is binding on insurers.

Test Yourself 3

As per the Consumer Protection Act, 1986, who cannot be classified as a consumer?

I. Hires goods / services for personal use
II. A person who buys goods for resale purpose
III. Buys goods and services for a consideration and uses them
IV. Uses the services of another for a consideration

D. Communication process

Communication skills in customer service

One of the most important set of skills that an agent or service employee needs to possess, for effective performance in the work place, is **soft skills**.

Unlike hard skills – which deal with an individual's ability to perform a certain type of task or activity, **soft skills relate to one's ability to interact effectively with other workers and customers, both at work and outside. Communication skills are one of the most important of these soft skills.**

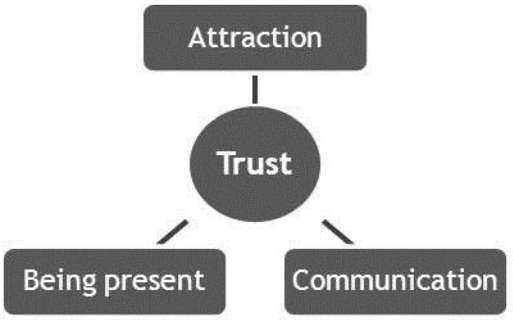
1. Communication and customer relationships

Customer service is one of the key elements in creating satisfied and loyal customers. But it is not enough. Customers are human beings with whom the company needs to build a strong relationship.
It is both the service and the relationship experience that ultimately shapes how the customer would look at the company.

What goes to make a healthy relationship?

At its heart, of course, there is trust. At the same time there are other elements, which reinforce and promote that trust. Let us illustrate some of the elements

Diagram 2: Elements for Trust



i. Every relationship begins with **attraction**:

One needs to be simply liked and must be able to build a rapport with the customer. Attraction is very often the result of first impressions that are derived when a customer comes in touch with the organisation or its representatives. Attraction is the first key to unlocking every heart. Without it a relationship is hardly possible. Consider a sales person who is not liked. Do you really think she will be able to make much headway in the sales career?

ii. The second element of a relationship is one's **presence** – being there when needed:

The best example is perhaps that of a marriage. Is it important for the husband to be available when the wife needs him? **Similarly in a customer relationship, the issue is whether and how the company or its representative is available when needed. Is she or he fully present and listening to the customer's needs?**

There may be instances when one is not fully present and do justice to all the expectations of one's customers. **One can still maintain a strong relationship if one can speak to the customer, in a manner that is assuring, full of empathy and conveys a sense of responsibility.**

All of the above points like:

- ✓ The impression one creates or
- ✓ The way one is present and listens or
- ✓ The message one sends across to another

are dimensions of communication and call for discipline and skills. In a sense what one communicates is ultimately a function of how one thinks and sees.

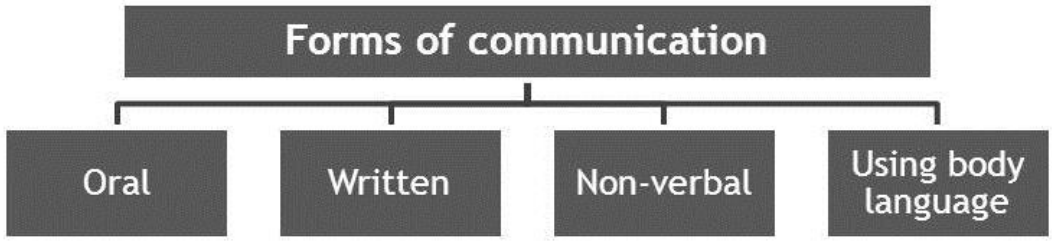
The companies emphasise a lot on customer relationship management as the cost of retaining a customer is far lower than acquiring a new customer. The customer relation occurs across many touch points e.g. while understanding customers insurance needs, explaining coverage's, handing over forms. So, there are many opportunities for the agent to strengthen the relation at each of these points.

2. Process of communication

What is communication?

All communications require a sender, who transmits a message, and a recipient of that message. The process is complete once the receiver has understood the message of the sender.

Diagram 3: Forms of communication



Communication may take place several forms

- ✓ Oral
- ✓ Written
- ✓ Non-verbal
- ✓ Using body language

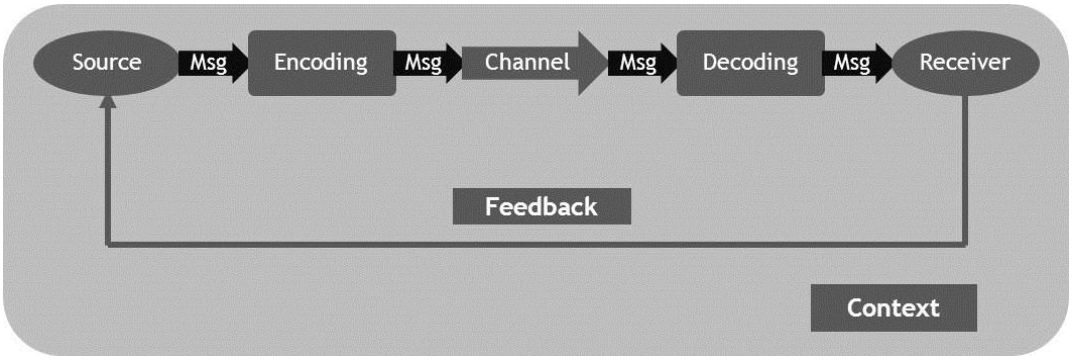
It may be face to face, over the phone, or by mail or internet. It may be formal or informal. Whatever the content or form of the message or the media used, the essence of communication is given by what the recipient has understood as being communicated.

It is important for a business to choose how and when it will send messages to intended receivers.

The communication process is illustrated below.

Let us define the terms in the diagram:

Diagram 4: Communication process



Definition

i. **Source**: As the source of the message, the agent must be clear about why she is communicating, and what she wants to communicate, and confident that the information being communicated is useful and accurate.

ii. **Message** is the information that one wants to communicate.

iii. **Encoding** is the process of transferring the information one wants to communicate into a form that can be sent and correctly decoded at the other end. Success in encoding depends on how well one is able to convey information and eliminate sources of confusion. For this it is necessary to know one's audience. Failure to do so can result in delivering messages that are misunderstood.

iv. A Message is conveyed through a **channel**, which has to be selected for the purpose. The channel may be verbal including personal face-to-face meetings, telephone and videoconferencing; or it may be written including letters, emails, memos, and reports.

v. **Decoding** is the step wherein the information gets received, interpreted and understood in a certain way, at its destination. It can be seen that decoding [or how one receives a message] is as important as encoding [how one conveys it].

vi. **Receiver**: Finally there is the receiver, the individual or individuals [the audience] to whom the message is sent. Each member of this audience has his own ideas, beliefs and feelings and these would influence how the message has been received and acted upon. The sender obviously needs to consider these factors when deciding what message to send.

vii. **Feedback**: Even as the message is being sent and received, the receiver is likely to send feedback in the form of verbal and non-verbal messages to the sender. The latter needs to look for such feedback and carefully understand these reactions as it would help to determine how the message has been received and acted upon. If necessary the message could be changed or rephrased.

3. Barriers to effective communication

Barriers to effective communication can arise at each step in the above process. Communication can get distorted because of the impression created about the sender, or because the message has been poorly designed, or because too much or too little has been conveyed, or because the sender has not understood the receiver's culture. The challenge is to remove all these barriers.

Test Yourself 4

What does not go on to make a healthy relationship?

I. Attraction
II. Trust
III. Communication
IV. Scepticism

E. Non-verbal communication

Let us now look at some concepts that the agent needs to understand.

Important

Making a great first impression

We have already seen that attraction is the first pillar of any relationship. You can hardly expect to get business from a customer who does not like you. In fact many individuals need just a quick glance, of maybe a few seconds, to judge and evaluate you when you meet for the first time. Their opinion about you gets based on your appearance, your body language, your mannerisms, and how you are dressed and speak. Remember that first impressions last for long. Some useful tips for making a good first impression are:

i. **Be on time always**. Plan to arrive a few minutes early, allowing flexibility for all kinds of possible delays.

ii. **Present yourself appropriately**. Your prospect, whom you are meeting for the first time, does not know you and your appearance is usually the first clue he or she has to go on.

- ✓ Is your appearance helping to create the right first impression?
- ✓ Is the way you dress appropriate for the meeting or occasion?
- ✓ Is your grooming clean and tidy – with good haircut and shave, clean and tidy clothes, neat and tidy make up?

iii. **A warm, confident and winning smile** puts you and your audience immediately at ease with one another.

iv. **Being open, confident and positive**

- ✓ Does your body language project confidence and self-assurance?
- ✓ Do you stand tall, smile, make eye contact, greet with a firm handshake?
- ✓ Do you remain positive even in the face of some criticism or when the meeting is not going as well as expected?

v. **Interest in the other person** - The most important thing is about being genuinely interested in the other person.

- ✓ Do you take some time to find out about the customer as a person?
- ✓ Are you caring and attentive to what he or she says?
- ✓ Are you totally present and available to your customer or is your mobile phone engaging you during half your interview?

1. Body language

Body language refers to movements, gestures, facial expressions. The way we talk, walk, sit and stand, all says something about us, and what is happening inside us.

It is often said that people listen to only a small percentage of what is actually said. What we don't say speaks a lot more and a lot louder. Obviously, one needs to be very careful about one's body language.

a) Confidence

Here are a few tips about how to appear confident and self-assured, giving the impression of someone to be seriously listened to:

- ✓ Posture – standing tall with shoulders held back.
- ✓ Solid eye contact - with a "smiling" face
- ✓ Purposeful and deliberate gestures

b) Trust

Quite often, a sales person's words fall on deaf ears because the audience does not trust her – her body language does not give the assurance that she is sincere about what she says. It is very important to be aware of some of the typical signs that may indicate when one is not honest and believable and be on guard against them as listed below:

- ✓ Eyes maintaining little or no eye contact, or rapid eye movements
- ✓ Hand or fingers are in front of one's mouth when speaking
- ✓ One's body is physically turned away from the other
- ✓ One's breathing rate increases
- ✓ Complexion changes colour; red in face or neck area
- ✓ Perspiration increases
- ✓ Voice changes such as change in pitch, stammering, throat clearing
- ✓ Speech – slow and clear with tone of voice kept moderate to low

Some body movements that indicate defensiveness and non-receptivity include:

- ✓ Hand/arm gestures are small and close to one 's body
- ✓ Facial expressions are minimal
- ✓ Body is physically turned away from you
- ✓ Arms are crossed in front of body
- ✓ Eyes maintain little contact, or are downcast

If your customer expresses any of these, perhaps it is time you checked yourself and paid more attention to what is going on in the customer's mind.

2. Listening skills

The third set of communication skills that one needs to be aware about and cultivate are listening skills. These follow from a well-known principle of personal effectiveness – 'first to understand before being understood'.

How well you listen has a major impact on your job effectiveness, and on the quality of your relationships with others. Let us look at some listening tips.

a) Active listening:

It is where we consciously try to hear not only the words but also, more importantly, try to understand the complete message being sent by another.

Let us look at some of the elements of active listening. They are:-

i. Paying attention

We need to give the speaker our undivided attention, and acknowledge the message. Note, non-verbal communication also "speaks" loudly. Some aspects of paying attention are as follows:

- ✓ Look at the speaker directly
- ✓ Put aside distracting thoughts
- ✓ Don't mentally prepare a rebuttal
- ✓ Avoid all external distractions [for instance, keep your mobile on silent mode]
- ✓ "Listen" to the speaker's body language

ii. Demonstrating that you are listening:

Use of body language plays an important role here. For instance one may:

- ✓ Give an occasional nod and smile
- ✓ Adopt a posture that is open and draws out the other to speak freely
- ✓ Have small verbal comments like yes and uh huh.

iii. Provide feedback:

A lot of what we hear may get distorted by our personal filters, like the assumptions, judgments, and beliefs we carry. As a listener, we need to be aware of these filters and try to understand what really is being said.

- ✓ This may require you to reflect on the message and ask questions to clarify what was said
- ✓ Another important way to provide feedback is to paraphrase the speaker's words

- ✓ Yet a third way is to periodically stop the speaker and make a summary of what the speaker has said and repeat it back to him or her.

Example

Asking for clarity - From what I have heard, am I right in assuming, that you have issues about the benefits of some of our health plans, could you be more specific?

Paraphrasing the speaker's exact words - So you are saying that 'our health plans are not providing benefits that are attractive enough' – have I understood you correctly?

iv. Not being judgemental:

One of the biggest hurdles to active listening is our **tendency to be judgmental and biased about the speaker**. The result is that the listener may hear what the speaker says but listens according to her own biased interpretation of what the speaker might be saying.

Such judgmental approach can result in the listener being unwilling to allow the speaker to continue speaking, considering it a waste of time. It can also result in interrupting the speaker and rebutting the speaker with counter arguments, even before he or she has been able to convey the message in full.

This will only frustrate the speaker and limits full understanding of the message. Active listening calls for:

- ✓ Allowing the speaker to finish each point before asking questions
- ✓ Not interrupting the speaker with any counter arguments

v. Responding appropriately:

Active listening implies much more than just hearing what a speaker says. The communication can be completed only when the listener responds in some way, through word or action. Certain rules need to be followed for ensuring that the speaker is not put down but treated with respect and deference. These include:

- ✓ Being candid, open, and honest in your response
- ✓ Asserting one's opinions respectfully
- ✓ Treating another person in a way you would like to be treated yourself

vi. Empathetic listening:

Being empathetic literally means putting yourself in the other person's shoes and feeling his or her experience as he or she would feel it.

Listening with empathy is an important aspect of all great customer service. It becomes especially critical when the other person is a customer with a grievance and in a lot of pain.

Empathy implies hearing and listening patiently, and with full attention, to what the other person has to say, even when you do not agree with it. It is important to show the speaker acceptance, not necessarily agreement. One can do so by simply nodding or injecting phrases such as "I understand" or "I see."

Test Yourself 5

Which among the following is not an element of active listening?

I. Paying good attention
II. Being extremely judgemental
III. Empathetic listening
IV. Responding appropriately

F. Ethical behaviour

1. Overview

Of late, serious concerns are voiced about the proprieties in business, because increasingly there are reports of improper behaviour. Some of the world's biggest companies have been found to have cheated through false accounts and dishonest audit certification. The funds of banks have been misused by their managements to bolster the greed of some friends. Officials have used their authority to promote personal benefits. Increasingly, people who are trusted by the community to perform their tasks are seen to have betrayed the trust. Personal aggrandisement and greed prevails.

Consequently, there is increasing discussion about accountability and corporate governance, all of which together can be called "Ethics" in business. **Acts like the 'Right to Information Act' and developments like 'Public Interest Litigation' have assumed considerable importance as instruments to achieve better accountability and governance**.

Ethical behaviour automatically leads to good governance. When one does her duty conscientiously and sincerely, there is good governance. Unethical behaviour shows little concern for others and high concern for self. When one tries to serve self-interest through one's official position, there is unethical behaviour. It is not wrong to look after one's interests. But it is wrong to do so at the cost of the interests of others.

Insurance is a business of trust. Issues of propriety and ethics are extremely important in this business of insurance. Breach of trust amounts to cheating and is wrong. Things go wrong when wrong information is given to the prospects tempting them to buy insurance or the plan of insurance suggested does not cater to all the needs of the prospect.

Unethical behaviour happens when the benefits of self are considered more important than of the other. The code of ethics spelt out by the IRDA in the various regulations is directed towards ethical behaviour.

While it is important to know every clause in the code of conduct to ensure that there is no violation of the code, compliance would be automatic if the insurer and its representatives always kept the interests of the prospect in mind. Things go wrong when the officers of insurers become concerned with the targets of business, rather than the benefits to the prospect.

2. Characteristics

Some characteristics of ethical behaviour are:

a) Placing best interests of the client above one's own direct or indirect benefits

b) Holding in strictest confidence and considering as privileged, all business and personal information pertaining to client's affairs

c) Making full and adequate disclosure of all facts to enable clients make informed decisions

There could be a likelihood of ethics being compromised in the following situations:

a) Having to choose between two plans, one giving much less premium or commission than the other

b) Temptation to recommend discontinuance of an existing policy and taking out a new one

c) Becoming aware of circumstances that, if known to the insurer, could adversely affect the interests of the client or the beneficiaries of the claim

Test Yourself 6

Which among the following is not a characteristic of ethical behaviour?

I. Making adequate disclosures to enable the clients to make an informed decision
II. Maintaining confidentiality of client's business and personal information
III. Placing self-interest ahead of client's interests
IV. Placing client's interest ahead of self interest

Summary

a) The role of customer service and relationships is far more critical in the case of insurance than in other products.

b) Five major indicators of service quality include reliability, assurance, responsiveness, empathy and tangibles.

c) Customer lifetime value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.

d) The role of an insurance agent in the area of customer service is absolutely critical.

e) IRDA has launched an Integrated Grievance Management System (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievance redress in the industry.

f) The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

g) Active listening involves paying attention, providing feedback and responding appropriately.

h) Ethical behaviour involves placing the customer's interest before self.

Key terms

a) Quality of service
b) Empathy
c) Integrated Grievance Management System (IGMS)
d) Customer Protection Act, 1986
e) District Consumer Forum
f) Insurance Ombudsman
g) Body language
h) Active listening
i) Ethical behaviour

Answers to Test Yourself

Answer 1

The correct option is III.

Sum of economic benefits that can be achieved by building a long term relationship with the customer is referred to as customer lifetime value.

Answer 2

The correct option is III.

Motor insurance for third party liability is mandatory by law and hence a debate on its need is not required.

Answer 3

The correct option is II.

As per the Consumer Protection Act, 1986, a person who buys goods for resale purpose cannot be classified as consumer.

Answer 4

The correct option is IV.

Scepticism does not go on to make a healthy relationship.

Answer 5

The correct option is II.

Being extremely judgemental is not an element of active listening.

Answer 6

The correct option is III.

Placing self-interest ahead of client's interests is not ethical behaviour.

Self-Examination Questions

Question 1

_____ is not a tangible good.

I. House
II. Insurance
III. Mobile Phone
IV. A pair of jeans

Question 2

_____ is not an indicator of service quality.

I. Cleverness
II. Reliability
III. Empathy
IV. Responsiveness

Question 3

In India _____ insurance is mandatory.

I. Motor third party liability
II. Fire insurance for houses
III. Travel insurance for domestic travel
IV. Personal accident

Question 4

One of the methods of reducing insurance cost of an insured is _____

I. Reinsurance
II. Deductible
III. Co-insurance
IV. Rebate

Question 5

A customer having complaint regarding his insurance policy can approach IRDA through

I. IGMS
II. District Consumer Forum
III. Ombudsman
IV. IGMS or District Consumer Forum or Ombudsman

Question 6

Consumer Protection Act deals with:

I. Complaint against insurance companies
II. Complaint against shopkeepers
III. Complaint against brand
IV. Complaint against insurance companies, brand and shopkeepers

Question 7

_____ has jurisdiction to entertain matters where value of goods or services and the compensation claim is up to 20 lakhs

I. High Court
II. District Forum
III. State Commission
IV. National Commission

Question 8

In customer relationship the first impression is created:

I. By being confident
II. By being on time
III. By showing interest
IV. By being on time, showing interest and being confident

Question 9

Select the correct statement:

I. Ethical behaviour is impossible while selling insurance
II. Ethical behaviour is not necessary for insurance agents
III. Ethical behaviour helps in developing trust between the agent and the insurer
IV. Ethical behaviour is expected from the top management only

Question 10

Active Listening involves:

I. Paying attention to the speaker
II. Giving an occasional nod and smile
III. Providing feedback
IV. Paying attention to the speaker, giving an occasional nod and smile and providing feedback

Answers to Self-Examination Questions

Answer 1

The correct option is II.

Insurance is not a tangible good.

Answer 2

The correct option is I.

Cleverness is not an indicator of service quality.

Answer 3

The correct option is I.

Motor third party liability insurance is mandatory in India.

Answer 4

The correct option is II.

One of the methods of reducing insurance cost of an insured is the deductible clause in a policy.

Answer 5

The correct option is I.

A customer having complaint regarding his insurance policy can approach IRDA through IGMS.

Answer 6

The correct option is IV.

Consumer Protection Act deals with complaint against insurance companies, shopkeepers and brands.

Answer 7

The correct option is II.

District Forum has jurisdiction to entertain where value of goods or services and the compensation claim is up to 20 lakhs.

Answer 8

The correct option is IV.

In customer relationship the first impression is created by being confident, on time and by showing interest.

Answer 9

The correct option is III.

Ethical behaviour helps in developing trust in the agent and the insurer.

Answer 10

The correct option is IV.

Active Listening involves paying attention to the speaker, giving an occasional nod and smile and providing feedback.

CHAPTER 3

GRIEVANCE REDRESSAL MECHANISM

Chapter Introduction

Insurance industry is essentially a service industry where, in the present context, customer expectations are constantly rising and dissatisfaction with the standard of services rendered is ever present. Despite there being continuous product innovation and significant improvement in the level of customer service aided by use of modern technology, the industry suffers badly in terms of customer dissatisfaction and poor image. Alive to this situation the Government and the regulator have taken a number of initiatives.

IRDAI's regulations stipulate the turnaround times (TAT) for various services that an insurance company has to render the consumer. These are part of the IRDAI (Protection of Policyholders' Interests Regulations), 2002.Insurance companies are also required to have an effective grievance redressal mechanism and IRDAI has created the guidelines for that too.

Learning Outcomes

A. Grievance redressal mechanism - Consumer courts, Ombudsman

A. Grievance redressal mechanism – Consumer courts, Ombudsman

1. Integrated Grievance Management System (IGMS)

IRDAI has launched an Integrated Grievance Management System (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievance redress in the industry.

For any grievance the complainant is required to first approach the respective insurer. If no response provided or resolution of grievance is not to the satisfaction of the complainant, the complainant can approach the Regulator under the IGMS. Policyholders can register on this system with their policy details and lodge their complaints. Complaints are then forwarded to the respective insurance companies.

Grievance redressal mechanism

IGMS tracks complaints and the time taken for their redressal. The complaints can be registered at the following URL:

http://www.policyholder.gov.in/Integrated_Grievance_Management.aspx

2. The Consumer Protection Act, 1986

Important

This Act was passed "to provide for better protection of the interest of consumers and to make provision for the establishment of consumer councils and other authorities for the settlement of consumer's disputes". The Act has been amended by the Consumer Protection (Amendment) Act, 2002.

Some definitions provided in the Act are as follows:

Definition

"**Service**" means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information. But it does not include the rendering of any service free of charge or under a contract of personal service. Insurance is included as a service

"**Consumer**" means any person who

- ✓ Buys any goods for a consideration and includes any user of such goods. But it does not include a person who obtains such goods for resale or for any commercial purpose or
- ✓ Hires or avails of any services for a consideration and includes beneficiary of such services.

"**Defect**" means any fault, imperfection, shortcoming inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

"**Complaint**" means any allegation in writing made by a complainant that:

- ✓ an unfair trade practice or restrictive trade practice has been adopted
- ✓ the goods bought by him suffer from one or more defects
- ✓ the services hired or availed of by him suffer from deficiency in any respect
- ✓ price charged is in excess of that fixed by law or displayed on package
- ✓ goods which will be hazardous to life and safety when used are being offered for sale to the public in contravention of the provisions of any law requiring trader to display information in regard to the contents, manner and effect of use of such goods

"**Consumer dispute**" means a dispute where the person against whom a complaint has been made, denies and disputes the allegations contained in the complaint.

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a) Consumer disputes redressal agencies

"Consumer disputes redressal agencies" are established in each district and state and at national level.

i. District Forum

- ✓ The forum has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs.20 lakhs.
- ✓ The District Forum is empowered to send its order/decree for execution to appropriate civil court.

ii. State Commission

- ✓ This redressal authority has original, appellate and supervisory jurisdiction.
- ✓ It entertains appeals from the District Forum.
- ✓ It also has original jurisdiction to entertain complaints where the value of goods/service and compensation, if any claimed exceeds Rs. 20 lakhs but does not exceed Rs. 100 lakhs.

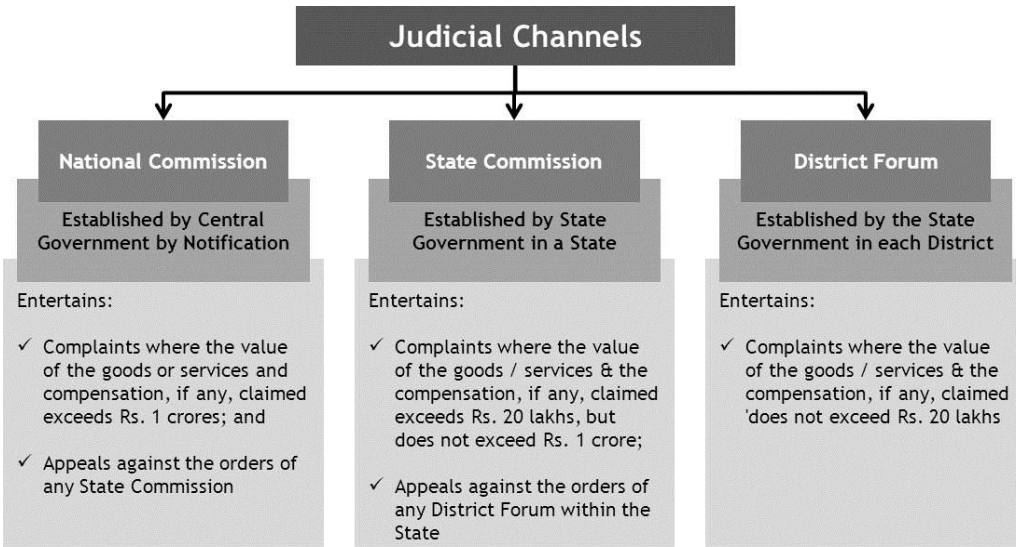
- ✓ Other powers and authority are similar to those of the District Forum.

iii. National Commission

- ✓ The final authority established under the Act is the National Commission.
- ✓ It has original, appellate as well as supervisory jurisdiction.
- ✓ It can hear the appeals from the order passed by the State Commission and in its original jurisdiction it will entertain disputes, where goods/services and the compensation claimed exceeds Rs.100 lakhs.
- ✓ It has supervisory jurisdiction over State Commission.

All the three agencies have powers of a civil court.

Diagram 1: Channels for grievance redressal



b) Procedure for filing a complaint

The procedure for filing a complaint is very simple in all above three redressal agencies. There is no fee for filing a complaint or filing an appeal whether before the State Commission or National Commission. The complaint can be filed by the complainant himself or by his authorised agent. It can be filed personally or can even be sent by post. It may be noted that no advocate is necessary for the purpose of filing a complaint.

c) Consumer Forum Orders

If the forum is satisfied that the goods complained against suffer from any of the defects specified in the complaint or that any of the allegations contained in the complaint about the services are proved, the forum can issue an order directing the opposite party to do one or more of the following namely,

i. To **return** to the complainant the **price**, (or premium in case of insurance), the charges paid by the complainant
ii. To award such amount as **compensation** to the consumers for any loss or injury suffered by the consumer due to negligence of the opposite party
iii. To remove the defects or **deficiencies** in the services in question
iv. To **discontinue the unfair trade practice** or the restrictive trade practice or not to repeat them
v. To provide for **adequate costs** to parties

d) Nature of complaints

The **majority of consumer disputes** with the three forums fall in the following main categories as far as insurance business are concerned

i. Delay in settlement of claims
ii. Non-settlement of claims
iii. Repudiation of claims
iv. Quantum of loss
v. Policy terms, conditions etc.

3. The Insurance Ombudsman

The Central Government under the powers of the Insurance Regulatory & Development Authority Act, 1999 made **Insurance Ombudsman Rules 2017** by a notification published in the official gazette on 25th April 2017. These rules apply to all of insurers and their agents and intermediaries In respect of all complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises. Personal lines that is, insurances taken in an individual capacity.

The objective of these rules is to resolve all complaints of all personal lines of insurance, group insurance policies, policies issued to sole proprietorship and micro enterprises on the part of insurance companies and their agents and intermediaries in a cost effective, and impartial manner

The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

The decision of the Ombudsman, whether to accept or reject the complaint, is final.

a) Complaint to the Ombudsman

Any complaint made to the Ombudsman should be in writing, signed by the insured or his legal heirs, nominee or assignee, addressed to an Ombudsman within whose jurisdiction, the insurer has a branch/ office, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought.

Complaints can be made to the Ombudsman if:

i. The complainant had made a previous written representation to the insurance company and the insurance company had:

   - ✓ Rejected the complaint or
   - ✓ The complainant had not received any reply within one month after receipt of the complaint by the insurer

ii. The complainant is not satisfied with the reply given by the insurer
iii. The complaint is made within one year from the date of rejection by the insurance company
iv. The complaint is not pending in any court or consumer forum or in arbitration

b) Recommendations by the Ombudsman

There are certain duties/protocols that the Ombudsman is expected to follow:

i. Recommendations should be made within one month of the receipt of such a complaint
ii. The copies should be sent to both the complainant and the insurance company
iii. Recommendations have to be accepted in writing by the complainant within 15 days of receipt of such recommendation
iv. A copy of acceptance letter by the insured should be sent to the insurer and his written confirmation sought within 15 days of his receiving such acceptance letter

c) Award

If the dispute is not settled by intermediation, the Ombudsman will pass an award to the insured which he thinks is fair, and is not more than what is necessary to cover the loss of the insured.

The awards by Ombudsman are governed by the following rules:

i. The award should not be in excess of loss suffered as a direct consequence OR more than Rs.30 lakh (including relevant expenses)

ii. The award should be made within a period of 3 months from the date of receipt of all requirements from the complainant and a copy of the award to be sent to the complainant and insurer. The complainant shall be entitled to such interest at a rate per annum as specified in the regulations framed by the IRDAI Act 1999 from the date the claim ought to have been settled until date of payment of awarded amount.

iii. The insurer shall comply with the award within 30 days of the receipt of the award and intimate compliance of the same to the Ombudsman
The award of the Ombudsman shall be binding on the insurer.

Test Yourself 1

The _____ has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs.20 lakhs.

I. District Forum
II. State Commission
III. Zilla Parishad
IV. National Commission

Summary

- IRDAI has launched an Integrated Grievance Management System (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievance redress in the industry.

- Consumer disputes redressal agencies are established in each district and state and at national level.

- As far as insurance business is concerned, the majority of consumer disputes fall in categories such as delay in settlement of claims, non-settlement of claims, repudiation of claims, quantum of loss and policy terms, conditions etc.

- The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

- If the dispute is not settled by intermediation, the Ombudsman will pass award to the insured which he thinks is fair, and is not more than what is necessary to cover the loss of the insured.

Key Terms

1. Integrated Grievance Management System (IGMS)
2. The Consumer Protection Act, 1986
3. District Forum
4. State Commission
5. National Commission
6. Insurance Ombudsman

Answers to Test Yourself

Answer 1

The correct answer is I.

The District Forum has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs. 30 lakhs.

Self-Examination Questions

Question 1

Expand the term IGMS.

I. Insurance General Management System
II. Indian General Management System
III. Integrated Grievance Management System
IV. Intelligent Grievance Management System

Question 2

Which of the below consumer grievance redressal agencies would handle consumer disputes amounting between Rs. 20 lakhs and Rs. 100 lakhs?

I. District Forum
II. State Commission
III. National Commission
IV. Zilla Parishad

Question 3

Which among the following cannot form the basis for a valid consumer complaint?

I. Shopkeeper charging a price above the MRP for a product
II. Shopkeeper not advising the customer on the best product in a category
III. Allergy warning not provided on a drug bottle
IV. Faulty products

Question 4

Which of the below will be the most appropriate option for a customer to lodge an insurance policy related complaint?

I. Police
II. Supreme Court
III. Insurance Ombudsman
IV. District Court

Question 5

Which of the below statement is correct with regards to the territorial jurisdiction of the Insurance Ombudsman?

I. Insurance Ombudsman has National jurisdiction
II. Insurance Ombudsman has State jurisdiction
III. Insurance Ombudsman has District jurisdiction
IV. Insurance Ombudsman operates only within the specified territorial limits

Question 6

How is the complaint to be launched with an insurance ombudsman?

I. The complaint is to be made in writing
II. The complaint is to be made orally over the phone
III. The complaint is to be made orally in a face to face manner
IV. The complaint is to be made through newspaper advertisement

Question 7

What is the time limit for approaching an Insurance Ombudsman?

I. Within two years of rejection of the complaint by the insurer
II. Within three years of rejection of the complaint by the insurer
III. Within one year of rejection of the complaint by the insurer
IV. Within one month of rejection of the complaint by the insurer

Question 8

Which among the following is not a pre-requisite for launching a complaint with the Ombudsman?

I. The complaint must be by an individual on a 'Personal Lines' insurance
II. The complaint must be lodged within 1 year of the insurer rejecting the complaint
III. Complainant has to approach a consumer forum prior to the Ombudsman
IV. The total relief sought must be within an amount of Rs.20 lakhs.

Question 9

Are there any fee / charges that need to be paid for lodging the complaint with the Ombudsman?

I. A fee of Rs 100 needs to be paid
II. No fee or charges need to be paid
III. 20% of the relief sought must be paid as fee
IV. 10% of the relief sought must be paid as fee

Question 10

Can a complaint be launched against a private insurer?

I. Complaints can be launched against public insurers only
II. Yes, complaint can be launched against private insurers
III. Complaint can be launched against private insurers only in the Life Sector
IV. Complaint can be launched against private insurers only in the Non-Life Sector

Answers to Self-Examination Questions

Answer 1

The correct option is III.

IGMS stands for Integrated Grievance Management System.

Answer 2

The correct option is II.

State Commission would handle consumer disputes amounting between Rs. 20 lakhs and Rs. 100 lakhs.

Answer 3

The correct option is II.

Shopkeeper not advising the customer on the best product in a category cannot form the basis of a valid consumer complaint.

Answer 4

The correct option is III.

Complaint is to be lodged with the Insurance Ombudsman under whose territorial jurisdiction the insurer's office falls.

Answer 5

The correct option is IV.

Insurance Ombudsman operates only within the specified territorial limits.

Answer 6

The correct option is I.

The complaint to the ombudsman is to be made in writing.

Answer 7

The correct option is III.

The complainant must approach the ombudsman within one year of rejection of the complaint by the insurer.

Answer 8

The correct option is III.

Complainant need not approach a consumer forum prior to the Ombudsman.

Answer 9

The correct option is II.

No fee / charges need to be paid for lodging the complaint with the Ombudsman.

Answer 10

The correct option is II.

Yes, a complaint can be launched against private insurers.

CHAPTER 4

REGULATORY ASPECTS OF CORPORATE AGENTS

Chapter Introduction

In this chapter, we discuss Regulatory aspects of corporate agents.

Learning Outcomes

A. Regulations of Corporate Agents

A. Regulations of Corporate Agents

The Corporate Agent regulations were amended in August, 2015 and shall come into effect from 1st April, 2016.

The following definitions are relevant.

1. Definitions:

(a) "Act" means the Insurance Act, 1938 (4 of 1938), as amended from time to time

(b) "Applicant" means -

(i) A company formed under the Companies Act, 2013 (18 of 2013) or any enactment thereof or under any previous company law which was in force; or
(ii) A limited liability partnership formed and registered under the Limited Liability Partnership Act, 2008; or
(iii) A Co-operative Society registered under Co-operative Societies Act, l9l2 or under any law for registration of co-operative societies, or
(iv) a banking company as defined in clause (4A) of section 2 of the Act; or
(v) a corresponding new bank as defined under clause (da) of sub-section (1) of section 5 of the Banking Companies Act, 1949 (10 of 1949); or
(vi) a regional rural bank established under section 3 of the Regional Rural Banks Act, 1976 (21 of 1976): or
(vii) a Non-Governmental organisation or a micro lending finance organization covered under the Co-operative Societies Act, 1912 or a Non-Banking Financial Company registered with the Reserve Bank of India; or
(viii) Any other person as may be recognized by the Authority to act as a corporate agent.

(c) “Approved Institution" means any institution engaged in education and/or training particularly in the area of insurance sales, service and marketing, approved and notified by the Authority from time to time, and includes Insurance Institute of India, Mumbai.

(d) "Authorized Verifier" means a person employed by a Telemarketer for the purpose of solicitation or sale over telephonic mode and shall fulfill the requirements as specified under regulation 7(3) of these regulations for a specified person;

(e) "Authority" means the Insurance Regulatory and Development Authority of India established under the provisions of Section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999).

(f) "Corporate Agent" means any applicant specified in clause (b) above holds a valid certificate of registration issued by the Authority under these regulations for solicitation and servicing of insurance business for any of the specified category of life, general and health.

(g) “Corporate Agent (Life)" means a corporate agent who holds a valid certificate of registration to act as such, issued by the Authority under these regulations, for solicitation and servicing of insurance business for life insurers as specified in these regulations;
(h) "Corporate Agent (General)" means a corporate agent who holds a valid certificate of registration to act as such, issued by the Authority under these regulations, for solicitation and servicing of insurance business for general insurers as specified in these regulations;
(i) "Corporate Agent (Health)" means a corporate agent who holds a valid certificate of registration to act as such, issued by the Authority under these regulations, for solicitation and servicing of insurance business for health insurers as specified in these regulations;
(j) "Corporate Agent (Composite)" means a corporate agent who holds a valid certificate of registration to act as such, issued by the Authority under these regulation, for solicitation and procurement of insurance business for life insurers, general insurers and health insurers or combination of any two or all three as specified in clauses (f) above:
(k) “Examination Body” for the purpose of these Regulations is Insurance Institute of India, Mumbai or any other body approved and notified by the Authority for conducting certification examination for principal officer and specified persons of the corporate agents.
(l) Fit and Proper" is the criteria for determining the suitability for registering an Applicant including his principal officer, directors or partners or any other employees to act as Corporate Agent.
(m) “Principal Officer" of a Corporate Agent means a director or a partner or any officer or employee so designated by it, and approved by the Authority, exclusively appointed to supervise the activities of Corporate Agent and who possesses the requisite qualifications and practical training and has passed examination as required under these Regulations.
(n) "Registration" means a certificate of registration to act as a corporate agent issued under these regulations.
(o) "Regulations" means Insurance Regulatory and Development Authority of India (Registration of Corporate Agent) Regulations, 2015.
(p) "Specified Person" means an employee of a Corporate Agent who is responsible for soliciting and procuring insurance business on behalf of a corporate agent and shall have fulfilled the requirements of qualification, training and passing of examination as specified in these regulations;
(q) "Telemarketer' means an entity registered with Telecom Regulatory Authority of India under Chapter III of the Telecom Commercial Communications Customer Preference Regulations, 2010 to conduct the business of sending commercial communications and holding a certificate issued by the Authority;
(r) Words and expressions used and not defined in these Regulations but defined in the Act, as amended from time to time, the Insurance Regulatory and Development Authority Act, 1999 or in any of the Regulations / Guidelines made there under shall have the meanings respectively assigned to them in those Acts / Regulations / Guidelines.

2. Scope and applicability of these Regulations:

(1) These regulations shall cover Registration of Corporate Agents for the purpose of soliciting, procuring and servicing of Insurance business of life insurers, general insurers and health insurers during the validity of certificate of registration as follows.

(a) A Corporate Agent (Life), may have arrangements with a maximum of three life insurers to solicit, procure and service their insurance Products.
(b) A Corporate Agent (General), may have arrangements with a maximum of three general insurers to solicit, procure and service their insurance products. Further, the Corporate Agent (General) shall solicit, procure and service retail lines of general insurance products and commercial lines of such insurers having a total sum insured not exceeding rupees five crores per risk for all insurances combined.
(c) A Corporate Agent (Health), may have arrangements with a maximum of three health insurers to solicit, procure and service their insurance products.
(d) In the case of Corporate Agent (Composite), the conditions as specified in clauses (a) to (c) shall apply.
(e) any change in the arrangement with the insurance companies shall be done only with the prior approval of the Authority and with suitable arrangements for servicing existing policyholders.

3. Consideration of application –

(1) The Authority while considering an application for grant of registration shall take into account, all matters relevant for carrying out the activities of a corporate agent.

(2) Without prejudice to the above, the Authority in particular, shall take into account the following, namely:-
(a) whether the applicant is not suffering from any of the disqualifications specified under sub-section (5) of section 42 D of the Act;
(b) whether the applicant has the necessary infrastructure, such as, adequate office space, equipment and trained manpower on their rolls to effectively discharge its activities;
(c) whether any person, directly or indirectly connected with the applicant, has been refused in the past the grant of license/registration by the Authority.

***a. Explanation**: - For the purposes of this sub-clause, the expression "directly or indirectly connected" means in the case of a firm or a company or a body corporate, an associate, a subsidiary, an interconnected undertaking or a group company of the applicant . It is hereby clarified that these terms shall have the same meanings as ascribed to ,hem in the Companies Act, 2013 or The Competition Act, 2002, as the case may be.*

(d) Whether the principal officer of the applicant is a graduate and has received at least fifty hours of theoretical and practical training from an approved institution according to a syllabus approved by the Authority, and has passed an examination, at the end of the period of training mentioned above, conducted by the examination body.

Provided that where the principal officer of the applicant is an Associate/ Fellow of the Insurance Institute of India, Mumbai; or Associate/Fellow of the CII, London; or Associate/Fellow of the institute of Actuaries of India; or holds any post graduate qualification of the Institute of Insurance and Risk Management, Hyderabad, the theoretical and practical training shall be twenty five hours.

(e) whether the principal officer' directors and other employees of the applicant have not violated the code of conduct as specified in Schedule III to these regulations during the last three years;

(f) Whether the applicant, in case the principal business of the applicant is other than insurance' maintain an arms-length relationship in financial matters between its activities as Corporate Agent and other activities.

(g) Whether the Principal Officer/Director(s)/Partner(s)/Specified Persons is/are Fit and Proper based on the statement in Annexure I of these regulation; and

(h) the Authority is of the opinion that the grant of registration will be in the interest of policyholders.

(3) The specified persons of the applicant shall fulfill the following requirements –

a. Having passed minimum of l2th Class or equivalent examination from a recognized Board/Institution:

b. (i) The specified person shall have undergone at least fifty hours of training' for the specified category of life, general, health for' which registration is sought for, from an approved institution and shall have passed the examination conducted by the examination body;

(ii) The specified person of corporate agent (composite) shall have undergone at seventy five hours of training from an approved institute and shall have pass the examination conducted by the examination body;

c. the specified persons engaged by the corporate agent to solicit and procure insurance business shall have valid certificate issued by the Authority as, specified in these Regulations. The certificate shall be valid for a period of three years from the date of issued subject to the valid registration of the corporate agent;

The specified person shall apply through the principal officer of the corporate agent to the Authority in the format specified in Annexure 3 of these regulations for issuance of certificate.

d. A specified person of a corporate agent wishes to switch over to any other corporate agent, shall do so by applying to the Authority through the new corporate agent along with a no objection certificate issued by the present corporate agent. In case, the present corporate agent does not issue a no objection certificate within 30 days, it shall be deemed that the said corporate agent has no objection to his switching over. The Authority after receipt of request from the corporate agent, issue a revised certificate changing the name of the corporate agent indicating the switching over.

e. Specified Persons and/or Chief Insurance Executives who are qualified and already working with a corporate agent licensed under Insurance Regulatory and Development Authority (Licensing of Corporate Agents) Regulation, 2002, may continue to work with corporate agents registered under these regulations. However, the details of such Specified Persons and/or Chief Insurance Executives shall be provide to the Authority in the manner specified at the time of making an application for granting registration or within six months from the date of their registration. The Authority after receipt of the details issue to such Specified Persons and/or Chief Insurance Executives a certificate as specified in sub- regulation (c) above.

4. **Renewal of registration** - (1) A corporate agent may, within thirty days before the expiry of the registration, make an application in Form A along with requisite fee to the Authority for renewal of registration.

Provided however that if the application reaches the Authority later than that period but before the actual expiry of the current registration, an additional fee of rupees one hundred, plus applicable taxes, shall be payable to the Authority.

Provided further that the Authority may for sufficient reasons offered in writing by the applicant for a delay not covered by the previous proviso, accept an application for renewal after the date of the expiry of the registration on payment of an additional fee of seven hundred and fifty rupees, plus applicable taxes, by the applicant.

Note: A corporate agent is permitted to submit the application for renewal of registration ninety days prior to the expiry of the registration.

(2) Principal Officer and specified persons before seeking a renewal of registration shall have completed, at least twenty five hours of therefore local and practical raining, imparted by an approved institution.

(3) An application for renewal, under sub-regulation (l) shall be dealt with in the same manner as specified under regulation 7.

(4) The Authority, on being satisfied that the applicant fulfills all the conditions specified for a renewal of the registration, shall renew the registration in Form C for a period of three years and send intimation to the applicant.

5. Procedure where a registration is not granted -

(1) Where an application for grant of a registration under regulation 4 or renewal thereof under regulation 11, does not satisfy the conditions set out in regulation 7, the Authority may refuse to grant or renew the Certificate of Registration.

Provided that no application shall be rejected unless the applicant has been given a reasonable opportunity of being heard.

(2) The refusal to grant or renew a Certificate of Registration shall be communicated by the Authority within thirty days of such refusal to the applicant stating therein the grounds on which the application has been rejected.

(3) Any applicant aggrieved by the decision of the Authority may make an appeal to Securities Appellate Tribunal, as per the procedure prescribed for such an appeal, within a period of forty-five days from the date on which a copy of the order made by the Authority under sub-regulation (2) above is received by it.

6. **Effect of refusal to grant registration-** An applicant, whose application for grant of registration under regulation 4 or of a renewal thereof under regulation 11 has been refused or rejected by the Authority, shall, on and from the date of the receipt of the communication under regulation 12(2) cease to act as a corporate agent. He, however, shall continue to be liable to provide services in respect of contracts already entered into through him. Such a service shall continue upto the period of expiry of those existing contracts, which have already been closed, or for a period of six months, whichever is earlier within which time they shall make suitable arrangements with the concerned insurer.

7. **Conditions of grant of registration to Corporate Agent:**

The registration granted under regulation 9 or the renewal granted under regulation 11 shall, inter alia, be subject to the following conditions:-

(i) The corporate agent registered under these regulations shall be permitted to solicit and service insurance business as specified in regulation (3) above only;
(ii) The corporate agent shall comply with the provisions of the Act, Insurance Regulatory and Development Authority Act, 1999 and the Regulations, Circulars, Guidelines and any other instructions issued there under from time to time by the Authority;

(iii) The corporate agent shall forthwith inform the Authority in writing, if any information or particulars previously submitted to the Authority by them are found to be false or misleading in respect of any material particular or if there is any material change in the information already submitted;

(iv) The corporate agent shall take adequate steps for redressal of grievances of its clients within 14 days of receipt of such complaint and keep the Authority informed about the number, nature and other particulars of the complaints received from such clients in format and manner as may be specified by the Authority;

(v) The corporate agent shall solicit and procure reasonable number of insurance policies commensurate with their resources and the number of specified persons they employ.

(vi) The corporate agent shall maintain records in the format specified by the Authority which shall capture policy-wise and specified person-wise details wherein each policy solicited by the corporate agent is tagged to the specified person, except for those products which are simple, sold over the counter and specifically approved by the Authority. The corporate agent shall put in place systems which allow regular access to such records and details by the Authority.

(vii) The corporate agent under no circumstance shall undertake multi-level marketing for solicitation of insurance products;

(viii) The Corporate Agent shall ensure compliance of Code of Conduct applicable to its directors, principal officer and specified persons;

(ix) The corporate agent shall maintain separate books of accounts for their corporate agency business as specified in regulation 31;

8. Payment of fees and the consequences of failure to pay fees –

(1) Every corporate agent shall at the time of application of registration and renewal thereof pay non refundable application fee of Rs.10,000/-, plus applicable taxes. The fees shall be Payable by an Account payee draft in in favour of "The Insurance Regulatory and Development Authority of India" payable at Hyderabad or by recognised electronic funds transfer to Insurance Regulatory and Development Authority of India. No application shall be processed without the application fee.

(2) Upon receipt of communication for grant of registration from the Authority, the applicant shall pay a fee of Rs.25,000/-, plus applicable taxes, within 15 days of receipt of such communication. On receipt of the fee and on satisfactory compliance of terms and conditions for grant of registration, the Authority shall grant the registration to act as a corporate agent under the category for which an application is made.

(3) A corporate agent desirous of applying for renewal shall make an application for renewal in the prescribed format along with a fee of Rs.25, 000/-, plus applicable taxes.

9. **Remuneration-**

(1) The payment of remuneration to or receipt of remuneration by a corporate agent shall be governed by the regulations notified in this behalf by the Authority from time to time.

(2) Corporate agents who were licensed under IRDA (Licensing of Corporate Agents) Regulations, 2002 may be allowed to receive remuneration for the business sourced and procured by them under those regulations provided they continue to service their customers as specified in regulation 24(2) of these regulations. In case such corporate agents desire to be registered under these regulations, they shall disclose the remuneration received under old contracts and new contracts separately in their books of accounts as specified in regulation 31.

10. Conflict of interest –

While soliciting and procuring the insurance business, the corporate agent shall comply with the following:

(i) The corporate agent having tie-ups with more than one insurer in a particular line of business, disclose to the prospective customer the list of insurers, with whom they have arrangements to distribute the products and provide them with the details such as scope of coverage, term of policy, premium payable, premium terms and any other information which the customer seeks on all products available with them. Further, disclose the scale of commission in respect of the insurance product offered, if asked by the prospect;

(ii) Where the insurance is sold as an ancillary product along with a principal business product, the corporate agent or its shareholder or its associates shall not compel the buyer of the principal business product to necessarily buy the insurance product through it. The Principal Officer and CFO (or its equivalent) of the corporate agent shall file with the Authority a certificate in the format given in the Schedule VIII on half-yearly basis, certifying that there is no forced selling of an insurance product to any prospect.

(iii) No insurer shall require the corporate agent to insure every client with it.

11. Disclosures to the Authority-

(1) An applicant desires to become a corporate agent shall disclose to the Authority at the time of filing application all material facts relevant for consideration of application, on its own. In case of any change in the information provided for consideration of their application, subsequent to filing of application or during the processing of application, such change shall be disclosed to the Authority, voluntary by the applicant, for consideration of the Authority.

(2) Similarly, a corporate agent who holds a valid registration issued by the Authority shall, subsequent to the issuance of registration, disclose, to the Authority voluntarily, any change in material facts, based on which a registration was made to them, within a reasonable time but not later than 30 days from the happening of such change.
The Authority upon receipt of such information, may seek any clarification or issue such directions as it deem fit.

(3) A corporate shall disclose to the Authority proceedings initiated against them by other regulatory or Government bodies within a reasonable time but not later than 30 days from the initiation of such proceedings. Any action or direction issued by such other bodies shall also be disclosed to the Authority within the time limits prescribed above

(4) The Authority may require, from time to time, the corporate agent to furnish such information or return as deemed appropriate.

(5) The corporate agent shall disclose to the Authority the details of its offices in which they propose to distribute insurance products and details of Specified Persons along with their certificate number issued by the Authority. Further, any opening or closure of an office by a corporate agent shall be informed to the Authority. The Authority may seek further information as it deem appropriate.

(6) Failure to adhere to the conditions set out above shall attract regulatory actions such as suspension or cancelation of registration, imposition of monetary penalty or any other action which the Authority deem fit.

12. Arrangements with insurers for distribution of products

a) Corporate agents registered under these regulations shall have to enter into arrangements with insurers for distribution of products. These arrangements shall have to be disclosed to the Authority within 30 days of entering into such arrangements. The minimum period of such arrangement shall be for one year;

(b) while entering into such arrangements, no corporate agent shall promise nor shall any insurer compel the corporate agent to distribute the products of a Particular insurer;

(c) Arrangements shall have provisions to include duties and responsibilities of corporate agents towards the policyholders, duties and responsibilities of insurers and corporate agents, terms and conditions for termination of arrangements;

(d) No arrangements shall be made against the interests of Policyholders;

(e) In case a corporate agent wishes to terminate arrangement with any insurer, they may do so after informing the insurer and the Authority, the reasons or termination of arrangement. In such cases, they shall ensure that the policies solicited and placed with the insurer are serviced till the expiry of policies, or for a Period of six months, whichever is earlier with in which time they shall make suitable arrangements with the concerned insurer;

(f) In case an insurer wishes to terminate the arrangement with any corporate agent, they may do so after informing the corporate agent and the Authority, the reasons for termination of arrangement. In such cases, the concerned insurer shall take the responsibility of servicing the policies Procured by the corporate agent. In all such cases, the insurer shall inform the policyholder concerned of the changes made in servicing arrangements;

(g) No insurer shall pay and no corporate agent shall receive any signing fee or any other charges by whatever name called, except those permitted by the Authority under relevant regulations, for becoming its corporate agent;

(h) No insurer shall directly pay incentives (cash or non-cash) to the principal officer, specified persons and other employees of the corporate agents;

(i) The Authority may, at any point in time, direct any insurer or corporate agent to terminate the distribution arrangements by recording the reasons there for.

13. Servicing of policyholders-

(1) A corporate agent registered under these regulations shall have the duty to service its policyholders during the entire period of contract. Servicing includes assisting in payment of premium required under section 64VB of the Act, providing necessary assistance and guidance in the event of a claim. providing all other services and guidance on issues which arise during the course of an insurance contract.

(2) In case of a corporate agent licensed under IRDA (Licensing of Corporate Agents) Regulations, 2002 they shall comply with regulation 1 (3) of these regulations. However, they shall continue to service their existing policyholders as required under sub-clause (1) of this regulation till the expiry of the term of such policies or for a period of six months, whichever is earlier, within which time they shall make suitable arrangements with the concerned insurer for servicing the contracts. The details of such contracts along with the arrangements shall be disclosed to the Authority within thirty days of such arrangements.

14. Sale of Insurance by tele-marketing mode and distance marketing activities of a corporate agent –

(1) A corporate agent who intends to engage the services of a telemarketer or engage in distance marketing activities for the purpose of distribution of insurance products shall follow the instructions as laid down in Schedule VII.

(2) Without prejudice to sub-regulation (1) above, a corporate agent shall have to comply with the following additional conditions for engaging the services of a telemarketer:

a. The telemarketer engaged by the corporate agent shall comply with various circulars and/or guidelines or any other direction issued by Telecom Regulatory Authority of India in the matter;
b. A corporate agent intends to undertake telemarketing activities for insurance intermediation shall seek prior approval of the Authority in the form specified by the Authority at Annexure 4 of these regulations. The Authority on verification of the same issue a certificate to the telemarketer;
c. Further, the corporate agent shall file with the Authority the names of Authorised verifiers engaged/
d. proposed to be engaged by the telemarketer in the form specified at Annexure 5 of these regulations, The Authority on verification of the same issue a certificate to the Authorised verifier.
e. In case an Authorised Verifier intends to switch to another telemarketer who is also dealing with insurance intermediation, they shall obtain a No Objection Certificate from the erstwhile telemarketer and submit the same to the Authority for issuing a fresh certificate. In case, the present telemarketer does not issue a no objection certificate within 30 days from the date of application for the same, it shall be deemed that the telemarketer has no objection to his switching over;
f. Application for removal or addition of Authorised Verifiers shall be made by the Corporate Agent concerned through the Principal Officer;
g. In case the corporate agent registers as telemarketer with TRAI, the corporate agent shall act as telemarketer for only those insurers with whom he has arrangements;
h. No corporate agent or its telemarketer shall make outbound calls to any person unless he or she has shown interest in buying an insurance policy by making enquiries to that effect. They shall maintain the database of such persons and the enquiry made for verification and checking by the Authority or any person authorized by it.
i. The telemarketer shall disclose to the prospective customer the following information
   (a) The name of the corporate agent they represent;
   (b) The registration number of the corporate agent;
   (c) Contact number of the telemarketer and-/or corporate agent in case the customer desires to call back or verify the telesales information;
   (d) Name and identification number of the person (Authorised Verifier) making the tele-call.
j. A corporate agent engaging a telemarketer shall enter into an agreement with the telemarketer and the agreement shall provide the details such as source of the database, duties and responsibilities, payment details, period of agreement, actions to be taken in case of violation of Act, regulations, guidelines, circulars, directions issued by the Authority, Code of Conduct of Authorised Verifiers. The agreements shall be made available to the Authority or any person authorized by the Authority for verification as and when required;
k. Every telemarketer and the authorized Verifier shall abide by the Code of Conduct applicable to corporate agents as specified in Schedule III of these regulations.

l. The Authority shall have the power to inspect the premises of the telemarketer or any other premises, which the Authority feels necessary for the verification of records / documents, and seek any document/record, record statements of any employee of the telemarketer or make copies of any documents/records at its discretion:
m. The telemarketer shall have to comply with any other terms and conditions as may be prescribed by the Authority from time to time in the matter.

(3) A telemarketer shall not be engaged with more than three insurers or insurance related entities

15. Code of conduct for Corporate Agents-

(1) Every Corporate Agent shall abide by the Code of Conduct as specified in Schedule III of these regulations,

(2) The corporate agent shall be responsible for all (he acts and omissions of its principal officer, specified persons and other employees including violation of code of conduct specified under these regulations and liable to a penalty which may extend to one crore rupees under the provisions of Sec.102 of the Act.

16. Maintenance of Records

A Corporate Agent shall maintain the following records including in electronic form and shall be made available as and when required by the Aurhority –

(i) Know Your Client (KYC) records of the client, as required under the relevant Authority's guidelines and provisions of Prevention of Money Laundering Act;
(ii) Copy of the proposal form duly signed by the client and submitted to the insurer with ACR signed by the specified person of corporate agent;
(iii) A register containing list of clients, details of policy such as type of policy, premium amount, date of issue of the policy, charges or fees received;
(iv) A register containing details of complaints received which include name of the complainant, nature of complaint, details of policy issued/solicited and action taken thereon;
(v) A register which shall contain the name, address, telephone no, photograph, date of commencement of employment, date of leaving the service, if any, monthly remuneration paid to the specified person;
(vi) Copies of the correspondence exchanged with the Authority;
(vii) Any other record as may be specified by the Authority from time to time.

17. Maintenance of books of account, records, etc. –

(1) A corporate agent, which is incorporated exclusively for the purposes of insurance intermediation, shall prepare the following books of accounts for every financial year -

(i) a balance sheet or a statement of affairs as at the end of each accounting period;
(ii) a profit and loss account for that period;
(iii) a statement of cash/fund flow:
(iv) Additional statements as may be required by the Authority from time to rime.

Note.1: For purposes of this regulation, the financial year shall be a period of 12 months (or less where a business is started after 1st April) commencing on the first day of the April of an year and ending on the 31st day of March of the year following and the accounts shall be maintained on accrual basis.

Note.2: There shall be a schedule to their financial statements or providing the details of all the incomes received from insurers and insurer's group companies, insurer-wise, by the corporate agent, and also the details of payments received by the group companies and/or associates of the corporate agent from any insurer and the details thereof.

(a) A copy of the audited financial statements as stated in sub-regulation (1) along with the auditor's report thereon shall be submitted to the Authority before 30th September every year along with the remarks or observations of the auditors, if any, on the conduct of the business, state of accounts, etc., and a suitable explanation on such observations shall be appended to such accounts filed with the Authority.
(b) Within ninety days from the date of the Auditor's report necessary steps to rectify any deficiencies, made out in the auditor's report, be made and informed to the Authority.
(c) All the books of account, statements, document, etc., shall be maintained at the head office of the corporate agent or such other branch office as may be designated and notified to the Authority, and shall be available on all working days to such officers of the Authority, and authorised in this behalf for inspection.
(d) All the books, documents, statements, contract notes etc., referred to in this regulation and maintained by the corporate agent shall be retained for a minimum period of ten years from the end of the year to which they relate. However, the documents pertaining to the cases where claims are reported and the settlement is pending for a decision from courts, the documents are required to be maintained till the disposal of the cases by the court.

(2) In the case of corporate agents whose principal business is other than insurance intermediation, they shall maintain segment wise reporting capturing the revenues received for insurance intermediation and other income from insurers.

(3) Every insurer who is engaging the services of a corporate agent shall file with the Authority a certificate, separately for all such corporate agents, in the format given in the Schedule VIA to be signed by the CEO and CFO. A similar certificate from the Principal Officer and CFO (or its equivalent) of the corporate agent specifying the commission/ remuneration received from the insurer shall be filed with the Authority as given in Schedule VlB.

18. General:

(1) From the date of notification of these regulations no person can function as a corporate Agent, except in cases as specified in regulation 1 (3) of these regulations, unless a registration has been granted to him by the Authority under these regulations.

(2) Any disputes arising between a Corporate Agent and an insurer or any other person either in the course of his engagement as a corporate agent or otherwise, may be referred to the Authority by the person so affected; and on receipt of the complaint or representation, the Authority may examine the complaint and if found necessary proceed to conduct an enquiry or an inspection or an investigation in terms of these regulations.

Code of Conduct

I. General Code of Conduct

1. Every corporate agent shall follow recognised standards of professional conduct and discharge their duties in the interest of the policyholders. While doing so-

a) conduct its dealings with clients with utmost good faith and integrity at all times;
b) act with care and diligence;
c) ensure that the client understands his relationship with the corporate agent and on whose behalf the corporate agent is acting;
d) treat all information supplied by the prospective clients as completely confidential to themselves and to the insurer(s) to which the business is being offered;
e) take appropriate steps to maintain the security of confidential documents in their possession;
f) No director of a company or a partner of a firm or the chief executive or a principal officer or a specified person shall hold similar position with another corporate agent;

2. Every Corporate Agent shall

a) be responsible for all acts of omission and commission of its principal officer and every specified person;
b) ensure that the principal officer and all specified persons are properly trained, skilled and knowledgeable in the insurance products they market;

c) ensure that the principal officer and the specified person do not make to the prospect any misrepresentation on policy benefits and returns available under policy;
d) ensure that no prospect is forced to buy an insurance product;
e) give adequate pre-sale and post-sale advice to the insured in respect of the insurance product;
f) Extend all possible help and cooperation to an insured in completion of all formalities and documentation in the event of a claim;
g) give due publicity to the fact that the corporate agent does not underwrite the risk or act as an insurer;
h) enter into agreements with the insurers in which the duties and responsibilities of both are defined

II. Pre-sale Code of Conduct

3. Every corporate agent or principal officer or a specified person shall also follow the code of conduct specified below:

i) Every corporate agent/principal officer/ specified person shall,-

a) identify himself and disclose his registration/ certificate to the prospect on demand;
b) disseminate the requisite information in respect of insurance products offered for sale by the insurers with whom they have arrangement and take into account the needs of the prospects while recommending a specific insurance plan;
c) disclose the scales of commission in respect of the insurance product offered for sale, if asked by the prospect;
d) indicate the premium to be charged by the insurer for the insurance product offered for sale;
e) explain to the prospect the nature of information required in the proposal form by the insurer, and also the importance of disclosure of material information in the purchase of an insurance contract;
f) bring to the notice of the insurer any adverse habits or income inconsistency of the prospect, in the form of a Confidential Report along with every proposal submitted to the insurer, and any material fact that may adversely affect the underwriting decision of the insurer as regards acceptance of the proposal, by making all reasonable enquiries about the prospect;
g) inform promptly the prospect about the acceptance or rejection of the proposal by the insurer;
h) obtain the requisite documents at the time of filing the proposal form with the insurer, and other documents subsequently asked for by the insurer for completion of the proposal;

ii) No corporate agent/ principal officer/ specified person shall,-----

a) solicit or procure insurance business without holding a valid registration/certificate;

b) induce the prospect to omit any material information in the proposal form;
c) induce the prospect to submit wrong information in the proposal form or documents submitted to the insurer for acceptance of the proposal;
d) behave in a discourteous manner with the prospect;
e) interfere with any proposal introduced by any other specified person or any insurance intermediary;
f) offer different rates, advantages, terms and conditions other than those offered by the insurer;
g) force a policyholder to terminate the existing policy and to effect a new proposal from him within three years from the date of such termination;
h) No corporate agent shall have a portfolio of insurance business from one person or one organization or one group of organizations under which the premium is in excess of fifty percent of total premium procured in any year ;
i) become or remain a director of any insurance company, except with the prior approval of the Authority,
j) indulge in any sort of money laundering activities;
k) indulge in sourcing of business by themselves or through call centers by way of misleading calls or spurious calls;
l) undertake multi-level marketing for soliciting and procuring of insurance products;
m) engage untrained and unauthorised persons to bring in business;
n) provide insurance consultancy or claims consultancy or any other insurance related services except soliciting and servicing of insurance products as per the certificate of registration.
o) Engage, encourage, enter into a contract with or have any sort of arrangement with any person other than
a specified person, to refer, solicit, generate lead, advise, introduce, find or provide contact details of prospective policyholders in furtherance of the distribution of the insurance product;
p) Pay or allow the payment of any fee, commission, incentive by any other name whatsoever for the purpose of sale, introduction, lead generation, referring or finding to any person or entity

III. Post-Sale Code of Conduct 4.
Every Corporate Agent shall -
a) advise every individual policyholder to effect nomination or assignment or change of address or exercise of options, as the case may be, and offer necessary assistance in this behalf, wherever necessary;
b) with a view to conserve the insurance business already procured through him, make every attempt to ensure remittance of the premiums by the policyholders within the stipulated time, by giving notice to the policyholder orally and in writing.
c) ensure that its client is aware of the expiry date of the insurance even if it chooses not to offer further cover to the client:
d) ensure that renewal notices contain a warning about the duty of disclosure including the necessity to advise changes affecting the policy, which have occurred since the policy inception or the last renewal date;

e) ensure that renewal notices contain a requirement for keeping a record (including copies of letters) of all information supplied to the insurer for the purpose of renewal of the contract;
f) ensure that the client receives the insurer’s renewal invitation well in time before the expiry date.
g) render necessary assistance to the policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims by the insurer;
h) explain to its clients their obligation to notify claims promptly and to disclose all material facts and advise subsequent developments as soon as possible;
i) advise the client to make true, fair and complete disclosure where it believes that the client has not done so. lf further disclosure is nor forthcoming it shall consider declining to act further for the client;
j) give prompt advice to the client of any requirements concerning the claim;
k) forward any information received from the client regarding a claim or an incident that may give rise to a claim without delay, and in any event within three working days;
l) advise the client without delay of the insurer's decision or otherwise of a claim; and give all reasonable assistance to the client in pursuing his claim.
m) shall not demand or receive a share of proceeds from the beneficiary under an insurance contract;
n) ensure that letters of instructior, policies and renewal documents contain details of complaints handling procedures:
o) accept complaints either by phone or in writing:
p) acknowledge a complaint within fourteen days from the receipt of correspondence, advise the member of staff who will be dealing with the complaint and the timetable for dealing with it;
q) ensure that response letters are sent and inform the complainant of what he may do if he is unhappy with the response;
r) ensure that complaints are dealt with at a suitably senior level;
s) have in place a system for recording and monitoring complaints.

CHAPTER 5

LEGAL PRINCIPLES OF AN INSURANCE CONTRACT

Chapter Introduction

In this chapter, we discuss the elements that govern the working of an insurance contract. The chapter also deals with the special features of an insurance contract.

Learning Outcomes

A. Insurance contracts – Legal aspects and special features

A. Insurance contracts – Legal aspects and special features

1. Insurance contracts – Legal aspects

a) The insurance contract

Insurance involves a contractual agreement in which the insurer agrees to provide financial protection against certain specified risks for a price or consideration known as the premium. The contractual agreement takes the form of an insurance policy.

b) Legal aspects of an insurance contract

We will now look at some features of an insurance contract and then consider the legal principles that govern insurance contracts in general.

Important

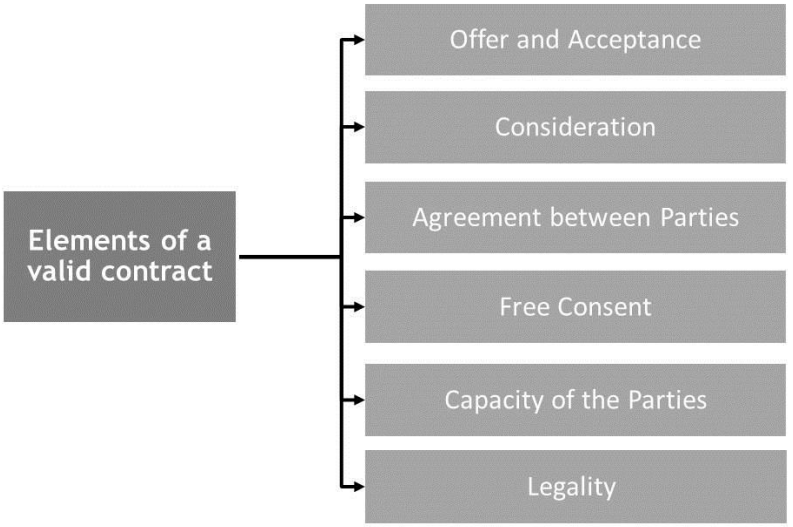
A contract is an agreement between parties, enforceable at law. The provisions of the Indian Contract Act, 1872 govern all contracts in India, including insurance contracts.

An insurance policy is a contract entered into between two parties, viz., the company, called the **insurer**, and the policy holder, called the **insured** and fulfils the requirements enshrined in the Indian Contract Act, 1872.

Diagram 1: Insurance contract

c) Elements of a valid contract

Diagram 2: Elements of a valid contract



The elements of a valid contract are:

i. Offer and acceptance

When one person signifies to another his willingness to do or to abstain from doing anything with a view to obtaining the assent of the other to such act, he is said to make an offer or proposal. Usually, the offer is made by the proposer, and acceptance made by the insurer.

When a person to whom the offer is made signifies his assent thereto, this is deemed to be an acceptance. Hence, when a proposal is accepted, it becomes a promise.

The acceptance needs to be communicated to the proposer which results in the formation of a contract.

When a proposer accepts the terms of the insurance plan and signifies his assent by paying the deposit amount, which, on acceptance of the proposal, gets converted to the first premium, the proposal becomes a policy.

If any condition is put, it becomes a counter offer.

The policy bond becomes the evidence of the contract.

ii. Consideration

This means that the contract must contain some mutual benefit for the parties. The premium is the consideration from the insured, and the promise to indemnify, is the consideration from the insurers.

iii. Agreement between the parties

Both the parties should agree to the same thing in the same sense. In other words, there should be **"consensus ad-idem"** between both parties. Both the insurance company and the policyholder must agree on the same thing in the same sense.

iv. Free consent

There should be free consent while entering into a contract.

Consent is said to be free when it is not caused by

- ✓ Coercion
- ✓ Undue influence
- ✓ Fraud
- ✓ Misrepresentation
- ✓ Mistake

When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is voidable.

v. Capacity of the parties

Both the parties to the contract must be legally competent to enter into the contract. The policyholder must have attained the age of majority at the time of signing the proposal and should be of sound mind and not disqualified under law. For example, minors cannot enter into insurance contracts.

vi. Legality

The object of the contract must be legal, for example, no insurance can be had for illegal acts. Every agreement of which the object or consideration is unlawful is void. The object of an insurance contract is a lawful object.

Important

i. **Coercion** - Involves pressure applied through criminal means.

ii. **Undue influence** - When a person who is able to dominate the will of another, uses her position to obtain an undue advantage over the other.

iii. **Fraud** - When a person induces another to act on a false belief that is caused by a representation he or she does not believe to be true. It can arise either from deliberate concealment of facts or through misrepresenting them.

iv. Mistake - Error in one's knowledge or belief or interpretation of a thing or event. This can lead to an error in understanding and agreement about the subject matter of contract.

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2. Insurance contracts - Special features

a) Uberrima Fides or Utmost Good Faith

This is one of the fundamental principles of an insurance contract. Also called uberrima fides, it means that every party to the contract must disclose all material facts relating to the subject matter of insurance.

A distinction may be made between Good Faith and Utmost Good Faith. All commercial contracts in general require that good faith shall be observed in their transaction and there shall be no fraud or deceit when giving information. Apart from this legal duty to observe good faith, the seller is not bound to disclose any information about the subject matter of the contract to the buyer.

The rule observed here is that of **"Caveat Emptor" which means Buyer Beware**. The parties to the contract are expected to examine the subject matter of the contract and so long as one party does not mislead the other and the answers are given truthfully, there is no question of the other party avoiding the contract

Utmost Good Faith: Insurance contracts stand on a different footing. Firstly, the subject matter of the contract is intangible and cannot be easily known through direct observation or experience by the insurer. Again there are many facts, which by their very nature, may be known only to the proposer. The insurer has to often rely entirely on the latter for information.

Hence the proposer has a legal duty to disclose all material information about the subject matter of insurance to the insurers who do not have this information.

Example

David made a proposal for an insurance policy. At the time of applying for the policy, David was suffering from and under treatment for Diabetes. But David did not disclose this fact to the insurance company. David was in his thirties, so the insurance company issued the policy without asking David to undergo a medical test. Few years down the line, David's health deteriorated and he had to be hospitalised. David could not recover and died in the next few days. A claim was raised on the insurance company.

To the surprise of David's nominee, the insurance company rejected the claim. In its investigation, the insurance company found out that David was already suffering from diabetes at the time of applying for the policy and this fact was deliberately hidden by David. Hence the insurance contract was declared null and void and the claim was rejected.

Material information is that information which enables the insurers to decide:

- ✓ Whether they will accept the risk?
- ✓ If so, at what rate of premium and subject to what terms and conditions?

This legal duty of utmost good faith arises under common law. The duty applies not only to material facts which the proposer knows, but also extends to material facts which he ought to know.

Example

Following are some examples of material information that the proposer should disclose while making a proposal:

i. **Life Insurance:** own medical history, family history of hereditary illnesses, habits like smoking and drinking, absence from work, age, hobbies, financial information like income details of proposer, pre-existing life insurance policies, occupation etc.
ii. **Fire Insurance:** construction and usage of building, age of the building, nature of goods in premises etc.
iii. **Marine Insurance:** description of goods, method of packing etc.
iv. **Motor Insurance:** description of vehicle, date of purchase, details of driver etc.
v. **Health Insurance:**

Insurance contracts are thus subject to a higher obligation. When it comes to insurance, good faith contracts become utmost good faith contracts.

Definition

The concept of "Uberrima fides" is defined as involving “a positive duty to voluntarily disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not".

If utmost good faith is not observed by either party, the contract may be avoided by the other. This essentially means that no one should be allowed to take advantage of his own wrong especially while entering into a contract of insurance.

It is expected that the insured should not make any misrepresentation regarding any fact that is material for the insurance contract. The insured must disclose all relevant facts. If this obligation did not exist, a person taking insurance might suppress certain facts impacting the risk on the subject matter and receive an undue benefit.

The policyholder is expected to disclose the status of his health, family history, income, occupation etc. truthfully without concealing any material fact so as to enable the underwriter to assess the risk properly. In case of non-disclosure or misrepresentation in the proposal form which may have impacted the underwriting decision of the underwriter, the insurer has a right to cancel the contract.

The law imposes an obligation to disclose all material facts.

Example

An executive is suffering from hypertension and had a mild heart attack recently following which he decides to take a medical policy but does not reveal the same. The insurer is thus duped into accepting the proposal due to misrepresentation of facts by insured.

An individual has a congenital hole in the heart and reveals it in the proposal form. The same is accepted by the insurer and proposer is not informed that pre-existing diseases are not covered for at least 4 years. This is misleading of facts by the insurer.

b) Material facts

Definition

Material fact has been defined as a fact that would affect the judgment of an insurance underwriter in deciding whether to accept the risk and if so, the rate of premium and the terms and conditions.

Whether an undisclosed fact was material or not would depend on the circumstances of the individual case and could be decided ultimately only in a court of law. The insured **has to disclose** facts that affect the risk.

Let us take a look at some of the types of material facts in insurance that one needs to disclose:

i. Facts indicating that the particular risk represents a greater exposure than normal.

Example

Hazardous nature of cargo being carried at sea, past history of illness

ii. Existence of past policies taken from all insurers and their present status

iii. All questions in the proposal form or application for insurance are considered to be material, as these relate to various aspects of the subject matter of insurance and its exposure to risk. They need to be answered truthfully and be full in all respects.

The following are some scenarios wherein material facts need not be disclosed

Information

Material Facts that need not be disclosed

It is also held that unless there is a specific enquiry by underwriters, the proposer has no obligation to disclose the following facts:

i. **Measures implemented to reduce the risk.**

Example: The presence of a fire extinguisher

ii. **Facts which the insured does not know or is unaware of**

Example: An individual, who suffers from high blood pressure but was unaware about the same at the time of taking the policy, cannot be charged with non-disclosure of this fact.

iii. **Which could be discovered, by reasonable diligence?**

It is not necessary to disclose every minute material fact. The underwriters must be conscious enough to ask for the same if they require further information.

iv. **Matters of law**

Everybody is supposed to know the law of the land.

Example: Municipal laws about storing of explosives

v. **About which insurer appears to be indifferent (or has waived the need for further information)**

The insurer cannot later disclaim responsibility on grounds that the answers were incomplete.

When is there a duty to disclose?

In the case of insurance contracts, the duty to disclose is present throughout the entire period of negotiation until the proposal is accepted and a policy is issued. Once the policy is accepted, there is no further need to disclose any material facts that may come up during the term of the policy.

Example

Mr. Rajan has taken a insurance policy for a term of fifteen years. Six years after taking the policy, Mr. Rajan has some heart problems and has to undergo some surgery. Mr. Rajan does not need to disclose this fact to the insurer.

However if the policy is in a lapsed condition because of failure to pay the premiums when due and the policy holder seeks to revive the policy contract and bring it back in force, he may, at the time of such revival, have the duty to disclose all facts that are material and relevant, as though it is a new policy.

Breach of Utmost Good Faith

We shall now consider situations which would involve a Breach of Utmost Good Faith. Such breach can arise either through Non-Disclosure or Misrepresentation.

Non-Disclosure: may arise when the insured is silent in general about material facts because the insurer has not raised any specific enquiry. It may also arise through evasive answers to queries raised by the insurer. Often disclosure may be inadvertent (meaning it may be made without one's knowledge or intention) or because the proposer thought that a fact was not material.

In such a case it is innocent. When a fact is intentionally suppressed it is treated as concealment. In the latter case there is intent to deceive.

Misrepresentation: Any statement made during negotiation of a contract of insurance is called representation. A representation may be a definite statement of fact or a statement of belief, intention or expectation. With regard to a fact it is expected that the statement must be substantially correct. When it comes to Representations that concern matters of belief or expectation, it is held that these must be made in good faith.

Misrepresentation is of two kinds:

i. **Innocent Misrepresentation** relates to inaccurate statements, which are made without any fraudulent intention.
ii. **Fraudulent Misrepresentation** on the other hand refers to false statements that are made with deliberate intent to deceive the insurer or are made recklessly without due regard for truth.

An insurance contract generally becomes void when there is a clear case of concealment with intent to deceive, or when there is fraudulent misrepresentation.

Recent amendments (March, 2015) to Insurance Act, 1938 have provided certain guidelines about the conditions under which a policy can be called into question for fraud. The new provisions are as follows

Fraud

A policy of insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival, of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud:

The insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based.

The term “Fraud” has been defined and specified as follows:

The expression "fraud" means any of the following acts committed by the insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a insurance policy:

(a) the suggestion, as a fact of that which is not true and which the insured does not believe to be true;

(b) the active concealment of a fact by the insured having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent.

Mere silence as to facts likely to affect the assessment of the risk by the insurer is not fraud, unless the circumstances of the case are such that regard being had to them, it is the duty of the insured or his agent, keeping silence to speak, or unless his silence is, in itself, equivalent to speak.

No insurer shall repudiate a insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer:

It is also provided that in case of fraud, the onus of disproving lies upon the ben eficiaries, in case the policyholder is not alive.

A person who solicits and negotiates a contract of insurance shall be deemed for the purpose of the formation of the contract, to be the agent of the insurer.

c) Insurable interest

The existence of ‘insurable interest’ is an essential ingredient of every insurance contract and is considered as the legal pre-requisite for insurance. Let us see how insurance differs from a gambling or wager agreement.

i. Gambling and insurance

Consider a game of cards, where one either loses or wins. The loss or gain happens only because the person enters the bet. The person who plays the game has no further interest or relationship with the game other than that he might win the game.

Betting or, wagering is not legally enforceable in a court of law and thus any contract in pursuance of it will be held to be illegal. In case someone pledges his house if he happens to lose a game of cards, the other party cannot approach the court to ensure its fulfillment.

Now consider a house and the event of it burning down. The individual who insures his house has a legal relationship with the subject matter of insurance – the house. He owns it and is likely to suffer financially, if it is destroyed or damaged. This relationship of ownership exists independent of whether the fire happens or does not happen, and it is the relationship that leads to the loss. The event (fire or theft) will lead to a loss regardless of whether one takes insurance or not.

Unlike a card game, where one could win or lose, a fire can have only one consequence – loss to the owner of the house.

The owner takes insurance to ensure that the loss suffered is compensated for in some way.

The interest that the insured has in his house or his money is termed as insurable interest. The presence of insurable interest makes an insurance contract valid and enforceable under the law.

Example

Mr. Chandrasekhar owns a house for which he has taken a mortgage loan of Rs. 15 lakhs from a bank. Ponder over the below questions:

- ✓ Does he have an insurable interest in the house?
- ✓ Does the bank have an insurable interest in the house?
- ✓ What about his neighbour?

Mr. Srinivasan has a family consisting of spouse, two kids and old parents. Ponder over the below questions:

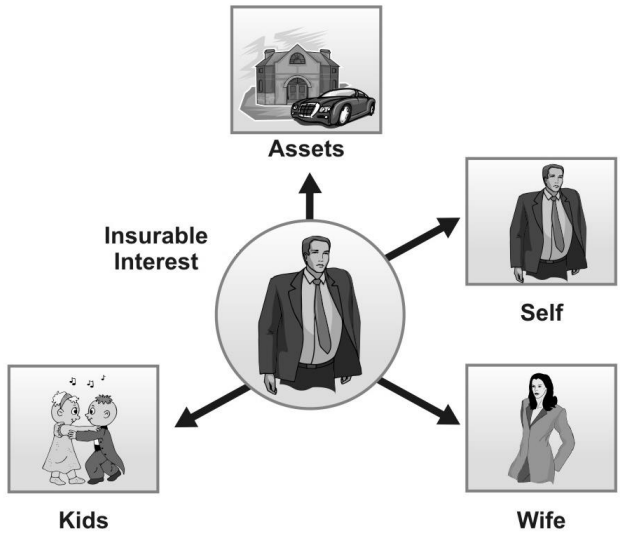
- ✓ Does he have an insurable interest in their well-being?
- ✓ Does he stand to financially lose if any of them are hospitalised?
- ✓ What about his neighbour's kids? Would he have an insurable interest in them?

It would be relevant here to make a distinction between the subject matter of insurance and the subject matter of an insurance contract.

Subject matter of insurance relates to property being insured against, which has an intrinsic value of its own.

Subject matter of an insurance contract on the other hand is the insured's financial interest in that property. It is only when the insured has such an interest in the property that he has the legal right to insure. The insurance policy in the strictest sense covers not the property per se, but the insured's financial interest in the property.

Diagram 3: Insurable interest according to common law



ii. Time when insurable interest should be present

In insurance, insurable interest should be present at the time of taking the policy. In general insurance, insurable interest should be present both at the time of taking the policy and at the time of claim with some exceptions like marine policies.

d) Proximate Cause

The last of the legal principles is the principle of proximate cause.
Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is indeed as a result of an insured peril. If the loss has been caused by the insured peril, the insurer is liable. If the immediate cause is an insured peril, the insurer is bound to make good the loss, otherwise not.

Under this rule, the insurer looks for the predominant cause which sets into motion the chain of events producing the loss. This may not necessarily be the last event that immediately preceded the loss i.e. it is not necessarily an event which is closest to, or immediately responsible for causing the loss.

Other causes may be classified as remote causes, which are separate from proximate causes. Remote causes may be present but are not effectual in causing an event.

Definition

Proximate cause is defined as the active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

How does the principle of proximate cause apply to insurance contracts? In general, since insurance provides for payment of a death benefit, regardless of the cause of death, the principle of proximate cause would not apply. However many insurance contracts also have an accident benefit rider wherein an additional sum assured is payable in the event of accidental death. In such a situation, it becomes necessary to ascertain the cause - whether the death occurred as a result of an accident. The principle of proximate cause would become applicable in such instances.

Contract of Adhesion

Adhesion contracts are those that are drafted by the party having greater bargaining advantage, providing the other party with only the opportunity to adhere to i.e., to accept the contract or reject it. Here the insurance company has all the bargaining power regarding the terms and conditions of the contract.
To neutralise this, a free-look period has been introduced whereby a policyholder, after taking a policy, has the option of cancelling the it, in case of disagreement, within 15 days of receiving the policy document. The company has to be intimated in writing and premium is refunded less expenses and charges.

e) Indemnity

The principle of indemnity is applicable to Non-life insurance policies. **It means that the policyholder, who suffers a loss, is compensated so as to put him or her in the same financial position as he or she was before the occurrence of the loss event**. The insurance contract (evidenced through insurance policy) guarantees that the insured would be indemnified or compensated up to the amount of loss and no more.

The philosophy is that one should not make a profit through insuring one's assets and recovering more than the loss. The insurer would assess the economic value of the loss suffered and compensate accordingly.

Example

Ram has insured his house, worth Rs. 10 lakhs, for the full amount. He suffers loss on account of fire estimated at Rs. 70000. The insurance company would pay him an amount of Rs. 70000. The insured can claim no further amount.

Consider a situation now where the property has not been insured for its full value. One would then be entitled to indemnity for loss only in the same proportion as one's insurance.

Suppose the house, worth Rs. 10 lakhs has only been insured for a sum of Rs. 5 lakhs. If the loss on account of fire is Rs. 60000, one cannot claim this entire amount. It is deemed that the house owner has insured only to the tune of half its value and he is thus entitled to claim just 50% [Rs. 30000] of the amount of loss. This is also known as underinsurance.

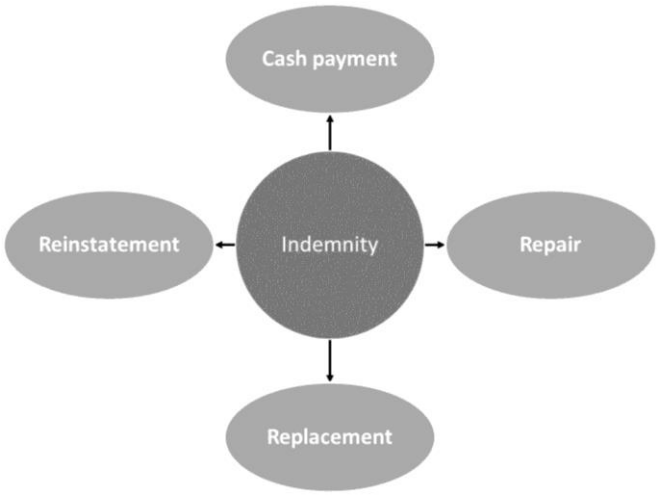
The measurement of indemnity to be paid would depend on the type of insurance one takes.

In most types of non-life insurance policies, which deal with insurance of property and liability, the insured is compensated to the extent of actual amount of loss i.e. the amount of money needed to replace lost or damaged property at current market prices less depreciation.

Indemnity might take one or more of the following modes of settlement:

- ✓ Cash payment
- ✓ Repair of a damaged item
- ✓ Replacement of the lost or damaged item
- ✓ Restoration, (Reinstatement) for example, rebuilding a house destroyed by fire

Diagram 1: Indemnity



But, there is some subject matter whose value cannot be easily estimated or ascertained at the time of loss. For instance, it may be difficult to put a price in the case of family heirlooms or rare artefacts. Similarly in marine insurance policies it may be difficult to estimate the extent of loss suffered in a ship accident half way around the world.

In such instances, a principle known as the Agreed Value is adopted. The insurer and insured agree on the value of the property to be insured, at the beginning of the insurance contract. In the event of total loss, the insurer agrees to pay the agreed amount of the policy. This type of policy is known as **"Agreed Value Policy"**.

f) Subrogation

Subrogation follows from the principle of indemnity.

Subrogation means the transfer of all rights and remedies, with respect to the subject matter of insurance, from the insured to the insurer.

It means that if the insured has suffered from loss of property caused due to negligence of a third party and has been paid indemnity by the insurer for that loss, the right to collect damages from the negligent party would lie with the insurer. Note that the amount of damage that can be collected is only to the extent of amount paid by the insurance company.

Important

Subrogation: It is the process an insurance company uses to recover claim amounts paid to a policy holder from a negligent third party.

Subrogation can also be defined as surrender of rights by the insured to an insurance company that has paid a claim against the third party.

Example

Mr. Kishore's household goods were being carried in Sylvain Transport service. They got damaged due to driver's negligence, to the extent of Rs 45000 and the insurer paid an amount of Rs 30000 to Mr. Kishore. The insurer stands subrogated to the extent of only Rs 30000 and can collect that amount from Sylvain Transports.

Suppose, the claim amount is for Rs 45,000/, insured is indemnified by the insurer for Rs 40,000, and the insurer is able to recover under subrogation Rs 45,000/ from Sylvain Transports, then the balance amount of Rs 5000 will have to be given to the insured.

This prevents the insured from collecting twice for the loss - once from the insurance company and then again from the third party. Subrogation arises only in case of contracts of indemnity.

Example

Mr. Suresh dies in an air crash. His family is entitled to collect the full sum assured of Rs 50 lakhs from the insurer who have issued a Personal Accident Policy plus the compensation paid by the airline, say, Rs 15 lakhs.

Test Yourself 1

Which among the following is an example of coercion?

I. Ramesh signs a contract without having knowledge of the fine print
II. Ramesh threatens to kill Mahesh if he does not sign the contract
III. Ramesh uses his professional standing to get Mahesh to sign a contract
IV. Ramesh provides false information to get Mahesh to sign a contract

Test Yourself 2

Which among the following options cannot be insured by Ramesh?

I. Ramesh's house
II. Ramesh's spouse
III. Ramesh's friend
IV. Ramesh's parents

Summary

- Insurance involves a contractual agreement in which the insurer agrees to provide financial protection against specified risks for a price or consideration known as the premium.

- A contract is an agreement between parties, enforceable at law.

- The elements of a valid contract include:

  i. Offer and acceptance
  ii. Consideration,
  iii. Consensus ad-idem,
  iv. Free consent
  v. Capacity of the parties and
  vi. Legality of the object

- The special features of insurance contracts include:

  i. Uberrima fides,
  ii. Insurable interest,
  iii. Proximate cause

Key Terms

1. Offer and acceptance
2. Lawful consideration
3. Consensus ad idem
4. Uberrima fides
5. Material facts
6. Insurable interest
7. Proximate cause

Answers to Test Yourself

Answer 1

The correct option is II.

Ramesh threatening to kill Mahesh if he does not sign the contract is an example of coercion.

Answer 2

The correct option is III.

Ramesh does not have insurable interest in his friend's life and hence cannot insure the same.

Self-Examination Questions

Question 1

Which element of a valid contract deals with premium?

I. Offer and acceptance
II. Consideration
III. Free consent
IV. Capacity of parties to contract

Question 2

_____ relates to inaccurate statements, which are made without any fraudulent intention.

I. Misrepresentation
II. Contribution
III. Offer
IV. Representation

Question 3

_____ involves pressure applied through criminal means.

I. Fraud
II. Undue influence
III. Coercion
IV. Mistake

Question 4

Which among the following is true regarding life insurance contracts?

I. They are verbal contracts not legally enforceable
II. They are verbal which are legally enforceable
III. They are contracts between two parties (insurer and insured) as per requirements of Indian Contract Act, 1872
IV. They are similar to wager contracts

Question 5

Which of the below is not a valid consideration for a contract?

I. Money
II. Property
III. Bribe
IV. Jewellery

Question 6

Which of the below party is not eligible to enter into a life insurance contract?

I. Business owner
II. Minor
III. House wife
IV. Government employee

Question 7

Which of the below action showcases the principle of "Uberrima Fides"?

I. Lying about known medical conditions on an insurance proposal form
II. Not revealing known material facts on an insurance proposal form
III. Disclosing known material facts on an insurance proposal form
IV. Paying premium on time

Question 8

Which of the below is not correct with regards to insurable interest?

I. Father taking out insurance policy on his son
II. Spouses taking out insurance on one another
III. Friends taking out insurance on one another
IV. Employer taking out insurance on employees

Question 9

When is it essential for insurable interest to be present in case of life insurance?

I. At the time of taking out insurance
II. At the time of claim
III. Insurable interest is not required in case of life insurance
IV. Either at time of policy purchase or at the time of claim

Question 10

Find out the proximate cause for death in the following scenario?

Ajay falls off a horse and breaks his back. He lies there in a pool of water and contracts pneumonia. He is admitted to the hospital and dies because of pneumonia.

I. Pneumonia
II. Broken back
III. Falling off a horse
IV. Surgery

Answers to Self-Examination Questions

Answer 1

The correct option is II.

The element of a valid contract deals with premium is consideration.

Answer 2

The correct option is I.

Misrepresentation relates to inaccurate statements, which are made without any fraudulent intention.

Answer 3

The correct option is III.

Coercion involves pressure applied through criminal means.

Answer 4

The correct option is III.

Life insurance contracts are contracts between two parties (insurer and insured) as per requirements of Indian Contract Act, 1872.

Answer 5

The correct option is III.

Bribe is not a valid consideration for a contract.

Answer 6

The correct option is II.

Minors are not eligible to contract a life insurance contract.

Answer 7

The correct option is III.

Disclosing known material facts on an insurance proposal form is in tune with the principle of "Uberrima Fides".

Answer 8

The correct option is III.

Friends cannot take out insurance on one another as there is no insurable interest present.

Answer 9

The correct option is I.

In case of life insurance insurable interest needs to be present at the time of taking out insurance.

Answer 10

The correct option is III.

Falling off the horse is the proximate cause for Ajay's death.

SECTION 2

HEALTH SECTION

CHAPTER 6

INTRODUCTION TO HEALTH INSURANCE

Chapter Introduction

This chapter will tell you about how insurance evolved over time. It will also explain what healthcare is, levels of healthcare and types of healthcare. You will also learn about the healthcare system in India and factors affecting it. Finally, it will explain how health insurance evolved in India and also the various players in the health insurance market in India.

Learning Outcomes

A. What is Healthcare
B. Levels of Healthcare
C. Types of Healthcare
D. Factors affecting health systems in India
E. Evolution of Health Insurance in India
F. Health Insurance Market

After studying this chapter, you should be able to:

1. Understand how insurance evolved.
2. Explain the concept of healthcare and the types and levels of healthcare.
3. Appreciate the factors affecting healthcare in India and the progress made since independence.
4. Discuss the evolution of health insurance in India.
5. Know the health insurance market in India.

A. What is Healthcare

You have heard of the saying "Health is Wealth". Have you ever tried to know what Health actually means? The word 'Health' was derived from the word 'hoelth', which means 'soundness of the body'.

In olden days, health was considered to be a 'Divine Gift' and illness was believed to have been caused due to the sins committed by the concerned person. It was Hippocrates (460 to 370 BC) who came up with the reasons behind illness. According to him, illness is caused due to various factors relating to environment, sanitation, personal hygiene and diets.

The Indian system of Ayurveda which existed many centuries before Hippocrates, considered health as a delicate balance of four fluids: blood, yellow bile, black bile and phlegm and an imbalance of these fluids causes ill health. Susruta, the Father of Indian medicine is even credited with complex surgeries unknown to the West in those times.

Over a period of time, modern medicine has evolved into a complex science and the goal of modern medicine is no longer mere treatment of sickness but includes prevention of disease and promotion of quality of life. A widely accepted definition of health is the one given by World Health Organisation in 1948; it states that "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease". It is to be noted that Indian system of medicine like Ayurveda incorporated such a complete view of health from times immemorial.

Definition

World Health Organisation (WHO): Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.

Determinants of health

It is generally believed that the following factors determine the health of any individual:

a) Lifestyle factors

Lifestyle factors are those which are mostly in the control of the individual concerned e.g. exercising and eating within limits, avoiding worry and the like leading to good health; and bad lifestyles and habits such as smoking, drug abuse, unprotected sex and sedentary life style (with no exercise) etc. leading to diseases such as cancer, aids, hypertension and diabetes, to name a few.

Though the Government plays a critical role in controlling / influencing such behaviour (e.g. punishing people with non-bailable imprisonment who abuse drugs, imposing high taxes on tobacco products etc.), the personal responsibility of an individual plays a deciding role in controlling diseases due to life style factors.

b) Environmental factors

Safe drinking water, sanitation and nutrition are crucial to health, lack of which leads to serious health issues as seen all over the world, especially in developing countries. Communicable diseases like Influenza and Chickenpox etc. are spread due to bad hygiene, diseases like Malaria and Dengue are spread due to bad environmental sanitation, while certain diseases are also caused due to environmental factors e.g. people working in certain manufacturing industries are prone to diseases related to occupational hazards such as Asbestos in workers in asbestos manufacture and also diseases of the lungs in coal miners.

c) Genetic factors

Diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends amongst the population spread across the globe based on race, geographical location and even communities.

It is quite obvious that a country's social and economic progress depends on the health of its people. A healthy population not only provides productive workforce for economic activity but also frees precious resources which is all the more crucial for a developing country like India. At an individual level, ill health can cause loss of livelihood, inability to perform daily essential activities and push people to poverty and even commit suicide.

Thus the world over, governments take measures to provide for health and wellbeing of their people and ensuring access and affordability of healthcare for all citizens. Thus 'spend' on healthcare usually forms a significant part of every country's GDP.

This poses a question as to whether different types of healthcare are required for different situations.

B. Levels of healthcare

Healthcare is nothing but a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. Health care to be effective must be:

- Appropriate to the needs of the people
- Comprehensive
- Adequate
- Easily available
- Affordable

Health status of a person varies from person to person. It is neither feasible nor necessary to make the infrastructure available at same level for all types of health problems. The health care facilities should be based upon the probability of the incidence of disease for the population. For example, a person may get fever, cold, cough, skin allergies etc. many times a year, but the probability of him/her suffering from Hepatitis B is less as compared to cold and cough.

Similarly, the probability of the same person suffering from a critical illness such as heart disease or Cancer is less as compared to Hepatitis B. Hence, the need to set up the healthcare facilities in any area whether a village or a district or a state will be based upon the various health care factors called indicators of that area such as:

- ✓ Size of population
- ✓ Death rate
- ✓ Sickness rate
- ✓ Disability rate
- ✓ Social and mental health of the people
- ✓ General nutritional status of the people
- ✓ Environmental factors such as if it is a mining area or an industrial area
- ✓ The possible health care provider system e.g. heart doctors may not be readily available in a village but may be in a district town
- ✓ How much of the health care system is likely to be used
- ✓ Socio-economic factors such as affordability

Based on the above factors, the government decides upon setting up of centres for primary, secondary and tertiary health care and takes other measures to make appropriate healthcare affordable and accessible to the population.

C. Types of Healthcare

Healthcare is broadly categorized as follows:

1. Primary healthcare

Primary health care refers to the services offered by the doctors, nurses and other small clinics which are contacted first by the patient for any sickness, that is to say that primary healthcare provider is the first point of contact for all patients within a health system.

In developed countries, more attention is paid to primary health care so as to deal with health issues before the same become widespread, complicated and chronic or severe. Primary health care establishments also focus on preventive health care, vaccinations, awareness, medical counselling etc. and refer the patient to the next level of specialists when required.

For example, if a person visits a doctor for fever and the first diagnosis is indicative of Dengue fever, the primary health care provider will prescribe some medicines but also direct the patient to get admitted in a hospital for specialized treatment. For most of the primary care cases, the doctor acts like a 'Family Doctor' where all the members of the family visit the doctor for any minor sickness.

This method also helps the medical practitioner in prescribing for symptoms based on genetic factors and give medical advice appropriately. For example, the doctor will advise a patient with parental diabetic history to be watchful of the lifestyle from young age to avoid diabetes to the extent possible.

At a country level, Primary Health care centres are set up both by Government and private players. Government primary health care centres are established depending upon the population size and are present right up to the village level in some form or the other.

2. Secondary healthcare

Secondary health care refers to the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patient. It includes acute care requiring treatment for a short period for a serious illness, often (but not necessarily) as an in-patient, including Intensive Care services, ambulance facilities, pathology, diagnostic and other relevant medical services.

Most of the times, the patients are referred to the secondary care by primary health care providers / primary physician. In some instances, the secondary care providers also run an 'In-house' Primary healthcare facility in order to provide integrated services.

Mostly, the secondary health care providers are present at the Taluk / Block level depending upon the population size.

3. Tertiary healthcare

Tertiary Health care is specialized consultative healthcare, usually for inpatients and on referral from primary/secondary care providers. The tertiary care providers are present mostly in the state capitals and a few at the district headquarters.

Examples of Tertiary Health care providers are those who have advanced medical facilities and medical professionals, beyond the scope of secondary health care providers e.g. Oncology (cancer treatment), Organ Transplant facilities, High risk pregnancy specialists etc.

It is to be noted that as the level of care increases, the expenses associated with the care also increase. While people may find it relatively easy to pay for the primary care, it becomes difficult for them to spend when it comes to secondary care and much more difficult when it comes to tertiary care. The infrastructure for different levels of care also varies from country to country, rural-urban areas, while socio-economic factors also influence the same.

D. Factors affecting the health systems in India

The Indian health system has had and continues to face many problems and challenges. These, in turn, affect the nature and extent of the healthcare system and the requirement at the individual level and healthcare organization at the structural level. These are discussed below:

1. Demographic or Population related trends

a) India is second largest populated country in the world.

b) This exposes us to the problems associated with population growth.

c) The level of poverty has also had its effect on the people's ability to pay for medical care.

2. Social trends

a) Increase in urbanization or people moving from rural to urban areas has posed challenges in providing healthcare.

b) Health issues in rural areas also remain, mainly due to lack of availability and accessibility to medical facilities as well as affordability.

c) The move to a more sedentary lifestyle with reduced need to exercise oneself has led to newer types of diseases like diabetes and high blood pressure.

3. Life expectancy

a) Life expectancy refers to the expected number of years that a child born today will survive.

b) Life expectancy has increased from 30 years at the time of independence to over 60 years today but does not address the issues related to quality of that longer lifespan.

c) This leads to a new concept of 'healthy life expectancy'.

d) This also requires the creation of infrastructure for 'Geriatric' (old age related) diseases.

E. Evolution of Health Insurance in India

While the government had been busy with its policy decisions on healthcare, it also put in place health insurance schemes. Insurance companies came with their health insurance policies only later. Here is how health insurance developed in India:

a) Employees' State Insurance Scheme

Health Insurance in India formally began with the beginning of the Employees' State Insurance Scheme, introduced vide the ESI Act, 1948, shortly after the country's independence in 1947. This scheme was introduced for blue-collar workers employed in the formal private sector and provides comprehensive health services through a network of its own dispensaries and hospitals.

ESIC (Employees State Insurance Corporation) is the implementing agency which runs its own hospitals and dispensaries and also contracts public/private providers wherever its own facilities are inadequate.

All workers earning wages up to Rs. 21,000 are covered under the contributory scheme wherein employee and employer contribute 1.75% and 4.75% of pay roll respectively; state governments contribute 12.5% of the medical expenses.

The benefits covered include:

a) Free comprehensive healthcare at ESIS facilities

b) Maternity benefit

c) Disability benefit

d) Cash compensation for loss of wages due to sickness and survivorship and

e) Funeral expenses in case of death of worker

It is also supplemented by services purchased from authorized medical attendants and private hospitals. The ESIS covers over 65.5 million beneficiaries as of March 2012.

b) Central Government Health Scheme

The ESIS was soon followed by the Central Government Health Scheme (CGHS), which was introduced in 1954 for the central government employees including pensioners and their family members working in civilian jobs.

It aims to provide comprehensive medical care to employees and their families and is partly funded by the employees and largely by the employer (central government).

The services are provided through CGHS's own dispensaries, polyclinics and empanelled private hospitals.

It covers all systems of medicine, emergency services in allopathic system, free drugs, pathology and radiology, domiciliary visits to seriously ill patients, specialist consultations etc.

The contribution from employees is quite nominal though progressively linked to salary scale – Rs.15 per month to Rs.150 per month.

In 2010, CGHS had a membership base of over 800,000 families representing over 3 million beneficiaries.

c) Commercial health insurance

Commercial health insurance was offered by some of the non-life insurers before as well as after nationalisation of insurance industry. But, as it was mostly loss making for the insurers, in the beginning, it was largely available for corporate clients only and that too for a limited extent.

In 1986, the first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies (these were then the subsidiaries of the General Insurance Corporation of India). This product, **Mediclaim** was introduced to provide coverage for the hospitalisation expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc. It underwent several rounds of revisions as the market evolved, the last being in 2012.

However, even after undergoing several revisions, the hospitalization indemnity-based annual contract continues to be the most popular form of private health insurance in India today, led by the current versions of Mediclaim. So popular is this product that private health insurance products are often termed by many people as 'Mediclaim covers' considering it as a product category rather than a specific product offered by the insurers.

With private players coming into the insurance sector in 2001, health insurance has grown tremendously but there is a large untapped market even today. Considerable variations in covers, exclusions and newer add-on covers have been introduced which will be discussed in later chapters.

Today, more than 300 health insurance products are available in the Indian market.

F. Health Insurance Market

The health insurance market today consists of a number of players some providing the health care facilities called providers, others the insurance services and also various intermediaries. Some form the basic infrastructure while others provide support facilities. Some are in the government sector while others are in the private sector. These are briefly described below:

A. INFRASTRUCTURE:

1. Public health sector

The Public health system operates at the national level, state level, district level and to a limited extent at the village level where, to implement the national health policies in villages, community volunteers have been involved to serve as links between the village community and government infrastructure. These include:

a) The **Anganwadi workers** (1 for every 1,000 population) who are enrolled under the nutrition supplementation programme and the Integrated Child Development Service scheme (ICDS) of Ministry of Human Resource Development.

b) The **Trained Birth Attendants** (TBA) and the **Village Health guides** (an earlier scheme of health departments in states).

c) **ASHA** (Accredited Social Health Activist) volunteers, selected by the community under the NRHM (National Rural Health Mission) programme, who are new, village-level, voluntary health workers trained to serve as health sector's links in the rural areas.

Sub-centres have been established for every 5,000 population (3,000 in hilly, tribal and backward areas) and are manned by a female health worker, also called the Auxiliary Nurse Mid-wife (ANM) and a male health worker.

Primary Health Centres which are referral units for about six sub-centres have been established for every 30,000 population (20,000 in hilly, tribal and backward areas). All PHCs provide outpatient services, and the majority also have four to six in-patient beds. Their staff comprises of one medical officer and 14 para-medical workers (which includes a male and a female health assistant, a nurse-midwife, a laboratory technician, a pharmacist and other supporting staff).

Community Health Centres are the first referral units for four PHCs and also provides specialist care. According to the norms each CHC (for every 1 lakh population) should have at least 30 beds, one operation theatre, X-ray machine, labour room and laboratory facilities and should be staffed by at least four specialists i.e. a surgeon, a physician, a gynaecologist and a paediatrician supported by 21 para-medical and other staff.

Rural hospitals have also been set up and these includes the sub-district hospitals called as the sub-divisional / Taluk hospitals / specialty hospitals (estimated to be about 2000 in the country);

Speciality and teaching hospitals are fewer and these include the medical colleges (about 300 in number presently) and other tertiary referral centres. These are mostly in district towns and urban areas but some of them provide very specialized and advanced medical services.

Other agencies belonging to the government, such as hospitals and dispensaries of railways, defence and similar large departments (Ports/ Mines etc.) also play a role in providing health services. However, their services are often restricted to the employees of the concerned organizations and their dependents.

2. Private sector providers

India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary. These range from voluntary, not-for-profit organisations and individuals to for-profit corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks). In India nearly 77% of the allopathic (MBBS and above) doctors are practicing in the private sector. Private health expenditure accounts for more than 75% of all health spending in India. The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level[2].

India also has the largest number of qualified practitioners in other systems of Medicine (Ayurveda/ Siddha/ Unani/ Homeopathy) which is over 7 lakh practitioners. These are located in the public as well as the private sector.

Apart from the for-profit private providers of health care, the NGOs and the voluntary sector have also been engaged in providing health care services to the community.

It is estimated that more than 7,000 voluntary agencies are involved in health-related activities. A large number of secondary and tertiary hospitals are also registered as non-profit societies or trusts, and contribute significantly to provision of inpatient services to insured persons.

3. Pharmaceutical industry

Coming to provider of medicines and health related products, India has a large pharmaceutical industry, which has grown from a Rs 10 crore industry in 1950 to a Rs 55,000 crore business today (including exports). It employs about 5 million people, with manufacturing taking place in over 6000 units.
The central level price regulator for the industry is the **National Pharmaceuticals Pricing Authority (NPPA)**, while the pharma sector is under the Ministry of Chemicals. Only a small number of drugs (76 out of the 500 or so bulk drugs) are under price control, while the remaining drugs and manufacture are under the free-pricing regime, carefully watched by the price regulator. The Drug Controllers of the States manage the field force which oversees quality and pricing of drugs and formulations in their respective areas.

B. INSURANCE PROVIDERS:

Insurance Companies especially in the general insurance sector provide the bulk of the health insurance services. These have been listed earlier. What is most encouraging is the presence of stand-alone health insurance companies - five as on date - with likelihood of a few more coming in to increase the health insurance provider network.

C. INTERMEDIARIES:

A number of people and organizations providing services as part of the insurance industry also form part of the health insurance market. All such intermediaries are governed by IRDA. These include:

1. **Insurance Brokers** who may be individuals or corporates and work independently of insurance companies. They represent the people who want insurance and connect them to insurance companies obtaining best possible insurance covers at best possible premium rates. They also assist the insuring people during times of loss and making insurance claims. Brokers may place insurance business with any insurance company handling such business. They are remunerated by insurance companies by way of insurance commission.

2. **Insurance Agents** are usually individuals but some can be corporate agents too. Unlike brokers, agents cannot place insurance with any insurance company but only with the company for which they have been granted an agency. As per current regulations, an agent can act only on behalf of one general insurance company and one life insurance company one health insurer and one of each of the mono line insurers. at the most. They too are remunerated by insurance companies by way of insurance commission.

3. **Third Party Administrators** are a new type of service providers who came into business since 2001. They are not authorized to sell insurance but provide administrative services to insurance companies.

Once a health insurance policy is sold, the details of the insured persons are shared with a appointed TPA who then prepares the data base and issues health cards to the insured persons. Such health cards enable the insured person to avail cashless medical facilities (treatment without having to pay cash immediately) at hospitals and clinics. Even if the insured person does not use cashless facility, he can pay the bills and seek reimbursement from the appointed TPA. TPAs are funded by the insurance companies for their respective claims and are remunerated by them by way of fees which are a percentage of the premium.

4. **Insurance Web Aggregators** are one of the newest types of service providers to be governed by IRDAI regulations. Through their web site and/or telemarketing, they can solicit insurance business through distance marketing without coming face to face with the prospect and generate leads of interested prospects to insurers with whom they have an agreement. They also display products of such insurance companies for comparison. They may also seek IRDAI authorization to perform telemarketing and outsourcing functions for the insurers such as premium collection through online portal, sending premium reminders and also various types of policy related services. They are remunerated by insurance companies based on the leads converted to business, display of insurance products as well as the outsourcing services performed by them.

5. **Insurance Marketing Firms** are the latest types of intermediaries to be governed by IRDAI. They can perform the following activities by employing individuals licensed to market, distribute and service such products:

   Insurance Selling Activities: To sell by engaging Insurance Sales Persons (ISP) insurance products of two Life, two General and two Health Insurance companies at any point of time, under intimation to the Authority. In respect of general insurance, the IMF is allowed to solicit or procure only retail lines of insurance products as given in the file & use guidelines namely motor, health, personal accident, householders, shopkeepers and such other insurance products approved by the Authority from time to time. Any change in the engagement with the insurance companies can be done only with the prior approval of the Authority and with suitable arrangements for servicing existing policyholders.

   Insurance Servicing Activities: These servicing activities shall be only for those insurance companies with whom they have an agreement for soliciting or procuring insurance products and are enumerated below:
   a. undertaking back office activities of insurers as allowed in the Guidelines on Outsourcing Activities by Insurance Companies issued by the Authority;
   b. becoming approved person of Insurance Repositories;
   c. undertaking survey and loss assessment work by employing on their rolls licensed surveyor & loss assessors;
   d. any other insurance related activity permitted by the Authority from time to time.

Financial Products Distribution: To distribute by engaging Financial Service Executives (FSE) who are individuals licensed to market, distribute and service such other financial products namely:

a. mutual funds of mutual fund companies regulated by SEBI;
b. pension products regulated by PFRDA;
c. other financial products distributed by SEBI licensed Investment Advisors;
d. banking/ financial products of banks/ NBFC regulated by RBI;
e. non-insurance products offered by Department of Posts, Government of India;
f. any other financial product or activity permitted by the Authority from time to time.

D. OTHERS IMPORTANT ORGANIZATIONS

There are a few more entities which form part of the health insurance market and these include:

1. **Insurance Regulatory and Development Authority of India (IRDAI)** which is the Insurance regulator formed by an Act of Parliament which regulates all business and players in the insurance market. It came into being in 2000 and is entrusted with the task of not only regulating but also developing insurance business.

2. **General Insurance and Life Insurance Councils**, who also make recommendations to IRDAI for governing their respective life or general insurance business.

3. **Insurance Information Bureau of India** was promoted in year 2009 by IRDA and is a registered society with a governing council of 20 members mostly from the insurance sector. It collects analyses and creates various sector-level reports for the insurance sector to enable data-based and scientific decision making including pricing and framing of business strategies. It also provides key inputs to the Regulator and the Government to assist them in policymaking. The Bureau has generated many reports, both periodic and one-time, for the benefit of the industry.

   IIB handles the Central Index Server which acts as a nodal point between different Insurance Repositories and helps in de-duplication of demat accounts at the stage of creation of a new account. The Central Index Server also acts as an exchange for transmission/routing of information pertaining to transactions on each policy between an insurer and the insurance repository.

   IIB has already launched its hospital unique ID master programme by enlisting the hospitals in 'the preferred provider network' serving the health insurance sector.

The latest initiative of IIB would be maintaining a health insurance grid connecting TPAs, insurers and hospitals. The aim of the initiative is to help the health insurance sector to come out with a system of insurance claims management with transparency in treatment costs and efficient pricing of health insurance products.

4. **Educational institutions** such as Insurance Institute of India and National Insurance Academy which provide a wide variety of insurance and management related training and a host of private training institutes which provide training to would-be agents

5. **Medical Practitioners** also assist insurance companies and TPAs in assessing health insurance risks of prospective clients during acceptance of risks and also advise insurance companies in case of difficult claims.

6. **Legal entities** such as the Insurance Ombudsman, Consumer courts as well as civil courts also play a role in the health insurance market when it comes to redressal of consumer grievances.

Summary

a) Insurance in some form or other existed many centuries ago but its modern form is only a few centuries old. Insurance in India has passed through many stages with government regulation.

b) Health of its citizens being very important, governments play a major role in creating a suitable healthcare system.

c) Level of healthcare provided depends on many factors relating to a country's population.

d) The three type of healthcare are primary, secondary and tertiary depending on the level of medical attention required. Cost of healthcare rises with each level with tertiary care being the costliest.

e) India has its own peculiar challenges such as population growth and urbanization which require proper healthcare.

f) The government was also the first to come up with schemes for health insurance followed later by commercial insurance by private insurance companies.

g) The health insurance market is made up of many players some providing the infrastructure, with others providing insurance services, intermediaries such as brokers, agents and third party administrators servicing health insurance business and also other regulatory, educational as well as legal entities playing their role.

Key terms

a) Healthcare
b) Commercial insurance
c) Nationalization
d) Primary, Secondary and Tertiary Healthcare
e) Mediclaim
f) Broker
g) Agent
h) Third Party Administrator
i) IRDAI
j) Ombudsman

CHAPTER 7

INSURANCE DOCUMENTATION

Chapter Introduction

In the insurance industry, we deal with a large number of forms, documents etc. This chapter takes us through the various documents and their importance in an insurance contract. It also gives an insight to the exact nature of each form, how to fill it and the reasons for calling specific information.

Learning Outcomes

A. Proposal forms
B. Acceptance of the proposal (underwriting)
C. Prospectus
D. Premium receipt
E. Policy Document
F. Conditions and Warranties
G. Endorsements
H. Interpretation of policies
I. Renewal notice
J. Anti-Money Laundering and 'Know Your Customer Guidelines

After studying this chapter, you should be able to:

a) Explain the contents of proposal form.
b) Describe the importance of Prospectus
c) Explain the premium receipt and Sec 64VB of Insurance Act, 1938
d) Explain terms and wordings in insurance policy document.
e) Discuss policy conditions, warranties and endorsement.
f) Appreciate why endorsements are issued.
g) Understand how policy wordings are seen in courts of law.
h) Appreciate why renewal notices are issued.
i) Know what Money Laundering is and what an agent needs to do regarding Know Your Customer guidelines.

A. Proposal forms

As stated earlier, insurance is a contract which is reduced in writing to a policy. Insurance documentation is not limited to issuance of policies. As there are many intermediaries like brokers and agents who operate between them, it is possible that an insured and his insurer may never meet.

The insurance company comes to know the customer and his/her insurance needs only from the documents that are submitted by the customer. Such documents also help the insurer to understand the risk better. Thus, documentation is required for the purpose of bringing understanding and clarity between insured and insurer. There are certain documents that are customarily used in the insurance business.

The insurance agent, being the person closest to the customer, has to face the customer and clarify all doubts about the documents involved and help him/her in filling them up. Agents should understand the purpose of each document involved and the importance and relevance of information contained in the documents used in insurance.

1. Proposal forms

The first stage of documentation is basically the proposal form through which the insured informs:

- ✓ who he/she is
- ✓ what kind of insurance he/she needs
- ✓ details of what he/she wants to insure and
- ✓ for what period of time

Details would mean the monetary value of the subject matter of insurance and all **material facts** connected with the proposed insurance.

a) Risk assessment by insurer

i. **Proposal form is to be filled in by the proposer** for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide:

- ✓ whether to accept or refuse to grant the insurance and
- ✓ in the event of acceptance of the risk, to determine the rates, terms and conditions of the cover to be granted

Proposal form contains information which are useful for the insurance company to accept the risk offered for insurance. The principle of utmost good faith and the duty of disclosure of material information begin with the proposal form for insurance.

The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the period of insurance and even after the conclusion of the contract.

Example

In the case of Personal Accident policy, If the insured has declared in the proposal form that he does not engage in motor sports or horse riding, he has to ensure that he does not engage himself in such pursuits throughout the policy period. This is a material fact for the insurer who will be accepting the proposal based on these facts and pricing the risk accordingly.

Proposal forms are printed by insurers usually with the insurance company's name, logo, address and the class / type of insurance / product that it is used for. It is customary for insurance companies to add a printed note in the proposal form, though there is no standard format or practice in this regard.

Examples

Some examples of such notes are:

'Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy issued',

'The company will not be on risk until the proposal has been accepted by the Company and full premium paid'.

Declaration in the proposal form: Insurance companies usually add a declaration at the end of the proposal form to be signed by the proposer. This ensures that the insured takes the pain to fill up the form accurately and has understood the facts given therein, so that at the time of a claim there is no scope for disagreements on account of misrepresentation of facts.

This also serves to stress the main principle of utmost good faith and disclosure of all material facts on the part of the insured.

The declaration converts the common law principle of utmost good faith to a contractual duty of utmost good faith.

Standard form of declaration

The IRDAI has specified the format of the standard declaration in the health insurance proposal as under:

1. I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

b) Nature of questions in a proposal form

The number and nature of questions in a proposal form vary according to the class of insurance concerned.

In personal lines like health, personal accident and travel insurance, proposal forms are designed to get information about the proposer's health, way of life and habits, pre-existing health conditions, medical history, hereditary traits, past insurance experience etc.

Elements of a proposal

i. Proposer's name in full

The proposer should be able to identify herself unambiguously. It is important for the insurer to know with whom the contract has been entered, so that the benefits under the policy would be received only by the insured. Establishing identity is important even in cases where someone else may have acquired an interest in the risk insured (like legal heirs in case of death) and have to make a claim.

ii. Proposer's address and contact details

The reasons stated above are applicable for collecting the proposer's address and contact details as well.

iii. Proposer's profession, occupation or business

In some cases like health and personal accident insurance, the proposer's profession, occupation or business are of importance as they could have a material bearing on the risk.

Example

A delivery man of a fast-food restaurant, who has to frequently travel on motor bikes at a high speed to deliver food to his customers, may be more exposed to accidents than the accountant of the same restaurant.

iv. Details and identity of the subject matter of insurance

The proposer is required to clearly state the subject matter that is proposed for insurance.

Example

The proposer is required to state if it is:

i. An overseas travel (by whom, when, to which country, for what purpose) or
ii. A person's health (with person's name, address and identification) etc. depending on the case

v. Sum insured indicates limit of liability of the insurer under the policy and has to be indicated in all proposal forms.

Example

In case of health insurance, it could be the cost of hospital treatment, while for personal accident insurance this could be a fixed amount for loss of life, loss of a limb, or loss of sight due to an accident.

vi. Previous and present insurance

The proposer is required to inform the details about his previous insurances to the insurer. This is to understand his insurance history. In some markets there are systems by which insurers confidentially share data about the insured.

The proposer is also required to state whether any insurer had declined his proposal, imposed special conditions, required an increased premium at renewal or refused to renew or cancelled the policy.

Details of current insurance with any other insurer including the names of the insurers are also required to be disclosed. Especially in property insurance, there is a chance that insured may take policies from different insurers and when a loss happens, claim from more than one insurer. This information is required to ensure that the principle of contribution is applied so that the insured is indemnified and does not gain/profit due to multiple insurance policies for the same risk.

Further, in personal accident insurance an insurer would like to restrict the amount of coverage (sum insured) depending on the sum insured under other PA policies taken by the same insured.

vii. Loss experience

The proposer is asked to declare full details of all losses suffered by him / her, whether or not they were insured. This will give the insurer information about the subject matter of insurance and how the insured has managed the risk in the past. Underwriters can understand the risk better from such answers and decide on conducting medical examination or collecting further details.

viii. Declaration by insured

As the purpose of the proposal form is to provide all material information to the insurers, the form **includes a declaration by the insured that the answers are true and accurate and he agrees that the form shall be the basis of the insurance contract.** Any wrong answer will give the right to insurers to avoid the contract. Other sections common to all proposal forms relate to **signature, date and in some cases, the agent's recommendation.**

ix. Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with, the proposer and incorporate the information in its policy. Where the insurer later claims that the proposer did not disclose any material information or provided misleading or false information on any matter material to the grant of a cover, the burden of proving it falls on the insurer.

It means **the insurance company has a duty to record all the information received even orally, which the agent has to keep in mind by way of follow up.**

Important

Given below are some of the details of proposal form for a health insurance policy:

1. The proposal form incorporates a prospectus which gives details of the cover, such as coverage, exclusions, provisions etc. The prospectus forms part of the proposal form and the proposer has to sign it as having noted its contents.

2. The proposal form collects information relating to the name, address, occupation, date of birth, sex, and relationship of each insured person with the proposer, average monthly income and income tax PAN No., name and address of the Medical Practitioner, his qualifications and registration number. Bank details of the insured are also now a days collected to make payment of claim money directly through bank transfer.

3. In addition, there are questions relating to the medical condition of the insured person. These detailed questions in the form are based on past claims experience and are to achieve proper underwriting of the risk.

4. The insured person is required to state full details if he has suffered from any of the specified diseases in the form.

5. Further, the details of any other illness or disease suffered or accident sustained are called for as follows:

    a. Nature of illness / injury and treatment
    b. Date of first treatment
    c. Name and address of attending Doctor
    d. Whether fully recovered

6. The insured person has to state any additional facts which should be disclosed to insurers and if he has any knowledge of any positive existence or presence of any illness or injury which may require medical attention.

7. The form also includes questions relating to past insurance and claims history and additional present insurance with any other insurer.

8. The special features of the declaration to be signed by the proposer must be noted.

9. The insured person agrees and authorises the insurer to seek medical information from any hospital / medical practitioner who has at any time attended or may attend concerning any illness which affects his physical or mental health.

10. The insured person confirms that he has read the prospectus forming part of the form and is willing to accept the terms and conditions.

11. The declaration includes the usual warranty regarding the truth of the statements and the proposal form as the basis of the contract.

Medical Questionnaire

In case of adverse medical history in the proposal form, the insured person has to complete a detailed questionnaire relating to diseases such as Diabetes, Hypertension, Chest pain or Coronary Insufficiency or Myocardial Infarction.

These have to be supported by a form completed by a consulting physician. This form is scrutinised by company's panel doctor, based on whose opinion, acceptance, exclusion, etc. are decided.

IRDAI has stipulated that a copy of the proposal form and the annexures thereof, have to be attached to the policy document and the same should be sent to the insured for his records.

2. Role of intermediary

The intermediary has a responsibility towards both parties i.e. insured and insurer

An agent or a broker, who acts as the intermediary between the insurance company and the insured has the responsibility to ensure all material information about the risk is provided by the insured to insurer.

IRDAI regulation provides that intermediary has responsibility towards the client.

Important

Duty of an intermediary towards prospect (client)

IRDAI regulation states that "An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest

Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect in a fair manner.

Where, for any reason, the proposal and other connected papers are not filled by the customer, a certificate may be incorporated at the end of proposal form from the customer that the contents of the form and documents have been fully explained to him and that he has fully understood the importance of the proposed contract."

B. Acceptance of the proposal (underwriting)

We have seen that a completed proposal form broadly gives the following information:

- ✓ Details of the insured
- ✓ Details of the subject matter
- ✓ Type of cover required
- ✓ Details of the physical features both positive and negative
- ✓ Previous history of insurance and loss

In the case of a health insurance proposal, the insurer may also refer the prospective customer e.g. above 45 years of age to a doctor and/or for medical check-up. Based on the information available in the proposal and, where medical check-up has been advised, based on the medical report and the recommendation of the doctor, the insurer takes the decision. Sometimes, where the medical history is not satisfactory, an additional questionnaire to get more information is also required to be obtained from the prospective client. The insurer then decides about the rate to be applied to the risk factor and calculates the premium based on various factors, which is then conveyed to the insured.

Proposals are processed by the insurer with speed and efficiency and all decisions thereof are communicated by it in writing within a reasonable period.

Note on Underwriting and processing of proposals

As per IRDAI guidelines, the insurer has to process the proposal within 15 days' time. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect / insured as and when required by way of customer service. This entire process of scrutinizing the proposal and deciding about acceptance is known as underwriting.

Test Yourself 3

As per guidelines, an insurance company has to process an insurance proposal within _____.

I. 7 days
II. 15 days
III. 30 days
IV. 45 days

C. Prospectus

A Prospectus is a document issued by the insurer or on its behalf to the prospective buyers of insurance. It is usually in the form of a brochure or leaflet and serves the purpose of introducing a product to such prospective buyers. Issue of prospectus is governed by the Insurance Act, 1938 as well as by Protection of Policyholders' Interest Regulations 2002 and the Health Insurance Regulations 2016 of the IRDAI.

The prospectus of any insurance product should clearly state the scope of benefits, the extent of insurance cover and explain in a clear manner the warranties, exceptions and conditions of the insurance cover.

The allowable riders (also called Add-on covers) on the product should also be clearly stated with regard to their scope of benefits. Also, the premium related to all the riders put together should not exceed 30% of the premium of the main product.

Other important information which a Prospectus should also disclose includes:

1. Any differences in covers and premium for different age groups or for different entry ages
2. Renewal terms of the policy
3. Terms of cancellation of policy under certain circumstances
4. The details of any discounts or loading applicable under different circumstances
5. The possibility of any revision or modification of the terms of the policy including the premium
6. Any incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer
7. A declaration that all its Health insurance policies are portable which means that these policies can be renewed with any other insurer who offers similar cover with the same benefits he would have enjoyed had he continued with the existing insurer.

Insurers of Health policies usually publish Prospectuses about their Health insurance products. The proposal form in such cases would contain a declaration that the customer has read the Prospectus and agrees to it.

D. Premium receipt

When the premium is paid by the customer to the insurer towards premium, the insurer is bound to issue a receipt. A receipt is also to be issued in case any premium is paid in advance.

Definition

Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance.

1. Payment of Premium in Advance (Section 64 VB of Insurance Act, 1938)

As per Insurance Act, **premium is to be paid in advance, before the start of the insurance cover.** This is an important provision, which ensures that only when the premium is received by the insurance company, a valid insurance contract can be completed and the risk can be assumed by the insurance company. This section is a special feature of non-life insurance industry in India.

Important

a) Section 64 VB of the Insurance Act-1938 provides that no insurer shall assume any risk unless and until the premium is received in advance or is guaranteed to be paid or a deposit is made in advance in the prescribed manner

b) Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with or dispatch by post to the insurer the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.

c) It is also provided that the risk may be assumed only from the date on which the premium has been paid in cash or by cheque.

d) Where the premium is tendered by postal or money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked or the cheque is posted as the case may be.

e) Any refund of premium which may become due to an insured on account of the cancellation of policy or alteration in its terms and conditions or otherwise, shall be paid by the insurer directly to the insured by a crossed or order cheque or by postal / money order and a proper receipt shall be obtained by the insurer from the insured. It is the practice now a days to credit the amount directly to the Insured's bank account. Such refund shall in no case be credited to the account of the agent.

There are exceptions to the above pre-condition payment of premium, provided in the Insurance Rules 58 and 59. One is for payment in instalments in case of policies which run for more than 12 months such as life insurance policies. Others include payment through a bank guarantee in specified cases where the exact premium cannot be ascertained in advance or by debit to a Cash Deposit account maintained by the client with the insurer.

2. Method of payment of premium

Important

The premium to be paid by any person proposing to take an insurance policy or by the policyholder to an insurer may be made in any one or more of the following methods:

a) Cash

b) Any recognised banking negotiable instrument such as cheques, demand drafts, pay order, banker's cheques drawn on any schedule bank in India;

c) Postal money order;

d) Credit or debit cards;

e) Bank guarantee or cash deposit;

f) Internet;

g) E-transfer

h) Direct credits via standing instruction of proposer or the policyholder or the life insured through bank transfers;

i) Any other method or payment as may be approved by the Authority from time to time;

As per IRDAI Regulations, in case the proposer / policyholder opts for premium payment through net banking or credit / debit card, the payment must be made only through net banking account or credit / debit card issued in the name of such proposer / policyholder.

Test Yourself 4

In case the premium payment is made by cheque, then which of the below statement will hold true?

I. The risk may be assumed on the date on which the cheque is posted
II. The risk may be assumed on the date on which the cheque is deposited by the insurance company
III. The risk may be assumed on the date on which the cheque is received by the insurance company
IV. The risk may be assumed on the date on which the cheque is issued by the proposer

E. Policy Document

Policy Document

The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899.

IRDAI Regulations for protecting policy holder's interest specified what

A health insurance policy should contain:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter
b) Full description of the persons or interest insured
c) The sum insured under the policy person and/or peril wise
d) Period of insurance
e) Perils covered and exclusions
f) Any excess / deductible applicable
g) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium
h) Policy terms, conditions and warranties
i) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy
j) The obligations of the insured in relation to the subject-matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances
k) Any special conditions
l) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured
m) The address of the insurer to which all communications in respect of the policy should be sent
n) The details of the riders, if any
o) Details of grievance redressal mechanism and address of ombudsman

Every insurer has to inform and keep (the insured) informed periodically on the requirements to be fulfilled by the insured regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him to enable the insurer to settle a claim early.

Test Yourself 5

No question here

F. Conditions and Warranties

Here, it is important to explain two important terms used in policy wordings. These are called Conditions and Warranties.

1. Conditions

A condition is a provision in an insurance contract which forms the basis of the agreement.

EXAMPLES:

a. One of the standard conditions in most insurance policies states:
If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under the policy or if the loss or damage be occasioned by the wilful act, or with the connivance of the Insured, all benefits under this policy shall be forfeited.

b. The Claim Intimation condition in a Health policy may state:
Claim must be filed within certain days from date of discharge from the Hospital. However, waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

A breach of condition makes the policy voidable at the option of the insurer.

2. Warranties

Warranties are used in an insurance contract to limit the liability of the insurer under certain circumstances. Insurers also include warranties in a policy to reduce the hazard. With a warranty, the insured, undertakes certain obligations that need to be complied within a certain period of time and also during the policy period and the liability of the insurer depends on the insured's compliance with these obligations. Warranties play an essential role in managing and improving the risk.

A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract. Warranty is not a separate document. It is part of the policy document. It is a condition precedent to (which operates prior to other terms of) the contract. It must be observed and complied with strictly and literally, whether it is material to the risk or not.

If a warranty is not fulfilled, the policy becomes voidable at the option of the insurers even when it is clearly established that the breach has not caused or contributed to a particular loss. However, in practice, if the breach of warranty is of a purely technical nature and does not, in any way, contribute to or aggravate the loss, insurers at their discretion may process the claims according to norms and guidelines as per company policy. In such case, losses can be treated as compromise claims and settled usual for a high percentage of the claim but not for 100 percent.

A personal accident policy may have the following warranty:

> It is warranted that not more than five Insured Persons should travel together in the same air conveyance at one time. The warranty may go on to say how the claims would be dealt if there is a breach of this warranty.

Test Yourself 6

Which of the below statement is correct with regards to a warranty?

I. A warranty is a condition which is implied without being stated in the policy
II. A warranty is a condition expressly stated in the policy
III. A warranty is a condition expressly stated in the policy and communicated to the insured separately and not as part of the policy document
IV. If a warranty is breached, the claim can still be paid if it is not material to the risk

G. Endorsements

It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others.

Definition

If certain terms and conditions of the policy need to be changed at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement.

It is attached to the policy and forms part of it. The policy and the endorsement together make up the contract. Endorsements may also be issued during the currency of the policy to record changes / amendments.

Whenever material information changes, the insured has to advice the insurance company who will take note of this and incorporate the same as part of the insurance contract through the endorsement.

Endorsements normally required under a policy relate to:

a) Variations /changes in sum insured

b) Change of insurable interest by way of taking of a loan and mortgaging the policy to a bank.

c) Extension of insurance to cover additional perils / extension of policy period

d) Change in risk, e.g. change of destinations in the case of an overseas travel policy

e) Transfer of property to another location

f) Cancellation of insurance

g) Change in name or address etc.

Specimen Endorsements

For the purpose of illustration, specimen wordings of some endorsements are reproduced below:

Cancellation of policy

At the request of the insured the insurance by this Policy is hereby declared to be cancelled as from <date>. The insurance having been in force for a period over nine months, no refund is due to the Insured.

Extension of cover to additional member in the Policy

At the request of the insured, it is hereby agreed to include Miss. Ratna Mistry, daughter of the insured and aged 5 years with a sum insured of Rs. 3 lakhs in the policy with effect from <date>.

In consideration, thereof an additional premium of Rs…….. is hereby charged to the insured.

Test Yourself 7

If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments through _____.

I. Warranty
II. Endorsement
III. Alteration
IV. Modifications are not possible

H. Interpretation of policies

Contracts of insurance are expressed in writing and the insurance policy wordings are drafted by insurers. These policies have to be interpreted according to certain well-defined rules of construction or interpretation which have been established by various courts. **The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself.** If the policy is issued in an ambiguous manner, it will be interpreted by the courts in favour of the insured and against the insurer on the general principle that the policy was drafted by the insurer.

Policy wordings are understood and interpreted as per the following rules:

a) An express or written condition overrides an implied condition except where there is inconsistency in doing so.

b) In the event of a contradiction in terms between the standard printed policy form and the typed or handwritten parts, the typed or handwritten part is deemed to express the intention of the parties in the particular contract, and their meaning will overrule those of the original printed words.

c) If an endorsement contradicts other parts of the contract the meaning of the endorsement will prevail as it is the later document.

d) Clauses in italics over-ride the ordinary printed wording where they are inconsistent.

e) Clauses printed or typed in the margin of the policy are to be given more importance than the wording within the body of the policy.

f) Clauses attached or pasted to the policy override both marginal clauses and the clauses in the body of the policy.

g) Printed wording is over-ridden by typewritten wording or wording impressed by an inked rubber stamp.

h) Handwriting takes precedence over typed or stamped wording.

i) Finally, the ordinary rules of grammar and punctuation are applied if there is any ambiguity or lack of clarity.

Important

1. Construction of policies

An insurance policy is proof of a commercial contract and the general rules of construction and interpretation adopted by courts apply to insurance contracts as in the case of other contracts.

The principal rule of construction is that the intention of the parties of the contract is most important. That intention must be gathered from the policy document itself and the proposal form, clauses, endorsements, warranties etc. attached to it and forming a part of the contract.

2. Meaning of wordings

The words used are to be construed in their ordinary and popular sense. **The meaning to be used for words is the meaning that the ordinary man in the street would construe.**

On the other hand, **words which have a common business or trade meaning will be construed with that meaning unless the context of the sentence indicates otherwise**. Where words are defined by laws, the meaning of that definition will be used as per laws.

Many words used in insurance policies have been the subject of previous legal decisions which will be ordinarily applied. Again, the decisions of a higher court will be binding on a lower court decision. Technical terms must always be given their technical meaning, unless there is an indication to the contrary.

I. Renewal Notice

Most of the non-life insurance policies are issued on annual basis.

There is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date. However, as a matter of courtesy and healthy business practice, insurers issue a renewal notice in advance of the date of expiry, inviting renewal of the policy. The notice shows all the relevant particulars of the policy such as sum insured, the annual premium, etc. It is also the practice to include a note advising the insured that he should intimate any material alterations in the risk.

The insured's attention is also to be invited to the statutory provision that no risk can be assumed unless the premium is paid in advance.

Test Yourself 8

Which of the below statement is correct with regards to renewal notice?

I. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 30 days before the expiry of the policy
II. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 15 days before the expiry of the policy
III. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 7 days before the expiry of the policy
IV. As per regulations there is no legal obligation on insurers to send a renewal notice to insured before the expiry of the policy

J. Anti-Money Laundering and Know Your Customer Guidelines

Criminals obtain funds through their illegal activities but seek to pass it on as legal money by a process called money laundering.

Money Laundering is the process by which criminals transfer funds to conceal the true origin and ownership of the proceeds of criminal activities. By this process, money can lose its criminal identity and appear valid.

Criminals attempt to use financial services, including banks and insurance, to launder their money. They make transactions by using false identities, for example, by purchasing some form of insurance and then managing to withdraw that money and then disappearing once their purpose is served.

Steps to prevent such attempts at money laundering have been receiving efforts at government levels world-wide, including India.

The legislation of Prevention of Money Laundering Act was enacted by the government in 2002. The Anti-Money Laundering guidelines issued by IRDAI soon after have indicated suitable measures to determine the true identity of customers requesting for insurance services, reporting of suspicious transactions and proper record keeping of cases involving or suspected of involving money laundering.

According to the Know Your Customer guidelines, every customer needs to be properly identified by collection of the following documents:

1. Address verification
2. Recent photograph
3. Financial status
4. Purpose of insurance contract

The agent is therefore required to collect documents at the time of bringing in business to establish the identity of customers:

1. In case of Individuals - Collect full name, address, contact numbers of insured with ID and address proof, PAN number and full bank details for NEFT purposes
2. In case of corporates - collect Certificate of Incorporation, Memorandum and Articles of Association, Power of Attorney to transact the business, copy of PAN card
3. In case of Partnership firms - Collect Registration certificate (if registered), Partnership deed, Power of Attorney granted to a partner or an employee of the firm to transact business on its behalf, Proof of identity of such person
4. In case of Trusts and foundations - similar to that of partnership

It is important to note here that such information also helps in cross-selling of products and is a helpful marketing tool.

Summary

a) The first stage of documentation is the proposal form through which the insured informs about herself and what insurance she needs

b) The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the policy period

c) Insurance companies usually add a declaration at the end of the Proposal form to be signed by the proposer.

d) Elements of a proposal form usually include:

   i. Proposer's name in full
   ii. Proposer's address and contact details
   iii. Bank details in case of health policies
   iv. Proposer's profession, occupation or business
   v. Details and identity of the subject matter of insurance
   vi. Sum insured
   vii. Previous and present insurance
   viii. Loss experience
   ix. Declaration by the insured

e) An agent, who acts as the intermediary, has the responsibility to ensure all material information about the risk is provided by the insured to insurer.

f) The process of scrutinising the proposal and deciding about acceptance is known as underwriting.

g) In health policies, a Prospectus is also provided to the insured and he has to declare in the proposal that he has read and understood it

h) Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance.

i) Payment of premium can be made by cash, any recognised banking negotiable instrument, postal money order, credit or debit card, internet, e-transfer, direct credit or any other method approved by authority from time to time.

j) A certificate of insurance provides proof of insurance in cases where it may be required

k) The policy is a formal document which provides an evidence of the contract of insurance.

l) A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract.

m) If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement.

n) The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself.

o) Money Laundering means converting money obtained through criminal means to legal money and laws to fight this have been introduced worldwide and in India

p) An agent has a responsibility to follow the Know Your Customer guidelines and obtain documents as required by these guidelines.

Key Terms

a) Policy form
b) Advance payment of premium
c) Certificate of Insurance
d) Renewal notice
e) Warranty
f) Condition
g) Endorsement
h) Money Laundering
i) Know Your Customer

CHAPTER 8

HEALTH INSURANCE PRODUCTS

Chapter Introduction

This chapter will give you an overall insight into the various health insurance products offered by insurance companies in India. From just one product – Mediclaim to hundreds of products of different kinds, the customer has a wide range to choose appropriate cover. The chapter explains the features of various health products that can cover individuals, family and group.

Learning Outcomes

A. Classification of health insurance products
B. IRDA guidelines on Standardization in health insurance
C. Hospitalization indemnity product
D. Top-up covers or high deductible insurance plans
E. Senior citizen policy
F. Fixed benefit covers – Hospital cash, critical illness
G. Long term care product
H. Combi-products
I. Package policies
J. Micro insurance and health insurance for poorer sections
K. Rashtriya Swasthya Bima Yojana
L. Pradhan Mantri Suraksha Bima Yojana
M. Pradhan Mantri Jan Dhan Yojana
N. Personal accident and disability cover
O. Overseas travel insurance
P. Group health cover
Q. Special products
R. Key terms in health policies

After studying this chapter, you should be able to:

a) Explain the various classes of health insurance
b) Describe the IRDAI guidelines on standardization in health insurance
c) Discuss the various types of health products available in the Indian market today
d) Explain Personal Accident insurance
e) Discuss overseas travel insurance
f) Understand key terms and clauses in health policies

A. Classification of health insurance products

1. Introduction to health insurance products

The Health Insurance Regulations of IRDA define health cover as follows

Definition

"Health insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

Health insurance products available in the Indian market are mostly in the nature of **hospitalization products.** These products cover the expenses incurred by an individual during hospitalization. Again, these types of expenses are very high and mostly beyond the reach of the common man due to increasing cost of healthcare, surgical procedures, new and more expensive technology coming in the market and cost of newer generation of medicines. In fact, it is becoming very difficult for an individual even if he is financially sound to bear such high expenses without any health insurance.

Therefore, health insurance is important mainly for two reasons:

- ✓ **Providing financial assistance to pay for medical facilities** in case of any illness.
- ✓ **Preserving the savings of an individual** which may otherwise be wiped out due to illness.

The first retail health insurance product covering hospitalization costs – Mediclaim - was introduced by the 4 public sector insurers in 1986. These companies also introduced a couple of other covers like Bhavishya Arogya Policy covering proposers at a young age for their post-retirement medical costs, the Overseas Mediclaim policy offering travel insurance and Jana Arogya Bima policy for the poorer people.

Later insurance sector was opened up to the private sector players, which led to many more companies entering including the health insurance market. With that came greater spread of this business, a number of variations in these covers and also a few new covers too.

Today, the health insurance segment has developed to a large extent, with hundreds of products offered by almost all general Insurance companies stand along health insurers and life insurers. However, the basic benefit structure of the Mediclaim policy i.e. cover against hospitalization expenses still remains the most popular form of insurance.

As per Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2016

1. Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.
2. Non-Life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium shall remain unchanged for the tenure.
3. In Order to Facilitate the Offering of Innovative Covers by Insurers, **'Pilot-Products'** may be Designed and Filed for Approval of the Authority, in accordance with the Product-Filing Guide-Lines, Specified by the Authority. Pilot-Products, referred herein, can be offered, Only by General-Insurers and Health-Insurers, for Policy-Tenure of **1 Year**. Every Pilot-Product may be offered Up To a Period, Not Exceeding **5 Years**. After 5 Years of Launch of the Pilot-Product, the Product needs to get converted into a Regular Product, or Based on Valid Reasons, may be Withdrawn, Subject to the Insured, Being Given an Option, to Migrate to Another Product, Subject to the Portability-Conditions. The Authority may specify the Guide-Lines for Pilot-Products, From-Time-To-Time. Where, a Pilot-Product gets converted into a Regular Product, Any Exception made in these Regulations, for Pilot-Products, shall, No Longer Apply; and the Insurer shall Ensure the Compliance with All the Provisions of these Regulations.

Pilot-Product is a Close-Ended Product, with a Policy-Term of **1 Year**, that may be Offered-for-Sale, by General-Insurers or Health-Insurers, for a Period, Not Exceeding **5 Years**, From the Date of Launch of the Product, with a View to Giving a Scope to Innovation, for Covering the Risks, that Have Not Been Offered Hitherto or Stand-Excluded in the Extant-Products.

2. Features of health policies

Health insurance basically deals with sickness and therefore expenses incurred due to sickness. Sometimes, the disease contracted by a person could be chronic or long lasting, lifelong or critical in terms of impact on day to day living activities. Expenses could also be incurred due to accidental injuries or due to disablement arising out of accident.

Various customers with different life styles, paying capacity and health status would have different requirements which need to be considered while designing suitable products to be offered to each customer segment. Customers also desire comprehensive cover while buying health insurance which would cover all their needs. At the same time, to achieve greater acceptability and bigger volume, health insurance products need to be kept affordable, they should also be easy to understand for the customer and also for the sales team to market them.

These are some of the desirable features of health insurance products which the insurance companies try to achieve in different forms for the customer.

3. Broad classification of health insurance products

Whatever be the product design, health insurance products can be broadly classified into 3 categories:

a) Indemnity covers

These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.

b) Fixed benefit covers

Also called as 'hospital cash', these products pay for a fixed sum per day for the period of hospitalization. Some products also have a fixed graded surgery benefit incorporated in the product.

c) Critical illness covers

This is a fixed benefit plan for payout on occurrence of a pre-defined critical illness like heart attack, stroke, cancer etc.

The world over health and disability insurance go together but in India, **personal accident cover** has traditionally been sold independent of health insurance.

Also health insurance usually does not include expenses incurred whilst outside India. For this purpose, another product – **overseas health insurance or travel insurance** - needs to be purchased. Only in recent times, a few high end health insurance products of private insurers include overseas insurance cover as part of regular health insurance cover, subject to certain terms and conditions.

4. Classification based on customer segment

Products are also designed keeping in mind the target customer segment. The benefit structure, pricing, underwriting and marketing for each segment is quite distinct. Products classified based on customer segments are:

a) **Individual cover** offered to retail customers and their family members

b) **Group cover** offered to corporate clients, covering employees and groups, covering their members

c) **Mass policies** for government schemes like RSBY covering very poor sections of the population.

B. **IRDA Guidelines on Standardization in health insurance**

With so many insurers providing numerous varied products and with different definitions of various terms and exclusions, confusion arose in the market. It became difficult for the customer to compare products and for third party administrators to pay claims against products of individual companies. Moreover, in critical illness policies, there was no clear understanding as to what was a critical illness and what was not. Maintaining electronic data for the health insurance industry was also becoming difficult.

To remove the confusion among insurers, service providers, TPAs and hospitals and the grievances of the insuring public, various organizations like IRDA, service providers, hospitals, Health Advisory Committee of the Federation of Chambers of Commerce and Industry got together to provide some kind of standardization in health insurance. Based on a common understanding, IRDA issued Guidelines on standardization in health insurance in 2016.
The guidelines now provide for standardization of:

1. definitions of commonly used insurance terms
2. definitions of critical illnesses
3. list of excluded items of expenses in hospitalization indemnity policies
4. claim forms and pre-authorization forms
5. billing formats
6. discharge summary of hospitals
7. standard contracts between TPAs, insurers and hospitals
8. standard File and Use format for getting IRDAI for new policies

This has been a big step to improve the quality of service of the health providers and the insurance industry and will also help in collection of meaningful health and health insurance data.

C. Hospitalization indemnity product

An indemnity based health insurance policy is the most common and highest sold health insurance product in India. The **Mediclaim policy** introduced in the eighties by the PSU insurers was the earliest standard health product and was the only product available in the market for a long time. Though this product, with a few changes, is marketed by different insurers under different brand names, Mediclaim continues to be the largest selling health insurance in the country.

Hospitalization indemnity products protect individuals from the expenditure they may need to incur in the event of hospitalisation. In most of the cases, they also cover a specific number of days before and after hospitalisation, but exclude any expenses not involving hospitalisation.

Such a cover is provided on an **'indemnity' basis**, that is, by making good part or all of the expenses incurred or amount spent during hospitalisation. This may be contrasted with the insurance coverage on **'benefit' basis**, where the amount that will be paid on the occurrence of a certain event (like hospitalisation, diagnosis of critical illness or each day of admission) is as stated in the insurance policy and is not related to the actual expenditure incurred.

Example

Raghu has a small family consisting of his wife and a 14 year old son. He has taken a Mediclaim policy, covering each member of his family, from a health insurance company, for an individual cover of Rs. 1 lakh each. Each of them could get recovery of medical expenses up to Rs. 1 lakh in case of hospitalisation.

Raghu was hospitalised due to heart attack and required surgery. The medical bill raised was Rs. 1.25 lakhs. The insurance company paid Rs 1 lakh according to the plan coverage and Raghu had to pay the remaining amount of Rs. 25,000 from his own pocket.

The main features of the indemnity based Mediclaim policy are detailed below, **though variations in limits of cover, additional exclusions or benefits or some add-ons may apply to products marketed by each insurer**. The student is advised that the following is only a broad idea about the product and he should acquaint himself with the product of the particular insurer he wishes to know more about. He also **needs to educate himself about some of the medical terms that may be used.**

1. Inpatient hospitalization expenses

An indemnity policy pays the insured the cost of hospitalization expenses incurred on account of illness / accident.

All expenses may not be payable and most products define the expenses covered which normally include:

i. Room, boarding and nursing expenses as provided by the hospital / nursing home. This includes nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges and similar expenses

ii. Intensive Care Unit (ICU) expenses

iii. Surgeon, anesthetist, medical practitioner, consultants, specialists fees

iv. Anesthetic, blood, oxygen, operation theatre charges, surgical appliances,

v. Medicines and drugs,

vi. Dialysis, chemotherapy, radiotherapy

vii. Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents

viii. Relevant laboratory / diagnostic tests and other medical expenses related to the treatment

ix. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured

A regular hospitalization indemnity policy covers expenses only if the duration of stay in hospital is for 24 hours or more. However with advancements in medical technologies, treatment procedures for many surgeries do not require hospitalization. Now as daycare procedures, they can be conducted at specialized daycare centers or hospitals as the case may be. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under daycare surgeries and the list is ever growing. These are also covered under the policy.

Coverage of outpatient expenses is still very limited in India, with very few such products offering OPD covers. However there are some plans that cover treatment as outpatient and also related health care expenses associated with doctor visits, regular medical tests, dental and pharmacy costs.

2. Pre and post hospitalization expenses

i. Pre hospitalization expenses

Hospitalization could be either emergency hospitalization or planned. If a patient goes in for a planned surgery, there would be expenses incurred by him prior to the hospitalization.

Definition

IRDA Health Insurance Standardization guidelines define Pre-hospital expenses as:

Medical expenses incurred immediately before the insured person is hospitalized, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Pre hospitalization expenses could be in the form of tests, medicines, doctors' fees etc. Such expenses relevant and pertaining to the hospitalization are covered under the health policies.

ii. Post hospitalization expenses

After stay in the hospital, in most cases there would be expenses related to recovery and follow-up.

Definition

Medical Expenses incurred immediately after the Insured Person is dischared from hospital, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days after hospitalization and will be considered as part of claim.

Post hospitalization expenses could be in the form of medicines, drugs, review by doctors etc. after discharge from hospital. Such expenses have to be related to the treatment taken in hospital and are covered under the health policies.

Though the duration of cover for pre and post hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for **thirty days pre and sixty days post hospitalization**.

Pre and post-hospitalization expenses form part of the overall sum insured for which cover is granted under the policy.

a) DOMICILIARY HOSPITALIZATION

Although this benefit is not commonly used by policyholders, an individual health policy also has a provision to take care of expenses incurred for medical treatment taken at home without being admitted to a hospital. However, the condition is that though the illness requires attention at a hospital, the condition of the patient is such that he cannot be moved to a hospital or there is lack of accommodation in hospitals.

This cover usually carries an **excess clause of three to five days** meaning that treatment costs for the first three to five days have to be borne by the insured. The cover also excludes domiciliary treatments for certain chronic or common oilments such as Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all type of Dysenteries including Gastroenteritis, Diabetes Mellitus Epilepsy, Hypertension, Influenza, Cough and Cold, fevers.

b) COMMON EXCLUSIONS

Some of the usual exclusions under hospitalization indemnity policies are given below. These are based on the suggested exclusions detailed in the Guidelines on Standardization in Health Insurance issued by IRDAI particularly Annexure IV. The student is advised to acquaint himself with the guidelines available on the IRDAI website.

It must be noted that if any of the exclusions are waived or any additional exclusions are imposed as per File and Use approved terms, these must be stated separately in the Customer Information Sheet and the policy.

1. Pre-existing diseases

This is almost always excluded under individual health plans since otherwise it would mean covering a certainty and poses a high risk to the insurer. One of the important disclosures required at the time of taking a health policy is regarding previous history of ailments / injuries of each insured person covered. This will enable the insurer to decide on accepting the proposal for insurance.

Definition

The IRDA guidelines on standardisation define Pre-existing as
"Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer."

The exclusion is: Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his / her first policy with the company.

2. Weight control programs/ supplies/ services
3. Cost of spectacles/ contact lenses/ hearing aids etc.
4. Dental treatment expenses that do not require hospitalisation
5. Hormone replacement
6. Home visit charges
7. Infertility/ subfertility/ assisted conception procedure
8. Obesity (including morbid obesity) treatment
9. Psychiatric & psychosomatic disorders
10. Corrective surgery for refractive error
11. Treatment of sexually transmitted diseases
12. Donor screening charges
13. Admission/registration charges
14. Hospitalisation for evaluation/ diagnostic purpose
15. Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed
16. Any expenses when the patient is diagnosed with retro virus and/or suffering from HIV/ AIDS etc. is detected directly or indirectly
17. Stem cell implantation/ surgery and storage
18. War and nuclear related causes
19. All non-medical items such as registration charges, admission fees, telephone, television charges, toiletries, etc.
20. A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident.

Example

Mira had taken a health insurance policy for coverage of expenses in the event of hospitalisation. The policy had a clause for initial waiting period of 30 days.

Unfortunately, 20 days after she took the policy, Mira contracted malaria and was hospitalised for 5 days. She had to pay heavy hospital bills.

When she asked for reimbursement from the insurance company, they denied payment of the claim because the event of hospitalization occurred within the waiting period of 30 days from taking the policy.

i. **Waiting periods:** This is applicable for diseases for which typically treatment can be delayed and planned. Depending on the product, waiting periods of one / two / four years apply for diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout and Rheumatism, Calculus Diseases, gout and rheumatism, age related osteoarthritis, osteoporosis.

c) COVERAGE OPTIONS AVAILABLE

i. Individual coverage

An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc. Some insurers do not have a restriction on the dependents who can be covered. It is possible to cover each of such dependent insureds under a single policy with a separate sum insured chosen for each insured person. In such covers, each person insured under the policy can claim upto the maximum amount of his sum insured during the currency of the policy. Premium will be charged for each individual insured according to his age and sum insured chosen and any other rating factor.

ii. Family floater

In the variant known as a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Example

If a floater policy of Rs. 5 lacs is taken for a family of four, it means that during the policy period, it will pay for claims related to more than one family member or multiple claims of a single member of the family. All these together cannot exceed the total coverage of Rs. 5 lacs. Premium will normally be charged based on the age of the oldest member of the family proposed for insurance.

The covers and exclusions under both these policies would be the same. Family floater policies are getting popular in the market as the entire family gets coverage for an overall sum insured which can be chosen at a higher level at a reasonable premium.

d) SPECIAL FEATURES

A number of changes to existing coverages and new value added features have been added to the basic indemnity cover offered under the earlier Mediclaim product. We shall discuss some of these changes. It is to be noted that not all products carry all the below mentioned features, and they may vary from insurer to insurer and product to product.

i. Sub limits and Disease specific capping

Some of the products have disease specific capping e.g. cataract. A few also have sub limits on room rent linked to sum insured e.g. per day room rent restricted to 1% of sum insured and ICU charges to 2% of sum insured. As expenses under other heads such as ICU charges, OT charges and even surgeon's fees are linked to the type of room opted for, room rent capping helps in restricting expenses under other heads also and hence the overall hospitalization expenses.

ii. Co-payment (popularly called Co-pay)

A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

This ensures that the insured exercises caution in selecting his options and thus reduces his overall hospitalization expenses voluntarily.

iii. Deductible

Deductible is a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Insurers are to define whether the deductible is applicable per year, per life or per event and the specific deductible to be applied.

iv. New exclusions have been introduced and later standardized by IRDAI:

- ✓ Genetic disorders and stem cell implantation / surgery.
- ✓ External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, slings, braces, stockings etc. of any kind, diabetic foot wear, glucometer / thermometer and similar related items etc. and also any medical equipment which is subsequently used at home etc.
- ✓ Any kind of Service charges, Surcharges, Admission fees / Registration charges etc. levied by the hospital
- ✓ Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period

v. Zone wise premium

Normally, the premium would depend on the age of the insured person and the sum insured selected. Premium differential has been introduced in certain zones with higher claims cost e.g. Delhi and Mumbai form part of highest premium zone for certain products by some insurers.

vi. Coverage of pre-existing diseases

In view of regulatory requirement, pre-existing diseases which were excluded earlier are specifically mentioned with a waiting period of four years. Few high end products by some insurance companies have reduced the period to 2 and 3 years.

vii. Renewability

Lifelong renewability was introduced by few insurers. Now, this has been made compulsory by IRDAI for all policies.

viii. Coverage for Day care procedure

Advancement of medical science has seen inclusion of large number of procedures under day care category. Earlier only seven procedures were specifically mentioned under daycare - Cataract, D and C, Dialysis, Chemotherapy, Radiotherapy, Lithotripsy and Tonsillectomy. Now, more than 150 procedures are covered and the list keeps growing.

ix. Cost of pre policy check up

Cost of medical examination was earlier borne by prospective clients. Now insurer reimburses the cost, provided the proposal is accepted for underwriting, the reimbursement varying from 50% to 100%. Now this has also been mandated by IRDAI that insurer would bear at least 50% of health checkup expenses.

x. Duration of pre and post hospital cover

Duration of pre and post hospital coverage is extended to 60 days and 90 days by most insurers especially in their high end product. Few insurers have also capped these expenses linked to certain percentage of claim amount, subject to a maximum limit.

xi. Add on covers

Various new additional covers called Add-on covers have been introduced by some of the insurers. Some of them are:

- ✓ **Maternity cover:** Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.

- ✓ **Critical illness cover:** Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.

- ✓ **Reinstatement of sum insured:** After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.

- ✓ **Coverage for AYUSH – Ayurvedic – Yoga - Unani – Siddha – Homeopath:** Few policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

xii. Value added covers

Few indemnity products include value added covers as listed below. The benefits are payable up to the limit of sum insured specified against each cover in the schedule of the policy, not exceeding the overall sum insured.

- ✓ **Outpatient cover:** As we know health insurance products in India mostly cover only in-patient hospitalization expenses. Few companies now offer limited cover for out-patient expenses under some of the high-end plans.

- ✓ **Hospital cash:** This provides for fixed lump sum payment for each day of hospitalization for a specified period. Normally the period is granted for 7 days excluding the policies deductible of 2/3 days. Thus, the benefit would trigger only if hospitalization period is beyond the deductible period. This is in addition to the hospitalization claim but within the overall sum insured of the policy or may be with a separate sub-limit.

- ✓ **Recovery benefit:** Lump sum benefit is paid if the total period of stay in hospital due to sickness and/or accident is not less than 10 days.

- ✓ **Donor's expenses:** The policy provides for reimbursement of expenses towards donor in case of major organ transplant as per the terms and condition defined in the policy.

- ✓ **Reimbursement of ambulance:** Expenses incurred towards ambulance by Insured/insured person are reimbursed up to a certain limit specified in the schedule of the policy.

- ✓ **Expenses for accompanying person:** This is intended to cover the expenses incurred by accompanying person towards food, transportation whilst attending to insured patient during the period of hospitalization. Lump sum payment or reimbursement payment as per the policy terms is paid, up to the limit specified in the schedule of the policy.

- ✓ **Family definition:** Definition of family has undergone changes in few health products.

Earlier, primary insured, spouse, dependent children were granted cover. Now there are policies where parents and in-laws can also be granted cover under the same policy.

D. Top-up covers or high deductible insurance plans

A top-up cover is also known as a high deductible policy. Most people in the international markets buy top-up covers in addition to high co-pay policies or uncovered diseases or treatment. However in India, the key reason for introduction of top-up cover initially seems to be lack of high sum insured products, though the same is no longer the case. The maximum amount of cover under a health policy remained at Rs 5,00,000 for a very long time. Anyone wanting a higher cover was forced to buy two policies paying double the premium. This led to the development of the Top-Up policies by insurers, which offers cover for high sums insured over and above a specified amount (called threshold).

This policy works along with a basic health cover having a low sum insured and comes at a comparatively reasonable premium. For example, Individuals covered by their employers can also opt for a top-up cover for additional protection (keeping the sum insured of the first policy as the threshold). This can be for self and family, which comes in handy in the unfortunate event of high cost treatment.

To be eligible to receive a claim under the top-up policy, the medical costs must be greater than the deductible (or threshold) level chosen under the plan and the reimbursement under the high deductible plan would be the amount of expense incurred i.e. greater than the deductible

Example

An individual is covered for a sum insured of Rs. 3 lacs by his employer. He could opt for a top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

If the cost of a single hospitalization is Rs. 5 lacs, the basic policy would cover up to Rs. three lacs only. With the top-up cover, the balance sum of Rs. two lacs would be paid out by the top-up policy.

Top-up policies come cheap and the cost of a single Rs. 10 lacs policy would be far higher than the top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

These covers are available on individual basis and family basis. Individual sum insured for each family member covered or a single sum insured floating over the family are offered in the market today.

In case the top-up plan requires the deductible amount to be crossed at every single event of hospitalization, the plan is known as a **Catastrophe based** high deductible plan. This means that to be payable, in the example given above, each and every claim must cross Rs. 3 lacs

However top-up plans that allow the deductible to be crossed post a series of hospitalizations during the policy period are known as **Aggregate based** high deductible plans **or Super top-up** cover as known in the Indian market. This means that, in the example given above, each and every claim is added and when this crosses Rs. 3 lacs, the Top-up cover would start paying claims.

Most of the standard terms, conditions and exclusions of a hospital indemnity policy apply to these products. In some markets, where basic health cover is provided by the Government, insurers mostly deal only with granting the Top-Up covers.

E. Senior citizen policy

These plans are designed to offer cover to elderly people who often were denied coverage after certain age (e.g. people over 60 years of age). The structure of the coverage and exclusions are much like a hospitalization policy.

Special attention is paid to diseases of the elderly in setting coverage and waiting period. Entry age is mostly after 60 years and renewable lifelong. Sum insured range from Rs. 50,000 to Rs. 5,00,000. There is variation of waiting period applicable to certain ailments. Example: Cataract may have 1 year waiting for one insurer and 2 year waiting period for some other insurer.

Also certain ailments may not have waiting period for a particular insurer where as another may have. Example: Sinusitis does not fall in waiting period clause of some insurers but few others include it in their waiting period clause.

Pre-existing disease has either a waiting period or capping in some policies. Pre-post hospital expenses are either paid as a percentage of hospital claims or a sub limit whichever is higher. In some policies they follow the typical indemnity plans such as expenses falling within specified period of 30/60 days or 60/90 days.

IRDAI has mandated special provisions for insured persons who are Senior Citizens:

1. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront.
2. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
3. All health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

F. Fixed benefit covers - Hospital cash, critical illness

The greatest risk to an insurer in a health insurance policy is unnecessary and unreasonable use of the policy benefits. Knowing that the patient is covered under a health policy, doctors, surgeons and hospitals tend to over treat him. They prolong the length of stay in the hospital, carry out unnecessary diagnostic and laboratory tests and thus inflate the cost of treatment beyond the necessary amount. Another major impact on insurer's costs is the constant rise in medical costs, usually higher than the increase in premium rates.

The answer to this is the Fixed Benefit cover. While providing adequate protection to the insured persons, the fixed benefits cover also help the insurer to effectively price his policy for a reasonable duration. In this product, commonly occurring treatments are listed under each system such as ENT, Ophthalmology, Obstetrics and Gynaecology, etc. and the maximum pay out for each of these is spelt out in the policy.

The insured also gets a fixed sum as claim amount irrespective of the amount spent by him for the named treatment. The package charges payable for each of these treatments is generally based on a study of the reasonable cost that would be needed for treating the condition.

The package charges would include all components of the cost such as:

a) Room rent,
b) Professional fees,
c) Diagnostics,
d) Drugs,
e) Pre and post hospitalization expenses etc.

The package charges could even include diet, transport, ambulance charges etc. depending on the product.

These policies are simple to administer as only proof of hospitalization and coverage of ailment under the policy are sufficient to process the claim.

Some products package a daily cash benefit along with the fixed benefit cover. The list of treatments covered could vary from around 75 to about 200 depending on the definitions of the treatments in the product.

A provision is made to pay a fixed sum for surgeries / treatment which do not find a place in the list named in the policy. Multiple claims for different treatments are possible during the policy period. However the claims are finally limited by the sum insured chosen under the policy.

Some of the fixed benefit insurance plans are:

- ✓ Hospital daily cash insurance plans
- ✓ Critical illness insurance plans

1. HOSPITAL DAILY CASH POLICY

a) Per day amount limit

Hospital cash coverage provides a fixed sum to the insured person for each day of hospitalization. Per day cash coverage could vary from (for example) Rs. 1,500 per day to Rs. 5,000 or even more per day. An upper limit is provided on the daily cash payout per illness as well as for the duration of the policy, which is usually an annual policy.

b) Number of payment days

In some of the variants of this policy, the number of days of daily cash allowed is linked to the disease for which treatment is being taken. A detailed list of treatments and duration of stay for each is stipulated which limits the daily cash benefit allowed for each type of procedure/ illness.

c) Standalone cover or add-on cover

The hospital daily cash policy is available as a standalone policy as offered by some insurers while, in other cases, it is an add-on cover to a regular indemnity policy. These policies help the insured to cover incidental expenses as the payout is a fixed sum and not related to the actual cost of treatment. This also allows the payout under the policy to be provided in addition to any cover received under an indemnity based health insurance plan.

d) Supplementary cover

These policies could supplement a regular hospital expenses policy as it is cost effective and provides compensation for incidental expenses and also expenses not payable under the indemnity policy such as exclusions, co-pay etc.

e) Other advantages of the cover

From the insurer's point of view, this plan has several advantages as it is easy to explain to a customer and hence can be sold more easily. It beats medical inflation as a fixed sum per day is paid for the duration of hospitalization whatever may be the actual expense. Also, acceptance of such insurance covers and claims settlements are really simplified.

2. CRITICAL ILLNESS POLICY

This product is also known as the **dreaded disease cover** or a **trauma care cover.**

With advancement in medical science, people are surviving some of the major diseases like cancer, strokes and heart attack etc. which in earlier times would have resulted in death. Again, life expectancy has increased considerably after surviving such major illnesses. However surviving a major illness entails huge expense for treatment as well as for living expenses post treatment. Thus onset of critical illness threatens financial security of a person

a) Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.

b) It is sold:
   - ✓ As a standalone policy or
   - ✓ As an add-on cover to a few health policies or
   - ✓ As an add-on cover in some life insurance policies

In India, critical illness benefits are most commonly sold by life insurers as riders to life policies and two forms of cover are offered by them – accelerated CI benefit plan and standalone CI benefit plan. Precise definition of the covered illnesses and good underwriting are extremely important when this benefit is sold. To avoid confusion, the definitions of 20 most common critical illnesses have been standardized under IRDA Health Insurance Standardization guidelines. (Please refer to the Annexure at the end).

However, the chance for adverse selection (whereby mostly those people most likely to be affected take this insurance) at issuance stage is quite high and it is important to determine health status of the proposers. Due to lack of sufficient data, currently pricing of critical illness plans is being supported through reinsurers' data.

c) Critical illnesses are major illnesses that could not only lead to very high hospitalization costs, but could also cause disability, loss of limbs, loss of earning etc. and may require prolonged care post hospitalization.

d) A critical illness policy is often recommended to be taken in addition to a hospital indemnity policy, so that the compensation under the policy could help in overcoming the financial burden of a family whose member is affected by such illness.

e) The critical illnesses covered vary across insurers and products, but the common ones include:
   - ✓ Cancers of specified severity
   - ✓ Acute myocardial infarction
   - ✓ Coronary artery surgery
   - ✓ Heart valve replacement
   - ✓ Coma of specified severity
   - ✓ Renal failure
   - ✓ Stroke resulting in permanent symptoms
   - ✓ Major organ / bone marrow transplant
   - ✓ Multiple sclerosis

- ✓ Motor Neuron disease
- ✓ Permanent paralysis of limbs
- ✓ Permanent disability due to major accidents

The list of critical illnesses is not static and keeps evolving. In a few international markets insurers classify conditions into 'core' and 'additional', even covering conditions like Alzheimer's disease. Sometimes 'terminal illness' is also included for coverage though premium would obviously be very high.

f) While most critical illness policies provide for a lump sum payment on diagnosis of illness, there are a few policies which provide hospitalization expenses cover only in the form of reimbursement of expenses. Few products offer combination of both covers i.e. indemnity for in patient hospitalization expenses and lump sum payment upon diagnosis of major diseases named in the policy.

g) Critical illness policies are usually available for persons in the age group of 21 years to 65 years.

h) The sum insured offered under these policies is quite high as the primary reason of such a policy would be to provide for the financial burden of long term care associated with such diseases.

i) Under these policies generally 100% of the sum insured is paid on diagnosis of a critical illness. In some cases compensation could vary from 25% to 100% of sum insured depending on the policy terms and conditions and severity of illness.

j) A standard condition seen in all critical illness policies is the waiting period of 90 days from inception of policy for any benefit to become payable under the policy and the survival clause of 30 days after diagnosis of the illness. The survival clause has been included as this benefit must not be confused with a "death benefit" but more interpreted as a "survival (living) benefit" i.e. the benefit provided to overcome the hardships that may follow a critical illness.

k) Rigorous medical examinations are to be undergone for persons especially over 45 years of age who wish to take the critical illness policy. Standard exclusions are quite similar to those found in health insurance products, failure to seek or follow medical advice, or delaying medical treatment in order to dodge the waiting period is also specifically excluded.

l) The insurer may compensate the insured only once for any one or more of the covered diseases of the policy or offer multiple payouts but up to a certain limited number. The policy terminates, once compensation is paid under the policy in respect of any of the insured person.

m) The critical illness policy is also offered to groups especially corporates who take policies for their employees.

G. Long term care insurance

Today, with increasing life expectancy, the population of aged people in the world is going up. With an ageing population, the world over, long term care insurance is also gaining importance. Elderly people require long term care and also those people suffering from any kind of disability. Long term care means all forms of continuing personal or nursing care for people who are unable to look after themselves without a degree of support and whose health is not going to get better in future.

There are two types of plans for long term care:

a) Pre-funded plans which are purchased by healthy insured to take care of their future medical expenses and

b) Immediate need plans which are purchased by a lump sum premium when the insured is requiring long term care.

The severity of disability (and expected survival period) decides the quantum of benefit. Long term care products are yet to be developed in Indian market.

Bhavishya Arogya policy

The first pre-funded insurance plan was the Bhavishya Arogya policy marketed by the four public sector general insurance companies. Introduced in the year 1990, the policy is basically meant to take care of the healthcare needs of an insured person after his retirement, while he pays premium during his productive life. It is similar to taking a life insurance policy except that it covers future medical expenses rather than death.

a) Deferred Mediclaim

The policy is a sort of deferred or future Mediclaim policy and provides cover similar to the Mediclaim policy. The proposer can join the scheme any time between the age of 25 and 55 years.

b) Retirement age

He can choose a retirement age between 55 and 60 years with a condition that there should be a clear gap of 4 years between the date of joining and the retirement age chosen. The policy retirement age means the age selected by the insured at the time of signing the proposal and specified in the schedule for the purpose of start of benefit under the policy. This age cannot be advanced.

c) Pre-retirement period

The pre-retirement period means the period starting from the date of acceptance of the proposal and ending with the policy retirement age specified in the schedule. During this period the insured shall be paying installment/single premium amount as applicable. The insured has the option of paying either one lump-sum premium or in installments.

d) Withdrawal

In case, the insured dies or wishes to withdraw from the scheme either before the retirement age or after retirement age chosen, then appropriate refund of premium would be allowed subject to no claim having occurred under the policy. There is a provision of grace period of 7 days for payment of premium in the event of satisfactory reason for delay in renewal.

e) Assignment

The scheme provides for assignment.

f) Exclusions

The policy does not have exclusion of pre-existing diseases, 30 days waiting period and first year exclusion for specified diseases as in Mediclaim. Since it is a future Mediclaim policy, this is quite logical.

g) Group insurance variant

Policy can also be availed of on group basis in which case, facility of group discount is available.

H. **Combi-products**

Sometimes, products pertaining to life insurance are combined with health insurance products. This is a good way of promoting more products in a packaged way through two insurers coming together and entering into an understanding.

Health plus Life Combi Products therefore mean products which offer the combination of a life insurance cover of a life insurance company and a health insurance cover offered by non-life and/or standalone health insurance company.

The products are jointly designed by the two insurers and marketed through the distribution channels of both insurers. Obviously, this would entail a tie-up between two companies and as per current guidelines, such tie-up is permitted only between one life insurer and one non-life insurer at any time. A Memorandum of Understanding between such companies must be in place for the way marketing, policy servicing and sharing of common expenses will be carried out and also policy servicing parameters and transmission of premium. Approval of IRDAI for the tie-up may be sought by any one of the insurers. The agreement should be of a long term nature and withdrawal from the tie-up will not be permitted except under exceptional circumstances and to the satisfaction of the IRDAI.

One of the insurance companies may be mutually agreed to act as a lead insurer to play a critical role in facilitating the policy service as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy service. However, the claims and commission payouts are handled by the respective insurers depending on which section of the policy is affected.

'Combi Product' filing shall follow the File and Use guidelines issued from time to time and individually cleared. The premium components of both risks are to be separately identifiable and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, sales literature etc.

The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

Free Look option is available to the insured and is to be applied to the 'Combi Product' as a whole. However, the Health portion of the 'Combi Product' shall entitle its renewability at the option of policyholder from the respective Non-Life/standalone health Insurance Company.

Marketing of Combi Products can be done through Direct marketing channels, Brokers and Composite Individual and Corporate Agents common to both insurers but not through Bank referral arrangements. However, they cannot be intermediaries who are not authorized to market either of the products of either of the insurers.

Specific disclosures have to be made in the proposal and sales literature especially features like there are two insurers involved, that each risk is distinct from the other, who will settle claims, matters relating to renewability of both or only one of the covers at the option of the insured, servicing facilities etc.

The IT system to service this business must be robust and seamless as it means a lot of integration of data between the two insurers and data generation to IRDAI as required.

I. Package policies

Package or umbrella covers give, under a single document, a combination of covers.

For instance in other classes of business, there are covers such as Householder's Policy, Shopkeeper's Policy, Office Package Policy etc. that, under one policy, seek to cover various physical assets including buildings, contents etc. Such policies may also include certain personal lines or liability covers.

Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

In the case of travel insurance, the policy offered is also a package policy covering not only health insurance but also accidental death / disability benefits along with Medical expenses due to illness / accident, Loss of or delay in arrival of checked in baggage, Loss of passport and documents, Third party liability for property / personal damages, Cancellation of trips and even Hijack cover.

J. Micro insurance and health insurance for poorer sections

Micro-insurance products are specifically designed to aim for the protection of low income people from rural and informal sectors. The low income people form a sizable part of our population and usually don't have any health security cover. Therefore, this low value product, with an affordable premium and benefit package, is initiated to help these people to cope with and recover from common risks. Micro insurance is governed by the IRDA Micro Insurance Regulations, 2005.

These products come with a small premium and typically, the sum insured is below Rs.30,000, as required vide the IRDA micro-insurance regulations, 2005. Such covers are mostly taken on a group basis by various community organizations or non-governmental organizations (NGOs) for their members. The IRDA's rural and social sector obligations also require that insurers should sell a defined proportion of their policies as micro-insurance products, to enable wider reach of insurance.

Two policies particularly created by PSUs to cater to the poorer sections of society are described below:

1. Jan Arogya Bima Policy

Following are the features of Jan Arogya Bima Policy:

a. This policy is designed to provide cheap medical insurance to poorer sections of the society.

b. The coverage is along the lines of the individual Mediclaim policy. Cumulative bonus and medical check-up benefits are not included.

c. The policy is available to individuals and family members.

d. The age limit is five to 70 years.

e. Children between the age of three months and five years can be covered provided one or both parents are covered concurrently.

f. The sum insured per insured person is restricted to Rs.5,000 and the premium payable as per the following table.

Table 2.1

Age of the person insured	Upto 46 yrs	46-55	56-65	66-70
Head of the family	70	100	120	140
Spouse	70	100	120	140
Dependent child up to 25 years	50	50	50	50
For family of 2+1 dependent child	190	250	290	330
For family of 2+2 dependent children	240	300	340	380

- Premium qualifies for tax benefit under Section 80D of the Income Tax Act.
- Service tax is not applicable to the policy.

2. Universal Health Insurance Scheme (UHIS)

This policy is available to groups of 100 or more families. In recent times even individual UHIS Policies were made available to the public.

Benefits
Following is the list of benefits of universal health insurance scheme:

- **Medical reimbursement**
  The policy provides reimbursement of hospitalization expenses up to Rs.30,000 to an individual / family subject to the following sub limits.

Table 2.2

Particulars	Limit
Room, boarding expenses	Up to Rs.150/- per day
If admitted in ICU	Up to Rs.300/- per day
Surgeon, Anaesthetist, Consultant, Specialists fees, Nursing expenses	Up to Rs.4,500/- per illness/ injury
Anaesthesia, Blood, Oxygen, OT charges, Medicines, Diagnostic material and X-Ray, Dialysis, Radiotherapy, Chemotherapy, Cost of pacemaker, Artificial limb, etc.	Up to Rs.4,500/- per illness/ injury
Total expenses incurred for any one illness	Up to Rs. 15,000/-

- **Personal accident cover**
  Coverage for death of the earning head of the family (as named in the schedule) due to accident: Rs.25,000/-.

- **Disability cover**
  If the earning head of the family is hospitalised due to an accident / illness compensation of Rs. 50/- per day will be paid per day of hospitalisation up to a maximum of 15 days after a waiting period of three days.
- **Premium**

Table 2.3

Entity	**Premium**
For an individual	Rs.365/- per annum
For a family up to five (including the first three children)	Rs.548/- per annum
For a family up to seven (including the first three children and dependent parents)	Rs.730/- per annum
Premium subsidy for BPL families	For families below the poverty line the Government will provide a premium subsidy.

K. Rashtriya Swasthya Bima Yojana

The government has also launched various health schemes, some of them applicable to particular states. To extend the reach of health benefits to the masses, it has implemented the Rashtriya Swasthya Bima Yojana in association with insurance companies. RSBY has been launched by the Ministry of Labour and Employment, Government of India, to provide health insurance coverage for the below poverty line (BPL) families.

Following are the features of Rashtriya Swasthya Bima Yojana:

a. Total sum insured of Rs. 30,000 per BPL family on a family floater basis.

b. Pre-existing diseases to be covered.

c. Coverage of health services related to hospitalization and services of surgical nature which can be provided on a day-care basis.

d. Cashless coverage of all eligible health services.

e. Provision of smart card.

f. Provision of pre and post hospitalization expenses.

g. Transport allowance of Rs.100/- per visit.

h. The Central and State Government pays the premium to the insurer.

i. Insurers are selected by the State Government on the basis of a competitive bidding.

j. Choice to the beneficiary between public and private hospitals.

k. Premium to be borne by the Central and State governments in the proportion of 3:1. Central Government to contribute a maximum amount of Rs. 565/- per family.

l. Contribution by the State Governments: 25 percent of the annual premium and any additional premium beyond Rs 750.

m. Beneficiary to pay Rs. 30/- per annum as registration fee/ renewal fee.

n. Administrative cost to be borne by the State Government.

o. Cost of smart card additional amount of Rs. 60/- per beneficiary would be available for this purpose.

p. The scheme shall commence operation from the first of the month after the next month from the date of issue of smart card. Thus, if the initial smart cards are issued anytime during the month of February in a particular district, the scheme will commence from 1st of April.

q. The scheme will last for one year till 31st March of next year. This would be the terminal date of the scheme in that particular district. Thus, cards issued during the intervening period will also have the terminal date as 31st March of the following year.

Claim settlement to be done through TPA's mentioned in the schedule or by the insurance company. The settlement is to be made cashless as far as possible through listed hospitals.

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 60 days from the date of last consultation with the hospital.

L. Pradhan Mantri Suraksha Bima Yojana

The recently announced PMSBY covering personal accident death and disability cover insurance has attracted lot of interest and the scheme details are as under:

Scope of coverage: All savings bank account holders in the age 18 to 70 years in participating banks are entitled to join. Participating banks must tie up with any approved non-life insurer who will offer a Master Policy to such bank for the cover. Any person would be eligible to join the scheme through one savings bank account only and if he enrols in more than one bank, he gets no extra benefit and the extra premium paid will stand forfeited. Aadhar would be the primary KYC for the bank account.

Enrollment Modality / Period: The cover shall be for the one year period from 1st June to 31st May for which option to join / pay by auto-debit from the designated savings bank account on the prescribed forms will be required to be given by 31st May of every year, extendable up to 31st August 2015 in the initial year. Initially on launch, the period for joining may be extended by Govt. of India for another three months, i.e. up to 30th of November, 2015.

Joining subsequently on payment of full annual premium may be possible on specified terms. Applicants may give an indefinite / longer option for enrolment / auto-debit, subject to continuation of the scheme with terms as may be revised on the basis of past experience. Individuals who exit the scheme at any point may re-join the scheme in future years through the above modality. New entrants into the eligible category from year to year or currently eligible individuals who did not join earlier shall be able to join in future years while the scheme is continuing.

Benefits under the insurance are as follows:

Table of Benefits	**Sum Insured**
Death	Rs. 2 Lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs. 2 Lakh
Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs. 1 Lakh

Joining and Nomination facility is available by sms, email or personal visit.

Premium: Rs.12/- per annum per member. The premium will be deducted from the account holder's savings bank account through 'auto debit' facility in one instalment on or before 1st June of each annual coverage period.

However, in cases where auto debit takes place after 1st June, the cover shall commence from the first day of the month following the auto debit. Participating banks will deduct the premium amount in the same month when the auto debit option is given, preferably in May of every year, and remit the amount due to the Insurance Company in that month itself.

The premium would be reviewed based on annual claims experience but efforts would be made to ensure that there is no upward revision of premium in the first three years.

Termination of cover: The accident cover for the member shall terminate:

1. On member attaining the age of 70 years (age nearest birth day) or
2. Closure of account with the Bank or insufficiency of balance to keep the insurance in force or
3. In case a member is covered through more than one account, insurance cover will be restricted to one only and the other cover will terminate while the premium shall be forfeited.

If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down. During this period, the risk cover will be suspended and reinstatement of risk cover will be at the sole discretion of Insurance Company.

M. **Pradhan Mantri Jan Dhan Yojana**

This financial inclusion campaign for Indian citizens in Banking Savings & Deposit Accounts, Remittance, Credit, Insurance and Pension in an affordable manner was launched by the Prime Minister of India, Narendra Modi on 28 August 2014 as announced on his first Independence Day speech on 15 August 2014. This scheme has set a world record in bank account opening during any one week. Aimed at including maximum number of people in the banking mainstream

An account can be opened in any bank branch or Business Correspondent (Bank Mitra) outlet. PMJDY accounts are being opened with Zero balance. However, if the account-holder wishes to get cheque book, he/she will have to fulfill minimum balance criteria.

Special Benefits under PMJDY Scheme

1. Interest on deposit.
2. Accidental insurance cover of Rs.1.00 lac
3. No minimum balance required.
4. Life insurance cover of Rs.30,000/-
5. Easy Transfer of money across India
6. Beneficiaries of Government Schemes will get Direct Benefit Transfer in these accounts.
7. After satisfactory operation of the account for 6 months, an overdraft facility will be permitted
8. Access to Pension, insurance products.
9. Accidental Insurance Cover
10. RuPay Debit Card which must be used at least once in 45 days.
11. Overdraft facility upto Rs.5000/- is available in only one account per household, preferably lady of the household.

As on 13th May 2015, a record 15.59 Crore accounts have been opened with a balance in account of Rs. 16,918.91 Crores. Of these, 8.50 Crore accounts have been opened with zero balance.

N. Personal Accident and disability cover

A **Personal Accident (PA) Cover** provides compensation due to death and disability in the event of unforeseen accident. Often these policies provide some form of medical cover along with the accident benefit.

In a PA policy, while the death benefit is payment of 100% of the sum insured, in the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability to weekly compensation for temporary disablement.

Weekly compensation means payment of a fixed sum per week of disablement subject to a maximum limit in terms of number of weeks for which the compensation would be payable.

1. Types of disability covered

Types of disability which are normally covered under the policy are:

i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,

ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.

iii. **Temporary total disability (TTD):** means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

The client has choice to select only death cover or death plus permanent disablement of Or Death plus permanent disablement and also temporary total disablement.

2. Sum insured

Sums insured for PA policies are usually decided on the basis of gross monthly income. Typically, it is 60 times of the gross monthly income. However, some insurers also offer on fixed plan basis without considering the income level. In such policies sum insured for each section of cover varies as per the plan opted.

3. Benefit plan

Being a benefit plan, PA policies do not attract contribution. Thus, if a person has more than one policy with different insurers, in the event of accidental death, PTD or PPD, claims would be paid under all the policies.

4. Scope of cover

These policies are often extended to cover medical expenses, which reimburses the hospitalization and other medical costs incurred following the accident. Today we have health policies which are issued to cover medical/ hospitalization expenses incurred consequent to an accident. Such policies do not cover diseases and their treatment and instead cover only accident related medical costs.

5. Value added benefits

Along with personal accident, many insurers also offer value added benefits like hospital cash on account of hospitalization due to accident, cost of transportation of mortal remains, education benefit for a fixed sum and ambulance charges on the basis of actual or fixed limit whichever is lower.

6. Exclusions

Common exclusions under personal accident cover are:

i. Any existing disability prior to the inception of policy

ii. Death or disability due to mental disorders or any sickness

iii. Directly or indirectly caused by venereal disease, sexually transmitted diseases, AIDS or insanity.

iv. Death or disability caused by radiation, infection, poisoning except where these arise from an accident.

v. Any injury arising or resulting from the Insured or any of his family members committing any breach of law with criminal intent.

vi. Death or disability or Injury due to accidental injury arising out of or directly or indirectly connected with or traceable to war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainments.

vii. In the event the insured person is a victim of culpable homicide, i.e. murder. However, in most policies, in case of murder where the insured is not himself involved in criminal activity, it is treated as an accident and covered under the policy.

viii. Death/Disablement/Hospitalization resulting, directly or indirectly, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.

ix. While the Insured/Insured Person is participating or training for any sport as a professional, serving in any branch of the Military or Armed Forces of any country, whether in peace or war.

x. Intentional self-injury, suicide or attempted suicide (whether sane or insane)

xi. abuse of intoxicants or drugs and alcohol

xii. whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or travelling in any aircraft or balloon other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world

Certain policies also exclude loss arising out of driving any vehicle without a valid driving license.

PA policies are offered to individuals, family and also to groups.

Family Package Cover

Family package cover may be granted on the following pattern:

- **Earning member (Persons Insured) and Spouse, if earning:** Independent capital sum insured for each, as desired, within usual limitations as in individual.

- **Spouse (if not earning member):** usually 50 percent of the capital sum insured of the earning member. This may be limited to a specified upper limit e.g. Rs.1,00,000 or Rs. 3,00,000.

- **Children (between the age of 5 years and 25 years):** usually 25 percent of the capital sum insured of the earning parent subject to a specified upper limit e.g. Rs. 50,000 per child.

Group Personal Accident Policies

Group Personal Accident Policies are usually annual policies only renewal being allowed on anniversary. However, non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

Following are different types of group policies:

- **Employer and Employee relationship**

  These policies are granted to firms, association etc. to cover:

  - Named employees

- Unnamed employees

- **Non Employer-Employee relationship**

  These policies are granted to associations, societies, clubs, etc. to cover:

  - Named members
  - Members not identified by name

  (Note: Employees may be covered separately)

Broken bone policy and compensation for loss of daily activities

This is a specialised PA policy. This policy is designed to provide cover against listed fractures.

i. Fixed benefit or percentage of sum insured mentioned against each fracture is paid at the time of claim.

ii. Quantum of benefit depends on the type of bone covered and nature of fracture sustained.

iii. To illustrate further, compound fracture would have higher percentage of benefit than simple fracture. Again, percentage of benefit for femur bone (thigh bone) would have higher percentage over benefit of finger bone.

iv. The policy also covers fixed benefit defined in the policy for loss of daily activities viz. eating, toileting, dressing, continence (ability to hold urine or stools) or immobility so that insured can take care of cost associated to maintain his/her life.

v. It also covers hospital cash benefit and accidental death cover. Different plans are available with varying sums insured and benefit payout.

O. Overseas travel insurance

1. Need for the policy

An Indian citizen travelling outside India for business, holidays or studies is exposed to the risk of accident, injury and sickness during his stay overseas. The cost of medical care, especially in countries such as USA and Canada, is very high and could cause major financial problems if a person travelling to these countries were to meet with an unfortunate accident/ illness. To protect against such unfortunate events, travel policies or overseas health and accident policies are available.

2. Scope of coverage

Such policies are primarily meant for accident and sickness benefits, but most products available in the market package a range of covers within one product. The covers offered are:

i. Accidental death / disability
ii. Medical expenses due to illness / accident
iii. Loss of checked in baggage
iv. Delay in arrival of checked in baggage
v. Loss of passport and documents
vi. Third party liability for property / personal damages
vii. Cancellation of trips
viii. Hijack cover

3. Types of plans

The popular policies are the Business and Holiday Plans, the Study Plans and the Employment Plans.

4. Who can provide this insurance

Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.

5. Who can take the policy

An Indian citizen travelling abroad on business, holiday or for studies can avail this policy. Employees of Indian employers sent on contracts abroad can also be covered.

6. Sum insured and premiums

The cover is granted in US Dollars and generally varies from USD 100,000 to USD 500,000. For the section covering medical expenses evacuation, repariation, which is the main section. For other sections the S.I. is lower, expect for the liability cover. Premiums can be paid in Indian rupees except in the case of the employment plan where premium has to be paid in dollars. The plans are usually of two types:

- ✓ World-wide excluding USA / Canada
- ✓ World-wide including USA / Canada

Some products provide for cover in Asian countries only, Schengen countries only etc.

1. Corporate frequent travellers plans

This is an annual policy whereby a corporate/employer takes individual policies for its executives who frequently make trips outside India. This cover can also be taken by individuals who fly overseas many times during a year. There are limits on the maximum duration of each trip and also the maximum number of trips that can be availed in a year.

An increasingly popular cover today is an annual declaration policy whereby an advance premium is paid based on the estimated man days of travel in a year by a company's employees.

Declarations are made weekly / fortnightly on the number of days of travel employee wise and premium is adjusted against the advance. Provision is also given for increase in the number of man days during the currency of the policy, as it gets exhausted on payment of additional advance premium.

The above policies are granted only for business and holiday travels.

Common exclusions under the OMP include pre-existing diseases. Persons with existing ailments cannot obtain cover for taking treatment abroad.

The health related claims under these policies are totally cashless wherein each insurer ties up with an international service provider with network in major countries who service the policies abroad.

P. Group health cover

1. GROUP POLICIES

As explained earlier in the chapter a group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals.

Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts.

Features of group policies- Hospitalisation benefit covers.

1. Scope of coverage

The most common form of group health insurance is the policy taken by employers covering employees and their families including dependent spouse, children and parents / parents in law.

2. Tailor-made cover

Group policies are often tailor-made covers to suit the requirements of the group. Thus, in group policies, one will find several standard exclusions of the individual policy being covered under the group policy.

3. Maternity cover

One of the most common extensions in a group policy is the maternity cover. This is now being offered by some insurers under individual policies, but with a waiting period of two to three years. In a group policy, it normally has a waiting period of nine months only and in some cases, even this is waived. Maternity cover would provide for the expenses incurred in hospitalization for delivery of child and includes C- section delivery. This cover is generally restricted to Rs. 25,000 to Rs. 50,000 within the overall sum insured of the family.

4. Child cover

Children are normally covered from the age of three months only in individual health policies. In group policies, coverage is given to babies from day one, sometimes restricted to the maternity cover limit and sometimes extended to include the full sum insured of the family.

5. Pre-existing diseases covered, waiting period waived off

Several exclusions such as the pre-existing disease exclusion, thirty days waiting period, two years waiting period, congenital diseases may be covered in a tailor-made group policy.

6. Premium calculation

The premium charged for a group policy is based on the age profile of the group members, the size of the group and most importantly the claims experience of the group. As the premium varies year on year based on experience, additional covers as mentioned above are freely given to the groups, as it is in the interest of the group policyholder to manage his claims within the premiums paid.

7. Non-employer employee groups

In India, regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking out a group insurance cover. When group policies are given to other than employers, it is important to determine the relation of the group owner to its members.

Example

A bank taking a policy for its saving bank account holders or credit card holders constitutes a homogenous group, whereby a large group is able to benefit by a tailor-made policy designed to suit their requirements.

Here the premium collected from each individual account holder may be quite low, but as a group the premium obtained by the insurer would be substantial and the bank offers a value add to its customers in the form of a superior policy and at better premium rates.

8. Pricing

In group policies, there is provision for discount on premium based on size of the group as also the claims experience of the group. Group insurance reduces the risk of adverse selection, as the entire group is covered in a policy and enables the group holder to bargain for better terms. However, in recent years, this segment has seen high loss ratios, primarily due to underpricing of premium due to competition. While, this has led to some to review of premium and cover by insurers, it is still difficult to declare that the situation has since been corrected.

9. Premium payment

The premiums could be either totally paid by the employer or group owner, but it is usually on a contribution basis by the employees or group members. However it is a single contract with the insurer, with the employer/group owner collecting the premium and paying the premium covering all the members.

10. Add-on benefits

Tailor-made group policies offer covers such as dental care, vision care, and cost of health checkup and sometimes, critical illness cover too at additional premiums or as complimentary benefits.

Notes:

IRDAI has laid down conditions for granting of group accident and health covers. This protects individuals from being misled by fraudsters into joining invalid and money making group policy schemes.

Recently introduced government health insurance schemes and mass products can also be classified as group health covers since the policies are purchased for an entire segment of the population by the government.

Definition

Group definition could be summarized as below:

a) A group should consist of persons with a commonality of purpose, and the group organizer should have the mandate from a majority of the members of the group to arrange insurance on their behalf.

b) No group should be formed with the main purpose of availing insurance.

c) The premium charged and benefits available should be clearly indicated in the group policy issued to individual members.

d) Group discounts should be passed on to individual members and premium charged should not be more than that given to the insurance company.

2. CORPORATE BUFFER OR FLOATER COVER

In most group policies, each family is covered for a defined sum insured, varying from Rs. One lac to five lacs and sometimes more. There arise situations where the sum insured of the family is exhausted, especially in the case of major illness of a family member. In such situations, the buffer cover brings relief, whereby the excess expenses over and above the family sum insured are met from this buffer amount.

In short the buffer cover would have a sum insured varying from Rs. ten lacs to a crore or more. Amounts are drawn from the buffer, once a family's sum insured is exhausted. However this utilization is usually restricted to major illness / critical illness expenses where a single hospitalization exhausts the sum insured.

The amount that could be utilized by each member from this buffer is also capped, often up to the original sum insured. Such buffer covers should be given for medium sized policies and a prudent underwriter would not provide this cover for low sum insured policies.

Q. Special Products

1. Disease covers

In recent years, disease specific covers like cancer, diabetes have been introduced in the Indian market, mostly by life insurance companies. The cover is long term - 5 years to 20 years and a wellness benefit is also included – a regular health check-up paid for by the insurer. There is incentive for better control of factors like blood glucose, LDL, blood pressure etc. in the form of reduced premiums from second year of policy onwards. On the other hand, a higher premium would be chargeable for poor control.

2. Product designed to cover diabetic persons

This policy can be taken by persons between 26 and 65 years and is renewable up to 70 years. Sum Insured ranges from Rs. 50,000 to Rs. 5,00,000. Capping on Room rent is applicable. Product is aimed to cover hospitalization complications of diabetes like diabetic retinopathy (eye), kidney, diabetic foot, kidney transplant including donor expenses.

Test Yourself 9

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for _____ pre-hospitalization.

I. Fifteen days
II. Thirty days
III. Forty Five days
IV. Sixty days

R. Key terms in health policies

1. Network Provider

Network provider refers to a hospital/nursing home/day care center which is under tie-up with an insurer/TPA for providing cashless treatment to insured patients. Insurers / TPAs normally negotiate favourable discounts on charges and fees from such providers who also guarantee a good level of service. Patients are free to go to out-of-network providers but there they are generally charged much higher fees.

2. Preferred provider network (PPN)

An insurer has the option to create a preferred network of hospitals to ensure quality treatment and at best rates. When this group is limited to only a select few by the insurer based on experience, utilization and cost of providing care, then we have what is known as the preferred provider network.

3. Cashless service

Experience has shown that one of the causes of debt is borrowing for treatment of illness. A cashless service enables the insured to avail of the treatment up to the limit of cover without any payment to the hospitals. All that the insured has to do is approach a network hospital and present his medical card as proof of insurance. The insurer facilitates a cashless access to the health service and directly makes payment to the network provider for the admissible amount. However, the insured has to make payment for amounts beyond the policy limits and for expenses not payable as per policy conditions.

4. Third party administrator (TPA)

A major development in the field of health insurance is the introduction of the third party administrator or TPA. Several insurers across the world utilize the services of independent organizations for managing health insurance claims. These agencies are known as the TPAs.

In India, a TPA is engaged by an insurer for provision of health services which includes among other things:

i. Providing an identity card to the policyholder which is proof of his insurance policy and can be used for admission into a hospital
ii. Providing a cashless service at network hospitals
iii. Processing of claims

TPAs are independent entities who are appointed by insurers for processing and finalizing health claims. TPAs service health policyholders starting from issuance of unique identity cards for hospital admissions up to settlement of claims either on cashless basis or reimbursement basis.

Third party administrators were introduced in the year 2001. They are licensed and regulated by IRDAI and mandated to provide health services. The minimum capital and other stipulations to qualify as a TPA are prescribed by IRDAI.

Thus health claims servicing are now outsourced by the insurers to the TPAs, at a remuneration of five-six percent of the premium collected.

Third party administrators enter into an MOU with hospitals or health service providers and ensure that any person who undergoes treatment in the network hospitals is given a cashless service. They are the intermediaries between the insurer(s) and the insured(s), who co-ordinate with the hospitals and finalize health claims.

5. Hospital

A hospital means any institution established for in-patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a) has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
b) has qualified nursing staff under its employment round the clock;
c) has qualified medical practitioner(s) in charge round the clock;
d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
e) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

6. Medical practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. However, insurance companies are free to make a restriction that the registered practitioner should not be the insured or any close family member.

7. Qualified nurse

Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

8. Reasonable and necessary expenses

A health insurance policy always contains this clause as the policy provides for compensation of expenses that would be deemed to be reasonable for treatment of a particular ailment and in a particular geographical area.

A common meaning would be the charges incurred that are medically necessary to treat the condition, does not exceed the usual level of charges for similar treatment in the locality in which it is incurred and does not include charges that would not have been made if no insurance existed.

IRDAI defines Reasonable Charges as the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

This clause provides protection to the insurer against inflation of bills by the provider and also prevents insured from going in for high end hospitals for treatment of common ailments, which could be otherwise done at reasonably low costs.

9. Notice of claim

Every insurance policy provides for immediate intimation of claim and specified time limits for document submission. In health insurance policies, wherever cashless facility is desired by the customer, intimations are given well before the hospitalization. However in cases of reimbursement claims, the insured sometimes does not bother to intimate insurers of the claim and submits the documents after a lapse of several days / months. Delay in submission of bills could lead to inflation of bills, frauds by insured / hospital, etc. It also affects making proper provisions for claims by the insurance company. Hence insurance companies usually insist on immediate intimation of claims. The time limit for submission of claim documents is normally fixed at 15 days from the date of discharge. This enables quick and accurate reporting of claims, and also enables the insurer to carry out investigations wherever required.

IRDA guidelines stipulate that claim intimation/paper submission beyond stipulated time should be considered if there is a justifiable reason for the same.

10. Free health check

In individual health policies, a provision is generally available to give some form of incentive to a claim free policyholder. Many policies provide for reimbursement of the cost of health check-up at the end of four continuous, claim free policy periods. This is normally capped at 1% of the average sum insured of the preceding three years.

11. Cumulative bonus

Another form of encouraging a claim free policyholder is providing a cumulative bonus on the sum insured for every claim free year. This means that the sum insured gets increased on renewal by a fixed percentage say 5% annually and is allowed up to a maximum of 50% for ten claim-free renewals. The insured pays the premium for the original sum insured and enjoys a higher cover.

As per IRDAI guidelines, cumulative bonus can be provided only on indemnity based health insurance policies and not benefit policies (except PA policies). The operation of cumulative bonus should be stated explicitly in the prospectus and the policy document. Moreover, if a claim is made in any particular year, the cumulative bonus accrued can only be reduced at the same rate at which it is accrued.

Example

A person takes a policy for Rs. 3 lacs at a premium of Rs. 5,000. In the second year, in case of no claims in the first year, he gets a sum insured of Rs. 3.15 lacs (5% more than the previous year) at the same premium of Rs. 5,000. This could go up to Rs. 4.5 lacs over a ten year claim free renewal.

12. Malus/ Bonus

Just as there is an incentive to keep the health policy free of claims, the opposite is called a malus. Here, if the claims under a policy are very high, a malus or loading of premium is collected at renewal.

Keeping in view that health policy is a social benefit policy, so far malus is not charged on individual health policies.

However, in case of group policies, the malus is charged by way of loading the overall premium suitably to keep the claim ratio within reasonable limits. On the other hand if experience is good a discount in premium rate is allowed which is turned as Bonus.

13. No claim discount

Some products provide for a discount on premium for every claim free year instead of a bonus on sum insured.

14. Co-payment

Co-payment is the concept of the insured bearing a portion of each and every claim under a health policy. These could be compulsory or voluntary depending on the product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations.

Some products in the market have co-payment clauses in respect of certain diseases only, such as major surgeries, or commonly occurring surgeries, or for persons above a certain age.

15. Deductible / Excess

Also called as excess, in health policies, it is the fixed amount of money the insured is required to pay initially before the claim is paid by insurer, for e.g. if the deductible in a policy is Rs. 10,000, the insured pays first Rs. 10,000 in each insured loss claimed for. To illustrate, if the claim is for Rs. 80,000, the insured bears the first Rs. 10,000 and the insurer pays Rs. 70,000.

Deductible may also be a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer.

16. Room rent restrictions

While several products are open ended with the sum insured being the maximum amount payable in the event of a claim, several products today place a restriction on the category of room that an insured chooses by linking it to the sum insured. Experience shows that all expenses of hospitalization follow the room rent, with higher room rent leading to proportionately higher charges under all heads of expenses. Hence a person with a sum insured of one lac would be entitled to a room of Rs 1,000 per day if the policy has a room rent restriction of 1% of sum insured per day. This clearly indicates that if one prefers luxury treatment at high end hospitals, then the policy too should be purchased for high sums insured at appropriate premium.

17. Renewability clause

The IRDA guidelines on renewability of health insurance policies makes lifetime guaranteed renewal of the health policies compulsory. An insurance company can deny renewal only on the grounds of fraud or misrepresentation or suppression by insured (or on his behalf) either in obtaining insurance or subsequently in relation thereto.

18. Cancellation clause

The cancellation clause is also standardized by regulatory provisions and an insurance company may at any time cancel the policy only on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured.

A minimum of fifteen days' notice in writing by registered A/D to the insured at his last known address is required. Where a policy is cancelled by the insurer, the company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance provided no claim has been paid under the policy.

In the event of cancellation by the insured, premium refund is on short period rates, meaning insured would receive refund of premium for a percentage less than the pro-rata. If a claim is made no refund would be made.

19. Free look in period

If a customer has bought a new insurance policy and received the policy document and then finds that the terms and conditions are not what he wanted, what are his options?

IRDAI has built into its regulations a consumer-friendly provision that takes care this problem. The customer can return it and get a refund subject to the following conditions:

1. This applies only to life insurance policies and to health insurance policies with tenure of at least one year.
2. The customer must exercise this right within 15 days of receiving the policy document
3. He has to communicate the same to the insurer in writing
4. The premium refund will be available only if no claim has been made on the policy and will be adjusted for
    a) proportionate risk premium for the period on cover
    b) expenses incurred by the insurer on medical examination and
    c) stamp duty charges

20. Grace period for renewal

A significant feature of a health insurance policy is maintaining continuity of insurance. As benefits under a policy are maintained only if policies are renewed without break, timely renewal is of great importance.

As per IRDAI guidelines, a 30 days grace period is allowed for renewal of individual health policies.

All continuity benefits are maintained if the policy is renewed within 30 days from expiry of the earlier insurance. Claims, if any, during the break period will not be considered.

Insurers may consider granting a longer grace period for renewal, depending on individual products.

Most of above key clauses, definitions, exclusions have been standardized under Health Regulations and Health Insurance Standardization guidelines issued by IRDA. Students are advised to go through the same and also keep themselves updated on guidelines and circulars issued by IRDA from time to time.

Test Yourself 10

As per IRDA guidelines, a _____ grace period is allowed for renewal of individual health policies.

I. Fifteen days
II. Thirty days
III. Forty Five days
IV. Sixty days

Summary

a) A health insurance policy provides financial protection to the insured person in the event of an unforeseen and sudden accident / illness leading to hospitalization.

b) Health insurance products can be classified on the basis of number of people covered under the policy: individual policy, family floater policy, group policy.

c) A hospitalization expenses policy or Mediclaim reimburses the cost of hospitalization expenses incurred on account of illness / accident.

d) Pre hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days (generally 30 days) prior to hospitalization and will be considered as part of claim.

e) Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days (generally 60 days) after hospitalization and will be considered as part of claim.

f) In a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

g) A hospital daily cash policy provides a fixed sum to the insured person for each day of hospitalization.

h) Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.

i) High Deductible or Top-up Covers offer cover for higher sum insured over and above a specified chosen amount (called threshold or deductible).

j) The fixed benefits cover provides adequate cover to the insured person and also helps the insurer to effectively price his policy

k) A Personal Accident (PA) Cover provides compensation in the form of death and disability benefits due to unforeseen accidents.

l) Out-patient covers provide for medical expenses like dental treatments, vision care expenses, routine medical examinations and tests etc. that do not require hospitalization.

m) A group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals.

n) Corporate Floater or Buffer Cover amount helps meet excess expenses over and above the family sum insured.

o) Overseas Mediclaim / Travel Policies provide cover to an individual against exposure to the risk of accident, injury and sickness during his stay overseas.

p) Corporate Frequent Travelers' Plan is an annual policy whereby a corporate takes individual policies for its executives who frequently make trips outside India.

q) Many terms used in health insurance have been standardized by IRDA by regulation to avoid confusion especially for the insureds.

Answers to Test Yourself

Answer 1

The correct option is II.

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for thirty days pre-hospitalization.

Answer 2

The correct option is I.

As per IRDA guidelines, a 30 days grace period is allowed for renewal of individual health policies.

Self-Examination Questions

Question 1

Which of the below statement is correct with regards to a hospitalization expenses policy?

I. Only hospitalization expenses are covered

II. Hospitalization as well as pre and post hospitalization expenses are covered
III. Hospitalization as well as pre and post hospitalization expenses are covered and a lumpsum amount is paid to the family members in the event of insured's death
IV. Hospitalization expenses are covered from the first year and pre and post hospitalization expenses are covered from the second year if the first year is claim free.

Question 2

Identify which of the below statement is correct?

I. Health insurance deals with morbidity
II. Health insurance deals with mortality
III. Health insurance deals with morbidity as well as mortality
IV. Health insurance neither deals with morbidity or mortality

Question 3

Which of the below statement is correct with regards to cashless service provided in health insurance?

I. It is an environment friendly go-green initiative started by insurance companies to promote electronic payments so that circulation of physical cash notes can be reduced and trees can be saved.
II. Service is provided free of cost to the insured and no cash is to be paid as the payment is made by the Government to the insurance company under a special scheme
III. All payments made by insured have to be made only through internet banking or cards as cash is not accepted by the insurance company
IV. The insured does not pay and the insurance company settles the bill directly with the hospital

Question 4

Identify the correct full form of PPN with regards to hospitals in health insurance.

I. Public Preferred Network
II. Preferred Provider Network
III. Public Private Network
IV. Provider Preferential Network

Question 5

Identify which of the below statement is incorrect?

I. An employer can take a group policy for his employees
II. A bank can take a group policy for its customers
III. A shopkeeper can take a group policy for its customers
IV. A group policy taken by the employer for his employees can be extended to include the family members of the employees

Answers to Self-Examination Questions

Answer 1

The correct option is **II.**

In a hospitalization expenses policy, hospitalization as well as pre and post hospitalization expenses are covered.

Answer 2

The correct option is I.

Health insurance deals with morbidity (rate of incidence of disease).

Answer 3

The correct option is IV.

Under the cashless service, the insured does not pay and the insurance company settles the bill directly with the hospital.

Answer 4

The correct option is II.

PPN stands for Preferred Provider Network.

Answer 5

The correct option is III.

Statements I, II and IV are correct. Statement III is incorrect as a shopkeeper cannot take group insurance for its customers.

CHAPTER 9

HEALTH INSURANCE UNDERWRITING

Chapter Introduction

This chapter aims to provide you detailed knowledge about underwriting in health insurance. Underwriting is a very important aspect of any type of insurance and plays a vital role in issuance of an insurance policy. In this chapter, you will get an understanding about basic principles, tools, methods and process of underwriting. It will also provide you the knowledge about group health insurance underwriting.

Learning Outcomes

A. What is underwriting?
B. Underwriting - Basic concepts
C. File and Use guidelines
D. Other health insurance regulations of IRDAI
E. Basic principles and tools for underwriting
F. Underwriting process
G. Group health insurance
H. Underwriting of Overseas Travel Insurance
I. Underwriting of Personal Accident Insurance

After studying this chapter, you should be able to:

a) Explain what is meant by underwriting
b) Describe the basic concepts of underwriting
c) Explain the principles and the various tools followed by underwriters
d) Appreciate the complete process of underwriting individual health policies
e) Discuss how group health policies are underwritten

Look at this Scenario

Manish aged 48 years, working as a software engineer, decided to take a health insurance policy for himself. He went to an insurance company, where they gave him a proposal form in which he was required to answer a number of questions related to his physical build and health, mental health, pre-existing illnesses, his family health history, habits and so on.

On receipt of his proposal form, he was also required to submit many documents such as identity and age proof, proof of address and previous medical records. Then they told him to undergo a health check-up and some medical tests which frustrated him.

Manish, who considered himself a healthy person and with a good income level, started wondering why such a lengthy process was being followed by the insurance company in his case. Even after going through all this, the insurance company told him that high cholesterol and high BP had been diagnosed in his medical tests, which increased the chances of heart diseases later. Though they offered him a policy, the premium was much higher than what his friend had paid and so he refused to take the policy.

Here, the insurance company was following all these steps as part of their underwriting process. While providing risk coverage, an insurer needs to evaluate risks properly and also to make reasonable profit. If the risk is not assessed properly and there is a claim, it will result in a loss. Moreover, insurers collect premiums on behalf of all insuring persons and have to handle these moneys like a trust.

A. What is underwriting?

1. Underwriting

Insurance companies try to insure people who are expected to pay adequate premium in proportion to the risk they bring to the insurance pool. This process of collecting and analyzing information from a proposer for the risk selection is known as underwriting. On the basis of information collected through this process, they decide whether they want to insure a proposer. If they decide to do so, then at what premium, terms and conditions so as to make a reasonable profit from taking such risk.

Health insurance is based on the concept of morbidity. Here morbidity is defined as the likelihood and risk of a person becoming ill or sick thereby requiring treatment or hospitalization. To a large extent, morbidity is influenced by age (generally being higher in senior citizens than in young adults) and also increases due to various other adverse factors, such as being overweight or underweight, personal history of certain past and present diseases or ailments, personal habits like smoking, current health status and also occupation of the proposer if it is deemed to be hazardous. Conversely, morbidity also decreases due to certain favourable factors like lower age, a healthy lifestyle etc.

Definition

Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted. Thus, it is a process of risk selection and risk pricing.

2. Need for underwriting

Underwriting is the backbone of an insurance company as acceptance of the risk carelessly or for insufficient premiums will lead to insurer's insolvency. On the other hand, being too selective or careful will prevent the insurance company from creating a big pool so as to spread the risk uniformly. It is therefore critical to strike the correct balance between risk and business, thereby being competitive and yet profitable for the organization.

This process of balancing is done by the underwriter, in accordance with the philosophy, policies and risk hunger of the insurance company concerned. The job of the underwriter is to classify the risk and decide the terms of acceptance at a proper price. It is important to note that acceptance of risk is like giving a promise of future claim settlement to the insured.

3. Underwriting – risk assessment

Underwriting is a process of risk selection which is based upon the characteristics of a group or individual. Here based on the degree of the risk, the underwriter decides whether to accept the risk and at what price. Under any circumstances, the process of acceptance has to be done with fairness and on an equitable basis i.e. every similar risk should be classified equally without any prejudice. This classification is normally done through standard acceptance charts whereby every represented risk is quantified and premiums are calculated accordingly.

Although age affects the chance of sickness as well as death, it must be remembered that sickness usually comes much before death and could be frequent. Hence, it is quite logical that the underwriting norms and guidelines are much tighter for health coverage than death coverage.

Example

An individual who is diabetic has a far higher chance of developing a cardiac or kidney complication requiring hospitalization than of death, and also health episodes can happen multiple times during the course of insurance coverage. A life insurance underwriting guideline might rate this individual as an average risk. However, for medical underwriting, he would be rated as a higher risk.

In health insurance, there is a higher focus on medical or health findings than financial or income based underwriting. However, the latter cannot be ignored as there has to be an insurable interest and financial underwriting is important to rule out any adverse selection and ensure continuity in health insurance.

4. Factors which affect chance of illness

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk are as follows:

a) **Age:** Premiums are charged corresponding with age and the degree of risk. For e.g. the morbidity premiums for infants and children are higher than young adults due to increased risk of infections and accidents. Similarly, for adults beyond the age of 45 years, the premiums are higher, as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much higher.

b) **Gender:** Women are exposed to additional risk of morbidity during child bearing period. However, men are more likely to get affected by heart attacks than women or suffer job related accidents than women as they may be more involved in hazardous employment.

c) **Habits:** Consumption of tobacco, alcohol or narcotics in any form has a direct bearing on the morbidity risk.

d) **Occupation:** Extra risk to accidents is possible in certain occupations, e.g. driver, blaster, aviator etc. Likewise, certain occupations may have higher health risks, like an X-Ray machine operator, asbestos industry workers, miners etc.

e) **Family history:** This has greater relevance, as genetic factors influence diseases like asthma, diabetes and certain cancers. This does impact the morbidity and should be taken into consideration while accepting risk.

f) **Build:** Stout, thin or average build may also be linked to morbidity in certain groups.

g) **Past illness or surgery:** It has to be ascertained whether the past illness has any possibility of causing increased physical weakness or even recur and accordingly the policy terms should be decided. For e.g. kidney stones are known to recur and similarly, cataract in one eye increases possibility of cataract in the other eye.

h) **Current health status and other factors or complaints:** This is important to ascertain the degree of risk and insurability and can be established by proper disclosure and medical examination.

i) **Environment and residence:** These also have a bearing on morbidity rates.

Test Yourself 1

Underwriting is the process of _____.

I. Marketing insurance products
II. Collecting premiums from customers
III. Risk selection and risk pricing
IV. Selling various insurance products

B. Underwriting – Basic concepts

1. Underwriting purpose

We begin with examining the purpose of underwriting. There are two purposes

i. To prevent anti-selection that is selection against the insurer
ii. To classify risks and ensure equity among risks

Definition

The term **selection of risks** refers to the process of evaluating each proposal for health insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection (or **adverse selection**) is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance eagerly and to gain in the process.

Example

If insurers were not selective about whom and how they offered insurance, there is a chance that people with serious ailments like diabetes, high BP, heart problems or cancer, who knew that they would soon require hospitalization, would seek to buy health insurance, create losses for the insurer.

In other words, if an insurer did not exercise selection it would be selected against and suffer losses in the process.

2. Equity among risks

Let us now consider equity among risks. The term "Equity" means that applicants who are exposed to similar degrees of risk must be placed in the same premium class. Insurers would like to have some type of standardization to determine the premiums to be charged. Thus people posing average risks should pay similar premium while people who pose higher risks should pay higher premium. They would like standardization to apply to the vast majority of individuals who pose average risks while they could devote more time to decide upon and rate risks which are more risky.

a) Risk classification

To usher equity, the underwriter engages in a process known as **risk classification** i.e. individuals are categorized and assigned to different risk classes depending on the degree of risks they pose. There are four such risk classes.

i. Standard risks

These consist of those people whose anticipated morbidity (chance of falling ill) is average.

ii. Preferred risks

These are the ones whose anticipated morbidity is significantly lower than average and hence could be charged a lower premium.

iii. Substandard risks

These are the ones whose anticipated morbidity is higher than the average, but are still considered to be insurable. They may be accepted for insurance with higher (or extra) premiums or subjected to certain restrictions.

iv. Declined risks

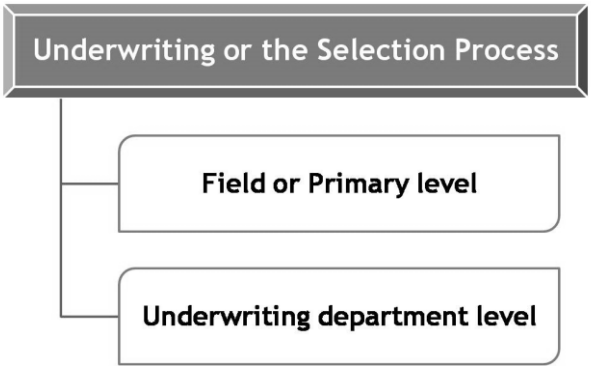
These are the ones whose impairments and anticipated extra morbidity are so great that they could not be provided insurance coverage at an affordable cost. Sometimes an individual's proposal may also be temporarily declined if he or she has been exposed to a recent medical event, like an operation.

3. Selection process

Underwriting or the selection process may be said to take place at two levels:

- ✓ At field level
- ✓ At underwriting department level

Diagram 1: Underwriting or the selection process



a) Field or Primary level

Field level underwriting may also be known as **primary underwriting**. It includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage.

The agent plays a critical role as primary underwriter. He is in the best position to know the prospective client to be insured.

A few insurance companies may require that agents complete a statement or a confidential report, asking for specific information, opinion and recommendations to be provided by the agent with respect to the proposer.

A similar kind of report, which has been called as **Moral Hazard report**, may also be sought from an official of the insurance company. These reports typically cover the occupation, income and financial standing and reputation of the proposed life.

What is Moral Hazard?

While factors like age, gender, habits etc. refer to the physical hazard of a health risk, there is something else that needs to be closely watched. This is the moral hazard of the client which can prove very costly to the insurance company.

An extreme example of bad moral hazard is that of an insured taking health insurance knowing that he will undergo a surgical operation within a short time but not disclosing this to the insurer. There is thus a deliberate intention of taking insurance just to collect a claim.

Indifference towards loss is another example. Because of the existence of insurance, the insured may be tempted to adopt a careless attitude towards his health knowing that any hospitalization would be paid by his insurer.

Another type of hazard called 'morale hazard' is also worthy of mention. Here the insured would not commit any fraud but, knowing that he has a large sum insured, he would prefer to take the most expensive treatment, staying in the most expensive hospital room etc. which he would not have done had he not been insured.

Fraud monitoring and role of agent as primary underwriter

Much of the decision with regard to selection of a risk depends on the facts that have been disclosed by the proposer in the proposal form. It may be difficult for an underwriter who is sitting in the underwriting department to know whether these facts are untrue and have been fraudulently misrepresented with deliberate intent to deceive.

The agent plays a significant role here. He or she is in the best position to ascertain that the facts that have been represented are true, since the agent has direct and personal contact with the proposer and can thus monitor if any willful non-disclosure or misrepresentation has been made with an intent to mislead.

b) Underwriting department level

The second level of underwriting is at the department or office level. It involves specialists and persons who are proficient in such work and who consider all the relevant data on the case to decide whether to accept a proposal for insurance and on what terms.

C. File and Use guidelines

It must be remembered that every insurer has to create it products before marketing them and this is also one of the functions of the underwriting department. The IRDAI has issued guidelines for this which are summarized below:

Every company designs its products keeping in mind the target customers' needs, wants and affordability, underwriting considerations, actuarial pricing, competitive conditions in the market etc. Thus we see high number of options for different categories of customers to choose from even though at the base level, hospitalization expense indemnity products dominate the Indian market.

Every new product needs approval of IRDA before introduction. The product needs to be filed with the Regulator under 'File and Use' provisions as mentioned below. Once introduced, product withdrawal also needs to follow guidelines. Students are advised to familiarize themselves with all provisions, forms, returns etc. related to File and Use guidelines.

File and use procedure for health insurance products as per IRDA guidelines:

a) No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use Procedure.

b) Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.

   1. Any revision or modification in a policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.

   2. The possibility of a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus.

c) The File and Use application form has been standardized by IRDAI and has to be sent along with many annexures including the Database sheet and the Customer Information Sheet.

   The Customer Information Sheet which is to be given to every insured along with the prospectus and the policy contains details of the cover, the exclusions, waiting period if any before claim becomes payable, whether the payout will be on reimbursement basis or a fixed amount, renewal conditions and benefits, details of co-pay or deductible and cancellation conditions etc.

The File and Use application for the prior approval of the Authority shall be certified by the Appointed Actuary and the CEO of the insurance company and shall be in such formats and accompanied by such documentation as may be stipulated by the Authority from time to time.

d) Withdrawal of health insurance product

1. To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing - policyholders.

2. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.

3. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.

4. The withdrawn product shall not be offered to the prospective customers.

e) All particulars of any product shall after introduction be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under File and Use procedure.

f) Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

D. Other Health Insurance regulations of IRDAI

In addition to the File and Use guidelines, the Health Insurance regulations also require the following:

a. All Insurance Company's shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The policy should among other matters prescribe the proposal form in which prospects may apply for purchasing a Health Policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Policy of the Company.
b. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.
c. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.
d. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
e. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document, clearly state the events which will require the submission of such information and the conditions applicable in such event.
f. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use guidelines.

Guidelines regarding portability of health policies

IRDAI has brought out very clear guidelines regarding portability of life and health insurance policies. These are enumerated below:

1. Portability shall be allowed in the following cases:
   a. All individual health insurance policies issued by non-life insurance companies including family floater policies
   b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right for portability at next renewal.

2. Portability can be opted by the policyholder only at renewal and not during currency of the policy.

3. A policyholder wanting to port his policy to another insurance company has to apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of the existing policy.

4. The new insurer may or may not offer portability if policyholder fails to make an application in the IRDAI-prescribed form at least 45 days before the premium renewal date.

5. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to the IRDAI guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.

6. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.

7. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.

8. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.

9. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.

10. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.

11. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

12. Where the outcome of acceptance of portability is still awaited from the new insurer on the date of renewal

a. the existing policy shall be allowed to be extended, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and

b. the existing policy shall not be cancelled until such time a confirmed policy from new insurer is received or at the specific written request of the insured

c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.

d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.

13. In case the policyholder has opted short period extension as stated above and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.

14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.

15. No commission shall be payable to any intermediary on the acceptance of a ported policy.

16. For any health insurance policy, waiting period already elapsed under the existing policy with respect to pre-existing diseases and time bound exclusions shall be taken into account and reduced to that extent under the newly ported policy.

    Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

    Note 2: For group health insurance policies, the individual member's shall be given credit as stated above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

17. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of Rs. 2 lakhs and accrued bonus of Rs. 50,000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs. 2.50 lakhs by charging the premium applicable for Rs. 2.50 lakhs. If insurer B has no product for Rs. 2.50 lakhs, insurer B would offer the nearest higher slab say Rs. 3 lakhs to insured by charging premium applicable for Rs. 3 lakhs SI. However, portability would be available only up to Rs 2.50 lakhs.

18. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

    a. all health insurance policies are portable;

    b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

E. Basic principles of insurance and tools for underwriting

1. Basic principles relevant to underwriting

In any form of insurance, whether it is life insurance or general insurance, there are certain legal principles which operate along with acceptance of risks. Health insurance is equally governed by these principles and any violation of the principles results in the insurer deciding to avoid the liability, much to the dissatisfaction and frustration of the policyholders. These core principles are:

1. Utmost good faith (Uberrima fides) and the insurable interest

2. Tools for underwriting

These are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. The following are the key tools for underwriting:

a) Proposal form

This document is the base of the contract where all the critical information pertaining to the health and personal details of the proposer (i.e. age, occupation, build, habits, health status, income, premium payment details etc.) are collected. This could range from a set of simple questions to a fully detailed questionnaire according to product and the needs/policy of the company, so as to ensure that all material facts are disclosed and the coverage is given accordingly. Any breach or concealment of information by the insured shall render the policy void.

b) Age proof

Premiums are determined on the basis of the age of the insured. Hence it is imperative that the age disclosed at the time of enrollment is verified through submission of an age proof.

Example

In India, there are many documents which can be considered as age proof but all of them are not legally acceptable. Mostly valid documents are divided into two broad categories. They are as follows:

a) Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc.
b) Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.

c) Financial documents

Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard. However, normally the financial documents are only asked for in cases of

a) Personal accident covers or
b) high sum assured coverage or
c) when the stated income and occupation as compared to the coverage sought, show a mismatch.

d) Medical reports

Requirement of medical reports is based on the norms of the insurer, and usually depends upon the age of the insured and sometimes on the amount of cover opted. Some replies in the proposal form may also contain some information that leads to medical reports being asked for.

e) Reports of sales personnel

Sales personnel can also be seen as grassroots level underwriters for the company and the information given by them in their report could form an important consideration. However, as the sales personnel have an incentive to generate more business, there is a conflict of interest which has to be watched out for.

Test Yourself 2

The principle of utmost good faith in underwriting is required to be followed by _____.

I. The insurer
II. The insured
III. Both the insurer and the insured
IV. The medical examiners

Test Yourself 3

Insurable interest refers to _____.

I. Financial interest of the person in the asset to be insured
II. The asset which is already insured
III. Each insurer's share of loss when more than one company covers the same loss
IV. The amount of the loss that can be recovered from the insurer

F. Underwriting process

Once the required information is received, the underwriter decides the terms of the policy. The common forms used for underwriting health insurance business are as below:

1. Medical underwriting

Medical underwriting is a process in which medical reports are called for from the proposer to determine the health status of an individual applying for health insurance policy. The health information collected is then evaluated by the insurers to determine whether to offer coverage, up to what limit and on what conditions and exclusions. Thus medical underwriting can determine the acceptance or declining of a risk and also the terms of cover.

However, medical underwriting involves high costs in terms of receiving and examining medical reports. Also, when insurers use a high degree of medical underwriting, they are blamed for 'cream-skimming' (accepting only the best kind of risk and denying others). It also causes frustration among prospective clients and reduces the number of people willing to insure with those insurers as they do not want to provide the requisite information and detail and to undergo the required tests.

Health status and age are important underwriting considerations for individual health insurance. Also current health status, personal and family medical history enable an underwriter to determine presence of any pre-existing diseases or conditions and eventually the probability of future health problems that may require hospitalization or surgical intervention.

Further proposal forms are designed in a manner to elicit information about past treatments taken, hospitalizations and surgeries undergone. This helps an underwriter to evaluate the possibility of recurrence of an earlier ailment, its impact on current or future health status or future complications. Some diseases for which the proposer is taking medicines only may soon require hospitalization any time soon or recur.

Example

Medical conditions like hypertension, overweight/obesity and raised sugar levels have a high probability of future hospitalization for diseases of the heart, kidney and the nervous system. So, these conditions should be carefully considered while assessing the risk for medical underwriting.

Since adverse changes in health status generally occur post 40 years, mainly due to normal ageing process, insurers do not require any medical examination or tests of the proposer earlier than the age of 45 years (some insurers could raise this requirement to 50 or 55 years too). Medical underwriting guidelines may also require a signed declaration of the proposer's health status by his/her family physician.

In the Indian health insurance market, the key medical underwriting factor for individual health insurance is the age of the person. Persons above the age of 45-50 years, enrolling for the first time are normally required to undergo specified pathological investigations to assess health risk profile and to obtain information on their current health status. Such investigations also provide an indication of prevalence of any pre-existing medical conditions or diseases.

Example

Drugs, alcohol and tobacco consumption may be difficult to detect and seldom declared by the proposer in the proposal form. Non-disclosure of these poses a major challenge in underwriting of health insurance. Obesity is another problem which threatens to become a major public health problem and underwriters need to develop underwriting tools to be able to adequately price the complications arising out of the same.

2. Non-medical underwriting

Most of the proposers which apply for health insurance do not need medical examination. If it could be known with a fair degree of accuracy that only one-tenth or less of such cases will bring the adverse results during medical examination, insurers could dispense with medical examination in majority of the cases.

Even, if the proposer were to disclose all material facts completely and truthfully and the same were checked by agent carefully, then also the need for medical examination could have been much less. In fact, a slight increase in the claims ratio can be accepted if there is savings in the costs of medical checkup and other expenses and also as it will reduce the inconvenience to the proposer.

Therefore, insurance companies are coming up with some medical policies where the proposer is not required to undergo any medical examination. In such cases, companies usually create a 'medical grid' to indicate at what age and stage should a medical underwriting be done, and therefore these non- medical limits are carefully designed so as to strike a proper balance between business and risk.

Example

If an individual has to take health insurance coverage quickly without going through a long process of medical examinations, waiting periods and processing delays, then he can opt for a non-medical underwriting policy. In a non-medical underwriting policy, premium rates and sum assured are usually decided on the basis of answers to a few health questions mostly based on age, gender, smoking class, build etc. The process is speedy but the premiums may be relatively higher.

3. Numerical rating method

This is a process adopted in underwriting, wherein numerical or percentage assessments are made on each component of the risk.

Factors like age, sex, race, occupation, residence, environment, build, habits, family and personal history are examined and scored numerically based on pre-determined criteria.

4. Underwriting decisions

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories. Based on the above tools and his judgment, the underwriter classifies the risk into the following categories:

a) Accept risk at standard rates
b) Accept risk at an extra premium (loading), though it may not be practiced in all companies
c) Postpone the cover for a stipulated period/term
d) Decline the cover
e) Counter offer (either restrict or deny part of the cover)
f) Impose a higher deductible or Co-pay
g) Levy permanent exclusion(s) under the policy

If any illness is permanently excluded, it is endorsed on the policy certificate. This becomes an additional exclusion apart from the standard policy exclusion and shall form the part of the contract.

Expert individual risk assessment by underwriters is vital to insurance companies as it keeps the insurance system in balance. Underwriting enables insurers to group together those with the same level of expected risk and to charge them the same premium for the protection they choose. The benefit for the policyholder is availability of insurance at a fair and competitive price whereas the benefit for an insurer is the ability to maintain the experience of its portfolio in line with the morbidity assumptions.

5. Use of general or standard exclusions

The majority of policies impose exclusions that apply to all their members. These are known as standard exclusions or sometimes referred to as general exclusions. Insurers limit their exposure by the implementation of standard exclusions.

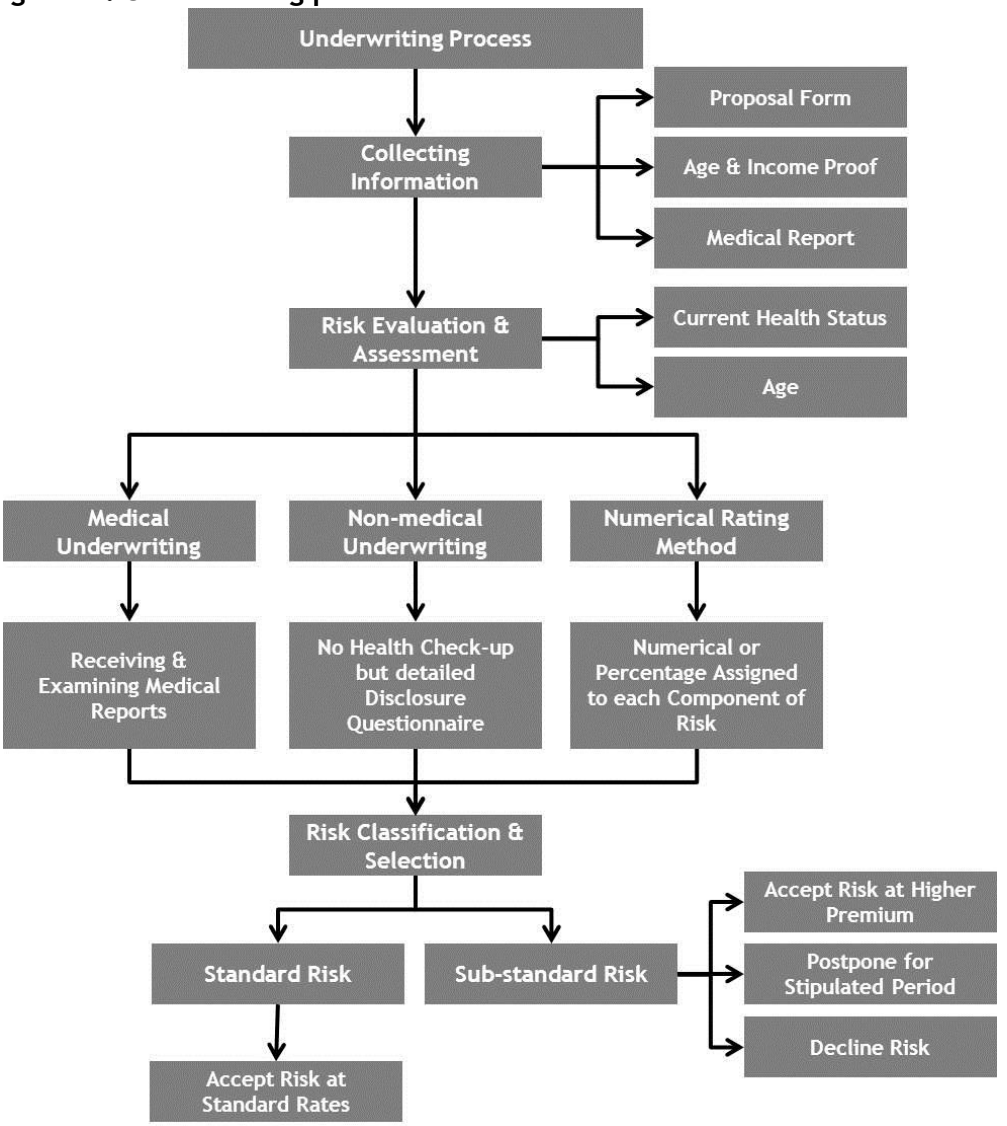
The same have been discussed in earlier chapter.

Test Yourself 4

Which of the following statements about medical underwriting is incorrect?

I. It involves high cost in collecting and assessing medical reports.
II. Current health status and age are the key factors in medical underwriting for health insurance.
III. Proposers have to undergo medical and pathological investigations to assess their health risk profile.
IV. Percentage assessment is made on each component of the risk.

Diagram 1: Underwriting process



G. Group health insurance

1. Group health insurance

Group insurance is underwritten mainly on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer. Thus, while accepting a group for health insurance, the insurers take into consideration the possibility of existence of a few members in the group who may have severe and frequent health problems.

Underwriting of group health insurance requires analyzing the characteristics of the group to evaluate whether it falls within the insurance company's underwriting guidelines as well as the guidelines laid down for group insurance by the insurance regulators.

Standard underwriting process for group health insurance requires evaluating the proposed group on the following factors:

a) Type of group

b) Group size

c) Type of industry

d) Eligible persons for coverage

e) Whether entire group is being covered or there is an option for members to opt out

f) Level of coverage – whether uniform for all or differently

g) Composition of the group in terms of sex, age, single or multiple locations, income levels of group members, employee turnover rate, whether premium paid entirely by the group holder or members are required to participate in premium payment

h) Difference in healthcare costs across regions in case of multiple locations spread in different geographical locations

i) Preference of the group holder for administration of the group insurance by a third party administrator (of his choice or one selected by the insurer) or by the insurer itself

j) Past claims experience of the proposed group

Example

A group of members working in mines or factories is at higher health risk than a group of members working in air-conditioned offices. Also the nature of diseases (thereby claims) are also likely to be quite different for both groups. Therefore, the insurer will price the group health insurance policy accordingly in both the cases.

Similarly to avoid adverse selection in case of groups with high turnover such as IT companies, insurers can introduce precautionary criteria requiring employees to serve their probationary period before becoming eligible for insurance.

Due to highly competitive nature of group health insurance business, insurers allow substantial flexibility and customization in benefits of the group insurance plans. In employer-employee group insurance plans, the benefits design is usually developed over time and used as an employee retention tool by the human resources department of the employer. Often, the flexibility is the result of competition among insurers to match or improve the benefits of the existing group insurance plan given by another insurer to capture and shift business.

2. Underwriting other than employer- employee groups

Employer-employee groups are traditionally the most common groups offered group health insurance. However, as health insurance gains acceptance as an effective vehicle of financing healthcare expenditure, different types of group formations have now developed. In such a scenario, it is important for group health insurance underwriters to take into consideration the character of the group composition while underwriting the group.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, multiple-employer groups, franchisee dealers, professional associations, clubs and other brotherhood organizations.

Governments in different countries have been buyers of group health insurance coverage for poorer sections of the society. In India, governments both at the central and state level have aggressively been sponsoring group health insurance schemes for the poor e.g. RSBY, Yeshaswini etc.

Though basic underwriting considerations for such diverse groups are similar to generally accepted group underwriting factors, additional aspects include:

a) Size of the group (small group size may suffer from frequent changes)
b) Different levels of healthcare cost in different geographical regions
c) Risk of adverse selection in case all group constituents do not participate in the group health insurance plan
d) Continuation of members in the group in the policy

There has been a growth in irregular types of group formations just to take advantage of such group health insurance benefits at cheap prices, called 'groups of convenience'. The insurance regulator IRDA has therefore issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. Such non-employer groups include:

a) Employer welfare associations
b) Holders of credit cards issued by a specific company
c) Customers of a particular business where insurance is offered as an add-on benefit
d) Borrowers of a bank and professional associations or societies

The rationale of the group insurance guidelines is to restrict formation of groups for the sole purpose of availing insurance with advantage of flexible design, coverage of benefits not available on individual policies and cost savings. It has been observed that such 'groups of convenience' have often led to adverse selection against the insurers and eventually high claim ratios. Group insurance guidelines by the regulatory authority, thus, help in responsible market conduct by the insurers. They instill discipline in underwriting by insurance companies and also in canvassing group insurance schemes by setting up administration standards for group schemes.

H. Underwriting of Overseas Travel Insurance

Since the main cover under Overseas Travel Insurance policies is the health cover, the underwriting would follow the pattern for health insurance in general.

The premium rating and acceptance would as per individual company guidelines but a few important considerations are given below:

1. Premium rate would depend on the age of the proposer and the duration of foreign travel.

2. As medical treatment is costly overseas, the premium rates are normally much higher compared to domestic health insurance policies.

3. Even among the foreign countries, USA and Canada premium is the highest.

4. Care should be taken to rule out the possibility of a proposer using the policy to take medical treatment abroad and hence the existence of any pre-existing disease must be carefully considered at the proposal stage.

I. Underwriting of Personal Accident Insurance

The underwriting considerations for personal accident policies are discussed below:

Rating

In personal accident insurance, the main factor considered is the occupation of the insured. Generally speaking exposure to personal accidents at home, on the street etc. is the same for all persons. But the risks associated with profession or occupation varies in accordance with the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is being constructed.

It is not practical, to fix a rate for each profession or occupation. Hence, occupations are classified into groups, each group reflecting, more or less, similar risk exposure. The following system of classification is simple and found to be feasible in practice. Individual companies may have their own basis of classification.

Classification of Risk

On the basis of occupation, the risks associated with the insured person may be classified into three groups:

- **Risk group I**
  Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, persons engaged in administration functions, persons primarily engaged in occupations of similar hazards.

- **Risk group II**
  Builders, Contractors and Engineers engaged in superintending functions only, Veterinary Doctors, paid drivers of motor cars and light motor vehicles and persons engaged in occupation of similar hazards.
  All persons engaged in manual labour (except those falling under Group III), cash carrying employees, garage and motor Mechanics, Machine operators, Drivers of trucks or lorries and other heavy vehicles, professional athletes and sportsmen, woodworking Machinists and persons engaged in occupations of similar hazards.

- **Risk group III**
  Persons working in underground mines, explosives magazines, workers involved in electrical installation with high tension supply, Jockeys, circus personnel, persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons engaged in occupations / activities of similar hazard.

Risk groups are also known in the form of 'Normal', 'Medium' and 'High' respectively.

Age Limits

The minimum and maximum age for being covered and renewed varies from company to company. Generally a band of 5 years to 70 years is the norm. However, in case of persons who already have a cover, policies may be renewed after they complete 70 years but up to the age of 80 subject to a loading of the renewal premium.

No medical examination is usually required for renewal or fresh cover.

Medical Expenses

The medical expenses cover is as follows:

- A personal accident policy can be extended by endorsement, on payment of extra premium to cover medical expenses incurred by the insured in connection with the accidental bodily injury.

- These benefits are in addition to the other benefits under the policies.

- It is not necessary that person has to be hospitalised.

War and Allied Risks

War risk cover may be covered to Indian personnel / experts working in foreign countries on civilian duties with additional premium.

- P.A. policies issued during peace time or normal period would be at say 50 percent extra over the normal rate (i.e. 150 percent of the normal rate.)

- P.A. policies issued during abnormal/ apprehensive period (i.e. during the period when warlike conditions have already occurred or are imminent in foreign country/i.e. where the Indian personnel are working on civilian duties) at say 150 percent extra over the normal rate (i.e. 250 percent of the normal rate)

The Proposal Form

The form elicits information on the following:

- Personal details
- Physical condition
- Habits and pastimes
- Other or previous insurances
- Previous accidents or illness

- Selection of benefits and sum insured
- Declaration

The above required details can be explained as follows:

- Personal details relate to, inter alia, age, height and weight, full description of occupation and average monthly income.

- Age will show whether the proposer is within the limits of age for entrants for the policy desired. Weight and height should be compared with a table of average weight for sex, height and age and further investigation would be made if the proposer is say 15 percent or more over or under the average.

- Physical condition details relate to any physical infirmity or defect, chronic diseases etc.

- Proposers who have lost a limb or the sight of an eye may only be accepted on special terms in approved cases. They constitute abnormal risks because they are "less able to avoid certain types of accidents and in view of the fact that if the remaining arm or leg is injured or the sight or the remaining eye is affected, the degree and length of disablement is likely to be much greater than normal.

- Diabetes may retard recovery as the wound may not heal quickly and the disablement may be unduly prolonged. The medical history of the proposer must be examined in order to determine whether and to what extent injuries or illnesses may affect the future accident risks. There are many complaints of such an obviously serious nature as to make the risk uninsurable, e.g. valvular disease of the heart.

- Hazardous pastimes like mountaineering, polo, motor racing, acrobatics etc., require extra premium.

Sum Insured

The sum insured in a personal accident policy has to be fixed with caution, as they are benefit policies and not subject to strict indemnity. Care should be taken to consider income derived through 'gainful employment'. In other words, income which will not be affected by accident to the proposer should not be considered while determining the sum insured.

As practices of fixing the S.I varies among insures/underwriters, the exact amount for which the cover could be granted depends on the underwriters. However the general practice that the cover granted should not exceed the equivalent of 72 months / 6 years' earning of the insured.

This restriction is not strictly applied if the policy is for capital benefits only.

For temporary total disablement cover however it should not happen that in the event of compensation payable, the same is disproportionate to his earnings during the same period. If the cover is for weekly compensation for TTD, the sum insured usually does not exceed twice his/her annual income.

While giving cover to persons who are not gainfully employed e.g. housewives, students etc. the insurers make sure that they provide for capital benefits only and that no weekly compensation is provided for.

Family Package Cover

For children and non-earning spouse the cover is limited to death and permanent disablement (total or partial). However, based on individual company's norms the Table of Benefits may be considered. Some Companies allow TTD cover to non-earning spouse also up to a particular limit.

A discount of 5 percent is usually granted on the gross premium.

Group Policies

A group discount is allowed off the premium, if the number of insured person exceeds a certain number say 100. Group policy however may be issued when number is smaller, say 25 but without any discount.

Normally, policies on unnamed basis are issued only to very valued clients, where the identity of the member is clearly ascertainable beyond doubt.

Group discount criteria

Group policies should be issued only in respect of the named groups. For the purpose of availing of group discount and other benefits, the proposed "Group" should fall clearly under any one of the following categories:

- Employer – employee relationship including dependents of the employee
- Pre identified segments / groups where the premium is to be paid by the State / Central Governments
- Members of a registered co-operative society
- Members of registered service clubs
- Holders of credit card of banks / Diners / Master / Visa
- Holders of deposit certificates issued by banks / NBFC's
- Shareholders of banks / public limited companies

In case of proposals relating to any further category different from the above categories, they may be deliberated and decided upon by the technical department of the respective insurers.

No group discount can be offered on the 'anticipated' group size. Group discount is to be considered and worked out only on the actual number of members registered in the 'Group' at the time of taking out the policy. It can be reviewed at renewals.

Sum insured

The sum insured may be fixed for specific amounts separately for each insured person or it may be linked to emoluments payable to the insured persons.

The principle of 'All or None' applies in a group insurance. Additions and deletions are made thereto with pro rata additional premium or refund.

Premium

Varying rates of premium are applicable to named employees as per the classification of risks and the benefits selected. Thus rates will vary according to the occupation of persons covered.

Example

The same rate will apply to well defined groups of employee all of whom, broadly speaking follow the same type of occupation.

In respect of unnamed employees the employer is required to declare the number of employees in each classification based on authentic records maintained by him.

Premium rates for named member of an association, clubs etc. apply according to the classification of risk.

When the membership is of a general nature and not restricted to any particular occupation, underwriters use their discretion in applying the rates.

On-duty covers

The cover provided during the on-duty hours is as follows:

- If P.A cover is required only for the restricted hours of duty (and not for 24 hours a day), a reduced premium say 75 percent of the appropriate premium is charged.

- The cover applies to accident to the employees arising out of and in the course of employment only.

Off-duty covers

If cover is required only for the restricted hours, when the employee is not at work and/or not on official duty, the reduced premium of say 50 percent of the appropriate premium may be charged.

Exclusion of death cover

It is possible to issue group P.A. policies excluding the death benefit, subject to individual company guidelines.

Group discount and Bonus/Malus

Since a large number of persons are covered under one policy, there is less administrative work and expense. Besides, usually all members of the group will be insured and there will be no adverse selection against the insurers. Hence, a discount in premium is allowed, according to a scale.

Rating under renewal of group policies is determined with reference to the claims experience.

- Favourable experience is rewarded with a discount in the renewal premium (bonus)
- Adverse experience is penalised by loading of renewal premium (malus), according to a scale
- Normal rates will apply for renewal if the claims experience is, say, 70 percent

Proposal form

- It is customary to dispense the forms for completion by the members and to have one document only, completed by the insured.
- He is required to make a declaration that no member suffers from a physical infirmity or defect that would render his participation unacceptable.
- Sometimes even this precaution is waived, it being understood and/or made clear by endorsement that disability prior to the commencement of cover and also any cumulative effect as a result of such disability stand excluded.

However the practice may vary among the companies.

Test Yourself 5

1) In a group health insurance, any of the individual constituting the group could anti-select against the insurer.
2) Group health insurance provides coverage only to employer-employee groups.

I. Statement 1 is true and statement 2 is false
II. Statement 2 is true and statement 1 is false
III. Statement 1 and statement 2 are true
IV. Statement 1 and statement 2 are false

Information

As part of the risk management process, the underwriter uses two methods of transferring his risks especially in case of large group policies:

Coinsurance: This refers to the acceptance of a risk by more than one insurer. Normally, this is done by way of allocating a percentage of the risk to each insurer. Thus the policy may be accepted by two insurers say, Insurer A with a 60% share and Insurer B with a 40% share. Normally, insurer A would be the lead insurer handling all matters relating to the policy, including issuance of the policy and settlement of claims. Insurer B would reimburse insurer A for 40% of the claims paid.

Reinsurance: The insurer accepts risks of various types and sizes. How can he protect his various risks? He does this by re-insuring his risks with other insurance companies and this is called reinsurance. Reinsurers therefore accept risks of insurers either by way of standing arrangements called treaties or on a case to case basis called facultative reinsurance. Reinsurance is done word-wide and hence it spreads risk far and wide.

Summary

a) Health insurance is based on the concept of morbidity which is defined as the risk of a person falling ill or sick.

b) Underwriting is the process of risk selection and risk pricing.

c) Underwriting is required to strike a proper balance between risk and business thereby maintaining the competitiveness and yet profitability for the organisation.

d) Some of the factors which affect a person's morbidity are age, gender, habits, occupation, build, family history, past illness or surgery, current health status and place of residence.

e) The purpose of underwriting to prevent adverse selection against the insurer and also ensure proper classification and equity among risks.

f) The agent is the first level underwriter as he is in the best position to know the prospective client to be insured.

g) The core principles of insurance are: utmost good faith, insurable interest, indemnity, contribution, subrogation and proximate cause.

h) The key tools for underwriting are: proposal form, age proof, financial documents, medical reports and sales reports.

i) Medical underwriting is a process which is used by the insurance companies to determine the health status of an individual applying for health insurance policy.

j) Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.

k) Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.

l) The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.

m) Group insurance is mainly underwritten based on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.

Answers to Test Yourself

Answer 1

The correct option is III.

Underwriting is the process of risk selection and risk pricing.

Answer 2

The correct option is III.

The principle of utmost good faith in underwriting has to be followed by both the insurer and the insured.

Answer 3

The correct option is I.

Insurable interest refers to the pecuniary or the financial interest of a person in the asset he is going to get insured and can suffer financial loss in the event of any damage to such asset.

Answer 4

The correct option is IV.

Percentage and numerical assessment is made on each component of the risk in numerical rating method, and not medical underwriting method.

Answer 5

The correct option is IV.

In a group health insurance, when all members of a group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, professional associations, clubs and other fraternal organisations.

Self-Examination Questions

Question 1

Which of the following factor does not affect the morbidity of an individual?

I. Gender
II. Spouse job
III. Habits
IV. Residence location

Question 2

According to the principle of indemnity, the insured is paid for _____.

I. The actual losses to the extent of the sum insured
II. The sum insured irrespective of the amount actually spent
III. A fixed amount agreed between both the parties
IV. The actual losses irrespective of the sum assured

Question 3

The first and the primary source of information about an applicant, for the underwriter is his _____.

I. Age proof documents
II. Financial documents
III. Previous medical records
IV. Proposal form

Question 4

The underwriting process is completed when _____.

I. All the critical information related to the health and personal details of the proposer are collected through the proposal form
II. All the medical examinations and tests of the proposer are completed
III. The received information is carefully assessed and classified into appropriate risk categories
IV. The policy is issued to the proposer after risk selection and pricing.

Question 5

Which of the following statements about the numerical rating method is incorrect?

I. Numerical rating method provides greater speed in the handling of a large business with the help of trained personnel.

II. Analysis of difficult or doubtful cases is not possible on the basis of numerical points without medical referees or experts.
III. This method can be used by persons without any specific knowledge of medical science.
IV. It ensures consistency between the decisions of different underwriters.

Answers to Self-Examination Questions

Answer 1

The correct option is II.

The morbidity of an individual is not affected by their spouse's job, though their own occupation is one of the important factors which can affect their morbidity.

Answer 2

The correct option is I.

According to the principle of indemnity, insured is compensated for the actual costs or losses, but to the extent of the sum insured.

Answer 3

The correct option is IV.

The primary source of information about an applicant, for the underwriter is his proposal form or application form, in which all the critical information related to the health and personal details of the proposer are collected.

Answer 4

The correct option is III.

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.

Answer 5

The correct answer is II.

A more careful analysis of difficult or doubtful cases is made possible by numerical rating method because past experience with reference to the doubtful points is expressed numerically in terms of a known standard and shadings.

CHAPTER 10

HEALTH INSURANCE CLAIMS

Chapter Introduction

In this chapter we will discuss about claim management process in health insurance, documentation required and the process of claim reserving. Apart from this we will also look into claims management under personal accident insurance and understand the role of TPAs.

Learning Outcomes

A. Claims management in insurance
B. Management of health insurance claims
C. Documentation in health insurance claims
D. Claims reserving
E. Role of third party administrators (TPA)
F. Claims management – personal accident
G. Claims management- Overseas travel insurance

After studying this chapter, you should be able to:

a) Explain the various stakeholders in insurance claims
b) Describe how health insurance claims are managed
c) Discuss the various documents required for settlement of health insurance claims
d) Explain how reserves for claims are provided for by insurers
e) Discuss personal accident claims
f) Understand the concept and role of TPAs

A. Claims management in insurance

It is very well understood that insurance is a '**promise**' and the policy is a '**witness**' to that promise. The occurrence of an insured event leading to a claim under the policy is the true test of that promise. How well an insurer performs is evaluated by how well it keeps its claims promises. One of the key rating factors in insurance is the claims paying ability of the insurance company.

1. Stakeholders in claim process

Before we look in detail at how claims are managed, we need to understand who are the interested parties in the claims process.

Diagram 1: Stakeholders in claim process

Customer	The person who buys insurance is the first stakeholder and 'receiver of the claim'.
Owners	Owners of the insurance company have a big stake as the 'payers of the claims'. Even if the claims are met from the policy holders' funds, in most cases, it is they who are liable to keep the promise.

Underwriters	Underwriters within an insurance company and across all insurers have the responsibility to understand the claims and design the products, decide policy terms, conditions and pricing etc.
Regulator	The regulator (Insurance Regulatory and Development Authority of India) is a key stakeholder in its objective to: ✓ Maintain order in the insurance environment ✓ Protect policy holders' interest ✓ Ensure long term financial health of insurers.
Third Party Administrators	Service intermediaries known as Third Party Administrators, who process health insurance claims.
Insurance agents / brokers	Insurance agents / brokers not only sell policies but are also expected to service the customers in the event of a claim.
Providers / Hospitals	They ensure that the customer gets a smooth claim experience, especially when the hospital is on the panel of the TPA the Insurer to provide cashless hospitalization.

Thus managing claims well means managing the objectives of the each of these stakeholders related to the claims. Of course, it may happen that some of these objectives can conflict with each other.

2. Role of claims management in insurance company

As per industry data- "the health insurance loss ratio of various insurers ranges from 65% to above 120%, with major part of the market operating at above 100% loss ratio". Most companies are making losses in health insurance business.

This means that there is a great need to adopt sound underwriting practices and efficient management of claims to bring better results to the company and the policyholders.

Test Yourself 1

Who among the following is not a stakeholder in insurance claim process?

I. Insurance company shareholders
II. Human Resource Department
III. Regulator
IV. TPA

B. Management of health insurance claims

1. Challenges in health insurance

It is important to understand the peculiar features of the health insurance portfolio in depth so that health claims can be effectively managed. These are:

a) Majority of the policies are for hospitalization indemnity where the subject matter covered is a human being. This brings forth emotional issues that are not normally faced in other classes of insurance.

b) India presents very peculiar patterns of illnesses, approach to treatment and follow up. These result in some people being excessively cautious with some others being unworried about their illness and treatment.

c) Health insurance can be purchased by an individual, a group such as a corporate organization or through a retail selling channel like a bank. This results in the product being sold as a standard commodity at one extreme while being tailored to satisfy needs of the customer at the other.

d) Health insurance depends on the act of being hospitalized, to trigger a claim under the policy. However, there is great difference in the availability, specialization, treatment methods, billing patterns and charges of all health service providers whether doctors, surgeons or hospitals which make it very difficult to assess claims.

e) The discipline of healthcare is the fastest developing one. New diseases and conditions keep occurring resulting in development of new treatment methods. Examples of this are key-hole surgeries, laser treatments, etc.
This makes health insurance more technical and the skills to handle the insurance claims for such procedure needs constant improvement.

f) More than all these factors, the fact that a human body cannot be standardized adds a completely new dimension. Two people could respond differently to the same treatment for the same illness or require different treatments or varying periods of hospitalization.

The portfolio of health insurance is growing rapidly. The challenge of such rapid growth is the huge number of products. There are hundreds of health insurance products in the market and even within a company one can find many different products. Each product and its variant has its peculiarity and therefore needs to be studied before a claim can be handled.

Growth of the health portfolio also brings about the challenge of numbers – a company selling 100,000 health policies to retail customers covering say, 300,000 members under these policies, has to be prepared to service about 20,000 claims at least! With the expectation of cashless service and speedy settlement of claims, organizing health insurance claims department is a significant challenge.

Typically health insurance policies written in India cover hospitalization anywhere within the country. The team handling claims must understand the practices across the country to be able to appreciate the claim presented.

The health claims manager meets these challenges using expertise, experience and various tools available to him.

In the final analysis, health insurance offers the satisfaction of having assisted a person who is in need and is undergoing the physical and emotional stress of illness of himself or his family.

Efficient claims management ensures that right claim is paid to right person at the right time.

2. Claim process in health insurance

A claim may be serviced either by the insurance company itself or through the services of a Third Party Administrator (TPA) authorized by the insurance company.

From the time a claim is made known to the insurer / TPA to the time the payment is made as per the policy terms, the health claim passes through a set of well-defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form the major part of health insurance business.

The general process and supporting documents for a claim under fixed benefit product or critical illness or daily cash product etc. would be quite similar, except for the fact that such products may not come with cashless facility.

The claim under an indemnity policy could be a:

a) Cashless claim

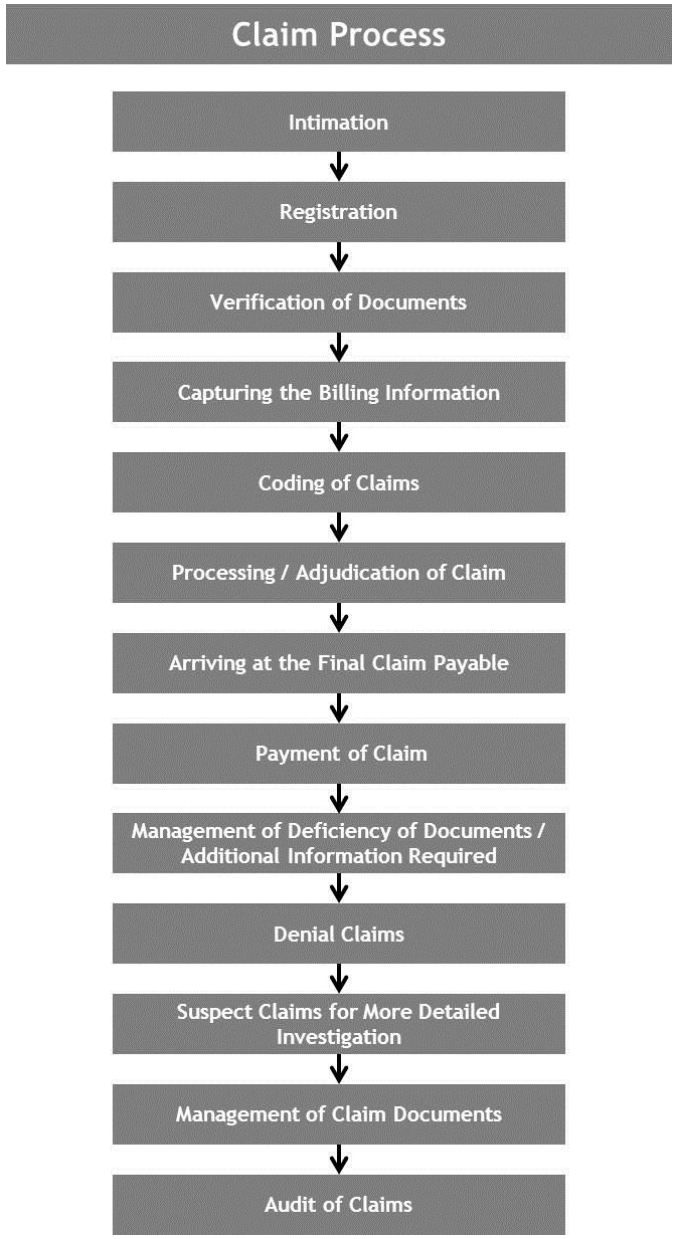
The customer does not pay the expenses at the time of admission or treatment. The network hospital provides the services based on a pre-approval from the insurer/TPA and later submits the documents to the insurer/TPA for settlement of the claim.

b) Reimbursement claim

The customer pays the hospital from his own resources and then files his claim with Insurer/TPA for payment of the admissible claim.

In both cases, the basic steps remain the same.

Diagram 2: Claim process broadly comprises of following steps (not in exact order)



a) Intimation

Claim intimation is the first instance of contact between the customer and the claims team. The customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently, the act of intimation of a claim event was a formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable. Typically it is required before hospitalization in case of planned admission, and within 24 hours of hospitalization in case of an emergency.

The timely availability of information about hospitalization helps the Insurer/TPA to verify that the hospitalization of the customer is genuine and there is no impersonation or fraud and sometimes, to negotiate the charges.

Intimation earlier meant 'a letter written, submitted and acknowledged' or by fax. With development in communication and technology, intimation is now possible through call centres run by insurers/TPAs open 24 hours as well as through the internet and e-mail.

b) Registration

Registration of a claim is the process of entering the claim in the system and creating a reference number using which the claim can be traced any time. This number is called Claim number, Claim reference number or Claim control number. The claim number could be numeric or alpha-numeric based on the system and processes used by the processing organization

Registration and generation of a reference no. is usually done once the claim intimation is received and the correct policy number and insured person's particulars are matched.

Once a claim is registered in the system, a reserve for the same would be created simultaneously in the accounts of the insurer. At the time of intimation/registration, the exact claim amount or estimate may not be known. The initial reserve amount is therefore a standard reserve (mostly based on historical average claim size). Once the estimate or expected amount of liability is known, the reserve is revised upward/downward to reflect the same.

c) Verification of documents

Once a claim is registered, the next step is to check for the receipt of all the required documents for processing.

It must be appreciated that for a claim to be processed following are the most important requirements:

1. The documentary evidence of the illness
2. Treatment provided
3. In-patient duration
4. Investigation Reports
5. Payment made to the hospital
6. Further advice for treatment
7. Payment proofs for implants etc.

Verification of documents follows a checklist which the claim processor checks out. Most of the companies ensure that such checklists are part of the processing documentation.

The missing documentation is noted at this stage – while some processes involve requesting for the documents not submitted by the customer / hospital at this point, most of the companies first complete the scrutiny of all the documents submitted before requesting for additional information so that the customer is not inconvenienced.

d) Capturing the billing information

Billing is an important part of the claim processing cycle. Typical health insurance policies provide for indemnifying expenses incurred in the treatment with specific limits under various heads. The standard practice is to classify the treatment charges into:

- ✓ Room, board and nursing expenses including registration and service charges.
- ✓ Charges for ICU and any intensive care operations.
- ✓ Operation theatre charges, anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and any medical expenses incurred which is integral part of the operation.
- ✓ Surgeon, anaesthetist, medical practitioner, consultant's, specialists fees.
- ✓ Ambulance charges.
- ✓ Investigation charges covering blood test, X-ray, scans, etc.
- ✓ Medicines and drugs.

Documents submitted by the customer are examined to capture information under these heads so that the settlement of claims can be done with accuracy.

Though there are efforts being made to standardize the billing pattern of hospitals, it is common for each hospital to use a different method for billing and the challenges faced in this are:

- ✓ Room charges can include some non-payables such as service charges or diet.

- ✓ Single bill can include different headings or a lump-sum bill for all investigations or all medicines.
- ✓ Non-standard names being used – e.g. nursing charges being called service charges.
- ✓ Use of words like "similar charges", "etc.", "allied expenses" in the bill.

Where the billing is not clear, the processor seeks the break up or additional information, so that the doubts on the classification and admissibility are resolved.

To address this issue, IRDAI issued Health Insurance Standardization Guidelines which have standardized the format of such bills and the list of non-payable items.

Package rates

Many hospitals have agreed package rates for treatment of certain diseases. This is based on the ability of the hospital to standardize the treatment procedure and use of resources. In recent times, for treatment at Preferred Provider Network and also in case of RSBY, package cost of many procedures has been pre-fixed.

Example

a) Cardiac packages: Angiogram, Angioplasty, CABG or Open heart surgery, etc.

b) Gynaecological packages: Normal delivery, Caesarean delivery, hysterectomy, etc.

c) Orthopaedic packages

d) Ophthalmological packages

Additional costs due to complications after surgery are charged separately on actual basis if incurred over and above these.

Packages have the advantages of certainty of the cost involved and standardization of the procedures and so such claims are easier to handle.

e) Coding of claims

The most important code set used is the World Health Organization (WHO) developed **International Classification of Diseases (ICD) codes.**

While ICD is used to capture the disease in a standardized format, procedure codes such as **Current Procedure Terminology (CPT) codes** capture the procedures performed to treat the illness.

Insurers are relying on the coding increasingly and Insurance Information Bureau (IIB), which is part of Insurance Regulatory and Development Authority (IRDAI), has started an information bank where such information that can be analyzed.

f) Processing of claim

A reading of the health insurance policy shows that while it is a commercial contract, it involves medical terms that define when a claim is payable and to what extent. The heart of claims processing in any insurance policy, is in answering two key questions:

- ✓ Is the claim payable under the policy?
- ✓ If yes, what is the net payable amount?

Each of these questions requires understanding of a number of terms and conditions of the policy issued as well as the rates agreed with the hospital in case treatment has taken place at a network hospital.

Admissibility of a claim

For a health claim to be admissible the following conditions must be satisfied.

i. The member hospitalized must be covered under the insurance policy

While this looks simple, we come across situations where the names (and in more cases, the age) of the person covered and person hospitalized do not match. This could be because of:

It is important to ensure that the person covered under the policy and the person hospitalized is the same. This kind of fraud is very common in health insurance.

ii. Admission of the patient within the period of insurance

iii. Hospital definition

The hospital where the person was admitted should be as per the definition of "hospital or nursing home" under the policy otherwise the claim is not payable.

iv. Domiciliary hospitalization

Some policies cover domiciliary hospitalization i.e. treatment taken at home in India for a period exceeding 3 days for an ailment which normally requires treatment at hospital/nursing home.

Domiciliary hospitalization, if covered in a policy, is payable only if:

- ✓ The condition of the patient is such that he/she cannot be removed to the Hospital/Nursing Home or
- ✓ The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

v. Duration of hospitalization

Health insurance policies normally cover hospitalization exceeding 24 hours as an in-patient. Therefore the date and time of admission as well as discharge becomes important to note if this condition is satisfied.

Day-care treatments

Technological developments in the healthcare industry have led to simplification of many procedures that earlier required complex and prolonged hospitalization. There are a number of procedures carried out on day care basis without need for hospitalization exceeding 24 hours.

Most of the day care procedures are on pre-agreed package rate basis, resulting in certainty in costs.

vi. OPD

Some policies cover treatment/consultations taken as an out-patient also, subject to a specific sum insured which is usually less than the hospitalization sum insured.

The coverage under OPD varies from policy to policy. For such reimbursements, the clause for 24 hours hospitalization is not applicable.

vii. Treatment procedure/line of treatment

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

- ✓ Unani
- ✓ Siddha
- ✓ Homeopathy
- ✓ Ayurveda
- ✓ Naturopathy etc.

Most policies exclude these treatments while some policies cover one or more of these treatments with sub-limits.

viii. Pre-existing illnesses

Definition

Pre-existing illnesses refer to "Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to his/her health policy with the company whether explicitly known to him or not."

The reason for excluding pre-existing illnesses is due to the fundamental principles of insurance that a certainty cannot be covered under insurance.

However, application of this principle is quite difficult and involves a systematic check of the symptoms and treatment to find out whether the person had the condition at the time of insuring. As medical professionals can differ in the opinions of duration of the illness, the opinion of when the disease first showed up is carefully taken before applying this condition to deny any claim.

In the evolution of health insurance, we come across two modifications to this exclusion.

- ✓ The first is in the case of group insurance where the entire group of people is insured, with no selection against the insurer. Group policies covering, say all government employees, all families below poverty line, all families of employees of a major corporate group, etc. are treated favorably as compared to a single family opting to cover for the first time. These policies often deleted the exception, with exception adequate price built in.
- ✓ The second modification is that pre-existing illnesses are covered after the a certain period of continuous coverage. This follows the principle that even a condition is present in a person, if it does not show up for a certain period of time, it cannot be treated as a certainty.

ix. Initial waiting period

A typical health insurance policy covers illnesses only after an initial 30 days (except accident related hospitalization).

Similarly, there are lists of illnesses such as:

✓ Cataract, ✓ Benign Prostatic Hypertrophy, ✓ Hysterectomy, ✓ Fistula, ✓ Piles,	✓ Hernia, ✓ Hydrocele, ✓ Sinusitis, ✓ Knee / Hip Joint replacement etc.

These are not covered for an initial period that could be one year or two years or more depending on specific insurance company's product.

The claim processor identifies if the illness is one of these and how long the person has been covered to check if it falls within this admissibility condition.

x. Exclusions

The policy lists out a set of exclusions which in general can be classified as:

- ✓ Benefits such as maternity (though this is covered in some policies).
- ✓ Outpatient and Dental treatments.
- ✓ Illnesses which are not intended to be covered such as HIV, Hormone therapy, obesity treatment, fertility treatment, cosmetic surgeries, etc.
- ✓ Diseases caused by alcohol/drug abuse.
- ✓ Medical treatment outside India.
- ✓ High hazard activities, suicide attempt, radioactive contamination.
- ✓ Admission for tests/investigation purpose only.

In such a case it is extremely important for the claims handler to specifically explain the circumstances so that the specialist opinion is exactly to the point and will stand the scrutiny in a court of law, if challenged.

xi. Compliance with conditions with respect to the claims.

The insurance policy also defines certain actions to be taken by the Insured in case of a claim, some of which are important for admissibility of the claim.

In general, these relate to:

- ✓ Intimation of claim within certain period – we have seen the importance of intimation earlier. The policy could stipulate a time within which such intimation must reach the company.

- ✓ Submission of claim documents within a certain period.

- ✓ Not being involved in misrepresentation, misdescription or non-disclosure of material facts.

g) Arriving at the final claim payable

Once the claim is admissible, the next step is to decide the the amount of claim payable. To compute this we need to understand the factors that decide the claim amount payable. These factors are:

i. Sum insured available for the member under the policy

There are policies issued with individual sum insured, some issued on floater basis where the sum insured is available across the family or policies which are on floater basis but with a limit per member.

ii. Balance sum insured available under the policy for the member after taking into account any claim made already:

While calculating the balance of sum insured available after deducting claims already paid, any later cashless authorization provided to the hospitals will also have to be noted.

iii. Sub-Limits

Most policies specify room rent limitation, nursing charges etc. either as a percentage of sum insured or as a limit per day. Similar limitation could be in force for consultant fee, or ambulance charges, etc.

iv. Check for any limits specific to illness

The policy could specify a certain amount or capping for maternity cover or for other diseases say, cardiac illness.

v. Check whether entitled or not to cumulative bonus

Verify whether the insured is entitled to any no-claim bonus (in case the insured has not claimed from his policy in the previous year/s). No-claim bonus often comes in the form of additional sum insured, which in fact increases the sum insured of the patient/insured. Sometimes, the cumulative bonus may also be wrongly stated as claims intimated towards the end of the previous year may not have been taken into account.

vi. Other expenses covered with limitation:

There could be other limits e.g. if treatment is undertaken under Ayurvedic system of medicine, usually the same has a much lower limit. Health check-up costs are only up to a certain limit after four years of the policy. Hospital cash payment also has a per day limit.

vii. Co-payment

This is normally a flat percentage of the assessed claim before payment. The co-pay could also be applicable only in select circumstances – only for parent claims, only for maternity claims, only from second claim onwards or even only on claims exceeding a certain amount.

Before the payable amount is adjusted to these limits, the claim amount payable is computed net of deductions for non-payable items.

Non-payable items in a health claim

The expenses incurred in treating an illness can be classified into:

- ✓ Expenses for cure and
- ✓ Expenses for care.

Expenses for curing an illness comprise of all the medical costs and the normal related facilities. In addition, there could be costs incurred to make the stay in a hospital more comfortable or even luxurious.

A typical health insurance policy attends to the expenses for curing an illness and unless stated specifically, the extra expenses for luxury are not payable.

These expenses can be classified into non-treatment charges such as registration charge, documentation charges, etc. and to items that can be considered if directly relating to the cure (e.g. protein supplement during the inpatient period specifically prescribed).

Earlier every TPA/insurer had its own list of non-payable items, now the same has been standardized under IRDAI Health Insurance Standardization Guidelines.

The order of arriving at the final claim payable is as follows:

Table 2.1

Step I	List all the bills and receipts under the various heads of room rent, consultant fee, etc.
Step II	Deduct the non-payable items from the amount claimed under each head
Step III	Apply any limits applicable for each head of expense
Step IV	Arrive at the total payable amount and check if it is within sum insured overall
Step V	Deduct any co-pay if applicable to arrive at the net claim payable

h) Payment of claim

Once the payable claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The approved claim amount is advised to the Finance / Accounts function and the payment may be made either by cheque or by transferring the claim money to the customer's bank account.

When the payment is made to the hospital, necessary tax deduction, if any is made from the payment.

Where the payment is handled by the Third Party Administrator, the payment process may vary from insurer to insurer. A more detailed insight into working of TPAs is provided later on.

Payment updates in the system are crucial for handling customer inquiries. Typically these details will be shared through the system with the call centre / customer service team.

Once payment is made, the claim is treated as settled. Reports have to be periodically sent to the company's management, intermediaries, customers and IRDAI for number and amount of settled claims. The typical analysis of settled claims includes the % settled, amount of non-payables as a proportion, average time taken to settle claims, etc.

i) Management of deficiency of documents / additional information required

Processing of a claim requires the scrutiny of a list of key documents. These are:

- ✓ Discharge summary with admission notes,
- ✓ Supporting investigation reports,
- ✓ Final consolidated bill with break up into various parts,
- ✓ Prescriptions and pharmacy bills,
- ✓ Payment receipts,
- ✓ Claim form and
- ✓ Customer identification.

Experience shows that one out of four claims submitted has a suffer from being incomplete in terms of the basic documents. It is therefore required that the customer is advised of the documents not submitted and is given a time limit within which he can attach them to his claim.

Similarly, it may happen that while a claim is being processed, additional information may be required because:

i. The discharge summary provided is not in the correct format as prescribed by IRDAI or does not capture some details of the diagnosis or the history of the illness.

ii. Treatment given has not been described in enough detail or requires clarification.

iii. The treatment is not in line with the diagnosis as per discharge summary or medicines prescribed are not related to the illness for which treatment was provided.

iv. The bills provided do not have the required break up.

v. Mismatch of age of the person between two of the documents.

vi. Mismatch in date of admission / date of discharge between discharge summary and the bill.

vii. The claim requires a more detailed scrutiny of the hospitalization and for this, the hospital's indoor case papers are required.

In both the cases, the customer is informed in writing or through email detailing the requirement of additional information. In most cases, the customer will be able to provide the information required. However, there are circumstances where the information required is too important to be overlooked but the customer does not respond. In such cases, the customer is sent reminders that the information is needed to process the claim and after three such reminders, a claim closure notice is sent.

In all correspondence relating to a claim when it is in process, you will see that the words "Without Prejudice" are mentioned on top of the letter. This is a legal requirement to ensure that the right of the insurer to reject a claim after these correspondences remains intact.

Example

The insurer may ask for indoor case papers to study the case in detail and may come to a conclusion that the procedure / treatment does not fall within the policy conditions. The act of asking for more information should not be treated as an act that implies that the insurer has accepted the claim.

Managing shortfalls in documentation and explanation and additional information required is a key challenge in claims management. While the claim cannot be processed without all the required information, the customer cannot be put to inconvenience by frequent requests for more and more information.

Good practice requires that such request is raised once with a consolidated list of all information that may be needed and no new requirement is raised thereafter.

j) Denial claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall within the terms of the policy. This could be because of a variety of reasons some of which are:

i. Date of admission is not within the period of insurance.

ii. The Member for whom the claim is made is not covered.
iii. Due to Pre-existing illness (where the policy excludes such condition).
iv. Undue delay in submission without valid reason.
v. No active treatment; admission is only for investigation purpose.
vi. Illness treated is excluded under the policy.
vii. The cause of illness is abuse of alcohol or drugs
viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing. Usually, such denial letter clearly states the reason for denial, narrating the policy term / condition on which the claim was denied.

Most insurers have a process by which a denial is authorized by a manager senior to the one authorized to approve the claim. This is to ensure that any denial is fully justified and will be explained in case the insured seeks any legal remedy.

Apart from the representation to the insurer, the customer has the option, to approach the following in case of denial of claim:

- ✓ Insurance Ombudsman or
- ✓ The consumer forums or
- ✓ IRDAI or
- ✓ Law courts.

In case of each denial the file is checked to assess if the denial will stand the legal scrutiny in the normal course and the documents are stored in a safe location, should a need to defend the decision arise.

k) Suspect claims for more detailed investigation

Insurers have been trying to handle the problem of fraud in all lines of business. In terms of sheer number of fraud claims handled, health insurance presents a great challenge to the insurers.

Few examples of frauds committed in health insurance are:

i. **Impersonation**, the person insured is different from person treated.

ii. **Fabrication of documents** to make a claim where there is no hospitalization.

iii. **Inflation of expenses**, either with the help of the hospital or by addition of external bills fraudulently created.

iv. **Outpatient treatment converted to in-patient / hospitalization** to cover cost of diagnosis, which could be high in some conditions.

With newer methods of frauds emerging on a daily basis, the insurers and TPAs have to continuously monitor the situation on the ground and come up with measures to find and control such frauds.

Claims are chosen for investigation based on two methods:

- ✓ Routine claims and
- ✓ Triggered claims

A TPA or an insurer may set an internal standard that a specific percentage of the claims be physically verified; this percentage could be different for cashless and reimbursement claims.

Under this method, claims are chosen using random sampling method. Some insurers stipulate that all claims above a certain value be investigated and a sampled set of claims which are below that limit are taken up for verification.

In the second method, each claim goes through a set of checkpoints which if not in line, trigger investigation such as

i. a high portion of the claim relating to medical tests or medicines
ii. customer too eager to settle
iii. bills with over-writing, etc.

If the claim is suspected to be not genuine, the claim is investigated, however small it is.

n. Cashless settlement process by TPA

How does the cashless facility work? At the heart of this is an agreement that the TPA insurer enters into, with the hospital. There are agreements possible with other medical service providers as well. We shall look at the process used for providing cashless facility in this section:

Table 3.1

Step 1	A customer covered under health insurance suffers from an illness or sustains an injury and so is advised admission into a hospital. He/she (or someone on his/her behalf) approaches the hospital's insurance desk with the insurance details such as: i. TPA name, ii. His membership number, iii. Insurer name, etc.

Step 2	The hospital compiles the necessary information such as: i. Illness diagnosis ii. Treatment, iii. Name of treating doctor, iv. Number of days of proposed hospitalization and v. The estimated cost This is presented in a format, called the **cashless authorization form.**
Step 3	The TPA studies the information provided in the *cashless authorization form*. It checks the information with the policy terms and the agreed tariff with the hospital, if any, and arrives at the decision on whether the cashless authorization could be provided and if so, for how much amount it should be authorized. The TPA could ask for more information to arrive at the decision. Once the decision is made, it is communicated to the hospital without delay. Both forms have now been standardized under IRDAI Health Insurance Standardization Guidelines; refer to Annexure at the end).
Step 4	The patient is treated by the hospital, keeping the amount authorized by the TPA as credit in the patient's account. The member may be called on to make a deposit payment to cover the non-treatment expenses and any co-pay required under the policy.
Step 5	When the patient is ready for discharge, the hospital checks the amount of credit in the account of the patient approved by the TPA against the actual treatment charges covered by insurance. If the credit is less, the hospital requests for additional approval of credit for the cashless treatment. TPA analyses the same and approves the additional amount.
Step 6	Patient pays the non-admissible charges and gets discharged. He will be asked to sign the claim form and the bill, to complete the documentation.

Step 7	Hospital consolidates all the documents and presents to the TPA the following documents for processing of the bill: i. Claim form ii. Discharge summary / admission notes iii. Patient / proposer identification card issued by the TPA and photo ID proof. iv. Final consolidated bill v. Detailed bill vi. Investigation reports vii. Prescription and pharmacy bills viii. Approval letters sent by the TPA
Step 8	TPA will process the claim and recommend for payment to the hospital after verifying details such as the following: i. The Patient treated is the same person for whom approval was provided. ii. Treated the patient for the same condition that it requested the approval for. iii. Expenses for treatment of excluded illness, if any, is not part of the bill. iv. All limits that were communicated to the hospital have been adhered to. v. Tariff rates agreed with the hospital have been adhered to, calculate the net payable amount.

The value of cashless facility is not in doubt. It is also important for the customer to know how to make the best use of the facility. The points to note are:

i. Customer must make sure that he/she has his/her insurance details with him/her. This includes his:

   - ✓ TPA card,
   - ✓ Policy copy,
   - ✓ Terms and conditions of cover etc.

   When this is not available, he can contact the TPA (through a 24 hour helpline) and seek the details.

ii. Customer must check if the hospital suggested by his/her consulting doctor is in the network of the TPA. If not, he needs to check with the TPA the options available where cashless facility for such treatment is available.

iii. He/she needs to make sure that the correct details are entered into the pre-authorization form. This form has been standardized by IRDAI as per Guidelines on Standardization in Health Insurance issued in 2013. If the case is not clear, the TPA could deny the cashless facility or raise query.

iv. He/she needs to ensure that the hospital charges are consistent with the limits such as room rent or caps on specified treatments such as cataract.

In case he/she wants to spend more than what is allowed by the policy, it is better to know, in advance, what would be his/her share of expenses.

v. The customer must inform the TPA in advance of the discharge and request the hospital to send to the TPA any additional approval that may be required before discharge. This will ensure the patient does not wait unnecessarily at the hospital.

It is also possible that the customer requests and takes an approval for cashless treatment at a hospital but decides to admit the patient elsewhere. In such cases, the customer must inform and ask the hospital to communicate to the TPA that the cashless approval is not being used.

If this is not done, the amount approved could get blocked in the customer's policy and could prejudice the approval of the subsequent request.

C. Documentation in health insurance claims

Health insurance claims require a range of documents for processing, as explained earlier. Each document is expected to assist in answering the two key questions – admissibility (Is it payable?) and extent of claim (how much?).

This section explains the need for and content of each of the documents required to be submitted by the customers:

1. Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. It details the complete information about the condition of the patient and the line of treatment.

As per IRDAI Standardization Guidelines the contents of a standard Discharge Summary are as follows:

1. Patient's Name
2. Telephone No / Mobile No
3. IPD No
4. Admission No
5. Treating Consultant/s Name, contact numbers and Department / Specialty
6. Date of Admission with Time
7. Date of Discharge with Time
8. MLC No / FIR No
9. Provisional Diagnosis at the time of Admission
10. Final Diagnosis at the time of Discharge
11. ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis
12. Presenting Complaints with Duration and Reason for Admission
13. Summary of Presenting Illness
14. Key findings on physical examination at the time of admission
15. History of alcoholism, tobacco or substance abuse, if any
16. Significant Past Medical and Surgical History, if any
17. Family History if significant/relevant to diagnosis or treatment
18. Summary of key investigations during Hospitalization
19. Course in the Hospital including complications if any
20. Advice on Discharge
21. Name & Signature of treating Consultant/ Authorized Team Doctor
22. Name & Signature of Patient / Attendant

A well written discharge summary helps the claim processing person immensely to understand the illness / injury and the line of treatment, thereby speeding up the process of settlement. Where the patient unfortunately does not survive, the discharge summary is termed **Death Summary** in many hospitals.

The discharge summary is always sought in original.

2. Investigation reports

Investigation reports assist in comparing the diagnosis and the treatment, thereby providing the necessary information to understand the exact condition that prompted the treatment and the progress made during the hospitalization.

Investigation reports usually consist of:

a) Blood test reports;

b) X-ray reports;

c) Scan reports and

d) Biopsy reports

All investigation reports carry the name, age, gender, date of test etc. and typically presented in original. The insurer may return the X-ray and other films to the customer on specific request.

3. Consolidated and detailed bills:

This is the document that decides what needs to be paid under the insurance policy. Earlier there was no standard format for the bill, but IRDAI Standardization Guidelines provide format for consolidated and detailed bills. The student is advised to understand the details available on the IRDAI website.

While the consolidated bill presents the overall picture, the detailed bill will provide the break up, with reference codes.

Scrutiny of non-payable expenses is done using the detailed bill, where the non-admissible expenses are rounded off and used for deduction under the expense head to which it belongs.

The bills have to be received in original.

4. Receipt for payment

Being a contract of indemnity, the reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid.

While the amount paid must correspond to the total of the bill, many hospitals do provide an element of concession or discount in the payable amount. In such a case, the insurer is called to pay only the amount actually paid on behalf of the patient.

The receipt should be numbered and or stamped and be presented in original.

5. Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. The claim form has now been standardized by IRDAI and broadly consists of:

a) Details of the primary insured and the policy number under which the claim is made.
b) Details of the insurance history

c) Details of the insured person hospitalized.

d) Details of the hospitalization such as hospital, room category, date and time of admission and discharge, whether reported to police in case of accident, system of medicine etc.

e) Details of the claim for which the hospitalization was done including breakdown of the costs, pre and post-hospitalization period, details of lump-sum/cash benefit claimed etc.

f) Details of bills enclosed

g) Details of bank account of primary insured for remittance of sanctioned claim

h) Declaration from the insured.

Besides information on disease, treatment etc., the declaration from the insured person makes the claim form the most important document in the legal sense.

It is this declaration which applies the **"doctrine of utmost good faith"** into the claim, breach of which attracts the misrepresentation clause under the policy.

6. Identity proof

With the increasing use of identity proof across various activities in our life, the general proof of identity serves an important purpose – that of verifying whether the person covered and the person treated are one and the same.

Usually identification document which is sought could be:

a) Voters identity card,

b) Driving license,

c) PAN card,

d) Aadhaar card etc.

Insistence on identity proof has resulted in a significant reduction of impersonation cases in cashless claims as the identity proof is sought before hospitalization, making it a duty of the hospital to verify and present the same to the insurer or the TPA.

In reimbursement claims, the identity proof serves a lesser purpose.

7. Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required. It states the cause of accident and if the person was under the influence of alcohol, in case of traffic accidents.

b) Case indoor papers in case of complicated or high value claims. Indoor case paper or case sheet is a document which is maintained at the hospital end, detailing all treatment given to patient on day to day basis for entire duration of hospitalization.

c) Dialysis / Chemotherapy / Physiotherapy charts where applicable.

d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked.

The claims team uses certain internal document formats for processing a claim. These are:

i. Checklists for document verification,

ii. Scrutiny/ settlement sheet,

iii. Quality checks / control format.

Though these formats are not uniform across the insurers, let us study the purpose of the documents with a specimen of the usual contents.

Table 2.2

1.	**Document verification sheet**	It is the simplest of all, a check mark placed on the list of documents received to note that these have been submitted by the customer. Some insurers may provide a copy of this as an acknowledgement to the customer.

2.	**Scrutiny/process sheet**	It is usually a single sheet where the entire processing notes are captured. a) Name of the customer and id number b) Claim number, date of receipt of the claim papers c) Policy overview, Section 64VB compliance d) Sum insured and utilization of sum insured e) Date of hospitalization and discharge f) Diagnosis and treatment g) Claim admissibility / processing comments with reason thereof h) Computation of claim amount i) Movement of the claim with dates and names of people who processed
3.	**Quality checks / control format**	Final check or quality control format for checking of claim by person other than claim handler Besides check list and claim scrutiny questionnaire, the quality control/audit format shall also include information relating to: a) Settlement of claim, b) Rejection of claim or c) Requesting for additional information.

Test Yourself 2

Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?

I. Investigation report
II. Settlement sheet
III. Case paper
IV. Hospital registration certificate

D. Claims reserving

1. Reserving

This refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims. While this looks very simple, the process of reserving requires enormous care – any mistake in reserving affects the insurer's profits and solvency margin calculation.

Processing systems today have built in capability to compute the reserves as at any point of time.

Test Yourself 3

The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.

I. Pooling
II. Provisioning
III. Reserving
IV. Investing

E. Role of third party administrators (TPA)

1. Introduction of TPAs in India

The insurance sector was opened to private players in the year 2000. Meanwhile, the demand for healthcare products was also growing with new products being launched. A need was therefore felt for the introduction of a channel for post-sale services in health insurance. This offered the opportunity for professional Third Party Administrators to be introduced.

Seeing this, the Insurance Regulatory and Development Authority allowed TPAs to be introduced into the market under license from IRDAI, provided they complied with The IRDAI (Third Party Administrators – Health Insurance) Regulations, 2001 notified on 17th Sept 2001.

Definition

As per Regulations,

"Third Party Administrators or TPA means any person who is licensed under the IRDAI (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

"Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

Thus the scope of TPA services starts after the sale and issue of the insurance policy. In case of insurers not using TPAs, the services are performed by in-house team.

2. Post sale service of health insurance

a) Once the proposal (and the premium) is accepted, the coverage commences.

b) If a TPA is to be used for servicing the policy, the insurer passes on the information about the customer and the policy to the TPA.

c) The TPA enrolls the members (while the proposer is the person taking the policy, members are those covered under the policy) and may issue a membership identification in the form of a card, either physical or electronic.

d) The membership with the TPA is used for availing cashless facility as well as processing of claims when the member requires the support of the policy for a hospitalization or treatment that is covered.

e) TPA processes the claim or cashless request and provides the services within the time agreed with the insurer.

The cut-off point from which the role of a TPA begins is the moment of allocation of the policy in the name of the TPA as the servicing entity. The servicing requirement continues through the policy period and through any further period that is allowed under the policy for reporting a claim.

When thousands of policies are serviced, this activity is continuous, especially when the same policy is renewed and the same TPA is servicing the policy.

3. Objectives of third party administration (TPA)

The concept of Third Party Administration in health insurance can be said to have been created with the following objectives:

a) To facilitate service to a customer of health insurance in all possible manners at the time of need.

b) To organise cashless treatment for the insured patient at network hospitals.

c) To provide fair and fast settlement of claims to the customers based on the claim documents submitted and as per procedure and guidelines of the insurance company.

d) To create functional expertise in handling health insurance claims and related services.

e) To respond to customers in a timely and proper manner.

f) To create an environment where the market objective of an insured person being able to access quality healthcare at a reasonable cost is achieved and

g) To help generate/collate relevant data pertaining to morbidity, costs, procedures, length of stay etc.,

4. Relationship between insurer and TPA

Many insurers utilize the services of the TPA for post-sale service of health insurance policies while few insurers, especially from the life insurance sector also seek assistance of a TPA for arranging pre-policy medical check-up service.

The relationship between an insurer and the TPA is contractual with a host of requirements and process steps built into the contract. IRDAI Health Insurance Standardization guidelines now lay down guidelines and provide a set of suggested standard clauses for contract between TPA and insurance company,

The services that an insurer expects out of the TPA are as follows:

A. Provider networking services

The TPA is expected to build a relationship with a network of hospitals across the country, with the objective of providing cashless claim payments for health claims to the insured persons. The recent guidelines by IRDAI require the relationship to be tri-partite including the insurer and not just between the TPA and the provider.

They also negotiate good scheduled rates for various hospitalization procedures and packages from such network hospitals reducing costs to insureds and also insurers.

B. Call centre services

The TPA is usually expected to maintain a call centre with toll-free numbers reachable at all times including nights, weekends and holidays i.e. 24*7*365. The call centre of the TPA will provide information relating to:

a) Coverage and benefits available under the policy.

b) Processes and procedures relating to health claims.

c) Guidance relating to the services and cashless hospitalization.

d) Information on network hospitals.

e) Information on balance sum insured available under the policy.

f) Information on claim status.

g) Advice on missing documents in case of claims.

The call centre should be accessible through a national toll free number and the customer service staff should be able to communicate in the major languages normally spoken by the customers. These details are of course governed by the contract between the insurers and their TPAs.

C. Cashless access services

Definition

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
To provide this service, the requirements of the insurer under the contract are:

a) All policy related information must be available with the TPA. It is the duty of the insurer to provide this to the TPA.

b) Data of members included in the policy should be available and accessible, without any error or deficiency.

c) The insured persons must carry an Identity Card that relates them to the policy and the TPA. This Identity Card must be issued by the TPA in an agreed format, reach the member within a reasonable time and should be valid throughout the policy period.

d) TPA must issue a pre-authorization or a Letter of Guarantee to the hospital based on the information provided for requesting the cashless facility. It could seek more information to understand the nature of illness, treatment proposed and the cost involved.

e) Where the information is not clear or not available, the TPA can reject the cashless request, making it clear that denial of cashless facility is not to be construed as denial of treatment. The member is also free to pay and file a claim later, which will be considered on its merits.

f) In emergency cases, the intimation should be done within 24 hours of admission and the decision on cashless communicated.

D. Customer relationship and contact management

The TPA needs to provide a mechanism by which the customers can represent their grievances. It is usual for health insurance claims to be subjected to scrutiny and verification. It is also noted that a small percentage of the health insurance claims are denied which are outside the purview of the policy terms and conditions.

In addition, almost all health insurance claims are subject to deduction on some amount of the claim. These deductions cause customer dissatisfaction, especially where the reason for the deduction or denial is not properly explained to the customer.

To make sure that such grievances are resolved as quickly as possible, the insurer requires the TPA to have an effective grievance solution management.

E. Billing services

Under billing services, the insurer expects the TPA to provide three functions:

a) Standardized billing pattern that can help the insurer analyze the use of coverage under various heads as well as decide the pricing.

b) Confirmation that the amount charged is relevant to the treatment really required for the illness.

c) Diagnosis and procedure codes are captured so that standardization of data is possible across all TPAs in accordance with national or international standards.

This requires trained and skilled manpower in the TPA who are capable of coding, verifying the tariff and standardizing the billing data capture.

F. Claim processing and payment services

This is the most critical service offered by the TPAs. Claim processing services offered by the TPA to the insurer is usually end-to-end service from registering intimation to processing to recommending approval and payment.

Payment of claims is done through the funds received from the insurer. The funds may be provided to the TPA in the form of advance money or may be settled directly by the insurer through its bank to the customer or to the hospital.

The TPA is expected to keep an account of the monies and provide periodic reconciliation of the amounts received from the insurance company. The money cannot be used for any other purpose except for payment of approved claims.

G. Management Information Services

Since the TPA performs claim processing, all information relating to the claims individually or collectively is available with the TPA. The insurer requires the data for various purposes and such data must be provided accurately and on a timely basis by the TPA.

Thus the scope of a TPA's services can be stated as end-to-end service of the health insurance policies issued by the insurers, could be restricted to few activities, depending on requirements and MOU with particular insurer.

H. TPA Remuneration

For these services, the TPA is paid a fee on one of the following basis:

a) A percentage of the premium (excluding service tax) charged to the customer,

b) A fixed amount for each member serviced by the TPA for a defined time period, or

c) A fixed amount for each transaction of the service provided by the TPA – e.g. cost per member card issued, per claim etc.

Thus through services of TPA, insurers gain access to:

i. Cashless services

ii. Data compilation and analysis

iii. A 24 hour call centre and assistance for the customers

iv. Network of hospitals and other medical facilities

v. Support to major group customers

vi. Facilitation of the claims interaction with the customer

vii. Negotiation of tariffs and procedure prices with the hospitals

viii. Technology enabled services to ease customer service

ix. Verification and investigation of suspect cases

x. Analysis of claim patterns across companies and provision of crucial information on costs, newer methods of treatment, emerging trends and in controlling frauds

xi. Expansion of reach of services quickly

F. Claims management – personal accident

1. Personal accident

Definition

Personal accident is a benefit policy and covers accidental death, accidental disability (permanent / partial), Temporary total disability and may also have add-on coverage of accidental medical expenses, funeral expenses, educational expenses etc. depending on particular product.

The peril covered under the PA policy is "Accident".

Definition

Accident is defined as anything sudden, unforeseen, unintentional, external, violent and by visible means.

Claims manager should mark caution and check following areas on receipt of the notification of the claim:

a) Person in respect of whom the claim is made is covered under the policy

b) Policy is valid as on date of loss and premium is received

c) Loss is within the policy period

d) Loss has arisen out of "Accident" and not sickness

e) Check for any fraud triggers and assign investigation if need be

f) Register the claim and create reserve for the same

g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

2. Claims investigation

If any red alert is noticed in the claim intimation or on receipt of the claim documents, claim may be assigned to a professional investigator for verification simultaneously.

Example

Examples of red alerts for personal accident claims (for purpose of further investigation, but does not indicate positive indication of fraud or claim being fraudulent):

- ✓ Close proximity claims (claim within a short time of start of insurance)
- ✓ High weekly benefit amount with longer period of disability
- ✓ Discrepancy in the claim documents
- ✓ Multiple claims by same insured
- ✓ Indication of alcohol
- ✓ Suspected suicide
- ✓ Late night Road Traffic Accident while vehicle was being driven by insured
- ✓ Snake bite
- ✓ Drowning
- ✓ Fall from height
- ✓ Suspected sickness related cases
- ✓ Poisoning
- ✓ Murder
- ✓ Bullet injury
- ✓ Frost bite disappearance
- ✓ Homicide etc.

The main objectives of investigation are:

a) Examine the cause of loss.

b) Ascertain the extent and nature of loss.

c) Collection of evidence and information.

d) To ascertain if there is element of fraud or exaggeration of claim amount.

Please note: the objective of investigation is to verify the facts of the case and gather necessary evidence.

It is important that Claims examiner guides the investigator as to the focus of investigation.

Example

Example of case guideline:

Road traffic accident

i. When did the incident take place – exact time and date place? Date and time

ii. Was the insured a pedestrian, traveling as passenger/pillion rider or driving the vehicle involved in accident?

iii. Description on the accident, how did it take place?

iv. Was the insured under the influence of alcohol at the time of accident?

v. In case of death, what was the exact time and date of death, treatment provided before death, at which hospital etc?

The possible reason for the accident:

Mechanical failure (steering, brake etc. failure) of the insured's or opponent vehicle, due to any sickness (heart attack, seizure etc.) of the driver of the vehicle, influence of alcohol, bad road condition, weather condition, speed of the vehicle etc.

Some examples of possible fraud and leakage in personal accident claims:

i. Exaggeration in TTD period.

ii. Illness presented as accident e.g. backache due to pathological reasons converted into a PA claim after reported 'fall/slip' at home.

iii. Pre-existing accidents are claimed as fresh, by fabricating documents- Natural death presented as accidental case or pre-existing morbidity leading to death after accident

iv. Suicidal deaths presented as accidental deaths

Discharge voucher is an important document for settlement of personal accident claim, especially those involving death claims. It is also important to obtain nominee details at the time of proposal and the same should form part of policy document.

3. Claim documentation

Table 2.3

Death claim	a) Duly completed Personal Accident claim form signed by the claimant's nominee/family member b) Original or Attested copy of First Information Report. (Attested copy of FIR / Panchnama / Inquest Panchnama) c) Original or Attested copy of Death certificate. d) Attested copy of Post Mortem Report if conducted. e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport / PAN card / Voter's ID / Driving license) for address verification (Telephone bill / Bank account statement / Electricity bill / Ration card). f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized

Permanent Total Disability (PTD) and Permanent Partial Disability(PPD) Claim	a) Duly completed Personal Accident claim form signed by the claimant. b) Attested copy of First Information Report if applicable. c) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
Temporary Total Disability(TTD) Claim	a) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer. **b)** Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Test Yourself 4

Which of the following documents are not required to be submitted for Permanent Total Disability claim?

I. Duly completed Personal Accident claim form signed by the claimant.
II. Attested copy of First Information Report if applicable.
III. Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
IV. Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

G. Claims management- Overseas travel insurance

1. Overseas travel insurance policy

Though Overseas travel insurance policy has many sections covering non-medical benefits, its underwriting and claims management has traditionally been under health insurance portfolio because medical and sickness benefit is the main cover under the policy.

The covers under the policy can be broadly divided into following sections. A specific product may cover all or few of the below mentioned benefits:

a) Medical and sickness section

b) Repatriation and evacuation

c) Personal accident cover

d) Personal liability

e) Other non-medical covers:

i. Trip Cancellation
ii. Trip Delay
iii. Trip interruption
iv. Missed Connection
v. Delay of Checked Baggage
vi. Loss of Checked Baggage
vii. Loss of Passport
viii. Emergency Cash Advance
ix. Hijack Allowance
x. Bail Bond insurance
xi. Hijack cover
xii. Sponsor Protection
xiii. Compassionate Visit
xiv. Study Interruption
xv. Home burglary

As the name suggests, the policy is intended for people travelling abroad, it is natural that loss would happen outside India and claims would need to be serviced appropriately as and when reported. In case of overseas travel insurance the claim servicing usually involves a **Third Party service provider** (Assistance Company) who has established a network for providing necessary support and assistance all over the world.

Claims services essentially include:

a) Taking down the claim notification 24*7 basis;
b) Sending the claim form and procedure;
c) Guiding customer on what to do immediately after loss;
d) Extending cashless services for medical and sickness claims;
e) Arranging for repatriation and evacuation, emergency cash advance.

2. Assistance companies – Role in overseas claims

Assistance companies have their own offices and tie ups with other similar providers world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

a) Medical assistance services:

i. Medical service provider referrals
ii. Arrangement of hospital admission

iii. Arrangement of Emergency Medical Evacuation
iv. Arrangement of Emergency Medical Repatriation
v. Mortal remains repatriation
vi. Compassionate visit arrangements
vii. Minor children assistance/escort

b) Monitoring of Medical Condition during and after hospitalisation

c) Delivery of Essential Medicines

d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.

e) Pre-trip information services and other services:

i. Visas and inoculation requirements
ii. Embassy referral services
iii. Lost passport and lost luggage assistance services
iv. Emergency message transmission services
v. Bail bond arrangement
vi. Financial Emergency Assistance

f) Interpreter Referral

g) Legal Referral

h) Appointment with lawyer

3. Claims management for cashless medical cases

Claims management approach differs for cashless medical cases, reimbursement medical cases and other non-medical cases. Again, cashless medical claims management differs in US than cashless medical in other countries. We shall now study step by step process

a) Claim notification

As and when loss happens, the patient takes admission into the hospital and shows the insurance details to the admission counter. Assistance Company receives notification of a new case from hospital and/or from patient or relatives/friends. Claim procedure is then explained to the claimant.

b) Case management steps:

These may vary from company to company, common steps are listed below:

i. Assistance Company case manager verifies the benefits, sum insured, policy period, name of the policy holder.

ii. Case manager then gets in touch with the hospital to obtain clinical /medical notes for an update on the patient's medical condition, billing information, estimates of cost. Assistance Company receives the clinical notes and estimate of medical cost and send an update to the Insurer.

iii. Admissibility of the claim is determined and Guarantee of payment is placed to hospital subject to approval from Insurance Company.

iv. There can be scenario where investigation may be necessary in India (local place of insured) and/or in loss location. Process of investigation is similar to what is explained in personal accident claims section. Investigator abroad is selected with the help of Assistance Company or through direct contact of insurance company.

v. Assistance Company's case manager continues to monitor the case on a daily basis to provide Insurer with a clinical and cost update, progress notes, etc. in order to obtain authorization for continuation of treatment.

vi. Once the patient is discharged, case manager works diligently with the hospital to confirm final charges.

vii. Assistance Company ensures that the bill is properly scrutinized, scrubbed and audited. Any error found is notified to the billing department of the hospital for rectification.

viii. Final bill is then re-priced as per the rates agreed between the provider and Assistance Company or its associate reprising agent. The earlier the payment assurance made to hospital, better discount through re-pricing is possible.

Re-pricing is typically characteristic of US healthcare and as such, is not applicable for non US cases. This is a major difference between cashless medical case in US and non-US cases.

c) Claims processing Steps:

i. The claims assessor receives the re-priced/original bill, verifies and ensures that coverage was in place for the dates of service and treatment rendered. The bill received by the Assistance Company is audited by the claims department to ensure the charges are in line and as per the treatment protocol. The discount is re-confirmed and the bill is processed.

ii. The bill is then sent to Insurer for payment accompanied by re-pricing notification sheet and explanation of benefits (EOB).

iii. Insurance company receives the bill and authorizes immediate payment to Assistance Company.

d) Payment process steps:

i. Assistance Company receives authorization from Insurer to release payment to the hospital via local office.

ii. The finance department releases the payment

e) Hospitalization Procedures

i. The system in overseas countries, especially US and Europe are quite different from the hospitals in India since majority of population has universal health coverage either through private insurance or through government schemes. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

In most countries treatment is not delayed for want of confirmation of insurance coverage or cash deposit.

Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

If payment is immediate, hospitals tend to offer very high discounts for immediate payment. Re-pricing agencies generally negotiate with hospitals for discounts for early settlement of hospital bills.

ii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.

iii. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.

iv. Hospitals usually contact the assistance companies/insurers on the call centre numbers to check the validity of the policy and verify coverage's.

v. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.

vi. Some basic information required by the insurer/assistance provider to determine admissibility are

1. Details of ailment

2. In case of any previous history ,details of hospital, local medical officer in India:

- ✓ Past history, current treatment and further planned course in hospital and request for immediate sending of
- ✓ Claim form along with attending physicians statement
- ✓ Passport copy
- ✓ Release of medical information form

f) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made though cheque or electronic transfer.

i. **Personal accident claims** are processed in similar fashion as explained in personal accident claims section.
ii. **Bail bond cases and financial emergency cases** are paid upfront by Assistance Company and later claimed from insurance company.
iii. **Claims repudiation** of untenable claims follows the same process as for all other claims.

g) Claim documentation for Medical Accident and Sickness Expenses

i. Claim form
ii. Doctor's report
iii. Original Admission/discharge card
iv. Original Bills/Receipts/Prescription
v. Original X-ray reports/ Pathological/ Investigative reports
vi. Copy of passport/Visa with Entry and exit stamp

The above list is only indicative. Additional information/documents may be required depending on specific case details or depending upon claim settlement policy/procedure followed by particular insurer.

Test Yourself 5

_____ are paid upfront by Assistance Company and later claimed from insurance company.

I. Bail bond cases
II. Personal accident claims
III. Overseas travel insurance claims
IV. Untenable claims

Summary

a) Insurance is a 'promise' and the policy is a 'witness' to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise.

b) One of the key rating parameter in insurance is the claims paying ability of the insurance company.

c) Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.

d) In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer / TPA and later submits the documents for settlement of the claim.

e) In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer / TPA for payment.

f) Claim intimation is the first instance of contact between the customer and the claims team.

g) If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/TPA or be entrusted to a professional investigation agency.

h) Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

i) In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer forums or even the legal authorities.

j) Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.

k) The TPA provides many important services to the insurer and gets remunerated in the form of fees.

Self-Examination Questions

Question 1

Who among the following is considered as primary stakeholder in insurance claim process?

I. Customers
II. Owners
III. Underwriters
IV. Insurance agents/brokers

Question 2

Girish Saxena's insurance claim was denied by insurance company. In case of a denial, what is the option available to Girish Saxena, apart from the representation to the insurer?

I. To approach Government
II. To approach legal authorities
III. To approach insurance agent
IV. Nothing could be done in case of case denial

Question 3

During investigation, of a health insurance claim presented by Rajiv Mehto, insurance company finds that instead of Rajiv Mehto, his brother Rajesh Mehto had been admitted to hospital for treatment. The policy of Rajiv Mehto is not a family floater plan. This is an example of _____fraud.

I. Impersonation
II. Fabrication of documents
III. Exaggeration of expenses
IV. Outpatient treatment converted to in-patient / hospitalization

Question 4

Under which of the following condition, is domiciliary hospitalization is covered in a health insurance policy?

I. The condition of the patient is such that he/she can be removed to the Hospital/Nursing Home , but prefer not to
II. The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein
III. The treatment can be carried out only in hospital/Nursing home
IV. Duration of hospitalization is exceeding 24 hours

Question 5

Which of the following codes capture the procedures performed to treat the illness?

I. ICD
II. DCI
III. CPT
IV. PCT

Answers to Self-Examination Questions

Answer 1

The correct option is I.

Customers are primary stakeholder in insurance claim process

Answer 2

The correct answer is II.

In case of insurance claim denial, individuals can approach legal authorities.

Answer 3

The correct option is I.

This is an example of impersonation, as the person insured is different from person treated.

Answer 4

The correct answer is II.

Domiciliary treatment is provided in health insurance policy, only when the patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

Answer 5

The correct option is III.
Current Procedure Terminology (CPT) codes capture the procedures performed to treat the illness.