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SUPPLEMENT ROFESSIONAL PROGRAMME

(NEW SYLLABUS)

for

June, 2022 Examination

INSURANCE - LAW & PRACTICE

MODULE 3

ELECTIVE PAPER 9.2

INDEX

Lesson 2 - Regulatory Framework of Insurance Business in India

Guidelines on Standard Professional Indemnity Policy for Insurance Brokers/Corporate Agent /Web Aggregators/Insurance Marketing Firms (Ref. No: IRDAI/ INT/ GDL/ 146/ 05/ 2021 dated June 11, 2021)

Insurance Regulatory and Development Authority of India (IRDAI) has issued Guidelines on Standard Professional Indemnity Policy for Insurance Brokers / Corporate Agent / Web Aggregators / IMF for insurance intermediaries which are engaged in solicitation and distribution of insurance products and are required to take Professional Indemnity Insurance policy in order to get themselves from claim lodged against them.
The objective of these guidelines is to specify the professional indemnity policy that meets the regulatory requirements.

These guidelines came into effect from 1st July, 2021. Policies issued shall cover all damages resulting from any claim for breach of duty of the insured, fraud and dishonesty of any employee which the insured becomes legally liable to pay arising out of claims first made in writing against the insured during policy period including costs and expenses incurred with prior consent of insurers subject always to the limits of indemnity and other terms, conditions and exceptions of the policy. The ratio of limit of indemnity any one accident to any one year shall not exceeds 1:1.

For details:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4509&flag=1

Discontinuance of an ULIP

Customers have the option to stop paying the premiums under any life insurance policy. Under ULIPs, since there is a term insurance portion and investment portion, for the investment portion, the investments have already been made and the fund value which represents the marked to market value of the investments is payable to the Policyholder. There is a lock-in period of 5 years under a ULIP policy from the commencement of the policy, during which the investments cannot be withdrawn. However, there are certain rules attached to such discontinuance as follows:

(1) For every premium there is a grace period which is 30 days for all modes, except for monthly modes for which the grace period is 15 days

- During the period of grace, the Customer has the full life cover and if death happens, full sum assured is paid subject to deduction of unpaid premiums. If the premiums are not paid within days of grace. Within five consecutive years from the commencement of the policy. The fund value shall be credited to the discontinued policy fund and shall be paid at the end of revival period or lock-in period of 5 years, whichever is later, or
- Beyond five consecutive years from the commencement of policy: The benefits shall be reduced on the basis of actual premium paid as against total premiums payable.

(2) If the premiums are not paid after the days of grace, a Notice is sent within 3 months from the unpaid premium to the Customer giving 2 options - either to revive the Policy within a period 3 years from the date of unpaid premium (or) to completely withdraw from the Fund (applicable if the premium is not paid beyond five consecutive years from the commencement of policy). Revival is the option given to Customer to pay all the arrears of premiums payable and reinstate the Policy for its full benefits.

(3) If the customer does not exercise any option:

- Where premium is not paid within five consecutive years from the commencement of the policy: The proceeds shall remain invested in the discontinued policy fund and shall be paid at the end of lock-in period of 5 years, or
- Where premium is not paid beyond five consecutive years from the commencement of policy: The proceeds of the fund value shall be paid at the end of the revival period.

The policy shall terminate upon such payment.

(4) If the Customer wants to revive the Policy within 2 years, then also the funds are moved from active ULIP fund to Discontinuance fund and remains in the Discontinuance fund till the completion of the 2-year period given for the Customer for exercising the option of revival.

Therefore, under ULIPs, even upon discontinuance, no payout is possible till completion for five Policy years from the date of commencement of Policy.

In summary, no benefit can be paid to the Policyholder under ULIPs till completion of 5 Policy years. This is primarily intended to distinguish ULIPs from Mutual Fund - Life insurance ULIPs are long term in nature whereas Mutual funds are short term.

Lesson 5- Applications of Life Insurance

Financial Planning is the process of framing financial policies in relation to procurement, investment and administration of funds of an enterprise/ Individual.

Objectives of Financial Planning

Financial Planning has got many objectives to look forward to:

a. Determining capital requirements- This will depend upon factors like cost of current and fixed assets, promotional expenses and long- range planning. Capital requirements have to be looked with both aspects: short- term and long- term requirements.
b. Determining capital structure- The capital structure is the composition of capital, i.e., the relative kind and proportion of capital required in the business. This includes decisions of debt- equity ratio- both short-term and long- term.
c. Framing financial policies with regards to cash control, lending, borrowings, etc.
d. A finance manager ensures that the scarce financial resources are maximally utilized in the best possible manner at least cost in order to get maximum returns on investment.

Examples of goals to focus on in personal financial plan:

- paying off your student loans;
- saving for a down payment on a house;
- taking a series of training courses to learn a new skill;
- paying off the debt from surgery, etc.

Financial habits

1. Regularly review and update your financial plan.
2. Set financial goals that are meaningful.
3. Create a budget and use it to guide your spending.
4. Find passive income to improve your income.

Basic Methods for Risk Management

Avoidance
Avoidance is a method for mitigating risk by not participating in activities that may incur injury, sickness, or death. Smoking cigarettes is an example of one such activity because avoiding it may lessen both health and financial risks.
Risk management strategies used in the financial world can also be applied to managing one's own health.

Retention
Retention is the acknowledgment and acceptance of a risk as a given. Usually, this accepted risk is a cost to help offset larger risks down the road, such as opting to select a lower premium health insurance plan that carries a higher deductible rate. The initial risk is the cost of having to pay more out-of-pocket

medical expenses if health issues arise.
If the issue becomes more serious or life-threatening, then the health insurance benefits are available to cover most of the costs beyond the deductible. If the individual has no serious health issues warranting any additional medical expenses for the year, then they avoid the out-of-pocket payments, mitigating the larger risk altogether.

Sharing
Sharing risk is often implemented through employer-based benefits that allow the company to pay a portion of insurance premiums with the employee. In essence, this shares the risk with the company and all employees participating in the insurance benefits. The understanding is that with more participants sharing the risks, the costs of premiums should shrink proportionately. Individuals may find it in their best interest to participate in sharing the risk by choosing employer health care and life insurance plans when possible.

Transferring
The use of health insurance is an example of transferring risk because the financial risks associated with health care are transferred from the individual to the insurer. Insurance companies assume the financial risk in exchange for a fee known as a premium and a documented contract between the insurer and individual. The contract states all the stipulations and conditions that must be met and maintained for the insurer to take on the financial responsibility of covering the risk.

Loss Prevention and Reduction
This method of risk management attempts to minimize the loss, rather than completely eliminate it. While accepting the risk, it stays focused on keeping the loss contained and preventing it from spreading. An example of this in health insurance is preventative care.
Health insurers encourage preventative care visits, often free of co-pays, where members can receive annual checkups and physical examinations. Insurers understand that spotting potential health issues early on and administering preventative care can help minimize medical costs in the long run. Many health plans also provide discounts to gyms and health clubs as another means of prevention and reduction in order to keep members active and healthy.

KEY TAKEAWAYS	
	Avoidance means not participating in activities that could harm you; in the case of health, smoking is a good example.
	Retention acknowledges the inevitability of certain risks, and in terms of health care, it could mean picking a less expensive health insurance plan that has a higher deductible rate.
	Sharing risk can be applied to how employer-based benefits are often more affordable than if an individual gets their own health insurance.
	Transferring risk relates to healthcare in that the cost of the care is transferred to the insurer from the individual, beyond the cost of premiums and a deductible.
	Loss prevention and reduction are used to minimize risk, not eliminate it—the same concept is used in healthcare with preventative care.

Investment Planning

Investment planning is the process of identifying financial goals and converting them through building a plan. Investment planning is the main component of financial planning. The investment planning begins with identification of goals and objectives.

4 steps to creating your plan

1. Set specific and realistic goals. For example, instead of saying you want to have enough money to retire comfortably, think about how much money you'll need.
2. Calculate how much you need to save each month.
3. Choose your investment strategy.
4. Develop an investment policy statement.

Investment Products

A. Equity Mutual Funds

Equity mutual fund schemes predominantly invest in equity stocks. As per current the Securities and Exchange Board of India (SEBI) Mutual Fund Regulations, an equity mutual fund scheme must invest at least 65 percent of its assets in equity and equity-related instruments. An equity fund can be actively managed or passively managed.

In an actively traded fund, the returns are largely dependent on a fund manager's ability to generate returns. Index funds and exchange-traded fund (ETFs) are passively managed, and these track the underlying index. Equity schemes are categorized according to market-capitalization or the sectors in which they invest. They are also categorized by whether they are domestic (investing in stocks of only Indian companies) or international (investing in stocks of overseas companies).

B. Debt Mutual Funds

Debt mutual fund schemes are suitable investors who want steady returns. They are less volatile and, hence, considered less risky compared to equity funds. Debt mutual funds primarily invest in fixed-interest generating securities like corporate bonds, government securities, treasury bills, commercial paper and other money market instruments.

However, these mutual funds are not risk free. They carry risks such as interest rate risk and credit risk. Therefore, investors should study the related risks before investing.

C. National Pension System (NPS)

The National Pension System is a long term retirement - focused investment product managed by the Pension Fund Regulatory and Development Authority (PFRDA). The minimum annual (April-March) contribution for an NPS Tier-1 account to remain active has been reduced from Rs. 6,000 to Rs. 1,000. It is a mix of equity, fixed deposits, corporate bonds, liquid funds and government funds, among others. Based on your risk appetite, you can decide how much of your money can be invested in equities through NPS.

D. Public Provident Fund (PPF)

The Public Provident Fund is one product a lot of people turn to. Since the PPF has a long tenure of 15 years, the impact of compounding of tax-free interest is huge, especially in the later years. Further, since the interest earned and the principal invested is backed by sovereign guarantee, it makes it a safe investment. Remember, interest rate on PPF in reviewed every quarter by the government.

E. Bank Fixed Deposit (FD)

A bank fixed deposit is considered a comparatively safer (than equity or mutual funds) choice for investing in India. Under the deposit insurance and credit guarantee corporation (DICGC) rules, each depositor in a bank is insured up to a maximum of Rs. 5 lakh with effect from 4th February, 2020 for both principal and interest amount.

Earlier, the coverage was maximum of Rs. 1 lakh for both principal and interest amount. As per the need, one may opt for monthly, quarterly, half-yearly, yearly or cumulative interest option in them. The interest rate earned is added to one's income and is taxed as per one's income slab.

F. Senior Citizens' Saving Scheme (SCSS)

Probably the first choice of most retirees, the Senior Citizens' Saving Scheme is a must-have in their investment portfolios. As the name suggests, only senior citizens or early retirees can invest in this scheme. SCSS can be availed from a post office or a bank by anyone above 60.
SCSS has a five-year tenure, which can be further extended by three years once the scheme matures. The upper investment limit is Rs. 15 lakh, and one may open more than one account. The interest rate on SCSS is payable quarterly and is fully taxable. Remember, the interest rate on the scheme is subject to review and revision every quarter.

However, once the investment is made in the scheme, then the interest rate will remain the same till the maturity of the scheme. Senior citizen can claim deduction of up to Rs 50,000 in a financial year under section 80TTB on the interest earned from SCSS.

G. Pradhan Mantri Vaya Vandana Yojana (PMVV Y)

PMVVY is for senior citizens aged 60 years and above to provide them an assured return of 7.4 per cent per annum. The scheme offers pension income payable monthly, quarterly, half-yearly or yearly as opted. The minimum pension amount is Rs. 1,000 per month and maximum Rs. 9,250 per month. The maximum amount that can be invested in the scheme Rs. 15 lakh. The tenure of the scheme is 10 years. The scheme is available till March 31, 2023. At maturity, the investment amount is repaid to the senior citizen. In the event of death of senior citizen, the money will be paid to the nominee.

H. Real Estate

The house that you live in is for self-consumption and should never be considered as an investment. If you do not intend to live in it, the second property you buy can be your investment. The location of the property is the single most important factor that will determine the value of your property and also the rental that it can earn. Investments in real estate deliver returns in two ways - capital appreciation and

rentals. However, unlike other asset classes, real estate is highly illiquid. The other big risk is with getting the necessary regulatory approvals, which has largely been addressed after coming of the real estate regulator.

I. Gold

Possessing gold in the form of jewellery has its own concerns such as safety and high cost. Then there's the 'making charges', which typically range between 6-14 per cent of the cost of gold (and may go as high as 25 percent in case of special designs). For those who would want to buy gold coins, there's still an option. Many banks sell gold coins now-a-days. An alternate way of owning gold is via paper gold. Investment in paper gold is more cost-effective and can be done through gold ETFs. Such investment (buying and selling) happens on a stock exchange (NSE or BSE) with gold as the underlying asset. Investing in Sovereign Gold Bonds is another option to own paper-gold. An investor can also invest via gold mutual funds.

J. Equity Market

This market is also known as share market or stock market and is the place where shares are purchased and sold. Share represents an ownership in the Company. Investing in stocks might not be everyone's cup of tea as it's a volatile asset class and there is no guarantee of returns. Further, not only is it difficult to pick the right stock, timing your entry and exit is also not easy.

The only silver lining is that over long periods, equity has been able to deliver higher than inflation-adjusted returns compared to all other asset classes.
At the same time, the risk of losing a considerable portion or even all of your capital is high unless one opts for stop-loss method to curtail losses. In stop-loss, one places an advance order to sell a stock at a specific price.
To reduce the risk to certain extent, you could diversify across sectors and market capitalisations. To directly invest in equity, one needs to open a demat account.

Factors that influence the price of a share:

(1) Economy - GDP, Inflation, Interest rate, employment, industrial production etc. Favourable news indicates health economy and share price will increase.
(2) Sectoral Factors - certain conditions in the economy or Government Policy announcements might impact a particular sector or group of sectors.
(3) Company specific news.
(4) Business Life Cycle - Shares prices depend on whether the business is just a start-up or at growth stage or matured one or in decline phase.

What Goes into WILL?

- **The Introductory Clause**
  Example: This is my last will and testament, or my will is as follows:
- **Revocation of Prior Wills**
- **Debt and Final Expenses:** Make provisions for payments of all existing debts. In case estate is not sufficient to pay expenses and debts, estate is considered "insolvent"

- **Bequest clauses:** Determines which survivors get how much and the base in which the estate can be distributed to the survivors.
  Example: All the rest/remainder and the residual of my estate I bequeath to my wife and children, to be divided equally among them.
- **Survivor clauses**
- **Appointment clauses**
- **The execution:** Final clauses are the most important and are called:
- **Testamonium clause:** In this clause the testator estate that he is signing the document as true Will as of a specific date.

- **Attestation clause:** This clause states that witness to Will agree that they have witnessed signing of will in each others presence

Sample WILL

This is the last will and testament of Raj Kohli resident of B 123 Lajpat Nagar, New Delhi

• I revoke all former wills and testamentary dispositions made by me and declare this to be my last will.

• I appoint Raman Sahni resident of A 321 Saket, New Delhi to be executor of my will and trustee of my estate. if my trustee is unable or unwilling to act, or dies before my estate is distributed, I appoint Manoj to be an alternative executor of my will and trustee of my estate.

Subject to the payment of my debts, and testamentary expenses and all probate and other duties payable in respect of my estate or in consequence of my death I give everything I own to my wife, Rajni Kohli.

But if the said Rajni Kohli fails to survive me, I give the balance of my estate to my trustee upon trust for such of my children who survive me and attain the age of eighteen years absolutely and if more than one in equal shares.

(A) I empower my trustee to apply for the maintenance, education and benefit of any minor beneficiary as my trustee in their absolute discretion shall think fit the whole or any part of the capital or the income or both of that part of my estate to which that beneficiary is entitled or may in the future be entitled.

(B) I give my trustee a discretionary power of sale over the said estate.

It is my wish that Robin Singh should be the guardian of my children until they attain the age of eighteen years.

In witness whereof I have here-unto set my hand this 19th day of May Two Thousand and Twenty One.

(Signed by the said testator in our presence and witnessed by us in the presence of)

(Name of witnesses and each other)

Signature of 1st witness

Signature of 2nd witness

Lesson 6 - Life Insurance – Finance

Accounting Procedures- Premium Accounting

Premiums paid are recorded in the life insurance premium expense account. As a practical matter, the difference between the annual increase in cash value and the annual premium paid will be reported as an item of income or expense - as appropriate.

How do you record insurance premiums in accounting?

At the end of any accounting period, the amount of the insurance premiums that remain prepaid should be reported in the current asset account, Prepaid Insurance. The prepaid amount will be reported on the balance sheet after inventory and could part of an item described as prepaid expenses.

Which Accounting Method Should Insurance Companies Use?

The accounting method used by insurance company will determine when you track expenses and income. There are two general accounting methods:

1. Cash-basis accounting: Transactions are recorded when money changes hands.: Using the cash-basis accounting method, you would not record a policy that's been sold until you receive the payment from the customer.

2. Accrual-basis accounting: Transactions are recorded as soon as the income is earned or an expense is incurred. Using the accrual-basis accounting method, you would record the sale of a policy when the agreement is signed, regardless of whether the customer pays at that time or later.

Accounting Procedures– Disbursements

What is a life insurance disbursement?

This option works like an annuity and allows a beneficiary to receive insurance proceeds as guaranteed income for life in fixed monthly payments. The amount of each payment is based on the amount of the death benefit and the beneficiary's gender and age at the time of the policyholder's death.

Life insurance should not be considered an investment despite the presence of investment-like cash value accounts in permanent policies. Because the Internal Revenue Service is aware of the potential for abuse and tax-free earnings from these products, restrictions have been placed on how and when money may be withdrawn and in what situations you must claim disbursements on your income taxes.

Policy Loans

Permanent life insurance policies accumulate a cash value, which you can borrow at any time for any reason. The cash value is a combination of excess premium contributions and any interest earned by the investments in that account. If you receive a cash disbursement from your policy, the life insurance company will structure it as a loan and you will be required to repay the money plus interest. Taxes are

not due on loan proceeds. Provided you repay the loan, you will not have to claim the disbursement on your income taxes.

Policy Surrenders

If you surrender your permanent life insurance policy and receive any money that remained in the cash value account, you might be required to claim that disbursement on your taxes. Only the amount you receive that is above your cost basis is considered taxable earnings. The IRS defines cost basis as "the total of premiums that you paid for the life insurance policy, less any refunded premiums, rebates, dividends, or unrepaid loans that were not included in your income." If the surrender value of your life insurance policy is less than your cost basis, you do not have to claim that money.

Death Benefits

In most cases, death benefit disbursements are not considered taxable income. As the beneficiary on a life insurance policy, any money you receive is free from federal income tax provided that sum is not larger than the policy's death benefit. If the insurance company places the death benefit in an interest-bearing account, rather than give you a lump sum, any interest earned in that account must be claimed on your taxes. The life insurance company Axa- Equitable explains that "The funds that the insurer holds are earning interest, and when a payment is made to your beneficiary, it may include both principal and interest earned by that principal, or only interest." Similarly, if the company pays the death benefit in installments, the IRS requires you to claim the interest portion of each payment.

Employer-Owned Policies

Before the Pension Protection Act of 2006, death benefit disbursements received by employers were tax-free. To stop the employer practice of insuring employees simply to collect tax-free money, part of the Pension Protection Act changed the rules regarding employer-owned life insurance policies. Unless specific notices are given and criteria met, disbursements to employers are fully taxable. To avoid taxation of death benefit proceeds, companies must notify workers in writing of their intent to purchase life insurance, the face amount of the policy and whether coverage will continue after employment is terminated. Workers must acknowledge these facts and provide consent to being insured under such terms.

Accounting Procedure: Expenses of Management

What are insurance management expenses?

Expenses of management would include all those in the nature of operating expenses - commission, brokerage, remuneration to agents and to intermediaries, charged to the revenue account. No general insurance or health insurance business can exceed the amount stipulated.

Example of Payment for Insurance Expense

Let's assume that a company is started on December 1 and arranges for business insurance to begin on December 1. On December 1 the company pays the insurance company $12,000 for the insurance premiums covering one year.

The company will record the payment with a debit of $12,000 to Prepaid Insurance and a credit of $12,000 to Cash. On December 31, the company writes an adjusting entry to record the insurance expense that was used up (expired) and to reduce the amount that remains prepaid. This is accomplished with a debit of $1,000 to Insurance Expense and a credit of $1,000 to Prepaid Insurance. This same adjusting entry will be prepared at the end of each of the next 11 months.

Sr. No.	**Premium payment term on in-force policies**	**Allowance % of premiums received**	
		Beyond 10 years of Life insurer's business operations	Up to 10 years of Life insurer's business operations
	Regular Premium Policies **(I) Regular Premium Pure Risk Policies** **For Premium payment of 10 years & above** (a) First year's premium (b) Renewal premium For Premium payment term of less than 10 years (a) First year's premium (100 -(PPT*7.5)) **(II) Regular premium (other than Pure Risk)** 5 to 7 years (both inclusive) (a) First Year's premium (b) Renewal premium 8 and 9 years (both inclusive) (a) First Year's Premium (b) Renewal Premium	 100 25 60 15 70 15	 100 25 70 18 80 19

Life Insurance Investment

Investment management is a backbreaking area of operation in any insurance company, which has to put aside certain sum for claim that might arise over a period of time keeping in view the changing nature of risk, regulations and variety of investment objectives implicit in mind of policyholders and shareholders. Investment earnings made by insurance firms constitute a significant proportion of their operating results; thereby improving their competitiveness. Investment results are increasingly key determinants of both adequacy and volatility of insurance companies' financial wellbeing and considered in calculation of premium rate and for declaration of bonus by insurers.

Investing In Life Insurance

In recent times, there has been growing awareness about life insurance products and the various benefits they offer. An insurance policy is primarily meant to protect the income of the family's breadwinner. The idea is, if the breadwinner dies, their dependents may continue to live comfortably. The circle of life begins at birth, followed by education, marriage and eventually, after a lifetime of work, people look forward to a life of retirement. Our finances too tend to change as we go through the various phases of our life. It is important to remember that with time, the needs and aspirations tend to change and we have to ensure that there is a suitable, dynamic financial plan in place to take care of both the certain and the uncertain phases of life. Life insurance is a tool that helps you achieve this objective.

Why Life Insurance?

Life insurance provides protection to the family - the family gets a specified amount of money in lump sum when they need it the most, that is, when the breadwinner is not around. While the emotional loss cannot be mitigated, the amount received from an insurance company can help take care of the family's financial future. Apart from this, various types of life insurance policies could provide financial stability even when you are alive through periodic payments of a portion of the insured amount, by providing returns for your invested corpus, or even by helping you to reduce taxes.

Advantages of Life Insurance

- Risk Cover: Life today is full of uncertainties; in this scenario life insurance ensures that your loved ones continue to enjoy a good quality of life against any unforeseen event.
- Planning for life stage needs: Life insurance not only provides for financial support in the event of untimely death, but also acts as a long term investment. You can meet your financial goals, be it your children's education, their marriage, building your dream home or planning a relaxed retired life, according to your life stage and risk appetite.
- Builds the habit of saving: Life insurance is a long-term contract where as policyholder, you have to pay a fixed amount at a defined periodicity. This builds the habit of long-term savings. Regular savings over a long period ensures that a decent corpus is built to meet financial needs at various life stages.
- Growth in investment amount: Some policies like Unit-Linked Insurance Plans (ULIPS) offer an opportunity to participate in the growth of an economy by investing in various avenues including stocks.
- Tax Benefits: A number of insurance plans allow you to offset the premiums that you pay for life insurance in your taxable income. The maturity amount may also be non-taxable. Insurance is widely suggested by financial advisors to reduce your tax burden.

Factors to be considered:

Although life insurance plans come with great advantages there are a few things that we need to avoid in order avoiding inconvenience later.

Buying plans that do not meet your needs/goals: For example, let's say you prefer periodic payments from the policy to take care of your intermediate financial needs. In this case money back plans may be ideal for you. But does it make sense if you buy term plan instead of money back plan? No. So choosing

the wrong product for the wrong purpose is a common mistake that people do.

Premium paying ability: Many times it so happens that an attractive policy with high coverage amount encourages us to buy policies that we cannot afford. We should be careful while choosing insurance so that payment of premium does not become a burden.

Not evaluating your Risk Appetite: A concrete concept of investing that most investors don't understand is that to earn higher returns, the risk taken is also higher. There are chances that you might lose your hard earned money by taking higher risk in pursuit of high returns. Especially when investing in ULIPS, we go blindly by the word of the brokers / agents, and never try to understand the risks involved which is dangerous for your invested amount.

Preparation of Financial Statements for FY2019-20 and Onwards

1. Presentation of Excess Expenses of Management (EoM) in Operating Expenses:

The Authority vide Insurance Regulatory and Development Authority of India (Expenses of Management of Insurers transacting General or Health Insurance business) Regulations, 2016 have prescribed the limits of expenses of management. In case expenses of management exceed the limits prescribed by the Regulations, the excess is required to be charged to Shareholders Account i.e., Profit and Loss Account.
It is observed that some insurers are disclosing the operating expenses net of excess EoM charged to shareholders account, in Revenue Account. This leads to distorted picture of the Underwriting Results of the Insurers. In light of the same, all Insurers are advised to present the excess of EoM in Financial Statements, as under:

I. Report the gross amount of Operating expenses in Schedule-4 and Revenue Account without deducting 'Excess of allowable expenses';
II. Report excess of allowable expenses as income under Revenue account under separate sub line item as "Contribution from Shareholders Funds towards Excess EoM" in the line item "Others";
III. Report excess of allowable expenses as expenses under Profit & Loss account under separate sub line item, "Contribution to policyholders Funds towards Excess EoM" in line item "Other Expenses".

2. Personal Accident Policies in Health Segment

In terms of Section 2(6C) of the Insurance Act, 1938, Personal Accident and Travel (Including domestic as well as overseas) are part of Health Insurance. In order to have uniformity in case of business from

Personal Accident and Travel, it is hereby specified that in Financial Statements:

I. Personal Accident shall continue to be shown as a separate sub-segment within "Miscellaneous segment";
II. As the Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002 do not provide a separate segment/sub segment for Travel (including domestic as well as overseas) insurance, it shall be clubbed with "Health Segment".

For computation of Expenses of Management, Personal Accident and Travel shall be clubbed with Health Segment.

3. Deviation from Formats prescribed

It is observed that some insurers have modified the formats as prescribed by the by IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002 by way of addition/ deletion of line items.
All insurers are advised to strictly adhere to the formats prescribed by the Regulations. Any new line item, if so warranted to be disclosed separately, may be shown under "Others" in Revenue Account, P&L Account and/or relevant schedule of the financial statements by giving the break up.

4. Creation of UPR and Outstanding Claims Reserve (Including IBNR/IBNER) for Premium Ceded under Clean-cut Reinsurance Treaties

It is observed that some insurers enter into one-year Quota Share Reinsurance Treaty on Clean-cut basis. The provision towards the unexpired premium reserve / IBNR / IBNER, on such treaties, is neither provided by Direct insurer (cedant) nor by the reinsurer(s).
It is hereby advised that Direct insurers (cedant) shall create the adequate reserves, as follows, in accordance with the IRDAI (Assets, Liabilities and Solvency Margin of General Insurance Business) Regulations, 2016:

I. Unearned Premium Reserve and Premium Deficiency Reserve towards the unexpired risk at the end of the treaty period; and
II. Outstanding Claims Reserve (including IBNR/IBNER) towards the outstanding claims on the date of expiry of the treaty.

5. Rewards and Remuneration to Agents/Brokers/Other intermediaries

In order to bring the consistency, uniformity and fair presentation, it is hereby advised that rewards and/or remuneration to agents, brokers or other intermediaries shall be shown as part of Commission.

6. Segregation of Policyholders' and Shareholders' Funds

The Authority has issued to Circular IRDA/F&A/CIR/CPM/010/01/2017 dated 12th January 2017 which mandates the insurers to segregate Policyholders' Funds and Shareholders' Funds. The provisions of the Circular, which was hitherto applicable till 31stMarch 2018, are now extended for FY2018-19 and onwards, till further orders. All other provisions of the above referred Circular shall continue to be applicable.

7. Corporate Social Responsibility Expenditure

In order to bring the consistency, uniformity and fair presentation, it is hereby advised that expenditure towards Corporate Social Responsibility shall be shown in Profit and Loss Account.

One Time Settlement (OTS)

Under mentioned information to be submitted with the OTS request:

1. Name of the Company,
2. Status of the company Existing/Wound-up / Under liquidation,
3. Whether registered in NCLT: Yes / No,
4. Status of the unit: Running / Closed. If running, present capacity utilization,
5. Names of other secured creditors indicating nature of charge,
6. Break-up of outstanding dues (Principal, Interest, Others) of other Secured creditors,
7. Details of OTS sanctioned by other secured creditors,
8. Is the unit under attachment of any Secured creditor / Govt. body? Yes/No. If yes, provide details,
9. Number, date, amount of Earnest Money Demand Draft enclosed with the proposal,
10. Amount offered under OTS,
11. Details of all company's litigations pending before Courts / DRTs /NCLT / Lok Adalat and decreed accounts etc.
12. Any other information.

(Signature of Authorized signatory)

How digital technologies can make financial reporting more valuable and useful?

Technology innovations are constantly redefining how stakeholders view and manage information, raising the bar for financial reporting. Many of today's financial statement users want customized information, when and how they want it. Some users just want summarized financial information that highlights the most important events of the period; yet, others desire a lot of detail to fuel their sophisticated models and analysis.

Preferences in presentation are also changing. Many users don't read a financial report like a book, from cover to cover in linear fashion; instead, they bounce from topic to topic looking for related information. Moreover, users don't just read information - they use information -- so they want easy access to advanced features such as search and extraction. They also want the ability to lay pieces of different reports side by side to make comparisons and identify trends. Therefore, users increasingly favor electronic documents over paper reports.

So, then, why not harness the latest digital technologies to satisfy the full range of user needs?

For example: Replace two-dimensional financial reports on paper (or PDFs) with interactive, multi-dimensional reports that layer information so users can view the specific level of detail they desire.

Insert hyperlinks and "pop-up" boxes to give users instant access to related information (including information that may be outside the financial report, such as press releases, related research studies, related information on a company's website) -- right where they need it.

Employ information tags that let users toggle between different views that enable switching between a summarized view and an in-depth view of financial information, as well as allowing for different viewpoints of the same information. For example, embedding technology that can provide a look at revenue and expenses from a functional viewpoint, a nature viewpoint, and a geographical viewpoint --

all from the same data set. Technology can also be used to display financial information visually in pictures and other visual formats (instead of just words and numbers) to provide greater insights.

Use of separate but linked files to isolate current period financial data from information that is relatively unchanged from year to year. For example, separate accounting policies or other background information that, while important to understanding the reporting entity, remains fairly consistent from year to year so users with familiarity with the reporting entity can more easily hone in on more current and changing information. Changes in policies and background can be flagged in the files for easy identification. Digging even deeper, technology has the potential to produce financial information that is fundamentally more useful.

For example, the vast majority of companies today still use only the indirect method for presenting operating cash flows, despite general agreement that the direct method provides more useful information. Why? Because back in the days when the requirement to provide a cash flow statement was initially implemented, it simply wasn't practical for large conglomerates to produce cash flow statements using the direct method. Today, however, thanks to new technologies such as tagging, companies may now (or soon) be able to efficiently produce cash flow statements using the direct method.

Insurance Regulatory and Development Authority of India (Indian Insurance Companies) (Amendment) Regulations, 2021 (Ref. No: F. No. IRDAI/ Reg/6/178 /2021 dated July 09, 2021)

Insurance Regulatory and Development Authority of India (IRDAI) has issued the IRDAI (Indian Insurance Companies) (Amendment) Regulations, 2021 to harmonise the provisions of various regulations applicable to insurance companies with Insurance (Amendment) Act, 2021 read with Indian Insurance Companies (Foreign Investment) Rules, 2015 by amending the corresponding regulations. The amendment *inter-alia* are as under:

Requirement of Resident Indian citizenship for Directors, Key Management Persons, etc.

In an Indian Insurance Company having foreign investment, —
(a) a majority of its directors,
(b) a majority of its Key Management Persons, and
(c) at least one among the chairperson of its Board, its managing director and its Chief Executive Officer, shall be Resident Indian Citizens.

Explanation: For the purpose of this regulation, the expression "Resident Indian Citizen" shall have the same meaning as assigned to it in clause (o) of sub-rule (1) of rule 2 of Indian Insurance Companies (Foreign Investment) Rules, 2015.

Requirements for foreign investment exceeding forty-nine percent

In an Indian Insurance Company having foreign investment exceeding forty-nine per cent. ,—
(a) for a financial year for which dividend is paid on equity shares and for which at any time the solvency margin is less than 1.2 times the control level of solvency, not less than fifty percent of the net profit for the financial year shall be retained in general reserve; and

(b) not less than fifty per cent of its directors shall be independent directors, unless the chairperson of its Board is an independent director, in which case at least one-third of its Board shall comprise of independent directors.".

For details:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4524&flag=1

Lesson 8- General Insurance ─Practices and Procedures

Q. In a contract of Insurance, who makes the offer and which party is accepting?

A. The applicant for insurance is making the offer of his risk and the insurance company is accepting the risk, if the proposed risk is more than average degree of risk, the insurance company may either accept conditionally or reject the application.
Hence, in India the application for insurance is called as a Proposal form.

Q. Can a Minor enter into a contract of insurance?

A. No a minor cannot enter into a contract of insurance on his own. However, he can a beneficiary under a contract of insurance.

Example
The deceased life assured had not disclosed that he had suffered from pulmonary TB with Haemoptysis in his proposal form. The claim was repudiated by the insurer on the grounds of non-disclosure of material facts. It was observed that the life assured had suffered from TB and did not mention the same in the proposal form since he thought that TB is curable. The discharge record clearly mentioned that the policyholder was a case of Cirrhosis of liver, old pulmonary TB with Haemoptysis.

Hence, it can be seen that there is suppression of material facts, the complaint was dismissed and the decision of the insurer in repudiating the claim was upheld by the court.

Policy Structure or key elements

Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017

Matters To Be Stated In General Insurance Policy:

A general insurance policy shall clearly state:

i. the name(s) and address(s) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance, UIN of the product, name, code number, contact details of the person involved in sales process;
ii. full description of the property or interest insured;
iii. the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;
iv. period of Insurance; III 21
v. sums insured;
vi. perils covered and not covered;
vii. any franchise or deductible applicable;
viii. premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;
ix. policy terms, conditions and warranties, Exclusions, if any.
x. action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;

xi. 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;
xii. any special conditions attaching to the policy;
xiii. the grounds for cancellation of the policy which in the case of a retail policy, for the insurer, can be only on the grounds of mis - representation, non-disclosure of material facts, fraud or non co-operation of the insured Explanation: Products approved as retail policies under File and Use guidelines notified by the Authority from time to time fall within the purview of retail policy referred above. Provided that in the case of Commercial policies alone, other circumstances under which the policy may be cancelled be given, along with the manner of calculation of refund and notice period for cancellation;
xiv. the address of the insurer to which all communications in respect of the insurance contract should be sent;
xv. the details of the endorsements, add-on covers attaching to the main policy;
xvi. that, on renewal, the benefits provided under the policy and/or terms and conditions of the policy including premium rate may be subject to change; and
xvii. details of insurer's internal grievance redressal mechanism along with address and contact details of Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

Case:

The life assured submitted proposal on 30.3.2005. Policy commenced from 28.3.2005. The life assured died of road accident on 13.5.2005. The insurer refused to pay accident sum assured since the life assured was under the influence of alcohol at the time of accident. The claimant argued that the life assured was not driving the vehicle and hence the double accident benefit claim cannot be rejected. The insurer contended that as per Medico-Legal- Manual if the alcohol content is 100 to 300 MG % the person would have some mental confusion, emotional instability, loss of critical judgment, impaired memory, sleeplessness, slowed reaction time, loss of muscular coordination etc. As the policy conditions of DAB, if death of the life assured is caused by intentional self injury, attempted suicide, insanity or immorality or when the life assured is under the influence of intoxicated liquor, drug or narcotic, the insurer is not liable to pay the additional sum assured. The complaint was dismissed since the forum didn ot wish to interfere with the policy conditions.

Claim Procedure for Motor Insurance

A man, his wife and her brother were travelling in a two- wheeler from Kinathu Kadavu to Pollachi at night. Three people were travelling in a two-wheeler and they met with an accident. The Wife and her brother died in the accident. The insurer refused to pay the accident benefit sum assured since the accident was caused due to breach of law.

Do you think the insurer is justified in repudiating the claim?

Since, as per the MV Act only two persons are permitted, there is a breach of law. The accident has happened and death occurred due to breach of law and therefore, insurer is correct in repudiating the Accident Benefit SA.

As per IRDAI 's Policyholders' Protection Regulaitons, 2017, Matters to be stated in a Health Insurance Policy are as follows:

A health insurance policy shall clearly state:

i. The name of the policyholder and the names of each beneficiary covered, UIN of the product, name, code number, contact details of the person involved in sales process;
ii. Date of birth of the insured and corresponding age in completed years;
iii. The address of the insured;
iv. The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break;
v. The sums Insured;
vi. The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross-reference to the concerned policy section;
vii. Co-pay limits if any;
viii. The pre-existing disease (PED) waiting period, if applicable;
ix. Specific waiting periods as applicable;
x. Deductible as applicable - general and specific, if any;
xi. Cumulative Bonus, if any;
xii. Periodicity of payment of premium instalment;
xii. Policy period;
xiii. Policy terms, conditions, exclusions, warranties;
xiv. Action to be taken on the occurrence of a claim for cashless and reimbursement options separately;
xv. Details of TPA, if any engaged, their address, toll free number, website details;
xvi. Details of Grievance Redressal mechanism of insurer;
xvii. Free look period facility and portability conditions;
xviii. Policy migration facility and conditions where applicable;
xix. that, on renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate;
xx. Provision for cancellation of the policy; and
xxi. Address and other contact details of Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

GENERAL PRINCIPLES GOVERNING ISSUANCE OF GENERAL AND HEALTH INSURANCE POLICIES:

1. In stipulating the exclusions of the policy, insurers shall endeavor to classify the exclusions, wherever possible as under:

(i) Standard exclusions applicable in all policies;
(ii) Exclusions specific to the policy which cannot be waived;
(iii) Exclusions specific to the policy, which can be waived on payment of additional premium.

2. The insurers may also endeavor to broadly categorize policy conditions into following, so as to give clarity and understanding of the conditions to the policyholder:
(i) Conditions precedent to the contract;

(ii) Conditions applicable during the contract;
(iii) Conditions when a claim arises;
(iv) Conditions for renewal of the contract.

3. Every insurer shall keep the insured informed on the requirements to be fulfilled regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him so as to settle claim early.

CLAIM PROCEDURE IN RESPECT OF A GENERAL INSURANCE POLICY

1. An insured or the claimant shall give notice to the insurer of any loss arising under contract of Insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear information to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/claim, it shall do so immediately, in any case within 72 hours of the receipt of intimation from the insured. Insurer shall communicate the details of the appointment of surveyor, including the role, duties and responsibilities of the surveyor to the insured by letter, email or any other electronic form immediately after the appointment of the surveyor.

2. The insurer / surveyor shall within 7 days of the claim intimation, inform the insured / claimant of the essential documents and other requirements that the claimant should submit in support of the claim. Where documents are available in public domain or with a public authority, the surveyor/insurer shall obtain them.

3. The surveyor shall start the survey immediately unless there is a contingency that delays immediate survey, in any case within 48 hours of his appointment. Interim report of the physical details of the loss shall be recorded and uploaded/forwarded to the insurer within the shortest time but not later than 15 days from the date of first visit of the surveyor. A copy of the interim report shall be furnished by the insurer to the insured/claimant, if he so desires.

4. Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor, as the case may be, shall inform in writing to the insured under information to the insurer about the consequent delay that may result in the assessment of the claim. It shall be the duty equally of the insurer and the surveyor to follow up with the insured for pending information/documents guiding the insured with regard to submissions to be made. The insurer and/or surveyor shall not call for any information/document that is not relevant for the claim.

5. (i) The surveyor shall, subject to sub-regulation 4 above, submit his final report to the insurer within 30 days of his appointment. A copy of the surveyor's report shall be furnished by the insurer to the insured/claimant, if he so desires. Notwithstanding anything mentioned herein, in case of claims made in respect of commercial and large risks the surveyor shall submit the final report to the insurer within 90 days of his appointment. However, such claims shall be settled by the insurer within 30 days of receipt of final survey report and/or the last relevant and necessary document as the case may be.

(ii) Where special circumstances exist in respect of a claim either due to its special / complicated

nature, or due to difficulties associated with replacement/reinstatement, the surveyor shall, seek an extension from insurer for submission of his report. In such an event, the insurer shall give the status to the insured/claimant fortnightly wherever warranted. The insurer may make provisional/on account payment based on the admitted claim liability.

6. If an insurer, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor, under intimation to the insured/claimant; to furnish an additional report on certain specific issues as may be required by the insurer. Such a request may be made by the insurer within 15 days of the receipt of the final survey report.
Provided that the facility of calling for an additional report by the insurer shall not be resorted to more than once in the case of a claim.

7. The surveyor, on receipt of this communication, shall furnish an additional report within three weeks from the date of receipt of communication from the insurer.

8. On receipt of the final survey report or the additional survey report, as the case may be, and on receipt of all required information/documents that are relevant and necessary for the claim, an insurer shall, with in a period of 30 days offer a settlement of the claim to the insured/claimant. If the insurer, for any reasons to be recorded in writing and communicated to the insured/claimant, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the final survey report and/or additional information/documents or the additional survey report, as the case may be.

9. In case, the amount admitted is less than the amount claimed, then the insurer shall inform the insured/ claimant in writing about the basis of settlement in particular, where the claim is rejected, the insurer shall give the reasons for the same in writing drawing reference to the specific terms and conditions of the policy document.

10. In the event the claim is not settled within 30 days as stipulated above, the insurer shall be liable to pay interest at a rate, which is 2% above the bank rate from the date of receipt of last relevant and necessary document from the insured/claimant by insurer till the date of actual payment.

CLAIM PROCEDURE IN RESPECT OF A HEALT H INSURANCE POLICY

1. Every insurer shall adhere to the procedure laid down under Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016 for settlement of health insurance claims.
(i) An Insurer shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.
(ii) In the case of delay in the payment of a claim, the insurer shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

2. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document. (i) In case of delay beyond stipulated 45 days

the Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

3. Return of premium on cancellation during Free Look Period shall be processed in accordance with the provisions of Regulation 14 of IRDAI (Health Insurance) Regulations, 2016. Any refund shall be processed with speed and shall be refunded within 15 days from the date of receipt of request for free look cancellation.

Explanation: Health Insurance claims for the purpose of this Regulation shall be claims arising under all insurance policies issued by Life, General and Health Insurers in respect of Health Insurance Business as defined in Section 2 (6C) of the Act.

CASE LAWS:

1. Chennai Ombudsman Centre Case No. 11.05.1146 / 2004-2005 *Mrs. J. Ammunisa* Vs. *The Oriental Insurance Co Ltd. Award* Dated 09.11.2004

Mr. Saffiulla was covered under individual JPA for the period 26.4.1999 to 25.4.2004 for Rs. 1,00,000 / and his wife Mr. Ammunisa was a nominee. It was reported that on 28.10.2003. While Mr. Saffiulla was doing some electrical work was electrocuted and died on the spot. The incident was not reported to Police and consequently no postmortem was done. The Insurer appointed M/s M.J.S. Associates to investigate the matter.

The Insurer repudiated the claim on 27.2.2004 on the ground that the death was not reported to the Police and no postmortem was done. The insured produced the death certificate issued by Thippusultan Mosque Muslim Sunnath Jamaath Committee confirming that the insured died due to eletric shock and his body was burried in the muslim grave yard The Investigator appointed by the Insurance Company contacted the doctor (Government Hospital, Namakkal) and also made discrete enquiries with the local people and neighbours.

Finally he concluded that the said Mr. Saffiulla while doing some electrical work died due to electrical shock. From the condition of the PA policy, it is noted that the postmortem and FIR are not prerequisite for settling the PA death claim. Whatever the papers submitted by the Insurer did not suspect or doubt the genuinenity of the claim but only confirm the genuineness of the claim.

The Forum cited instances where the Insurance Companies settled the death claims based on circumstantial evidence including investigation report, doctor's certificate, etc., without relying solely on PM and FIR. Under the circumstances, the complaint was allowed and the Insurer was directed to settle the claim.

2. *Shri Sasanka Sekhar Maity Vs. The National Insurance Co. Ltd. Award* Dated : 26.10.2004

The complainant, Shri Sasanka. Sekhar Maity stated that his son. Late Swapan Maity died of accident on 17.06.2002 being run over by train. His claim for Rs. 2,00,000/- was turned down by the Insurer on the ground that the death was due to suicide. The complainant stated that the Insurance Co. repudiated the claim without considering the P.M. report and other relevant documents in support of his contention that the death was due to accident and the claim was covered by JPA Policy. The Insurance Co. stated that Late Swapan Maity took a JPA Policy on 01.02.2001 for a sum assured of Rs. 2,00,000/- from National Insurance Co. through M/s G.T.F.S. He died on 17.06.2002. As per Inquest Report the dead body was found cut in two pieces from the waist. The final police report

revealed that the case might be accepted and filed as an accidental and run over case. The Post Mortem Report stated that "as per inquest report and P.M. findings the option regarding the cause of death goes in favour of shock and haemorrhage due to accidental run over by the train. The Insurance Co. engaged an Investigator to find out the actual cause of Death. According to his report along with Inquest Report which was made by the Investigator the actual cause of death was found to be suicide. Suicide was specially excluded under JPA Policy and hence the claim was repudiated.

Lesson 9- Fire & Consequential Loss Insurance

Question: M/s. XX General Insurance Company Ltd. delivers a fire policy to Mr. Ajay on April 15. However, the insured paid the premium on a later date. Unfortunately there was a fire in the premises resulting in loss of property insured. The company denied its liability on the basis of the fact that the premium was overdue at the time of loss. Is it correct? Discuss.

Answer: No, the company cannot deny its claim. When an insurance company delivers a policy without requiring immediate payment of the premium, they incur responsibility for the risk, because having delivered the policy, they are held to have given credit for the premium. Moreover, when once the contract is concluded with the premium and other particulars fixed, the policy drawn and delivered, the insurer becomes liable for loss by fire, and it is immaterial whether the premium is paid before or after the fire.

Example: A person is having two godowns at Delhi and the value of stock is Rs. 50 lakhs and he is not having the value at each location then he can insure the stock under floating policy by paying an additional premium.
The premium charged is the highest rate chargeable to any one location with a nominal rate of loading. If the stocks are located in the same compound no loading is charged on the premium. The premium may be loaded by say 25% for three locations and 50% for more than 3 locations.
A trader has stocks stored in 3 godowns namely X, Y & Z. The premium chargeable at different locations is given below:

Godown	Rate of premium per '000
X	Rs. 1.25
Y	Rs. 1.75
Z	Rs. 2.00

Sum assured Rs. 12,00,000, since the highest premium is Rs. 2.00 per Rs. 1000 the premium chargeable is Rs. 2400. The loading is taken as 25% here because there are only three locations. So, the loading is 25% of Rs. 2400 that is equal to Rs. 600. Thus, the premium payable is Rs. 25000.

Example:

Sum assured	Rs.5,00,00,000/-
Rate per 1000	Rs.1.20
Premium due	Rs.60,000/-
Provisional premium	Rs.60,000/-

Monthly declarations of stock values:

Jan	3,00,00,000
Feb	2,75,00,000
March	4,20,00,000
April	2,00,00,000
May	1,00,00,000

June	2,25,00,000
July	1,50,00,000
August	75,00,000
Sept	4,75,00,000
Oct	5,00,00,00
Nov	4,25,00,000
Dec	3,15,00,000
Total	34,60,00,000

Average sum insured is Rs.34,60,00,000/12 = 2,88,33,333.33
Premium on average sum insured at Rs. 1.20 per 1000 will be Rs.34600.
Therefore, the premium to be refunded is Rs.60,000 - 34,600 = Rs.25,400
The balance refunded to the insured shall not exceed 50% of the provisional premium. The insurer is liable at the most to the sum insured and cannot receive any excess premium.

Illustration:
Let us assume that declaration for April is Rs.6,40,00,000, for May Rs.6,25,00,000 and on June 6th the stock is destroyed by fire causing a loss of 13,00,000. Later it is found that the actual declaration for May is 6,50,00,000.

Then, the loss payable is calculated as follows: 1300000 / 65000000 x 62500000 = Rs. 12,50,000
If the insured has taken any other policy in addition to declaration policy, then the claim is settled first by the other policy. The declaration policy operates for the excess of the stock value over the sum insured under the other policy.

Question: Mr. Kappor insured his machinery and stock of goods stored in the factory premises against damage by fire and a protection note was given, subject to the usual conditions of the company's policy, one warranty clause being "smoking and cooking be strictly prohibited in or about the premises". The stocks were damaged by fire said to be accidental in nature. But the insurance company claimed that smoking a cigarette or bidi carelessly by some employee occasioned the fire. Is the denial justified?

Answer: In the above case, the company denied the claim on the ground that there was a breach of warranty as the fire was occasioned by smoking which is strictly prohibited. But as there was no eye-witness to the origin of the fire, the court held that the cause of fire was a matter of conjecture. [Bhattacharjee vs. Sentinal Insurance Co.] In the famous case Dekhari Tea Co. vs. Assam Bengal Roadways Co. it was also held that fire cannot always be explained, and it must be a matter of conjecture. As regards the warranty, as the plaintiff had put notices strictly prohibiting smoking in and around the places, in fact there is no breach of warranty. Hence, the denial on the part of the insurance company is not justified. On the other hand, the company should make good the loss.

Case:

Loss or damage to property insured if removed to any building or place other than in which it is herein stated to be insured, except machinery and equipment temporarily removed for repairs, cleaning, renovation, or other similar purposes for a period not exceeding 60 days.The Claimant, i.e. the Proprietor of M/s Kunal Impex lodged his complaint with Ombudsman for sanction of interest in respect of the

delayed settlement of claim under their various Policies. The Insured covered their stock under various Policy Nos. 21700/2003/131, 121700/2003/459, 121700/2003/1679 & 121700/2003/2020 held in the godown of M/s Vardhaman Warehousing Co, situated at Vitthal Mangalbhai compound, Dal Mill Compound, Opp. J. K. Petrol Pump, Thane Bhiwandi Road. The Surveyors, M/s Mulchand Nagda & Co. was appointed by the Insurance Co. It seems huge losses were reported under the Policies issued by all four Public Sector Companies and the Surveyor had to submit his report after joint meetings with other Surveyors appointed and after completion of other formalities.

As per their recommendations, 75% on account payment was to be released to the Insured, which was done by sending a Discharge Voucher dated 25.07.2003 to the claimant. The complainant's charge that there was delay which called for interest payment. It was submitted to this Forum that following huge losses in the area, the Public Sector Insurance Companies formed a Committee to carry out technical audit of the claims relating to Bhiwandi fire of 8t h March, 2003 to examine the stock of the warehouses before the fire, split between insured and uninsured stock, reconciliation of the same with individual claim assessment. They had also appointed M/s H. Kannan & Co., as Co-ordinator of Bhiwandi Claims Co-ordination committee. In the facts and circumstances and in view of the compulsions of procedural aspects of the claim being of a special nature, it is agreed to accept the contention of the Company that virtually no delay had taken place from their end in the settlement of the above claim and therefore does not merit additional payment of interest. The complaint of the Claimant i.e. Proprietor of M/s Kunal Impex to sanction interest for the delayed settlement of their claim is hereby rejected.

Case:
Insured complainant insured his Anandpur grocery godown named as M/s –Om Maa Mangala Agency with New India Assurance Co. Ltd. Due to fire on 4.1.2000 the stocks of entire go down burnt into ashes. The surveyor has assessed the loss for Rs. 2,50,879/-. Insurer appointed an investigator who has opined the loss due to fire was genuine but sales register was not maintained properly for which the loss could not be quantified. Insurer asked for certain documents from the insured complainant due to non compliance of which the claim was closed. During hearing insured complainant stated that he has submitted all the documents to surveyor, investigator and insurer. Hon'ble Ombudsman directed the insurer to pay Rs. 2,50,879/- to the complainant as the loss has been properly assessed by accredited surveyor.

Case:
The complaint under Rule No. 12 (1)(b) read with Rule 13 of the RPG, 1998 is as a result of the indiscriminate over charging of tariff under a Fire insurance Policy by the Respondent Insurer. The complainant and his daughter own a shopping complex at Ernakulam and the Insurer charged Rs. 1.85 per mille for the entire property under their Official Shield Policy. While only one floor of the building came under the nomenclature "Shops" the rest of the four floors of the five storied building was to be classified as "Offices".

The rates as per the TAC recommendations were 0.50 per mille for the offices etc. and Rs. 1.80 per mille for shops. In view of this property of the complainant was to be classified only as "Offices" to be charged at Rs. 1.80 per mille and rest was to be classified only as "Offices" to be charged at 0.50 per mille. The Insurer had disputed the classification and charged a uniform rate of Rs. 1.85 per mille for the entire building while the Policy document etc. were inordinately delayed thereby keeping the complainant in the dark as to the nature of the classification. The Insurer's action was arbitrary and without justification and therefore the Insurer was asked to reimburse the difference of premium to the complainant.

Case:

The shop of the complainant was gutted in a devastating fire on 22.12.01. The claim preferred by the complainant was investigated by appointment of surveyor but not settled showing this or that ground causing unnecessary delay & Oriental Insurance Co. Ltd. (opposite party) has made an offer for settlement of the claim of Rs. 1,05,743.00 when case was pending.

Contention of the complainant is that after the fire incident he approached the opposite party for making assessment of the loss. That the opposite party on this & that ground refused to settle the claim on the ground that cash memos were not genuine & there was no fire brigade report etc. That the officers of the opposite party demanded extra money in private for settlement of the claim. The contention of the opposite party is that allegations made by the complainant against the opposite party are false & fabricated. The policyholder took as fire policy to cover his stock of tall kinds of stationery goods, manohari goods, cosmetic goods, plastic goods & similar nature of other goods.

Lesson 12- Motor Insurance

MOTOR VEHICLE (AMENDMENT) ACT, 2019

The Motor Vehicle Amendment Act, 2019 ("Act") came into force on 1st September 2019. The Amendment Act replaced the Motor Vehicles Act, 1988. A notification issued by the Union Ministry of Road Transport and Highways ("Notification") stated that September 1, 2019, is to be appointed as the date on which Section 1 of the Amendment Act will come into force.

The salient features of the Act are:

1. Caseh Less Treatment during Golder Hour- The Act has made provisions for the cashless treatment of victims of road accidents during the 'golden hour', which has been defined as the time period up to one hour from the occurrence of the accident. This 'golden hour' is hence the time period in which the chances of survival of the victim are maximum if subjected to proper treatment and immediate care.

2. Compensation for road accident victims- The amount of compensations has been revised and increased the minimum compensation for hit and run cases. According to the Act, the compensation in case of death increased m Rs. 25,000/- to 2 lakhs, and in case of grievous injury from Rs. 12,500/- to Rs. 50,000.

3. Road and environment health - To increase the road safety for passengers and drivers the act had new amendment related to manufacturing defect and it directs the manufacturers to take back the vehicles, in case the vehicles are not fit for use on roads and cause environmental damage and harm the health of others. The manufacturers have been given the choice to either reimburse or replace the defective vehicle with one of similar make.

4. National Road Safety Board - A key feature of this Act is that it provides for the setting up of a National Road Safety Board under the central government in order to advise the governments of all the states and also the central government on matters relating to traffic management and road safety.

5. Compulsory insurance - The Act instructs the Central Government to establish a 'Motor Vehicles Accident Fund' for providing compulsory insurance to all the drivers of the country.
6. Fitness of Vehicles - The Amendment has laid down mandates for the automated testing of vehicles for doing a fitness check for improving road safety by removing unfit vehicles from the traffic. There are specific provisions in the Act for those who intentionally violate environment and safety regulations. The Act promotes the certification of automobiles after being successfully tested. Also, it aims at setting testing standards and bringing the agencies issuing automotive approvals under the Motor Vehicles Act.

7. Taxi Aggregators - 'Taxi aggregators' are defined by the Act as the intermediaries using a digital platform for connecting drivers to passengers, who, according to the provisions, are to be provided with licenses from the governments of the respective states and are instructed to follow the rules and regulations of the Information And Technology Act, 2000.

8. Online Driving Licenses - This Act provides for online issuance of learner's license and mandates online identity verification. This is aimed at improving efficiency and limits the issuance of fake licenses to a large extent. This Act also provides that commercial licenses would be valid up to a period of five

years instead of three years. Driver training schools have been provided for, in order to ensure the production of better drivers on roads.

9. National Register - This Amendment Act encourages harmonization and integration of issuance of driving license with vehicle registration. The Act lays down that this would be done by the creation of a National Register for Driving License and National Register for Vehicles with the online portals of 'Sarathi' and 'Vahan' in order to ensure the creation of a uniform system of licenses and vehicle registration throughout the country.

10. Protection of Good Samaritan - It has been often observed that generous persons who help the victims of road accidents end up being the victims of harassment. The Act defines 'Samaritan' as a person who stands up for helping out a road accident victim, immediately after such an accident takes place. It ensures that they are not harmed in any manner and protects them from any kind of suits or proceedings, even if they cause the death of the victim negligently.

11. National Transportation Policy- The idea of the formation of a National Transportation Policy has been promoted by the Amendment of 2019. Such a policy has to be made by the Central government in collaboration with all the state governments and would structure a framework for road transport.

Lesson 13 - Liability Insurance

Product Structure for Cyber Insurance (Ref. no. IRDAI/NL/CIR/MISC/242/09/2021 dated September 08, 2021)

There are rising incidences of cyber attacks along with a growing number of high profile data breaches. The online exposures for individuals, business organizations, offices and other establishments continue to increase more so in the current pandemic situation. The Authority had, therefore, constituted a working group with a focus to examine the possibility of bringing standardisation of Cyber Liability Insurance policy wording. The Working Group, after conducting wide consultations with various stakeholders, and after internal deliberations concluded that standardisation of policy wording is not desirable at this juncture keeping in view of the evolving nature of legislative frameworks in dealing with cyber risk, fast growing digital ecosystem, increasing interconnectedness globally and complexity of IT systems and emergence of new risks.

For details:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4560&flag=1

Title Insurance Products (Ref. no: IRDAI/CIR/MISC/243/09/2021 dated September 08, 2021)

Title insurance is a form of indemnity insurance that protects a potential owner of a property against financial loss from defects in title to real property. The policy is a retrospective one where the insured is protected against losses arising from the events that occurred prior to the date of issuing the policy. In order to ensure that the general insurers offer basic Title Insurance covers for legal liabilities of promotors/developers in case of any loss caused to allottees due to defective title of the property, protection for individual buyers for the purchased units in projects and to facilitate easy marketability of these products, the Authority had constituted a Working Group to suggest, inter alia, product construct and policy wording for two new products in addition to the existing products.

For details:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo4558&flag=1

Lesson 16 - Corporate Governance for Insurance Companies

Conflicts of Interest

Adequate systems, policies and procedures to address potential conflicts of interest and compliance with the provisions of Companies Act, 2013 need to be established by the insurers. These include Board level review of key transactions, disclosure of any conflicts of interest to manage and control such issues. Where the transactions with related parties are in the nature of transactions such as reinsurance arrangements or investment transactions or outsourcing to related parties, for which specific regulations or guidelines have been notified, compliance with the respective regulations or guidelines shall also be ensured.

Role and Responsibility of the Board

In addition to the provisions of the Companies Act, 2013, the Board of Directors of insurance companies are entrusted with the following specific areas of responsibilities as detailed in the Annexure 1 to the Corporate Governance Guidelines for Insurers in India issued by IRDAI.

1) The Board should ensure that the Governance principles set for the insurer comply with all relevant laws, regulations and other applicable codes of conduct.

2) The Board should set the following policies in consultation with the Management of the Company.

a) Define and periodically review the business strategy.

b) Define the underwriting policy of the insurer.

c) Determine the retention and reinsurance policy and in particular, the levels of retentions of risk by the insurer and the nature and extent of reinsurance protection to be maintained by the insurer.

d) Define the policy of the insurer as regards investment of its assets consistent with an appropriate asset liability management structure.

e) Define the insurer's policy on appointments and qualification requirements for human resources and ensure that the incentive structure does not encourage imprudent behaviour.

3. The Board should define and set the following standards:-

a) Define the standards of business conduct and ethical behaviour for directors and senior management.

b) Define the standards to be maintained in policyholder servicing and in redressal of grievances of policyholders.

4. The Board would be responsible to provide guidance for implementation of business strategy and review the same periodically.

5. As an integral part of proper implementation of the business strategy, the Board should take action as under:-

a) Establish appropriate systems to regulate the risk appetite and risk profile of the Company. It will also enable identification and measurement of significant risks to which the company is exposed in order to develop an effective risk management system.

b) Ensure that all directions of IRDAI are submitted to the Board and the recommendations are implemented as per the Board philosophy.

c) Ensure that the IT systems in the company are appropriate and have built-in checks and balances to produce data with integrity and put in place a business continuity and disaster recovery plan.

d) Ensure that the company has put in place a robust compliance system for all applicable laws and regulations.

e) Prescribe requirements and frequency of reporting in respect of each of the above areas of responsibility as may be decided by the Board.
6. In discharge of the above and other Governance functions, the Board may delegate the responsibilities to mandated/ other recommended Empowered Committees of Directors while retaining its primary accountability.

The Board would primarily concentrate on the direction, control and governance of the insurer and in particular should articulate and commit to a corporate philosophy and governance that will shape the level of risk adoption, standards of business conduct and ethical behaviour of the company at the macro level. The Board should also set clear and transparent policy framework for translation of the corporate objectives. The Board can delegate its authority to the Board Committees in the discharge of this responsibility, but such delegation does not absolve the Board from its primary responsibilities.

In this regard, the Board should seek detailed and transparent information flow from the senior management (CEO and other KMPs) through well documented agenda notes and also devise appropriate systems to serve as effective monitoring arrangements. As the Boards generally do not meet at frequent intervals, it is imperative that the senior management is clearly made accountable for the two-way information flow. The structure of the Board of Directors should be oriented to setting-up of objectives to meet the expectations of various stakeholders, strategies for their fulfillment and for monitoring the achievements. The Boards of insurance companies need to consider interests of all stakeholders, and especially their policyholders as a specific group.

Further, since there could arise a conflict of interest amongst the various stakeholders, a key board function would be to establish strategies and policies that define ethical individual and corporate behaviour and ongoing, effective processes that ensure adherence to these strategies and policies.

Thus, with a view to being effective, the Board in active consultation with the Key Management Persons, should establish and evaluate strategies and policies to address, at the minimum, a broad range of areas, as indicated below-
• Overall direction of the business of the insurance company, including policies, strategies and risk management across all the functions;
• Projections on the capital requirements, revenue streams, expenses and the profitability. While laying down the projections, the Board must address the expectations of the shareholders and the policyholders;
• Obligation to fully comply with the Insurance Act and the regulations framed thereunder, and other statutory requirements applicable to it;
• Addressing conflicts of interest;
• Ensuring fair treatment of policyholders and employees;
• Ensuring information sharing with and disclosures to stakeholders, including investors, policyholders, employees, the regulators, consumers, financial analysts and/or rating agencies;
• Establishing channels for encouraging and facilitating employees raising concerns or reporting a possible breach of law or regulations, with appropriate measures to protect whistle blowers;
• Developing a corporate culture that recognizes and rewards adherence to ethical standards.
There should concurrently be arrangements to review the policies from time to time to ensure that they are dynamic.

Constitution of Committees

With a view to providing adequate Board time for discharge of the significant corporate responsibilities, the Board can consider setting up of various Committees of Directors by delegating the overall monitoring responsibilities after laying down the roles and responsibilities of these Committees to the Board.

The other Committees which can be set up by the Board, include the Ethics Committee and ALM Committee (other than life insurers). In cases where Board decides not to constitute such Committees, their functions and responsibilities can be addressed in such manner as the Board may deem fit. However, once these Optional Committees are in place, the insurer is required to comply with the requirements on the "Role and Responsibilities" of such Committees as laid down under these Guidelines.

Actuary- An actuary is a business professional who deals with the measurement and management of risk and uncertainty. The name of the corresponding field is actuarial science. These risks can affect both sides of the balance sheet and require asset management, liability management, and valuation skills. Actuaries provide assessments of financial security systems, with a focus on their complexity, their mathematics, and their mechanisms.