STUDY MATERIAL

PROFESSIONAL PROGRAMME

INSURANCE LAW AND PRACTICE

MODULE 3

ELECTIVE PAPER 9.3

THE INSTITUTE OF
Company Secretaries of India
भारतीय कम्पनी सचिव संस्थान
IN PURSUIT OF PROFESSIONAL EXCELLENCE
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PROFESSIONAL PROGRAMME

INSURANCE LAWS AND PRACTICE

Company Secretaries have a pivot role to play in the Insurance Sector. A Company Secretary can work as a compliance officer in an Insurance Company and play an important role in ensuring compliance to complicated legal, regulatory and supervisory issues all the time, transcending various spheres of banking operations. So, in order to build the capacity of Companies Secretaries to work as a compliance officer in Insurance Companies and to provide them a specialized knowledge in Insurance laws and practice, New Syllabus for Professional Program contains one of the five elective papers titled ' Insurance Laws and Practice'. The students interested in pursuing their career in Insurance sector may opt for this subject.

The syllabus and contents of this paper has been developed in association of Insurance Institute of India, Mumbai.

An attempt has been made to cover fully the syllabus prescribed for each module/subject. The presentation of topics may not always be in the same sequence as given in the syllabus. Candidates are expected to take note of all the latest developments relating to the subjects covered in the syllabus by referring to IRDA Circulars, Financial Dailies, Economic Journals, Latest Books and Publications on the subjects/topics concerned

Although due care has been taken in publishing this study material, yet the possibility of errors, omissions and/or discrepancies cannot be ruled out. This publication is released with an understanding that the Institute shall not be responsible for any errors, omissions and/or discrepancies or any action taken in that behalf.

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There is open book examination for this Elective Subject of Professional Programme. This is to inculcate and develop skills of creative thinking, problem solving and decision making amongst students of its professional programme and to assess their analytical ability, real understanding of facts and concepts and mastery to apply, rather than to simply recall, replicate and reproduce concepts and principles in the examination.

PROFESSIONAL PROGRAMME

SYLLABUS
FOR

MODULE III - PAPER 9.3: INSURANCE LAW AND PRACTICE (100 Marks)

Level of Knowledge: Expert Knowledge

Objective: *To acquire specialized knowledge of law and practice relating to Insurance.*

Detailed Contents:

1. **Understanding and Managing Risk - Risk Management** - Perils - Nature – Risk Analysis – Planning – Control - Mechanism for Transfer of risk – Insurance and Reinsurance
2. **General Principles and Concepts of Insurance**

   Insurable Interest - Indemnity - *Uberrimae fidei* - Proximate Cause - Subrogation and Contribution - Differentiation Insurance and Guarantee - Insurance and Wager - Disclosure – Moral Hazards
3. **Insurance Contract and Indian Market Conditions**

   Nature of Insurance Contract - Features of Insurance Contract - Types of Insurance - Concept of Intermediaries – Market Players and their Roles - Agents, Brokers, Surveyors & Loss Assessors, Health Third Party Administrators, Certification of Insurance Professionals, Training Organizations.
4. **Regulatory Environment – Specific Legislations**

   Regulation of Insurance Business, Insurance Act, Insurance Regulatory and Development Act, Powers and Functions of IRDA, Relevant Regulations and Guidelines issued by IRDA, Licensing, Audit & Supervision, Investments, Amalgamation and Transfer, Grievance Redressal, Rural and Social Sector obligations, Micro Insurance, Financial inclusion, Product Approval.
5. **Regulatory Environment - General**

   Other Relevant Legislation (Motor Vehicles Act, Marine Insurance Act, Employees State Insurance Act etc.), Consumer Protection, Courts, Tribunals, Insurance Ombudsmen, Arbitration.
6. **International Regulatory Framework** – International Association of Insurance Supervisors – Future Trends
7. **Life Insurance - Practices, Procedures**

   Application of Principles in Life Insurance Contract –- Representation - Assignment and Nomination - Title and Claims - Tax Law Implications - Concept of Trusts in Life Policy - Stamp Duties - Role and Function of Life Insurance Companies.
8. **Life Insurance & Pension Products** - Life Insurance Products – Proposals, Policy and documentation
9. **General Insurance - Practices and Procedures – Focus Claims**

   Claims Procedures – Underinsurance - Condition of Average - Recovery – Salvage.
10. **General Insurance - Practices and Procedures – Focus Underwriting**

    Application of Principles in General Insurance Contracts – Structure of the Policy – Insurance Documentation – Underwriting and Rating - Disclosure - Terms and Conditions.
11. **General Insurance Products**

    - Property Insurance (Fire and Engineering)
    - Marine Insurance (Hull and Cargo)

- Motor Insurance
- Business Interruption
- Liability Insurance (Public, Products, Professional, Directors & Officers etc)
- Personal Lines (Health, Accident, Travel, Residential Premises etc.)
- Rural and Agricultural
- Micro-Insurance
- Other Miscellaneous lines (Burglary, Bankers' Risks, Fidelity etc.)

12. Ethics and Corporate Governance Framework for Insurance Companies

Financial Statements, Protection of Policy holders, Concept of Treating Customers Fairly (TCF), Actuarial and Other Certifications

LIST OF RECOMMENDED BOOKS

MODULE III

PAPER 9.3: INSURANCE LAW AND PRACTICE

Recommended Readings and References:

1.	M. N. Srinivasan	:	Principles of Insurance Law, Wadhwa & Co.
2.	Rajiv Jain	:	Insurance Law and Practice, Vidhi Publication Private Limited
3.	Taxmann	:	Insurance Manual, Taxmann Publication Private Limited
4.	Bharat	:	Manual of insurance Laws, Bharat Publication Private limited
5.	Dr. Avtar Singh	:	Law of Insurance, Universal Publication Pvt. Limited
6.	George E. Rejda	:	Principles of Risk Management and Insurance

ARRANGEMENT OF STUDY LESSONS

PAPER 9.3: INSURANCE LAW AND PRACTICE (100 Marks)

PROFESSIONAL PROGRAMME

INSURANCE LAW AND PRACTICE

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Lesson 1
UNDERSTANDING AND MANAGING RISK

LESSON OUTLINE

- Risk Management
- Role of Insurance in Risk Management
- Perils - Nature
- Risk Analysis
- Risk Planning
- Risk Control
- Mechanism for Transfer of risk
- Insurance and Reinsurance
- Lesson Round up
- Self-Test Questions

LEARNING OBJECTIVES

There is nothing certain in this world except the death and the Tax; yet the Death and Tax are uncertain as no body knows when will he die or when the tax will change." **- Benjamin Franklin**

We live in a risky world. Forces that threaten our financial well being constantly surround us and are largely outside our control. Some people experience the premature and tragic death of a beloved family member, loss or destruction of their property from both manmade and natural disasters. There is other group of people where there is no accident but are exposed to the traumatic effects of a liability lawsuit.

The purpose of this chapter is to unable the students to understand—

1. Meaning and classification of different types of risk,
2. Meaning of Perils and Hazards,
3. The meaning of Risk Management,
4. Risk Management process and its different steps,
5. Mechanism of handling risk, and
6. Insurance and reinsurance as a risk transfer tool.

WHAT IS RISK

Risk is part of every human endeavor. From the moment we get up in the morning, drive or take public transportation to get to school or to work until we get back into our beds (and perhaps even afterwards), we are exposed to risks of different degrees. What makes the study of risk fascinating is that while some of this risk bearing may not be completely voluntary, we seek out some risks on our own (speeding on the highways or gambling, for instance) and enjoy them. While some of these risks may seem trivial, others make a significant difference in the way we live our lives. On a loftier note, it can be argued that every major advance in human civilization, from the caveman's invention of tools to gene therapy, has been made possible because someone was willing to take a risk and challenge the status quo.

Risk is the potential of loss (an undesirable outcome, however not necessarily so) resulting from a given action, activity and/or inaction. The notion implies that a choice having an influence on the outcome sometimes exists (or existed). Potential losses themselves may also be called "risks". Any human endeavor carries some risk, but some are much riskier than others.

Risk can be defined in seven different ways

1. The probability of something happening multiplied by the resulting cost or benefit if it does.
2. The probability or threat of quantifiable damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through preemptive action.

UNCERTAINTY

Uncertainty is at the very core of the concept of risk itself. It is uncertainty about the outcome in a given situation. Uncertainty does not exist in the natural order of things though there are a number of outcomes, which are uncertain. For example: the weather for the test match; the possibility of being made redundant; the risk of having an accident. There is surely uncertainty surrounding all of these events.

In 1921, Frank Knight summarized the difference between risk and uncertainty thus: "… Uncertainty must be taken in a sense radically distinct from the familiar notion of Risk, from which it has never been properly separated. … The essential fact is that "risk" means in some cases a quantity susceptible of measurement, while at other times it is something distinctly not of this character; and there are far-reaching and crucial differences in the bearings of the phenomena depending on which of the two is really present and operating. … It will appear that a measurable uncertainty, or "risk" proper, as we shall use the term, is so far different from an un-measurable one that it is not in effect an uncertainty at all."

Risk is incorporated into so many different disciplines from insurance to engineering to portfolio theory that it should come as no surprise that it is defined in different ways by each one. It is worth looking at some of the distinctions:

a. **Risk versus Probability:** While some definitions of risk focus only on the probability of an event occurring, more comprehensive definitions incorporate both the probability of the event occurring and the consequences of the event. Thus, the probability of a severe earthquake may be very small but the consequences are so catastrophic that it would be categorized as a high-risk event.

b. **Risk versus Threat**: In some disciplines, a contrast is drawn between risk and a threat. A threat is a low probability event with very large negative consequences, where analysts may be unable to assess the probability. A risk, on the other hand, is defined to be a higher probability event, where there is enough information to make assessments of both the probability and the consequences.

c. **All outcomes versus Negative outcomes**: Some definitions of risk tend to focus only on the downside scenarios, whereas others are more expansive and consider all variability as risk. The engineering definition of risk is defined as the product of the probability of an event occurring, that is viewed as undesirable, and an assessment of the expected harm from the event occurring.

   Risk = Probability of an accident * Consequence in lost money/deaths

   In contrast, risk in finance is defined in terms of variability of actual returns on an investment around an expected return, even when those returns represent positive outcomes. Building on the last distinction, we should consider broader definitions of risk that capture both the positive and negative outcomes

PERIL AND HAZARD

The terms "peril" and "hazard" should not be confused with the concept of risk discussed earlier. Let us first consider the meaning of peril.

Peril

We often use the word risk to mean both the event which will give rise to some loss, and the factors which may influence the outcome of a loss. When we think about cause, we must be clear that there are at least these two aspects to it. We can see this if we think back to the two houses on the river bank and the risk of flood. The risk of flood does not really make sense, what we mean is the risk of flood damage. Flood is the cause of the loss and the fact that one of the houses was right on the bank of the river influences the outcome.

Flood is the peril and the proximity of the house to the river is the hazard. The peril is the prime cause; it is what will give rise to the loss. Often it is beyond the control of anyone who may be involved. In this way we can say that storm, fire, theft, motor accident and explosion are all perils.

Peril is defined as the cause of loss. Thus, if a house burns because of a fire, the peril, or cause of, loss, is the fire. If a car is totally destroyed in an accident with another motorist, accident (collision) is the peril, or cause of loss. Some common perils that result in the loss or destruction of property include fire, cyclone, storm, landslide, lightning, earthquakes, theft, and burglary.

Hazard

Factors, which may influence the outcome, are referred to as hazards. These hazards are not themselves the cause of the loss, but they can increase or decrease the effect should a peril operate. The consideration of hazard is important when an insurance company is deciding whether or not it should insure some risk and what premium to charge. So a hazard is a condition that creates or increases the chance of loss. There are three major types of hazards: Hazard can be physical or moral or Morale.

Physical Hazard

Physical hazard relates to the physical characteristics of the risk, such as the nature of construction of a building, security protection at a shop or factory, or the proximity of houses to a riverbank. Therefore a physical hazard is a physical condition that increases the chances of loss. Thus, if a person owns an older building with defective wiring, the defective wiring is a physical hazard that increases the chance of a fire. Another example of physical hazard is a slippery road after the rains. If a motorist loses control of his car on a slippery road and collides with another motorist, the slippery road is a physical hazard while collision is the peril, or cause of loss.

Moral Hazard

Moral hazard concerns the human aspects which may influence the outcome. Moral hazard is dishonesty or character defects in an individual that increase the chance of loss. For example, a business firm may be overstocked with inventories because of a severe business recession. If the inventory is insured, the owner of the firm may deliberately burn the warehouse to collect money from the insurer. In effect, the unsold inventory has been sold to the insurer by the deliberate loss. A large number of fires are due to arson, which is a clear example of moral hazard.

Moral hazard is present in all forms of insurance, and it is difficult to control. Dishonest insured persons often rationalise their actions on the grounds that "the insurer has plenty of money". This is incorrect since the company can pay claims only by collecting premiums from other policy owners.

Because of moral hazard, premiums are higher for all insured, including the honest. Although an individual may believe that it is morally wrong to steal from a neighbour, he or she often has little hesitation about stealing from an insurer and other policy owners by either causing a loss or by inflating the size of a claim after a loss occurs.

Morale Hazard

This usually refers to the attitude of the insured person. Morale hazard is defined as carelessness or indifference to a loss because of the existence of insurance. The very presence of insurance causes some insurers to be careless about protecting their property, and the chance of loss is thereby increased. For example, many motorists know their cars are insured and, consequently, they are not too concerned about the possibility of loss through theft. Their lack of concern will often lead them to leave their cars unlocked. The chance of a loss by theft is thereby increased because of the existence of insurance.

Morale hazard should not be confused with moral hazard. Morale hazard refers to an Insured who is simply careless about protecting his property because the property is insured against loss.

Moral hazard is more serious since it involves unethical or immoral behaviour by insurers who seek their own financial gain at the expense of insurers and other policy owners. Insurers attempt to control both moral and morale hazards by careful underwriting and by various policy provisions, such as compulsory excess, waiting periods, exclusions, and exceptions.

When used in conjunction with peril and hazard we find that risk means the likelihood that the hazard will indeed cause the peril to operate and cause the loss. For example, if the hazard is old electrical wiring prone to shorting and causing sparks, and the peril is fire, then the risk, is the likelihood that the wiring will indeed be a cause of fire.

BASIC CATEGORIES OF RISK

With regards insurability, there are basically two categories of risks:

1. Speculative or dynamic risk; and
2. Pure or static risk.

Speculative or Dynamic Risk

Speculative (dynamic) risk is a situation in which either profit OR loss is possible. Examples of speculative risks are betting on a horse race, investing in stocks/bonds and real estate. In the business level, in the daily conduct of its affairs, every business establishment faces decisions that entail an element of risk. The decision to venture into a new market, purchase new equipments, diversify on the existing product line,

expand or contract areas of operations, commit more to advertising, borrow additional capital, etc., carry risks inherent to the business. The outcome of such speculative risk is either beneficial (profitable) or loss. Speculative risk is uninsurable.

Pure or Static Risk

The second category of risk is known as pure or static risk. Pure (static) risk is a situation in which there are only the possibilities of loss or no loss, as oppose to loss or profit with speculative risk. The only outcome of pure risks are adverse (in a loss) or neutral (with no loss), never beneficial. Examples of pure risks include premature death, occupational disability, catastrophic medical expenses, and damage to property due to fire, lightning, or flood.

It is important to distinguish between pure and speculative risks for three reasons. First, through the use of commercial, personal, and liability insurance policies. Insurance companies in the private sector generally insure only pure risks. Speculative risks are not considered insurable, with some exceptions.

Second, the law of large numbers can be applied more easily to pure risks than to speculative risks. The law of large numbers is important in insurance because it enables insurers to predict loss figures in advance. It is generally more difficult to apply the law of large numbers to speculative risks in order to predict future losses. One of the exceptions is the speculative risk of gambling, where casinos can apply the law of large numbers in a very efficient manner.

Finally, society as a whole may benefit from a speculative risk even though a loss occurs, but it is harmed if a pure risk is present and a loss occurs. For instance, a computer manufacturer's competitor develops a new technology to produce faster computer processors more cheaply. As a result, it forces the computer manufacturer into bankruptcy. Despite the bankruptcy, society as a whole benefits since the competitor's computers work faster and are sold at a lower price. On the other hand, society would not benefit when most pure risks, such as an earthquake, occur.

Fundamental Risks and Particular Risks

Fundamental risks affect the entire economy or large numbers of people or groups within the economy. Examples of fundamental risks are high inflation, unemployment, war, and natural disasters such as earthquakes, hurricanes, tornadoes, and floods.

Particular risks are risks that affect only individuals and not the entire community. Examples of particular risks are burglary, theft, auto accident, dwelling fires. With particular risks, only individuals experience losses, and the rest of the community are left unaffected.

The distinction between a fundamental and a particular risk is important, since government assistance may be necessary in order to insure fundamental risk. Social insurance, government insurance programs, and government guarantees and subsidies are used to meet certain fundamental risks in our country. For example, the risk of unemployment is generally not insurable by private insurance companies but can be insured publicly by federal or state agencies. In addition, flood insurance is only available through and/or subsidized by the federal government.

Subjective Risk

Subjective risk is defined as uncertainty based on a person's mental condition or state of mind. For example, assume that an individual is drinking heavily in a bar and attempts to drive home after the bar closes. The driver may be uncertain whether he or she will arrive home safely without being arrested by the police for drunken driving. This mental uncertainty is called subjective risk.

Objective Risk

Objective risk is defined as the relative variation of actual loss from expected loss. For example, assume that a fire insurer has 5000 houses insured over a long period and, on an average, 1 percent, or 50 houses are destroyed by fire each year. However, it would be rare for exactly 50 houses to burn each year and in some years, as few as 45 houses may burn. Thus, there is a variation of 5 houses from the expected number of 50, or a variation of 10 percent. This relative variation of actual loss from expected loss is known as objective risk.

Objective risk declines as the number of exposures increases. More specifically, objective risk varies inversely with the square root of the number of cases under observation. Now assume that 5 lacs instead 5000 houses are insured. The expected number of houses that will burn is now 5000, but the variation of actual loss from expected loss is only 50. Objective risk is now 50/5000, or 1 percent.

Objective risk can be statistically measured by some measure of dispersion, such as the standard deviation or coefficient of variation. Since objective risk can be measured, it is an extremely useful concept for an insurance company or a corporate risk manager.

As the number of exposures increases, the insurance company can predict its future loss experience more accurately because it can rely on the “Law of large numbers.” The law of large numbers states that as the number of exposure units increase, the more closely will the actual loss experience approach the probable loss experience. For example, as the number of homes under observation increases, the greater is the degree of accuracy in predicting the proportion of homes that will burn.

Static Risks

Static risks are risks connected with losses caused by the irregular action of nature or by the mistakes and misdeeds of human beings. Static risks are the same as pure risks and would, by definition, be present in an unchanging economy.

Dynamic Risk

Dynamic risks are risks associated with a changing economy. Important examples of dynamic risks include the changing tastes of consumers, technological change, new methods of production, and investments in capital goods that are used to produce new and untried products.

Static and dynamic risks have several important differences –

(a) Most static risks are pure risks, but dynamic risks are always speculative risks where both profit and loss are possible.

(b) Static risks would still be present in an unchanging economy, but dynamic risks are always associated with a changing economy.

(c) Dynamic risks usually affect more individuals and have a wider impact on society than do static risks.

(d) Dynamic risks may be beneficial to society but static risks are always harmful.

Financial and Non-financial Risks

A financial risk is one where the outcome can be measured in monetary terms.

This is easy to see in the case of material damage to property, theft of property or lost business profit following a fire. In cases of personal injury, it can also be possible to measure financial loss in terms of a court award of damages, or as a result of negotiations between lawyers and insurers. In any of these cases,

the outcome of the risky situation can be measured financially.

There are other situations where this kind of measurement is not possible. Take the case of the choice of a new car, or the selection of an item from a restaurant menu. These could be construed as risky situations, not because the outcome will cause financial loss, but because the outcome could be uncomfortable or disliked in some other way. We could even go as far as to say that the great social decisions of life are examples of non-financial risks: the selection of a career, the choice of a marriage partner, having children. There may or may not be financial implications, but in the main the outcome is not measurable financially but by other, more human, criteria.

Insurance is primarily concerned with risks that have a financially measurable outcome. But not all risks are capable of measurement in financial terms. One example of a risk that is difficult to measure financially is the effect of bad publicity on a company - consequently this risk is very difficult to insure.

However, this is a good point to stress how innovative some insurers are in that they are always looking for ways to provide new covers, which the customers want. The difficult part is to be innovative and still make a profit.

Now after understanding meaning of Risk and their classification, we will discuss Risk Management, Risk Analysis, Risk Planning, Risk Control and Insurance and Reinsurance as a risk Transfer mechanism.

RISK MANAGEMENT

'Risk, in insurance terms, is the possibility of a loss or other adverse event that has the potential to interfere with an organization's ability to fulfill its mandate, and for which an insurance claim may be submitted'.

What is risk management?

Risk management ensures that an organization identifies and understands the risks to which it is exposed. Risk management also guarantees that the organization creates and implements an effective plan to prevent losses or reduce the impact if a loss occurs.

A risk management plan includes strategies and techniques for recognizing and confronting these threats. Good risk management doesn't have to be expensive or time consuming; it may be as uncomplicated as answering these three questions:

1. What can go wrong?
2. What will we do, both to prevent the harm from occurring and in response to the harm or loss?
3. If something happens, how will we pay for it?

Benefits to managing risk

Risk management provides a clear and structured approach to identifying risks. Having a clear understanding of all risks allows an organization to measure and prioritize them and take the appropriate actions to reduce losses. Risk management has other benefits for an organization, including:

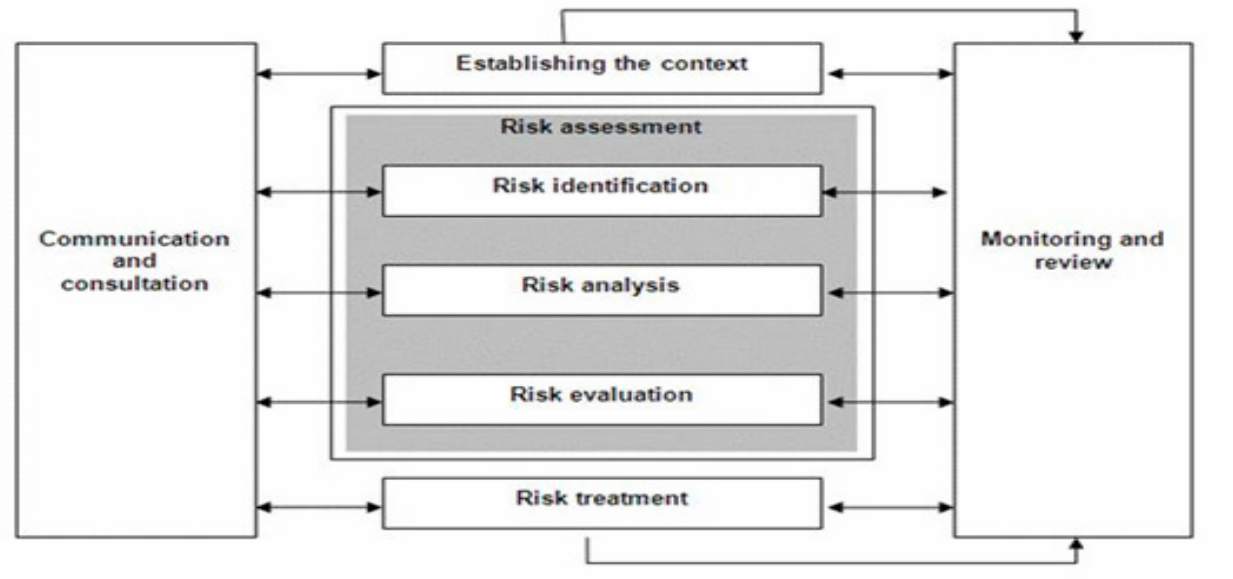
- Saving resources: Time, assets, income, property and people are all valuable resources that can be saved if fewer claims occur.
- Protecting the reputation and public image of the organization.
- Preventing or reducing legal liability and increasing the stability of operations.
- Protecting people from harm.

- Protecting the environment.
- Enhancing the ability to prepare for various circumstances.
- Reducing liabilities.
- Assisting in clearly defining insurance needs.

An effective risk management practice does not eliminate risks. However, having an effective and operational risk management practice shows an insurer that your organization is committed to loss reduction or prevention. It makes your organization a better risk to insure.

Role of insurance in risk management Insurance is a valuable risk-financing tool. Few organizations have the reserves or funds necessary to take on the risk themselves and pay the total costs following a loss. Purchasing insurance, however, is not risk management. A thorough and thoughtful risk management plan is the commitment to prevent harm. Risk management also addresses many risks that are not insurable, including brand integrity, potential loss of tax-exempt status for volunteer groups, public goodwill and continuing donor support.

Risk Management Process



Risk Management Comprises of mainly three steps

(A) Risk Analysis

(i) Risk Identification

(ii) Risk Assessment

(B) Risk Planning

(C) Risk Controlling

RISK ANALYSIS

Risk Analysis is the process of identifying, analyzing and communicating the major risks.

Risk analysis involves:

Once risks have been identified, they must then be assessed as to their potential severity of impact (generally a negative impact, such as damage or loss) and to the probability of occurrence. These quantities can be either simple to measure, in the case of the value of a lost building, or impossible to know for sure in the case of the probability of an unlikely event occurring. This process is known as risk analysis. In the assessment process it is critical to make the best educated decisions in order to properly prioritize the implementation of the risk management plan.

RISK PLANNING AND CONTROL

Once risk and identified and analyzed, it is important to plan and adopt a suitable strategy for controlling the risk. Risk planning and controlling is the stage which comes after the risk analysis process is over.

There are five major methods of handling and controlling risk.

(a) Risk avoidance;
(b) Risk retention;
(c) Risk transfer;
(d) Loss control; and
(e) Insurance.

Risk Avoidance

Risk avoidance is one method of handling risk. For example, you can avoid the risk of being pick pocketed in Metropolitan cities by staying out of them; you can avoid the risk of divorce by not marrying; a career employee who is frequently transferred can avoid the risk of selling a house in a depressed real estate market by renting instead of owning; and a business firm can avoid the risk of being sued for a defective product by not producing the product.

But as a practical matter, not all risks can or even should be avoided. For example, you can avoid the risk of death or disability in a plane crash by refusing to fly. But is this practical and desirable? The alternatives are not appealing. You can drive or take a bus or train, all of which take considerable time and often involve

great fatigue. Although the risk of a plane crash is present, the safety record of commercial airlines is excellent, and flying is a reasonable risk to assume. Or one may wish to avoid the risk of business failure by refusing to go into business for oneself. But a person may have the necessary skills and capital to be successful in business, and risk avoidance may not be the best approach for him to follow in this case.

Risk Retention

Risk retention is a second method of handling risk. An individual or a business firm may retain all or part of a given risk. Risk retention can be either active or passive.

Active risk retention

Active risk retention means that an individual is consciously aware of the risk and deliberately plans to retain all or part of it. For example, a motorist may wish to retain the risk of a small collision loss by purchasing an own damage insurance policy with a Rs. 2,000 voluntary excess. A homeowner may retain a small part of the risk of damage to the house by purchasing a Householders policy with substantial voluntary excess. A business firm may deliberately retain the risk of petty thefts by employees, shoplifting, or the spoilage of perishable goods. Or a business firm may use risk retention in a self-insurance program, which is a special application of risk retention. In these cases, the individual or business firm makes a conscious decision to retain part or all of a given risk. Active risk retention is used for two major reasons. First, risk retention can save money. Insurance may not be purchased at all, or it may be purchased with voluntary excesses; either way, there is often a substantial saving in the cost of insurance. Second, the risk may be deliberately retained because commercial insurance is either unavailable or can be obtained only by the payment of prohibitive premiums. Some physicians, for example, practice medicine without professional liability insurance because they perceive the premiums to be inordinately high.

Passive risk retention

Risk can also be retained passively. Certain risks may be unknowingly retained because of ignorance, indifference, or lasiness. This is often dangerous if a risk that is retained has the potential for destroying a person financially. For example, many persons with earned incomes are not insured against the risk of long-term disability under either an individual or group disability income plan. However, the adverse financial consequences of a long-term disability generally are more severe than premature death. Thus, people who are not insured against the risk of long-term disability are using the technique of risk retention in a most dangerous and inappropriate manner.

In summary, risk retention can be an extremely useful technique for handling risk, especially in a modern corporate risk management program. Risk retention, however, is appropriate primarily for high frequency, low severity risks where potential losses are relatively small. Except under unusual circumstances, an individual should not use the technique of risk retention to retain low frequency, high severity risks, such as the risk of catastrophic losses like earthquake and floods.

Risk Transfer

Risk transfer is another technique for handling risk. Risks can be transferred by several methods, among which are the following:

(a) Transfer of risk by contracts;

(b) Hedging price risks; and

(c) Conversion to Public Limited Company.

Transfer of Risk by Contracts

Unwanted risks can be transferred by contracts. For example, the risk of a defective television or stereo set can be transferred to the retailer by purchasing a service contract, which makes the retailer responsible for all repairs after the warranty expires. The risk of a substantial increase in rent can be transferred to the landlord by a long-term lease. The risk of a substantial price increase in construction costs can be transferred to the builder by having a firm price in the contract rather than a cost-plus contract.

Hedging Price Risks

Hedging price risks is another example of risk transfer. Hedging is a technique for transferring the risk of unfavourable price fluctuations to a speculator by purchasing and selling futures contracts on an organized exchange, such as NSE.

In recent years, institutional investors have sold stock index futures contracts to hedge against adverse price declines in the stock market. This technique is often called portfolio insurance. However, it is not formal insurance but is a risk transfer technique that provides considerable protection against a decline in stock prices.

Conversion to Public Limited Company

Incorporation is another example of risk transfer. If a firm is a sole proprietorship, creditors for satisfaction of debts can attach the owner's personal assets, as well as the assets of the firm. If a firm incorporates, however, creditors for payment of the firm's debts cannot attach the personal assets of the stockholders. In essence, by incorporation, the liability of the stockholders is limited, and the risk of the firm having insufficient assets to pay business debts is shifted to the creditors.

Loss Control

Loss control is another important method for handling risk. Loss control consists of certain activities undertaken to reduce both the frequency and severity of losses. Thus, loss control has two major objectives:

(a) Loss prevention.

(b) Loss reduction.

Loss Prevention

Loss prevention aims at reducing the probability of loss so that the frequency of losses is reduced. Several examples of personal loss prevention can be given. Automobile accidents can be reduced if motorists pass a safe driving course and drive defensively. Dropping out of college can be prevented by intensive study on a regular basis. The number of heart attacks can be reduced if individuals watch their weight, give up smoking, and follow good health habits.

Loss prevention is also important for business firms. For example, a boiler explosion can be prevented by periodic inspections by a safety engineer; occupational accidents can be reduced by the elimination of unsafe working conditions and by strong enforcement of safety rules; and fire can be prevented by forbidding workers to smoke in an area where highly flammable materials are being used. In short, the goal of loss prevention is to prevent the loss from occurring.

Loss Reduction

Although stringent loss prevention efforts can reduce the frequency of losses, some losses will inevitably occur. Thus, the second objective of loss control is to reduce the severity of a loss after it occurs. For example, a warehouse can install a sprinkler system so that a fire is promptly extinguished, thereby reducing the loss; highly flammable materials can be stored in a separate area to confine a possible fire to that area; a plant can be constructed with fire resistant materials to minimize a loss; and fire doors and fire walls can be

used to prevent a fire from spreading.

Loss control-Ideal method for handling risk

From the viewpoint of society, loss control is the ideal method for handling risk. This is true for two reasons. First, the indirect costs of losses may be large, and in some instances, they can easily exceed the direct costs. For example, a worker may be injured on the job. In addition to being responsible for the worker's medical expenses and a certain percentage of earnings (direct costs), the firm may also incur sizeable indirect costs: a machine may be damaged and must be repaired; the assembly line may have to be shut down; costs are incurred in training a new worker to replace the injured worker; and a contract may be cancelled because goods are not shipped on time. By preventing the loss from occurring, both indirect costs and direct costs are reduced.

Second, the social costs of losses must also be considered. For example, assume that the worker in the preceding example dies from the accident. Substantial social costs are incurred because of the death. Society is deprived forever of the goods and services that the deceased worker could have produced. The worker's family loses its share of the worker's earnings and may experience considerable grief and financial insecurity. And the worker may personally experience great pain and suffering before he or she finally dies. In short, these social costs can be reduced through an effective loss control programme.

INSURANCE AND REINSURANCE AS A RISK TRANSFER TECHNIQUES.

Insurance and reinsurance are both forms of financial protection which are used to guard against the risk of losses. Losses are guarded against by transferring the risk to another party through the payment of an insurance premium, as an incentive for bearing the risk. Insurance and reinsurance are similar in concept even though they are quite different to each other in terms of how they are used.

INSURANCE

Insurance is a more commonly known concept that describes the act of guarding against risk. An insured is the party who will seek to obtain an insurance policy while the insurer is the party that shares the risk for a paid price called an insurance premium. The insured can easily obtain an insurance policy for a number of risks. The most common types of insurance policy taken out is a vehicle/auto insurance policy as this is mandated by law in many countries. Other policies include home owner's insurance, renter's insurance, medical insurance, life insurance, liability insurance, etc.

The insured who takes out a vehicle insurance will specify the losses against which he wishes to be insured. This may include repairs to the vehicle in case of an accident, damages to the party who is injured, payment for a rented vehicle until such time the insured's vehicle is fixed, etc. The insurance premium paid will depend upon a number of factors such as the insured's driving record, driver's age, any medical complications of the driver, etc. If the driver has had a reckless driving record he may be charged a higher premium as the probability of loss is higher. On the other hand, if the driver has had no previous accidents then the premium will be lower since the probability of loss is relatively low.

REINSURANCE

Reinsurance is when an insurance company will guard themselves against the risk of loss. Reinsurance in simpler terms is the insurance that is taken out by an insurance company. Since insurance companies provide protection against the risk of loss, insurance is a very risky business, and it is important that an insurance company has its own protection in place to avoid bankruptcy.

Through a reinsurance scheme, an insurance company is able to bring together or 'pool' its insurance policies and then divide up the risk among a number of insurance providers so that in the event that a large loss occurs this will be divided up throughout a number of firms, thereby saving the one insurance company from large losses.

Insurance vs Reinsurance

Insurance and reinsurance are similar in concept in that they are both tools that guard against large losses. Insurance, on the one hand, is a protection for the individual, whereas reinsurance is the protection taken out by a large insurance firm to ensure that they survive large losses. The premium that is paid by an individual will be received by the company that provides the insurance whereas the insurance premium paid for reinsurance will be divided among all the insurance companies in the pool that bear the risk of loss.

LESSON ROUND-UP

1. Risk is the potential of loss (an undesirable outcome, however not necessarily so) resulting from a given action, activity and/or inaction. The notion implies that a choice having an influence on the outcome sometimes exists (or existed). Potential losses themselves may also be called "risks". Any human endeavor carries some risk, but some are much riskier than others.
2. Peril is defined as the cause of loss. Thus, if a house burns because of a fire, the peril, or cause of, loss, is the fire. Some common perils that result in the loss or destruction of property include fire, cyclone, storm, landslide, lightning, earthquakes, theft, and burglary.
3. Factors, which may influence the outcome, are referred to as hazards. Hazard can be physical or moral or Morale.
   (a) Physical hazard: Physical hazard relates to the physical characteristics of the risk, such as the nature of construction of a building, security protection at a shop or factory, or the proximity of houses to a riverbank.
   (b) Moral hazard: Moral hazard concerns the human aspects which may influence the outcome. Moral hazard is dishonesty or character defects in an individual that increase the chance of loss.
   (c) Morale hazard: This usually refers to the attitude of the insured person. Morale hazard is defined as carelessness or indifference to a loss because of the existence of insurance.
4. With regards insurability, there are basically two categories of risks;
   (a) Speculative or dynamic risk: Speculative (dynamic) risk is a situation in which either profit OR loss is possible. Examples of speculative risks are betting on a horse race, investing in stocks/bonds and real estate
   (b) Pure or static risk: Pure (static) risk is a situation in which there are only the possibilities of loss or no loss, as oppose to loss or profit with speculative risk.
5. Fundamental risks affect the entire economy or large numbers of people or groups within the economy while on the other hand; particular risks are risks that affect only individuals and not the entire community. Examples of fundamental risks are high inflation, unemployment, war, and natural disasters such as earthquakes, hurricanes, tornadoes, and floods and Examples of particular risks are burglary, theft, auto accident, dwelling fires.
6. Subjective risk is defined as uncertainty based on a person's mental condition or state of mind while objective risk is defined as the relative variation of actual loss from expected loss.
7. Static risks are risks connected with losses caused by the irregular action of nature or by the mistakes and misdeeds of human beings while Dynamic risks are risks associated with a changing economy.
8. Risk management process ensures that an organization identifies and understands the risks to which it is exposed. Risk management also guarantees that the organization creates and implements an effective plan to prevent losses or reduce the impact if a loss occurs.

9 Risk Management Comprises of mainly three steps:

(a) Risk Analysis

(i) Risk Identification

(ii) Risk Assessment

(b) Risk Planning

(c) Risk Controlling

10 Insurance and reinsurance are both forms of financial protection which are used to guard against the risk of losses. Losses are guarded against by transferring the risk to another party through the payment of an insurance premium, as an incentive for bearing the risk. Insurance and reinsurance are similar in concept even though they are quite different to each other in terms of how they are used.

SELF-TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. What do you mean by Risk Management? Explain different steps in risk management process.
2. Differentiate between Active & Passive Risk Retention.
3. What is a Risk? Explain difference between uncertainly and risk.
4. What is the difference between chance and loss?
5. What is the difference between objective and subjective probability?
6. What are the methods of handling risk? Explain each one in details
7. What are the basic categories of risk?
8. What is the difference between insurance and reinsurance? Explain

Lesson 2
GENERAL PRINCIPLES AND CONCEPTS OF INSURANCE

LESSON OUTLINE

- Insurable Interest
- Indemnity
- *Uberrimae fidei*
- Proximate Cause
- Subrogation and Contribution
- Differentiation Insurance and Guarantee
- Insurance and Wager
- Disclosure
- Moral Hazards
- Lesson Round up
- Self-Test Questions

LEARNING OBJECTIVES

Insurance is a very technical subject. In Many cases, insurance claim are rejected by the Insurance companies on some technical grounds. So, while dealing in insurance matters, finance professional or an investor should understand the basic concepts and principles of insurance. This lesson has been prepared so as enable the students to understand

1. The need of studying principles of insurance
2. Meaning of insurable interest in insurance agreements and its importance
3. Meaning of indemnity and its importance in insurance claims
4. Meaning of '*Uberrimae fidei'* and its use in Insurance contracts
5. Subrogation and Contribution's meaning and importance in Insurance contracts
6. Difference between insurance and Guarantee's contract
7. Difference between the wager contracts and insurance contract
8. Importance of disclosures in Insurance contracts
9. Various types of moral hazards in insurance contracts.

UNDERSTANDING PRINCIPLES OF INSURANCE

The business of insurance aims to protect the economic value of assets or life of a person. Through a contract of insurance the insurer agrees to make good any loss on the insured property or loss of life (as the case may be) that may occur in course of time in consideration for a small premium to be paid by the insured.

Apart from the above essentials of a valid contract, insurance contracts are subject to additional principles. These are:

1. Principle of Utmost good faith
2. Principle of Insurable interest
3. Principle of Indemnity
4. Principle of Subrogation
5. Principle of Contribution
6. Principle of Proximate cause
7. Principle of Loss of Minimization

These distinctive features are based on the basic principles of law and are applicable to all types of insurance contracts. These principles provide guidelines based upon which insurance agreements are undertaken.

A proper understanding of these principles is therefore necessary for a clear interpretation of insurance contracts and helps in proper termination of contracts, settlement of claims, enforcement of rules and smooth award of verdicts in case of disputes.

Now we will be discussing various principles of Insurance in detail

1. PRINCIPLE OF UBERRIMAE FIDEI (Utmost Good Faith)

- Both the parties i.e. the insured and the insurer should have a good faith towards each other.
- The insurer must provide the insured complete, correct and clear information of subject matter.
- The insurer must provide the insured complete, correct and clear information regarding terms and conditions of the contract.
- This principle is applicable to all contracts of insurance i.e. life, fire and marine insurance.

Principle of *Uberrimae fidei* (a Latin phrase), or in simple english words, the Principle of Utmost Good Faith, is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in an absolute good faith or belief or trust.

The person getting insured must willingly disclose and surrender to the insurer his complete true information regarding the subject matter of insurance. The insurer's liability gets void (i.e legally revoked or cancelled) if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.

The principle of Uberrimae fidei applies to all types of insurance contracts.

For example, if any person has taken a life insurance policy by hiding the fact that he is a cancer patient and later on if he dies because of cancer then insurance company can refuse to pay the compensation as the fact was hidden by the insured.

2. PRINCIPLE OF INSURABLE INTEREST

- The insured must have insurable interest n the subject matter of insurance.
- In life insurance it refers to the life insured.
- In marine insurance it is enough if the insurable interest exists only at the time of occurrence of the loss.
- In fire and general insurance it must be present at the time of taking policy and also at the time of the occurrence of loss.
- The owner of the party is said to have insurable interest as long as he is the owner of it.
- It is applicable to all contracts of insurance.

The principle of insurable interest states that the person getting insured must have insurable interest in the object of insurance. A person has an insurable interest when the physical existence of the insured object gives him some gain but its non-existence will give him a loss. In simple words, the insured person must suffer some financial loss by the damage of the insured object.

For example: - The owner of a taxicab has insurable interest in the taxicab because he is getting income from it. But, if he sells it, he will not have an insurable interest left in that taxicab.

From above example, we can conclude that, ownership plays a very crucial role in evaluating insurable interest. Every person has an insurable interest in his own life. A merchant has insurable interest in his business of trading. Similarly, a creditor has insurable interest in his debtor.

For example, if a person has taken the loan against the security of a factory premises then the lender can take fire insurance policy of that factory without being the owner of the factory because he has financial interest in the factory premises.

3. PRINCIPLE OF INDEMNITY

- Indemnity means guarantee or assurance to put the insured in the same position in which he was immediately prior to the happening of the uncertain event. The insurer undertakes to make good the loss.
- It is applicable to fire, marine and other general insurance.
- Under this the insurer agreed to compensate the insured for the actual loss suffered.

Indemnity means security, protection and compensation given against damage, loss or injury. According to the principle of indemnity, an insurance contract is signed only for getting protection against unpredicted financial losses arising due to future uncertainties. Insurance contract is not made for making profit else its sole purpose is to give compensation in case of any damage or loss.

In an insurance contract, the amount of compensations paid is in proportion to the incurred losses. The amount of compensations is limited to the amount assured or the actual losses, whichever is less. The compensation must not be less or more than the actual damage. Compensation is not paid if the specified loss does not happen due to a particular reason during a specific time period. Thus, insurance is only for giving protection against losses and not for making profit.

However, in case of life insurance, the principle of indemnity does not apply because the value of human life cannot be measured in terms of money.

For example, a person insured a car for 2.5 lakh against damage on an accident case. Due to accident he suffered a loss of 1.5 lakh, then the insurance company will compensate him 1.5 lakh only not the policy amount i.e., 2.5 lakh as the purpose behind it is to compensate not to make profit.

4. PRINCIPLE OF SUBROGATION

- As per this principle after the insured is compensated for the loss due to damage to property insured, then the right of ownership of such property passes to the insurer.
- This principle is corollary of the principle of indemnity and is applicable to all contracts of indemnity.

Subrogation means substituting one creditor for another. Principle of Subrogation is an extension and another corollary of the principle of indemnity. It also applies to all contracts of indemnity.

According to the principle of subrogation, when the insured is compensated for the losses due to damage to his insured property, then the ownership right of such property shifts to the insurer.

This principle is applicable only when the damaged property has any value after the event causing the damage. The insurer can benefit out of subrogation rights only to the extent of the amount he has paid to the insured as compensation.

For example:- Mr. Arvind insures his house for Rs. 1 million. The house is totally destroyed by the negligence of his neighbour Mr. Mohan. The insurance company shall settle the claim of Mr. Arvind for Rs. 1 million. At the same time, it can file a law suit against Mr. Mohan for Rs. 1.2 million, the market value of the house. If insurance company wins the case and collects Rs. 1.2 million from Mr. Mohan, then the insurance company will retain Rs. 1 million (which it has already paid to Mr. Arvind) plus other expenses such as court fees. The balance amount, if any will be given to Mr. Arvind, the insured.

5. PRINCIPLE OF CONTRIBUTION

- The principle is corollary of the principle of indemnity.
- It is applicable to all contracts of indemnity.
- Under this principle the insured can claim the compensation only to the extent of actual loss either from any one insurer or all the insurers.

Principle of Contribution is a corollary of the principle of indemnity. It applies to all contracts of indemnity, if the insured has taken out more than one policy on the same subject matter. According to this principle, the insured can claim the compensation only to the extent of actual loss either from all insurers or from any one insurer. If one insurer pays full compensation then that insurer can claim proportionate claim from the other insurers.

For example :- Mr. Arvind insures his property worth Rs. 100,000 with two insurers "AIG Ltd." for ₹90,000 and "MetLife Ltd." For ₹60,000. Arvind's actual property destroyed is worth Rs. 60,000, then Mr. Arvind can claim the full loss of ₹60,000 either from AIG Ltd. or MetLife Ltd., or he can claim ₹36,000 from AIG Ltd. and ₹24,000 from Metlife Ltd.

So, if the insured claims full amount of compensation from one insurer then he cannot claim the same compensation from other insurer and make a profit. Secondly, if one insurance company pays the full compensation then it can recover the proportionate contribution from the other insurance company.

6. PRINCIPLE OF CAUSA PROXIMA (NEAREST CAUSE)

- The loss of insured property can be caused by more than one cause in succession to another.
- The property may be insured against some causes and not against all causes.
- In such an instance, the proximate cause or nearest cause of loss is to be found out.
- If the proximate cause is the one which is insured against, the insurance company is bound to pay the compensation and vice versa.

Principle of *Causa Proxima* (a Latin phrase), or in simple english words, the Principle of Proximate (i.e Nearest) Cause, means when a loss is caused by more than one causes, the proximate or the nearest or the closest cause should be taken into consideration to decide the liability of the insurer.

The principle states that to find out whether the insurer is liable for the loss or not, the proximate (closest) and not the remote (farest) must be looked into.

For example:- A cargo ship's base was punctured due to rats and so sea water entered and cargo was damaged. Here there are two causes for the damage of the cargo ship - (i) The cargo ship getting punctured beacuse of rats, and (ii) The sea water entering ship through puncture. The risk of sea water is insured but the first cause is not. The nearest cause of damage is sea water which is insured and therefore the insurer must pay the compensation.

However, in case of life insurance, the principle of Causa Proxima does not apply. Whatever may be the reason of death (whether a natural death or an unnatural death) the insurer is liable to pay the amount of insurance.

PRINCIPLE OF LOSS MINIMIZATION

- Under this principle it is the duty of the insured to take all possible steps to minimize the loss to the insured property on the happening of uncertain event.

According to the Principle of Loss Minimization, insured must always try his level best to minimize the loss of his insured property, in case of uncertain events like a fire outbreak or blast, etc. The insured must take all possible measures and necessary steps to control and reduce the losses in such a scenario. The insured must not neglect and behave irresponsibly during such events just because the property is insured. Hence it is a responsibility of the insured to protect his insured property and avoid further losses.

For example :- Assume, Mr. Arvind's house is set on fire due to an electric short-circuit. In this tragic scenario, Mr. Arvind must try his level best to stop fire by all possible means, like first calling nearest fire department office, asking neighbours for emergency fire extinguishers, etc. He must not remain inactive and watch his house burning hoping, "Why should I worry? I've insured my house."

DIFFERENTIATION INSURANCE AND GUARANTEE

Insurance is a contract of indemnity whereby Insurer agrees to indemnify, or pay, the insured for certain types of loss while in a contract of guarantee, one party agrees to act on behalf of another should that second party default. In plain terms, this means that if an individual fails to pay her guaranteed debt or to perform some other duty or obligation, the guarantor -- the party who has agreed to act on behalf of another -- will step in to pay or perform the obligation.

There are two major differences between insurance and guarantees. One difference is that insurance is a direct agreement between the insurance provider and the policyholder, while a guarantee involves an indirect

agreement between a beneficiary and a third party, along with the primary agreement between the principal and beneficiary. A second difference is that insurance policy calculations are based on underwriting and possible loss, while a guarantee is focused strictly on performance or nonperformance. In addition, insurance providers or policyholders can cancel policies with notice, while guarantees often cannot be canceled. The difference between a contract of Insurance and a contract of guarantee are as given below:

INSURANCE	GUARANTEE
In a contract of insurance, there are two parties i.e. insurer and insured.	In a contract of Guarantee there are three parties i.e. Main Debtor, Creditor & Surety.
Insurance contract is generally Cancellable.	Contract of Guarantee is Non-Cancellable
Insurance premium is based on the probability and quantum of losses.	In contract of business, loss cannot be estimated generally so fee is charged for the guarantee service rendered
An insurance contract transfers the Risk.	There is No Transfer of Risk in a contract of guarantee

INSURANCE AND WAGER

A contract of Insurance, i.e. life, accident, fire, marine, etc. is not a wager though it is performable upon an uncertain event. It is so because; the principle of insurable interest distinguishes insurance from a wagering contract. Insurable interest is the interest which one has in the safety or preservation of the subject matter of insurance. Where insurable interest is not present in insurance contracts, it becomes a wagering contract and is therefore void.

The following are the points of distinction between wagering agreements and insurance contracts.

1. A contract of insurance is a contract to make good the loss of property (or life) of another person against some consideration called premium. A wagering agreement is an agreement to pay money or money's worth on the happening of an uncertain event.
2. The parties have no insurable interest in a wagering agreement. But the holder of an insurance policy must have an insurable interest.
3. In wagering agreement, neither party has any interest in happening or non-happening of an event. But in a contract of insurance, both parties are interested in the subject-matter.
4. Contracts of insurance are contracts of indemnity except life insurance contract, which is a contingent contract. But a wagering agreement is a conditional contract.
5. Contract of insurance are based on scientific and actuarial calculation of risks, where as wagering agreements are a gamble without any scientific calculation of risk.
6. Contracts of insurance are regarded as beneficial to the public and hence encouraged by the State but wagering agreements serve no useful purpose.
7. A contract of insurance is a valid contract where as a wagering agreement is void being expressly declared by law.

DISCLOSURES

The principle of Uberrimae fidei applies to all types of insurance contracts and is a very basic and primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e insurer and insured) in absolute good faith or belief or trust.

The person getting insured must willingly **disclose** and surrender to the insurer **all relevant complete true information regarding the subject matter of insurance.** The insurer's liability is voidable (i.e legally revoked or cancelled) if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured..

The principle forbids either party to an insurance contract, by non-disclosure or mis-representation of a material fact, which he knows or ought to know, to draw the other into the bargain, from his ignorance of that fact and his believing the contrary. The duty of the utmost good faith is implied in insurance contracts because they are entered into by parties who have not the same access to relevant information. In this, they differ from contracts of sale to which the maxim caveat emptor (let the buyer beware) applies.

Although the duty rests upon both parties, it is the duty of the proposer which needs to be discussed in some detail for he usually has the advantage of knowing most of the particulars relating to the subject-matter. Until a definite offer to enter into an insurance contract has been unconditionally accepted the duty of the utmost good faith must be strictly observed. The obligation arises again prior to each renewal and, to a limited extent, when the insured desires an alteration in the policy. In the latter case, he must inform the insurer of any facts material to the alteration.

MATERIAL FACTS

Material fact is every circumstance or information, which would influence the judgment of a prudent insurer in assessing the risk.

Or

Those circumstances which influence the insurer’s decision to accept or refuse the risk or which affect the fixing of the premium or the terms and conditions of the contract, must be disclosed.

A material fact is one which would have influenced the judgment of a prudent insurer in deciding whether he would accept the risk in whole or in part and, if so, at what amount of premium. The materiality of a fact depends upon the application of this test to the particular circumstances of the case as at the date that the fact should have been communicated.

Material facts may have a bearing on the physical hazard or on the moral hazard, or they may show that if a loss occurs the insurer's liability is likely to be greater than would normally be expected.

FACTS, WHICH MUST BE DISCLOSED

i. Facts, which show that a risk represents a greater exposure than would be expected from its nature e.g., the fact that a part of the building is being used for storage of inflammable materials.

ii. External factors that make the risk greater than normal e.g. the building is located next to a warehouse storing explosive material.

iii. Facts, which would make the amount of loss greater than that normally expected e.g. there is no segregation of hazardous goods from non-hazardous goods in the storage facility.

iv. History of Insurance (a) Details of previous losses and claims (b) if any other Insurance Company

has earlier declined to insure the property and the special condition imposed by the other insurers; if any.

v. The existence of other insurances.

vi. Full facts relating to the description of the subject matter of Insurance

EXAMPLES OF MATERIAL FACTS

(a) In Fire Insurance: The construction of the building, the nature of its use i.e. whether it is of concrete or Kucha - having thatched roofing and whether it is being used for residential purposes or as a godown, whether fire fighting equipment is available or not.

(b) In Motor Insurance: The type of vehicle, the purpose of its use, its age (Model), Cubic capacity and the fact that the driver has a consistently bad driving record.

(c) In Marine Insurance: Type of packing, mode of carriage, name of carrier, nature of goods, the route.

(d) In Personal Accident Insurance: Age, height, weight,occupation, previous medical history and occupation especially if it is likely to increase the chance of an accident. Proclivity of substance abuse has to be disclosed as well- eg. alcohol or drug addiction.

(e) Burglary Insurance: Nature of stock, value of stock, type of security precautions taken.

The above are just indicatory of the type of material facts that must be disclosed.

Details of previous losses is a material fact that has to be disclosed in all cases.

FACTS, WHICH NEED NOT BE DISCLOSED

(a) Facts of Law: Ignorance of law is not excusable - every one is deemed to know the law.

Overloading of goods carrying vehicles is legally banned. The transporter cannot take shelter behind the excuse that he was not aware of this provision; in the vent of an accident.

(b) Facts which lessen or diminishes the Risk: The existence of a good fire fighting system in the building.

(c) Facts of Common Knowledge: The insurer is expected to know the areas of strife and areas susceptible to riots and of the process followed in a particular trade or Industry. Any fact which is known or which, by law, may be presumed to be known to the insurer the insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer, in the ordinary course of his business, ought to know.

(d) Facts which could be reasonably discovered: For e.g.the previous history of claims which the Insurer is supposed to have in his record.

(e) Facts which the insurer's representative fails to notice: In burglary and fire Insurance it is often the practice of Insurance companies to depute surveyors to inspect the premises and in case the surveyor fails to notice hazardous features and provided the details are not withheld by the Insured or concealed by him them the Insured cannot be unless inquiry is made, it is not necessary to disclose the following facts.Any fact which it is superfluous to disclose by reason of an express or implied condition.

(f) Any fact as to which information is waived by the insurer.

(g) Any fact as to which inurer is given sufficient information to put him on inquiry.

TIME OF DISCLOSURE

The duty of disclosure must be observed, from the time of submission of proposal and continued throughout the negotiations until the contract is concluded. Any material fact, therefore, which, at any stage of negotiations, comes to the knowledge of the proposer assured, including any alteration of circumstances which brings into existence of material fact or in consequence of which a fact previously immaterial becomes material, must be at once communicated to the users.

EFFECT OF NON-DISCLOSURE

Where there has been non-disclosure, whether innocent or fraudulent, sometimes called concealment the contract is voidable at the option of the insurer. This is the position where the matter is not dealt with by a policy condition. The ground is usually covered by a policy condition which may do no more than state the common law rule.

REPRESENTATIONS

Representations are statements made during the negotiations with the object of inducing the other party to enter into the contract: they must be distinguished from statements which are introduced into the contract, and upon the truth of which the validity of the contract is made to depend. Representations may be as to a matter of fact, and, **if material must be substantially correct.**

Where there has been misrepresentation it is necessary to decide whether it was fraudulent or innocent. A fraudulent misrepresentation is one which was known to be false; or which was made without belief in its truth, or recklessly, careless whether it was true or false. Fraudulent misrepresentation of a material fact entitles the insurer to avoid the policy.

Every material fact which the insured ought to know in the ordinary course of business must be stated ; an innocent misrepresentation of such a fact would entitle the insurer to avoid the policy. This must be so, otherwise the duty to disclose material facts and to state them accurately would not be correlative.

ACTIVE AND PASSIVE DUTY OF DISCLOSURE

The question here is what method is used to acquire the material information.

Two different approaches are used in this respect. The first - an “active” duty of disclosure, and the second approach is characterized as a “passive” duty of disclosure. The former argues that the duty to assess what information is material for the insurer rests with the person effecting the insurance. On the other hand, a passive duty of disclosure implies that the insurer will have to define what information is material through a questionnaire. A passive duty of disclosure implies that information not asked for is not material.

The common law systems seem mainly to apply an active duty of disclosure, but elements of a passive duty of disclosure is found in some countries in the form of proposals.

MORAL HAZARDS

Moral hazard is a situation in which one agent decides on how much risk to take, while another agent bears (parts of) the negative consequences of risky choices.

The person who buys insurance is protected against monetary damages. Therefore, he may engage in more risky behavior than if he has to bear the risk himself.

Moral hazard can arise in the insurance industry when insured parties behave differently as a result of having insurance. There are two types of moral hazard in insurance: *ex ante* and *ex post*

Ex-Ante Moral Hazard - Ed the Aggressive Driver: Ed, a driver with no auto insurance, drives very cautiously because he would be fully responsible for any damages to his vehicle. Ed decides to get auto insurance and, once his policy goes into effect, he begins speeding and making unsafe lane changes. Ed's case is an example of ex-ante moral hazard. As an insured motorist, Ed has taken on more risk than he did without insurance. Ed's choice reflects his new, reduced liability.

Ex-Post Moral Hazard - Marie and Her Allergies: Marie has had no health insurance for a few years and develops allergy symptoms each spring. This winter she starts a new job that offers insurance and decides to consult a physician for her problems. Had Marie continued without insurance, she may never have gone to a doctor. But, with insurance, she makes an appointment and is given a prescription for her allergies. This is an example of ex-post moral hazard, because Marie is now using insurance to cover costs she would not have incurred prior to getting insurance.

Insurers try to decrease their exposure by shifting a portion of liability to policyholders in the form of deductibles and co-payments. Both represent the amount of money a policyholder must pay before the insurance company's coverage begins. Policyholders can often opt for lower deductibles and co-payments, but this will raise their insurance premiums.

LESSON ROUND-UP

1. Beside the valid above essentials of a valid contract, insurance contracts are subject to additional principles. Like Principle of Utmost good faith, Principle of Insurable interest, Principle of Indemnity, Principle of Subrogation, Principle of Contribution, Principle of Proximate cause, Principle of Loss of Minimization
2. According to the principle of utmost good faith, the insurance contract must be signed by both parties (i.e insurer and insured) in an absolute good faith or belief or trust.
3. The principle of insurable interest states that the person getting insured must have insurable interest in the object of insurance. A person has an insurable interest when the physical existence of the insured object gives him some gain but its non-existence will give him a loss. In simple words, the insured person must suffer some financial loss by the damage of the insured object.
4. Indemnity means security, protection and compensation given against damage, loss or injury. According to the principle of indemnity, an insurance contract is signed only for getting protection against unpredicted financial losses arising due to future uncertainties
5. According to the principle of subrogation, when the insured is compensated for the losses due to damage to his insured property, then the ownership right of such property shifts to the insurer
6. According to the principle of contribution, the insured can claim the compensation only to the extent of actual loss either from all insurers or from any one insurer. If one insurer pays full compensation then that insurer can claim proportionate claim from the other insurers
7. Principle of *Causa Proxima* (a Latin phrase), or in simple english words, the Principle of Proximate (i.e Nearest) Cause, means when a loss is caused by more than one causes, the proximate or the nearest or the closest cause should be taken into consideration to decide the liability of the insurer.
8. There are two major differences between insurance and guarantees. One difference is that insurance is a direct agreement between the insurance provider and the policyholder, while a guarantee involves an indirect

agreement between a beneficiary and a third party, along with the primary agreement between the principal and beneficiary.

9. The second difference between insurance and guarantee is that insurance policy calculations are based on underwriting and possible loss, while a guarantee is focused strictly on performance or nonperformance.
10. The principle of insurable interest distinguishes insurance from a wagering contract. Insurable interest is the interest which one has in the safety or preservation of the subject matter of insurance. Where insurable interest is not present in insurance contracts, it becomes a wagering contract and is therefore void
11. Where there has been non-disclosure of material facts, whether innocent or fraudulent, sometimes called concealment the contract is voidable at the option of the insurer
12. Moral hazard is a situation in which one agent decides on how much risk to take, while another agent bears (parts of) the negative consequences of risky choices

SELF-TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. What are the basic principles of Insurance? Explain each one of them in detail.
2. What do you mean by the term 'Insurable insurance'? Explain the importance of term.
3. What is the difference between Insurance and Guarantee
4. Explain the difference between the contract of Insurance and contract of wager
5. What do you mean by the principle of utmost good faith? What is the impact of non disclosure of material facts in an insurance policy?
6. Mr Ram took a insurance policy on 14.8.2006. He died on 16.7.2007. Intimation about the death was given on 6.1.2008. Investigation revealed that he was under medical treatment while applying for the policy. Insurer took a decision to repudiate the claim on 20.8.2008. The claimant has gone to the court for remedy. State with reasons how the court would consider the case.

Lesson 3
INSURANCE CONTRACT AND INDIAN MARKET CONDITIONS

LESSON OUTLINE

- Nature of Insurance Contract
- Features of Insurance Contract
- Types of Insurance
- Concept of Intermediaries
- Market Players and their Roles:
  (a) Agents,
  (b) Brokers,
  (c) Surveyors & Loss Assessors,
  (d) Health Third Party Administrators,
- Certification of Insurance Professionals-Training Organizations
- Lesson Round up
- Self Test Questions

LEARNING OBJECTIVES

The role of insurance in the overall health of the economy is well-understood. Without the protection from risk that insurance provides, commercial activities would slow, perhaps grinding to a halt, thus stunting or eliminating economic growth and the financial benefits to businesses and individuals that such growth provides. The role of insurance intermediaries in the overall economy is, essentially, one of making insurance – and other risk management products – widely available, thereby increasing the positive effects of insurance generally – risk-taking, investment, provision of basic societal needs and economic growth.

This lesson has been prepared in order to enable the student to understand

1. The nature and feature of insurance contract.
2. Different types of insurance
3. Meaning of insurance intermediaries
4. Role of Insurance agent
5. Role of Insurance brokers
6. Role of Insurance and loss surveyors
7. Role of Third party administrator-Health
8. Training of Insurance intermediaries

Nature of Insurance Contract

A contract of insurance is an agreement whereby one party, called the insurer, undertakes, in return for an agreed consideration, called the premium, to pay the other party, namely the insured, a sum of money or its equivalent in kind, upon the occurrence of a specified event resulting in a loss to him. The policy is a document which is an evidence of the contract of insurance.

As per Anson, a contract is an agreement enforceable at law made between two or more persons by which rights are acquired by one more persons to certain acts or forbearance on the part of other or others.

The Indian Contract Act, 1872, sets forth the basic requirements of a Contract. As per Section 10 of the Act:

"All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void…..".

An Insurance policy is also a contract entered into between two parties, viz., the Insurance Company and the Policyholder and fulfills the requirements enshrined in the Indian Contract Act.

Essentials for a valid contract

1. **Proposal:** When one person signifies to another his willingness to do or to abstain from doing anything, with a view to obtaining the assent of that other to such act or abstinence, he is said to make a proposal ("Promisor").

In Insurance paralance, a Proposal form (also called application for insurance) is filled in by the person who wants to avail insurance cover giving the information required by the insurance company to assess the risk and arrive at a price to be charged for covering the risk (called "premium). When a proposal form is submitted, the Customer does not make a proposal, but it is only "invitation to offer". The insurance company, based on the information furnished in the proposal form, assesses the risk (also called underwriting), and conveys the decision – if accepted, at what premium and on what terms and conditions. This is also called "counter offer" in insurance terminology by the insurance company to the Customer. A medical examination is also conducted, where necessary, before making the counter offer.

Where the insurance company cannot accept the risk, the proposal is declined. Where the insurance company conveys its decision to accept the risk quoting a premium, a proposal is made.

2. **Acceptance:** When a person to whom the proposal is made, signifies his assent thereto, the proposal is said to be accepted ("Promisee"). A proposal, when a accepted, becomes a promise;

When the Customer accepts the terms of the offer and signifies his assent by paying the First Premium (the amount payable as the consideration), the proposal is accepted by the Customer. A proposal of the insurance company (terms of offer), when accepted by the Customer, becomes a promise.

3. **Consideration:** When, at the desire of the promisor, the promisee or any other person has done or abstained from doing, or does or abstains from doing, or promises to do or to abstain from doing, something, such act or abstinence or promise is called a consideration for the promise;

As can be seen from the above, amount equal to First Premium paid by the Customer becomes the consideration for the contract. This first premium would be the first instalment premium (either first annual, quarterly, half yearly or monthly premium.

In the case of monthly premiums normally 2 monthly premiums are collected along with the Proposal form. In the case of single premium, one lump sum is paid along with the Proposal.

Every promise and every set of promises, forming the consideration for each other, is an agreement;

4. **Competency to contract:** Every person is competent to contract who is of the age of majority according to the law to which he is subject, and who is sound mind and is not disqualified from contracting by any law to which he is subject.

In the case of Insurance the person with whom the Contract is entered into is called "Policyholder" or "Policy Owner" who could be different from the subject matter which is insured. In Life insurance contracts, for example, the person whose life is insured could be different. For example, the Policyholder could be the Father and the Life assured could be the son. In the case of Fire insurance, the Policy owner could be the Owner of a building and the subject matter of insurance would be the building itself.

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 any law. However, the life assured could suffer from the above infirmities.

5. **Consensus ad idem:** Two or more person are said to consent when they agree upon the same thing in the same sense.

Both the insurance company and the Policyholder must agree on the same thing in the same sense. The Policy document issued to the Policyholder ("Customer") clearly defines the obligations of the insurer and the terms and conditions upon which the Insurance contract is issued.

Free consent: Consent is said to be free when it is not caused by –

1, Coercion, or
2. Undue influence, or
3. Fraud, or
4. Misrepresentation, or
5. Mistake

The third and fourth grounds which vitiate consent are more relevant in insurance. Insurance contracts are based on the principles of 'utmost good faith'. The Policyholder is expected to disclose about the status of his health, family history, income, occupation or about the subject matter insured truthfully without concealing any material fact to enable the underwriter to assess the risk properly. In case it is established by the insurance company that the Policyholder did not truthfully disclose any fact in the Proposal form which had a material impact on the decision of the underwriter, the insurance company has a right to cancel the contract.

When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is a contract voidable at the option of the party whose consent was so caused.

6. **Lawful object:** The consideration or object of an agreement must be lawful, The consideration or object of an agreement is unlawful under the following circumstances:

(a) Where a contract is forbidden by law or

(b) Where the contract is of such nature that, if permitted, it would defeat the provisions of any law or is fraudulent;

(c) Where the contract involves or implies, injury to the person or property of another; or

(d) Where the Court regards it as immoral, or opposed to public policy.

Every agreement of which the object or consideration is unlawful is void.

The object of an insurance contract, i.e. to cover the risk by taking out an insurance policy, is a lawful object.

7. **Agreement must not be in restraint of trade or legal proceedings:** Every agreement by which anyone is restrained from exercising a lawful profession, trade or business of any kind, is to that extent void. Every agreement, by which any party thereto is restricted absolutely from enforcing his rights under or in respect of any contract, by the usual legal proceedings in the ordinary tribunals, or which limits the time within which he may thus enforce his rights, is void to the extent

8. **Agreement must be certain and not be a wagering contract:** Agreements, the meaning of which is not certain, or capable of being made certain, are void. Agreements by way of wager are void; and no suit shall be brought for recovering anything alleged to be won on any wager, or entrusted to any person to abide the result of any game or other uncertain event on which may wager is made.

Anson defined wager as “a promise to give money or money’s worth upon the determination or ascertainment of an uncertain event”. For example, if A agrees to pay B Rs.1,000, if it rains tomorrow, it becomes a gambling, since there is no certainty that it will rain tomorrow. A wagering contract is void, it is not illegal. Further a contingent contract is defined under Section 31 of the The Indian Contract Act, 1872. Act as “a contract to do or not to do something, if some event collateral to such contract, does or does not happen”. For example, A contracts to pay B Rs.10,000 if B’s house is burnt. This is a contingent contract. An insurance contract is a contingent contract and the example given above is nothing but Fire insurance. While all Wagering contracts are Contingent contracts, Section 30 of the The Indian Contract Act, 1872 has declared all Wagering contracts to be void.

Features of Insurance Contract

Though all contracts share fundamental concepts and basic elements, insurance contracts typically possess a number of characteristics not widely found in other types of contractual agreements. The most common of these features are listed here:

Aleatory

If one party to a contract might receive considerably more in value than he or she gives up under the terms of the agreement, the contract is said to be aleatory. Insurance contracts are of this type because, depending upon chance or any number of uncertain outcomes, the insured (or his or her beneficiaries) may receive substantially more in claim proceeds than was paid to the insurance company in premium dollars. On the other hand, the insurer could ultimately receive significantly more money than the insured party if a claim is never filed.

Adhesion

In a contract of adhesion, one party draws up the contract in its entirety and presents it to the other party on a 'take it or leave it' basis; the receiving party does not have the option of negotiating, revising, or deleting any part or provision of the document. Insurance contracts are of this type, because the insurer writes the contract and the insured either 'adheres' to it or is denied coverage. In a court of law, when legal determinations must be made because of ambiguity in a contract of adhesion, the court will render its interpretation against the party that wrote the contract. Typically, the court will grant any reasonable expectation on the part of the insured (or his or her beneficiaries) arising from an insurer-prepared contract.

Utmost Good Faith

Although all contracts ideally should be executed in good faith, insurance contracts are held to an even

higher standard, requiring the utmost of this quality between the parties. Due to the nature of an insurance agreement, each party needs - and is legally entitled - to rely upon the representations and declarations of the other. Each party must have a reasonable expectation that the other party is not attempting to defraud, mislead, or conceal information and is indeed conducting themselves in good faith. In a contract of utmost good faith, each party has a duty to reveal all material information (that is, information that would likely influence a party's decision to either enter into or decline the contract), and if any such data is not disclosed, the other party will usually have the right to void the agreement.

Executory

An executory contract is one in which the covenants of one or more parties to the contract remain partially or completely unfulfilled. Insurance contracts necessarily fall under this strict definition; of course, it's stated in the insurance and agreement that the insurer will only perform its obligation after certain events take place (in other words, losses occur).

Unilateral

A contract may either be bilateral or unilateral. In a bilateral contract, each party exchanges a promise for a promise. However, in a unilateral contract, the promise of one party is exchanged for a specific act of the other party. Insurance contracts are unilateral; the insured performs the act of paying the policy premium, and the insurer promises to reimburse the insured for any covered losses that may occur. It must be noted that once the insured has paid the policy premium, nothing else is required on his or her part; no other promises of performance were made. Only the insurer has covenanted any further action, and only the insurer can be held liable for breach of contract.

Conditional

A condition is a provision of a contract which limits the rights provided by the contract. In addition to being executory, aleatory, adhesive, and of the utmost good faith, insurance contracts are also conditional. Even when a loss is suffered, certain conditions must be met before the contract can be legally enforced. For example, the insured individual or beneficiary must satisfy the condition of submitting to the insurance company sufficient proof of loss, or prove that he or she has an insurable interest in the person insured.

There are two basic types of conditions: conditions precedent and conditions subsequent. A condition precedent is any event or act that must take place or be performed before the contractual right will be granted. For instance, before an insured individual can collect medical benefits, he or she must become sick or injured. Further, before a beneficiary will be paid a death benefit, the insured must actually become deceased. A condition subsequent is an event or act that serves to cancel a contractual right. A suicide clause is an example of such a condition. Typical suicide clauses cancel the right of payment of the death benefit if the insured individual takes his or her own life within two years of a life insurance policy's effective date.

Personal contract

Insurance contracts are usually personal agreements between the insurance company and the insured individual, and are not transferable to another person without the insurer's consent. (Life insurance and some maritime insurance policies are notable exceptions to this standard.) As an illustration, if the owner of a car sells the vehicle and no provision is made for the buyer to continue the existing car insurance (which, in actuality, would simply be the writing of the new policy), then coverage will cease with the transfer of title to the new owner.

Warranties and Representations

A warranty is a statement that is considered guaranteed to be true and, once declared, becomes an actual part of the contract. Typically, a breach of warranty provides sufficient grounds for the contract to be voided. Conversely, a representation is a statement that is believed to be true to the best of the other party's knowledge. In order to void a contract based on a misrepresentation, a party must prove that the information misrepresented is indeed material to the agreement. According to the laws of most states and in most circumstances, the responses that a person gives on an insurance application are considered to be a representations, and not warranties.

As an example, consider an individual seeking life insurance coverage. He or she would routinely be required to complete an application, on which the applicant's sex and age would be requested. The accuracy of this information is necessary for the insurer to correctly ascertain its risk and determine the policy premium. If the applicant gives these responses incorrectly, they would likely be deemed (in the absence of outright fraud) as misrepresentations, and could possibly be used by the insurance company as grounds for voiding the policy.

There is, however, a difference between the representation (or misrepresentation) of a fact and the expression of an opinion. Take, for instance, a common insurance application question such as, "To the best of your knowledge, do you now believe yourself to be in good health?" An applicant answering 'yes' while knowing that he or she suffers from a particular condition would be guilty of misrepresenting an actual fact. However, if the applicant had no symptoms of any kind that would be recognizable to an average person and no doctor's opinion to the contrary, he or she would simply be stating an opinion and not making a misrepresentation.

Misrepresentations and Concealments

A misrepresentation is a statement, whether written or oral, that is false. Generally speaking, in order for an insurance company to void a contract because of misrepresented information, the information in question must be material to the decision to extend coverage.

Concealment, on the other hand, is the failure to disclose information that one clearly knows about. To void a contract on the grounds of concealment, the insurer typically must prove that the applicant willfully and intentionally concealed information that was of a material nature.

Fraud

Fraud is the intentional attempt to persuade, deceive, or trick someone in an effort to gain something of value. Although misrepresentations or concealments may be used to perpetrate fraud, by no means are all misrepresentations and concealments acts of fraud. For instance, if an insurance applicant intentionally lies in order to obtain coverage or make a false claim, it could very well be grounds for the charge of fraud. However, if an applicant misrepresents some piece of information with no intent for gain (such as, for example, failing to disclose a medical treatment that the applicant is personally embarrassed to discuss), then no fraud has occurred.

Impersonation (False pretenses)

When one person assumes the identity of another for the purpose of committing a fraud, that person is guilty of the offense of impersonation (also known as false pretenses). For instance, an individual that would likely be turned down for insurance coverage due to questionable health might request a friend to stand in for him (or her) in order to complete a physical examination.

Parol (or Oral) evidence rule

This principle limits the effects that oral statements made before a contract's execution can have on the contract. The assumption here is that any oral agreements made before the contract was written were automatically incorporated into the drafting of the contract. Once the contract is executed, any prior oral statements will therefore not be allowed in a court of law to alter or counter the contract.

Types of insurance

The following are the various types of insurance businesses recognised under the Insurance Act, 1938:

(a) Life insurance business

(b) General insurance business (also called “Non-Life” business). This is sub divided into the following 3 sub-categories:

1. Fire insurance business
2. Marine insurance business
3. Miscellaneous insurance business

Life insurance business covers the risk of contingencies dependent on human life. For example payment of an amount (called “sum assured”) on the death of the life assured. Further, annuity contracts (which provide for periodic payments to life assured as long as the policyholder is alive) or the provisions of accident benefits also form part of life insurance business.

All businesses other than Life are classified as General insurance business. Fire insurance, as the name suggests covers the risks associated with loss due to a fire accident to properties. Marine insurance means the business of effecting insurance contracts upon vessels of any description, including cargoes, freights and other interests which may be insured for transit by land or water or both and includes warehouse risks or similar risks incidental to such transit. Miscellaneous insurance include all insurance businesses other than Fire and Marine insurance business (and Life insurance business). It includes Motor, Liability, Health and Burglary insurances.

Generally, indemnity based health insurance policies (which reimburse hospitalisation expenses) were classified under the General insurance business. Under the Insurance Bill, Health insurance business has been categorised as a separate line of business than the General insurance business. Standalone health insurance companies have been licensed by IRDA to sell only health insurance policies, given the huge potential for this business.

Concept of intermediaries

A basic definition defines an intermediary as ‘action between two parties - mediatory’ or ‘situated or occurring between two things - intermediate’. The latter form refers more to a position within a process or level of achievement. The former, by contrast, refers to an intermediary as an agent in some form, as ‘one who acts between others - a do-between or mediator’, or as ‘something acting between things persons or things’. As actors then, what intermediaries do is mediate, they work in-between, make connections, enable a relationship between different persons or things. Indeed in common parlance the meaning implied by the concept intermediary tends to refer to a neutral player trying to mediate between different sets of interests. The assumption of neutrality is however, problematic. Rather than focus on everything as an intermediary, the interesting question is to ask in what ways, where, when and how particular things, people, organisations etc. are/ become defined as ‘intermediaries’. Further still, there is the question of the active role that intermediaries play in defining the relationship between other actors.

In Insurance industries, an insurance intermediary is a person or a company that helps you in buying insurance. Insurance intermediaries facilitate the placement and purchase of insurance, and provide services to insurance companies and consumers that complement the insurance placement process. Traditionally, insurance intermediaries have been categorized as either insurance agents or insurance brokers.

ROLE OF INTERMEDIARIES IN INSURANCE INDUSTRY

As players with both broad knowledge of the insurance marketplace, including products, prices and providers, and an acute sense of the needs of insurance purchasers, intermediaries have a unique role – indeed many roles – to play in the insurance markets in particular and, more generally, in the functioning of national and international economies.

Intermediary activity benefits the overall economy at both the national and international levels:

The role of insurance in the overall health of the economy is well-understood. Without the protection from risk that insurance provides, commercial activities would slow, perhaps grinding to a halt, thus stunting or eliminating economic growth and the financial benefits to businesses and individuals that such growth provides. The role of insurance intermediaries in the overall economy is, essentially, one of making insurance – and other risk management products – widely available, thereby increasing the positive effects of insurance generally – risk-taking, investment, provision of basic societal needs and economic growth.

There are several factors that intermediaries bring to the insurance marketplace that help to increase the availability of insurance generally:

Innovative marketing

Insurance intermediaries bring innovative marketing practices to the insurance marketplace. This deepens and broadens insurance markets by increasing consumers' awareness of the protections offered by insurance, their awareness of the multitude of insurance options, and their understanding as to how to purchase the insurance they need.

Dissemination of information to consumers

Intermediaries provide customers with the necessary information required to make educated purchases/ informed decisions. Intermediaries can explain what a consumer needs, and what the options are in terms of insurers, policies and prices. Faced with a knowledgeable client base that has multiple choices, insurers will offer policies that fit their customers' needs at competitive prices.

Dissemination of information to the marketplace

Intermediaries gather and evaluate information regarding placements, premiums and claims experience. When such knowledge is combined with an intermediary's understanding of the needs of its clients, the intermediary is well-positioned to encourage and assist in the development of new and innovative insurance products and to create markets where none have existed. In addition, dissemination of knowledge and expansion of markets within a country and internationally can help to attract more direct investment for the insurance sector and related industries.

Sound competition

Increased consumer knowledge ultimately helps increase the demand for insurance and improve insurance

take-up rates. Increased utilization of insurance allows producers of goods and services to make the most of their risk management budgets and take advantage of a more competitive financial climate, boosting economic growth.

Spread insurers' risks

Quality of business is important to all insurers for a number of reasons including profitability, regulatory compliance, and, ultimately, financial survival. Insurance companies need to make sure the risks they cover are insurable – and spread these risks appropriately – so they are not susceptible to catastrophic losses. Intermediaries help insurers in the difficult task of spreading the risks in their portfolio. Intermediaries work with multiple insurers, a variety of clients, and, in many cases, in a broad geographical spread. They help carriers spread the risks in their portfolios according to industry, geography, volume, line of insurance and other factors. This helps insurers from becoming over-exposed in a particular region or a particular type of risk, thus freeing precious resources for use elsewhere.

Reducing costs

By helping to reduce costs for insurers, broker services also reduce the insurance costs of all undertakings in a country or economy. Because insurance is an essential expense for all businesses, a reduction in prices can have a large impact on the general economy, improving the overall competitive position of the particular market.

Of course, the insurance cycle of "hard" and "soft" markets can have a significant impact on the benefits – both good and bad – of increased availability. Generally, however, increased availability benefits the consumer by leading to product competition, price competition, and improved services. By reducing insurance costs across markets, intermediaries make an important contribution to improving the economic conditions in a country.

Market Players and their Roles

There are many market players in insurance industries i.e.

a. Agents,

b. Brokers,

c. Surveyors & Loss Assessors,

d, Health Third Party Administrators.

The role of various players of insurance market is being discussed hereby:

Insurance Agent

Section 2(10) of the Insurance Act, 1938, defines an Insurance Agent as an insurance agent who received or agrees to receive payment by way of commission or other remuneration in consideration of his soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance.

First going in detail about the role of an insurance agent, we will discuss the standing of Insurance agent.

Principal-Agent relationship- Legal Implications and Status

Sections 182 to 238 of the Indian Contract Act, 1872 govern the relationship between a Principal and an Agent. An insurance agency contract is also governed by the principles enshrined therein. An Agent

("Insurance Agent") is a person employed to do any act for another or to represent another in dealings with third persons. The function of an agent is to bring his principal into contractual relations with third persons. A Principal ("Insurer") is a person for whom the above act is done or who is so represented.

There are two important rules of agency:

1. Whatever a person can do personally, he can do through an agent.
2. He who does an act through another does it by himself.

In this regard, it is pertinent to note the provisions of Section 237 of the Indian Contract Act, 1872 on the extent to which the acts of the Agent bind the Principal. Where an Agent has, without authority, done acts or incurred obligations to third persons on behalf of his principal, the principal is bound by such acts or obligations, if he has by his words or conduct induced such third persons to believe that such acts and obligations were within the scope of the agent's authority.

Further Section 238 of the Indian Contract Act, 1872 states that misrepresentation or frauds committed by the agent acting in the course of business for their principals, have the same effect on agreements made by such agents as if such misrepresentation or frauds had been made or committed by the principals. But misrepresentation or frauds committed by agents in matters which do not fall within their authority do not affect the principals.

For example, if an insurance agent misrepresents to the customer while selling an insurance product, the policy contract (agreement between insurer and policyholder) may become voidable at the option of the Policyholder.

An agent, who acts within the scope of authority conferred by his or her principal, binds the principal in the obligations he or she creates against third parties. There are essentially three kinds of authority recognized in law, viz., actual authority (express or implied), apparent authority and ratified authority.

Actual authority denotes the authority conferred on an agent by the Principal. It may be express or implied. Implied authority, as opposed to an express authority which is clearly given to the agent, is the authority which the agent has by virtue or being reasonably necessary to carry out his express authority, which might be incidental or ancillary to the express authority.

Apparent authority or the ostensible authority exists where the Principal's word or conduct would lead a reasonable person in the third party's position to believe that the agent was authorised to act, even if the principal and the purported agent had never discussed such a relationship. This is also called as "agency by estoppel" or the "doctrine of holding out".

Acts of the Agent constitute the acts of the Principal (Insurance company) if the said Agent acts within the scope of authority granted by the Principal. Further the principle of estoppel is also applicable. Here it is a mentionable fact that relationship between Brokers to an Insurance company is on a "principal to principal" basis. Since Broker represents a customer, acts of a Broker does not bind an insurer.

Types of Insurance Agents

The following are the different types of Insurance Agents recognised under the Regulations:

(a) Individual Agent

(b) Corporate Agent

(c) Micro Insurance Agent

(d) Bancassurance

Individual Agents

IRDA (Licensing of Insurance Agents) Regulations, 2000 as amended from time to time, contains provisions relating to licensing of individual Insurance Agents. The following are the different types of licences issued within the Regulations:

(a) Direct Life

(b) Direct Non Life

(c) Composite Licence (both Life and Non-Life)

The following are the pre-requisites for a candidate intending to get a licence issued (common for all types of agents):

(a) Minimum qualifications: The minimum qualifications prescribed are a pass in 12^{th} standard or equivalent examination conducted by a recognised Board/Institution. This condition is relaxed to a pass in 10^{th} standard for applicants residing in a place where the population is not less than 5,000 ('Rural agents')

(b) The applicant must not suffer from the following disqualifications:

a. That the applicant is not minor

b. That he is not found to be of unsound mind by a Court of competent jurisdiction

c. That he has not been found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or an abetment of or an attempt to commit any offence by a Court of competent jurisdiction and five years have not elapsed from the date of conviction

d. That he has not been found guilty of or has knowingly participated in or connived at any fraud, dishonesty or misrepresentation against an insurer or an insured during the course of:

   i. Any judicial proceeding relating to any policy of insurance (or)

   ii. Winding up of an insurance company (or)

   iii. In the course of investigation of affairs of an insurer

e. That he does not violate the code of conduct prescribed under the Regulations

(c) Practical Training: The applicant shall undergo a minimum of 50 hours practical training on insurance related matters in life or general insurance business, as the case may be, spreading to 1 to 2 weeks. Where the application is for a composite licence, the training shall be 75 hours spread over 3 to 4 weeks covering both life and general insurance subjects. Where the applicant holds special qualifications such as membership of Institute of Chartered Accountants of India, Institute of Cost and Works Accountants of India, Institute of Company Secretaries of India, Insurance Institute of India or the Institute of Actuaries of India or a Masters degree in Business Administration of any institution recognised by Central Government or State Government, it is sufficient if the training is undergone for 25 hours (35 hours if the licence is composite). The training can be undergone in any of the IRDA accredited training institutions

(d) Examination: Every applicant shall undergo a pre-recruitment examination in life or general insurance business or both, as the case may be, conducted by the Insurance Institute of India or

any other body authorised by IRDA.

(e) AML & ULIP training: In addition to the above, the insurer with whom the agent is attached provides a special training on Anti money laundering (under the IRDA's Anti money laundering Guidelines dated 31 March 2006) for all Insurance Agents. Training in Unit Linked Insurance Products (ULIP) is compulsory for life insurance agents before they are allowed to sell ULIPs on behalf of a life insurer (under the IRDA (Linked Insurance Products) Regulations, 2013)

(f) Payment of fees of Rs.250 alongwith the application for grant of licence enclosing proof of age, qualifications, training and examination.

Renewal of licence

A licence is issued for a period of three years at a time. At the end of the third year, the licence is required to be renewed. The following are the conditions for renewal of licence:

(a) Completion of practical training for 25 hours for Life or General insurance, as the case may be or 50 hours for renewal of composite agency licence

(b) Payment of fees of Rs.250 towards renewal of licence. If the application for renewal does not reach atleast 30 days before the due date for renewal, an additional fee of Rs.100 by way of penalty is payable. If the application for renewal reaches after the expiry of licence, IRDA may consider the application for renewal upon imposition of a penalty of Rs.750.

(c) Maintenance of a minimum persistency of 50% during the licence period (as per IRDA's persistency guidelines dated 11 February 2011

(d) The Agent does not suffer from any of the disqualifications mentioned in the previous section

(e) Renewal training on Anti-money laundering as may be prescribed by the insurer from time to time

Authorisation to sell for one insurer at a time

A licence issued under the provision of the above Regulations entitles an Insurance Agent to sell on behalf of one life insurer or one General insurer at a time. An identity card is issued by the concerned Insurer for this purpose. An Agent is entitled to change insurer but has to follow the process laid down in IRDA's circular on issue of a 'No objection Certificate" by the insurers, dated 2 September 2009.

Licensing of Corporate Agents

The IRDA (Licensing of Corporate Agents) Regulations, 2002 provides the licensing framework for Corporate Agents similar to the Regulations applicable to Individual Agents. The Corporate Agents regulations recognize agents who are one of the following entities (as against individual agents who are licensed under the IRDA (Licensing of Insurance Agents) Regulations, 2002):

(a) Firm

(b) Company under the Companies Act, 1956

(c) Banking company

(d) Co-operative society

(e) Panchayat or local authority

(f) Non-Government organisation

The licence is issued to the entity as against the individual under licensing of individual agents. However, the

persons who are authorised to sell on behalf of a Corporate Agent will have to undergo the training and examination requirements similar to that of an Individual agent. The Corporate agent shall have the following persons at the minimum as per the Regulations:

(a) Corporate Insurance Executive ('CIE')

(b) Specified Persons ('SP')

A Corporate Insurance Executive is the Director or Partner or one or more of its officers or employees so designated by it (where the applicant is a Company or a Firm). Where the applicant is any other person, the Chief Executive or one or more of his employees designated by him shall be the CIE. In either case, the CIE shall possess the minimum qualifications, undergo the practical training and pass the required examination.

A Specified Person is responsible for soliciting or procuring insurance business on behalf of the Corporate Agent entity. He may be a Director or a Partner or one or more of its officers or other employees so designated by the Corporate Agent. The individual desirous of acting as a Specified Person shall also possess the requisite qualifications, undergo the practical training and pass the examination. A Certificate is issued to a Specified Person which authorises him to solicit or procure insurance business on behalf of the Corporate Agent. There may be as many number of Specified Persons as the Corporate Agent requires depending upon the business requirements.

The minimum qualifications, practical training and examination requirements are similar to that of an individual agent. A Corporate Agent is also allowed to act for only one life insurer (Direct-Life) or one general insurer (Direct-Non-Life) or Composite Corporate Agent (one Life and one General at a time)

As per the IRDA guidelines on Corporate Agents, dated 14 July 2005, two types of Corporate Agents are recognized:

(A) Exclusive Corporate Agents – i.e. those entities whose primary activity is solicitation or procuration of insurance business. Such entities shall be Public Limited companies under the Companies Act, 1956, with a minimum paid up capital of Rs.15 lakhs deposited in a Scheduled Commercial Bank. Further entities belonging to Banking or Insurance Groups alone are allowed to form Exclusive Corporate Agencies

(B) Non-exclusive Corporate Agents – entities which are already engaged in some other business and would like to take up insurance agency as a subsidiary activity.

Further a Group to which the applicant Corporate Agent belongs to, can be granted only one corporate agency licence. In other words, any proposal from an applicant, some of whose group entities are already engaged in insurance business, such as corporate agent, broker, insurer etc., shall not be normally granted a corporate agency licence. IRDA does not normally grant any exception unless the entities are licensed by Reserve Bank of India with substantial client base or otherwise have assets, turnover or net worth of Rs.15 Crores.

Requirements for becoming a Corporate Agent:

(a) Formation or existence of an entity as required under the Regulations as above

(b) Identification of persons possessing the minimum qualifications to become a CIE or SP (a minimum of 1 CIE and 2 SPs are normally insisted by IRDA at the time of licensing). The actual number of persons will depend on the business plan of the applicant Corporate agent. CIEs or SPs can also be changed or added (in addition to minimum) subsequently

(c) Document evidencing constitution of the Corporate agent entity (e.g. Memorandum and Articles of

Association) shall contain "procuring or solicitation of insurance business" as one of the main objects

(d) Proof of CIE and SPs having undergone the practical training and passed the required examination

(e) Either CIE or one of the SPs must possess one of the following additional qualification:

(i) An Associate/Fellow of the Insurance Institute of India, Mumbai.

(ii) an Associate/Fellow of the Institute of Chartered Accountants of India, New Delhi; with diploma in Insurance and Risk Management.

(iii) an Associate/Fellow of the Institute of Costs and Works Accountants of India, Calcutta;

(iv) an Associate/Fellow of the Institute of Company Secretaries of India, New Delhi;

(v) an Associate/Fellow of the Actuarial Society of India, Mumbai;

(vi) possessing Certified Associate ship of Indian Institute of Bankers (CAIIB)

(vii) MBA (Two year) Course / PG Diploma (One year) course in Insurance from Amity School of Insurance & Actuarial Science, Noida

(viii) PG Diploma (One year) course in Insurance from Institute of Insurance and Risk Management, Hyderabad

(ix) MBA (Two year) course in Insurance from National Insurance Academy, Pune

(x) PGMBA (Two Year) course in Insurance from National Law University, Jodhpur

(xi) PGMBA (Two year) course in Insurance from MET, Mumbai

(xii) MBA (Two year) course in Insurance from Birla Institute of Management Technology, Noida

The persons with above qualifications (except at (a)) shall undergo a "Workshop for Insurance executives" at National Insurance Academy, Pune or Insurance Institute of India, Mumbai or Institute of Insurance and Risk Management, Hyderabad as prescribed by the Authority.

(f) In the case of exclusive Corporate Agencies, proof of formation of a public company, injection of a capital of Rs.15 lakhs and depositing the money into a Bank

(g) Fee of Rs.250 for issue of licence to the Corporate Agent and Rs.500 for issue of Certificate for each Specified person

Renewal of licence

A license is issued for a period of 3 years and shall expire at the end of the term, unless renewed. The annual fee to the Authority in such manner as may be specified by the regulations for renewal of an individual agency license. The conditions for renewal of licence for a Corporate agent is similar to that of an individual agent, including maintenance of a minimum persistency of 50%.

Micro Insurance Agents

Micro insurance Agents are a special category of insurance agents who support financial inclusion, i.e. the distribution of financial services at an affordable cost to the masses. Micro insurance contracts are typically low sum assured contracts which provide for the sum assured to be paid either on death – both natural and accidental, or an Endowment (which also provides a sum assured on maturity in addition to death) or a health insurance.

Only a Non-Governmental organisation or a Self Help Group Micro Finance Institutions or Associations not formed for Profit are entitled to become Micro Insurance Agents. Such Agents can distribute the products of one life insurer or one general insurer or both. A Micro insurance agent shall employ Specified persons with the prior approval of the Insurer to distribute the micro insurance products on its behalf. All the Micro insurance agents and their Specified persons shall be imparted a 25 hour training by the insurer in local vernacular language in the areas of insurance selling, policyholder servicing and claims administration.

A Micro insurance agent can sell only a Micro insurance product and not any other type of insurance products. However an Agent who is licensed to sell all products of an insurer can sell the Micro insurance products of such insurer, if any. An Insurance Broker who can sell any product of any insurer, can sell Micro insurance products of any insurer as well.

All Micro insurance policies may be reckoned for the purpose of fulfillment of social obligations of an insurer pursuant to the provisions of the Insurance Act and Regulations. Where a micro insurance policy is issued in a rural area and falls under the definition of social sector, such policy may be reckoned for both under rural and social sector obligations as well.

Bancassurance

Bancassurance is an arrangement in which a bank and an insurance company form a partnership so that the insurance company can sell its products to the bank's client base. This partnership arrangement can be profitable for both companies. Banks can earn additional revenue by selling the insurance products, while insurance companies are able to expand their customer bases without having to expand their sales forces or pay commissions to insurance agents or brokers.

Role of an Insurance Agent

An insurance agent represents the insurer with whom he or she is attached. He solicits or procures insurance business only for such insurer. The responsibilities of an insurance agent broadly include the following:

(a) Perform Need analysis for the customer – The agent is expected to sell the products of the insurance company, which suit the needs of the customer. For this purpose he has to analyse the needs of the customer, such as Insurance protection for family, Asset protection needs, Children's marriage or education needs, Health insurance, Pension etc. Depending on the needs and the stage of the life cycle of the customer, the appropriate product of the insurer which suits the customer is recommended

(b) Explain the product benefits, premiums, exclusions and other terms and conditions so that the customer can take an informed decision

(c) Assist the customer in getting the requisite documents for the purpose of seeking an insurance cover and clarify the doubts of the customer in the proposal form filling process

(d) Bring to the notice of the insurer any adverse habits of the customer which will have a bearing on the insurer's decision to accept a risk

(e) Inform the customer about the decision of the insurer to issue a policy or otherwise

(f) Provide assistance to customer at various stages of policy servicing and when a claim is made

INSURANCE BROKER

Regulation 2(i) of the IRDA (Insurance Brokers) Regulations, 2002, defines Insurance Broker as a person for

the time being licensed by the Authority under Regulation 11, who for remuneration arranges insurance contracts with insurance companies and/or reinsurance companies on behalf of his clients.

Licensing of Insurance Brokers

Every Insurance Broker shall possess a valid and subsisting licence to act as an Insurance Broker issued by IRDA. The framework for licensing of an Insurance Broker is similar to that of a Corporate Agent. However, as we have seen earlier a Broker differs from an Agent in the sense that a Broker represents customers interests and is required to select the best product amongst all insurance companies, while an agent represents an insurer at any point in time (one in life and one in general insurance) and will present the product of only such insurer(s) with whom the agent is attached with.

Categories of Insurance Brokers

(a) Direct Broker (Life)

(b) Direct Broker (General)

(c) Direct Broker (Life & General)

(d) Reinsurance Broker (Reinsurance Life or General)

(e) Composite Broker (Life and/or General + Reinsurance)

A Direct Broker is authorised to recommend the products of any of the life insurance companies or general insurance companies to their clients, as the case may be.

A Reinsurance broker arranges for reinsurance contracts between direct insurers and reinsurance companies. Reinsurance is a contract under which insurance companies can pass on the risk they assume under the policies issued by them, to yet another insurance company (called reinsurer). Therefore, the insurance company which issues the policy becomes the Policyholder under the reinsurance contract entered into with a reinsurer. A broker can be an intermediary who can arrange reinsurance contracts with reinsurance companies. Except for GIC, the National Reinsurer, all the other reinsurance companies doing business in India are located abroad. Therefore the role of reinsurance brokers in getting a best deal for insurance companies cannot be undermined.

A Composite Broker is one who arranges for both insurance contracts both for retail and institutional clients as a Direct Broker as well as for insurance companies as a reinsurance broker.

Role of an Insurance Broker

Regulation 3 of the IRDA (Insurance Brokers) Regulations, 2002 summarises the functions of a Direct Broker:

(a) Since a Broker represents a client, he is expected to obtain detailed information on client's business and risk management philosophy and familiarise himself with the client's business

(b) Render proper advice to the client in selecting the appropriate insurance as well as terms of insurance

(c) Possessing a detailed knowledge of insurance markets to be in a position to advice his client

(d) Submitting quotation received from insurance companies for consideration of a client

(e) Providing the information required about the client or the subject matter to be insured, to enable insurer to properly assess the risk and give a premium quotation

(f) Updating customer about the progress of the proposal submitted and providing written acknowledgements

(g) Assisting clients in paying premiums under Section 64VB of the Insurance Act, 1938

(h) Assisting clients in negotiation of claims and maintenance of claim records

Regulation 4 lists down the functions of a Reinsurance Broker:

(a) Familiarising himself about the client's business and risk retention philosophy

(b) Maintaining clear records of insurer to assist reinsurers

(c) Rendering advice based on technical data on the reinsurance covers available in the international insurance and the reinsurance markets

(d) Maintaining a database of available reinsurance markets including solvency ratings of individual reinsurers

(e) Rendering consultancy and risk management services for reinsurance

(f) Selecting and recommending a reinsurer or a group of reinsurers

(g) Negotiating with a reinsurer on client's behalf

(h) Assisting in the case of commutation of reinsurance contracts placed with them

(i) Acting promptly on instructions from a client and providing it written acknowledgement and progress reports

(j) Collecting and remitting premiums and claims within such time as agreed upon

(k) Assisting in the negotiation and settlement of claims

(l) Maintaining proper records of claims

(m) Exercising due care and diligence at the time of selection of reinsurers and international reinsurance brokers having regard to their respective security rating and establishing respective responsibilities at the time of engaging their services

The person entitled to become an Insurance Broker can be an individual, firm, a Company under the Companies Act, 1956; a Co-operative Society registered under the Co-operative Societies Act, 1912 or under any other law for the registration of Co-operative Societies or such other persons as IRDA recognises to act as an insurance broker. Normally, IRDA encourages only Companies to take up Insurance Broking.

Requirements for licensing of an Insurance Broker

(a) Application for broking licence, duly filled in and signed by the authorised signatory, alongwith supporting documents

(b) Memorandum and Articles of Association shall contain "solicitation or procuring insurance business as an Insurance Broker" as the main object

(c) Appointment of a Principal Officer who is the Director or the Chief Executive Officer appointed exclusively to carry out the functions of an insurance broker. Such a Principal Officer is subject to minimum qualifications as prescribed under the Regulations and shall undergo theoretical and practical training from IRDA accredited training institutes and has passed the examination conducted by National Insurance Academy, Pune or any other examining body.

(d) Atleast two employees of the applicant entity who have the minimum qualifications as prescribed by the Regulations and has undergone the practical training and passed the examination as mentioned above. Only such employees are authorised to solicit or procure insurance business on behalf of the insurance broker. An insurance broker may have as many number of authorized employees fulfilling the above conditions, as required depending on the business plan.

(e) The entity formed shall be solely engaged in the business of insurance broking and no other business

(f) The non-resident equity in insurance broking entity shall not exceed 26%

(g) Minimum capital requirements for the broking entity:

Direct Broker	₹50 lakhs
Reinsurance Broker	₹200 lakhs
Composite Broker	₹250 lakhs

(h) A minimum of 20% of the initial capital shall be kept in a Bank deposit which shall not be released without the prior approval of IRDA

(i) A professional indemnity insurance policy shall be taken by the broker as prescribed in the Regulations. IRDA may suitable cases allow a newly licensed broker to product the policy within 15 months from the date of issue of original licence

(j) Payment of Registration fee as follows:

Category of Insurance Broker	**Amount of Registration fee payable**
Direct Broker	₹20,000
Reinsurance broker	₹25,000
Composite Broker	₹40,000

(k) Qualifications and Disqualifications

The Principal Officer and each of the employees authorised to sell on behalf of the Insurance Broker shall possess one of the following minimum qualifications:

(a) Bachelor's or Masters Degree in arts, science or social sciences, engineering or its equivalent, law or its equivalent

(b) Master's Degree in Business Administration or its equivalent from any institution or university

(c) Associate or Fellow of the Insurance Institute of India or Institute of Risk Management or Institute of Chartered Accountants of India or Institute of Cost and Works Accountants of India or Institute of Company Secretaries of India or Institute of Actuaries of India or a Certified Associate of the Indian Institute of Bankers

(d) Such other qualification as may be prescribed by IRDA

The Insurance Broker shall not suffer from any of the disqualifications which are similar to the disqualifications prescribed for an individual agent

Theoretical and Practical Training requirements

The Principal Officer and each of the employees authorised to sell on behalf of the Insurance Broker shall

undergo 100 hours of theoretical and practical training from an IRDA accredited Training institution. The training hours are reduced to 50 where the Principal Officer of the applicant has been carrying on reinsurance related activity or insurance consultancy for a period of 7 years preceding the year in which the application for broking is made or has been working for not less than 7 years as a Principal Underwriter or has held the position of a Manager with any one of the nationalised insurance companies in India or is an Associate or Fellow of the Insurance Institute of India or the Institute of Risk Management or Institute of Actuaries of India or a Post graduate qualification of the Institute of Insurance and Risk management, Hyderabad.

Annual Fee

Every Broker shall pay an Annual Licence Fee as follows:

Category of Insurance Broker	**Amount of annual license fee payable per annum**
Direct Broker	A sum calculated at the rate of 0.50 per cent of the remuneration earned in the preceding financial year subject to minimum of INR 25000 and maximum of INR 100000
Reinsurance broker	A sum calculated at the rate of 0.50 per cent of the remuneration earned in the preceding financial year subject to minimum of INR 75000 and maximum of INR 300000
Composite Broker	A sum calculated at the rate of 0.50 per cent of the remuneration earned in the preceding financial year subject to minimum of INR 125000 and maximum of INR 500000

Renewal of licence

A licence issued to an Insurance Broker is valid for 3 years unless suspended or cancelled before the expiry of the 3 year period. The licence shall be renewable for a further period of 3 years subject to the following conditions:

(a) Application for renewal has to be submitted 30 days in advance of the date of expiry of licence

(b) Additional fee of Rs.100 in case the application reaches after the 30 days but before the expiry of licence

(c) Additional fee of Rs.750 in case the application reaches after the expiry of the licence for valid reasons to the satisfaction of IRDA

(d) Principal Officer and every employee authorised to sell on behalf of the insurance broker to undergo 25 hours of theoretical and practical training by IRDA accredited training institutes

Difference between Insurance Agent and Insurance Broker

The basic difference between an Insurance Broker and an Insurance Agent is that while an Insurance Broker represents the client, while an Insurance Agent represents the insurance company. As a corollary to the above, an Insurance Broker is licensed to recommend the products of any insurance company, whereas

Insurance Agent at any point in time can sell the insurance products of only one insurance company with which he is attached.

SURVEYORS AND LOSS ASSESSORS

A Surveyor or a Loss Assessor is relevant for general insurance business, where assessment of the loss of the subject matter insured is very important for deciding the claim amount. As general insurance contracts are indemnity contracts in nature, the amount paid by the insurance company cannot exceed the amount of actual loss incurred. The job of the Surveyor or a Loss Assessor is therefore to arrive at the exact amount of loss incurred and his role is critical to a general insurer.

Every person who is a student-member of the Institutes of Surveyors and Loss Assessors intending to act as a Surveyor or Loss Assessor is required to be licensed by IRDA before he starts performing his functions for any general insurer. A licence issued for a Surveyor or a Loss Assessor shall be valid for a period of 5 years after which it is required to be renewed.

A Surveyor and Loss Assessor shall be categorized into 3 categories, The three categories are Licentiate, Associateship and Fellowship which is awarded by the Institute of Surveyors and Loss Assessors. The nature of surveyor or loss assessment work which can be undertaken would depend upon the categorization. Further IRDA shall also allot the department or the area work for the Surveyor and Loss Assessor from time to time.

Requirements for issue of a licence for Surveyor or Loss Assessor

Regulation 3 of the Insurance Surveyors and Loss Assessors (Licensing, Professional and Code of conduct) Regulations, 2000 specifies the requirements for issue of a licence:

(a) He holds a degree in any branch of engineering (or) Post graduate diploma in general insurance issued by Institute of Insurance and Risk Management (or) a Degree in Agriculture (or)

(b) He is a member of the Institute of Chartered Accountants of India or the Institute of Cost and Works Accountants of India (or)

(c) He possesses actuarial qualifications or holds a degree or diploma of any recognised university or an institute in relation to insurance (or)

(d) He holds a diploma in insurance granted or recognised by the Government (or)

(e) He holds such other technical qualifications as prescribed by IRDA (and)

(f) He does not suffer from any of the disqualifications mentioned in section 42(4) Where the entity is a company or a firm, all the directors or partners shall possess one of the qualifications as prescribed above and none of the directors or partners suffer from any of the disqualifications mentioned as above (and)

(g) Payment of fees based on the categorisation of the applicant (and)

(h) Has undergone practical training as a Student-member under a licensed Surveyor and Loss Assessor (who shall be a Fellow or Associate member of the Institute) for a period of 12 months as contained in Chapter VII (persons who have more than 15 years experience in risk management and general insurance are exempt from this training) (and)

(i) Has passed the Surveyor examination conducted by the Insurance Institute of India or such other institute recognised by IRDA (and)

(j) Has undergone the special training provided by the Indian Institute of Surveyors and Loss

Assessors for 100 hours for Fellowship, 50 hours for Associate and 25 hours for Licentiate level (and)

(k) He attends seminars and workshops organised by the Institute for a minimum number of seminars, viz., 10 seminars for fellowship, 8 for Associateship and 5 for Fellowship level

Where the applicant is a company or firm, all the directors or partners, or one or more of its officers or other employees so designated by it and in the case of any other person, the chief executive by whatever name called, or one or more of his employees designated by him" as the case may be, shall possess one or more of the qualifications specified above and does not suffer form any of the disqualifications mentioned in Section 42D(4) of the Insurance Act, 1938. At least 2 Directors or partners shall be members of the institute and shall hold the licence to act as a surveyor and loss assessor. The level of membership or the department to which the directors or partners belong to shall become the level of membership or the department for the company or firm. Employees of the company of the firm, who are licensed as surveyor and loss assessor shall undertake survey only in those areas allotted to them based on the level of membership and the department to which they are eligible as per their individual licence. However this eligibility is subject to the level of membership or the department of the company or the firm (which is dependent on the directors/partners eligibility as above).

The following are the further conditions prescribed:

(a) Foreign equity in the Surveyor and Loss assessor entity shall not exceed 26%

(b) Common directors or partners between two Surveyor and Loss assessor entities prohibited

(c) One Promoter or Subscriber can have only one Surveyor and Loss assessor licence

(d) Main objects clause of the deed of constitution shall contain the activity of “to carry our insurance survey and loss assessment”

(e) Name of the Company or firm shall contain the words “Insurance Surveyors and Loss Assessors”

The Fees payable for issue of licence are as follows:

Sr.No.	***Level of membership in the Institute***	***Individual licence*** ₹	***Corporate licence*** ₹
1	Fellowship	10,000	15,000
2	Associateship	7,500	20,000
3	Licentiate	5,000	15,000

IRDA, on being satisfied that the applicant is eligible for issue of a licence shall send an intimation to the applicant together with an identity card mentioning the particular class or category of general insurance business, namely, fire, marine cargo, marine hull, engineering, motor, miscellenous and loss of profit, for which the Authority has granted licence.

Role of a Surveyor or Loss Assessor

The primary responsibility of a Surveyor or a Loss assessor is to estimate the liability of the loss incurred by the Policyholder who has taken an insurance cover, to enable the insurance company to arrive at the amount to be indemnified to the Policyholders under the terms of insurance contract. The following are the specific duties and responsibilities as enshrined under the Regulations:

(a) Declaration of conflicts of interest: In case the surveyor is interested in the subject matter under loss

assessment or in the policyholder whose subject matter is being assessed, he must declare the conflict to the insurer and stay away from the assessment exercise. For example, if the Surveyor is the son of the Policyholder whose car has been damaged in a fire accident, such a Surveyor cannot assess the loss of the car of his Father, in view of the conflict of interest. He must declare this relationship to the insurer concerned and not conduct the survey proceedings in such cases

(b) Maintenance of confidentiality and neutrality in the loss assessment exercise. He has to keep the interests of both the insurer and the policyholder in mind

(c) He must investigate the causes and circumstances of the loss in question

(d) He must personally conduct a spot survey and comment upon excess insurance or under insurance

(e) Advise the insurer about loss minimisation or loss control efforts or security and safety measures which can be adopted to ensure that the incidence of loss is reduced or avoided in future

(f) Pointing out discrepancy in policy wordings, if any

(g) Satisfying the queries of the insured or the insurer in connection with the claim or loss

(h) Recommending applicability of depreciation and its percentage and quantum

(i) Commenting on salvage and its disposal

Either the insurance company or the insured can appoint a licensed surveyor for any loss exceeding ₹20,000,within 72 hours of knowledge of loss to the insured. Notice of such appointment shall be sent to the insurance company or the insured, as the case may be. The Surveyor and Loss Assessor shall undertake survey only in the department for which license was In case there is any dispute or difference by the insured, another licensed surveyor shall be appointed to conduct the survey at the cost of the insured. Dispute on the quantum of loss may be referred to arbitration.

A surveyor shall submit his report within 30 days of his appointment. In exceptional cases, the surveyor may seek extension of time upto 6 months from the insurer, under intimation to the insured. Where the report is incomplete, the insurer may seek additional report within 15 days of submission of the report by the Surveyor. Under such circumstances, the Surveyor shall submit the additional report within 3 weeks of request from the insurer.

THIRD PARTY ADMINISTRATORS-HEALTH

A Third Party Administrator ('TPA') is a person appointed by an insurance company to render services in connection with health insurance business or health cover, excluding the insurance business of an insurer and soliciting or procuring insurance business directly or through an intermediary or an insurance agent. TPAs are normally engaged to provide services in connection with hospitalization of an insured under a health insurance policy taken through a general insurance company or a standalone health insurance company or under health insurance rider covers offered by life insurance companies. They also offer certain other services like arranging for medical examination of the insured before a policy is issued by an insurance company etc.

Requirements for becoming a TPA

A person can act as a TPA only with a valid licence issued by IRDA to perform the functions of a TPA. The requirements for obtaining a licence are as follows:

(a) **Entity:** The person applying for a licence shall be an entity which is a Company under the Companies Act, 2013

(b) **Primary object:** The main object as per the Memorandum and Articles of Association shall be to carry on business in India as TPA in the health services. Further engaging in any business other than TPA is prohibited

(c) Minimum paid up capital: Rupees **Four** crore and maintenance of working capital of Rs.1 crore at all times.

(d) One of the Directors to be registered with Medical Council: One of the directors of the TPA shall be a qualified medical doctor registered with Medical Council of India

(e) Foreign equity restricted to 26%: TPA entity shall not have foreign holdings in excess of 26%

Transfer of shares in excess of 5%: Prior approval of IRDA necessary before effecting any transfer of shares in excess of 5% either through direct transfer or through issue of fresh equity shares to new or existing shareholders

(f) Fee: A processing fee of ₹20,000 shall be payable alongwith the application. A further sum of ₹30,000 shall be payable as licence fee before the licence is issued.

A licence granted under these Regulations shall be valid for 3 years, after which, upon payment of a renewal of ₹30,000, may be renewed for a further period of 3 years.

Intimation of certain changes to IRDA

Every TPA shall inform the appointment of a new Chief Executive Officer ('CEO') or Chief Administrative Officer ('CAO') or a Director on the Board of TPA to IRD within 30 days of appointment

Every TPA shall inform IRDA the details of head office or branch offices closed or relocated within 15 days of such closure or relocation

Qualifications of CEO or CAO

Every person proposed to be appointed as a CEO or a CAO of the TPA shall possess the following qualifications:

(a) He shall hold a degree in arts, science, commerce or management or health or hospital administration or medicine

(b) A pass in the Associateship examination conducted by the Insurance Institute of India or such equivalent examination as decided by IRDA

(c) Completion of 100 hours of practical training with institutions recognized by IRDA

(d) He shall not be of unsound mind or un-discharged insolvent or a person who had been subject to imprisonment for a period of 3 months by a Court on the grounds of misfeasance, misconduct or forgery etc.

Decision making on claims by TPAs prohibited

A TPA is prohibited from taking any decisions on any claims. A TPA can only assess and recommend admission of a claim or otherwise based on the guidelines provided by the insurer in terms of the agreement entered with them. Once the insurer takes a decision on the claim and communicates it to the TPA, the TPA shall clearly state as follows in their communication to the Policyholder who has registered a claim:

"As per the instructions of the insurer <Name of the Insurer>. the claim is being settled/denied for ₹ <amount> on account of <specifics of treatment/grounds of denial>. For any further clarifications, you may directly contact the insurer."

Bar on Non-insurance healthcare schemes

The TPA shall offer health services only in accordance with the IRDA (Third Party Administrators) Regulations, 2001 and shall not provide any services:

(a) directly or indirectly to non-insurance healthcare schemes or

(b) directly to health insurance schemes promoted, sponsored or approved by entities not being insurance companies, such as Governments, PSU's etc.

(c) directly or indirectly to the policyholder or insured, except the health services as per the agreement with the insurer.

Agreement between a TPA and an Insurance company

a. The insurer and the TPA shall themselves define the scope of the Agreement, the health and related services that may be provided by the TPA and the remuneration therefor.

   Provided that there shall be a clause in the Agreement for its termination by either party on grounds of mutual consent or any fraud, misrepresentation, inadequacy of service or other non-compliance or default fraud.

   Provided further that, there shall be no element in the Agreement which dilutes, restricts or otherwise modifies the stipulations of the IRDA in respect of Policy Holder welfare, protection, service standards and turnaround-time parameters.

b. The remuneration to the TPA shall be based on the services rendered to the insurer and shall not be related to the product/policy experience or the reduction of claim costs or loss ratios of the insurer.

c. A copy of the Agreement entered into between the TPA and the Insurance Company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

d. More than one TPA may be engaged by an insurance company and, similarly, a TPA can serve more than one insurance company.

e. The Authority from time to time may prescribe minimum standard clauses to be included in the agreement between insurer and TPA.

Change of TPAs for servicing of Health Insurance Policies

a. A change in the TPA by the insurer shall be communicated to the policyholders 30 days before giving effect to the change.

b. The contact details like helpline numbers, addresses, etc. of the new TPA shall be made immediately available to all the policyholders in case of change of TPA.

c. The insurers shall take over all the data in respect of the policies serviced by the earlier TPA and make sure that the same is transferred seamlessly to the newly assigned TPA, if any. It shall be ensured that no inconvenience or hardship is caused to the policyholders as a result of the change. In this regard, the following aspects shall receive special attention:

   i. Status of cases where pre-authorization has already been issued by existing TPA.

   ii. Status of cases where claim documents have been submitted to the existing TPA for processing.

iii. Status of claims where processing has been completed by the TPA and payment is pending with the insurer/ TPA.

Data and related issues

a. The TPA and the insurer shall establish a seamless flow of data transfer for all the claims.

b. The respective files shall be handed over to the insurer within 15 days of the claim settlement or rejection.

CERTIFICATION OF INSURANCE PROFESSIONALS AND TRAINING ORGANISATIONS

It would be noted across the IRDA regulations on insurance agents and intermediaries that undergoing training is mandatory condition in most of the cases as one of the prerequisites to licensing. The training can be imparted only by IRDA approved training institutions. While institutions like Insurance Institute of India, Indian Institute of Risk Management, and National Insurance Academy are associated with the insurance industry to provide training inputs on an ongoing basis to the various functionaries within the industry, the IRDA accredited training institutes play a major role in training insurance distributors like Individual agents, corporate agents, Insurance Brokers etc.

IRDA has issued standard instructions and guidelines applicable for approval/renewal of agents training institutes vide ref: IRDA/AGTS/CIR/GLD/269/12/2011 dated 7th December 2011

Let us see the salient features of instructions as issued by IRDA for accredited training institutes.

A Training facility can be provided by either IRDA accredited Agents Training Institutes ('ATIs') or by the Insurer's own accredited Training college (which is a part of the insurance company's organisation). Further a Training can be provided either offline or online by such Institutes.

An accreditation is provided to Training Institute by IRDA subject to the following conditions:

(a) Institutes which are engaged in training for financial / insurance products for more than 3 years are eligible to apply for starting an offline/online institute. However this will not apply to in-house institutes of insurers

(b) Only entities registered as Company under the Companies Act and Society and trusts registered under Societies Registration Act shall be eligible to apply for accreditation as ATIs.

(c) The accreditation will be given on need basis. The existing private ATIs will be granted a one-time permission as assessed by the Committee to relocate the centers within the state. The existing ATIs will also be eligible for reallocation of the centres within the state based on the assessments made by the Standing Committee.

(d) For a new location if more than one private Agents Training Institutes apply for accreditation, internal grading and marking system will be applied to give accreditation on merits. The ATIs shall register themselves with PF Commissioner and scrupulously follow the statutory provisions regarding the contribution of the PF amount to the accounts of the employees.

(e) The initial approval will be for a period of 3 years and consideration of further renewal next 3 years would depend on the satisfactory compliance of requirements of accreditation. Accreditation of any centre which has not conducted any pre recruitment training for one year continuously will be liable for cancellation. For renewal cases the ATIs are required to apply with all documents/details 3 months in advance of expiry of accreditation.

How Training shall be conducted for Distributors

The 50 hours training which is normally required to be conducted for all Individual Agents, Specified Persons of Corporate Agents and Authorised employees of Insurance Brokers etc., shall be as follows:

(a) The training shall be based on the books prescribed by the Authority for life insurance i.e. IC-33 and for non-life insurance IC-34.

(b) The training duration for new license is 7 days minimum including Sundays but excluding national holidays with 8 hours per day excluding lunch and tea break applicable for full time batches.

(c) For the part-time batches the training can be imparted 4 hours daily excluding tea break and the minimum duration of the training will be 14 days including Sundays but excluding national holidays. In case of composite training duration are 11 days & 22 days respectively for full time and part time training.

(d) Any candidate to qualify for the exam must complete 50 hours or 75 hours training as applicable. For renewal of license candidate must attend 25 hours training in each stream i.e. life or non-life separately in 4 days or 8 days respectively. Product related training and market survey shall not be included in this statutory training. The product training, if any, to be given by the insurance company should be conducted separately and over and above the minimum training hours prescribed by the Authority.

Attendance

The attendance record of the trainees should be maintained at the Institute for necessary inspection at any given point of time.

Faculty

(a) Every Institute should have at least one qualified permanent full-time faculty for each stream i.e. for Life and Non-Life having any of the qualifications as prescribed below:-

1. I 0 years of experience in the managerial cadre with any insurer.
2. The qualified surveyors, Engineers with B.Tech Degree from recognized universities, CA, CS and ICWAI qualified professional*
3. LOMA level 1 Qualification*.
4. Associate from Insurance Institute of India*.
5. Post graduation qualification in insurance provided by university recognised by UGC like PG diploma in insurance, MBA in insurance, Associate from CII, London and Diploma from IIRM, Hyderabad*.
6. Qualified students of post graduate diploma in insurance earlier approved by IRDA in year 2003 offered by IRDA approved institutes*.

* A three day workshop either at NIA,III ,IIRM will be mandatory, for qualifications mentioned at 2,3,4,5,6.

(b) The attendance register of the faculty members should be maintained at the training institutes.

(c) The record of the payment made to faculty should be maintained at the training institute i.e. batch-wise payment detail should be maintained. In case the employment of the faculty is full time, record of monthly wages payment should be maintained. All payments to faculty will be made through bank.

(d) The faculty should provide details of the other Institutes with whom they have been empanelled as part-time/guest faculty. The faculty must also inform the other Institutes of his/her leaving one institute and joining any other training institute. Any change in main qualified permanent faculty must be intimated to the Authority within one month.

(7) The Agents Training Institutes must impart pre recruitment training to only those candidates who are sponsored by insurers by online allotment of training slot and training completion certification on portal.

(8) The Agents training institutes are permitted to undertake courses on insurance, sponsored by Insurers or being conducted by III, NIA, IIRM, Actuarial society of India, CII London or any other insurance related training. Agents Training Institute must have at least one classroom dedicated for pre recruitment training.

(9) For the purpose of accreditation of private Agents Training Institute the proof of ownership or tenancy of the premises in the name of Agent Training Institute are sufficient for accreditation. In case of in-house Agents Training institute where the training centre is situated in the branch approved by IRDA, copy of IRDA approval of branch is acceptable.

(10) Infrastructure: It is mandatory for every Agent Training Institute to have at-least one classroom with a minimum carpet area of 200 sq. Feet apart from office room and wash room, dedicated to 50125 hours training. Every Agent Training Institute must provide one computer for each classroom to practice the online exam mock test. The classroom should have comfortable seating arrangements permanently available.

(11) Batch size the maximum number of candidates permitted in a batch for training will be 40. To reduce the cost of training, Agent Training Institutes may include candidates from different insurers in the same batch provided the total number does not exceed maximum number of candidates permitted.

(12) The insurance institute of India (I.I.I) shall regularly send their officials to oversee the proper conduct of the training at the institutes and would not sponsor candidates to those institutes that are not maintaining the required standards of and facilities for the training. In-house training centers will be subject to regular inspections and audit by the insurer concerned in addition to inspection by officials of the Authority and I.I.I.

(13) The training institute must display the certificate of accreditation to impart training issued by the Authority at the training institute.

(14)The institute should not allow a franchisee to conduct courses on its behalf, even with the faculty of the Institute. The institute should conduct the training only on its approved premises with proper infrastructure.

(15) No marketing fee/consultancy fee payment is permitted for getting the training batches.

(16) It will be the responsibility of the insurance Company to check the status of the institute before sponsoring any candidates for training.

(17) In case of the cities where there are no accredited institutes or the institute is situated 50 Km away an insurance company intends to appoint agents, it will be the responsibility of the insurance company to conduct training. The employed faculty only of the in-house training centers may impart training at such places. No temporary/guest faculty is permissible for the in-house training centers of the insurers. The insurers may seek prior approval to conduct such batches from the Authority.

(18) The Institutes must keep with them one set of original records of the training at the place where the training is being imparted. The institute with multiple locations must keep copy of all training records at head office of the institute however original record has to be kept at respective center only.

(19) The Institute should confine its activities generally within 50 KM radius only to the place city for which it

has been given the approval. No training for the candidates outside the said place city is permitted. If during the course of the inspection by the officials of the Authority, it is found that the institute is not maintaining dedicated class-room, the accreditation of the institute will stand cancelled without giving any notice.

(20) The institute may ensure that the batch size/batches taken by the institute are commensurate with the infrastructure1 facilities available and approved by the Institute.

(21) In order to ensure prompt compliance and smooth monitoring all the insurers are advised to nominate a nodal officer at corporate level who will be responsible for communicating with Authority in the area of training on the lines of designated officers for licensing.

(22) The existing Institutes should report compliance with these instructions within 15 days from the date of issuance of these guidelines. The institutes must inform the authority the location and contact details of head office of the institute.

(23) The Insurance companies/ATIs are advised to consider the current address of the candidates for nomination to a particular location. Training institutes are allowed to admit candidates from the same district where the ATI is located or any other district which shares the boundary with the district of the ATI.

LESSON ROUND-UP

1. A contract of insurance is an agreement whereby one party, called the insurer, undertakes, in return for an agreed consideration, called the premium, to pay the other party, namely the insured, a sum of money or its equivalent in kind, upon the occurrence of a specified event resulting in a loss to him. An insurance agreement should satisfy all essentials of valid agreement i.e.
   (a) Proposal
   (b) Acceptance
   (c) Consideration
   (d) Competency to Contract
   (e) Free Consent
   (f) Lawful object
2. A insurance contract have some basic features namely:
   (a) It is aleatory in nature
   (b) It is a contract of adhesion.
   (c) It is based on the principle of Utmost good faith
   (d) It is executor in Nature
   (e) It is unilateral and conditional
   (f) Insurance contracts are usually personal agreements between the insurance company and the insured individual,
3. There are mainly two types of insurance businesses recognised under the Insurance Act, 1938:
   (i) Life insurance business
   (ii) General insurance business (also called “Non-Life” business). This is sub divided into the following

3 sub-categories:

i. Fire insurance business

ii. Marine insurance business

III Miscellaneous insurance business

4. An insurance intermediary is a person or a company that helps you in buying insurance. Insurance intermediaries facilitate the placement and purchase of insurance, and provide services to insurance companies and consumers that complement the insurance placement process. Traditionally, insurance intermediaries have been categorized as either insurance agents or insurance brokers.

5. The market players in insurance industries includes

   (A) Agents,

   (B) Brokers,

   (C) Surveyors & Loss Assessors,

   (D) Health Third Party Administrators,

6. Section 2(10) of the Insurance Act, 1938, defines an Insurance Agent as an insurance agent licensed under Section 42 of the said Act and who received or agrees to receive payment by way of commission or other remuneration in consideration of his soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance

7. Regulation 2(i) of the IRDA (Insurance Brokers) Regulations, 2002, defines Insurance Broker as a person for the time being licensed by the Authority under Regulation 11, who for remuneration arranges insurance contracts with insurance companies and/or reinsurance companies on behalf of his clients.

8. The basic difference between an Insurance Broker and an Insurance Agent is that while an Insurance Broker represents the client, while an Insurance Agent represents the insurance company. As a corollary to the above, an Insurance Broker is licensed to recommend the products of any insurance company, whereas Insurance Agent at any point in time can sell the insurance products of only one insurance company with which he is attached.

9. A Surveyor or a Loss Assessor is relevant for general insurance business, where assessment of the loss of the subject matter insured is very important for deciding the claim amount. As general insurance contracts are indemnity contracts in nature, the amount paid by the insurance company cannot exceed the amount of actual loss incurred. The job of the Surveyor or a Loss Assessor is therefore to arrive at the exact amount of loss incurred and his role is critical to a general insurer

10. IRDA has issued standard instructions and guidelines applicable for approval/renewal of agents training institutes vide ref: IRDA/AGTS/CIR/GLD/269/12/2011 dated 7th December 2011

SELF-TEST QUESTIONS

1. What is the nature of Insurance contract? Explain various features of insurance contract.
2. What are various elements of a valid insurance agreements
3. What are different types of Insurance contract?
4. What do you mean by insurance intermediaries? Explain the role of insurance intermediaries in insurance business.

5. What are the difference types of insurance agent? Explain their role in insurance agent.
6. Explain the requirements for becoming a insurance broker? Explain difference between insurance agent and insurance broker.
7. Explain the role of insurance and loss surveyors?

Lesson 4
REGULATORY ENVIRONMENT – SPECIFIC LEGISLATIONS

LESSON OUTLINE

- History Of Insurance In India
- Regulation Of Insurance Business In India
- Acts/ Regulations Common To General And Life Insurance Business In India
- Regulations Governing/ Affecting Life Insurance Business In India
- Regulations Affecting General Insurance Business In India
- Why Regulation Of Insurance Businesses:
- Constitution Of Insurance Regulatory And Development Authority
- Powers /Functions Of IRDA
- Framework Under The Insurance Act, 1938
- Relevant Regulations And Guidelines Issued By IRDA For Licensing, Audit & Supervision IRDA Guidelines For Grievance Redressal
- IRDA Guidelines To Financial Inclusion
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

A well developed and evolved insurance sector is a boon for economic development of a country. It provides long-term funds for infrastructure development and concurrently strengthens the risk-taking ability of the country. India's rapid rate of economic growth over the past decade has been one of the most significant developments in the global economy.

The Indian insurance industry is at the crossroads of development. The industry is on its way to development and a number of factors govern that growth. The development of the insurance industry in India is likely to be critically dependent on the nature and quality of regulation. Overall, the regulatory environment is favourable and takes care that players maintain prudent underwriting standards, and reserve valuation and investment practices. The primary objective for the current regulations is to promote stability and fair play in the market place.

After going through this unit you should be able to understand:

- Need for a regulation of insurance business
- Framework under the Insurance Act, 1938
- Insurance Regulatory and Development Authority, their powers and functions
- Various areas regulated by IRDA

WHAT IS RISK

HISTORY OF INSURANCE IN INDIA

In India, insurance has a deep-rooted history. It finds mention in the writings of Manu (*Manusmrithi*), Yagnavalkya (*Dharmasastra*) and Kautilya (*Arthasastra*). The writings talk in terms of pooling of resources that could be re-distributed in times of calamities such as fire, floods, epidemics and famine. This was probably a pre-cursor to modern day insurance. Ancient Indian history has preserved the earliest traces of insurance in the form of marine trade loans and carriers' contracts. Insurance in India has evolved over time heavily drawing from other countries, England in particular. Now, we will be discussing brief about the history of Life Insurance and General Insurance in India.

Life Insurance

Year 1818 saw the **advent of life insurance business in India** with the establishment of the Oriental Life Insurance Company in Calcutta. This Company however failed in 1834. In 1829, the Madras Equitable had begun transacting life insurance business in the Madras Presidency. 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. This era, however, was dominated by foreign insurance offices which did good business in India, namely Albert Life Assurance, Royal Insurance, Liverpool and London Globe Insurance and the Indian offices were up for hard competition from the foreign companies.

In 1914, the Government of India started publishing returns of Insurance Companies in India. The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies. In 1938, with a view to protecting the interest of the Insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938 with comprehensive provisions for effective control over the activities of insurers.

The Insurance Amendment Act of 1950 abolished Principal Agencies. However, there were a large number of insurance companies and the level of competition was high. There were also allegations of unfair trade practices. The Government of India, therefore, decided to nationalize insurance business.

An Ordinance was issued on 19th January, 1956 nationalising the Life Insurance sector and Life Insurance Corporation came into existence in the same year. The LIC absorbed 154 Indian, 16 non-Indian insurers as also 75 provident societies—245 Indian and foreign insurers in all. The LIC had monopoly till the late 90s when the Insurance sector was reopened to the private sector.

General Insurance

The **history of general insurance dates** back to the Industrial Revolution in the west and the consequent growth of sea-faring trade and commerce in the 17th century. It came to India as a legacy of British occupation. General Insurance in India has its roots in the establishment of Triton Insurance Company Ltd., in the year 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd, was set up. This was the first company to transact all classes of general insurance business.

1957 saw the formation of the General Insurance Council, a wing of the Insurance Associaton of India. The General Insurance Council framed a code of conduct for ensuring fair conduct and sound business practices.

In 1968, the Insurance Act was amended to regulate investments and set minimum solvency margins. The Tariff Advisory Committee was also set up then.

In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business was nationalized with effect from 1st January, 1973. 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd. The General Insurance Corporation of India was incorporated as a company in 1971 and it commence business on January 1st 1973.

Regulation of Insurance Business in India

This millennium has seen insurance come a full circle in a journey extending to nearly 200 years. The process of **re-opening of the sector** had begun in the early 1990s and the last decade and more has seen it been opened up substantially. In 1993, the Government set up a committee under the chairmanship of RN Malhotra, former Governor of RBI, to propose recommendations for reforms in the insurance sector. The objective was to complement the reforms initiated in the financial sector. The committee submitted its report in 1994 wherein, among other things, it recommended that the private sector be permitted to enter the insurance industry. They stated that foreign companies be allowed to enter by floating Indian companies, preferably a joint venture with Indian partners.

Following the recommendations of the Malhotra Committee report, in 1999, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body to regulate and develop the insurance industry. The IRDA was incorporated as a statutory body in April, 2000. The key objectives of the IRDA include promotion of competition so as to enhance customer satisfaction through increased consumer choice and lower premiums, while ensuring the financial security of the insurance market.

The IRDA opened up the market in August 2000 with the invitation for application for registrations. Foreign companies were allowed ownership of up to 26%. The Authority has the power to frame regulations under Section 114A of the Insurance Act, 1938 and has from 2000 onwards framed various regulations ranging from registration of companies for carrying on insurance business to protection of policyholders' interests.

In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer. Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002.

Today there are 29 general insurance companies including the ECGC and Agriculture Insurance Corporation of India and 24 life insurance companies operating in the country.

Beside IRDA Act and Insurance Act, 1938, there are some common Act/Regulation to the General and Life Insurance Business in India and some Acts have been made for specific requirement of Life Insurance/General Insurance.

Acts/ Regulations common to General and Life Insurance Business in India

The following Acts regulate the Insurance Business in India.

- Insurance Act, 1938
- IRDA Act, 1999
- Insurance Amendment Act, 2002
- Exchange Control Regulations (FEMA)

- Insurance Co-op Society
- Indian Stamp Act, 1899
- Consumer Protection Act, 1986
- Insurance Ombudsman

Regulations Governing/ Affecting Life Insurance Business in India

The following Acts govern /regulate the life insurance business in India.

- LIC Act, 1956
- Amendments to LIC Act

Regulations Affecting General Insurance Business in India

The following Acts affect, circumscribe or regulate in some way or the other, some aspect of the General Insurance Business in India.

- General Insurance Nationalization Act, 1972
- Amendments to GIN Act, 1972
- Multi-Modal Transportation Act, 1993
- Motor Vehicles Act. 1988
- Inland Steam Vessels Amendment Act, 1977
- Marine Insurance Act, 1963
- Carriage of Goods by Sea Act, 1925
- Merchant Shipping Act, 1958
- Bill of Lading Act, 1855
- Indian Ports (Major Ports) Act, 1963
- Indian Railways Act, 1989
- Carriers Act, 1865
- Indian Post Office Act, 1898
- Carriage by Air Act, 1972
- Workmens' Compensation Act, 1923
- ESI Act, 1948
- Public Liability Insurance Act. 1991

Why Regulation of Insurance Businesses:

Any industry wherein the stakes of the public are high would come within the purview of a Regulation – reason being that failure of such companies could result in serious implications on the economy of the country at large.

Insurance business involves collection of money from various Policyholders, investing them properly, honouring the obligations of the Policyholders and providing an efficient service. It is important to ensure that the entities providing these services stick to their commitments. Failure to honour commitments by such entities could have major repercussions on the financial services industry.

After liberlisation and entrance of Private players in Insurance business and seeing the large numbers of customers and high risk potential, Government of India constituted the Insurance Regulatory and Development Authority in Year 1999.

Constitution of Insurance Regulatory and Development Authority

The IRD Act has established the Insurance Regulatory and Development Authority ("IRDA" or "Authority") as a statutory regulator to regulate and promote the insurance industry in India and to protect the interests of holders of insurance policies. The IRDA Act also carried out a series of amendments to the Act of1938 and conferred the powers of the Controller of Insurance on the IRDA. The members of the IRDA are appointed by the Central Government from amongst persons of ability, integrity and standing who have knowledge or experience in life insurance, general insurance, actuarial science, finance, economics, law, accountancy, administration etc. The Authority consists of a chairperson, not more than five whole-time members and not more than four part-time members.

Every Chairperson and member of IRDA appointed shall hold office for a term of five years. However, Chairperson shall not hold office once he or she attains 65 years while whole time members shall not hold office beyond 62 years. A part-time member shall hold office for a term not exceeding five years from the date on which he enters upon his office.

Central Government may remove any member from office if he or she is adjudged insolvent or is physically or mentally incapacitated or has been convicted of an offence involving moral turpitude or has acquired financial or other interests or has abused his position. Chairperson and the whole time members shall not for a period of two years from the date of cessation of office in IRDA, hold office as an employee with Central Government or any State Government or with any company in the insurance sector.

POWERS /FUNCTIONS OF IRDA

Under Section 14 of the IRDA Act, IRDA has the following powers:

(a) Issue of Certificate of Registration to insurance companies, renew, modify, withdraw, suspend or cancel the certificate of registration

(b) Protection of interests of policyholders in matters concerning assignment of policies, nomination, insurable interest, claim settlement, surrender value and other terms and conditions of insurance contract

(c) Specification of requisite qualifications, practical training and code of conduct for insurance agents and intermediaries

(d) Specification of code of conduct for surveyors and loss assessors

(e) Promoting efficiency in the conduct of insurance business

(f) Promoting and regulating professional organizations connected with insurance and reinsurance business

(g) Levying fees and other charges for carrying out the purposes of the Act

(h) Calling for information from or undertaking inspection of insurance companies, intermediaries and other organizations connected with insurance business

(i) Control and regulation of rates, advantages, terms and conditions that may be offered by general

insurance companies

(j) Specifying the form and manner in which books of account shall be maintained by insurance companies and intermediaries

(k) Regulation of investments of funds by insurance companies

(l) Regulation of maintenance of margin of solvency

(m) Adjudication of disputes between insurers and insurance intermediaries

(n) Supervising the functioning of Tariff Advisory Committee

(o) Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations

(p) Specifying the percentage of insurance business to be undertaken by insurers in rural or social sectors

(q) Such other powers as may be prescribed.

FRAMEWORK UNDER THE INSURANCE ACT, 1938

The Insurance Act, 1938, broadly provides the ground rules for the operating insurance companies in India. The Act provides for the following:

The Insurance Act is the parent legislation which aimed at consolidating and amending the law relating to the business of insurance in February 1938, when, during the British Rule in India, there were many insurance companies which were operating. The Insurance Act, 1938, broadly provides the ground rules for the operating insurance companies in India.

- The Insurance Act, 1938 has been segregated into five parts

1. Part I: (Section 1 to Section 2B)

Part I of Insurance Act, 1938 deals with Definitions, interpretation of Certain Words and expressions and Appointment of Authority in India

2. Part II: (Section 2C to Section 64)

Part II of Insurance Act contains provisions relating to:

(a) Insurers (Section 2 C to Section 26)

(b) Investment, Loans and Management(Section 27 to Section 32C)

(c) Investigation (Section 33)

(d) Appointment of Staff (Section 33A to Section 34)

(e) Control over Management(Section 34A to Section 34H)

(f) Amalgamation and Transfer of Insurance Business(Section 35 to Section 37A)

(g) Assignment or Transfer of Policies and Nominations (Section 38 to Section 39)

(h) Commission and Rebates and Licensing of Agents(Section 40 to Section 44A)

(i) Special Provisions of Law(Section 45 to Section 52)

(j) Management by Administrator(Section 52 A to Section 52G)

(k) Acquisition of the Undertakings of Insurers in certain cases(Section 52H to Section 52N)

(l) Winding up(Section 53 to Section 61)

(m) Special Provisions relating to External Companies(Section 62 to Section 64)

PART II A (Section 64A to Section 64T)

PART II A contains provisions relating to Insurance Association of India, Council of the Association and Commi1lees thereof (Section 64 to Section 64T)

PART IIB (Section 64U to Section 64UM)

PART II B contains provisions relating to TARIFF ADVISORY (Section 64U to Section 64UM)

PART IIC (Section 64 V to Section 64VC)

PART II C contains provisions relating to Solvency Margin, Advance Payment of Premium and Restrictions on the Opening of A New Place of Business

3. PART III (Section 65 to Section 94)

Part III contains provisions relating to Provident Societies

PART IIIA (Section 94A)

Part III A contains provisions relating to **Insurance Co-Operative Societies**

4. PART IV (Section 95 to Section 101)

Part IV contains provisions relating to Mutual insurance Companies and cooperative life insurance societies

PART IVA (Section 101A to Section 101C)

Part IV A contains provisions relating To Re-Insurance

5. PART V (Section 102 to Section 120)

Part V contains provisions relating to miscellaneous matters

THE DETAILS OF FEW OF THE IMPORTANT PROVISIONS OF INSURANCE ACT, 1938 ARE DESCRIBED BELOW

(a) Incorporation of insurance companies, issue of licence and renewal of licence (Sections 2C to 5)

Only Companies formed and registered under the Companies Act, 1956, whereunder the foreign equity is not more than 49% (from July 2014), are allowed (IRDA allows only Public limited companies). Every insurer who proposes to do insurance business has to register with IRDA and obtain a licence before they start doing insurance business. Three lines of businesses recognised within insurance – Life insurance, Non-life insurance and Standalone Health insurance. Life insurance companies provide insurance coverage on human lives – i.e. provision of a defined sum on the happening of any contingency linked to human life. Non-life insurance companies are also allowed provide insurance coverage on all contingencies other than the ones linked to human life, including health insurance. Standalone Health insurance companies focus only on providing hospitalisation and sickness coverage. In addition, re-insurance is also recognized as a separate line of business. Insurance companies are allowed to pass on the risk which they assume to other insurers,

called re-insurers. Currently only one Reinsurer GIC is licensed in India as the National Reinsurer. Separate companies will have to be formed for doing Life, Non-Life and Standalone Health insurance business. Such companies cannot transact any business other than the insurance business for which the licence is issued. All companies formed for the purpose of doing insurance business shall carry the suffix "Assurance" or "Insurance" in their names to enable anyone to recognise that they are engaged in insurance business.

A Public company is first incorporated under the Companies Act, 1956/ Companies Act, 2013, with the primary object of engaging in the business of life or non-life or standalone health insurance business. Applicants for insurance licence will have to submit, among other things, certified true copy of memorandum and articles of association, list of directors, certain affidavits and undertakings from Promoters and the fees required for registration. IRDA conducts due diligence on the Promoters, their background before they issue a licence. Reference is made to the Regulatory of the country in which the foreign promoter operates, as most foreign promoters of insurance companies are established players in other jurisdictions outside India.

IRDA is vested with powers under the Act to cancel the registration of insurers on certain grounds such as default in complying with the provisions of the Act or Regulations passed thereunder, carrying on business other than insurance business etc.

Licence is issued for a financial year and is renewable on an yearly basis on payment of the required fees. The fee for renewal is 0.20% of total gross premium written direct by an insurer in India during the financial year preceding the year in which the application for renewal of certificate is required to be made, subject to an overall cap of Rs.5 Crores.

Requirements as to Capital, Transfer of shares, Voting rights etc.(Sections 6, 6A to 6B)

Every insurer carrying on insurance business shall have a minimum paid up equity capital of Rs.100 Crores for life insurance and general insurance business and Rs.200 crores for an insurer carrying on reinsurance business. This capital shall be maintained after preliminary expenses incurred upon formation of the insurance company and registration of insurance business. The intention of prescribing a minimum capital is to ensure that only serious players who look at a longer term for return of investment enter insurance business.

Further the capital of an insurance company shall consist of only Equity Share capital and no other forms of capital are allowed. All the equity shares shall have a single face value. Further, notwithstanding the provisions contained in the Companies Act, 1956 / Companies Act, 2013, the voting rights on equity shares shall be strictly in proportion to the paid up amount of the equity shares held.

The Act also provides for restrictions on transfer of shares in an insurance company. Before an insurance company can put through transfer of shares in excess of the following limits, prior approval of IRDA is required:

(1) Where, after the transfer, the transferee's holding will cross 5% of the paid up equity capital of the insurance company (2.5% if the transferee is a banking company or an investment company)

(2) Where the nominal value of the shares proposed to be transferred by an individual, firm, group or body corporate under the same management exceeds 1% of the paid up equity capital of the insurance company

Persons holding beneficial interest in the equity shares of an insurance company held in another person's name, are required to submit a declaration of their interest to the insurance company, failing which such person shall have no right or title in such shares and the insurance companies are expected to record the beneficial ownership in a separate Register maintained for this purpose.

While the maximum foreign in an insurance company is 26%, Indian Promoter(s) can hold upto 100% in an Indian insurance company. However, where the Indian promoter(s) hold more than 26% of the paid up equity capital of an insurance company, the holding of an Indian promoter in excess of 26% shall, immediately after the completion of 10 years from the date of commencement of insurance business, be brought down to 26%. The intention behind this section was to broadbase the equity shareholding of an Insurance company after 10 years in such a way that one Indian promoter cannot control more than 26% equity stake in an insurance company. Either the holding in excess of 26% shall be divested in favour of other Indian promoters or in favour of public upon listing.

Accounts, Audit and Actuarial report and abstract (Sections 10, 11, 12)

Separate books of account are required to be maintained for each class of business. Since separate companies will have to be formed for Life, Non-Life or Reinsurance, this provision is automatically taken care for formation of separate companies and consequent maintenance of separate books of account. Further a separate fund called Life insurance fund shall be formed, the assets of which shall be separate and distinct from all other assets of the insurer. By virtue of the powers given under Section 11, IRDA have framed Regulations for Financial Statements which provides for forms of Revenue Account, Profit and Loss Account and Balance Sheet alongwith the form of Management Report and some of the documents annexed to the financial statements. Further, every insurer shall keep separate accounts relating to funds of shareholders and policyholders. The forms provided in Schedule III to the Companies Act, 2013 is not applicable to Insurance companies as they are required to follow the forms prescribed under the IRDA Regulations.

The accounts and the statements referred to in Section 11 shall be signed by the Chairman of the Board of the Insurance company and two other Directors, the Principal Officer of the Company (CEO or Managing Director) and shall be accompanied by a statement containing the names, descriptions and occupations of, and the directorships held by the persons in charge of the management of the business during the period to which the accounts and statements relate to.

Section 12 provides for audit. The financial statements shall be audited by an auditor. Detailed guidelines have been framed by IRDA on the qualifications of persons who can be appointed as Statutory Auditors of the Company.

Section 13 requires investigation of financial condition of the life insurance business carried on by an actuary. While the section mandates actuarial valuation not more than once in two years, IRDA have mandated an yearly actuarial valuation. IRDA have issued detailed regulations on preparation of Actuarial Report and Abstract.

Provisions relating to Investments (Sections 27, 27A, 27B, 27E)

Section 27 requires insurance companies to invest in the manner specified in the section an amount equivalent to the amount of liabilities of the insurance companies on account of matured claims and on account of liability on policies maturing for payment after deducting the premiums due but grace period not expired and the amount of loans outstanding against the policies issued by the insurer. The manner in which the investment is required to be made is – not less than 50% in Government and Approved securities (out of which 25% only in Government securities) and the balance in Approved investments as specified in Section 27A. The deposits made with Reserve Bank of India under Section 7 are deemed to be Government Securities for this purpose.

Section 27A prescribes the approved investments for the purpose of Section 27. It lists down various investments which have been recognised for this purpose. The following are some of the approved investments recognized under the section:

(a) Approved securities as defined under Section 2(3) of the Insurance Act, 1938.

(b) Debentures of companies having a interest paying track record of 5 years immediately preceding or five out of the 6 of 7 years immediately preceding, secured by a first charge on any immovable property, plant or equipment of the Company.

(c) Debentures of companies secured by a first charge on the immovable property, plant of machinery of a Company where the book value or the market value whichever is less of the asset is atleast three times the value of debentures (in such cases, interest track record is not mandatory).

(d) First debentures secured by a floating charge on all assets of a Company which has paid dividends on Equity shares for five years or atleast five out of six or seven years preceding.

(e) First mortgage on immovable property situated in India (other than leasehold property with an outstanding term of less than 30 years and the value of property exceeds one-third of the mortgage money (if it is building, one-half).

(f) Preference shares of any company on which dividends on equity shares have been paid for the immediately preceding five years or for atleast five out of the six or seven years immediately preceding.

(g) Preference shares of a company which has paid dividends on such preference shares for five years immediately preceding or for atleast five out of six or seven years immediately preceding and such Preference shares have priority over equity shares in the event of winding up.

(h) Equity shares of a Company which has paid dividends of not less than four percent for the seven years immediately preceding or for atleast seven out of the eight or nine years immediately preceding.

(i) Fixed deposits with Banks.

(j) Such other investments notified by IRDA as Approved Investments through Regulations.

Investment in "Other investments"

Any investment in other than Approved Investments as above is allowed upto 15% of the sum specified in Section 27, provided such investments are made with the consent of all the directors present at a Board meeting and eligible to vote, in respect of which a special notice has been given to all the Directors in India.

CEILINGS ON INVESTMENTS

(a) in one Banking Company or Investment Company (Section 27A(3))

An insurance company cannot out of the Controlled fund invest or keep invested in the shares of any one banking company or investment company, an amount exceeding two and a quarter percent of the amount specified in Section 27 (or) 2% of the subscribed share capital and debentures of the Banking company or investment company concerned, whichever is less

(b) in any Company other than Banking Company or Investment Company (Section 27A(4))

An insurance company cannot out of the controlled fund invest or keep invested in the shares of any one company other than banking or investment company, an amount exceeding two and a quarter percent of the amount specified in Section 27 (or) 10% of the subscribed share capital and debentures of the Company

(c) in Fixed Deposits or Current deposits of Banks or Co-operative Societies

Not more than 3% of the Controlled funds is allowed to be deposited in the Fixed or Current deposits with any one Banking company or any one Co-operative Society registered under the Co-operative Societies Act, 1912

Formation of subsidiary companies for doing insurance business (Proviso to Section 27A(4)

The restriction given as above will not be applicable if an insurance company invests in the share capital of a subsidiary company for carrying on insurance business after getting previous approval of the Authority. This is more relevant in the context of recent notification of IRDA permitting formation of foreign subsidiaries engaged in insurance business

Prohibited Investments (Section 27A(5) and 27C)

Investments in the shares or debentures of a Private Limited Company and investments out of Policyholders funds outside India are prohibited.

Encumbrance, charge or hypothecation of Assets forming part of Controlled fund

All assets forming part of Controlled fund to be kept of free of any encumbrance or charge except to the extent not exceeding $1/10^{th}$ of the controlled fund, subject to such conditions as may be prescribed by IRDA. Such charge or encumbrance can be created only for the purpose of a loan taken by an insurance company for the purpose of any investment. However, Government Securities and Approved Securities forming part of the Controlled fund cannot be subject to any charge or encumbrances

Note: Controlled Fund is defined as all funds pertaining to life insurance business, except for any part of the fund in respect of which IRDA is satisfied that it would not be in the interests of the insurer to apply the provisions of Section 27A.

Prohibition of Loans

Section 29 prohibits grant of any loans or temporary advances to any Director, Actuary or Auditor of the insurance company or to any company or firm in which any such Director, Actuary or Auditor holds the position of a Director, Actuary or partner. This prohibition is not applicable to:

(a) loans made by an insurer to a banking company in which such Director, Actuary or Auditor is interested

(b) loans or advances made by an insurance company to its subsidiary or to the loans or advances made by an insurance company to its holding company

(c) Policy loans granted by the insurance company within the surrender value of the policy

Loans to Insurance Agents

Subject to the above provisions, an insurance company can grant any temporary advances to an insurance agent upto the renewal commission earned by such agent in the year immediately preceding the year of grant. Where the Insurance Agent is newly appointed and has not earned any renewal commission, the total amount of loan which can be sanctioned cannot exceed one hundred rupees and the total amount of advances so made cannot exceed Rs.10,000 (Note: these monetary limits were placed under the Insurance Act, 1938 which have been removed in the Insurance Bill. The only limit as per the Bill would be the restriction of advance to the preceding year's renewal commission)

Minimum Insurance business under Rural and Social Sectors & Third party Insurance of Motor Vehicles

Section 32B and 32C requires every insurer to undertake such minimum percentage of the insurance business for covering risks associated with persons forming part of rural and social sector, workers in the unorganized or informal sector or economically vulnerable or backward classes of society or such classes as

prescribed by IRDA. Further, Section 32D requires every insurer to undertake such minimum percentage of the insurance business for covering risks associated in third party risks of motor vehicles.

Appointment of Managing or Whole Time Director or Chief Executive Officer requires previous approval of IRDA (Section 34A)

An insurance company needs to have a Chief Executive Officer who is also the Principal Officer of the Company. He is normally on the Board of Directors of the Company and designated as the Managing Director. Some insurance companies appoint Executive or Whole Time Directors who hold some functional responsibilities in the Company. The appointment of all such positions – i.e. Managing Director, Chief Executive Officer, Principal Officer, Whole Time Director or Executive Director require the prior approval of IRDA. Due diligence is conducted by the Authority on the candidate proposed to be appointed to the above positions and only after they are satisfied about the background of the person the approval is given. Further, IRDA approval is also required for payment of any remuneration or increase in any remuneration or termination of appointment of the persons occupying the above positions

The provisions related to **Managing or Whole Time Director or Chief Executive Officer as prescribed in Companies Act, 2013,** shall apply in relation to matters in respect of which an approval from IRDA has been obtained from IRDA.

It may be noted that Section 48B prohibits common directors between two life insurance companies

Assignments and Nominations under Insurance policies (Section 38 & 39)

Assignments are transfer of insurance policies from Policyholder to another with or without a valid consideration. Any assignment to be valid must satisfy the following conditions:

(a) Endorsement for assignment upon the policy document or by a separate instrument signed in either case by the transferor or his duly authorized agent and attested by one witness

(b) Notice of assignment to be given to the insurer and the endorsement or instrument itself or a copy thereof certified to be correct both by transferor and transferee or their duly authorized agents have been delivered to the insurer

(c) Registration of assignment by the insurer in their records after receiving the above document and effecting an endorsement upon the policy document

On and from the date of receipt of notice of assignment alongwith documents, the insurer shall recognize transferee or assignee as the only person entitled to any benefits under the policy after the date of assignment.

Nomination is effected by the person taking the policy on his own life, to decide the person who will receive the benefits upon the death of the policyholder (since the policyholder will not be alive at that time). For minor nominees, a Guardian (called “appointee”), other than the policyholder himself, needs to be appointed. In order to effective, the name of the nominee must be incorporated in the policy document itself, based on the name of the nominee mentioned in the Proposal form (application for life insurance). However, a nomination, if not made at the proposal stage, can be made by way of an endorsement in the policy by the Insurer subsequently, for which a notice has to be given by the Policyholder to the insurer. Upon receipt of such notice, the insurer shall register the nomination and make an endorsement on the Policy document. Similar process is adopted for change of nominations as well. An assignment under a policy shall automatically cancel a nomination subsisting on the date of assignment. This is because nomination is valid only for policies taken on one’s own life. Upon assignment, the policyholder becomes a person different from life

assured and assignee is the only person entitled to receive any benefit upon death of the life assured (assignor).

Indisputability of policies (Section 45)

Insurance contracts are contracts of utmost good faith, based on the principles of *'ubberima fidae'*. The person taking the insurance policy is expected to disclose the information required in the application form concerning his health, occupation, family history, habits and all other material questions truthfully without withholding any information required. This is to enable accurate assessment of the risk and fixing of the premium by the insurer accordingly. Since only the person taking the insurance is privy to the personal information, obligation to truthfully disclose lies with the person taking the insurance. If there is any misstatement or concealment of a material fact (any information which would have impacted the decision to accept the risk), the insurance company has the right to cancel the contract (repudiation) and deny the policy benefits.

Section 45 however, places burden on the insurer's right to repudiate beyond 3 years from the date the policy was effected. In such cases, the insurer has to prove the following 3 points in order to repudiate any policy benefit:

(a) Statement(s) made in the proposal for insurance or in any medical report or any other document leading to issue of policy was inaccurate or false on a material matter (i.e. on a matter which could have affected judgment of underwriter)

(b) The statements were made with fraudulent intention

(c) The policyholder knew at the time of making the statement that it was false or knew that material facts were suppressed

However, the insurer's right of calling for proof of age even after 3 years subsequent to issuance of policy and adjusting the terms of the policy accordingly would not be affected by the provisions of the above section.

Provisions relating to licensing of Insurance Agents and Insurance Intermediaries

An Insurance Agent is a person who, after obtaining a licence from IRDA, is authorized to solicit or procure insurance business on behalf of one life insurer, one general insurer, one health insurer and one of each of the other mono-line insurers with whom the Agent is attached. An Insurance Broker is an intermediary, licensed by IRDA to solicit or procure insurance business on behalf of any insurer. While an Agent represents an insurance company with whom he is attached, an Insurance Broker represents customers. An Agent can be an individual agent or a Corporate Agent – meaning a Partnership Firm or a Company acting as an Agent.

Section 42 provides for the eligibility conditions for obtaining a licence by an insurance agent, the disqualifications etc. A licence granted under this section is valid for a period of 3 years after which it can be renewed. Fees for renewal of licences have been prescribed. The disqualifications for a person to become an Agent are as follows:

(a) That the person is a minor

(b) That he is found to be of unsound mind by a Court of competent jurisdiction

(c) That he has been found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or similar acts of misconduct by a Court of competent jurisdiction

(d) That in the course of any judicial proceeding relating to policy of insurance or winding up proceedings of the insurer or in the course of investigation of affairs of the insurer by IRDA, it has been found that the agent has been guilty of or has knowingly participated in or connived at any fraud, dishonesty or misrepresentation against the insurer or an insured

(e) That in the case of individual agent, he does not possess the requisite qualifications undergone practical training and passed the examinations as specified by IRDA or where the proposed agent is a Corporate agent, the persons authorised to sell on behalf to solicit or procure insurance business, does not possess the requisite qualifications, have not undergone the required practical training or passed the required examinations as prescribed by IRDA

(f) That the agent violates the code of conduct prescribed under the regulations

Section 41 prohibits offering of any rebates by anyone to customers as an inducement for purchase of an insurance policy or for continuance of an insurance policy or for reinstatement of a lapsed insurance policy.

Section 48A prohibits insurance agents of life insurance companies from acting or becoming a Director of any insurance company carrying on life insurance business

Powers of IRDA with reference to control of management of insurance companies, takeover of management, mergers, acquisitions and winding up

Section 52A empowers IRDA to make a report to Central Government if the affairs of a Life insurance Company are carried on in any manner prejudicial to the interests of policyholders. Based on the Report, the Central Government is empowered to appoint an Administrator to manage the affairs of the life insurance company. A report shall be filed by such Administrator to the Central Government giving his recommendations on the way forward, including the options of transfer of business to an existing insurer or winding up, as he deems fit. Securities Appellate Tribunal is empowered to take such action as it deems fit based on the Report of the Administrator.

Section 52H empowers Securities Appellate Tribunal to acquire the undertaking of any insurer based on a report from IRDA on failure to comply with directions or if the insurance company is being managed in a manner detrimental to the public interest or in the interests of public or policyholders it is appropriate to do so. Securities Appellate Tribunal may make a scheme for transfer of undertaking of the insurer to another insurer in such cases and decide the appropriate compensation in such cases. The Central Government may constitute a Tribunal by the name of Securities Appellate Tribunal comprising of a Chairman (a person who is or has been a Judge of the Supreme Court or a High Court) and two other members (one of whom has experience in insurance and the other a Chartered Accountant) for this purpose.

Section 53 empowers the Tribunal to order for winding up in accordance with the Companies Act, 1956 / Companies Act, 2013,, if based on a petition presented by shareholders holding not less than one-tenth of the whole body of shareholders and holding not less than one-tenth of the whole share capital or by not less than fifty policyholders holding life insurance policies in force for not less than three years of total value of not less than Rs.50,000, the Tribunal is satisfied to do so.

In addition, IRDA may also apply to the Tribunal for winding up on the following grounds:

(a) That the insurance company failed to deposit or keep deposited with Reserve Bank of India, the amount required to be deposited under Section 7 or Section 98

(b) That the insurance company has failed to comply with any requirement of the Insurance Act or has continued contravention for a period of three months after notice of such failure or contravention has been conveyed to the Company by IRDA

(c) That it appears from returns or statements filed by the Company or from the results of the Company that the company is deemed to be insolvent

(d) That the continuance of the company is prejudicial to the interests of the policyholders or to the public interest generally

It may be noted that Section 54 of the Act prohibits voluntary winding up of insurance companies, except for the purpose of effecting an amalgamation or reconstruction of the company or on the ground that by reason of its liabilities it cannot continue its business. This provision overrides the provisions of the Companies Act, 1956 on this point.

An appeal against the Tribunal formed under the Insurance Act shall lie with the National Company Law Appellate Tribunal

Insurance Association of India, Insurance Councils and Committees thereof

Section 64A provides for constitution of an Insurance Association of India comprising of all insurers who carry on insurance business in India. The Insurance Association shall have two councils – a Life Insurance Council and a General Insurance Council, comprising of the Life and Non-Life insurance companies, respectively, as their members. An Executive Committee is also constituted under the Section 64F for each of the above two Councils.

The Executive Committee of the Life Insurance Council shall comprise of the following members:

(a) Four (4) representatives of members of the Life Insurance Council elected in their individual capacity by the members in such manner as may be laid down in the bye-laws of the Council – One of them is nominated as Chairman an eminent person not connected with insurance business, nominated by the Authority;

(b) three (3) persons to represent insurance agents, intermediaries and policyholders respectively as may be nominated by the Authority;

(c) one (1) representative each from self-help groups and Insurance Co-operative Societies:

The Executive Committee of the General Insurance Council shall comprise of the following members:

(a) four representatives of members of the General Insurance Council elected in their individual capacity by the members in such manner as may be laid down in the bye-laws of the Council - One of them is nominated as Chairman; an eminent person not connected with insurance business, nominated by the Authority; and

(b) four persons to represent insurance agents, third party administrators, surveyors and loss assessors and policyholders respectively as may be nominated by the Authority:

Section 64I empowers Life insurance council, with the approval of IRDA, to authorize its Executive Committee to hold examinations for individuals who wish to qualify themselves as insurance agents and that only such individuals who have passed such examinations shall be eligible for issue of a licence under Section 42.

The Executive Committees of the Insurance Councils act as an advisory body for the Life insurance and General insurance companies for setting up standard of conduct and sound practice and in matters relating to efficient service to policyholders. Further they are also empowered to render advice to IRDA in matters relating to controlling of expenses of the insurance companies.

In this regard it is pertinent to note that Section 40B read with Rule 17D of the Insurance Rules 1939

prescribes limits to expenses of management for insurance companies (the limits are calculated as a percentage of the premiums sourced by the Insurance Companies). In this regard, Insurance councils are empowered to recommend to IRDA for fixing revised limits for a particular insurance company or for groups of insurance companies, having regard to the conditions obtaining in the respective insurance businesses.

Insurance Companies to accept risk on an insurance policy only after receipt of premiums in advance

Section 64VB prohibits insurance companies accepting a risk on an insurance policy without receiving the consideration (Premium) in advance. A risk can also be assumed based on a guaranteed provided e.g. Bank Guarantee, in accordance with the provisions of Insurance Rules. However, in terms of sub-section (2) of Section 64VB, in respect of risks where the premium can be ascertained in advance, the risk cannot be assumed earlier than the date on which the premium has been paid in cash or cheque to the insurer. Any refund of premium on account of a cancellation of a policy shall be paid by the insurance company directly to the life insured by a crossed account payee cheque or by postal money order and a proper receipt shall be obtained from the insured. In any case, refund to the account of the Agent is strictly prohibited. Further, where an insurance agent collects a premium on behalf of an insurer, the Agent is required to deposit the premium collected without deduction of his commission, within 24 hours of collection excluding bank and postal holidays.

Opening of places of business requires prior approval of IRDA

Section 64VC requires every insurance company to take an approval in advance in IRDA for opening any place of business or for relocation of an existing place of business outside the same city, town or village. The approval is required to be sought for opening of any offices, whether called as Branch office, Head Office, Administrative office, Satellite office or any other similar names.

Powers of IRDA for imposition of penalties for default in complying with the Act (Section 102)

Section 102 empowers IRDA to impose a penalty of one lakh rupees for each day during which such failure continues or one crore rupees, whichever is less by an insurance company:

(a) Failure to furnish any document, statement, account, return or report to IRDA

(b) Failure to comply with the directions (Section 34 empowers IRDA to issue directions if it is satisfied to do so in the interests of public or for prevention of affairs being conducted detrimental to policyholders or to secure proper management of any insurer)

(c) Failure to maintain the required solvency margin

(d) Failure to comply with the directions on the insurance treaties

Further Section 105B empowers IRDA to impose a penalty not exceeding Rupees twenty fivce crores for failure to comply with Section 32B and for failure to comply with Section 32C.

RELEVANT REGULATIONS AND GUIDELINES ISSUED BY IRDA FOR LICENSING, AUDIT & SUPERVISION

Before discussing the IRDA regulations and guidelines relating to licensing, audit and supervision, we need to understand that there are many participants in Insurance business namely

A. Insurance Companies

B. Corporate Brokers

C. Individual Agents

D. Insurance Surveyors and Loss Assessors

E. Third Party Administrators

Now, we will discuss the requirement for each participants

Regulation/Guidelines relating to Licensing Audit and Supervisions of Insurance Companies

Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations, 2000, contains the provisions relating to licensing of Insurance companies in India. These provisions have been amended from time to time and provide detailed guidelines for registration as Insurance Company in India. For supervising the operations of Insurance Companies in India, IRDA has issued various guidelines from time to time and discussed under relevant chapters.

As per the Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations, 2000 (as amended), every entity wishes to work as an Insurance Company needs to apply with IRDA in the prescribed format.

IRDA (Licensing of Insurance Agents) Regulations, 2000 & IRDA (Licensing of Corporate Agents), 2002

These Regulations provide for the conditions of licensing for individual insurance agents under Section 42. The Regulations cover the following:

(a) Prescription of application for IRDA licensing alongwith the fees required

(b) Prescription of minimum qualifications for becoming an insurance agent – 12^{th} standard or equivalent examination if the Agent resides at places with population of 5,000 or more as per census and a pass in the 10^{th} standard or equivalent examination for candidates residing in any other place

(c) Practical training requirements from an approved training institution for 50 hours covering various insurance subjects. Further, the training hours for an agent who is going for a composite licence – i.e. one life and one non-life licence, the training requirement is 75 hours Where the applicant possesses professional qualifications such as membership of the Institute of Chartered Accountants, Cost an Works Accountant or Company Secretaries, Actuaries or an MBA, the number of training hours is reduced to 25.

(d) Pre-recruitment examinations to be conducted by the Insurance Institute of India

(e) Prescription of codes of conduct for Agents

In the case of Corporate Agents, i.e. where the entity licensed as an agent is a Company or firm, it must have at the minimum a Corporate Insurance Executive and Specified Persons who are employees of the Corporate Agent entity and who will have to possess minimum qualifications, undergo the practical training and pass the examination conducted by the Insurance Institute of India.

A licence issued under these Regulations is valid for a period of 3 years after which it shall be renewed for continued eligibility for Agents to solicit or procure insurance business.

Insurance Surveyors and Loss Assessors (Licensing, Professional Requirements and Code of Conduct) Regulations, 2000,

Insurance Surveyors and Loss Assessors (Licensing, Professional Requirements and Code of Conduct)

Regulations, 2000, as amended by, Insurance Surveyors and Loss Assessors (Licensing, Professional Requirements and Code of Conduct) (Amendment) Regulations, 2013 contains provisions relating to registration, regulation and supervision of Insurance and loss surveyors in India.

Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013 contains the provisions relating to registration and other requirement relating to third party administrator in India.

IRDA (INVESTMENT) REGULATIONS, 2013

In a bid to direct long term savings in infrastructure sector, Insurance Regulatory Development Authority (IRDA) amended investment regulations in Year 2013. These guidelines provide for the following:

Types of investments (based on nature of investments)

The objective behind this classification is to categorises the investments based on the avenues where investments are made and place a ceiling (cap) or floor (minimum) depending on the type of investment.

Investments of insurers are categorised into the following buckets:

(a) Government Securities – these are predominantly Securities issued by Central Government or State Government which have a sovereign rating and carry a very high safety

(b) Approved Securities include securities issued by an authority constituted under a Central or State Legislature or by a Corporation

(c) Approved Investments are controlled investments which satisfy any of the conditions mentioned in Section 27A (for Life) and 27B (Non-Life) of the Insurance Act. Further, IRDA have also specified additional investments as "Approved investments" under the Regulations

(d) Other investments – these are investments which are 'other category of investments', other than the ones specified above and which are not prohibited investments

(e) Prohibited investments – investments in Private Limited Companies and investments out of Policyholders funds outside India

Investment categories based on type of business

Investment assets of an insurer have broadly been classified as follows for the purpose of regulating investments:

(a) Unit reserves of unit linked business – These constitute the reserves against the units of a unit linked insurance business which are dependent upon the investment pattern chosen by the Policyholders. Hence these investments are classified separately

(b) Pension & Annuity business – Pension & Annuity business are relatively long term in nature and guarantee annuity over a fairly long period of time and hence requires to be treated differently. Group business other than unit linked and One year Renewal Group Term insurance also fall under this category.

(c) Life insurance business – this is the residual category which comprises of :

a. Shareholders' funds representing solvency margin

b. Participating and Non-participating Policyholders funds

c. One year Renewable Group Term Insurance

d. Non-unit reserves of unit linked insurance business

For a Non-life insurer (including Health business), there is only one category of investible funds – which includes both shareholders funds and policyholders funds.

Prescription of floor and ceiling for investment categories (based on type of business)

(a) For unit reserves of unit linked business – the investments are required to be made in such forms of instruments in such proportion as per the pattern of investment for the fund selected by the Policyholders. However, atleast 75% of the investments made as per the pattern shall be in such instruments which belong to "Approved investment" category

(b) For Pension & Annuity business – a minimum of 40% of the funds in this category will have to be invested in Central government, State government or other Approved Securities (out of which 20% shall be Central Government Securities). At the same time not more than 60% is allowed in Approved investment categories. Investments in "Other investments" prohibited for Pension & Annuity business

(c) For Life insurance business (other than (a) and (b) above):
Out of the total funds in this category of business:

Mandatory investments:

(a) a minimum of 50% to be invested in Central or State Government or Approved Securities (out of which 25% shall be Central Government Securities)

(b) a minimum of 15% to be invested in Housing & Infrastructure investments

Optional investments

(a) upto 50% allowed in Approved investments

(b) upto 15% allowed in "Other Investments"

Note: The pattern of investments is not applicable for Shareholders funds held in excess of the solvency margin, provided they are kept separately and based on an Actuarial certification filed with the Authority and provided the Shareholders funds held to support solvency margin are invested as per the investment pattern as above.

Housing & Infrastructure investments

Bonds or debentures issued by HUDCO or National Housing Bank or Housing Finance Companies accredited by the Bank for housing finance activities or carrying Government guarantee of a rating of not less than AA only would qualify. If an Asset backed Security is backed by an underlying housing loan which satisfies the above condition, such a Security would also qualify under this category.

If a Central or State Government Security is issued to specifically meet the needs of a sector falling under infrastructure facility, such a security shall qualify for the purpose of investments in "Housing and Infrastructure" investment category.

All investments in Approved investments and "Other Investments" shall be subject to Exposure and Prudential norms, including housing and infrastructure investments.

Investment controls based on rating of instruments

A credit rating evaluates the credit worthiness of a debtor, especially a business (company) or a government.

It is an evaluation made by a credit rating agency of the debtor's ability to pay back the debt and the likelihood of default.

As a general rule, no investment can be in an instrument which is capable of being rated, but is not rated for some reason. Also, the rating must be done by an authorised Credit Rating agency under the SEBI Regulations.

Classification as Approved investments based on rating

The following investments shall be classified as "Approved investments" based on Credit rating as follows:

Sr. No.	***Nature of Security***	***Credit rating***	***Type of investment/ Category recognised***	***Remarks***
1.	Corporate bonds or debentures	Minimum 'AA' or equivalent	Approved investments	Nil
2.	Short term bonds, debentures, Certificate of deposits, Commercial papers	Minimum 'P1' or equivalent	Approved investments	Nil
3.	Debt instruments issued by All India financial institutions	Minimum 'AA' or equivalent rating	Approved investments	If investments in 'AA' not allowed, 'A+' allowed with Investment Committee approval

Minimum and maximum investments based on Credit rating

(a) Minimum investments in 'AAA', Sovereign or 'P1' rating for Debt instruments

A minimum of 75% (65% in the case of non-life) of Debt instruments (including Government and Approved Securities) shall be invested in instruments with sovereign rating or 'AAA' or equivalent for long term and sovereign debt and 'P1' or equivalent for short term instruments. For unit linked business, at each segregated fund level, the above condition must be satisfied. Investments in Reverse repo backed with underlying corporate bonds, Fixed Deposits, Promoter group Mutual Funds and unrated Mutual Funds must not be considered while calculating the above percentage.

(b) Maximum investments in 'A' or below for Debt instruments

A maximum of 5% (8% in the case of non-life) of Debt instruments (including Government Securities and Approved Securities) can be invested in instruments having a rating of 'A' or below or equivalent for the long term, out of life insurance fund and unit linked fund for a life insurer (and overall funds of a non-life insurer). However, no part of the Pension and Annuity Fund of a life insurer can be invested in such instruments.

In other words, while investments in long term debt instruments in 'AAA' rated shall be 75% in each category of investments, investments in debt instruments rated 'A' or below cannot be more than 5%, which means the remaining 20% is required at the minimum to be rated between 'AA+' to 'A+'. The rating of the remaining 20% has to be decided keeping in mind the overall limit of 15% for investments in "Other investments" out of Life insurance funds.

In respect of short term debt securities, not less than 75% shall be invested in securities rated 'P1+' and above while short term corporate bonds and debentures rated 'P1' and above shall be rated as 'Approved investments'. This would mean that short term debt securities rated less than 'P1' cannot exceed 15% (limit for 'Other investments').

Listed equities – investments only in "actively traded scrips"

All listed equity investments to be made only in those securities which are actively traded in stock exchanges, i.e. other than ones which are classified as "thinly traded" as per SEBI Regulations

Investment controls based on Exposure norms

These norms aim to control the investment risk by limiting the exposure to the Company where the funds are invested, limiting the exposure to a Group of companies to which the Investee company belongs to and also limits the exposure to one industry. This follows the golden principle "do not put all your eggs in one basket".

Exposure norms are applicable to all the three investment categories based on the types of business given above and shall be calculated for the following types of investments:

(a) Approved investments

(b) 'Other investments'

(c) Housing & infrastructure investments

Investee Company limits:

There are 2 limits for calculation of exposure norms to an Investee company:

(a) Overall exposure limit of all the funds of the insurer in all types of Securities in a Single Company

(b) Security-wise exposure limit for each Investee company for each type of investment category

The lower of (a) or (b) above determines the exposure limit for an Investee Company

(a) Overall exposure limit:

The overall exposure limit is calculated as follows:

(i) Aggregate all types of investments, viz., equity, debt etc. in a Single investee company

(ii) Aggregate investment assets of the insurer (i.e. addition of unit reserves, pension and annuity including Group and Life insurance funds)

(iii) (i) divided by (ii) shall not exceed 10%

In the case of non-life insurers the limit is 10% of their total funds

(b) Exposure limit based on nature of security for each type of fund

(i) For investment in equity, preference shares and convertible debentures

The limit is calculated as 10% of the outstanding face value of equity shares of the Investee company or 10% of assets belonging to each investment category based on type of business (unit reserves, Pension and Annuity including Group and Life insurance business). For non-life, total investment assets (policyholders' funds and shareholders' funds) are considered.

The lower of (a)(iii) and (b)(i) is the Investee company limit.

(ii) For investments in Debentures, loans and other permitted investments (other than mentioned in (i) above)

The limit is calculated as 10% of the Capital, Free reserves, Debentures and Bonds of the investee company or 10% of each investment category based on type of business, as mentioned in (i) above

The lower of (a)(iii) and (b)(ii) is the Investee company limit.

Increase in the limit of 10% based on the size of investment assets

If the size of investment assets for an insurer touches Rs.50,000 Crores, the investee company limit (on outstanding face value of equity shares for equity and Paidup capital, free reserves, debentures and bonds for Debt, loans and other permitted investments) stands increased to 12% and if the amount touches Rs.2,50,000 Crores, the limit stands further enhanced to 15%.

Therefore, even though as per one rule, a limit of 10% for equity shares and 10% for debentures for each investment asset category is allowed, the overall exposure limit under (a) above, would bring down the exposure to 10% of all the funds. On the other hand, eventhough an insurance company is within 10% on the overall exposure limit under (a) above, it still will have to be within the limit of 10% for equity shares and 10% for debentures separately for each investment asset category. Thus, the investee company limits aims to achieve two objectives:

(i) Limiting the investment in each type of security, viz., equity, debt in each investee company to 10% of each type of investment category, i.e. unit reserves, pension & annuity and life insurance business

(ii) Limiting the overall exposure (all investments put together) to one investee company to 10% of overall investment assets

The above 2 limits are subject to a further limit of 10% (of 12% or 15% in some cases as explained above) of outstanding face value of equity shares of the investee company (for equity investments) or Share capital, free reserves, bonds, debentures (for Debentures, loans and other permitted investments), as the case may be.

Special dispensation for Infrastructure related investments

Exposure to a Public Limited Infrastructure investment company can be increased to 20% of the Equity capital at face value for equity investments and 20% of equity plus free reserve plus debentures and bonds in the case of debt. However, this is subject to the overall exposure (all investments put together) at 10% of overall investment assets.

A special dispensation has also been given to Public Sector Special Purpose Vehicle engaged in infrastructure sector by allowing an investment upto 20% of the project cost, which is categorised as Approved investments, subject to the limit of 10% of overall investment assets

Investment in Immovable Properties

The limit for investments in immovable property is 5% of the aggregate of life funds, pension and annuity funds and group funds in the case of life insurers and 5% of investment assets in the case of general insurer

Investments in Promoter Group companies of insurer

The overall limit for investments in all the Promoter Group companies of the insurer is set at 5% of the aggregate funds of the insurer. Investments in Private equities prohibited. However investments in subsidiary companies allowed in terms of the provisions of Section 27A or 27B of the Insurance Act, 1938

Investment in Securitised Assets, e.g. Asset backed securities

The limit is 10% of investment assets for Life insurers and 5% for Non-life insurers

Exposure to financial and insurance activities

The exposure to these activities under the Industry exposure norms cannot exceed 25% of investment assets. However, this limit excludes Bank deposits in terms of Section 27A or 27B

Limits for Group to which Investee Company belongs to

The limit to a Group to which the Investee company belongs shall be the least of the following:

(i) 15% of each of the investment asset categories

(ii) 15% of investment assets in all Companies belonging to the Group

Industry exposure limits

The limit to the industry to which the investee company belongs to shall be the least of the following:

(i) 15% of each of the investment asset categories

(ii) 15% of investment assets

Governance related controls

Investment Committee

Every insurer is required to form an Investment Committee which consists of a minimum of 2 non executive directors, Chief Investment Officer, Chief Financial Officer and Appointed Actuary to oversee the performance of the Investment function

Investment Policy

The Board, on the basis of approval of Investment Committee, has to approve an Investment Policy for the Company on an yearly basis, with a half yearly review mechanism. The policy shall address the issues relating to Prudential norms, liquidity, management of assets and liabilities, scope of internal and concurrent audit and all other internal control of investment operations. It shall ensure adequate return on policyholders' funds and shareholders' funds.

Board shall review fund wise and product wise investment performance on a quarterly basis. The Board shall also lay down the norms for investing in "Other investments" category.

Operational level controls

Segregation of Front office, Mid office and Back office

Every insurer is required to segregate Front office, Mid office and Back office and clearly lay down the roles and responsibilities. The Chief Investment Officer shall report to the Chief Executive Officer. No function falling under any of these three sub units can be outsourced. Further data servers for the investment management system shall be within India.

Risk Management systems review

The Board shall implement a Investment Risk Management Systems and Process which shall be certified by a Chartered Accountant as per the Technical guide issued by the Institute of Chartered Accountants of India. This shall be reviewed once in 2 years by the Chartered Accountant and the Report be filed with IRDA.Further a quarterly internal/concurrent audit is mandated (if Assets under management crosses Rs.1,000 crores concurrent audit by external auditor required).

Qualifications and experience for Risk Management Auditors as well as Concurrent Auditors prescribed. Necessary certification shall be taken from them before appointment and filed with IRDA.

IRDA (SCHEME OF AMALGAMATION AND TRANSFER OF LIFE INSURANCE BUSINESS) REGULATIONS, 2013 AND IRDA (SCHEME OF AMALGAMATION AND TRANSFER OF GENERAL INSURANCE BUSINESS REGULATIONS, 2011

Under the provisions of the Act, a Scheme of amalgamation or transfer is possible only between two life insurance companies or two general insurance companies, It is not possible for a life insurance company to be acquired by a general insurance company or *vice versa*, since separate insurance companies are required to be formed for transacting life and general insurance businesses.

The Regulations require submission of every proposal for implementation of proposed amalgamation to be submitted to IRDA for a prior approval alongwith the draft Scheme of amalgamation.

However, before submission of the application, notice of intention to submit the application shall be submitted one month before filing the application for approval for every proposal for implementation as above alongwith a statement on the nature of amalgamation or transfer alongwith the following documents:

(a) Draft of the agreement for the proposed amalgamation or transfer

(b) Balance Sheets of both the target insurance company and the acquiring insurance company

(c) Financial Condition Report. Solvency Statements and Incurred but not Reported (IBNR) Report of both the insurance companies

(d) Report by an Independent Actuary (who has not been connected with any of the two insurance companies during the past 3 years) on the proposed amalgamation or transfer

(e) Executive summary of the proposed amalgamation or transfer along with the terms on which the transaction has been contemplated

(f) Report on the manner in which the interests of Policyholders will be protected and the compliance with the applicable laws including the Competition Act, 2002

The financial statements shall be prepared as on the appointed date, i.e. date fixed for the purpose of giving effect to the scheme of amalgamation or transfer and

IRDA may cause an independent actuarial valuation of the insurance businesses of the transacting parties.

IRDA would then consider issue of an in-principle approval for the proposed amalgamation or transfer. Upon receipt of the in-principle approval, the transacting parties shall inform their respective Policyholders about the proposed Scheme of amalgamation or transfer as follows:

(a) Keeping the Scheme open for inspection for Policyholders at the Head office

(b) Uploading the Scheme in the website of the transacting parties

(c) Statement on nature and terms of amalgamation to be published in one leading National and one vernacular Newspaper and filing copies with IRDA

(d) Informing all the Policyholders individually giving notice about the application for the proposed amalgamation or transfer

Upon receipt of the in-principle approval from IRDA, the transacting parties would seek other legal clearances or regulatory approvals, including the following:

(a) Filing of the Scheme of arrangement, alongwith the in-principle approval of IRDA, before the relevant Court or Tribunal for confirmation of the Scheme of arrangement under Sections 391 to 394 of the Companies Act, 1956

(b) Filing applications before the Foreign Investments Promotion Board or Reserve Bank of India for seeking necessary approvals

(c) If the insurance companies have a foreign insurance company as a promoter who is regulated in their country of origin, necessary regulatory approvals for the proposed Scheme from the concerned regulator

(d) Such other approvals, including the approval of Securities and Exchange Board of India or the Competition Commission of India

Upon receipt of all the legal clearances or other regulatory approvals, the transacting parties shall submit all the other approvals to IRDA for seeking their final approval. A final approval is then considered by IRDA keeping in mind the stipulations laid down by the Court/Tribunal and other regulatory authorities and the following considerations:

(a) compliance with the solvency margin requirements after the proposed transfer

(b) compliance with other applicable laws

(c) protection of interests of Policyholders

(d) orderly growth of the insurance industry and shall accordingly grant the final approval.

Upon receipt of final approval from IRDA, the following are the consequences:

(a) The scheme of amalgamation and transfer shall take effect from such date as may be specified by IRDA while granting the final approval

(b) The final approval shall be binding on all Policyholders, Creditors or employees of both the transacting parties

(c) The assets and liabilities of the transferor insurer shall vest with the transferee insurer from the effective date of transfer

(d) Publication in one national and one vernacular newspaper confirming completion of the process of amalgamation or transfer

In respect of amalgamation or transfer completed between two life insurance companies, the transferee insurer shall file a certified true copy of the scheme, deed or agreement under which the amalgamation or transfer has been effected alongwith a declaration from the Chairman and the Principal Officer listing down the various payments made or to be made to any person on account of the amalgamation or transfer effected.

IRDA GUIDELINES FOR GRIEVANCE REDRESSAL

In order to enforce timely reedressal of Customer grievance ,the Insurance Regulatory and Development Authority (IRDA) has issued guidelines for grievance redressal by insurance companies.

A Grievance is defined as an expression of dissatisfaction by a customer on the action or inaction on the standard of service or deficiency of service of an insurance company or any intermediary and asks for remedial action. It is distinguished from inquiry or a request which is seeking information or requesting for a service and are not considered as Grievances.

Every insurance company shall have a designated senior officer at the level of CEO or Compliance Officer of the Company as the Grievance Officer. Further every office of the insurer shall also have a designated Grievance officer for such office.

The process for handing a Grievance is as follows:

(a) Every grievance shall be acknowledged within 3 working days of receipt of grievance, containing the name and designation of the person who will deal with the grievance

(b) The Grievance redressal procedure including the time taken for resolution of disputes shall be mentioned in the acknowledgement

(c) Normally a Grievance shall be resolved within 3 days. However, where it is not possible to resolve within 3 days, the insurer shall resolve the complaint within 2 weeks and shall send a final letter of resolution

(d) Where a complaint is rejected, the reasons shall be clearly stated alongwith the recourse available if the customer is still dissatisfied

(e) Further if the insurer shall inform the customer that if the customer does not come back within 8 weeks from the date of providing resolution, the grievance shall be treated as closed

(f) A grievance can be closed only if the following conditions are satisfied:

  (i) Where the insurance company has acceded to customer's grievance, upon acceding to the request of the customer

  (ii) Where the insurance company rejects the customer's grievance, upon receipt of a communication from customer accepting the company's resolution

  (iii) Where the insurance company rejects the customer's grievance and the customer does not respond within 8 weeks of receipt of resolution, upon completion of the 8 weeks

  (iv) In all the above instances, the Grievance Redressal Officer shall certify that the Insurance company has discharged its contractual, statutory or regulatory obligations

Every insurance company shall publish the Grievance Redressal Procedure in the website of the insurance company. The Policyholders Protection Committee of the Insurance Company shall receive reports concerning Grievances and shall monitor the process of handling grievances.

IRDA (Obligations of Insurers to Rural and Social Sectors) Regulations, 2000 (as amended from time to time)

IRDA (Obligations of Insurers to Rural and Social Sectors) Regulations, 2000 provides that Every insurance company is required to undertake a minimum percentage of business providing insurance coverage to persons residing in rural areas and providing coverage to persons who are engaged in social sector.

Rural areas have been defined as those places which have been classified as rural areas as per the latest census. The obligations of insurers under Rural Sector is calculated as a percentage of the total number of policies sold by an insurance company and is dependent on the age of the insurance company as follows:

For a life insurance company, the percentage with 7% (2%) in the first financial year of operations, increases to 12% (5%) in third financial year and 16%(5%) in the fifth financial year and 20% (7%) in the tenth financial year.

Note: figures in brackets indicate obligations of general insurance companies.

In respect of Social sector, the obligation is in terms of number of Lives assured covered under an Insurance policy belonging to social sector occupations as defined in the Regulations.

The number of lives required to be covered under this sector is also dependent on the age of the insurance company as follows:

For both Life and General insurance companies, the number of lives to be covered increases from 5,000 lives in the first financial year to 20,000 lives in the fifth financial year and 55,000 lives in the tenth financial year

Social Sector is defined unorganised sector, informal sector, economically vulnerable or backward classes and other categories of persons, both in rural and urban areas.

IRDA (MICRO INSURANCE) REGULATIONS, 2005

A micro insurance product is designed to meet the needs of persons, especially residing in rural areas, whose primary requirement is basic insurance coverages in life, such as payment of insurance benefit upon death of the bread winner, to the family or Health insurance etc. The intention is provide a low cost product to such persons.

A life micro insurance product is therefore a pure term insurance product, or an endowment assurance product or a health insurance product with or without accident benefit. A general micro insurance product includes health insurance, insurance coverage on huts, livestock, tools or instruments or any personal accident contract.

Minimum and maximum amount of sum assured have been prescribed for each product category under Schedule I and Schedule II to the Regulations. For any of the product categories the sum assured cannot be less than Rs.5,000 or more than Rs.50,000.

A Non Governmental Organisation or a Self Help Group or a Micro Finance Institution or a Non-profit organisation (Companies registered under Section 25 of the Companies Act, 1956) can be appointed by an insurer to act as a Micro Insurance Agent.

The Regulations provide for a tie up between a Life insurance company and a General insurance company for offering both life and general micro insurance products together to a customer.

A micro insurance product may be distributed by a licensed agent or an insurance broker, but a Micro insurance agent is prohibited from distributing any insurance product other than micro insurance products. A micro insurance agent is allowed to act as an agent for micro insurance products of one life insurance company and one general insurance company at a time by entering into an agreement with them. The insurers concerned shall impart 25 hours training on micro insurance products, customer service, claims etc. to the Micro insurance agents.

A micro insurance agent shall appoint Specified persons who are authorised to sell on behalf of the Micro insurance agent (who can be a NGO or SHG or MFI as above)

All insurance companies are expected to issue polices in vernacular language to facilitate customer understanding of the policy terms and conditions. Where it is not possible a write up in vernacular language must be attached with the policy document.

A micro insurance agent may be paid a remuneration not exceeding 10% for single premiums received, 20% (15% for general insurance companies) for the premiums received during all policy years.

All micro insurance products sold shall be reckoned for the purpose of social sector obligations of an insurance company. Where the micro insurance product is also sold in a rural area, it shall be counted both for rural and social sector obligations separately.

Exposure draft to Micro Insurance (Modification) Regulations

On comprehensively examining the existing business model adopted under Micro Insurance vis-a-vis the extant regulations on Micro Insurance, IRDA proposed to review the IRDA (Micro Insurance) Regulations, 2005. Accordingly, an exposure draft on Micro Insurance (Modification) Regulations was issued in July, 2012 for further and wider deliberations on the subject.

As on August, 2013, the modified rules are yet to be published by IRDA

IRDA GUIDELINES TO FINANCIAL INCLUSION

Insurance Regulatory & Development Authority (IRDA) has been making immense efforts to educate and empower the common citizens about insurance industry in India and their rights & responsibilities. IRDA has been at the forefront of insurance sector deepening, protecting the rights of policyholders, regulating insurance companies & advisors and bringing about insurance inclusion in India for all segments esp. the poor. Some of the steps taken by IRDA for financial inclusion include

National Strategy for Financial Education

The Insurance Regulatory and Development Authority (IRDA) has released the draft **National Strategy for Financial Education** for comments and feedback in Year 2012. The final strategy is yet to be notified by the IRDA.

The National Strategy recognises that financial literacy and financial education play a vital role in financial inclusion and inclusive growth and envisages ways towards creating awareness and educating consumers on access to financial services, availability of various types of products and their features; changing attitudes to translate knowledge into responsible financial behaviour; and making consumers of financial services understand their rights and obligations.

The National Strategy seeks to create a financially aware and empowered India. It aims at undertaking a massive Financial Education campaign to help people manage money more effectively to achieve financial well being by accessing appropriate financial products and services through regulated entities with fair and transparent machinery for consumer protection and grievance redressal.

1. Website on Insurance Education

In an attempt to increase insurance awareness levels across the country, the authority has taken a number of consumer education initiatives and has recently launched an exclusive insurance education website www.policyholder.gov.in

This website has self-explanatory menus and gives information in simple language on topics such as:

- Buying insurance
- Making a claim
- Policyholder Protection and Grievance Redressal
- Handbooks in 13 languages
- Do's and Don'ts for a policyholder
- Comic series
- Consumer Affairs Annual Booklets

2. Grant of Corporate Agency license to Department of Postal

To promote financial inclusion, insurance regulator Insurance Regulatory and Development Authority (IRDA) has granted corporate agency license to the Department of Post for distributing insurance products.

3. Emphasis on educating insurance agents to weed out mis-selling

India's Insurance Regulatory and Development Authority (IRDA) has been chalking out an ambitious plan to combat mis-selling, a menace that has been haunting the industry for about a decade now, especially after the emergence of equity-oriented insurance products.

During fiscal year 2012, the regulator received 1 lakh complaints on mis-selling. IRDA has been emphasizing specialized training to the country's 2.5 million insurance agents after they clear the basic examination to qualify as a licensed agent to sell insurance products.

The training, aimed at instilling seriousness among insurance agents about sales as a career and stop unfairly selling insurance schemes just to earn commissions.

IRDA REGULATION RELATING TO PRODUCTS APPROVAL

An insurance company cannot launch any product unless the product specifications are filed with IRDA and are approved by them. This procedure is popularly called "file and use" procedure under the IRDA Regulations. This procedure is required to be followed whenever a new product is launched or whenever an existing product is withdrawn or modified.

IRDA have recently issued the following two Regulations, subsuming all the existing notifications with reference to Product design:

(a) IRDA (Non-Linked Insurance Products) Regulations, 2013

(b) IRDA (Linked Insurance Products) Regulations, 2013

A linked life insurance product is one which combines the benefit of insurance coverage and investment in one product. Under this type of product, the balance amount available after appropriation of charges, including the mortality charges, in invested in market linked investments. For example, investment in listed equities or bonds. The Policyholder, in addition to providing the fundamental risk coverage, a linked insurance product also provides an investment management service and the value of investment is reflected in the form of Net asset value from time to time. The risk on the investment portion lies with the Policyholders.

A non-linked life insurance product, on the other hand, does not provide the investment management service on behalf of the policyholders. Typically, the following are the benefits under a non-linked

insurance product:

(a) Covers risk of mortality – i.e. risk of dying early – provides sum assured on death, e.g. Term insurance policies or whole life insurance policies which provide sum assured only on death

(b) Additional sum assured which can be provided on survival to the maturity of the policy, e.g. Endowment Policies which provide for sum assured on death or on maturity whichever is earlier

(c) Annuity contracts, which covers the risk of living longer, by providing periodic payments as long as the policyholder is alive

(d) Health insurance contracts, which cover the risk of hospitalization (General insurance companies also offer health insurance contracts on indemnity basis)

(e) Rider benefits e.g. Accident Death Benefit rider (where an additional sum assured is paid on death due to accident)

Regulations on non-linked insurance products

These regulations cover various aspects of non-linked insurance products. Life insurance companies are required to ensure compliance with these regulations before 31st July 2013 for group products and before 30 September 2013 for individual products. The significant regulatory changes in relation to non-linked insurance products include:

(i) Minimum floors on sums assured have been introduced for single and regular premium products depending on the age of the insured.

(ii) For individual products, the minimum policy term and the minimum premium term (for non-single premium policies) have both been set at five years.

(iii) Maximum commission (or remuneration to distributors in any form) limits have been introduced for all non-linked insurance products. The key changes include:

  (a) The first year commission (FYC) limits for non-pension regular premium products with premium terms lower than 12 years have been reduced from the current limits. The limits on maximum commission increase with premium term, although the highest limit is the same as that currently permitted.

  (b) The maximum distributor remuneration for group products is set at 2% of premium, subject to absolute INR-denominated caps.

  (c) No commission payment is permitted on business procured through the direct marketing channel.

  (d) Minimum guaranteed surrender values have been introduced at different policy durations. These levels are higher than the existing minimum guaranteed surrender value requirements. Companies are also required to pay 'special surrender values' based on asset shares underlying the policies. These asset shares are required to be calculated in accordance with the professional guidance provided by the Institute of Actuaries of India.

  (e) 'Variable insurance products,' which have been defined as any non-linked products for which benefits depend upon regular interest rate credits, are now subjected to the same regulations as those applicable to unit-linked products.

(f) Benefit illustrations are now required to be presented assuming gross investment returns of 4% p.a. and 8% p.a. The regulations also require illustrations to be provided based on the rates specified by IRDA or the Life Insurance Council (which are currently at 6% p.a. and 10% p.a.)

(g) Significant regulations are introduced around the management of participating business, covering the need to set up an asset share framework; a governance mechanism involving a 'with-profits committee' which would include an independent director of the Board, the CEO, Appointed Actuary and an independent actuary; and the granting of power to the IRDA to prescribe methodology to allocate expenses between different funds.

The new regulations appear to be an attempt by the IRDA to improve the level of transparency and value for money for policyholders of non-linked life insurance products.

Regulations on linked insurance products

These regulations are largely in line with the earlier unit-linked guidelines released by the IRDA in September 2010. They split linked insurance products into unit-linked products and variable-linked products and provide regulations for each of them separately. As with non-linked products, life insurance companies are required to ensure compliance with these regulations before 31st July 2013 for group products and before 30 September 2013 for individual products.

The key changes in these regulations as compared with the previously released unit-linked guidelines include the following:

(a) Maximum commission (or remuneration to distributors in any form) limits have been introduced in line with those now applicable under the new non-linked product regulations.

(b) Companies are now not allowed to offer the so-called 'highest NAV guaranteed' products and any closed ended funds. However, companies can provide guarantees at a product level (as opposed to a fund level) even at maturity.

(c) The regulations now require companies to provide comprehensive information to IRDA in respect of the guarantee charges levied on the products offering investment guarantees.

(d) Benefit illustrations are now also required to be presented using investment returns of 4% p.a and 8% p.a.

(e) There are no changes to the maximum reduction in yield to policyholder at maturity as prescribed by the IRDA in earlier guidelines. However, insurance companies are required to demonstrate compliance with these requirements using six different gross investment return assumptions at the time of filing of the product.

LESSON ROUND-UP

- Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business.
- In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect statistical information about both life and non-life business transacted in India by Indian and foreign insurers including provident insurance societies.
- In 1972 with the passing of the General Insurance Business (Nationalisation) Act, general insurance business was nationalized with effect from 1st January, 1973.
- In December, 2000, the subsidiaries of the General Insurance Corporation of India were restructured as independent companies and at the same time GIC was converted into a national re-insurer.
- The IRD Act has established the Insurance Regulatory and Development Authority ("IRDA" or "Authority")

as a statutory regulator to regulate and promote the insurance industry in India and to protect the interests of holders of insurance policies.

- The Insurance Act, 1938, broadly provides the ground rules for the operating insurance companies in India. Only Companies formed and registered under the Companies Act, 1956, whereunder the foreign equity is not more than 26%, are allowed (IRDA allows only Public limited companies).
- IRDA is vested with powers under the Act to cancel the registration of insurers on certain grounds such as default in complying with the provisions of the Act or Regulations passed thereunder, carrying on business other than insurance business etc.
- An insurance company needs to have a Chief Executive Officer who is also the Principal Officer of the Company.
- An Insurance Agent is a person who, after obtaining a licence from IRDA, is authorized to solicit or procure insurance business on behalf of one Insurance Company with whom the Agent is attached.
- Insurance companies are allowed to pay a consideration called "commission" which is calculated as a percentage of premium on the policies procured by the Agent.
- The Insurance Association shall have two councils – a Life Insurance Council and a General Insurance Council, comprising of the Life and Non-Life insurance companies, respectively, as their members.
- In order to enforce timely reedressal of Customer grievance ,the Insurance Regulatory and Development Authority (IRDA) has issued guidelines for grievance redressal by insurance companies.
- A Non Governmental Organisation or a Self Help Group or a Micro Finance Institution or a Non-profit organisation (Companies registered under Section 25 of the Companies Act, 1956) can be appointed by an insurer to act as a Micro Insurance Agent.

SELF-TEST QUESTIONS

1. Write a brief on the history of regulation of insurance business in India.
2. Explain the regulations governing Life Insurance Business in India.
3. What are the regulations affecting General Insurance Business in India? Explain.
4. Why the insurance needs regulation?
5. Write short notes on:
   (a) Constitution of IRDA
   (b) Powers /Functions of IRDA
   (c) IRDA Guidelines For Grievance Redressal
   (d) IRDA Guidelines To Financial InclusionWhat is the nature of Insurance contract? Explain various features of insurance contract.

Lesson 5
REGULATORY ENVIRONMENT – GENERAL INSURANCE

LESSON OUTLINE

- Introduction
- The Insurance ACT, 1938
- General Insurance Business Nationalization Act, 1972
- Motor Vehicles Act, 1988
- Marine Insurance Act, 1963
- Employees State Insurance Act
- Consumer Protection Act,1986
- Redressal of Public Grievances Rules, 1998
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

As in the case of all financial institutions, insurance is an activity that needs to be regulated. This is so because the smooth functioning of business depends on the trust and confidence reposed by the customers in the solvency of the financial institutions. Insurance products are of little value to customers, if they cannot trust the company to keep its promise. The regulatory framework in relation to the insurance companies seeks to take care of three major concerns – (a) protection of consumers' interest, (b) to ensure the financial soundness of the insurance industry, and (c) to help the healthy growth of the insurance market. So long as insurance remained the monopoly of the Government, the need for an independent regulatory authority was not felt. However, with the acceptance of the idea that there can be private insurance entities, the need for a regulatory authority becomes paramount. With the passing of the Insurance Development and Regulatory Act in 2000, the insurance regulatory authority has become a statutory authority. Protecting consumer interest involves proper disclosure, keeping prices affordable, some mandatory products and standardization. Most importantly, it has to make sure that consumers get paid by insurers. A conducive regulatory framework is essential for achieving sustainability and at the same time needed for the expanding insurance services to all income segments of the society.

In this chapter we will study about various laws and regulations related to general insurance business in India.

INTRODUCTION

Insurance other than 'Life Insurance' falls under the category of General Insurance. General Insurance comprises of insurance of property against fire, burglary, etc., personal insurance such as Accident and Health Insurance, and liability insurance which covers legal liabilities. There are also other covers such as Errors and Omissions insurance for professionals, credit insurance, agricultural insurance, etc. Non-life insurance companies have products that cover property against fire and allied perils, flood storm and inundation, earthquake and so on. There are products that cover property against burglary, theft etc. The non-life companies also offer policies covering machinery against breakdown, there are policies that cover the hull of ships and so on. A marine cargo policy covers goods in transit including by sea, air and road. Further, insurance of motor vehicles against damages and theft forms a major chunk of non-life insurance business. In respect of insurance of property, it is important that the cover is taken for the actual value of the property to avoid being imposed a penalty should there be a claim.

Personal insurance covers include policies for Accident, Health etc. Products offering Personal Accident cover are benefit policies. Health insurance covers offered by non-life insurers are mainly hospitalization covers either on reimbursement or cashless basis. The cashless service is offered through Third Party Administrators who have arrangements with various service providers, i.e., hospitals. The Third Party Administrators also provide service for reimbursement claims. Sometimes the insurers themselves process reimbursement claims.

Accident and health insurance policies are available for individuals as well as groups. A group could be a group of employees of an organization or holders of credit cards or deposit holders in a bank etc. Normally when a group is covered, insurers offer group discounts.

Liability insurance covers such as Motor Third Party Liability Insurance, Workmen's Compensation Policy, etc., offer cover against legal liabilities that may arise under the respective statutes— Motor Vehicles Act, The Workmen's Compensation Act, etc. Some of the covers such as the foregoing (Motor Third Party and Workmen's Compensation Policy) are compulsory by statute. Liability Insurance not compulsory by statute is also gaining popularity these days. Many industries insure against Public liability. There are liability covers available for Products as well.

There are general insurance products that are in the nature of package policies offering a combination of the covers mentioned above. For instance, there are package policies available for householders, shop keepers and also for professionals such as doctors, chartered accountants etc. Apart from offering standard covers, insurers also offer customized or tailor-made ones. Industries also need to protect themselves by obtaining insurance covers to protect their building, machinery, stocks, etc. They need to cover their liabilities as well. Financiers insist on insurance. So, most industries or businesses that are financed by banks and other institutions do obtain covers.

Most general insurance covers are annual contracts. However, there are few products that are long-term.

It is important for proposers to read and understand the terms and conditions of a policy before they enter into an insurance contract. The proposal form needs to be filled in completely and correctly by a proposer to ensure that the cover is adequate and the right one. Unlike Life insurance, General insurance contracts are based on indemnity of the loss incurred by the insured. Therefore, the losses will have to be measured accurately. The Surveyor and Loss Assessor, as we saw in one of the earlier Chapters, play a crucial role in assessing the extent of damages to arrive at the compensation. While assessing the loss on account of fire

accident to a Car could be relative simple, it becomes complex in certain cases for example, Public Liability insurance. Therefore, it is important for the reader to appreciate how the framework around determination of liability in General insurance operates in India.

Insurance business is one of the most highly regulated businesses globally for reasons of equity and efficiency. It has a well-defined regulatory and legislative framework to operate. Insurance law by itself is both unique and comprehensive because it operates within the limitations of all the other governing legislations and ensures the legal provisions by incorporating the same in its various policies. The transactions of general insurance business in India are governed by two main statues, namely:

- The Insurance Act, 1938
- General Insurance Business (Nationalisation) Act, 1972

THE INsURANCE ACT, 1938

This Act was passed in 1938 and was brought into force from 1st July, 1939. This act applies to the GIC and the four subsidiaries. The act was amended several times in the years 1950, 1968, 1988, 1999,2015. This Act specifies the restrictions and limitations applicable as specified by the Central Government under powers conferred by section 35 of the General Insurance Business (Nationalization) Act. The important provisions of the Act relate to:

Registration: Every insurer is required to obtain a Certificate of Registration from the Controller of Insurance, by making the payment of requisite fees. Registration should be renewed annually and required to pay annual fees.

Accounts and audit: An insurer is required to maintain separate accounts of the receipts and payments in each class of insurance viz. Fire, Marine and Miscellaneous Insurance. The insurance company is also required to maintain separate account relating to the funds of shareholders and policyholders. Apart from the regular financial statements, the companies are required to maintain the following documents in respect of each class of insurance:

- Record of Cover notes specifying the details of the risk covered
- Record of policies
- Record of premiums
- Record of endorsements
- Record of Bank guarantees
- Record of claims
- Register of agency force and business procured by each with details of commission
- Register of employees
- Cash Books
- Reinsurance details
- Claims register

Investments: Investments of insurance company are usually made in approved investments under the provisions of the Act. The guidelines and limitations are issued by the Central Government from time to time.

Limitation on management expenses: The Act prescribes the maximum limits of expenses of management including commission that may be incurred by an insurer. The percentages are prescribed in relation to the

total gross direct business written by the insurer in India. The insurance company is also required to shall furnish to the Authority, the details of expenses of management in such manner and form as may be specified by the regulations made under this Act.

Prohibition of Rebates: The Act prohibits any person from offering any rebate of commission or a rebate of premium to any person to take insurance. Any person found guilty would be punished with a fine up to five hundred rupees.

Powers of Investigation: The Central Government may at any time direct the Controller or any other person by order, to investigate the affairs of any insurer and report to the central government.

Other Provisions: Other provisions of the Act deal with the licensing of agents, surveyors, advance payment of premium and Tariff Advisory Committee (TAC).

- Prohibition of rebates
- Powers of investigation
- Licensing of agents
- Advance payments of premiums
- Tariff Advisory Committee

GENERAL INSURANCE BUSINESS NATIONALIZATION ACT, 1972

This Act came into force on 1st January, 1973. This Act gave effect to clause (c) of Article 39 of the constitution of India. Article 39 (c) read as follows:

"The State shall direct its policy towards securing that the operation of the economic system does not result in concentration of wealth and means of production so as to prove harmful to the common interest of the community".

Under this Act, there were no longer private insurers in the country. As a result general insurance business became the domain of the State. The General Insurance Corporation of India (GIC) became the holding company with four subsidiaries, namely United India Insurance Company with Head Office in Chennai (Madras) , Oriental Insurance Company with Head Office in New Delhi, National Insurance Company with Head Office in Kolkata (Calcutta) and New India Assurance Company with Head Office in Mumbai (Bombay).

The ownership of all shares of both the Indian insurance companies and the foreign insurers from then on vested in the Central Government with effect from 1.1.1973. The services of all the personnel in the private sector were also transferred to the holding company and subsidiaries based on factors such as qualification, seniority, position and location.

This Act was amended in 2002 i.e. 07th August 2002 entitling the private insurance company to carry on the business of general insurance.

Objectives of the Act

The object of the Act was primarily,

- To serve the needs of the economy by development of general insurance business .
- To establish the GIC by the central government under the provisions of the Companies Act of 1956, with an initial authorized share capital of seventy five crores .

- To aid, assist, and advise the companies in the matter of setting up of standards in the conduct of general insurance business .
- To encourage healthy competition amongst the companies as far as possible .
- To ensure that the operation of the economic system does not result in the concentration of wealth to the common detriment.
- To ensure that no person shall take insurance in respect of any property in India with an insurer whose principal registered office is outside India .
- To carry on of any part of the general insurance business if it thinks it desirable to do so .
- To advice the companies in the matter of controlling their experience and investment of funds.

The Mission of GIC

- To provide need-based and low cost general insurance covers to rural population.
- To administer a crop insurance scheme for the benefit of the farmers.
- To develop and introduce covers with social security benefits.
- To develop a marketing network throughout the country including areas with low premium potential.
- Promote balanced regional development irrespective of cost considerations.
- To make benefits of insurance available to the masses.

INSURANCE REGULATORY AUTHORITY (IRA)

The Insurance Act, 1938, recommended the appointment of the Controller of Insurance, to ensure the compliance of the various provisions under the Act by insurance companies. The Controller approves the terms and conditions of various plans and adequacy of premiums. The Authority also periodically scrutinizes the return on investments, annual accounts, and periodical actuarial valuation submitted by insurance companies. The IRA consists of not more than seven (see below) members out of which a Chairman and two members representing the Life and general insurance business are appointed on full time basis. The whole time members shall hold office for 5 years or until the age of 62 (65 years for the Chairman) whichever is earlier. The part time members hold the office for not more than 5 years.

Composition of Authority: The Authority shall consist of the following members, namely:- to be appointed by the Central Government from amongst persons of ability, integrity and standing who have knowledge or experience in life insurance, general insurance, actuarial science, finance, economics, law, accountancy, administration or any other discipline which would, in the opinion of the Central Government, be useful to the Authority.

The important duties of the IRA include the following:

- To regulate, promote and ensure orderly growth of the insurance business
- To exercise all powers and functions of the Authority
- To protect the interests of the policyholder with regard to settlement of claims and other terms and conditions
- To promote and regulate professional bodies connected with insurance organization
- To undertake inspection, investigation, and audit of companies, intermediaries, and other organizations connected with the insurance business.

- To regulate and control the rates of non-tariffed general insurance policies under section 64(u) of the Insurance Act.
- To prescribe the format for the maintenance and submission of accounts by insurers
- To regulate the investment of funds
- To regulate the margins of solvency
- To adjudicate disputes between the insurer and intermediaries.

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (IRDA)

The Committee on reforms of the insurance sector under the chairmanship of Shri R N Malhotra, ex-governor of Reserve Bank of India, recommended for the creation of a more efficient and competitive financial system in tune with global trends. It recommended amendments to regulate the insurance sector to adjust with the economic policies of privatization. The government in pursuance of the recommendation of the committee, decided to establish a Provisional Insurance Regulatory and Development Authority in 1996, to replace the erstwhile authority called the Controller of Insurance constituted under the Insurance Act, 1938, which initially worked under the Ministry of Commerce and later transferred to the Ministry of Finance.

Finally, the decision to establish the Insurance Regulatory and Development Authority was implemented by the passing of the Insurance Regulatory and Development Authority Act, 1999. In India, presently after the opening up of the insurance sector, the regulator for the monitoring of the operations of the insurance companies is the IRDA, having its head office in Hyderabad. The regulatory framework mainly aims to focus on three areas, viz.,

- The protection of the interest of the consumers
- To ensure the financial soundness of the insurance industry
- To pave the way to help a healthy growth of the insurance market where both the government and the private players play simultaneously.

OTHER IMPORTANT LEGISLATIONS GOVERNING GENERAL INSURANCE BUSINESS IN INDIA

1. Motor Vehicles Act, 1988

The Motor Vehicles Act, 1988 is an Act of the Parliament of India which regulates all aspects of road transport vehicles. The Act came into force from 1 July 1989. It replaced the Motor Vehicles Act, 1938 which earlier replaced the first such enactment Motor Vehicles Act, 1914. The Act provides in detail the legislative provisions regarding licensing of drivers and conductors, registration of motor vehicles, control of motor vehicles through permits, special provisions relating to state transport undertakings, traffic regulations, insurance, liability, offences and penalties etc. Further, in order to exercise the legislative provisions of the Act, the Government of India made the Central Motor Vehicles Rules, 1989.

Necessity for insurance against third party risk

Section 146 of the above Act states that no person shall use, other than as a passenger or allow to use a motor vehicle in a public place unless a policy of insurance which covers the liability to third party on account of death or bodily injury to such third party or damage to any property of a third party arising out of the use of the vehicle in a public place. Therefore, it is mandatory for the owner of any motor vehicle to obtain, at the minimum, a policy from any General insurance company holding a valid licence from IRDA, which covers the risk of death or bodily injury to a third party arising out of usage of the vehicle in a public place.

The liabilities which require compulsory insurance are as follows:

(a) death or bodily injury of any person including the owner of the goods or his authorised representative carried in the carriage

(b) damage to any property of a third party

(c) death or bodily injury of any passenger of a public service vehicle

(d) liability arising under the Workmen's Compensation Act, 1923 in respect of death or bodily injury of the paid driver of the vehicle, conductor or ticket examiner (public service vehicles) and workers carried in a goods vehicle

(e) The limit of liability to third party property is Rs.6,000. However, there is no bar for the insurer undertaking a higher liability i.e. liability for a greater amount than that mentioned in the Act. Thus the insured and the insurer can contract and can provide for a higher liability.

No Fault liability

Section 140 of the Motor Vehicles Act, 1988, provides for liability of the owner of the Motor Vehicles to pay compensation in certain cases, on the principle of no fault. The amount of compensation so payable is Rs.50,000 for death and Rs.25,000 for permanent disablement of any person resulting from an accident arising out of the use of the motor vehicles. The principle of "no fault" means that the claimant need not prove negligence on the part of the motorist. Liability is automatic in such cases. Further, under Section 141(1) of the said Act, claims for death or permanent disablement can also be pursued under other provisions of the Act on the basis of negligence (fault liability).

Duty of insurers to satisfy judgments and awards against persons insured in respect of third party risks

Where a judgment or an award has been given against a insured person in respect of a third party liability covered under the insurance policy, then, notwithstanding the rights or the insurer to avoid or cancel the insurance policy, the insurer shall be liable to pay to the person entitled to the benefit of decree (third party), as if the insurer were the judgment debtor, together with any amount payable in respect of costs and any sum payable alongwith interest.

However, no sum as above shall be payable by an insurer if notice of the bringing of any such proceedings in which the judgment or award is given, is given to insurer and the insurer can defend the action on the ground of breach of any of the following conditions in the policy document:

(a) Condition that the vehicle on the date of contract of insurance not covered by a permit to ply for hire or reward – if the vehicle was used for hire or reward

(b) For organised racing and speed testing

(c) For purposes not allowed by the permit under which vehicle is used where the vehicle is a transport vehicle

(d) Without side car being attached where the vehicle is a motor cycle

(e) Usage of car by an unlicensed person

(f) Condition excluding liability for injury caused or contributed by conditions of war, civil war, riot or civil commotion

(g) The policy was obtained by non disclosure of a material fact or by representation of a fact which was false in some material particular.

A settlement between the insurer and insured shall be valid only if the third party is also made a party to the settlement contract. Insolvency of the insured person will not affect the liability of the insured or claims by third parties.

Issuance of Certificate of Insurance

As per the Act, policy of insurance shall have no effect unless and until a certificate of insurance in the form prescribed under the Rules of the Act is issued. The only evidence of the existence of a valid insurance as required by the Motor Vehicles Act acceptable to the police authorities and R.T.O. is a certificate of insurance issued by the insurers. The certificate of insurance contains all the details of the motor vehicle, its owner, liabilities, etc

Transfer of insurance upon sale of vehicle

Where a person holding a Certificate of insurance for a motor vehicle, transfers the ownership of the vehicle to another person, the certificate of insurance and the policy described in the certificate shall be deemed to have been transferred in favour of the person to whom the motor vehicle is transferred with effect from the date of transfer.

The transferee shall apply within 14 days from the date of transfer in the prescribed form to the insurer for making necessary changes in regard to the fact of the transfer in the certificate of insurance and the policy described in the certificate in his favour and the insurer shall make the necessary changes in the certificate and the policy of insurance in regard to the transfer of insurance.

"Hit and Run" Accident

Section 161 defines "hit and run motor accident" as accident arising out of a motor vehicle or motor vehicles the identity of whereof cannot be ascertained in spite of reasonable efforts for the purpose. The Section provides for payment of compensation as follows in such cases:

(a) In respect of death of any person resulting from a "hit and run" accident, a fixed sum of Rs.25,000

(b) In respect of grievous hurt to any person resulting from a hit and run motor accident, a fixed sum of Rs.12,500

(c) Compensation known as Solatium is payable out of a "Solatium Fund" established by the Central Government

HIT & RUN CLAIMS PROCEDURE

The victim of the "hit-and-run" vehicle or his legal representative shall make an application to the Claim Enquiry Officer in each Taluka. After due enquiries, the Claims Enquiry Officer will submit a report together with certificate of post mortem or injury certificate to the claims settlement commissioner who will either the District Collector or the Deputy Commissioner at the District level. He will process the claims and sanction the payment within 15 days from the receipt of report from Claim Enquiry Officer and communicate sanction order to the nominated office of the Insurance Company. The administration of claims is done by insurance company which has nominated one Divisional Manager in each district at District Level Committee which is headed by District Collector.

Motor Accidents Claim Tribunals

For speedy disposal of third party claims and at a minimum cost, the Claims Tribunals have been constituted by different State Governments. Only a nominal fee has to be paid for instituting a case and Court fee is not based on the value of the suit. Thus it is very much less expensive and poor third party claimants are not

prevented from making proper claims.

Where a Tribunal has been set up for an area, no Civil Court has any jurisdiction to entertain any claim falling under the tribunal's jurisdiction.

2. Marine Insurance Act, 1963

Marine Insurance covers the risks associated with marine adventures. For example, transportation of cargo through ships. The consignment is exposed to the perils associated with transportation through sea and hence requires an insurance cover against sea perils such as tempest, fire, war perils, pirates, rovers, thieves, captures, seizures, restraints and detainments of princes and peoples, jettisons, barratry which could result in damage to the ship as well as the goods consigned.

However, as per Section 4 of the Act, a Marine insurance can cover the land as well as the sea risks associated with the goods transported. However, such land risks must be incidental to the sea voyage. For example, if goods will have to be consigned from Delhi to Nagpur to Dubai. The nearest port is Mumbai. Therefore the goods are sent by truck from Nagpur to Mumbai and from Mumbai to Dubai through a ship. An insurance policy can be considered for coverage of Mixed Land and Sea Risks.

Insurable Interest in Marine insurance

Marine Insurance Act specifically declares marine contracts without any insurable interest as wagering contracts which are void under Section 30 of the Indian Contract Act 1872. It is sufficient in marine insurance contracts that the insurable interest is present at the time of loss.

Insurable interest, in relation to a marine insurance, means the interest which the Policyholder has in the subject matter which has been insured – in such a way that the Policyholder will benefit if the insured property arrives safely or will be prejudiced in case there is a loss or damage to the insured property.

An insurer has insurable interest in the risk the insurer has assumed and therefore can reinsure the risks with a reinsurance company.

Valuation of the insured property

The valuation of the subject matter of insurance is done as per the following principles as specified in Section 18:

(a) In insurance on ship, the insurable value is the value, at the commencement of the risk, of the ship, including all disbursements incurred to make the ship fit for the voyage or adventure contemplated by the policy, plus the charges of insurance upon the whole:

(b) The insurable value, in the case of a steamship, includes also the machinery, boilers, and coals and engine stores if owned by the assured; in the case of a ship driven by power other than steam includes also the machinery and fuels and engine stores, if owned by the assured; and in the case of a ship engaged in a special trade, includes also the ordinary fittings requisite for that trade:

(c) In insurance on freight or cargo (goods transported), whether paid in advance or otherwise, the insurable value is the gross amount of the freight at the risk of the assured, plus the charges of insurance;

(d) In insurance on goods or merchandise, the insurable value is the prime cost of the property insured, plus the expenses of and incidental to shipping the charges of insurance upon the whole:

(e) In insurance on any other subject-matter, the insurable value is the amount at the risk of the assured when the policy attaches, plus the charges of insurance.

Marine Insurance is contract *uberrimae fidei*

A contract of marine insurance, like any other contract, is a contract based upon the utmost good faith, and if the utmost good faith is not observed by either party, the contract may be avoided by the other party.

Therefore the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known to him.

If the assured fails to make such disclosure, the insurer may avoid the contract.

A circumstance is material if it could influence the judgment of a prudent insurer in fixing the premium, or determining whether or not he will take the risk.

"No obligation to disclose"

In the absence of inquiry from the insurer, the following circumstances need not be disclosed, by the insured, namely:-

(a) any circumstance which diminishes the risk;

(b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business as such, ought to know;

(c) any circumstance as to which information is waived by the insurer;

(d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.

Subject to the above, the Insurance Agent is also obliged to disclose to the insurer the circumstances which are within his knowledge and circumstances which he ought to know.

However, it is essential for us to know what is the material circumstance which has to be disclosed to the insurer. It is the duty of the assured to disclose facts to the insurer but not everything. The disclosure made by the assured should contain the risk factor which shall allow the insurer to enable him to make his underwriting judgement. It is necessary for the agent or the broker to disclose every material circumstance known to him. According to Marine Insurance Act of 1906 ' every material circumstance which the assured is bound to disclose, unless it comes to the assureds knowledge too late to communicate it to the agent.' It shall be the responsibility of the broker to pass on every material circumstance within the assured's knowledge. The other two important aspects of section 19 of the Marine Insurance Act of 1906 is that he needs to keep the material facts confidential which are obtained from the insurer while acting for another and the second important aspect is that this section does not have impact on the intermediate brokers in a chain but only to a placing broker. The remedy which is available for the breach of duty of disclosure is avoidance of the contract.

Representations by Insured and their impact

Section 22 of the Act lists down the representations by insured before the policy issued by the insurer and the impact thereof as follows:

(a) All material representations made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it is established that any of the representations is untrue, the insurer may avoid the contract.

(b) A representation is considered "material" if it influences the judgment of a prudent insurer in fixing

the premium, or determining whether he will take the risk.

(c) A representation may be either as to a matter of fact, or as to a matter of expectation or belief.

(d) A representation as to a matter of fact is true, if it be substantially correct, that is to say, if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer.

(e) A representation as to a matter of expectation or belief is true if it be made in good faith.

(f) A representation may be withdrawn or corrected before the contract is concluded.

(g) Whether a particular representation be material or not, is, in each case, a question of fact.

Requirements as to Marine Insurance Policy issued by the insurer

The following are the requirements as to the Marine Insurance Policy contract issued by the Insurance Company:

(a) All Marine Insurance Policy contract must be signed by and on behalf of the insurer.

(b) The Marine insurance contract shall embodied in the Policy document itself

(c) A Marine insurance contract shall contain the following:

(d) the name of the assured, or of some person who effects the insurance on his behalf;

1. the subject-matter insured and the risk insured against;
2. the voyage, or period of time, or both, as the case may be, covered by the insurance;
3. the sum or sums insured;
4. the name or names of insurer or insurers

Voyage and Time Policies

Section 27 recognises two types of Marine insurance policies – a Voyage Policy and a Time Policy. A Voyage Policy, as the name suggests, provides insurance cover only for a particular voyage and expires at the end of the voyage. Time Policy, on the other hand, provides insurance coverage for a specific period irrespective of the expiry of the voyage. However, a Time Policy for a period exceeding one year is void.

Valued and Unvalued Policies

Sections 29 and 30 recognises Valued and Unvalued Policies. A Valued Policy is one where the value of the insured property is ascertained in advance at the time of issuance of the policy. This value is conclusive whether or not the loss is total or partial. An Unvalued Policy, on the other hand, does not ascertain or fix the value in advance, but, subject to the sum assured under the policy, allows the value to be fixed subsequently.

Double Insurance

Section 34 of the Act deals with Double insurance in Marine insurance contracts. It is possible that the Policyholder can take multiple marine insurance policies for the same cargo or freight with different insurers. Under such circumstances, where two or more policies are effected by or on behalf of the same assured on the same adventure and interest or any part thereof, and the sums insured exceed the indemnity allowed by this Act, the assured is said to be over-insured by double insurance.

Where the assured is over-insured by double insurance:

(a) the assured, unless the policy otherwise provides, may claim payment from the insurers in such order as he may think fit. However, he is not entitled to receive any sum in excess of the indemnity allowed by this Act.

(b) where the policy under which the assured claims is a valued policy, the assured must give credit as against the valuation, for any sum received by him under any other policy, without regard to the actual value of the subject-matter insured

(c) where the policy under which the assured claims is an unvalued policy he must give credit, as against the full insurable value, for any sum received by him under any other policy;

(d) where the assured receives any sum in excess of the indemnity allowed by this Act, he is deemed to hold such sum in trust for the insurers, according to their right of contribution among themselves.

Warranties in Marine Insurance

A Warranty means a stipulation or term, the breach of which entitles the insures to avoid the policy altogether and this is so even though the breach arises through circumstances beyond the control of the warrantor. The following types of warranties are recognized under the Marine Insurance Act:

(a) Warranty of neutrality - where insurable property, whether ship or goods, is expressly warranted neutral, there is an implied condition that the property insured shall have a neutral character at the commencement of the risk, and that, so far as the assured can control the matter, its neutral character shall be preserved during the risk.

(b) Warranty of good safety – the warranty that the subject-matter insured is warranted "well" or "in good safety"

(c) Warranty of seaworthiness of ship - in a voyage policy there is an implied warranty that at the commencement of the voyage the ship shall be seaworthy for the purpose of the particular adventure insured. Where the policy attaches while the ship is in port, there is also an implied warranty that she shall, at the commencement of the risk, be reasonably fit to encounter the ordinary perils of the port.

(d) Where the policy relates to a voyage which is performed in different stages, during which the ship requires different kinds of or further preparation or equipment, there is an implied warranty that at the commencement of each stage the ship is seaworthy in respect of such preparation or equipment for the purposes of that stage.

(e) A ship is deemed to be seaworthy when she is reasonably fit in all respect to encounter the ordinary perils of the seas of the adventure insured.

(f) In a time policy there is no implied warranty that the ship shall be seaworthy at any stage of the adventure, but where, with the privity of the assured, the ship is sent to sea in an unseaworthy state, the insurer is not liable for any loss attributable to unseaworthiness.

(g) In a voyage policy on goods or other movables there is an implied warranty that at the commencement of the voyage the ship is not only seaworthy as a ship, but also that she is reasonably fit to carry the goods or other movables to the destination contemplated by the policy

(h) Warranty of legality.- There is an implied warranty that the adventure insured is a lawful one, and that, so far as the assured can control the matter, the adventure shall be carried out in a lawful manner.

Implied condition as to commencement of risk

Where the subject-matter is insured by a voyage policy "at and from" or "from" a particular place, it is not necessary that the ship should be at that place when the contract is concluded, but there is an implied condition that the adventure shall be commenced within a reasonable time, and that if the adventure be not so commenced the insurer may avoid the contract.

The implied condition may be negatived by showing that the delay was caused by circumstances known to the insurer before the contract was concluded, or by showing that he waived the condition.

Alteration of Port of departure or deviation in the course of voyage

Where the ship departs from a Port other than the one place specified in the Policy, the risk is not covered. Where the ship deviates from the voyage contemplated in the policy, without any lawful excuse, the insurer is discharged from his liability. It is immaterial whether ultimately the course was regained or not.

Condonation of deviation or delay

Deviation or delay in prosecuting the voyage contemplated by the policy is condoned under the following circumstances:

(a) where such deviation or delay is authorised by any special term in the policy; or

(b) where it is caused by circumstances beyond the control of the master and his employer; or

(c) where the deviation or delay was reasonably necessary in order to comply with an express or implied warranty; or

(d) where reasonably necessary, delay of deviation happened for the safety of the ship or subject-matter insured; or

(e) if it was for the purpose of saving human life or aiding a ship in distress where human life may be in

(f) danger; or

(g) where reasonably necessary for the purpose of obtaining medical or surgical aid for any person on board the ship; or

(h) where it was caused by the barratrous * conduct of the master or crew, if barratry be one of the perils insured against.

* every wrongful act willfully committed by the master or crew to the prejudice of the owner, or, as the case may be, the charterer.

When the cause excusing the deviation or delay ceases to operate, the ship must resume her course, and prosecute her voyage, with reasonable dispatch.

Principle of Causa Proxima

This principle is based on the maxim *in jure non remota cause, sed proxima spectator*, which means in law the immediate and not the remote cause is to be considered in measuring the damages. Where a loss is brought by several causes in succession to one another, the proximate or nearest cause of loss must be taken into account. If the proximate cause is covered by the policy, only then the insurance company will be liable to compensate the insured.

Total Loss and Partial Loss

A total loss implies that the subject matter insured is fully destroyed and is totally lost to its owner. It can be:

(a) Actual total loss (or)

(b) Constructive total loss

In actual total loss, the subject matter is completely destroyed or so damaged that it ceases to be a thing of the kind insured. For example, sinking of ship, completely destruction of cargo by fire etc.

In the case of constructive total loss, the ship or cargo insured is not completely destroyed but is so badly damaged that the cost of repair or recovery would be greater than the value of the property saved. For example when a vessel sinks in the deep ocean and the act of retrieving the ship back from the water is so costlier than the cost of ship itself. Then the ship is left to rest and is taken as constructive total loss.

A Partial Loss occurs when the subject matter is partially destroyed or damaged. Partial loss can be:

(a) General average (or)

(b) Particular average

General Average refers to the sacrifice made during extreme circumstances for the safety of the ship and the cargo. The loss has to be borne by all the parties who have an interest in the marine adventure. For example, a loss caused by throwing overboard of goods in order to prevent the ship from sinking, is a general average and must be shared by various parties.

Particular Average may be defined as a loss arising from damage accidentally caused by the perils insured against. Such a loss is borne by the underwriter who insured the object damaged. For example, if a ship is damaged due to bad weather, the loss incurred is a particular average loss.

Right of subrogation of the insurer

Where the insurer pays for a total loss, either of the whole, or in the case of goods of any apportionable part, of the subject-matter insured, he thereupon becomes entitled to take over the interest of the assured in whatever may remain of the subject-matter so paid for, and he is thereby subrogated to all the rights and remedies of the assured in and in respect of that subject matter as from the time of the casualty causing the loss. In simple words, we can say that the insurer has step-in the shoes of insured.

Right of Contribution

Where the assured is over-insured by double insurance, each insurer is bound, as between himself and the other insurers, to contribute rateably to the loss in proportion to the amount for which he is liable under his contract.

If any insurer pays more than his proportion of the loss, he is entitled to maintain a suit for contribution against the other insurers, and is entitled to the like remedies as a surety who has paid more than this proportion of the debt.

3. Public Liability Insurance Act, 1991

Very often we can notice members of the public are affected because of major accidents in establishments. This Act provides for mandatory public liability insurance for installations handling hazardous substances to provide minimum relief to victims of accidents , other than employees. For example, the Bhopal Gas Tragedy, which arose on account of leakage of the methyl isocynate gas from the Union Carbide plant in Bhopal on 2 & 3 December 1984, resulting into a liability of US$ 470 million for Union Carbide. In a way, this incident led to the enactment of Public Liability Insurance Act in 1991.

The Act imposes no fault liability, i.e. irrespective of any wrongful act, neglect or default on the owner to pay relief in the event of (a) death of or injury to any person (other than workman) or (b) damage to property of any person arising out of accident while handling any hazardous substance. No fault liability means that the claimant is not required to prove that the death, injury or damage was due to any wrongful act, neglect or default of any person.

Amount of relief

The amount of relief payable under Section 3 is as per the schedule incorporated in the Act as follows:

(i) Reimbursement of medical expenses incurred up to a maximum of Rs. 12,500 in each case.

(ii) For fatal accidents the relief will be Rs. 25,000 per person in addition to reimbursement of medical expenses if any, incurred on the victim up to a maximum of Rs. 12,500.

(iii) For permanent total or permanent partial disability or other injury or sickness, the relief will be

  (a) reimbursement of medical expenses incurred, if any, up to a maximum of Rs. 12,500 in each case and

  (b) cash relief on the basis of percentage of disablement as certified by an authorised physician. The relief for total permanent disability will be ₹ 25,000.

(iv) For loss of wages due to temporary partial disability which reduces the earning capacity of the victim, there will be a fixed monthly relief not exceeding ₹1,000 per month up to a maximum of 3 months: provided the victim has been hospitalised for a period of exceeding 3 days and is above 16 years of age.

(v) Up to ₹6,000 depending on the actual damage, for any damage to private property.

Compulsory insurance

The liability has to be compulsorily insured under a contract of insurance for an amount of the paid up capital of the undertaking handling any hazardous substance. The maximum aggregate liability of the insurer to pay relief under an award to the several claimants arising out of an accident shall not exceed rupees five crores and in case of more than one accident during the currency of the policy or one year, whichever is less, shall not exceed rupees fifteen crores in the aggregate. Every owner, in addition to premium, has to pay to the insurer an equivalent amount to be credited to the Environment Relief Fund established under the act. The contribution received by the insurer shall be remitted as per the Scheme made by the Government.

Policy exclusions

The policy does not cover the following liabilities:

(a) Arising out of willful or intentional non compliance of any statutory provisions

(b) In respect of fines, penalties, punitive and/or exemplary damages

(c) In respect of damage to property owned, leased etc., by the insured or in his custody. This is not deemed to be third party property. The insured can avail of a separate Material Damage Policy

Industrial Risks and Non-industrial Risks

There are two types of Public Liability insurance policies – Industrial and Non Industrial Risks. Industrial Risk Policies cover the risks arising in manufacturing premises including godowns, warehouses etc., forming part thereof.

Non Industrial Risks comprise of risks arising out of the following establishments:

(a) Hotels, Motels, Club Houses, Restaurants etc.

(b) Cinema Halls, Auditoriums and similar public places

(c) Residential premises

(d) Office or administrative premises, medical establishments, airport premises etc.

(e) Schools, Educational Institutions, Libraries

(f) Exhibitions, fairs, stadia

(g) Amusement parks

(h) Film studios

(i) Depots, Warehouses, Godowns, Shops, Tank farms and similar other non industrial risks

Coverage

The coverage under the policy include the following indemnities:

(a) Legal liabilities

(b) Other than liabilities under the Public Liability Insurance Act or any other statute

(c) Compensation including claimant's costs, fees and expenses

Products Liability Policy

The demand for products liability insurance has arisen because of the wide variety of products, e.g. canned food stuff, aerated waters, medicines, injections etc., manufactured and sold to the public in the modern industrial society which products, if defective, may cause death, bodily injury or illness or even damage to property. Apart from the goods, the containers too can cause injury or damage. These liabilities are covered under a Products Liability Policy.

Lift (Third party) Insurance

The policy is designed for owners of passenger lifts in building to cover third party liabilities for personal injuries or property damage arising out of the use and operation of lifts. The coverage applies to:

(a) Death or bodily injury of any person (not being a member of the insured's family or an employee of the insured)

(b) Loss of or damage to property (not being the property of the insured or of his family members or of his employees)

(c) Direct damage to personal effects of any person (not being a member of the insured's family or an employee of the insured)

Professional Indemnity Policies

Professional indemnities are designed to provide insurance protection to professional people against their legal liability to pay damages arising out of negligence in the performance of their professional duties and legal liability arises out of professional misconduct.

Such policies are available to Doctors, Medical establishments, Engineers, Architects and Interior decorators, Chartered Accountants, Company Secretary, Financial Consultants, Management Consultants, Lawyers etc.

Professional risks fall into the following two broad groups:

(a) Where professional negligence may result in bodily injuries (fatal or otherwise). Doctors, Dentists etc., fall into this group

(b) Where professional negligence may result in financial loss. Chartered Accountants, Company Secretary, Lawyers etc. fall into this group.

Employer's Liability Policy

This is also known as the Workmen's Compensation Insurance. The policy protects the employers against their legal liability for payment of compensation arising as a result of death of disablement of the employees arising out of and in the course of employment. The policy provides indemnity against legal liability under the Workmen's Compensation Act, Fatal Accidents Act and Common Law.

The policy does not specify any sum insured because the amounts of compensation stipulated in the Act(s) or awarded by a Court of Law determine the limits of liability of the insurers.

The total earnings of the employees cannot be accurately computed at the commencement of the policy. An estimate of the total earnings is made and a deposit premium is charged. The premium is finally adjusted after the expiry of the policy, on the basis of the actual total earnings of the employees during the period.

Directors and Officers Liability Policy

This is a specialised insurance policy introduced to cover the liabilities of Directors or Officers of a Company. Since they hold positions of trust and responsibility, they may become liable to pay damages to shareholders, employees, creditors etc. of the company for wrongful acts committed by them in the supervision and management of the affairs of the Company. Besides the Company itself may be liable. The policy is designed to provide protection to the Company as well as its Directors and Officers against their personal civil liability

1. Consumer Protection Act, 1986

Consumer Protection Act is an act of Parliament enacted in 1986 to protect interests of consumers in India. It makes provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for mattes connected therewith. Consumer Protection Councils are established at the national, state and district level to increase consumer awareness. The Central Consumer Protection Council is established by the Central Government which consists of the Minister of Consumer Affairs as the chairman and such number of other official or non official members representing such interests as may be prescribed. The State Consumer Protection Council consists of the Minister in charge of consumer affairs in the State Government as the Chairman and such other officials appointed by the Central and State Government.

Complainant

The word complainant means:

(a) a Consumer

(b) a voluntary consumer association

(c) Central Government or State Government

(d) One or more consumers where there are numerous consumers having the same interest

In the case of death of a consumer, his or her legal heir or representative

Consumer

Consumer means any person who:

(a) Buys any goods for a consideration which has been paid or promised or partly paid and partly promised or under any system of deferred payment

(b) Any user of the such goods other than the person who buys such goods as above if such use is made with the approval of the person who has bought it

(c) Hires or avails of any services for a consideration which has been paid or promised or partly paid and partly promised or under any system of deferred payment and includes any beneficiary of such services other than the person who hires or avails of the services for consideration paid or promised or partly paid and partly promised or under any system of deferred payment with the approval of the first mentioned person. It does not include a person who avails of such services for any commercial purposes.

What is a Complaint

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

(a) an unfair trade practice or a restrictive trade practice has been adopted by any trader or service provider

(b) the goods bought by him or agreed to be bought by him suffer from one or more defects

(c) the services hired or availed of or agreed to be hired or availed off by him suffer from deficiency in any respect

(d) A trader or service provider as the case may be has charged for the goods or for the services mentioned in the complaint, a price in excess of the price fixed by or under any law for the time being in force displayed on the goods or any package containing such goods, displayed on the price list exhibited by him by or under any law for the time being in force, agreed between the parties.

(e) Goods which will be hazardous to life and safety when used are being offered for sale to the public – In contravention of any standards relating to safety of such goods as required to be compiled with, by or under any law for the time being in force; If the trader could have known with due diligence that the goods so offered are unsafe to the public;

(f) Service which are hazardous or likely to be hazardous to the life and safety of the public when used, are being offered by the service provider which such person could have known with due diligence to be injurious to life and safety.

Who is a Consumer

Any person who buys goods or avails services for consideration. Consideration may be fully paid, partially paid or fully promised to be paid or partially promised to be paid. Consumer also include anybody who uses the goods or services with the consent of the consumer

What is a defect

Fault, imperfection or a shortcoming in the quality, quantity, potency, purity or standards which is required to be maintained by or under any law for the time being in force

What is a service

“ Service” means service of any description, which is made available to potential users and includes, but not

limited to the provisions of the facilities in connection with 1) banking 2) financing 3) insurance 4) transport 5) processing 6) supply of electrical or other energy 7) boarding or lodging or both 8) house construction 9) entertainment 10) amusement or 11) the purveying or new or other information But does not include the rendering of any service free of charge or under a contract of personal service

Consumer Disputes Redressal Agencies

(a) District Consumer Disputes Redressal Forum established by the State Government in each district of the State. The State Government may establish more than one District Forum in a district. It is a district level court that deals with cases valuing upto Rs.20 lakhs.

(b) State Consumer Disputes Redressal Forum established by the State Government takes up cases valuing less than Rs.1 Crore.

(c) National Consumer Disputes Redressal Commission established by the Central Government , which works as a national level Court and deals with amounts more than Rs.1 Crore.

None of the above forum can entertain a complaint unless it is filed within two years from the date on which the cause of action had arisen. Notwithstanding the above, a complaint may be entertained after the period of two years, if the complainant satisfies the concerned forum that he had sufficient cause for not filing the complaint within such period and the reason for condonation of the delay is recorded by the concerned forum.

Filing of complaints

A complaint may be filed by the consumer to whom the goods are sold or services are provided, any recognised consumer association, one or more consumers with same interest, central government or state government.

Power of Civil Court to District Forum

The District Forum shall have the powers of Civil Court while trying a suit in respect of the following matters:

(a) The summoning and enforcing attendance of any defendant or witness and examining the witness on oath

(b) The discovery and production of any document or other material object producible as evidence.

(c) The reception of evidence on affidavit

(d) The requisition of the report of the concerned analysis or test from the appropriate laboratory of from any other relevant source.

(e) Any other matter which may be prescribed.

Relief to the Complainant

If the complaint is proved the Forum shall order to remove defect pointed out by the appropriate laboratory from the goods in question or to replace the goods with new goods of similar description which shall be free from any defect or to return to the complainant the price, or , as the case may be, the charges paid by the complainant or to pay such amount as may be awarded by it as compensation to the consumer for any loss or injury suffered by the consumer due to negligence of the opposite party or to remove the defect in goods or deficiency in the services in question. The following relieves may be provided to the Complainants:

(a) to discontinue the unfair trade practice or the restrictive trade practice or not to repeat them;

(b) not to offer hazardous goods for sale;

(c) to withdraw the hazardous goods from being offered for sale;

(d) to cease manufacture of hazardous goods and to desist from offering services which are hazardous in nature;

(e) to pay such sum as may be determined by it, if it is of the opinion that loss or injury has been suffered by a large number of consumers who are not identifiable conveniently;

(f) to issue corrective advertisements to neutralise the effect of misleading advertisement at the cost of the opposite party responsible for issuing such misleading advertisement;

(g) to provide for adequate cost to parties.

Appeal

An appeal shall be filed within thirty days. Delay in filing appeal may be condoned if there is sufficient cause.

Limitation Period

Limitation period shall apply within two years from the date on which the cause of action has arisen.

The Consumer Protection Bill, 2015, was introduced in Lok Sabha on August 10, 2015 by the Minister of Consumer Affairs, Food and Public Distribution, Mr. Ram Vilas Paswan. The Bill when passed will replace the Consumer Protection Act, 1986. The Statement of Objects and Reasons of the Bill states that this is to widen the ambit and modernise the law on consumer protection due to the changes in the markets. The major changes as proposed by the bill are **Definition of consumer, Rights of consumers, Central Consumer Protection Authority (CCPA), Product liability, Consumer Disputes Redressal Commissions, Consumer Mediation Cell, etc.**

Redressal of Public Grievances Rules, 1998

The main objective of these Rules is to provide for a speedy redressal of certain grievances specific to insurance sector. This is an alternative dispute resolution mechanism which is managed by insurance companies to solve the disputes arising within the industry. The Act shall apply to all the insurance companies operating in general insurance business and in life insurance business, provided that the Central Government may exempt an insurance company from the provisions of these act, if it is satisfied that an insurance company has already a grievance redressal machinery, which fulfills the requirements of these act

The Governing Body of the Insurance council shall consist of representatives of each of the insurance companies, which shall ordinarily be the Chairman or the Managing Director or one of the Directors of the insurance companies. The Governing body shall formulate its own procedure for conducting its business including the election of the Chairman.

Ombudsman

The Governing body shall appoint one or more persons as Ombudsman for the purpose of resolving insurance disputes. The Ombudsman selected may be drawn from a wider circle including those who have experience or have been exposed to the industry, civil service, administrative service, etc. in addition to those drawn from judicial service.

Persons eligible to be appointed as Insurance Ombudsmen

Only the following persons shall be eligible to be appointed as Insurance Ombudsmen:

(a) Persons who served in the capacity of Chairman or Managing Director in Public Sector Insurance

Companies

(b) Persons who have served the Indian Administrative Service or the Indian Revenue Service

(c) Persons who are retired Judges of the Supreme Court or the High Courts

An Ombudsman shall be appointed by the Governing body from a panel prepared by a Committee comprising of:

(a) Chairman, IRDA

(b) Two representatives of Insurance council including one each from Life Insurance business and from General Insurance respectively

(c) One representative of Central Government

Term of office and Remuneration of Ombudsmen

An Ombudsman shall serve for a term of three years and shall be eligible for reappointment. However, an Ombudsman shall not hold office after he or she attains the age of **70**

The Ombudsman shall be allowed a fixed pay of two lakh twenty-five thousand rupees per month and any pension to which he is entitled from the Central Government or a State Government shall be deducted from his salary or such revised pay as may be determined by the Executive Council of Insurers with the prior approval of the Central Government

Powers of Ombudsmen

(1) The Ombudsman may receive and consider:

(a) Complaints under rule 13;

(b) Any partial or total repudiation of claims by an insurer;

(c) Any dispute in regard to premium paid or payable in terms of the policy;

(d) Any dispute on the legal construction of the policies in so far as such disputes relate to claims;

(e) Delay in settlement of claims;

(f) Non-issue of any insurance document to customers after receipt of premium.

(2) The Ombudsman shall act as counsellor and mediator in matters, which are within his terms of reference and, if requested to do so in writing by mutual agreement by the insured person and insurance company.

(3) The Ombudsman's decision whether the complaint is fit and proper for being considered by it or not shall be final.

Procedure for making a complaint

Any person who has a grievance against the insurer may himself or through the legal heirs make a complaint in writing to the Ombudsman within whose jurisdiction the branch or office of the insurer complained against is located.

The Complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to the complaint, supported by the documents, if any, relied on by the complainant, the nature and extent of the loss caused to the complainant and the relief sought from

the Ombudsman.

In order that a complaint is entertained before the Ombudsman, the following conditions must be satisfied:

(a) The complainant must have first exhausted the remedies available within the insurance company for settling the grievance and approach the Ombudsman only if either the insurance company rejects the grievance or complainant not satisfied with the reply or the insurer fails to respond within one month of submission of the grievance

(b) No complaint can be preferred before the Ombudsman after one year from the date of rejection or final letter from the insurance company on the representation made by the complainant

(c) If the complainant has not preferred alternative legal remedies and the proceedings are not pending before any Court or Consumer forum

Recommendations by the Ombudsman

After hearing both the parties and the submissions made, the Ombudsman can make his recommendations on the case. Copies of recommendations shall be sent to the complainant and the insurance company concerned. Such recommendation shall be made not later than one month from the date of receipt of the complaint. If the complainant accepts the recommendation, a copy of the acceptance is communicated to the insurance company concerned. The insurer shall comply with the terms of recommendation not later than 15 days of receipt of the recommendation.

Award

Where the complaint is not settled by agreement, the Ombudsman shall pass an Award which shall be in writing shall state the amount awarded to the complainant. The amount of compensation shall not grant an award exceeding Rs.20 lakhs (including *ex-gratia* and other expenses)

All Awards shall be passed within 3 months of receipt of the complaint and issue a copy of the Award to both the insurer and complainant. The complainant shall furnish to the insurer within a period of one month of date of receipt of the award, a letter of acceptance that the award is in full and final settlement of the claim.

Thereafter, the insurer shall comply with the award within 15 days of receipt of the acceptance letter and shall intimate the compliance to the Ombudsman.

Policyholder litigations before IRDA

As per the Annual Report for 2014-15 published by the IRDA, out of the total outstanding complaints of 20063 as on 31.03.2015, number of 6449 entertainable complaints received against life insurance companies and out of such entertainable complaints , 3402 complaints disposed by recommendations/award, 1329 disposed by withdrawal/settlement, 1718 complaints disposed by dismissal.

In respect of General insurance companies, as per the above Report, out of the total number of 4864 entertainable complaints received against general insurance companies and out of such entertainable complaints , 2687 complaints disposed by recommendations/award, 773 disposed by withdrawal/settlement, 1404 complaints disposed by dismissal.

LESSON ROUND UP

- The transactions of general insurance business in India are governed by two main statues, namely the Insurance Act, 1938 and General Insurance Business (Nationalisation) Act, 1972.
- The Insurance Act specifies the restrictions and limitations applicable as specified by the Central

Government under powers conferred by section 35 of the General Insurance Business (Nationalization) Act.

- The Motor Vehicles Act, 1988 is an Act of the Parliament of India which regulates all aspects of road transport vehicles. The Act came into force from 1 July 1989.
- Section 146 of the Motor Vehicles Act states that no person shall use, other than as a passenger or allow to use a motor vehicle in a public place unless a policy of insurance which covers the liability to third party on account of death or bodily injury to such third party or damage to any property of a third party arising out of the use of the vehicle in a public place.
- The principle of "no fault" means that the claimant need not prove negligence on the part of the motorist. Liability is automatic in such cases.
- "Hit and run motor accident" is accident arising out of a motor vehicle or motor vehicles the identity of whereof cannot be ascertained in spite of reasonable efforts for the purpose.
- Marine Insurance covers the risks associated with marine adventures. For example, transportation of cargo through ships.
- Insurable interest, in relation to a marine insurance, means the interest which the Policyholder has in the subject matter which has been insured – in such a way that the Policyholder will benefit if the insured property arrives safely or will be prejudiced in case there is a loss or damage to the insured property.
- Public Liability Insurance Act provides for mandatory public liability insurance for installations handling hazardous substances to provide minimum relief to victims of accidents , other than employees.
- Consumer Protection Act is an act of Parliament enacted in 1986 to protect interests of consumers in India. It makes provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for mattes connected therewith.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. Discuss the dual role of IRDA in the present insurance market in India.
2. Discuss the important provisions of the Motor Vehicles Act with regards to the third party liability.
3. What is the rationale behind the provisions of the Public liability Act of 1991?
4. How is an insurance consumer protected under the provisions of the Consumer protection Act, 1986?
5. Explain some of the important provisions of Marine Insurance Act.

Lesson 6
INTERNATIONAL REGULATORY FRAMEWORK

LESSON OUTLINE

International Association of Insurance Supervisors (IAIS)

- Introduction
- Objectives of IAIS
- The Secretariat of IAIS
- IAIS Governance

Insurance Core Principles, Standards, Guidance and Assessment Methodology

- Need for a common standards
- Scope and coverage of the Insurance Core Principles
- Application of Insurance Core Principles ICPs
- Application of ICPs and standards to group-wide supervision
- Implementation and assessment of ICPs
- Preconditions for effective insurance supervision
- Assessment Methodology
- Insurance Core Principles (ICPs)
- Future Outlook
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

Insurance is of fundamental importance to both individuals and business because it replaces insecurity with security and stability. The protection provided by insurance and the investments made by insurers contribute to economic growth and structural development. The role of public authorities is to provide an adequate regulatory framework allowing consumers to benefit from product innovation and to be protected.

In this chapter we will study about the international regulations related to the insurance with special reference to International Association of Insurance Supervisors and the core principles formulated by it for the regulation of international insurance sector.

INTERNATIONAL ASSOCIATION OF INSURANCE SUPERVISORS (IAIS)

Introduction

The IAIS is the only truly global body focusing its attention entirely and exclusively on the regulatory and supervisory issues of the insurance sector. The International Association of Insurance Supervisors (IAIS) was established in 1994. It is a voluntary membership organization of insurance supervisors and regulators from more than 200 jurisdictions in nearly 140 countries. In addition to its Members, more than 130 Observers representing international institutions, professional associations and insurance and reinsurance companies, as well as consultants and other professionals participate in IAIS activities. It constitutes 97% of the world's Insurance Premium. Thus it is truly a representative standard-setting body, attuned to the realities of developing countries alongside developed countries.

The main purpose of this association is to promote a globally consistent approach towards insurance regulation aimed at supporting the overall stability and growth of the financial sector of a country. It helps in adopting the best practices which protect the interests of all the stakeholders in insurance. The IAIS issues global insurance principles, standards and guidance, including application and issues papers, provides training and support on issues related to insurance supervision, and organises meetings and seminars for insurance supervisors. In 2012, the IAIS formed the Financial Inclusion Sub-committee to develop standards and to engage with supervisors and others on financial inclusion issues, especially micro insurance, in response to the needs of many IAIS members

It was founded in 1994, 20 years after the BCBS and roughly 10 years after IOSCO was formed. Its relatively late arrival upon the global regulatory and supervisory scene was a reflection of a number of insurance specific factors. It was primarily a reflection of the relatively low level of trans-nationalization of national insurance markets. For a number of economic, social and political reasons, insurance markets remained largely "nations-based".

The IAIS is working to create a Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). ComFrame has the goal of establishing a comprehensive framework for supervisors to address group-wide activities and risks of internationally active insurance groups (IAIGs) and also lay the groundwork for better supervisory cooperation and coordination. The IAIS initiated ComFrame to build on individual member efforts to improve group supervision and provide better insights to regulators on how IAIGs operate. U.S. state regulators and the NAIC are active in the development of ComFrame. After a three-year development phase and a third public consultation period that ended in December 2013, ComFrame has a target adoption date of 2019.

In addition, there is significant activity currently underway at the IAIS in the area of capital developments for the application of global systemically important insurers (G-SII's) and in conjunction with its work on ComFrame. The Financial Stability Board (FSB) directed the IAIS to develop for the purposes of the higher loss absorption (HLA) capacity G-SII policy measure, "straightforward, backstop capital requirements to apply to all group activities, including non-insurance subsidiaries." The IAIS is also currently developing a risk-based global insurance capital standard (ICS). An initial Version 1.0 of the ICS is due to be developed by mid-2017. A final Version 2.0 of the ICS is scheduled to be adopted, along with rest of ComFrame, by the end of 2019

Objectives of IAIS

The following are the objectives of formation of IAIS:

(a) Promote effective and globally consistent supervision of the insurance industry in order to develop

and maintain fair, safe and stable insurance markets for the benefit and protection of policyholders; and

(b) Contribute to global financial stability

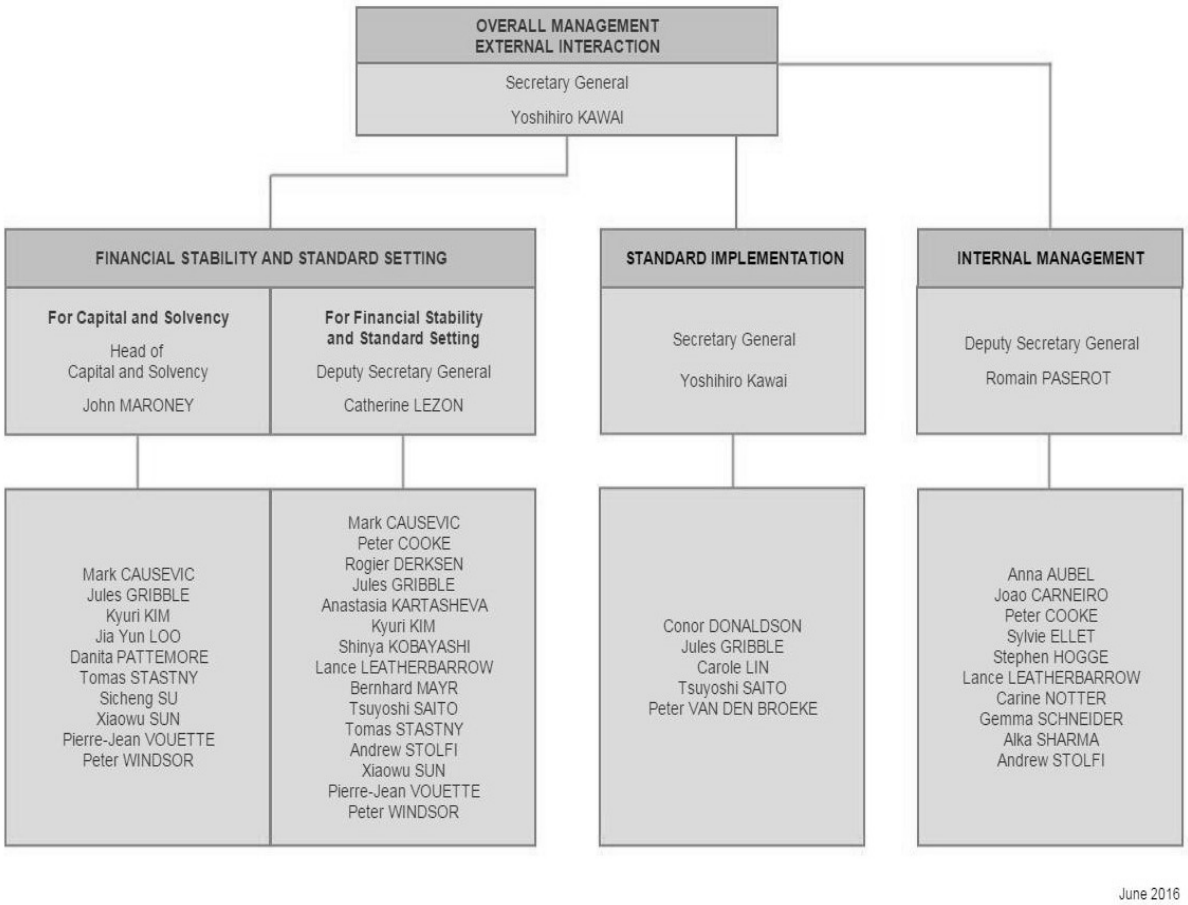
(c) Promote the development of well-regarded Insurance Market.

The objectives of the IAIS are accomplished by a number of activities including the development of principles, standards and guidance for insurance supervisors, encouraging their implementation, promoting the cooperation among supervisory authorities and cooperation with other relevant international organisations.

The Secretariat of IAIS

The activities of the IAIS are supported by its Secretariat located in Basel and headed by a Secretary General. A figure outlining the Secretariat Structure is available here, and a Secretariat Support Directory listing the Committee and Working Party responsibilities of each member of the Secretariat is mentioned in the Secretariat Structure as below

Secretariat Structure



GOVERNANCE

The IAIS constituency is split into members and observers. Members of the Association are in principle, insurance industry regulators and supervisors. Additionally the By-laws allow specifically for the membership of the NAIC, the U.S. Federal Insurance Office and the international organisations made up of governments or statutory bodies which receive recommendation for membership from the Executive Committee.

At the end of 2011, the list of these organisations included the IMF, The World Bank, the OECD and the European Commission. Altogether at the end of 2011, the membership of the Association comprised insurance regulatory and supervisory authorities representing 190 jurisdictions from about 130 countries, 57 of them representing the U.S. Furthermore, since 2011 it also includes the European Insurance and Occupational Pensions Authority (EIOPA). It effectively covers around 97 per cent of the global insurance market which means that its legitimacy to represent the global insurance supervisory community is extremely high. Since 1999, members of the IAIS are supplemented by observers who accounted, at the end of 2011, for 120 institutions. They also include a number of international bodies such as the Association of Mutual Insurers and Insurance Cooperatives (AMICE), Insurance Europe (formerly CEA), Federación Interamericana de Empresas de Seguros (FIDES), Institute of International Finance (IIF), International Actuarial Association (IAA), World Federation of Insurance Intermediaries (WFII) and The Geneva Association.

Corporate governance of the IAIS is quite typical in its general set-up. Major authority is vested in the General Meeting of the members. It decides by a simple majority. A two-third majority is required only for the most important decisions. These include amendments of the By-laws, adoption of principles, standards and guidance and the dissolution of the Association (Article 12). The General Meeting is held every calendar year. Effective management of the Association is in the hands of the Executive Committee (ExCo), composed of 9-24 voting members and elected by the General Meeting. The ExCo elects from within its members a chair and a vice-chair. Geopolitical considerations and the perceived need for balanced geographical representation play an important role in allocating these seats to individual jurisdictions, as is the case for the chairs of the most prominent and influential committees.

The Executive Committee oversees the work of four other committees: the Technical Committee, responsible for standard setting; the Implementation Committee, responsible for standards implementation; the Budget Committee, overseeing the budgetary matters; and the Financial Stability Committee, concentrating on financial stability issues. This last committee was added to the structure in 2010 and reflects the growing role of the stability work and concerns within the Association in the aftermath of the financial crisis. Much of its work is currently driven by the FSB and the G-20 desire to identify potential systemically important financial institutions (SIFIs) in all parts of the financial sector, including insurance.

The work of the ExCo, specialised committees and working parties is assisted by the office staff (around 30 people) of the Secretariat, headed by the Secretary General and his two deputies. However many of the activities within the Association are performed by its member organisations, i.e. the supervisory authorities themselves. It allows the IAIS, on the one hand, to maintain low expenses and keep better pace with the national and international developments through bodies that are directly involved while, on the other hand, it privileges larger and richer bodies at the expense of the others, thus adding an element of internal asymmetry to the whole Association.

Insurance Core Principles, Standards, Guidance and Assessment Methodology

One strong workstream for the IAIS is the development of the Insurance Core Principles (ICPs), which are not legally binding but de facto high-level good practices of the insurance activities and its supervision. With

the support of the IMF/World Bank and their FSAP projects, the ICPs help to converge national regulatory and supervisory set-ups. Besides them, the IAIS concentrates increasingly on cross-border and systemic issues. Thus it is currently in the process of developing the Common Framework (ComFrame) for the supervision of IAIGs. It is additionally entrusted by the FSB with devising an appropriate methodology for the possible identification of G-SIFIs in insurance including creating a list of such entities, similar to that existing for banks.

Since 2007, the IAIS has also been heavily engaged in developing international cooperation and information exchange for supervisory purposes with the help of special multilateral agreements and dedicated institutional frameworks. At the end of 2011, 21 member jurisdictions had already signed the Multilateral Memorandum of Understanding (MMoU) (IAIS, 2011b). The list of signatories includes important bodies such as BaFin/Germany, the Australian Prudential Regulation Authority (APRA), the Autorité de contrôle prudentiel (ACP/France), the Comisión Nacional de Seguros y Finanzas (CNSF/Mexico) and the Financial Services Agency (FSA/Japan). The IAIS has always underlined its desire for transparency in its activities for key stakeholders. In 2007, along with the development of periodic meetings with executives of large insurers, systematic observer hearings were introduced which provide a structured way, especially for the important and influential Technical Committee, to discuss key issues with observers from the industry.

Insurance Core Principles (ICPs) framed by IAIS provide the globally accepted framework for Insurance Sector. Many of these principles have been adopted by the Insurance Regulators in the developed and developing countries. It provides common minimum standards which serve as a benchmark for the insurance regulators across the globe.

Need for a common standards

(a) Stability of insurance sector is fundamental to the growth of financial services industry. Further it sets the base for protection of interests of policyholders and their beneficiaries which is the fundamental mission of any Insurance Regulator.

(b) The impact of wide range of social, technological and global economic forces is seen in Insurance Industry like other financial industry. Insurance supervisory systems and practices must be continually upgraded to cope with these developments. Insurance and other financial sector supervisors and regulators should understand and address financial and systemic stability concerns arising from the insurance sector as they emerge and their interaction with other financial sectors.

(c) The nature of insurance activity - covering risks for the economy, financial and corporate undertakings and households, when compared with other financial sectors has both similarities and differences. Insurance, unlike most financial products, is characterised by the reversal of the production cycle insofar as premiums are collected when the contract is entered into and claims arise only if a specified event occurs. Insurers intermediate risks directly. They manage these risks through diversification and risk pooling enhanced by a range of other techniques.

(d) In addition to business risks, significant risks to insurers are generated on the liability side of the balance sheet. These risks are referred to as technical risks and relate to the actuarial and/or statistical calculations used in estimating liabilities, and other risks associated with such liabilities. Insurers incur market, credit, liquidity and operational risk from their investments and financial operations, including risks arising from asset-liability mismatches. Life insurers also offer products of life cover with savings content and pension products that are usually managed with a long-term perspective. The regulatory and supervisory system must address all these risks.

(e) Finally, the regulatory and supervisory system must address the increasing presence in the market of insurance groups and financial conglomerates, as well as financial convergence. The importance

of the insurance sector for financial stability matters has been increasing which has implications for insurance supervision as it requires more focus on a broad set of risks. Supervisors at a jurisdictional and international level must collaborate to ensure that these entities are effectively supervised so that policyholders are protected and financial markets remain stable; to minimise the risk of contagion from one sector or jurisdiction to another; and to reduce supervisory gaps and avoid unnecessary supervisory duplication.

Scope and coverage of the Insurance Core Principles

The Insurance Core Principles (ICPs) provide a globally accepted framework for the regulation of the insurance sector. The ICP material is presented according to a hierarchy of regulatory or supervisory material. The ICP statements are the highest level in the hierarchy and prescribe the essential elements that must be present in the supervisory regime in order to promote a financially sound insurance sector and provide an adequate level of policyholder protection. The next in hierarchy comes Standards that are fundamental to the implementation of ICP statements and then comes Guidance material in the hierarchy, which is the lowest level. It provides detail on how to implement an ICP statement or standard.

The ICPs apply to insurance supervision in all jurisdictions regardless of the level of development or sophistication of the insurance markets and the type of insurance products or services being supervised. Nevertheless, supervisory measures should be appropriate to attain the supervisory objectives of a jurisdiction and should not go beyond what is necessary to achieve those objectives.

The ICPs apply to the supervision of all insurers whether private or government controlled insurers that compete with private enterprises, wherever their business is conducted, including through e-commerce. The ICPs do not normally apply to the supervision of intermediaries but where they do, this is specifically indicated.

Insurance supervision within an individual jurisdiction may be the responsibility of more than one authority. The supervisor must operate in a transparent and accountable manner. It needs legal authority to perform its tasks. The supervisor must recognise that transparency and accountability in all its functions contribute to its legitimacy and credibility.

Application of Insurance Core Principles ICPs

THE ICPs apply to Insurance Regulation in all jurisdictions regardless of the level of development insurance markets and the type of insurance products or services being regulated. supervisors should have the flexibility to tailor supervisory requirements in accordance with nature, scale and complexity of individual insurers and actions so that they are commensurate with the risks posed by individual insurers as well as the potential risks posed by insurers to the insurance sector or the financial system as a whole.

The ICPs apply to the regulation of all insurers whether private or government-controlled insurers that compete with private enterprises, wherever their business is conducted, including through e-commerce. Where the principles do not apply to reinsurers, this is indicated in the text. The ICPs do not normally apply to the regulation of intermediaries but where they do, this is specifically indicated.

Insurance supervision within an individual jurisdiction may be the responsibility of more than one authority. For example, the body that sets out the legal framework for insurance supervision may be different from the body that implements it.

The regulator must operate in a transparent and accountable manner. It needs legal authority and the regulator to perform its tasks. The regulator must recognise that transparency and accountability in all its

functions contribute to its legitimacy and credibility. The regulator should also establish clear timelines for public consultation and action, where appropriate.

Application of ICPs and standards to group-wide supervision

The ICPs and standards apply to the regulation of insurers at the legal entity and the insurance group level, unless otherwise specified. The application of individual ICPs and standards to insurance groups may vary and where appropriate, further guidance is provided under individual ICPs and standards.

It is recognised that the implementation of the ICPs and standards relevant to group-wide regulation may vary across jurisdictions depending on the regulatory powers and structure within a jurisdiction. There are direct and indirect approaches to group-wide regulation. Under the direct approach, the regulator has the necessary powers over the parent and other entities in the insurance group and can impose relevant regulatory measures directly on such entities, including non-regulated entities. Under the indirect approach, regulatory powers focus on the insurance legal entities and regulatory measures are applied to those insurance legal entities to address the group-wide risks posed by other entities within the group, including non-regulated entities. There may also be different combinations of elements of the direct and indirect approaches.

Regardless of the approach, the regulator must be able to demonstrate that in effect, the outcome is similar to having the regulatory requirements applied directly on those entities within the insurance group from which the risks are emanating. This is to ensure effective group-wide supervision, which includes ensuring that all relevant group-wide risks impacting the insurance entities are addressed appropriately.

Implementation and assessment of ICPs

The ICPs can be used to establish or enhance a jurisdiction's supervisory system. They can also serve as the basis for assessing the existing supervisory system and in so doing may identify weaknesses, some of which could affect policyholder protection and market stability. ICPs sets out factors that should be considered when using or implementing these ICPs and describes how observance should be evaluated.

When implementing the ICPs and standards in a jurisdiction, it is important to take into account the domestic context, industry structure and developmental stage of the financial system and overall macroeconomic conditions. The methods of implementation will vary across jurisdictions, and while established implementation practices should be kept in mind, there is no mandated method of implementation. In the ICPs, the term "legislation" is used to include both primary legislation (which generally requires full legislative consent) and secondary and other forms of legislation, including rules and regulations which have the legal force of law but are usually the responsibility of the supervisor.

For an ICP to be regarded as being "observed" by a jurisdiction, the standards must be met without any significant shortcomings although there may be instances, where one can demonstrate that the ICPs have been observed through different means other than those identified in the standards. Conversely, owing to the specific conditions in individual jurisdictions, the standards identified in this document may not always be sufficient to achieve the objective of the specific ICP and therefore additional elements may have to be taken into account.

Preconditions for effective insurance supervision

An effective system of insurance supervision needs a number of external elements, or preconditions, on which to rely as they can have a direct impact on supervision in practice. The preconditions include:

- sound and sustainable macroeconomic and financial sector policies;

- a well developed public infrastructure;
- effective market discipline in financial markets;
- mechanisms for providing an appropriate level of protection (or public safety net); and
- efficient financial markets.

As these preconditions are normally outside the control or influence of the supervisor, the supervisor should not be assessed against these preconditions. However, the preconditions can have a direct impact on the effectiveness of supervision in practice. Therefore, where shortcomings exist, the supervisor should make the government aware of these and their actual or potential negative repercussions for the supervisory objectives and should seek to mitigate the effects of such shortcomings on the effectiveness of supervision. The supervisor should have the necessary powers to make rules and establish procedures to address shortcomings. Where the preconditions for effective insurance supervision are not yet met, the supervisor should have additional powers or adopt other measures to address the weaknesses.

Sound macroeconomic policies must be the foundation of a stable financial system. This is not within the mandate of supervisors, although they will need to react if they perceive that existing policies are undermining the safety and soundness of the financial system. In addition, financial sector supervision needs to be undertaken within a transparent government policy framework aimed at ensuring financial stability, including effective supervision of the insurance and other financial sectors.

A well developed public infrastructure needs to comprise the following elements, which if not adequately provided, can contribute to the weakening of financial systems and markets or frustrate their improvement:

- a system of business laws, including corporate, insolvency, contract, consumer protection and private property laws, which is consistently enforced and provides a mechanism for the fair resolution of disputes;
- an efficient and independent judiciary;
- comprehensive and well defined accounting principles and rules that command wide international acceptance;
- a system of independent audits for companies, to ensure that users of financial statements, including insurers, have independent assurance that the accounts provide a true and fair view of the financial position of the company and are prepared according to established accounting principles, with auditors held accountable for their work;
- the availability of skilled, competent, independent and experienced actuaries, accountants and auditors, whose work complies with transparent technical and ethical standards set and enforced by official or professional bodies in line with international standards and is subject to appropriate oversight;
- well defined rules governing, and adequate supervision of, other financial sectors and, where appropriate, their participants;
- a secure payment and clearing system for the settlement of financial transactions where counterparty risks are controlled; and
- the availability (to the supervisor, financial services and public) of basic economic, financial and social statistics.

Effective market discipline depends, in part, on adequate flows of information to market participants, appropriate financial incentives to reward well managed institutions, and arrangements that ensure that

investors are not insulated from the consequences of their decisions. Among the issues to be addressed are the existence of appropriate corporate governance frameworks and ensuring that accurate, meaningful, transparent and timely information is provided by borrowers to investors and creditors.

In general, deciding on the appropriate level of policyholder protection is a policy question to be addressed by the relevant authorities, particularly if it may result in a commitment of public funds. Supervisors will normally have a role to play because of their in-depth knowledge of the entities involved. They should be prepared, as far as possible, and equipped to manage crises involving insurers. Such mechanisms of protection could include a system of policyholder compensation in the event of insolvency of an insurer. Provided such a system is carefully designed to limit moral hazard, it can contribute to public confidence in the system.

Efficient financial markets are important to provide for both long-term and short-term investment opportunities for insurers. They facilitate the assessment of the financial and risk position of insurers and execution of their investment and risk management strategies. When the financial market loses its efficiency, assessment of financial and risk positions can be more challenging for both insurers and supervisors. Therefore, supervisors will need to give due consideration to the impact of financial market efficiency on the effectiveness of their supervisory measures.

A Primary legislation clearly defines the authority (or authorities) responsible for insurance Regulation and the mandate and responsibilities of the regulator. Primary legislation gives the regulator adequate powers to conduct insurance supervision, including powers to issue and enforce rules by administrative means and take immediate action.

In India, the Insurance Act, 1938 and IRDA Act, 1999, gives powers to Insurance Regulatory and Development Authority to regulate the insurance sector.

Assessment Methodology

Review of preconditions for effective insurance supervision

The review of preconditions should include an overview of the preconditions for effective insurance supervision:

- sound and sustainable macroeconomic and financial sector policies;
- a well developed public infrastructure;
- effective market discipline in financial markets;
- mechanisms for providing an appropriate level of systemic protection (or
- public safety net); and
- efficient financial markets.

The review should pay close attention to the adequacy of preconditions and provide a succinct and well structured factual summary. This review should give a clear picture of the interaction of the preconditions with the assessment of observance with the ICPs which should flag the individual ICPs which are most likely to be affected by any material weakness in the preconditions.

The review should not evaluate a jurisdiction's observance of the preconditions, as this is beyond the scope of the assessment of observance with the ICPs. Instead, the objective of the review of preconditions is to inform the assessment of the ICPs. The report normally should take up no more than one or two paragraphs

for each type of precondition. Assessors may rely to the extent possible on IMF, World Bank and other official documents that assess the issues covered by the preconditions.

In particular, with regard to the presence of sound and sustainable macroeconomic policies, the report on the preconditions should be descriptive, and should not express an opinion on the adequacy of policies in these areas, other than through reference to analyses and recommendations in existing official documents. When relevant, the review should attempt to include an analysis of the linkages between these factors and the stability of the insurance sector.

The review should also include a review of the relevant government financial sector policies, including whether there is a clear and published framework assigning responsibility to different bodies involved in financial stability and supervisory work.

A factual review of the public infrastructure should focus on elements relevant to the insurance sector. The review of the effectiveness of market discipline could, for instance, cover issues such as the presence of rules on corporate governance, transparency and audited financial disclosure, appropriate incentive structures for the hiring and removal of managers and Board members, protection of shareholders' and other stakeholders' rights, adequate availability of market and consumer information, an effective framework for new entrants, mergers, takeovers, and acquisition of equity interests, including those involving foreign entities.

An overview of the appropriateness of safety nets could, for instance, include the following elements: an analysis of the functions of the various entities involved such as supervisors, the policyholder protection fund and, if appropriate, the central bank. The review should include a review of the extent to which supervisors are prepared and equipped to manage crises involving one or more insurers, including whether simulation exercises are undertaken and the availability of appropriate skills and adequate resources.

The review should also include a review of any arrangements for the use of public funds (including central bank funds) and whether measures are in place to minimise moral hazard.

The overview of whether there are efficient financial markets could cover, for example, the range of instruments and issuers (e.g. is there a spread of public sector issues, index-linked as well as conventional government bonds) and the spread of available maturities. The review could take note of how liquidity has been affected in markets in periods of stress. The review should focus on relevant issues for the carrying on of insurance business, taking into account the products offered, for example, whether annuities or other long term contracts of insurance are provided.

Assessment of ICPs

The factors that should be considered when carrying out an assessment of a jurisdiction or authority's observance of the ICPs and standards are set out below. When carrying out an assessment of observance, it is important to take into account the domestic context, industry structure and developmental stage of the financial system and overall macroeconomic conditions.

The IAIS strongly encourages implementation of the framework for effective supervision described by the ICPs. Assessments can facilitate implementation by identifying the extent and nature of any weaknesses in a jurisdiction's supervisory framework – especially those aspects that could affect policyholder protection and insurance sector stability – as well as recommending possible remedies.

The framework described by the ICPs is general. Supervisors have flexibility in determining the specific methods for implementation which are tailored to their domestic context (e.g. legal and market structure). The standards set requirements that are fundamental to the implementation of each ICP. They also facilitate

assessments that are comprehensive, precise and consistent. While the results of the assessments may not always be made public, it is still important for their credibility that they are conducted in a broadly uniform manner from jurisdiction to jurisdiction.

Scope

Assessments against the ICPs can be conducted in a number of contexts including:

- self assessments, on either the full set of ICPs or against specific ICPs, performed by insurance supervisors themselves, sometimes with the assistance of other experts. Self assessments may be followed by peer review and analysis.
- reviews conducted by third parties
- reviews conducted in the context of the IMF and World Bank Financial Sector Assessment Program (FSAP).

Normally, but not always, the ICPs should be equally applicable to both life and non-life sectors in order for an overall rating to be assigned. Similarly, it is possible that certain specialized parts of the insurance sector would have observance with the ICPs differing from the other insurance business in the jurisdiction. Where the legal or practical position is materially different between life and non-life insurance or with respect to specialized parts of the insurance business in the jurisdiction such that it would give rise to a different rating had the assessments been carried out separately, it is open to the assessor to consider assigning a level of observance separately for the two parts of the insurance sector for that particular principle

Generally, an assessment should be conducted on a system-wide jurisdictional basis. However, follow-up assessments could focus on identified weaknesses or areas of particular risk. Full FSAP reviews are always done with respect to the jurisdiction as a whole. Where more than one authority is involved in the supervisory process, the interaction of supervisory roles should be clearly described in the assessment. If an assessment is conducted in the context of an individual supervisor, a standard may be assessed as **not applicable** if the responsibility lies with another authority within the jurisdiction.

Conduct of independent assessments - assessment by experts

The process of assessing each ICP requires a judgmental weighing of numerous elements that only qualified assessors with practical and relevant experience can provide. Assessors not familiar with the insurance sector could come to incorrect or misleading conclusions due to their lack of sector specific knowledge. Therefore, independent assessments should only be conducted by those with relevant background and professional experience.

Conduct of independent assessments - access to information

When conducting an independent assessment, prior consent from the relevant local authorities is required so that assessors can have access to a range of information and people. The required information may include not only published information such as the legislation and administrative policies but also non-published information, such as self-assessments, operational guidelines for insurance supervisors and the like. The information should be provided as long as it does not violate confidentiality requirements. This information should be provided and analyzed in advance to the extent possible, in order to ensure that subsequent on-site visits are efficient and derive the most value. The assessor will need to meet with various individuals and organizations, including the insurance supervisor or supervisors, other domestic supervisory authorities, any relevant government ministries, insurers and insurance industry associations, actuaries, auditors, and other financial sector participants.

Assessment Categories

Assessment of standards

In making the assessment, each of the **standards** has to be considered. The standards should be assessed using five categories: **observed, largely observed, partly observed, not observed,** and **not applicable**.

For a standard to be considered **observed** it is usually necessary that the supervisor has the legal authority to perform its tasks and that it exercises this authority to a satisfactory level. Where the supervisor sets requirements it should also ensure that these requirements are implemented. Having the necessary resources is essential for the supervisor to effectively implement the requirements. Authority provided in the legislation is insufficient for full observance to be recorded against a standard except where the standard is specifically limited in this respect. In the event that the supervisor has a history of using a practice for which it has no explicit legal authority, the assessment may be considered as observed if the practice is clearly substantiated as common and generally accepted.

Assessments are based solely on the legislation and other supervisory requirements and practices that are in place at the time. Nevertheless, improvements already proposed by the supervisor can be noted in the assessment report by way of additional comments so as to give credit for efforts that are important but at the time the assessment is made, have yet to be fully implemented. Similarly, legislation that does not meet with a satisfactory level of observance in practice cannot provide the basis for recording a standard as "observed".

For a standard to be considered as **largely observed,** it is necessary that only minor shortcomings exist which do not raise any concerns about the supervisor's ability to achieve full observance with the standard. A standard will be considered **partly observed** whenever, despite progress, the shortcomings are sufficient to raise doubts about the supervisor's ability to achieve observance. A standard will be considered **not observed** whenever no substantive progress toward observance has been achieved.

A standard would be considered **not applicable** if the standard does not apply given the structural, legal and institutional features of a jurisdiction.

Assessment of principles

An ICP will be considered **observed** whenever all the standards are considered to be observed or when all the standards are observed except for a number that are considered not applicable. An ICP will be considered to be **not applicable** when the standards are considered to be not applicable.

With respect to an assessment of an ICP that is other than observed or not applicable, similar guidance is to be used as applies to the standards themselves. So, for an ICP to be considered **largely observed,** it is necessary that only minor shortcomings exist which do not raise any concerns about the supervisor's ability to achieve full observance with the ICP. An ICP will be considered **partly observed** whenever, despite progress, the shortcomings are sufficient to raise doubts about the supervisor's ability to achieve observance. An ICP will be considered **not observed** whenever no substantive progress toward observance has been achieved.

While it is generally expected that full observance of an ICP would be achieved through the observance of the standards, there may be instances, where a jurisdiction can demonstrate that observance with an ICP has been achieved through different means. Conversely, due to specific conditions in a jurisdiction, meeting the standards

may not be sufficient to achieve observance of the objective of an ICP. In these cases, additional measures

are needed in order for observance of the particular ICP to be considered effective.

Reporting

The IAIS does not prescribe the precise format or content of reports that result from an assessment against the ICPs. It does, however, consider that the report should:

- be in writing
- include both the assessment of observance itself and any additional information referred to in this section
- identify the scope and timing of the assessment
- in the case of an external assessment, identify the assessors
- in the case of an external assessment, refer to the information reviewed and meetings conducted, and note when any of the necessary information was not provided and the impact that this may have had on the accuracy of the assessment
- in the case of an external assessment, include prioritized recommendations for achieving improved observance of the ICPs recognizing that the assessment should not be considered as an end in itself
- in the case of an external assessment, include the formal comments provided by the supervisors in response to the assessment
- include a review of areas identified in this section as the preconditions to effective
- supervision.

INSURANCE CORE PRINCIPLES (ICP)

1. **ICP 1 Objectives, Powers and Responsibilities of the Supervisor:** The authority (or authorities) responsible for insurance supervision and the objectives of insurance supervision are clearly defined.
2. **ICP 2 Supervisor:** The supervisor, in the exercise of its functions and powers:
    - is operationally independent, accountable and transparent
    - protects confidential information
    - has appropriate legal protection
    - has adequate resources
    - meets high professional standards
3. **ICP 3 Information Exchange and Confidentiality Requirements:** The supervisor exchanges information with other relevant supervisors and authorities subject to confidentiality, purpose and use requirements.
4. **ICP 4 Licensing:** A legal entity which intends to engage in insurance activities must be licensed before it can operate within a jurisdiction. The requirements and procedures for licensing must be clear, objective and public, and be consistently applied.
5. **ICP 5 Suitability of Persons:** The supervisor requires Board Members, Senior Management, Key Persons in Control Functions and Significant Owners of an insurer to be and remain suitable to fulfil their respective roles.
6. **ICP 6 Changes in Control and Portfolio Transfers:** Supervisory approval is required for

proposals to acquire significant ownership or an interest in an insurer that results in that person (legal or natural), directly or indirectly, alone or with an associate, exercising control over the insurer. The same applies to portfolio transfers or mergers of insurers.

7. **ICP 7 Corporate Governance:** The supervisor requires insurers to establish and implement a corporate governance framework which provides for sound and prudent management and oversight of the insurer's business and adequately recognises and protects the interests of policyholders.
8. **ICP 8 Risk Management and Internal Controls:** The supervisor requires an insurer to have, as part of its overall corporate governance framework, effective systems of risk management and internal controls, including effective functions for risk management, compliance, actuarial matters and internal audit.
9. **ICP 9 Supervisory Review and Reporting:** The supervisor takes a risk-based approach to supervision that uses both off-site monitoring and on-site inspections to examine the business of each insurer, evaluate its condition, risk profile and conduct, the quality and effectiveness of its corporate governance and its compliance with relevant legislation and supervisory requirements. The supervisor obtains the necessary information to conduct effective supervision of insurers and evaluate the insurance market.
10. **ICP 10 Preventive and Corrective Measures:** The supervisor takes preventive and corrective measures that are timely, suitable and necessary to achieve the objectives of insurance supervision.
11. **ICP 11 Enforcement:** The supervisor enforces corrective action and, where needed, imposes sanctions based on clear and objective criteria that are publicly disclosed.
12. **ICP 12 Winding-up and Exit from the Market:** The legislation defines a range of options for the exit of insurance legal entities from the market. It defines insolvency and establishes the criteria and procedure for dealing with insolvency of insurance legal entities. In the event of winding-up proceedings of insurance legal entities, the legal framework gives priority to the protection of policyholders and aims at minimising disruption to the timely provision of benefits to policyholders.
13. **ICP 13 Reinsurance and Other Forms of Risk Transfer:** The supervisor sets standards for the use of reinsurance and other forms of risk transfer, ensuring that insurers adequately control and transparently report their risk transfer programmes. The supervisor takes into account the nature of reinsurance business when supervising reinsurers based in its jurisdiction.
14. **ICP 14 Valuation:** The supervisor establishes requirements for the valuation of assets and liabilities for solvency purposes.
15. **ICP 15 Investment:** The supervisor establishes requirements for solvency purposes on the investment activities of insurers in order to address the risks faced by insurers.
16. **ICP 16 Enterprise Risk Management for Solvency Purposes:** The supervisor establishes enterprise risk management requirements for solvency purposes that require insurers to address all relevant and material risks.
17. **ICP 17 Capital Adequacy:** The supervisor establishes capital adequacy requirements for solvency purposes so that insurers can absorb significant unforeseen losses and to provide for degrees of supervisory intervention.
18. **ICP 18 Intermediaries:** The supervisor sets and enforces requirements for the conduct of insurance intermediaries, to ensure that they conduct business in a professional and transparent

manner.

19. **ICP 19 Conduct of Business:** The supervisor sets requirements for the conduct of the business of insurance to ensure customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied.
20. **ICP 20 Public Disclosure:** The supervisor requires insurers to disclose relevant, comprehensive and adequate information on a timely basis in order to give policyholders and market participants a clear view of their business activities, performance and financial position. This is expected to enhance market discipline and understanding of the risks to which an insurer is exposed and the manner in which those risks are managed.
21. **ICP 21 Countering Fraud in Insurance:** The supervisor requires that insurers and intermediaries take effective measures to deter, prevent, detect, report and remedy fraud in insurance.
22. **ICP 22 Anti-money Laundering and Combating the Financing of Terrorism (AML/CFT):** The supervisor requires insurers and intermediaries to take effective measures to combat money laundering and the financing of terrorism. In addition, the supervisor takes effective measures to combat money laundering and the financing of terrorism.
23. **ICP 23 Group-wide Supervision:** The supervisor supervises insurers on a legal entity and group-wide basis.
24. **ICP 24 Macroprudential Surveillance and Insurance Supervision:** The supervisor identifies, monitors and analyses market and financial developments and other environmental factors that may impact insurers and insurance markets and uses this information in the supervision of individual insurers. Such tasks should, where appropriate, utilise information from, and insights gained by, other national authorities
25. **ICP 25 Supervisory Cooperation and Coordination:** The supervisor cooperates and coordinates with other relevant supervisors and authorities subject to confidentiality requirements.
26. **ICP 26 Cross-border Cooperation and Coordination on Crisis Management:** The supervisor cooperates and coordinates with other relevant supervisors and authorities such that a cross-border crisis involving a specific insurer can be managed effectively.

(1) ICP1 - Objectives, Powers and Responsibilities of the Regulator

The authority responsible for insurance regulation and the objectives of insurance regulation are clearly defined in this principle. The main objective of supervision is to promote the maintenance of a fair, safe and stable insurance sector for the benefit and protection of policyholders. Where, in the fulfillment of its objectives, the supervisor identifies conflicts between legislation and supervisory objectives, the supervisor initiates or proposes correction in legislation. This principle is fundamental to any insurance regulatory regime. Without there being a regulatory authority vested with adequate statutory powers, it will be impossible to regulate and develop a stable insurance sector. In an insurance industry there are many players like the insurance companies, the intermediaries, the policyholders etc.

(2) ICP 2 Requirements as to Supervisor of the Insurance industry

- The supervisor, in the exercise of its functions and powers:
  - is operationally independent, accountable and transparent
  - protects confidential information

- has appropriate legal protection
- has adequate resources
- meets high professional standards

- Operational independence of a Regulator is very important to ensure that the Regulator performs its role without any bias or conflict. The internal governance procedures, including internal audit arrangements, must be in place to ensure this independence and ensure integrity of supervisory actions.
- Responsibility and independence go hand in hand. The Regulator is accountable if there is a deviation from the accepted course of action. Usually the Regulator is accountable to the Government or a Governmental body. A rationale for the decisions taken must be provided by the Regulator.
- The procedures for appointment or removal of the Head of the Regulator must be explicitly defined and members of the governing body of the insurers, if there is one. The reason for removal of a Regulator must be publicly announced.
- Another hall mark of operational independence is the absence of influence on the Regulator from any political, governmental or industry. Though operationally a Regulator might report to a Governmental body, it must be ensured that there is no interference from the bureaucrats within the Government or Politicians in the discharge of the Regulator's duties. However, this does not mean that a Regulator's acts should not be questioned. There must in fact be a health debate on the performance of the Regulator by the concerned Governmental agency and provide feedback to the Regulator.
- In order to ensure that the decisions taken by the Regulator are fair, there must be a process of appeal against the decisions made by the Regulator, either through a judicial process or a quasi judicial process. However, this must not undermine the role of a Regulator.
- The supervisor and its staff have the necessary legal protection against lawsuits for actions taken in good faith while discharging their duties.
- The supervisor and its staff act with integrity and observe the highest professional standards, including observing conflict of interest rules.
- Where the supervisor outsources supervisory functions to third parties, the supervisor sets expectations, assesses their competence and experience, monitors their performance, and ensures their independence from the insurer or any other related party.

(3) ICP 3 Information Exchange and Confidentiality Requirements

- The supervisor has the legal authority to exchange information with other relevant supervisors and authorities subject to confidentiality, purpose and use requirements.
  - The information for the purpose of insurance legal entities or groups may include:
  - Management and operational systems and controls operated by insurer;
  - financial data relating to an insurer;
  - individual holding positions or responsibility in insurers;
  - regulatory investigations and reviews and restrictions imposed, if any;
  - reporting information within groups;

— information on legal entity and group-wide business;

- It is essential to establish agreements and understandings between Regulators that can be used to institute a framework between supervisors to facilitate the efficient execution of requests for provision of information. Few important Agreements are MMOU (Multilateral Memorandum of Understanding), MoU(Bilateral Memorandum of Understanding). These Agreements are valuable where there is a need and set out the types of information that has to be exchanged. It is the responsibility of each supervisor within the Supervisory college to ensure the safe handling of confidential information. Unintentional divulgence of information must be avoided and informations must be exchanged in a secure environment.
- The supervisor assesses each request for information from another supervisor on a case by case basis. Whilst requests for information should normally be made in writing, it is not necessary in an emergency situation. Timely and comprehensive manner of responding to requests from supervisors seeking information should be maintained.Before using the information for another purpose, including exchanging it with other parties, the supervisor obtains agreement of the originating supervisor.

(4) ICP 4 Licensing

- A legal entity which intends to engage in insurance activities must be licensed before it can operate within a jurisdiction. The requirements and procedures for licensing must be clear, objective and public, and be consistently applied.
- In India, a licensing is required for insurance companies and various intermediaries including Insurance agents, Insurance Brokers, Surveyors and Loss Assessors, Third Party Administrators etc.
- Licensing contributes to efficiency and stability in the insurance sector. Strict conditions governing the formal approval through licensing of insurance legal entities are necessary to protect consumers. The relevant licensing criteria should be applied to prospective entrants consistently to promote a level playing field at point of admission to the insurance sector. Licensing requirements and procedures should not be used inappropriately to prevent or unduly delay access to the market.
- The role of the supervisor in licensing is to assess whether insurance legal entities are able to fulfil their obligations to policyholders on an ongoing basis. The licensing procedure is the first step towards achieving this objective.
- Licensing is distinct from approval granted in terms of general domestic company, trade or commercial law. Apart from applying for a supervisory licence, other requirements pertaining to company, trade or commercial law should be met (e.g. filing incorporation documents or applying to the registrar of commerce).

Licensing requirements

The insurance legislation:

- includes a definition of insurance activities which are subject to licensing;
- prohibits unauthorised insurance activities;
- defines the permissible legal forms of domestic insurance legal entities;
- allocates the responsibility for issuing licences; and
- sets out the procedure and form of establishment by which foreign insurers are allowed to conduct insurance activities within the jurisdiction.

Jurisdictions may decide to exclude some activities from the definition of insurance activities subject to licensing. Any such activities should be explicitly stated in the legislation. Jurisdictions may do this for various reasons, such as:

- the insured sums do not exceed certain amounts;
- losses are compensated by payments in kind;
- activities are pursued following the idea of solidarity between policyholders (e.g., small mutuals, cooperatives and other community-based organisations, especially in the case of microinsurance); or
- the entities' activities are limited to a certain geographical area, limited to a certain number or class of policyholders and/or offer special types of cover such as products not offered by licensed domestic insurance legal entities.

Given the principle that all entities engaged in insurance activities must be licensed, the exclusion of limited insurance activities from licensing requirements should give due regard to having appropriate alternative safeguards in place to protect policyholders.

Similarly, jurisdictions may allow a simplified process for non significant entities (e.g. limited geographic scope, limited size, and limited lines of business) for the purposes of licensing. In such situations, the legislation should state clearly the applicability, requirements and process for such authorization.

In jurisdictions where an authority other than the insurance supervisor is responsible for issuing licenses, the insurance supervisor should be able to give input and recommend conditions or restrictions (including refusal) on a license where appropriate to the licensing authority.

A jurisdiction controls through licensing which entities are allowed to conduct insurance activities within its jurisdiction.

Entities should neither be allowed to present themselves nor act as licensed insurance legal entities without or before having been granted a license.

Depending on the legal forms that are permitted in a jurisdiction, foreign insurers may be allowed to conduct insurance activities within the jurisdiction by way of a local branch or subsidiary or on a cross-border provision of services basis. A subsidiary is a domestically established legal entity that needs to be licensed. A branch is not separate from the insurance legal entity, and can be established in a jurisdiction other than the insurance legal entity's home jurisdiction. A host jurisdiction may require that branches of foreign insurance legal entities be licensed or otherwise authorized by the host supervisor. Cross-border provision of services does not require a local establishment but may require authorization from the host supervisor.

In some regions, a number of jurisdictions have agreed to a system of pass porting as a manner of acknowledging each other's licenses.

This provides the opportunity for insurance legal entities established in one of the jurisdictions to open branches or provide insurance services across borders on the basis of their home jurisdiction authorization to conduct insurance activities. Where a foreign insurer may be allowed to operate through a branch or cross-border provision of services without a license or other authorization from the host supervisor, it is important that bilateral or multilateral agreements are in place which ensure that the insurer:

- is subject to supervision in its home jurisdiction which has been recognised as adequate by the host jurisdiction; and
- may be subject to sanction or other supervisory measures if it does not meet the legal provisions of the host jurisdiction. In such circumstances, the home supervisor should be informed.

Licensing requirements and procedures are clear, objective and public, and are consistently applied. At a minimum, the applicant is required to:

- have sound business and financial plans;
- have a corporate or group structure that does not hinder effective supervision;
- establish that the applicant's Board Members, both individually and collectively, Senior Management, Key Persons in Control Functions and Significant Owners are suitable;
- have an appropriate governance framework; and
- satisfy capital requirements.

In addition to being publicly available, licensing requirements should also be easily accessible. Supervisors should issue guidelines on how to file an application for a license, which include advice on the required format of documents and the expected time it would take to process an application upon the receipt of all relevant documents.

Supervisors should assess the applicant's business and financial plans to ascertain that the proposed business lines will be soundly managed and adequately capitalized. Business and financial plans should be projected for a minimum of three years by the applicant and include information such as the products to be offered, distribution methods and channels to be used, risk profile, projected setting-up and development costs by business line, capital requirements and solvency margins. Information regarding primary insurance and reinsurance should also be provided.

Where the applicant is part of a group, the applicant should submit its corporate and group structure, indicating all of the material entities within the group (including both insurance legal entities and other entities, including non-regulated entities). Information on the type of related party transactions and/or relationships between all material entities within the group should also be provided.

The applicant should also provide information to demonstrate the appropriateness of its systems of risk management and internal controls, including contracts with affiliates, outsourcing arrangements, information technology systems, policies and procedures.

If applying to be licensed to underwrite both life insurance business and non-life insurance business (where such is allowed), the applicant should demonstrate to the satisfaction of the supervisor that its systems of risk management and internal controls are adequate to manage the risks separately for each business stream on both a going concern and a gone concern basis.

Requirements on the supervisor

The supervisor assesses applications, makes decisions and informs applicants of the decision within a reasonable time, which is clearly specified, and without undue delay.

The supervisor should require an entity to submit an application if it proposes to conduct insurance activities. The application should include information on the types of business to be written and contain all the documents and information required by the legislation to confirm that the licensing requirements are met.

In instances where the application is deemed not complete, the supervisor should inform the applicant without delay, and the applicant should be given the opportunity to provide additional information to complete the application.

In assessing the application, the supervisor could rely on audits by external bodies, actuarial reports, or in the case of branches or foreign subsidiaries on the opinion of other supervisors. Supervisors should consider the reports or opinions from these various sources carefully and apply their own judgment in making the final decision on the application. Before placing reliance on reports from external auditors or actuaries, supervisors should consider:

- whether the external auditors and actuaries have the necessary expertise and experience to perform the roles; and
- their independence from the entity and the consideration they give to the protection of policyholders' interests.

The supervisor should make its assessment and finalise its decision within a reasonable timeframe and without undue delay. A time period should be indicated to the applicant for the assessment procedure, commencing from the date on which all complete application documentation has been submitted to the supervisor. Within this period, the supervisor should decide on the acceptability of the application for a licence. However, this does not preclude the supervisor from conducting additional due diligence if necessary. If the supervisor has not come to a decision within the indicated timeframe and the licence cannot be granted, the supervisor should communicate the reason for the delay to the applicant.

The supervisor refuses to issue a licence where the applicant does not meet the licensing requirements. Where the supervisor issues a licence, it imposes additional requirements, conditions or restrictions on an applicant where appropriate. If the licence is denied, conditional or restricted, the applicant is provided with an explanation.

In general, requirements, conditions or restrictions that are imposed on an applicant at the point of issue of the licence deal with the scope of activities that an insurance legal entity is permitted to conduct or the nature of its customers (e.g. retail versus sophisticated customers). If necessary, the supervisor should impose additional requirements, conditions or restrictions on an applicant not only at the point of issue of the licence, but also as part of its on-going supervision of the insurance legal entity.

The denial of a licence or conditions or restrictions on a licence should be confirmed in writing to the applicant. The explanation should be provided to the applicant in a transparent manner. Supervisors should convey their concerns with regard to an applicant's proposed insurance activities and explain the reasons for imposing licensing conditions or restrictions.

A licence clearly states its scope.

- A licence should clearly state the classification of insurance activities that the insurance legal entity is licensed to conduct. Regarding classification, legislation should categorise insurance business into types and classes of insurance (at least into life and non-life).
- Before adding new classes of insurance to the list of classes already granted to the insurance legal entity, the supervisor should consider all of the above mentioned licensing requirements, as applicable.

The supervisor publishes a complete list of licensed insurance legal entities and the scope of the licences granted.

- The supervisor should publish the complete list of licensed insurance legal entities and clearly state the scope of licence that has been granted to each insurance legal entity. This would provide clarity to the public as to which entities are licensed for specific classes of business.
- If the conditions or restrictions to the license would impact the public or any person dealing with the

insurance legal entity, the supervisor should either publish these conditions or restrictions or require the insurance legal entity to disclose these conditions or restrictions accordingly. Conditions or restrictions that would impact the public could include, for example, the lines or classes of insurance business an insurance legal entity is permitted to conduct.

Foreign operations

- In deciding whether and if so on what basis, to license or continue to license a branch or subsidiary of a foreign insurer in its jurisdiction, the supervisor consults the relevant supervisor(s) as necessary.
- As part of the consultation, supervisors should use the modes available for supervisory cooperation, in particular, the ability to exchange information relevant for the application (e.g. check of suitability of directors and owners) with domestic or foreign authorities. The exchange of information may be governed by law, agreement or memorandum of understanding, especially if the information is deemed confidential. Having such arrangements in place is important so as to not unduly delay the processing of an application.
- Before making a decision to grant the licence, the host supervisor should have an understanding of how the home supervisor and/or the group-wide supervisor supervise the insurer on an ongoing basis.
- Host supervisors should consult home supervisors on relevant aspects of any licensing proposal, but in any event they should always consider checking that the home supervisor of the insurance legal entity has no objection before granting a licence. The home supervisor and/or the group wide supervisor should assess the risks posed to the insurer of establishing an insurance legal entity in a foreign jurisdiction and highlight any material reservations or concerns to the host supervisor as soon as practicable. The host supervisor should inform the home supervisor of the scope of the licence, including any restrictions or prohibitions imposed on the licence.
- Host supervisors should reject applications for a licence from foreign entities which are not subject to regulation and supervision in the home jurisdiction. In the case of joint ventures, if there is lack of clear parental responsibility, the supervisor should reject such applications.

Where an insurance legal entity is seeking to conduct cross-border insurance activities without a physical presence in the jurisdiction of the host supervisor, the host supervisor concerned consults the home supervisor, as necessary, before allowing such activities.

- Jurisdictions or regions may have a system or cooperation agreements in place whereby such consultation is not necessary or required. Information exchanged as part of a consultation should include:

confirmation from the home supervisor that the insurance legal entity is authorised to conduct the proposed types of insurance activities; and

- confirmation from the home supervisor that the insurance legal entity meets all the insurance regulatory requirements in the home jurisdiction.

(5) ICP 5 Suitability of Persons

Suitability requirements may extend to other individuals (e.g.financial controllers and treasurers) to account for the roles of such individuals that may differ depending on the jurisdiction and the legal form and governance structure of the insurer.

The supervisor requires Board Members, Senior Management, Key Persons in Control Functions and

Significant Owners of an insurer to be and remain suitable to fulfill their respective roles. Financial soundness, competence and integrity are the important criteria as to fulfill their roles.

Suitability requirements for Board Members, Senior Management and Key Persons in Control Functions:

1. Competence is demonstrated generally through the level of an individual's professional or formal qualifications and knowledge,skills and pertinent experience within the insurance and financial industries or other businesses. Competence also includes having the appropriate level of commitment to perform the role.
2. Integrity is demonstrated generally through character, personal behaviour and business conduct.
3. The supervisor should require the insurer to take the necessary measures to ensure that these requirements are met by setting high internal standards of ethics and integrity, promoting sound corporate governance and requiring that these individuals have pertinent experience, and maintain a sufficient degree of knowledge and decision making ability.
4. To ensure an appropriate level of suitability, Board Members, Senior Management and Key Persons in Control Functions should acquire,maintain and enhance their knowledge and skills to fulfil their roles, for example, by participating in induction and ongoing training on relevant issues. Sufficient time, budget and other resources should be dedicated for this purpose, including external expertise drawn upon as needed. More extensive efforts should be made to train those with more limited financial, regulatory or risk-related experience.

Suitability requirements for Significant Owner:

At a minimum, the necessary qualities of a Significant Owner relate to:

- Financial soundness demonstrated by sources of financing/funding and future access to capital;;
- the integrity demonstrated in personal behavior and in business conduct. .

The supervisor requires the insurer to demonstrate initially and on an ongoing basis, the suitability of Board Members, Senior Management, Key Persons in Control Functions and Significant Owners. The suitability requirements and the extent of review required by the supervisor depend on the person's role.

The supervisor should assess the suitability of Board Members, Senior Management, Key Persons in Control Functions and Significant Owners of an insurance legal entity as part of the licensing procedure before the insurance legal entity is permitted to operate.

The supervisor should assess the suitability of Board Members, Senior Management, Key Persons in Control Functions and Significant Owners of insurers either prior to changes in the positions or as soon as possible after appointment. The supervisor should also require the insurer to perform internal suitability assessments of Board Members, Senior Management and Key Persons in Control Functions on an ongoing basis, for example on an annual basis or when there are changes in the circumstances of the individuals. The supervisor may require the insurer to certify that it has conducted such assessments and demonstrate how it reached its conclusions.

With regard to Control Functions, the individual(s) to be assessed should be the Key Persons in Control Functions.

The supervisor should have sufficient and appropriate information to assess whether an individual meets suitability requirements. The information to be collected and the supervisor's assessment of such information may differ depending on the role.

For the purpose of the assessment, the supervisor should require the submission of a résumé or similar indicating the professional qualifications as well as previous and current positions and experience of the individual and any information necessary to assist in the assessment, such as:

- evidence that the individual has sufficient relevant knowledge and pertinent experience within the insurance and financial industries or other businesses; and
- evidence that the individual has the appropriate level of commitment to perform the role.

The application of suitability requirements relating to competence for Board Members, Senior Management and Key Persons in Control Functions of an insurer may vary depending on the degree of their influence and on their roles. It is recognised that an individual considered competent for a particular position within an insurer may not be considered competent for another position with different responsibilities or for a similar position within another insurer. When assessing the competence of the Board Members, regard should be given to respective duties allocated to individual members to ensure appropriate diversity of qualities and to the effective functioning of the Board as a whole.

In assessing the integrity of an individual Board Member, Senior Management, Key Person in Control Functions and Significant Owner, the supervisor should consider a variety of indicators such as:

- Legal indicators: These provide information on possible legal misconduct. Such indicators could include civil liability, criminal convictions or pending proceedings:
  - for breaches of law designed to protect members of the public from financial loss, e.g. dishonesty, or misappropriation of assets, embezzlement and other fraud or other criminal offences (including anti-money laundering and the combating of the financing of terrorism.
  - against the individual in his/her personal capacity;
  - against an entity in which the individual is or was a Board Member, a member of the Senior Management, a Key Person in Control Functions or a Significant Owner; or
  - incurred by the individual as a consequence of unpaid debts.
- Financial indicators: These provide information on possible financial misconduct, improper conduct in financial accounting, or negligence in decision-making. Such indicators could include:
  - financial problems or bankruptcy in his/her private capacity; or
  - financial problems, bankruptcy or insolvency proceedings of an entity in which the individual is or was a Board Member, a member of the Senior Management or a Key Person in Control Functions.
- Supervisory indicators: These provide information gathered by or that comes to the attention of supervisors in the performance of their supervisory duties. These supervisors could also be authorities with supervisory responsibility in sectors other than insurance. Such indicators could include:
  - the withholding of information from public authorities or submission of incorrect financial or other statements;
  - conduct of business transgressions;
  - prior refusal of regulatory approval for key positions;
  - preventive or corrective measures imposed (or pending) on entities in which the individual is or was a Board Member, a member of the Senior Management, or a Key Person in Control

Functions; or

- outcome of previous assessments of suitability of an individual, or sanctions or disciplinary actions taken (or pending) against that individual by another supervisor.

- Other indicators: These may provide other information that could reasonably be considered material for the assessment of the suitability of an individual. Examples include:
  - suspension, dismissal or disqualification of the individual from a position as a Board Member or a member of the Senior Management of any company or organisation;
  - disputes with previous employers concerning incorrect fulfilment of responsibilities or noncompliance with internal policies, including code of conduct, employment law or contract law;
  - disciplinary action or measures taken against an individual by a professional organisation in which the individual is or was a member (e.g., actuaries, accountants or lawyers); or
  - strength of character, such as the ability and willingness to challenge, as an indicator of a person's integrity as well as competence to perform the respective role.

The presence of any one indicator may, but need not in and of itself, determine a person's suitability. All relevant indicators, such as the pattern of behaviour, should be considered in a suitability assessment. Consideration should also be taken to the lapse of time since a particular indicator occurred and its severity, as well as the person's subsequent conduct.

For Significant Owners, the supervisor sets out minimum standards of financial soundness. If the Significant Owner that is to be assessed is a legal person or a corporate entity, the supervisor should collect sufficient and appropriate information such as:

- the nature and scope of its business;
- its ownership structure, where relevant;
- its source of finance/funding and future access to capital;
- the group structure, if applicable, and organisation chart; and
- other relevant factors.

In determining the financial soundness of Significant Owners, the supervisor should assess their source of financing/funding and future access to capital. To do so, the supervisor may consider financial indicators such as:

- Financial statements and exhibits. If the Significant Owner is a legal person, financial statements may include annual financial statements; for a natural person, it may include financial information (such as tax accounts or personal wealth statements) that are reviewed by an independent public accountant; and
- Transactions and agreements such as: loans; investments; purchase, sale or exchange of securities or other assets; dividends and other distributions to shareholders; management agreements and service contracts; and tax allocation agreements.

Additionally the supervisor should also consider matters such as, but not limited to, whether:

- Significant Owners understand their role as potential future sources of capital, if needed;
- there are any indicators that Significant Owners will not be able to meet their debts as they fall due;

- appropriate prudential solvency requirements are met if the
- Significant Owner is a financial institution;
- Significant Owners have been subject to any legally valid judgment, debt or order that remains outstanding or has not been satisfied within a reasonable period;
- Significant Owners have made arrangements with creditors, filed for bankruptcy or been adjudged bankrupt or had assets sequestered; and
- Significant Owners have been able to provide the supervisor with a satisfactory credit reference.

The presence of any one indicator may, but need not in and of itself, determine a person's suitability. All relevant indicators, such as the pattern of behaviour, should be considered in a suitability assessment. If the Significant Owner is regulated by another supervisor, the suitability assessment done by the latter may be relied upon to the extent that this assessment reasonably meets the requirements of this standard.

The supervisor requires notification by insurers of any changes in Board Members, Senior Management, Key persons in Control Functions and Significant Owners, and of any circumstances that may materially adversely affect the suitability of its Board Members, Senior Management, Key Persons in Control Functions and Significant Owners.

Insurers should be required to report promptly any information gained about these persons that may materially affect their suitability, for example, if a Board Member is convicted of a financial crime.

The supervisor takes appropriate action to rectify the situation when Board Members, Senior Management and Key Persons in Control Functions or Significant Owners no longer meet suitability requirements.

The supervisor should impose measures in respect of Board Members, Senior Management and Key Persons in Control Functions who do not meet the suitability requirements. Examples of such measures include:

- requesting the insurer to provide additional education, coaching or the use of external resources in order to achieve compliance with suitability requirements by an individual in a position as Board Member, member of the Senior Management or Key Person in Control Functions;
- preventing, delaying or revoking appointment of an individual in a position as Board Member, member of the Senior Management or Key Person in Control Functions;
- suspending, dismissing or disqualifying an individual in a position as a Board Member, Senior Management or Key
- Person in Control Function, either directly or by ordering the insurer to take these measures;
- requiring the insurer to appoint a different person for the position in question who does meet the suitability requirements, to reinforce the sound and proper management and control of the insurer;
- imposing additional reporting requirements and increasing solvency monitoring activities; or
- withdrawing or imposing conditions on the business licence, especially in the case of a major breach of suitability requirements, taking into account the impact of the breach or the number of members of the Board,Senior Management or Key Persons in Control Functions involved.

The supervisor should impose measures of a preventive and corrective nature in respect of Significant Owners who do not meetsuitability requirements. Examples of such measures include:

- requiring the Significant Owners to dispose of their interests in the insurer within a prescribed period of time;

- the suspension of the exercise of their corresponding voting rights; or
- the nullification or annulment of any votes cast by the Significant Owners.

There can be circumstances where a Board Member, a member of the Senior Management or a Key Person in Control Functions is unable to carry out his/her role and a replacement needs to be appointed on short notice. In jurisdictions where the supervisor approves the post-licensing appointment of Board Members, Senior Management or Key Persons in Control Functions, it may be appropriate for the supervisor to permit the post to be filled temporarily until the successor's suitability assessment is affirmed. In such circumstances, a supervisor may require that these temporary replacements meet certain suitability requirements, depending on his/her position or responsibilities within the insurer. However, such assessment should be conducted and concluded in a timely manner.

The supervisor exchanges information with other authorities inside and outside its jurisdiction where necessary to check the suitability of Board Members, Senior Management, Key Persons in Control Functions and Significant Owners of an insurer.

(6) ICP 6 - Changes in control and Portfolio Transfers

Supervisory approval is required for proposals to acquire significant ownership or an interest in an insurer that results in that person (legal or natural), directly or indirectly, alone or with an associate, exercising control over the insurer. The same applies to portfolio transfers or mergers of insurers.

The term "control" over an insurer is defined in legislation and it addresses, at a minimum:

- holding of a defined number or percentage of issued shares or financial instruments above a designated threshold in an insurer or its intermediate or ultimate beneficial owner.
- voting rights attached to the aforementioned shares or financial instruments
- power to appoint directors to the Board and other executive committees or remove them.

The supervisor requires the insurer to provide notification of any proposed acquisitions or changes in control of the insurer. The supervisor grants or denies approval to person(s) that want(s) to acquire significant ownership or a controlling interest in an insurer, whether directly or indirectly, alone or with an associate. They also approve any significant increase above the predetermined control levels.

The supervisor requires insurers to provide appropriate information on their shareholders and any other person directly or indirectly exercising control.

To assess applications for proposed acquisitions or changes in control of insurers the supervisor establishes requirements for financial and non-financial resources.

A change of a mutual company to a stock company, or vice versa, is subject to the supervisor's approval. The supervisor satisfies itself with the new constitution or governing organisational document of the company before giving approval.

Portfolio Transfer

The transfer of all or part of an insurer's business is subject to approval by the supervisor. The financial position of the transferee and the transferor is considered. Interests of the policyholders of both the transferee and transferor will be protected.

(7) ICP 7 Corporate Governance

The corporate governance framework of an insurer:

- promotes the development, implementation and effective oversight of policies that clearly define and support the objectives of the insurer;
- defines the roles and responsibilities of persons accountable for the management and oversight of an insurer by clarifying who possesses legal duties and powers to act on behalf of the insurer and under which circumstances;
- sets requirements relating to how decisions and actions are taken including documentation of significant or material decisions, along with their rationale;
- provides sound remuneration practices which promote the alignment of remuneration policies with the long term interests of insurers to avoid excessive risk taking;
- provides for communicating with the supervisor, as appropriate, matters relating to the management and oversight of the insurer; and
- provides for corrective actions to be taken for non-compliance or weak oversight, controls or management.
- An effective corporate governance framework enables an insurer to be flexible and transparent; to be responsive to developments affecting its operations in making timely decisions and to ensure that powers are not unduly concentrated. The corporate governance framework supports and enhances the ability of the key players responsible for an insurer's corporate governance; i.e. the Board, Senior Management and Key Persons in Control functions to manage the insurer's business soundly and prudently.

Organisational structures

The insurer should establish a transparent organisational structure which supports the strategic objectives and operations of the insurer. The board and senior management should know and understand the structure and the risks that it poses. The ways in which an insurer chooses to organise and structure itself can vary depending on a number of factors such as:

- jurisdictional corporate law, which may allow or require different board structures (such as one-tier or two-tier Boards);
- organisational structure such as stock companies, mutuals or co-operatives; and
- group, branches, or solo legal entity operations.

Mutuals and co-operatives

Governance of insurers formed as mutuals or co-operatives is different from that of insurers formed as joint stock companies (i.e.,bodies corporate). These standards are nevertheless sufficiently flexible to be adapted to mutuals and co-operatives to promote the alignment of actions and interests of the Board and Senior Management with the broader interests of policyholders. Where there are references to shareholders or stakeholders, they should be generally treated as references to policyholders in mutuals, unless otherwise indicated.

Insurance Groups

Insurance groups should ensure that the corporate governance framework is appropriate to the structure, business and risks of the insurance group and its legal entities. The corporate governance framework should

include policies, processes and controls which address risks across the insurance group and legal entities.

When setting up or evaluating their corporate governance framework, insurance groups should be aware of the specific challenges which might arise from the organisational model adopted by a group (e.g. centralised or decentralised model).

Branch operations

If an insurer is a branch, these standards would generally apply to the legal entity in its home jurisdiction. However, the host supervisor may require designated oversight and/or management accountabilities and structures to be maintained at the branch, including in some cases a designated representative responsible for the management of the branch. In such cases, these standards should also apply, as appropriate, to the oversight and management roles maintained within the branch taking due account of the governance structures and arrangements as determined by the host supervisor.

Appropriate allocation of oversight and management responsibilities

The supervisor requires the insurer's Board to:

- ensure that the roles and responsibilities allocated to the Board, Senior Management and Key Persons in Control Functions are clearly defined so as to promote an appropriate separation of the oversight function from the management responsibilities; and
- provide oversight of the Senior Management.

Corporate culture, business objectives and strategies of the insurer

The supervisor requires the insurer's Board to set and oversee the implementation of the insurer's corporate culture, business objectives and strategies for achieving those objectives, in line with the insurer's long term interests and viability.

Structure and governance of the Board

The supervisor requires the insurer's Board to have, on an on-going basis:

- an appropriate number and mix of individuals to ensure that there is an overall adequate level of competence at the Board level commensurate with the governance structure;
- appropriate internal governance practices and procedures to support the work of the Board in a manner that promotes the efficient, objective and independent judgment and decision making by the Board;
- adequate powers and resources to be able to discharge its duties fully and effectively.

Duties of individual Board members

The supervisor requires that an individual member of the Board:

- act in good faith, honestly and reasonably;
- exercise due care and diligence;
- act in the best interests of the insurer and policyholders, putting those interests ahead of his/her own interests;
- exercise independent judgment and objectivity in his/her decision making, taking due account of the interests of the insurer and policyholders; and

- not use his/her position to gain undue personal advantage or cause any detriment to the insurer.

Duties related to risk management and internal controls

The supervisor requires the insurer's Board to provide oversight in respect of the design and implementation of risk management and internal controls.

It is the Board's responsibility to ensure that the insurer has appropriate systems and functions for risk management and internal controls and to provide oversight to ensure that these systems and the functions that oversee them are operating effectively and as intended.

Duties related to remuneration

The supervisor requires the insurer's Board to:

- adopt and oversee the effective implementation of a written remuneration policy for the insurer, which does not induce excessive or inappropriate risk taking, is in line with the corporate culture, objectives, strategies, identified risk appetite, and long term interests of the insurer, and has proper regard to the interests of its policyholders and other stakeholders; and
- ensure that such a remuneration policy, at a minimum, covers those individuals who are members of the Board, Senior Management, Key Persons in Control Functions and other employees whose actions may have a material impact on the risk exposure of the insurer (major risk–taking staff).

Reliable and transparent financial reporting

The supervisor requires the insurer's Board to ensure there is a reliable financial reporting process for both public and supervisory purposes that is supported by clearly defined roles and responsibilities of the Board, Senior Management and the external auditor**.** The Board is responsible for overseeing the insurer's systems and controls to ensure that the financial reports of the insurer present a balanced and accurate assessment of the insurer's business and its general financial health and viability as a going concern.

The Board carries out functions including:

- overseeing the financial statements, financial reporting and disclosure processes;
- monitoring whether accounting policies and practices of the insurer are operating as intended;
- overseeing the internal audit process (reviews by internal audit of the insurer's financial reporting controls) and
- reviewing the internal auditor's plans and material findings;
- reporting to the supervisor on significant issues concerning the financial reporting process, including actions taken to address or mitigate identified financial reporting risks.

External Audit

The supervisor requires the insurer's Board to ensure that there is adequate governance and oversight of the external audit process.

The Board should ensure that the insurer:

- applies robust processes for approving, or recommending for approval, the appointment, reappointment, removal and remuneration of the external auditor;
- applies robust processes for monitoring and assessing the independence of the external auditor and to ensure that the appointed external auditor has the necessary knowledge, skills, expertise, integrity

and resources to conduct the audit and meet any additional regulatory requirements;

- monitors and assesses the effectiveness of the external audit process throughout the audit cycle;
- investigates circumstances relating to the resignation or removal of an external auditor, and ensuring prompt actions are taken to mitigate any identified risks to the integrity of the financial reporting process, and
- reports to the supervisor on circumstances relating to the resignation or removal of the external auditor.

Communications

The supervisor requires the insurer's Board to have systems and controls to ensure appropriate, timely and effective communications with the supervisor on the governance of the insurer.

Communications with the supervisor should promote effective engagement of the supervisor on the governance of the insurer to enable informed judgments about the effectiveness of the Board and Senior Management in governing the insurer. Subject to any reasonable commercial sensitivities and applicable privacy or confidentiality obligations, the insurer's communication policies and strategies should include providing to the insurer's stakeholders information such as the following:

- the insurer's overall strategic objectives, covering existing or prospective lines of business and how they are being or will be achieved;
- the insurer's governance structures, such as allocation of oversight and management responsibilities between the Board and the Senior Management, and organizational structures, including reporting lines;
- members of the Board and any Board committees, including their respective expertise, qualifications, track-record, other positions held by such members, and whether such members are regarded as independent;
- processes in place for the Board to evaluate its own performance and any measures taken to improve the Board's performance;
- the general design, implementation and operation of the remuneration policy;
- major ownership and group structures, and any significant affiliations and alliances; and
- material related-party transactions.

Duties of Senior Management

The supervisor requires the insurer to ensure that Senior Management:

- carries out the day-to-day operations of the insurer effectively and in accordance with the insurer's corporate culture, business objectives and strategies for achieving those objectives in line with the Insurer's long term interests and viability;
- promotes sound risk management, compliance and fair treatment of customers;
- provides the Board adequate and timely information to enable the Board to carry out its duties and functions including the monitoring and review of the performance and risk exposures of the insurer, and the performance of Senior Management; and
- maintains adequate and orderly records of the internal organisation.

Supervisory review

The supervisor requires the insurer to demonstrate the adequacy and effectiveness of its corporate governance framework. The supervisor plays an important role by requiring the Board and Senior Management of the insurer to demonstrate that they are meeting the applicable corporate governance requirements, consistent with these standards, on an on-going basis. The onus for demonstrating, to the satisfaction of the supervisor, that the corporate governance framework is effective and operates as intended rests with the insurer.

The Supervisor should assess through its supervisory review and reporting processes whether the insurer's overall corporate governance framework is effectively implemented and remains adequate.

To help facilitate the supervisory review and reporting processes, the supervisor should establish effective channels of communication with the insurer, and have access to relevant information concerning the governance of the insurer. This may be obtained through periodic reports to the supervisor and any information obtained on an ad-hoc basis . Communication may also be facilitated by the supervisor having regular interaction with the Board, Senior Management and Key Persons in Control Functions.

The supervisor should assess the governance effectiveness of the Board and Senior Management and determine the extent to which their actions and behaviors contribute to good governance. This includes the extent to which the Board and Senior Management contribute to setting and following the "tone at the top;" how the corporate culture of the insurer is communicated and put into practice; how information flows to and from the Board and Senior Management; and how potential material problems are identified and addressed throughout the insurer. To ascertain the on-going effectiveness of the Board and Senior Management, the supervisor may also consider the use of measures such as the following, where appropriate:

- on-going mandatory training that is commensurate with their respective duties, roles and responsibilities of the Board and Senior Management within the insurer;
- a review of the periodic self-evaluation undertaken by the Board
- meetings and/or interviews with the Board and Senior Management, both collectively and individually as appropriate, particularly to reinforce expectations relating to their performance and to get a sense of how informed and proactive they are; and
- attending and observing Board proceedings.

(8) ICP 8 Risk Management and Internal Controls

As part of the overall corporate governance framework and in furtherance of the safe and sound operation of the insurer and the protection of policyholders, the Board is ultimately responsible for ensuring that the insurer has in place effective systems of risk management and internal controls and functions to address the key risks it faces and for the key legal and regulatory obligations that apply to it. Senior Management effectively implements these systems and provides the necessary resources and support for these functions.

In some jurisdictions, risk management is considered a subset of internal controls, while other jurisdictions would see it the other way around. The two systems are in fact closely related. Where the boundary lies between risk management and internal controls is less important than achieving, in practice, the objectives of each.

The systems and functions should be adequate for the insurer's objectives, strategy, risk profile, and the applicable legal and regulatory requirements. They should be adapted as the insurer's business and internal and external circumstances change.

The nature of the systems that the insurer has is dependent on many factors. The systems typically include:

- strategies setting out the approach of the insurer for dealing with specific areas of risk and legal and regulatory obligation;
- policies defining the procedures and other requirements that members of the Board and employees need to follow;
- processes for the implementation of the insurer's strategies and policies;
- and controls to ensure that such strategies, policies and processes are in fact in place, are being observed and are attaining their intended objectives.

An insurer's functions (whether in the form of a person, unit or department) should be properly authorized to carry out specific activities relating to matters such as risk management, compliance, actuarial matters and internal audit. These are generally referred to as control functions.

Special considerations for groups

Group wide risks may affect insurance legal entities within a group, while risks at the insurance legal entity level could also affect the group as a whole. To help address this, groups should have strong risk management and compliance culture across the group and at the insurance legal entity level. Thus, in addition to meeting group governance requirements, the group should take into account the obligations of its insurance legal entities to comply with local laws and regulations.

Additionally, a group's governance approach will also affect the way in which its control functions are organised and operated. Coordination between the insurance legal entity and group control functions is important to help ensure overall effective systems of risk management and internal controls. Regardless of how the group control functions are organised and operated, the result should provide an overall view of the group-wide risks and how they should be managed.

Supervisors should require the establishment of comprehensive and consistent group governance and assess its effectiveness. While the group-wide supervisor is responsible for assessing the effectiveness of the group's systems of risk management and internal controls, the other involved supervisors undertake such assessments on a legal entity basis. Appropriate supervisory cooperation and coordination is necessary to have a group-wide view and to enhance the assessment of the legal entities.

Systems for risk management and internal controls

1. The supervisor requires the insurer to establish, and operate within, an effective risk management system.

Basic components of a risk management system

(i) The risk management system is designed and operated at all levels of the insurer to allow for the identification, assessment, monitoring, mitigation and reporting of all risks of the insurer in a timely manner. It takes into account the probability, potential impact and time horizon of risks.

(ii) An effective risk management system typically includes elements such as:

- a clearly defined and well documented risk management strategy, which includes a clearly defined risk appetite and takes into account the insurer's overall business strategy and its business activities (including any business activities which have been outsourced);
- relevant objectives, key principles and proper allocation of responsibilities for dealing with risk across the business areas and business units of the insurer

- a documented process defining the Board approval required for any deviations from the risk management strategy or the risk appetite and for settling any major interpretation issues that may arise;
- appropriate documented policies that include a definition and categorisation of material risks (by type) to which the insurer is exposed, and the levels of acceptable risk limits for each type of these risk. These policies describe the risk standards and the specific obligations of employees and the businesses in dealing with risk, including risk escalation and risk mitigation tools;
- suitable processes and tools (including stress testing and, where appropriate, models) for identifying, assessing, monitoring and reporting on risks. Such processes should also cover contingency planning;
- regular reviews of the risk management system (and its components) to help ensure that necessary modifications and improvements are identified and made in a timely manner;
- appropriate attention to other matters set out in ICP (16 Enterprise Risk Management for Solvency Purposes);
- an effective risk management function.

Scope and embedding of the risk management system

The risk management system should at least cover underwriting and reserving, asset-liability management, investments, liquidity and concentration risk management, operational risk management, conduct of business, and reinsurance and other risk-mitigation techniques.

The risk management system should be aligned with the insurer's risk culture and embedded into the various business areas and units with the aim of having the appropriate risk management practices and procedures embedded in the key operations and structures.

Identification

The risk management system should take into account all reasonably foreseeable and relevant material risks to which the insurer is exposed, both at the insurer and the individual business unit levels. This includes current and emerging risks.Significant new or changed activities and products that may increase an existing risk or create a new type of exposure should be subject to appropriate risk review and be approved by the Board and Senior Management.

Assessment

Insurers should assess material risks both qualitatively and, where appropriate, quantitatively. Appropriate consideration should be given to a sufficiently wide range of outcomes, as well as to the appropriate tools and techniques to be used. The interdependencies of risks should also be analysed and taken into account in the assessments.

Monitoring

The risk management system should include early warnings or triggers that allows timely consideration of, and adequate response to, material risks. An insurer may decide to tolerate a risk, when it is acceptable within the risk appetite that has been set.

Mitigation

The risk management system should include strategies and tools to mitigate against material risks. In most

cases an insurer will control or reduce the risk to an acceptable level. Another response to risk is to transfer the risk to a third party. If risks are not acceptable within the risk appetite and it is not possible to control, limit or transfer the risk, the insurer should cease or change the activity which creates the risk.

Reporting

Risks, the overall assessment of risks and the related action plans should be reported to the Board and/or to Senior Management, as appropriate, using qualitative and quantitative indicators and effective action plans. The insurer's documented risk escalation process should allow for reporting on risk issues within established reporting cycles and outside of them for matters of particular urgency.

The Board should have appropriate ways to carry out its responsibilities for risk oversight. The risk management policy should therefore cover the content, form and frequency of reporting that it expects on risk from Senior Management and each of the control functions. Any proposed activity that would go beyond the Board-approved risk appetite should be subject to appropriate review and require Board approval.

Risk Policies

The insurer's risk policies should be written in a way to help employees understand their risk responsibilities. They should also help explain the relationship of the risk management system to the insurer's overall corporate governance framework and to its corporate culture. The overall risk management policy of the insurer should outline how relevant and material risks are managed. Related policies should be established, either as elements of the risk management policy, or as separate sub-policies. At a minimum, these should include policies related to the risk appetite framework, an asset-liability management policy, an investment policy, and an underwriting risk policy. Regular internal communications and training on risk policies should take place.

Changes to the risk management system

Both the Board and Senior Management should be attentive to the need to modify the risk management system in light of new internal or external circumstances.

Material changes to an insurer's risk management system should be documented and subject to approval by the Board. The reasons for the changes should be documented. Appropriate documentation should be available to internal audit, external audit and the supervisor for their respective assessments of the risk management system.

2. The supervisor requires the insurer to establish, and operate within, an effective system of internal controls.

Basic components of an internal controls system

- The internal controls system should ensure effective and efficient operations, adequate control of risks, prudent conduct of business,reliability of financial and non-financial information reported (both internally and externally), and compliance with laws, regulations, supervisory requirements and the insurer's internal rules and decisions. It should be designed and operated to assist the Board and Senior Management in the fulfilment of their respective responsibilities for oversight and management of the insurer. Some insurers have a designated person or function to support the advancement, coordination and/or management of the overall internal controls system on a more regular basis.
- The internal controls system should cover all units and activities of the insurer and should be an integral part of the daily activities of an insurer. The controls should form a coherent system, which

should be regularly assessed and improved as necessary. Each individual control10 of an insurer, as well as all its controls cumulatively, should be designed for effectiveness and operate effectively.

- An effective internal control system requires an appropriate control structure with control activities defined at every business unit level. Depending on the organisational structure of the insurer, business or other units should own, manage and report on risks and should be primarily accountable for establishing and maintaining effective internal control policies and procedures. Control functions should determine and assess the appropriateness of the controls used by the business or other units. The internal audit function shouldprovide independent assurance on the quality and effectiveness of the internal controls system.

Segregation of duties and prevention of conflicts of interest

- appropriate segregation of duties and controls to ensure such segregation is observed. This includes, amongstothers, having sufficient distance between those accountable for a process or policy and those who check if for such a process or policy an appropriate control exists and is being applied. It also includes appropriate distance between those who design a control or operate a control and those who check if such a control is effective in design and operation;
- up-to-date policies regarding who can sign for or commit the insurer, and for what amounts, with corresponding controls, such as practice that key decisions should be taken at least by two persons and the practice of double or multiple signatures. Such policies and controls should be designed, among other things, to prevent any major transaction being entered into without appropriate governance review or by anyone lacking the necessary authority and to ensure that borrowing, trading, risk and other such limits are strictly observed. Such policies should foresee a role for control functions, for example by requiring for major matters the review and sign-off by Risk Management or Compliance, and/or approval by a Board level committee;

Policies and processes

- appropriate controls for all key business processes and policies, including for major business decisions and transactions (including intra-group transactions), critical IT functionalities, access to critical IT infrastructure by
- employees and related third parties, and important legal and regulatory obligations;
- policies on training in respect of controls, particularly for employees in positions of high trust or responsibility or involved in high risk activities;
- a centralised documented inventory of insurer-wide key processes and policies and of the controls in place in respect of such processes and policies, that also may introduce a hierarchy among the policies;

Information and communication

- appropriate controls to provide reasonable assurance over the accuracy and completeness of the insurer's books, records, and accounts and over financial consolidation and reporting, including the reporting made to the insurer's supervisors;
- adequate and comprehensive internal financial, operational and compliance data, as well as external market information about events and conditions that are relevant to decision making. Information should be reliable, timely, accessible, and provided in a consistent format;
- information processes that cover all significant activities of the insurer, including contingency arrangements;

- effective channels of communication to ensure that all staff fully understand and adhere to the internal controls and their duties and responsibilities and that other relevant information is reaching the appropriate personnel;
- policies regarding escalation procedures;

Monitoring and review

- processes for regularly checking that the totality of all controls forms a coherent system and that this system works as intended; fits properly within the overall corporate governance structure of the insurer; and provides an element of risk control to complement the risk identification, risk assessment, and risk management activities of the insurer. As part of such review, individual controls are monitored and analysed periodically to determine gaps and improvement opportunities with Senior Management taking such measures as are necessary to address these; and
- periodic testing and assessments (carried out by objective parties such as an internal or external auditor) to determine the adequacy, completeness and effectiveness of the internal controls system and its utility to the Board and Senior Management for controlling the operations of the insurer.

Responsibilities of the Board

The Board should have an overall understanding of the control environment across the various entities and businesses, and require Senior Management to ensure that for each key business process and policy, and related risks and obligations, there is an appropriate control.

In addition, the Board should ensure there is clear allocation of responsibilities within the insurer, with appropriate segregation, including in respect of the design, documentation, operation, monitoring and testing of internal controls. Responsibilities should be properly documented, such as in charters, authority tables, governance manuals or other similar governance documents.

To Board should determine which function or functions report to it or to any Board Committees in respect of the internal controls system.

Reporting

Reporting on the internal controls system should cover matters such as:

- the strategy in respect of internal controls (such as responsibilities, target levels of compliance to achieve, validations and implementation of remediation plans);
- the stage of development of the internal controls system, including its scope, testing activity, and the performance against annual or periodic internal controls system goals being pursued;
- an assessment of how the various business units are performing against internal control standards and goals;
- control deficiencies, weaknesses and failures that have arisen or that have been identified (including any identified by the internal or external auditors or the supervisor) and the responses thereto (in each case to the extent not already covered in other reporting made to the Board); and
- controls at the appropriate levels so as to be effective, including at the process or transactional level.

Control functions (general)

The supervisor requires the insurer to have effective control functions with the necessary authority, independence and resources.

As part of the effective systems of risk management and internal controls, insurers have control functions, including for risk management, compliance, actuarial matters and internal audit. Control functions add to the governance checks and balances of the insurer and provide the necessary assurance to the Board in the fulfilment of its oversight duties. The existence of control functions does not relieve the Board or Senior Management of their respective governance and related responsibilities. The control functions should be subject to periodic review either by the internal audit function (for control functions other than internal audit) or an objective external reviewer.

Appointment and dismissal of heads of control functions

The appointment, performance assessment, remuneration, discipline and dismissal of the head of control functions should be done with the approval of, or after consultation with, the Board or the relevant Board committee. For the head of the internal audit function, the appointment, performance assessment, remuneration,

discipline and dismissal should be done by the Board, its Chair or the Audit Committee. The insurer should notify the supervisor of the reasons for dismissals of heads of control functions.

Authority and independence of control functions

The Board should approve the authority and responsibilities of each control function to allow each control function to have the authority and independence necessary to be effective. The authority and responsibilities of each control function should be set out in writing and made part of, or referred to in, the governance documentation of the insurer. The head of each control function should periodically review such document and submit suggestions for any changes to Senior Management and the Board for approval, where appropriate. A control function should be led by a person of appropriate level of authority. The head of the control function should not have operational business line responsibilities. Insurers should organise each control function and its associated reporting lines into the insurer's organisational structure in a manner that enables such function to operate and carry out their roles effectively. This includes direct access to the Board or the relevant Board committee.

Notwithstanding the possibility for insurers to combine certain control functions, a control function should be sufficiently independent from Senior Management and from other functions to allow its staff to:

- serve as a component of the insurer's checks and balances;
- provide an objective perspective on strategies, issues, and potential violations related to their areas of responsibility; and
- implement or oversee the implementation of corrective measures where necessary.

Resources and qualifications of the control functions

Each control function should have the resources necessary to fulfil its responsibilities and achieve the specific goals in its areas of responsibility. This includes qualified staff and appropriate IT/management information processes. The function should be organized in an appropriate manner to achieve its goals.

Persons who perform control functions should be suitable for their role and meet any applicable professional qualifications and standards. Higher expectations apply to the head of each control function. Persons who perform control functions should receive regular training relevant to their role to remain up to date on the developments and techniques related to their areas of responsibility.

Board access and reporting by the control functions

Board assessment of control functions

Risk management function

The supervisor requires the insurer to have an effective risk management function capable of assisting the insurer to

- identify, assess, monitor, mitigate and report on its key risks in a timely way; and
- promote and sustain a sound risk culture.

A robust risk management function that is well positioned, resourced and properly authorised and staffed is an essential element of an effective risk management system. Within some insurers, and particularly at larger or more complex ones, the risk management function is typically led by a Chief Risk Officer.

Access and reporting to the Board by the risk management function

The risk management function should have access and provide written reports to the Board as required by the Board, typically on matters such as:

- an assessment of risk positions and risk exposures and steps being taken to manage them;
- an assessment of changes in the insurer's risk profile relative to risk appetite;
- where appropriate, an assessment of pre-defined risk limits;
- where appropriate, risk management issues resulting from strategic affairs such as corporate strategy, mergers andacquisitions and major projects and investments;
- an assessment of risk events and the identification of appropriate remedial actions.

Main activities of the risk management function

The risk management function should establish, implement and maintain appropriate mechanisms and activities including to:

- assist the Board and Senior Management in carrying out their respective responsibilities, including by providing specialist analyses and performing risk reviews;
- identify the individual and aggregated risks (actual, emerging and potential) the insurer faces;
- assess, aggregate, monitor and help manage and otherwise address identified risks effectively; this includes assessing theinsurer's capacity to absorb risk with due regard to the nature, probability, duration, correlation and potential severity of risks;
- gain and maintain an aggregated view of the risk profile of the insurer both at a legal entity and/or group-wide level;
- establish a forward-looking assessment of the risk profile;
- evaluate the internal and external risk environment on an ongoing basis in order to identify and assess potential risks as early as possible. This may include looking at risks from different perspectives, such as by territory or by line of business;
- consider risks arising from remuneration arrangements and incentive structures;
- conduct regular stress testing and scenario analyses
- regularly provide written reports to Senior Management, Key Persons in Control Functions and the Board on the insurer's risk profile and details on the risk exposures facing the insurer and related

mitigation actions as appropriate;

- document and report material changes affecting the insurer's risk management system to the Board to help ensure that the system is maintained and improved; and
- conduct regular self-assessments and implement or monitor the implementation of any needed improvements.

Compliance function

The supervisor requires the insurer to have an effective compliance function capable of assisting the insurer to:

- meet its legal, regulatory and supervisory obligations; and
- promote and sustain a compliance culture, including through the monitoring of related internal policies.

Compliance Officer.

Board access and reporting of the compliance function

The compliance function should have access and provide written reports to Senior management, key persons in control functions and the Board on matters such as:

- an assessment of the key compliance risks the insurer faces and the steps being taken to address them;
- an assessment of how the various parts of the insurer (e.g. divisions, major business units, product areas) are performing against compliance standards and goals;
- any compliance issues involving management or persons in positions of major responsibility within the insurer, and the status of any associated investigations or other actions being taken;
- material compliance violations or concerns involving any other person or unit of the insurer and the status of any associated investigations or other actions being taken; and
- material fines or other disciplinary actions taken by any regulator or supervisor in respect of the insurer or any employee.

Main activities of the compliance function

The compliance function should establish, implement and maintain appropriate mechanisms and activities including to:

- promote and sustain an ethical corporate culture that values responsible conduct and compliance with internal and external obligations; this includes communicating and holding training on an appropriate code of conduct or similar that incorporates the corporate values of the insurer, aims to promote a high level of professional conduct and sets out the key conduct expectations of employees;
- identify, assess, report on and address key legal and regulatory obligations, including obligations to the insurer's
- supervisor, and the risks associated therewith; such analyses should use risk and other appropriate methodologies;
- ensure the insurer monitors and has appropriate policies, processes and controls in respect of key areas of legal,

- regulatory and ethical obligation;
- hold regular training on key legal and regulatory obligations particularly for employees in positions of high responsibility or who are involved in high risk activities;
- facilitate the confidential reporting by employees of concerns, shortcomings or potential or actual violations in respect of insurer internal policies, legal or regulatory obligations, or ethical considerations; this includes ensuring there are appropriate means for such reporting;
- address compliance shortcomings and violations, including ensuring that adequate disciplinary actions are taken and any necessary reporting to the supervisor or other authorities is made; and
- conduct regular self-assessments of the compliance function and the compliance processes and implement or monitor needed improvements.

Actuarial function

The supervisor requires the insurer to have an effective actuarial function capable of evaluating and providing advice regarding, at a minimum, technical provisions, premium and pricing activities, capital adequacy, reinsurance and compliance with related statutory and regulatory requirements.

Board access and reporting of the actuarial function

The actuarial function should have access to and periodically report to the Board on matters such as:

- any circumstance that may have a material effect on the insurer from an actuarial perspective;
- the adequacy of the technical provisions and other liabilities;
- distribution of profits to participating policyholders;
- stress testing and capital adequacy assessment with regard to the prospective solvency position of the insurer; and
- any other matters as determined by the Board.

Main activities of the actuarial function

The actuarial function evaluates and provides advice to the insurer on matters including:

- the insurer's insurance liabilities, including policy provisions and aggregate claim liabilities, as well as determination of reserves for financial risks;
- asset liability management with regards to the adequacy and the sufficiency of assets and future revenues to cover the insurer's obligations to policyholders and capital requirements, as well as other obligations or activities;
- the insurer's investment policies and the valuation of assets;
- an insurer's solvency position, including a calculation of minimum capital required for regulatory purposes and liability and loss provisions;
- an insurer's prospective solvency position by conducting capital adequacy assessments and stress tests under various scenarios, and measuring their relative impact on assets, liabilities, and actual and future capital levels;
- risk assessment and management policies and controls relevant to actuarial matters or the financial condition of the insurer;
- the fair treatment of policyholders with regard to distribution of profits awarded to participating

policyholders;

- the adequacy and soundness of underwriting policies;
- the development, pricing and assessment of the adequacy of reinsurance arrangements;
- product development and design, including the terms and conditions of insurance contracts and pricing, along with estimation of the capital required to underwrite the product;
- the sufficiency, accuracy and quality of data, the methods and the assumptions used in the calculation of technical provisions;
- the research, development, validation and use of internal models for internal actuarial or financial projections, or for solvency purposes as in the ORSA; and
- any other actuarial or financial matters determined by the Board.

Appointed actuary

Some jurisdictions may require an "appointed actuary," "statutory actuary," or "responsible actuary" (referred to here as an "Appointed Actuary") to perform certain functions, such as determining or providing advice on an insurer's compliance with regulatory requirements for certifications or statements of actuarial opinion. The tasks and responsibilities of the Appointed Actuary should be clearly defined and should not limit or restrict the tasks and responsibilities of other individuals performing actuarial functions. The insurer should be required to report the Appointed Actuary's appointment to the supervisor. The Appointed Actuary should not hold positions within or outside of the insurer that may create conflicts of interest or compromise his or her independence. If the Appointed Actuary is not an employee of the insurer, the Board should determine whether the external actuary has any potential conflicts of interest, such as if his or her firm also provides auditing or other services to the insurer. If any such conflicts exist, the Board should subject them to appropriate controls or choose another Appointed Actuary.

Internal audit function

The supervisor requires the insurer to have an effective internal audit function capable of providing the Board with independent assurance in respect of the quality and effectiveness of the insurer's corporate governance framework.

One of the oversight roles of the Board is to ensure that the information provided by the internal audit function allows the Board to effectively validate the effectiveness of the internal control system.

The internal audit function should provide independent assurance to the Board through general and specific audits, reviews, testing and other techniques in respect of matters such as:

- the overall means by which the insurer preserves its assets and those of policyholders, and seeks to prevent fraud, misappropriation or misapplication of such assets;
- the reliability, integrity and completeness of the accounting, financial and risk reporting information, as well as the capacity and adaptability of IT architecture to provide that information in a timely manner to the Board and Senior management;
- the design and operational effectiveness of the insurer's individual controls in respect of the above matters, as well as of the totality of such controls (the internal controls system);
- other matters as may be requested by the Board, Senior Management, the supervisor or the external auditor; and
- other matters which the internal audit function determines should be reviewed to fulfil its mission, in

accordance with its charter, terms of reference or other documents setting out its authority and responsibilities.

Authority and independence of the internal audit function

To help ensure objectivity, the internal audit function is independent from management and other control functions and is not involved operationally in the business. The internal audit function's ultimate responsibility is to the Board, not management. To help ensure independence and objectivity, the internal audit function should be free from conditions that threaten its ability to carry out its responsibilities in an unbiased manner. In carrying out its tasks, the internal audit function forms its judgments independently. If necessary, the internal audit function should consider the need to supplement its own assessment with third party expertise in order to make objective and independent decisions.

The Board should grant suitable authority to the internal audit function, including the authority to:

- access and review any records or information of the insurer which the internal audit function deems necessary to carry out an audit or other review;
- undertake on the internal audit function's initiative a review of any area or any function consistent with its mission;
- require an appropriate management response to an internal audit report, including the development of a suitable remediation, mitigation or other follow-up plan as needed; and
- decline doing an audit or review, or taking on any other responsibilities requested by management, if the internal audit function believes this is inconsistent with its mission or with the strategy and audit plan approved by the Board. In any such case, the internal audit function should inform the Board or the Audit Committee and seek their guidance.

Board access and reporting of the internal audit function

The head of the internal audit function reports to the Board (or to any member who is not part of the management) or to the Audit Committee if one exists (or its Chair). In its reporting, the internal audit function should cover matters such as:

- the function's annual or other periodic audit plan, detailing the proposed areas of audit focus, and any significant
- modifications to the audit plan;
- any factors that may be adversely affecting the internal audit function's independence, objectivity or effectiveness;
- material findings from audits or reviews conducted; and
- the extent of management's compliance with agreed upon corrective or risk mitigating measures in response to identified control deficiencies, weaknesses or failures, compliance violations or other lapses.

Main activities of the internal audit function

The audit function should carry out such activities as are needed to fulfil its responsibilities. These activities include:

- establishing, implementing and maintaining a risk-based audit plan to examine and evaluate alignment of the insurer's processes with their risk culture;

- monitoring and evaluating the adequacy and effectiveness of the insurer's policies and processes and the documentation and controls in respect of these, on a legal entity and groupwide basis and on an individual subsidiary, business unit, business area, department or other organisational unit basis;
- reviewing levels of compliance by employees, organizational units and third parties with laws, regulations and supervisory requirements, established policies, processes and controls, including those involving reporting;
- evaluating the reliability, integrity and effectiveness of management information processes and the means used to identify, measure, classify and report such information;
- monitoring that identified risks are effectively addressed by the internal control system;
- evaluating the means of safeguarding insurer and policyholder assets and, as appropriate, verifying the existence of such assets and the required level of segregation in respect of insurer and policyholder assets;
- monitoring and evaluating the effectiveness of the insurer's control functions, particularly the risk management and
- compliance function; and
- coordinating with the external auditors and, to the extent requested by the Board and consistent with applicable law, evaluating the quality of performance of the external auditors.

Outsourcing of material activities or functions

The supervisor requires the insurer to retain at least the same degree of oversight of, and accountability for, any outsourced material activity or function (such as a control function) as applies to non-outsourced activities or functions.

Outsourcing, should not materially increase risk to the insurer or materially adversely affect the insurer's ability to manage its risks and meet its legal and regulatory obligations.

(9) ICP 9 Supervisory Review and Reporting

The supervisor takes a risk-based approach to supervision that uses both off-site monitoring and on-site inspections to examine the business of each insurer, evaluate its condition, risk profile and conduct, the quality and effectiveness of its corporate governance and its compliance with relevant legislation and supervisory requirements. The supervisor obtains the necessary information to conduct effective supervision of insurers and evaluate the insurance market.

For example, in India, IRDA conducts regular onsite and offsite inspection of insurance companies as well as other intermediaries within the insurance industry. They check compliance of such regulated entities with reference to the applicable regulations and issue necessary regulatory orders which are aimed at correcting the course of action of such insurance companies.

Supervisory Powers

The supervisor has the necessary legal authority, powers and resources to perform off-site monitoring and conduct on-site inspections of insurers, including monitoring and inspecting services and activities outsourced by the insurer. The supervisor also has the power to require insurers to submit information necessary for supervision.

The supervisor has a documented framework for supervisory review and reporting which takes intoaccount

the nature, scale and complexity of insurers. The framework encompasses a supervisory plan that sets priorities and determines the appropriate depth and level of off-site monitoring and on-site inspection activity.

Framework for supervisory review and reporting

The supervisor has a documented framework for supervisory review and reporting which takes into account the nature, scale and complexity of insurers. The framework encompasses a supervisory plan that sets priorities and determines the appropriate depth and level of off-site monitoring and on-site inspection activity.

The supervisor has a mechanism to check periodically that its supervisory framework pays due attention to the evolving nature, scale and complexity of risks which may be posed by insurers and of risks to which insurers may be exposed.

Supervisory reporting

The Supervisor:

- establishes documented requirements for the submission of regular qualitative and quantitative information on a timely basis from all insurers licensed in its jurisdiction;
- defines the scope, content and frequency of those reports and information;
- requires more frequent and/or more detailed additional information on a timely basis whenever there is a need;
- sets out the relevant principles and norms for supervisory reporting, in particular the accounting standards to be used;
- requires that inaccurate reporting is corrected as soon as possible; and
- requires that an external audit opinion is provided on annual financial statements.

In particular, the supervisor requires insurers to report:

- off-balance sheet exposures;
- material outsourced functions and activities; and
- any significant changes to their corporate governance.

The supervisor also requires insurers to promptly report any material changes or incidents that could affect their condition or customers.

The supervisor periodically reviews its reporting requirements to ascertain that they still serve their intended objectives and to identify any gaps which need to be filled. The supervisor sets any additional requirements that it considers necessary for certain insurers based on their nature, scale and complexity.

Off-site monitoring

The supervisor monitors and supervises insurers on an on-going basis, based on regular communication with the insurer, information obtained through supervisory reporting and analysis of market and other relevant information.

On-site inspectiontion

The supervisor sets the objective and scope for on-site inspections, develops corresponding work programmes and conducts such inspections

Supervisory feedback and follow-up

The supervisor discusses with the insurer any relevant findings of the supervisory review and the need for any preventive or corrective action. The supervisor follows up to check that required actions have been taken by the insurer.

(10) ICP 10 Preventive and Corrective Measures

The supervisor takes preventive and corrective measures that are timely, suitable and necessary to achieve the objectives of insurance supervision.

The supervisor has the power to take action against individuals or entities that conduct insurance activities without the necessary licence.

The supervisor has sufficient authority and ability, including the availability of adequate instruments, to take timely preventive and corrective measures if the insurer fails to operate in a manner that is consistent with sound business practices or regulatory requirements. There is a range of actions or remedial measures which include allowing for early intervention when necessary. Preventive and corrective measures are applied commensurate with the severity of the insurer's problems.

There is a progressive escalation in actions or remedial measures that can be taken if the problems become worse or the insurer ignores requests from the supervisor to take preventive and corrective action.

If necessary, the supervisor requires the insurer to develop an acceptable plan for prevention and correction of problems. Preventive and corrective plans include agreed and acceptable steps to be taken to resolve the issues raised within an acceptable timeframe. Once preventive and corrective plans have been agreed to or imposed, the supervisor periodically checks to determine that the insurer is complying with the measures.

The supervisor communicates with the Board and Senior Management and Key Persons in Control Functions and brings to their attention any material concern in a timely manner to ensure that preventive and corrective measures are taken and the outstanding issues are followed through to a satisfactory resolution.

The supervisor initiates measures designed to prevent a breach of the legislation from occurring, and promptly and effectively deals with noncompliance that could put policyholders at risk or impinge on any other supervisory objectives.

(11) ICP 11 Enforcement

The supervisor enforces corrective action and, where needed, imposes sanctions based on clear and objective criteria that are publicly disclosed.

The supervisor has the power to enforce corrective action in a timely manner where problems involving insurers are identified. The supervisor issues formal directions to insurers to take particular actions or to desist from taking particular actions. The directions are appropriate to address the problems identified.

The supervisor has a range of actions available in order to apply appropriate enforcement where problems are encountered. Powers set out in legislation should at a minimum include restrictions on business activities and measures to reinforce the financial position of an insurer.

At a minimum, the supervisor should have the power to issue the following:

- restrictions on business activities
- prohibiting the insurer from issuing new policies

- withholding approval for new business activities or acquisitions
- restricting the transfer of assets
- restricting the ownership of subsidiaries
- restricting activities of a subsidiary where, in its opinion, such activities jeopardise the financial situation of the insurer.
- directions to reinforce financial position
- requiring measures that reduce or mitigate risks
- requiring an increase in capital
- restricting or suspending dividend or other payments to shareholders
- restricting purchase of the insurer's own shares.
- other directions
- arranging for the transfer of obligations under the policies from a failing insurer to another insurer that accepts this transfer
- suspending or revoking the licence of an insurer
- barring individuals acting in responsible capacities from such roles in future

After necessary corrective action has been taken or remedial measures, directions or sanctions have been imposed, the supervisor checks compliance by the insurer and assesses their effectiveness.

The supervisor has effective means to address management and governance problems, including the power to require the insurer to replace or restrict the power of Board Members, Senior Management, Key Persons in Control Functions, significant owners and external auditors.

Where necessary and in extreme cases, the supervisor imposes conservatorship over an insurer that is failing to meet prudential or other requirements. The supervisor has the power to take control of the insurer, or to appoint other specified officials or receivers for the task, and to make other arrangements for the benefit of the policyholders.

There are sanctions by way of fines and other penalties against insurers and individuals where the provisions of the legislation are breached. The sanctions are proportionate to the identified breach. In some cases it may be appropriate to apply punitive sanctions against insurers or individuals.

The legislation provides for sanctions against insurers and individuals who fail to provide information to the supervisor in a timely fashion, withhold information from the supervisor, provide information that is intended to mislead the supervisor or deliberately misreport to the supervisor.

The process of applying sanctions does not delay necessary preventive and corrective measures and enforcement.

The supervisor, or another responsible body in the jurisdiction, takes action to enforce all the sanctions that have been imposed.

The supervisor ensures consistency in the way insurers and individuals are sanctioned, so that similar violations and weaknesses attract similar sanctions.

(12) ICP 12 Winding-up and Exit from the Market

The legislation defines a range of options for the exit of insurance legal entities from the market. It defines

insolvency and establishes the criteria and procedure for dealing with insolvency of insurance legal entities. In the event of winding-up proceedings of insurance legal entities,the legal framework gives priority to the protection of policyholders and aims at minimising disruption to the timely provision of benefits to policyholders.

This ICP is applicable only to individual legal entities. The focus of this ICP is on insolvency and run-off under distressed conditions. However policyholder protection also applies for financially sound run-offs.

An insurer may no longer be financially viable or may be insolvent. In such cases, the supervisor can be involved in resolutions that require a take-over by or merger with a healthier institution. When all other measures fail, the supervisor should have the ability to close or assist in the closure of the troubled insurer having regard to the objective of the protection of policyholder interests.

The objective of this regulation is to protect the interests of Policyholders.

(13) ICP 13 Reinsurance and Other Forms of Risk Transfer

Reinsurance is a mechanism through which insurance companies transfer the risks they assume on insurance policies to another insurer, called Reinsurer. Accordingly a Reinsurance contract is entered into with the Reinsurer by the primary insurer.

The supervisor sets standards for the use of reinsurance and other forms of risk transfer, ensuring that insurers adequately control and transparently report their risk transfer programmes. The supervisor takes into account the nature of reinsurance business when supervising reinsurers based in its jurisdiction.

The supervisory focus should be on expectations of the Board and Senior Management of the cedant (insurer which is ceding the risks with the reinsurer), discussions with them about their approach and an assessment of that approach and how it is executed. This focus does not preclude other activities which supervisors should undertake, both as part of the initial licensing process (where applicable) and as part of ongoing supervision.

The assessment of reinsurance arrangements by the supervisor should be based on a number of factors, which need to be reviewed on a case-by-case basis, including:

- the relative financial strength and claims payment record of the reinsurers in question (both in normal and stressed conditions);
- the soundness of the risk and capital management strategy;
- the appropriateness of the reinsurance strategy given the underlying insurance portfolios;
- the structure of the programme including any alternative risk transfer mechanisms;
- the extent to which relevant functions are outsourced, either externally or within the same group of companies;
- the levels of aggregate exposure to a single reinsurer or different reinsurers being part of the same group;
- the proportion of business ceded so that the net risks retained commensurate with the cedant's financial resources;
- the level of effective risk transfer;
- the resilience of the reinsurance programme in stressed claims situations;

The supervisor requires that cedants have reinsurance and risk transfer strategies appropriate to the nature,

scale and complexity of their business, and which are part of their wider underwriting and risk and capital management strategies. The supervisor also requires that cedants have systems and procedures for ensuring that such strategies are implemented and complied with, and that cedants have in place appropriate systems and controls over their risk transfer transactions.

(14) ICP 14 Valuation

The supervisor establishes requirements for the valuation of assets and liabilities for solvency purposes.

Valuation is the process of evaluation of assets and liabilities of an insurance company to determine the solvency of an insurer. This process can be conducted only by a qualified Actuary.

The following principles shall be kept in mind by the Supervisor while framing regulations on valuation:

(a) The valuation addresses recognition, derecognition and measurement of assets and liabilities. – the method of valuation, assets to be considered, what is the weightage, liabilities to be considered etc. must be laid down by the supervisor

(b) The valuation of assets and liabilities is undertaken on a consistent basis – Consistency in the valuation methodology must be ensured so that there is uniformity in approach across the years and across various regulated entities

(c) The valuation is conducted in a reliable, decision useful and transparent manner

(d) An economic valuation of assets and liabilities is undertaken

Detailed regulations have been framed by IRDA under the IRDA (Assets, Liabilities and Solvency Margin of Insurance) Regulations, 2000

(15) ICP 15 Investment

The supervisor establishes requirements for solvency purposes on the investment activities of insurers in order to address the risks faced by insurers.

(a) The supervisor establishes requirements that are applicable to investment activities of the insurer

(b) The supervisor is open and transparent as to the regulatory investment requirements that apply and is explicit about the objectives of those requirements

(c) The regulatory investment requirements address at a minimum, the

- Security;
- Liquidity; and
- Diversification;

of an insurer's portfolio of investments as a whole

(d) The supervisor requires the insurer to invest in a manner that is appropriate to the nature of its liabilities

(e) The supervisor requires the insurer to invest only in assets whose risks it can properly assess and manage

(f) The supervisor establishes quantitative and qualitative requirements, where appropriate, on the use of more complex and less transparent classes of assets and investment in markets or instruments that are subject to less governance or regulation

(16) ICP 16 Enterprise Risk Management for Solvency Purposes

The supervisor establishes enterprise risk management requirements for solvency purposes that require insurers to address all relevant and material risks.

(a) The supervisor requires the insurer's enterprise risk management framework to provide for the identification and quantification of risk under a sufficiently wide range of outcomes using techniques which are appropriate to the nature, scale and complexity of the risks the insurer bears and adequate for risk and capital management and for solvency purposes.

(b) Enterprise risk management framework - documentation

(c) The supervisor requires the insurer's measurement of risk to be supported by accurate documentation providing appropriately detailed descriptions and explanations of the risks covered, the measurement approaches used and the key assumptions made.

(c) *Enterprise risk management framework - risk management policy*

The supervisor requires the insurer to have a risk management policy which outlines how all relevant and material categories of risk are managed, both in the insurer's business strategy and its day-to-day operations.

(d) The supervisor requires the insurer to have a risk management policy which describes the relationship between the insurer's tolerance limits, regulatory capital requirements, economic capital and the processes and methods for monitoring risk.

(e) The supervisor requires the insurer to have a risk management policy which includes an explicit asset-liability management (ALM) policy which clearly specifies the nature, role and extent of ALM activities and their relationship with product development, pricing functions and investment management.

(f) The supervisor requires the insurer to have a risk management policy which is reflected in an explicit investment policy which:

- specifies the nature, role and extent of the insurer's investment activities and how the insurer complies with the regulatory investment requirements established by the supervisor; and
- establishes explicit risk management procedures within its investment policy with regard to more complex and less transparent classes of asset and investment in markets or instruments that are subject to less governance or regulation.

(g) The supervisor requires the insurer to perform its own risk and solvency assessment (ORSA) regularly to assess the adequacy of its risk management and current, and likely future, solvency position

(h) The supervisor requires the insurer's Board and Senior Management to be responsible for the ORSA

(17) ICP 17 Capital Adequacy

The supervisor establishes capital adequacy requirements for solvency purposes so that insurers can absorb significant unforeseen losses and to provide for degrees of supervisory intervention.

The supervisor requires that a total balance sheet approach is used in the assessment of solvency to recognise the interdependence between assets, liabilities, regulatory capital requirements and capital resources and to require that risks are appropriately recognised.

The supervisor establishes regulatory capital requirements at a sufficient level so that, in adversity, an insurer's obligations to policyholders will continue to be met as they fall due and requires that insurers maintain capital resources to meet the regulatory capital requirements

The regulatory capital requirements include solvency control levels which trigger different degrees of intervention by the supervisor with an appropriate degree of urgency and requires coherence between the solvency control levels established and the associated corrective action that may be at the disposal of the insurer and/or the supervisor

Regulatory capital requirements establish:

- a solvency control level above which the supervisor does not intervene on capital adequacy grounds. This is referred to as the Prescribed Capital Requirement (PCR). The PCR is defined such that assets will exceed technical provisions and other liabilities with a specified level of safety over a defined time horizon.
- a solvency control level at which, if breached, the supervisor would invoke its strongest actions, in the absence of appropriate corrective action by the insurance legal entity. This is referred to as the Minimum Capital Requirement (MCR). The MCR is subject to a minimum bound below which no insurer is regarded to be viable to operate effectively.

In the context of group-wide capital adequacy assessment, the regulatory capital requirements establish solvency control levels that are appropriate in the context of the approach to group-wide capital adequacy that is applied.

The regulatory capital requirements are established in an open and transparent process, and the objectives of the regulatory capital requirements and the bases on which they are determined are explicit. In determining regulatory capital requirements, the supervisor allows a set of standardised and, if appropriate, other approved more tailored approaches such as the use of (partial or full) internal models.

The supervisor addresses all relevant and material categories of risk in insurers and is explicit as to where risks are addressed, whether solely in technical provisions, solely in regulatory capital requirements or if addressed in both, as to the extent to which the risks are addressed in each. The supervisor is also explicit as to how risks and their aggregation are reflected in regulatory capital requirements.

The supervisor sets appropriate target criteria for the calculation of regulatory capital requirements, which underlie the calibration of a standardised approach. Where the supervisor allows the use of approved more tailored approaches such as internal models for the purpose of determining regulatory capital requirements, the target criteria underlying the calibration of the standardised approach are also used by those approaches for that purpose to require broad consistency among all insurers within the jurisdiction.

Any variations to the regulatory capital requirement imposed by the supervisor are made within a transparent framework, are appropriate to the nature, scale and complexity according to the target criteria and are only expected to be required in limited circumstances.

The supervisor defines the approach to determining the capital resources eligible to meet regulatory capital requirements and their value, consistent with a total balance sheet approach for solvency assessment and having regard to the quality and suitability of capital elements.

The supervisor establishes criteria for assessing the quality and suitability of capital resources, having regard to their ability to absorb losses on both a going-concern and wind-up basis.

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the

supervisor:

- establishes appropriate modelling criteria to be used for the determination of regulatory capital requirements, which require broad consistency among all insurers within the jurisdiction; and
- identifies the different levels of regulatory capital requirements for which the use of internal models is allowed.

Initial validation and supervisory approval of internal models:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires:

- prior supervisory approval for the insurer's use of an internal model for the purpose of calculating regulatory capital requirements;
- the insurer to adopt risk modelling techniques and approaches appropriate to the nature, scale and complexity of its current risks and those incorporated within its risk strategy and business objectives in constructing its internal model for regulatory capital;
- purposes;
- the insurer to validate an internal model to be used for regulatory capital purposes by subjecting it, as a minimum, to three tests: "statistical quality test", "calibration test" and "use test"; and
- the insurer to demonstrate that the model is appropriate for regulatory capital purposes and to demonstrate the results of each of the three tests.

Statistical quality test for internal models:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires:

- the insurer to conduct a "statistical quality test" which assesses the base quantitative methodology of the internal model, to demonstrate the appropriateness of this methodology, including the choice of model inputs and parameters, and to justify the assumptions underlying the model; and
- that the determination of the regulatory capital requirement using an internal model addresses the overall risk position of the insurer and that the underlying data used in the model is accurate and complete.

Calibration test for internal models:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires the insurer to conduct a "calibration test" to demonstrate that the regulatory capital requirement determined by the internal model satisfies the specified modelling criteria.

Use test and governance for internal models:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires:

- the insurer to fully embed the internal model, its methodologies and results, into the insurer's risk strategy and operational processes (the "use test");
- the insurer's Board and Senior Management to have overall control of and responsibility for the construction and use of the internal model for risk management purposes, and ensure sufficient understanding of the model's construction at appropriate levels within the insurer's organisational

structure. In particular, the supervisor requires the insurer's Board and Senior Management to understand the consequences of the internal model's outputs and limitations for risk and capital management decisions; and

- the insurer to have adequate governance and internal controls in place with respect to the internal model.

Documentation for internal models:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires the insurer to document the design, construction and governance of the internal model, including an outline of the rationale and assumptions underlying its methodology. The supervisor requires the documentation to be sufficient to demonstrate compliance with the regulatory validation requirements for internal models, including the statistical quality test, calibration test and use test outlined above.

Ongoing validation and supervisory approval of the internal model:

Where a supervisor allows the use of internal models to determine regulatory capital requirements, the supervisor requires:

- the insurer to monitor the performance of its internal model and regularly review and validate the ongoing appropriateness of the model's specifications. The supervisor requires the insurer to demonstrate that the model remains fit for regulatory capital purposes in changing circumstances against the criteria of the statistical quality test, calibration test and use test;
- the insurer to notify the supervisor of material changes to the internal model made by it for review and continued approval of the use of the model for regulatory capital purposes;
- the insurer to properly document internal model changes; and
- the insurer to report information necessary for supervisory review and ongoing approval of the internal model on a regular basis, as determined appropriate by the supervisor. The information includes details of how the model is embedded within the insurer's governance and operational processes and risk management strategy, as well as information on the risks assessed by the model and the capital assessment derived from its operation.

(18) ICP 18 Intermediaries

The supervisor sets and enforces requirements for the conduct of insurance intermediaries, to ensure that they conduct business in a professional and transparent manner.

The supervisor ensures that insurance intermediaries are required to be licensed.

The supervisor ensures that insurance intermediaries licensed in its jurisdiction are subject to ongoing supervisory review.

The supervisor requires insurance intermediaries to possess appropriate levels of professional knowledge and experience, integrity and competence.

The supervisor requires that insurance intermediaries apply appropriate corporate governance.

The supervisor requires insurance intermediaries to disclose to customers, at a minimum:

- the terms and conditions of business between themselves and the customer;

- the relationship they have with the insurers with whom they deal; and
- information on the basis on which they are remunerated where a potential conflict of interest exists.

The supervisor requires an insurance intermediary who handles client monies to have sufficient safeguards in place to protect these funds.

The supervisor takes appropriate supervisory action against licensed insurance intermediaries, where necessary, and has powers to take action against those individuals or entities that are carrying on insurance intermediation without the necessary licence.

(19) ICP 19 Conduct of Business

The supervisor sets requirements for the conduct of the business of insurance to ensure customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied.

Fair treatment of customers

The supervisor requires insurers and intermediaries to act with due skill, care and diligence when dealing with customers.

The supervisor requires insurers and intermediaries to establish and implement policies and procedures on the fair treatment of customers that are an integral part of their business culture.

The supervisor requires insurers to take into account the interests of different types of customers when developing and marketing insurance products.

The supervisor requires insurers and intermediaries to promote products and services in a manner that is clear, fair and not misleading.

The supervisor sets requirements for insurers and intermediaries with regard to the timing, delivery, and content of information provided to customers at point of sale.

The supervisor requires insurers and intermediaries to ensure that, where customers receive advice before concluding an insurance contract, such advice is appropriate, taking into account the customer's disclosed circumstances.

The supervisor requires insurers and intermediaries to ensure that, where customers receive advice before concluding an insurance contract, any potential conflicts of interest are properly managed.

The supervisor requires insurers to:

- service policies appropriately through to the point at which all obligations under the policy have been satisfied;
- disclose to the policyholder information on any contractual changes during the life of the contract; and
- disclose to the policyholder further relevant information depending on the type of insurance product.

The supervisor requires that insurers have policies and processes in place to handle claims in a timely and fair manner.

The supervisor requires that insurers and intermediaries have policies and processes in place to handle complaints in a timely and fair manner.

Legislation identifies provisions relating to privacy protection under which insurers and intermediaries are allowed to collect, hold, use or communicate personal information of customers to third parties

The supervisor requires insurers and intermediaries to have policies and procedures for the protection of private information on customers.

The supervisor publicly discloses information that supports the fair treatment of customers.

(20) ICP 20 Public Disclosure

The supervisor requires insurers to disclose relevant, comprehensive and adequate information on a timely basis in order to give policyholders and market participants a clear view of their business activities, performance and financial position. This is expected to enhance market discipline and understanding of the risks to which an insurer is exposed and the manner in which those risks are managed.

Insurers disclose, at least annually, appropriately detailed quantitative and qualitative information in a way that is accessible to market participants on their profile, governance and controls, financial position, technical performance and the risks to which they are subject. In particular, information disclosed must be:

- decision useful to decisions taken by market participants;
- timely so as to be available and up-to-date at the time those decisions are made;
- comprehensive and meaningful;
- reliable as a basis upon which to make decisions
- comparable between different insurers operating in the same market; and
- consistent over time so as to enable relevant trends to be discerned.

Disclosure about the financial position of the insurer includes appropriately detailed quantitative and qualitative information about the determination of technical provisions. Technical provisions are presented by appropriate segment. This disclosure includes, where relevant to policyholders and market participants, information about the future cash flow assumptions, the rationale for the choice of discount rates, and risk adjustment methodology where used or other information as appropriate to provide a description of the method used to determine technical provisions

Disclosure about the financial position of the insurer includes appropriately detailed quantitative and qualitative information about capital adequacy. An insurer discloses information that enables users to evaluate the insurer's objectives, policies and processes for managing capital and to assess its capital adequacy. This information encompasses the generic solvency requirements of the jurisdiction(s) in which the insurer operates and the capital available to cover regulatory capital requirements. If an internal model is used to determine capital resources and requirements, information about the model must be provided, having due regard to proprietary or confidential information

Disclosure about the financial position of the insurer includes appropriately detailed quantitative and qualitative information about financial instruments and other investments by class. In addition, information disclosed about investments includes:

- investment objectives;
- policies and processes;
- values, assumptions and methods used for general purpose financial reporting and solvency purposes, as well as an explanation of the differences (where applicable); and

- information concerning the level of sensitivity to market variables associated with
- disclosed amounts

Disclosure about the financial position of the insurer includes appropriately detailed quantitative and qualitative information about enterprise risk management (ERM) including asset-liability management (ALM) in total and, where appropriate, at a segmented level. At a minimum, this information includes the methodology used and the key assumptions employed in measuring assets and liabilities for ALM purposes and any capital and/or provisions held as a consequence of a mismatch between assets and liabilities

Disclosure includes appropriately detailed quantitative and qualitative information on financial performance in total and by segmented financial performance. Where relevant, disclosures must include a quantitative source of earnings analysis, claims statistics including claims development, pricing adequacy, information on returns on investment assets and components of such returns

Disclosure about the financial position of the insurer includes appropriately detailed quantitative and qualitative information on all reasonably foreseeable and relevant material insurance risk exposures and their management. This disclosure must include information on its objectives and policies, models and techniques for managing insurance risks (including underwriting processes). At a minimum, disclosures must include:

- information about the nature, scale and complexity of risks arising from
- insurance contracts;
- how the insurer uses reinsurance or other forms of risk transfer;
- an understanding of the interaction between capital adequacy and risk; and
- a description of risk concentrations

Disclosure includes appropriately detailed information about the company profile, including the nature of its business, a general description of its key products, the external environment in which it operates and information on the insurer's objectives and the strategies in place to achieve them

Disclosures include the key features of the insurer's corporate governance framework and management controls including how these are implemented.

Subject to the nature, scale and complexity of an insurer, supervisors require insurers to produce, at least annually, audited financial statements and make them available to market participants

(21) ICP 21 Countering Fraud in Insurance

The supervisor requires that insurers and intermediaries take effective measures to deter, prevent, detect, report and remedy fraud in insurance.

Fraud in insurance is addressed by legislation which prescribes adequate sanctions for committing such fraud and for prejudicing an investigation into fraud

The supervisor has a thorough and comprehensive understanding of the types of fraud risk to which insurers and intermediaries are exposed. The supervisor regularly assesses the potential fraud risks to the insurance sector and requires insurers and intermediaries to take effective measures to address those risks

The supervisor has an effective supervisory framework to monitor and enforce compliance by insurers and intermediaries with the requirements to counter fraud in insurance

The supervisor regularly reviews the effectiveness of the measures insurers and intermediaries and the

supervisor itself are taking to deter, prevent, detect, report and remedy fraud. The supervisor takes any necessary action to improve effectiveness.

The supervisor has effective mechanisms in place, which enable it to cooperate, coordinate and exchange information with other competent authorities, such as law enforcement authorities, as well as other supervisors concerning the development and implementation of policies and activities to deter, prevent, detect, report and remedy fraud in insurance.

(22) ICP 22 Anti-Money Laundering and Combating the Financing of Terrorism

The supervisor requires insurers and intermediaries to take effective measures to combat money laundering and the financing of terrorism. In addition, the supervisor takes effective measures to combat money laundering and the financing of terrorism.

The supervisor has a thorough and comprehensive understanding of the ML/FT risks to which insurers and intermediaries are exposed and uses available information to assess the ML/FT risks to the insurance sector in its jurisdiction on a regular basis.

The supervisor:

- issues to insurers and intermediaries enforceable rules on AML/CFT obligations consistent with the FATF Recommendations, for matters which are not in law or regulation;
- establishes guidelines that will assist insurers and intermediaries to implement and comply with their respective AML/CFT requirements; and
- provides insurers and intermediaries with adequate and appropriate feedback to promote AML/CFT compliance.

The supervisor has an effective supervisory framework to monitor and enforce compliance by insurers and intermediaries with AML/CFT requirements.

The supervisor regularly reviews the effectiveness of the measures that insurers and intermediaries and the supervisor itself are taking on AML/CFT. The supervisor takes any necessary action to improve effectiveness.

The supervisor has effective mechanisms in place which enable it to cooperate, coordinate and exchange information with other domestic authorities, such as the financial intelligence unit, as well as with supervisors in other jurisdictions for AML/CFT purposes.

Where the insurance supervisor is not a designated AML/CFT competent authority

The supervisor is aware of and has an understanding of ML/FT risks to which insurers and intermediaries are exposed. It liaises with and seeks to obtain information from the designated competent authority relating to AML/CFT by insurers and insurance intermediaries.

The supervisor has effective mechanisms in place which enable it to cooperate, coordinate and exchange information with other domestic authorities, such as the financial intelligence unit, as well as with supervisors in other jurisdictions for AML/CFT purposes

(23) ICP 23 Group-wide Supervision

The supervisor supervises insurers on a legal entity and group-wide basis.

The supervisor, in cooperation with other involved supervisors as necessary, identifies the scope of the

group to be subject to group-wide supervision.

The group-wide supervisor, in cooperation and coordination with other involved supervisors, identifies all legal entities that are part of the insurance group.

To ascertain the identity of an insurance group, supervisors should first identify all insurance legal entities within the corporate structure.Supervisors should then identify all entities which have control over those insurance legal entities.

A practical method for determining the entities within the insurance group is often to start with entities included in the consolidated accounts. The head of an insurance group including an insurance led financial conglomerate is at least one of the following:

- an insurance legal entity
- a holding company

The identified insurance group includes the head of the insurance group and all the legal entities controlled by the head of the insurance group. Legal entities within a group could include:

- operating and non-operating holding companies (including intermediate holding companies);
- other regulated entities such as banks and/or securities companies;
- non-regulated entities; and
- special purpose entities.

In addition to considering the consolidated accounts, the supervisor should consider other relationships such as

- common Directors;
- membership rights in a mutual or similar entity;
- involvement in the policy-making process; and
- material transactions.

The insurance group may be

- a subset/part of a bank-led or securities-led financial conglomerate; or
- a subset of a wider group, such as a larger diversified conglomerate with both financial and non-financial entities

The group-wide supervisor, in cooperation and coordination with other involved supervisors, determines the scope of group-wide supervision.

Involved supervisors should consult and agree on the scope of group-wide supervision of the insurance group to ensure that there are no gaps and no unnecessary duplication in supervision among jurisdictions.

The group-wide supervisor and other involved supervisors do not narrow the identification of the insurance group or the scope of group-wide supervision due to lack of legal authority or supervisory power over particular legal entities.

In some jurisdictions, the supervisor may not be granted legal authority or supervisory power for the direct supervision of some entities within the identified insurance group or the scope of groupwide supervision. These may include legal entities regulated in another sector or non-regulated entities within the same jurisdiction.

(24) ICP 24 Macroprudential Surveillance and Insurance Supervision

The supervisor identifies, monitors and analyses market and financial developments and other environmental factors that may impact insurers and insurance markets and uses this information in the supervision of individual insurers. Such tasks should, where appropriate, utilise information from, and insights gained by, other national authorities.

The supervisor identifies underlying trends within the insurance sector by collecting data on, but not limited to, profitability, capital position, liabilities, assets and underwriting, to the extent that it has information available at the level of legal entities and groups. The supervisor also develops and applies appropriate tools that take into account the nature, scale and complexity of insurers, as well as non-core activities of insurance groups, to limit significant systemic risk.

The supervisor, in performing market analysis, considers not only past developments and the present situation, but also trends, potential risks and plausible unfavourable future scenarios with the objective and capacity to take action at an early stage, if required.

The supervisor performs both quantitative and qualitative analysis and makes use of both public and other sources of information, including horizontal reviews of insurers and relevant data aggregation.

The supervisor uses market-wide data to analyse and monitor the actual or potential impact on the financial stability of insurance markets in general and of insurers in particular and takes appropriate action. The supervisor also makes sufficiently detailed aggregated market data publicly available.

The supervisor assesses the extent to which macro-economic vulnerabilities and financial market risks impinge on prudential safeguards or the financial stability of the insurance sector The supervisor has an established process to assess the potential systemic importance of insurers, including policies they underwrite and instruments they issue in traditional and non-traditional lines of business.

If the supervisor identifies an insurer as systemically important, it develops an appropriate supervisory response, which is commensurate with the nature and degree of the risk.

(25) ICP 25 – Supervisory Cooperation and Coordination

The Supervisor cooperates and coordinates with other relevant coordinators subject to confidentiality requirements

The supervisor takes steps to put in place adequate coordination arrangements with involved supervisors on cross-border issues on a legal entity and a group-wide basis in order to facilitate the comprehensive oversight of these legal entities and groups. Insurance supervisors cooperate and coordinate with relevant supervisors from other sectors, as well as with central banks and government ministries.

Coordination agreements include establishing effective procedures for:

- information flows between involved supervisors;
- communication with the head of the group;
- convening periodic meetings of involved supervisors; and
- conduct of a comprehensive assessment of the group.

Supervisors cooperate and coordinate in the supervision of an insurance legal entity with a branch in another jurisdiction in accordance with their authorities and powers.

Supervisors cooperate and coordinate in the supervision of insurance groups and insurance legal entities that are parts of insurance groups in accordance with their authorities and powers.

Supervisors establish a process to identify a Group-wide supervisor for all cross-border insurance groups.

The designated group-wide supervisor takes responsibility for initiating discussions on suitable coordination arrangements, including establishing a supervisory college, and acts as the key coordinator or chairman of the supervisory college, where it is established. Other involved supervisors participate with the Group-wide supervisor in coordination discussions and in the supervisory college.

There is appropriate flexibility in the establishment of a supervisory college

- both when to establish and the form of its establishment
- and other coordination mechanisms to reflect their particular role and functions.

The designated group-wide supervisor establishes the key tasks of the supervisory college and other coordination mechanisms. Other involved supervisors undertake the functions of the Supervisory college as agreed.

The designated group-wide supervisor understands the structure and operations of the group. Other involved supervisors understand the structure and operations of parts of the group at least to the extent of how operations in their jurisdictions could be affected and how operations in their jurisdictions may affect the group.

The designated group-wide supervisor takes the appropriate lead in carrying out the responsibilities for group-wide supervision. A group-wide supervisor takes into account the assessment made by the legal entity supervisors as far as relevant.

(26) ICP 26 Cross-border Cooperation and Coordination on Crisis Management

The supervisor cooperates and coordinates with other relevant supervisors and authorities such that a cross-border crisis involving a specific insurer can be managed effectively.

The supervisor meets regularly with other relevant supervisors and authorities to share and evaluate information relating to specific cross border insurers and to analyse and assess specific issues (including whether there are systemic implications) in non-crisis periods.

The supervisor develops and maintains plans and tools for dealing with insurers in crisis and seeks to remove practical barriers to efficient and internationally coordinated resolutions. These will be designed flexibly in order to be able to adapt them to the specific issues of a cross-border crisis as well as individual insurers.

The group-wide supervisor coordinates crisis management preparations with involvement from other relevant supervisors and ensures that all supervisors in the relevant jurisdictions (at a minimum those where the insurer is of systemic importance) are kept informed of the crisis management preparations.

As far as legal frameworks and confidentiality regimes allow, the supervisor shares with other relevant supervisors, at a minimum, information on the following:

- group structure (including legal, financial and operational intragroup dependencies),
- interlinkages between the insurer and the financial system in each jurisdiction where it operates,
- potential impediments to a coordinated solution.

The supervisory regime requires that insurers be capable of supplying, in a timely fashion, the information required to manage a financial crisis.

The supervisory regime requires insurers to maintain contingency plans and procedures based on their specific risk for use in a going- and gone concern situation.

Managing a cross-border crisis

1. The supervisor informs the group-wide supervisor as soon as it becomes aware of an evolving crisis. The group-wide supervisor coordinates such that this information and any other relevant information that it has become aware of on its own is shared among other relevant supervisors and other relevant authorities promptly.
2. Subject to legislative requirements and confidentiality regimes, the supervisor shares information with relevant supervisors and authorities and in a way that does not compromise the prospects of a successful resolution. The supervisor shares information with other relevant authorities or networks as well, whenever necessary, and subject to the same legislative and confidentiality requirements.
3. The group-wide supervisor analyses and assesses the crisis situation and its implications as soon as practicable and supervisors try to reach a common understanding of the situation. The supervisor cooperates to find internationally coordinated, timely and effective solutions.
4. If a fully coordinated supervisory solution is not possible, the supervisor discusses jurisdictional measures with other relevant supervisors as soon as possible.

In a crisis situation, the group-wide supervisor coordinates public communication at each stage of the crisis.

FUTURE OUTLOOK

The IAIS, endorsed their new Insurance Core Principles (ICPs) in October 2011. These new ICPs herald a new regulatory environment for insurers and supervisors, essentially requiring supervisory regimes worldwide to establish risk-based solvency requirements. This reflects a total balance sheet approach on an economic basis, addressing all reasonably foreseeable and relevant material risks. These solvency capital reforms are supplemented by required enhancements in the role and activities of insurer risk management, which effectively link the front-end processes of accepting and monitoring risk more closely with the overall strategic goals and risk appetite at Board level.

For many jurisdictions, enacting such changes into local frameworks will require significant effort and the impact on the insurance sector is likely to be considerable, especially in less well-developed markets such as Eastern Europe, Africa, the Middle East and many parts of Asia and South America.

The IAIS is developing the ComFrame proposal – a comprehensive supervisory framework for the supervision of internationally active insurance groups (IAIGs) – and in July 2011 presented its initial concept paper. The IAIS has outlined the aims of ComFrame as:

- Developing methods of operating group-wide supervision of IAIGs in order to make group-wide supervision more effective and more reflective of actual business practices;
- Establishing a comprehensive framework for supervisors to address group-wide activities and risks and also set grounds for better supervisory Evolving Insurance Regulation co-operation to allow for a more integrated and international approach; and
- Fostering global convergence of regulatory and supervisory measures and approaches.

As the international standard setter for insurance, the IAIS has so far developed a generic approach to building a global framework for the supervision of IAIGs, including developing the ICPs (of which some ICPs, such as ICP 23, specifically address group-wide supervision). Notwithstanding, the IAIS still lacks a multilateral response to the supervision of IAIGs and ComFrame is intended to fill this void. Encouragingly, there was generally broad support from IAIS members and observers for the structure and outline presented in the concept paper released in June 2011. Many recognised that ComFrame needs to exist in order to address issues in the supervision of IAIGs and that the project is therefore a significant development in international insurance supervision.

LESSON ROUND UP

- The International Association of Insurance Supervisors (IAIS), was established in 1994.
- It is a voluntary membership organization of insurance supervisors and regulators from more than 200 jurisdictions in nearly 140 countries.
- The IAIS issues global insurance principles, standards and guidance, including application and issues papers, provides training and support on issues related to insurance supervision, and organises meetings and seminars for insurance supervisors.
- Insurance Core Principles (ICPs) framed by IAIS provide the globally accepted framework for Insurance Sector.
- The Insurance Core Principles (ICPs) provide a globally accepted framework for the regulation of the insurance sector.
- The ICPs apply to the regulation of all insurers whether private or government-controlled insurers that compete with private enterprises, wherever their business is conducted, including through e-commerce.
- The application of individual ICPs and standards to insurance groups may vary and where appropriate, further guidance is provided under individual ICPs and standards.
- When implementing the ICPs and standards in a jurisdiction, it is important to take into account the domestic context, industry structure and developmental stage of the financial system and overall macroeconomic conditions.
- In India, the Insurance Act, 1938 and IRDA Act, 1999, gives powers to Insurance Regulatory and Development Authority to regulate the insurance sector.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. Explain the role and objectives of International Association of Insurance Supervisors (IAIS).
2. What is the need for common standards in Insurance? Explain the scope and coverage of the Insurance Core Principles.
3. Briefly write about the ICPs given by International Association of Insurance Supervisors (IAIS).
4. What is the assessment methodology described by IAIS? Explain briefly.

Lesson 7
LIFE INSURANCE - PRACTICES, PROCEDURES

LESSON OUTLINE

- Basic principles of life insurance
- Insurable interest
- Insurance on the life of spouse
- Representation implications of concealment, non disclosure or misrepresentation by the insured
- Implications of non-disclosure by the insurer
- Assignment
- Nomination
- Matter to be Stated in Life Insurance Policy
- Title and claims in life insurance
- Claims on small life insurance policies
- Tax law implications in life insurance
- Concept of trusts in life policy –
- Stamp duties:
- Role and function of life insurance companies
- IRDA New Guidelines on Life Insurance: Moving towards transparency and efficiency
- Lesson Round up
- Self Test Questions

LEARNING OBJECTIVES

Insurance is an economic device whereby the individual substitutes a small, certain cost (called premium) for a large uncertain financial loss called the contingency insured against, which would exist if it were not for the insurance. The essence of insurance is viewed in different ways like business, economic, social and so on. From an economic viewpoint, insurance is a system for reducing financial risk by transferring it from a policy owner to an insurer. The social aspect of insurance involves the collective bearing of losses through contributions by all members of a group to pay for losses suffered by some group members. From a business viewpoint, insurance achieves the sharing of risk by transferring risks from individuals and businesses to financial institutions specializing in risk. The insurer is not in fact paying for the loss. The insurer writes the claim check, but is actually transferring funds from individuals who as part of a pool, paid premiums that created the fund from which the claims are paid. Insurance practice largely depends on the regulatory choice of the country but insurance principles are universal transcending local evolution and devolution of insurance acts, laws, rules and regulations Life insurance is based on several basic principles that apply to all types of insurance, and that form the foundation of the insurance contract. Insurance is governed by contract of adhesion where the insurer unilaterally does the drafting of the contract and the insured can only accept it to be insured or reject it to remain uninsured. Understanding these principles will help one to understand better how life insurance works. In this chapter we will study the basic principles which govern insurance contract.

The insurance industry of India consists of 53 insurance companies of which 24 are in life insurance business and 29 are non-life insurers. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company. Apart from that, among the non-life insurers there are six public sector insurers. In addition to these, there is sole national re-insurer, namely, General Insurance Corporation of India (GIC). Other stakeholders in Indian Insurance market include agents (individual and corporate), brokers, surveyors and third party administrators servicing health insurance claims.

Basic Principles of Life Insurance

Life Insurance as a means of protection against loss through death of key persons- Key Man Insurance-is one of the primary commercial forms of life insurance. The value of life insurance as an agency for increasing the individual's sense of responsibility and for relieving the community of much needless expense in supporting members of destitute families, has been recognized for years by the governments of all civilized countries. To understand better about how life insurance works there are certain basic principles which are formulated and applied to all types of insurance and formulate a insurance contract.

Few of the Basic Principles of Life insurance are discussed below.

1. Risk Pooling

Life insurance is based on a concept called risk pooling, or a group sharing of losses. People exposed to a risk agree to share losses fairly or on an equitable basis. They transfer the economic risk of loss to an insurance company. Insurance companies collect and pool the premiums of thousands of people, spreading the risk of losses across the entire pool. By carefully calculating the probability of losses that will be sustained by the members of the pool, insurance companies can equitably spread the cost of the losses to all the members. The risk of loss is transferred from one to many and shared by all insured in the pool.

Example of Risk Pooling

Ten thousand males aged 35 contribute to a life insurance pool. If Twenty-one of them are expected to die this year and each of the 10,000 contributes Rs.210 to fund death benefits (ignoring costs of operation), a death benefit of Rs.100,000 could be paid for each of the 21 expected deaths.

2. Principle of Large Numbers

The Principle *of large numbers* states that as the size of the sample (insured population) increases, the actual loss experience will more and more closely approximate the true underlying probability. This means that the insurer's statistical group must be large enough to produce reliable results, and that the group actually insured must be large enough to produce results that are consistent with what probability predicts. Insurance relies on the law of large numbers to minimize the speculative element and reduce volatile fluctuations in year-to-year losses. The greater the number of exposures (lives insured) to a peril (cause of loss/death), the less the observed loss experience (actual results) will deviate from expected loss experience (probabilities). Uncertainty diminishes and predictability increases as the number of exposure units increases. It would be a gamble to insure one life, but insuring 500,000 similar persons will result in death rates that will vary little from the expected. A peril is a cause of a loss. In life insurance, the event against which protection is granted, death is uncertain for any one year, but the probability of death increases with age until it becomes a certainty. If a life insurance policy is to protect an insured during his or her entire life, an adequate fund must be accumulated to meet a claim that is certain to occur.

Example: To insure a single life against death for say Rs 1000 during a given year, is clearly a gamble. If the

number of persons insured be increased to say 1000, the element of uncertainty will still be present to a large extent, although the possibility of at least one death is much greater. If one million of similar lives with similar physical conditions are combined into one group, the fluctuation in the rate of death from year to year is likely to vary by only a fraction of one percent.

3. Principle of Utmost Faith

Insurance contract is based on utmost good faith principle. Each party to the contract is entitled to rely upon the representations of the other without any attempt to deceive or withhold material information. The rule of caveat emptor [let the buyer beware] does not generally apply. The insurer must depend to a great extent on the statements of prospective the policy holders in assessing their acceptability for insurance purpose, and that the insurance contract is an extremely intricate and highly technical contract, which forces the buyer to rely upon the good faith of the insurer. If the two parties are to be *ad idem* (of the same mind), they must observe utmost good faith towards each other.

Utmost good faith is fundamental for insurance contract. Any breach of this fundamental principle will lead to repudiation of claim.

CASE ON UTMOST GOOD FAITH

In a case filed with Ahmedabad the Ombudsman Centre, case no : 21-012-0270 between Mrs. X v/s MetLife Insurance Company Ltd., the company has repudiated the claim on the grounds of breach of utmost good faith. The text of the judgement is:

The death claim was repudiated on the ground of mis-statement of educational qualifications and employment of the deceased. While filling the proposal form, the life assured had mentioned that he had passed B.Com and that he was working with Khodiyar Music with nature of duties as " Administration and Music". During the course of submission and in the Hearing too, the widow of the deceased confirmed that the deceased had studied upto 9^{th} standard only. Again it was found that the deceased was not in full employment. He was the freelancer rather than a full time employee and would pay Band and be paid on per program basis. The contradictions being proved, the alleged mis-statement got established it sniped at *Utmost Good Faith* that forms the cornerstone of insurance contract. As such, repudiation was upheld with relief to the complainant.

INSURABLE INTEREST

In the law of insurance, the insured must have an interest in the subject matter of his or her policy, or such policy will be void and unenforceable since it will be regarded as a form of gambling. An individual ordinarily has an insurable interest when he or she will obtain some type of financial benefit from the preservation of the subject matter, or will sustain pecuniary loss from its destruction or impairment when the risk insured against occurs.

An insurable interest is an economic stake in an event for which an insurance policy is purchased to mitigate risk of loss. An insurable interest is a basic requirement for an insurance company to issue a policy. Entities not subject to financial loss from an event do not have an insurable interest and cannot purchase an insurance policy to cover that event. Insurable interest is what makes an insurance contract legal and valid, and protects against intentionally harmful acts. If there is no insurable interest, the contract becomes wagering (gambling) contract. All wagering contracts are illegal & therefore null & void.

Insurable interest in Own Life Policy

So long as the Insurance is on one's own life, the "Insurance Interest" presents no difficulty. A person has

insurable interest in his own life to an unlimited extent. The absence of a limit in this case is reasonable. When a person insures his life he obtains protection against loss to his estate; for in the event of his untimely death the estate would not benefit by the future accumulation he hopes to make during the normal span of life. It is not easy to compute with any degree of certainty what the future earnings of a person would be. Hence no limit may be fixed in respect of life Insurance he may effect. Where, however, insurer rejects a proposal for an amount of assurance, which is disproportionate to the means of the proposer, it is not normally for lack of Insurable interest but on considerations of "moral hazard". Indeed it may also be presumed in a case where a person proposes for a policy for a large amount, which he may not be able to maintain having regard to his income, that it will be financed by some other person and that there is no insurable interest

Insurance on the life of spouse

As a wife is normally supported by her husband, she can validly effect an insurance on her life for adequate amount. The service and help rendered by the wife used to be thought of as the basis of insurable interest which supports any policy which a man takes on the life of his wife. In *Griffiths* vs. *Elemming* the Court of Appeal in England stated that it was difficult to uphold such interest on the basis of pecuniary interest but thought that such interest could be presumed on broader grounds.

Insurance Interest on the Insurance taken on the life of Parent and Child

Following the practice in U.K. in India also a parent is not considered to have insurable interest in the life of the child. The same is the case with a child in respect of his parent's life. Whether this position requires to be reviewed now appears to be engaging the attention of people here.

A Hindu is under a legal obligation to maintain his parents. Even as per traditional law Sec.20 of the Hindu Adoption and Maintenance Act has given statutory form to the legal obligation. The parents have, therefore, a right to maintenance subject to their being aged or infirm. An order for maintenance of parents may also be passed under Sec. 125 of the Code of Criminal Procedure, 1973. It may be stated, therefore, that a parent has pecuniary interest in the life of the child, and an assurance effected on that basis cannot be hit by Sec.30 of the Contract Act as a wagering contract. However, it may be noted that the pecuniary interest is not a present interest unless the parent is unable to maintain himself or herself at the time when the Insurance is effected. It may therefore, be argued that a parent cannot have insurable interest in the life of the child until the right to maintenance arises; but when a person is not able to maintain oneself how can he be expected to have the means to insure the life of his children?

As a matter of fact in India, even today a child is a potential breadwinner for the parents in their old age. The present affluent circumstances of a parent do not alter that situation. Under the traditional law a right to maintenance could be claimed only against the sons; the statute has now extended the obligation to the daughters as well. Having regard to the social and economic set up of the people in the country a review of the question seems to be appropriate.

Insurance Interest on the life of other relations

In the case of other relations, insurable interest cannot be presumed from the mere existence of their relationship. Moral obligations or duties are not sufficient to sustain an insurable interest.

In every other case, the insurable interest must be a pecuniary interest and must be founded on a right or obligation capable of being enforced by Courts of law. The following are illustrations of such cases of insurable interest:

(a) Employer – Employee: An employer has insurable interest in the life of his employee, and the employee

in the life of the employer; An employer can create insurable interest in the lives of his employees by undertaking to provide monetary benefit to the family or estate of the employees in the event of death. Group Insurances effected by companies on the lives of their employees are on the basis of such insurable interest.

(b) Creditor – debtor: A creditor has insurable interest in the life of his debtor upto the amount of the debt; This is not a satisfactory basis; for in the event of death of the debtor after the debt has been repaid, the creditor would still be entitled to the policy moneys and thus can be in a position to gain by the death of the debtor once the loan is repaid. The better arrangement would be for the debtor to take out a policy for the required amount and mortgage the policy to the creditor. The creditor then cannot take benefits under the policy in excess of his dues.

(c) Partner: A partner has insurable interest in the life of his co-partner to the extent of the capital to be brought in by the latter.

(d) Surety and principal debtor-Co-surety: A surety has insurable interest in the life of his co-surety to the extent of the proportion of his debt and also in the life of his principal debtor.

Effect on Contract when Insurable interest is not present

Where, therefore, the proposal is on the life of another, unless the proposer has insurable interest in the life to be assured, the contract shall be void. Lack of insurable interest is a defence, which the insurer may plead in resisting a claim. There may be also cases where Insurance on one's own life is surreptitiously financed and held by another for his benefit, which if detected by the insurer, may be declared void. As a life Insurance contract is not one of indemnity, the existence of insurable interest and the amount thereof will have to be considered at the time of effecting the contract since lack of such interest would render the contract void. If insurable interest existed at the inception of the policy, the contract would be enforceable though such interest might cease later.

Representation

All disclosures relating to an insurance policy must be made at the time of entering into the insurance contract. The insurance company hands over the application proforma to the person buying insurance seeking complete details. The person has to mention his profession, income, age, family, history of family, general health, ailments suffered, medical reports, matters relating to conduct and character, any criminal record, etc.

Similarly in case of general insurance while insuring an asset all facts regarding the condition, frequency of usage, wear and tear that may have occurred have to be disclosed by the buyer. These details given by the proposer known as **representations** demand correct and full disclosure by the buyer of insurance. Though it may not be possible in the proforma to ask all the required questions since the details vary from person to person, the insurance company determines the materiality of the given facts by exercising due diligence through proper scrutiny.

It is also open to an insurer to seek clarification regarding gaps in information to be furnished. If required, further enquiry is made. This is important, because based on this, the severity of risk is assessed and the amount of premium to be charged can be determined.

The application also mentions the stipulations and conditions which when fulfilled obligate the insurance company to fulfill its promises. It has to be noted that it is the duty of the insurer to inform and explain the insured about the working of those stipulations and broadly set the conditions in which the insurer may be relieved of such obligations to give the insured an idea about the performance of the contract. This helps in dispelling any misunderstanding or ignorance. Of course certain information, which is normally assumed to

be of common knowledge to everyone, need not be disclosed. Thus while buying insurance for an electric generator in India it is not necessary to mention that power failure is common in India and that the gadget will be used more often. Also when a person buys a second policy from the same insurer it is presumed that the insurer will check for the relevant facts about him by referring to the first policy and without seeking explanation all over again. Information related to following matters need not be disclosed:

1. Facts related to law
2. Facts of common knowledge to all
3. Facts which can reasonably be discovered by the insurer
4. Facts which could have been revealed by a survey
5. Facts which have been covered by policy conditions
6. Facts which reduce the risk

Implications of concealment, non disclosure or misrepresentation by the insured

It may turn out from the representations furnished by the customer that the details are incomplete or any important information is concealed or is misleading. In such circumstances it is the choice of the insurer whether to:

1. Incorporate the required changes in the contract and charge a different premium.
2. Accept the policy and pay compensation especially if the facts have negligible importance.
3. Avoid any obligation on its part as per the policy.

It has to be proved by the insurer that the non-disclosure or misrepresentation was intentional on the part of the insured to commit fraud and deceive the insurer before it can stop payment of compensation. As per section 45 of the Insurance Act the insurance company can resort to this stance before the passage of two years after which it cannot take such recourse. Non-disclosure may be unintentional on the part of the insured. Even so such a contract is rendered voidable at the insurers option and it can refuse any compensation. Any concealment of material facts is considered intentional. In this case also the policy is considered void. Suppose a person discovers that he has cancer, which is in its last stages and is hopeless to go for medical treatment. Immediately he buys a life insurance policy where he conceals this fact from the insurers. He dies four months after buying the policy. The insurance company can contest the claim for payment of policy proceeds to his beneficiary on the ground that a vital fact material to the contract was concealed.

Implications of non-disclosure by the insurer

It is true that in a contract of insurance the insured has to furnish more information about him. But there are certain covenants in a contract, which have to be thoroughly elaborated to the insured. These relate to the conditions in which the insurance company may or may not perform its promises.

It has to be noted that it is the duty of both the insurance agent and the company authorities that this particular aspect is looked into. Any laxity at this point may tilt the judgments in favor of the insured in case of a dispute.

Example

In the case of LIC vs. Shakuntalabai, the insured had availed a life insurance policy from LIC. Before taking the policy he had suffered from indigestion for a few days and at the first instance had availed treatment from an ayurvedic doctor. This fact was not disclosed by the insured.

The insured died of jaundice within a few months after buying the policy. Eventually LIC refused to accept the claim on the ground of non-disclosure of information. However the court rejected this stand of LIC since it had not explained this covenant clearly to the insured, which amounts to non-compliance of its responsibilities. Such casual ailments are common and occur many times over and they can be treated by over the counter drugs. It is normally not possible for a person to distinguish a potentially serious ailment inherent in such symptoms. Also it is not possible for a person to remember the details of all such illnesses like cough, cold, headaches, etc., and the medications taken for them after a few months. So these facts are not to be considered as material to the contract and thus their nondisclosure does not invalidate the contract.

Assignment

Assignment is the transfer of the rights to receive the benefits under a contract accruing to the party to that contract. In life insurance parlance, assignment is the transfer of rights to receive benefits stated in the life insurance policy from the Policyholder to the Assignee. The benefits under an insurance policy accrue by way of survival benefits and death benefits. While death benefits accrue in every insurance policy, survival benefits typically relate to maturity benefits under an insurance policy with an underlying investment component, e.g. Endowment Policy, Money-back Policy, Unit Linked Insurance Policy etc.

The concept and procedure for Assignment is dealt with under Section 38 of the Insurance Act, 1938. The Section treats an Assignment and a Transfer at par. It lays down that a transfer or assignment of a policy of life insurance, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the transferor or by the assignor or his duly authorised agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment.

In practice, a ‘space for endorsements’ is provided in the insurance policy contract where the Policyholder (Assignor) affixes the statement of assignment alongwith reasons therefor. This endorsement is required to be signed by the Policyholder and the signature should be witnessed by any person competent to contract. An assignment can be only for valid reasons.

Assignee can be anybody including a minor. In case of the death of the assignee, the property will devolve upon his legal successors. There can be one or more assignees: the policy monies will have to be paid to the legal heirs of the deceased assignee/assignees.

Subsection (1) of Section 38, the Insurance Act,1938, states that an assignment can be made with or without consideration. But all assignments without consideration are not valid.

The insurance policy can be assigned for reasons of ‘love and affection’ within the immediate family members, or for a ‘valid consideration’ to any external person or entity. A majority of insurance policy assignments are carried out towards providing the insurance policy as a collateral security towards loans taken from financial institutions. In these cases, a condition is added to the endorsement which states that on the repayment of the loan, the policy shall stand automatically re-assigned to the policyholder and the future benefits shall become payable to the policyholder. Assignment of an insurance policy to an unrelated person without a valid consideration is also viewed as a possible route for money laundering, thereby attracting enhanced scrutiny.

Under the current laws, the Insurer has the limited authority of ensuring that the assignment documents are in order and has the obligation to register the assignment. The Insurer cannot deny an assignment. An assignment is effective on the date when the assignment documents in proper order are received by the Insurer.

Upon registration of the assignment with the Insurer, the Assignee becomes the absolute owner of the benefits under the policy. Any nominations made by the Assignor (Policyholder) stands cancelled. However some insurance policies enable granting of a loan by the Insurer, in which case the Policy gets assigned to the Insurer. Under such assignments, if the policy is reassigned or if the assignment is cancelled, the nomination made earlier by the policyholder survives and the policyholder is not required to make a fresh nomination after reassignment.

Nomination

Nomination is a facility that enables a Policyholder to nominate an individual, who can claim the proceeds of the Policy, upon the demise of the Policyholder.

Nomination is dealt with under Section 39 of the Insurance Act, 1938. It lays down that the Policyholder who holds a policy of life insurance on his own life, may nominate the person or persons to whom the money secured by the policy shall be paid in the event of his death. Nominee can only receive monies. In case of survival of the life assured till the date of maturity, nomination will be ineffective.

Where any nominee is a minor, a major should be appointed to receive the money secured by the policy in the event of death of the policyholder during the minority of the nominee.

A nomination can be made either at the time of buying the policy or at any time before the policy matures for payment. Any nomination made earlier can be replaced by a new nomination during the term of the policy. Any such nomination in order to be effectual is required to be incorporated within the policy either by way of a text in the policy itself or by way of an endorsement to the policy. While it is the right of the Policyholder to effect the endorsement, in order to be effective, such nomination should be communicated by the policyholder to the Insurer and registered by the Insurer in the records relating to the policy.

Where a nomination is cancelled or changed by an endorsement or a will and a notice of such change in nomination is given by the policyholder to the Insurer, the Insurer is not liable for any payment made under the policy to a nominee mentioned in the text of the policy or registered in records of the insurer.

Where the policy matures for payment during the lifetime of the Policyholder or where the nominee(s) die before the policy matures for payment, the amount secured by the policy shall be payable to the policyholder or his heirs or legal representatives or the holder of a succession certificate, as the case may be.

Where the policy matures for payment during the lifetime of the person whose life is insured or where the nominee or, if there are more nominees than one, all the nominees die before the policy-holder or his heirs or legal representatives or the holder of a succession certificate, as the case may be.

Where the nominee or, if there are more nominees than one, a nominee or nominees survive the person whose life is insured, the amount secured by the policy shall be payable to such survivor or survivors.

Nomination once made is automatically cancelled by:

1. Cancellation/ further change of nomination.
2. Assignment in favour of third party. In case assignment is done in favour of insurance company for a loan out of surrender value of the policy, then nomination will not get cancelled.
3. A will

The legal position of a nominee in an insurance policy, has been well laid down by the Supreme Court in the Smt. Sarabati Devi & Anr v/s Smt. Usha Devi case where it held that a mere nomination made under Section 39 of the Insurance Act, 1938 does not have the effect of conferring on the nominee any beneficial interest in

the amount payable under the life insurance policy on the death of the accused. The nomination only indicates the hand which is authorised to receive the amount, on the payment of which the insurer gets a valid discharge of its liability under the policy. The amount, however, can be claimed by the heirs of the assured in accordance with the law of succession governing them.

Difference between Nomination and Assignment:-

Sl. No	Nomination	Assignment
1.	Nomination is appointing some person(s) to receive policy benefits only when the policy has a death claim.	Assignment is transfer of rights, title and interest of the policy to some person(s).
2.	In other words, by merely nominating someone, the right, title and interest of the insured over the policy is not transferred straight forwardly to that nominated person and remains with the insured person only.	In other words, the insurer is bound to pass over the benefits, claims and/or interests to the assigned person(s). Even during the time the insured is alive (or even prior to the death of the insured person). since the policy benefits are assigned till the time the assignment is revoked once again.
3.	Nomination is done at the instance of the insured	Along with the instance of the insured, consent of insurer is also required
4.	It can be changed or revoked several times.	Normally assignment is done once or twice during the policy period. Assignment can be normally revoked after obtaining the "no objection certificate" from the concerned Assignees.
5	May be witnessed	Must be witnessed, otherwise it will be invalidated
6	If the nominee dies after the life assured and before settlement of claim, the policy monies would be payable to the hiers of the life assured	If the assignee dies after the life assured and before settlement, the policy monies would be payable to the heirs of the assignee.
7	Creditors of the life assured can attach the policy monies.	Creditors cannot attach the policy, unless the assignment is shown to have been made to defraud the creditors.

Matters to be stated in life insurance policy

As per IRDA Regulation 2002, the matters that should be stated in Life Insurance Policy are stated below:

(1) A life insurance policy shall clearly state:

(a) the name of the plan governing the policy, its terms and conditions;

(b) whether it is participating in profits or not;

(c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;

(d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

(e) the details of the riders attaching to the main policy;

(f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;

(g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value.

(h) the age at entry and whether the same has been admitted;

(i) the policy requirements for (a) conversion of the policy into paid up policy, (b) surrender (c) non-forfeiture and (d) revival of lapsed policies;

(j) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;

(k) the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan;

(l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and

(m) the address of the insurer to which all communications in respect of the policy shall be sent.

(n) the documents that are normally required to be submitted by a claimant in support of a claim under the policy.

(2) While acting under regulation 6(1) in forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

(3) In respect of a unit linked policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

(4) In respect of a cover, where premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before issuance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon as possible.

TITLE AND CLAIMS IN LIFE INSURANCE

Title

A life insurance contract provides both survival and death benefits. Hence it is important to ascertain the ownership title to the contract at all stages of benefit payment. While usually the title to the insurance

contract is held by the Policyholder, where the policy has been assigned, the title to the contract passes on to the Assignee and therefore the Assignee assumes the right to receive all survival and death benefits under the contract.

In case of a benefit payable on death, the title to the contract passes on to the Assignee or nominee as the case may be. As discussed earlier, where a policy is assigned, the nomination is treated as cancelled and accordingly, the death benefits become payable to the Assignee. The title to the contract is always determined based on the policy records as available with the Insurer.

There are policies taken by the parent/legal guardian covering the life of a minor child where the benefits are intended to be passed on to the child when the child attains the age of majority. These are typically termed 'juvenile' policies. In these policies, the parent/ legal guardian holds the title to the policy on behalf of the minor child till the child attains the age of majority. The policy provisions are designed in a manner such that the title to the policy automatically vests in the life assured, upon the child attaining the age of majority.

Claim

A claim under a life insurance contract is triggered by the happening of one or more of the events covered under the insurance contract. Claims can be survival claims and death claim. While a death claim arises only upon the death of the life assured, survival claims can be caused by one or more events. Examples of events triggering survival claims are:

a. Maturity of the policy;

b. Surrender of the policy either by the policyholder or Assignee;

c. An instalment payable upon reaching the milestone under a money-back policy;

d. Critical illnesses covered under the policy as a rider benefit;

For payment of a survival claim, the Insurer has to ascertain that the event has occurred as per the conditions stipulated in the policy. Maturity claims, money-back instalment claims and surrender claims are easier to be established as they are based on dates and positive action by the policyholder. Critical illness claims are ascertained based on the medical and other records provided by the policyholder in support of his claim. The complexity arises in case of a policy that has a critical illness claim rider and such policy is assigned. It is intended that a critical illness benefit should be paid to the policyholder so as to enable him defray his expenses. However where the policy is assigned, all benefits are payable to the assignee which, although legally correct, may not meet the intended purpose. In order to avoid such situation, it is important to educate the policyholder of such policies on the extent of benefits that the policyholder may assign, by way of a conditional assignment.

The triggering of a maturity or death claim leads to termination of the insurance cover under the contract and no further insurance cover is available. This is irrespective of whether the claim is actually paid or not. Nonpayment of a claim does not assure the continuity of insurance cover under the contract.

While in most cases, a claim is disputed by the Insurer on the basis of such claim not meeting the policy conditions, there are times where the insurer has ascertained that the death claim is payable but is unable to settle the same due to conflicting claims or insufficiency of proof of title of the rightful claimant. This happens under the following circumstances:

1. Absence of nomination by the policyholder;

2. Non-registration of an assignment;

3. Multiple claimants with conflicting claims with insufficient proof of title;
4. Where the claimant has approached the Court for settlement of property disputes including insurance claims;
5. Circumstances where it is impossible for the Insurer to obtain a satisfactory discharge from the claimant.

Under these circumstances, Section 47 of the Insurance Act, 1938 provides as follows:

Section 47(1) Where in respect of any policy of life insurance maturing for payment an insurer is of opinion that by reason of conflicting claims to or insufficiency of proof of title to the amount secured thereby or for any other adequate reason it is impossible otherwise for the insurer to obtain a satisfactory discharge for the payment of such amount, the insurer may, apply to pay the amount into the Court within the jurisdiction of which is situated the place at which such amount is payable under the terms of the policy or otherwise.

(2) A receipt granted by the Court for any such payment shall be a satisfactory discharge to the insurer for the payment of such amount.

(3) An application for permission to make a payment into Court under this section shall be made by a petition verified by an affidavit signed by a principal officer of the insurer setting forth the following particulars, namely:

a. the name of the insured person and his address;
b. if the insured person is deceased, the date and place of his death;
c. the nature of the policy and the amount secured by it;
d. the name and address of each claimant so far as is known to the insurer with details of every notice of claim received;
e. the reasons why in the opinion of the insurer satisfactory discharge cannot be obtained for the payment of the amount; and
f. the address at which the insurer may be served with notice of any proceeding relating to disposal of the amount paid into Court.

(4) An application under this section shall not be entertained by the Court if the application is made before the expiry of six months from the maturing of the policy by survival, or from the date of receipt of notice by the insurer of the death of the insured, as the case may be.

(5) If it appears to the Court that a satisfactory discharge for the payment of the amount cannot otherwise be obtained by the insurer it shall allow the amount to be paid into Court and shall invest the amount in Government securities pending its disposal.

(6) The insurer shall transmit to the Court every notice of claim received after the making of the application under sub-section (3), and any payment required by the Court as costs of the proceedings or otherwise in connection with the disposal of the amount paid into Court shall as to the cost of the application under sub-section (3) be borne by the insurer and as to any other costs be in the discretion of the Court.

(7) The Court shall cause notice to be given to every ascertained claimant of the fact that the amount has been paid into Court, and shall cause notice at the cost of any claimant applying to withdraw the amount to be given to every other ascertained claimant.

(8) The Court shall decide all questions relating to the disposal of claims to the amount paid into Court.

Claims on small life insurance policies

47A (1) In the event of any dispute relating to the settlement of a claim on a policy of life insurance assuring a sum not exceeding two thousand rupees (exclusive of any profit or bonus not being a guaranteed profit or bonus) issued by an insurer in respect of insurance business transacted in India, arising between a claimant under the policy and the insurer who issued the policy or has otherwise assumed liability in respect thereof, the dispute may at the option of the claimant be referred to the Authority for decision and the Authority may, after giving an opportunity to the parties to be heard and after making such further inquires as he may think fit, decide the matter.

(2) The decision of the Authority under this sub-section shall be final and shall not be called in question in any Court, and may be executed by the Court which would have been competent to decide the dispute if it had not been referred to the Authority as if it wore a decree passed by that Court.

(3) There shall be charged and collected in respect of the duties of the Authority under this section such fees whether by way of percentage or otherwise as may be prescribed.

The IRDA (Protection of Policyholders Interests) Regulations, 2002 also provides as follows:

Regulation 8. Claims procedure in respect of a life insurance policy

(1) A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.

(2) A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible**,** shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

(3) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

(4) Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

(5) Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

TAX LAW IMPLICATIONS IN LIFE INSURANCE

Historically life insurance in India has been driven mainly by benefits doled out under the Income Tax Act, 1961. Different sections under the Income Tax Act, 1961 deal with benefits at the purchase, renewal and claim stages of a life insurance policy. Life insurance policies have been used as effective tax planning tools.

Following are some of the sections under the Income Tax Act, 1961 dealing with tax benefits for life insurance policies:

Deductions under Sections 80C/80CCC/80D:

Under Section 80C of the Act, premiums paid by the Assessee on policies held by himself, spouse or children is eligible for deduction to an overall ceiling of 1.5 lakhs from the gross total income. Not all life insurance premium paid is tax deductible. If the policy is issued on or before March 31, 2012, annual premium up to a maximum of 20% of the Sum Assured is tax deductible. In case the policy is issued on or after April 1, 2012, annual premium up to a maximum of 10% of Sum Assured is tax deductible. An additional relaxation of 5% (i.e. up to 15% of Sum Assured) is available to person suffering from disability or sever disability (as specified under Section 80 U) or to those suffering from a disease or ailment as specified under Section 80DDB. For a life insurance policy, Sum Assured is the minimum amount assured to the nominee (of the policyholder) in the event of death of the policy holder.

Let's consider an example. If you purchase an insurance policy with a sum assured of Rs 8 lacs and an annual premium of Rs 1 lacs, only Rs 80,000 (10% of Sum Assured) is tax deductible. You won't get any tax benefits for the balance premium. Any premium in excess of the aforesaid limit (10% of Sum Assured for the new policies) shall not qualify for tax deduction under section 80C of the Income Tax Act.

Section 80CCC deals with contributions to approved pension products. It lays down that an individual assessee who has paid premiums out of his income chargeable to tax to effect or keep in force a contract for any annuity plan of Life Insurance Corporation of India or any other insurer for receiving pension from the fund approved under Section 10 (23AAB), he shall be allowed a deduction in the computation of his total income, of the whole of the amount paid or deposited (excluding interest or bonus accrued or credited to the assessee's account, if any) upto a maximum of Rs.10000/- in the previous year.

However any amount received under the policy by the assessee either by way of surrender of the policy or pension from the annuity plan, such amount shall be treated as income chargeable to tax during the year of receipt.

Section 80CCD deals with contributions to approved pension products by an individual assessee. It lays down that where an assessee, being an individual has in the previous year paid or deposited any amount in his account under a notified pension scheme, he shall be allowed a deduction in the computation of his total income, of the whole of the amount so paid or deposited as does not exceed 10% of his salary (in case of Central Government employees) or 10% of his gross total income (in any other case) in the previous year.

However any amount received under the policy by the assessee either by way of surrender of the policy or pension from the annuity plan, such amount shall be treated as income chargeable to tax during the year of receipt.

CONCEPT OF TRUSTS IN LIFE POLICY

The concept of Trusts in a Life policy is necessitated by the applicability of estate duty on transfer/inheritance of benefits under a life insurance policy, including annuities. While with the abolition of estate duty in India, the concept of Trusts may no longer be preferred, it is beneficial to understand the subject in detail. Further Section 6 of the Married Women's Property Act, 1874 provides for security of benefits under a Life insurance policy to the wife and children and this is also been discussed later in this chapter.

A Trust under a life insurance policy is created by the Policyholder holding the policy on his own life and where the survival benefits inure to the policyholder. The Trust is set-up under a irrevocable, non-amendable Trust Deed and can hold one or more insurance policies. It is important to appoint a trustee for administration

of the Trust property, being benefits under the life policy. By creating a Trust to hold the insurance policies, the policyholder gives up his rights under the policy and upon the death of the life insured, the Trustee invests the insurance proceeds and administers the Trust for one or more beneficiaries. While, it is a practice to create the Trust for the benefit of the spouse and children, the beneficiaries can be any other legal person. Creating a Trust ensures that the policy proceeds are invested wisely during the minority of the beneficiary and also secures the benefits against future creditors.

Section 6 of the Married Women's Property Act, 1874 also provides for creation of a Trust. It lays down that a policy of insurance effected by any married man on his own life, and expressed on the face of it to be for the benefit of his wife, or of his wife and children, or any of them, shall ensure and be deemed to be a trust for the benefit of his wife, or of his wife and children, or any of them, according to the interest so expressed, and shall not, so long any object of the trust remains, be subject to the control of the husband, or to his creditors, or form part of his estate.

If the Policyholder does not appoint a special trustee to receive and administer the benefits under the policy, the sum secured under the policy becomes payable to the Official Trustee of the State in which the office at which the insurance was effected is situated.

Creation of a Trust under the Act does not destroy or impede the right of any creditor to be paid out of the proceeds of any policy of assurance, which may have been effected with intent to defraud creditors.

STAMP DUTIES

Stamp duty payable on a policy of life insurance is governed by the Indian Stamp Act, 2014.

Section 2(19) of the Act defines a Policy of insurance to include a life-policy, and any policy insuring any person against accident or sickness, and any other personal insurance;

Section 2(19A) of the Act defines a policy of group insurance to mean any instrument covering not less than fifty or such smaller number as the Central Government may approve, either generally or with reference to any particular case, by which an insurer, in consideration of a premium paid by an employer or by an employer and his employees jointly, engages to cover, with or without medical examination and for the sole benefit of persons other than the employer, the lives of all the employees or of any class of them, determined by conditions pertaining to the employment, for amounts of insurance based upon a plan which precludes individual selection;

Schedule 47(D) of Schedule 1 to the Indian Stamp Act, 1899 lays down the manner of calculation of stamp duty on a policy of life insurance. The stamp duty is calculated at 0.02% per Rs.1000/- sum assured. If a policy of group insurance is renewed or otherwise modified whereby the sum insured exceeds the sum previously insured, duty is payable on the excess sum so insured.

On a Policy of annuity, stamp duty is calculated as follows:

(a) Annuity Certain – Where the annuity is guaranteed for a predetermined period, the amount of stamp duty will be based on the total annuity amount payable during such certain period i.e. the annuity per annum multiplied by number of years.

(b) Annuity for Life – Where the annuity is payable during the lifetime of the annuitant, the amount of stamp duty will be based on the annuity amount payable for 12 years.

ROLE AND FUNCTION OF LIFE INSURANCE COMPANIES

Life Insurance Companies in India have a big role to play. It is the life insurance Companies which collects

the savings of a person and converts into the wealth. The functions and role of Life Insurance Company may be understood as:

1. Saving Institution:

Life insurance companies both promote and mobilises saving in the country. The income tax concession provides further incentive to higher income persons to save through LIC's policies. The total volume of insurance business has also been growing with the spread of insurance-consciousness in the country.

2. Term Financing Institution:

Life Insurance Companies also functions as a large term financing institution (or a capital market) in the country. The annual net accrual of investible funds from life insurance business (after making all kinds of payments liabilities to the policy holders) and net income from its vast investment are quite large. During 1994-95, LIC's total income was Rs. 18,102.92 crore, consisting of premium income of Rs. 11,528.00 crore investment income of Rs. 6,336.19 crore, and miscellaneous income of Rs. 238.33 crore.

3. Investment Institutions:

LIC is a big investor of funds in government securities. Under the law, LIC is required to invest at least 50% of its accruals in the form of premium income in government and other approved securities.

LIC funds are also made available directly to the private sector through investment in shares, debentures, and loans. LIC also plays a significant role in developing the business of underwriting of new issues.

4. Stabiliser in Share Market:

LIC acts as a downward stabiliser in the share market. The continuous inflow of new funds enables LIC to buy shares when the market is weak. However, the LIC does not usually sell shares when the market is overshot. This is partly due to the continuous pressure for investing new funds and partly due to the disincentive of the capital gains tax.

5. Biggest Employers in economy

Life Insurance Companies in India are one of the biggest employers. In addition to direct employment, Lakhs of People are getting the employment as Agents.

IRDA New Guidelines on Life Insurance: Moving towards transparency and efficiency

The new guidelines issued by The Insurance Regulatory and Development Authority (IRDA) for life insurance products specially traditional products, is an attempt at making life insurance true to its core value, more transparent and customer friendly. Most of the new guidelines require noteworthy changes in processes, systems, as well as fundamental changes to product design and offerings.

The guidelines follow overarching themes of providing:

1. Transparency
2. Protection Orientation
3. Customer centricity
4. Long term focus

1. Transparency

In order to bring transparency, the regulator has ensured that all insurance products provide the prospective

policyholder a customised benefit illustration on guaranteed and non-guaranteed benefits at gross investment returns of 4% and 8% respectively for all products. Currently, this is mandatory only for ULIPs. This benefit illustration should be signed by the customer and the agent as a part of the policy contract. This will give policyholders an indicative idea of the benefits they can expect not only at maturity, but also every year of the policy term as well.

Another step to ensure transparency in the requirement to set up a "With Profit Committee", at the board level of every insurance company. This committee will approve asset mix and expense allocated for and investment income earned on the fund. This in turn will lead to improved and more transparent corporate governance in the administration of participating or 'with profit' policies.

2. Protection Orientation

The regulator has directed that the minimum sum for all policies will now be 10 times of the annual premium for people below 45 years and above 7 times for 45 years and above. At any point the death benefit will have to be at least 105% of all premiums paid till date. Through this the regulator aims to promote life insurance for its core value of protection.

3. Customer Centricity

As per the new norms, traditional policies will now have better surrender value after the completion of 5 years. If the policyholder has to exit their policy before completion of policy tenure, he/she will be entitled to a higher surrender value especially in early part of the policy tenure. Currently, there are no preset rules. In the new regime the minimum guaranteed surrender value will be 30% of all premiums paid going up to 90% of the premiums paid in the last two policy years. Through this step the regulator has acted in the larger interests of the consumer by providing liquidity for sudden emergencies that may occur. Thus with these new regulations customer retention and need based selling becomes even more important by the day.

4. Long term focus

In order to re-emphasize the long term nature of the life insurance business the guidelines have also correlated agents' Compensation to the policy terms. Short-term policies will now have a lower commission than traditional products with a policy term of 12 years or more. In case of regular premium insurance policies, a policy with a premium paying term (PPT) of five years will limit commissions to 15% in the first year, 7.5% in the second and third year and 5% subsequently. Products with PPT of 12 years or more will have first year commissions up to 35% in case the company has completed 10 years of existence and 40% for the company in business for less than 10 years. This will incentivize intermediaries in selling long-term life insurance products espousing benefits for disciplined savers.

LESSON ROUND UP

- Risk pooling Life insurance is based on a concept called *risk pooling,* or a group sharing of losses.
- People exposed to a risk agree to share losses fairly or on an equitable basis.
- The Principle *of large numbers* states that as the size of the sample (insured population) increases, the actual loss experience will more and more closely approximate the true underlying probability.
- The object of Insurance should be lawful; the person proposing for Insurance must have interest in the continued life of the insured & would suffer pecuniary loss if the insured dies.
- Where the proposal is on the life of another, unless the proposer has insurable interest in the life to be assured, the contract shall be void.

- Assignment is the transfer of the rights to receive the benefits under a contract accruing to the party to that contract.
- In life insurance parlance, assignment is the transfer of rights to receive benefits stated in the life insurance policy from the Policyholder to the Assignee.
- Nomination is a facility that enables a Policyholder to nominate an individual, who can claim the proceeds of the Policy, upon the demise of the Policyholder.
- As per IRDA Regulation 2002, there are certain matters that should be stated in Life Insurance Policy
- While usually the title to the insurance contract is held by the Policyholder, where the policy has been assigned, the title to the contract passes on to the Assignee and therefore the Assignee assumes the right to receive all survival and death benefits under the contract.
- A claim under a life insurance contract is triggered by the happening of one or more of the events covered under the insurance contract.
- Claims under Section 80C of the Act, premiums paid by the assessee on policies held by himself, spouse or children is eligible for deduction to an overall ceiling of Rs 1.5 lakhs from gross total income.
- The concept of Trusts in a Life policy is necessitated by the applicability of estate duty on transfer/inheritance of benefits under a life insurance policy, including annuities.
- The new guidelines issued by The Insurance Regulatory and Development Authority (IRDA) for life insurance products specially traditional products, is an attempt at making life insurance true to its core value, more transparent and customer friendly

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. Explain the basic principles of life insurance with examples.
2. What do you mean by Nomination? Explain the difference between Assignment and Nomination.
3. As per IRDA Regulation 2002, what are the matters that should be stated in Life Insurance Policy.
4. Describe Titles and Claims in insurance contracts.
5. What are the tax implications in life insurance under the Income Tax Act of India?
6. Write a short note on role and functions of Insurance companies.
7. What are the new guidelines issued by the IRDA for making life insurance transparent and friendly.

Lesson 8
LIFE INSURANCE AND PENSION PRODUCTS

LESSON OUTLINE

- Life Insurance Products
- Pure Protection Insurance
- Protection + Savings Insurance
- Pure Savings And Pensions
- Proposal Form
- Policy Contract And Documentation
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

The main risks in respect of life insurance are:

(1) Risk of dying too young;

(2) Risk of living too long

While the risk of dying too young can be addressed by taking a pure term life insurance cover that protects the financial loss to the family on the death of the member, the risk of living too long is addressed by savings and pension plans that helps accumulate a corpus to be received as annuity during the old age. Pure protection plans provide a financial benefit for the family while pension plans provide a benefit for the policyholder himself.

In this chapter we will discuss about the various types of life insurance products that can be designed as per the regulations issued by the Insurance Regulatory and Development Authority. We further discuss the design and contents of a Proposal form, Policy contract and the documentation required at various stages of the Policy life cycle.

LIFE INSURANCE PRODUCTS

Section 2(11) of the Insurance Act, 1938 [As amended by the Insurance Laws (Amendment) Act, 2015] defines Life Insurance Business as follows:

"Life Insurance Business" means the business of effecting contracts of insurance upon human life, including any contract whereby the payment of money is assured on death (except death by accident only) or the happening of any contingency dependent on human life, and any contract which is subject to payment of premiums for a term dependent on human life and shall be deemed to include--

(a) the granting of disability and double or triple indemnity accident benefits, if so provided in the contract of insurance,

(b) the granting of annuities upon human life; and

(c) the granting of superannuation allowances and benefit payable out of any fund applicable solely to the relief and maintenance of persons engaged or who have been engaged in any particular profession, trade or employment or of the dependents of such persons;

(Explanation – For the removal of doubts, it is hereby declared that “Life insurance business” shall include any unit linked insurance policy or scrips or any such instrument or unit, by whatever name called, which provides a component of investment and a component of insurance issued by an insurer referred to in clause (9) of this section.)

While under the current Act, health insurance has not been identified as a separate sector, the Bill proposes to introduce a separate sub-section to define health insurance business as follows:

(6C) “Health Insurance Business” means the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover

Given the above, life insurance products can be broadly classified into:

A. Pure protection plans;

B. Protection cum savings plans;

C. Pure savings and pension plans;

These can be further classified into:

I. Term insurance & Health Insurance plans

II. Endowment & Money-back plans

III. Whole life plans

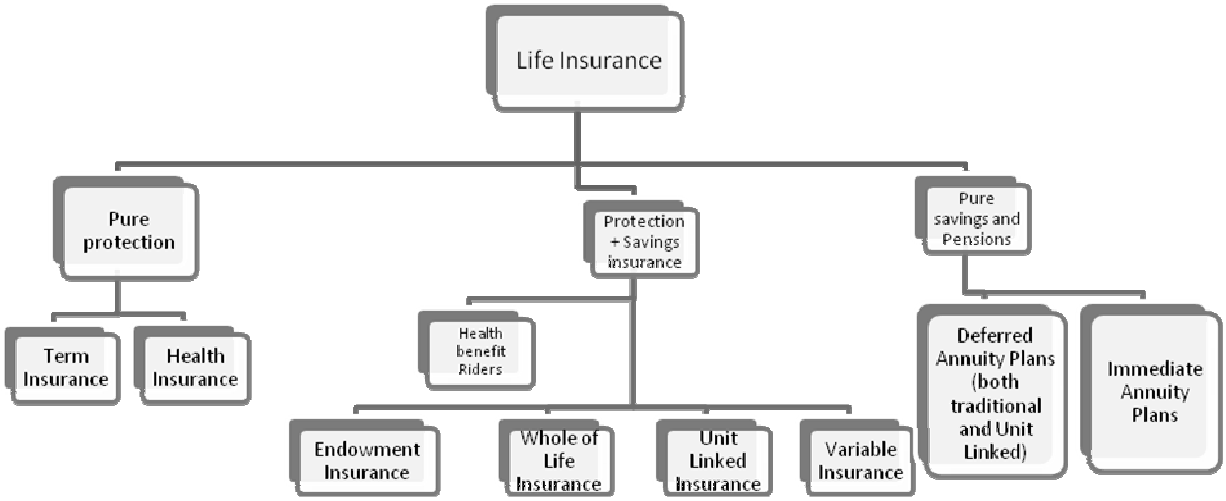
IV. Pension and savings plans

V. Unit linked insurance plans (ULIPs)

VI. Variable Insurance plans (VIPs)

Further, apart from stand-alone health insurance companies providing health insurance products, health insurance is also provided by life insurance companies both as riders to other products as well as standalone health plans.

A graphical representation of the different types of life insurance plans is reproduced below:



Pure term insurance as well as Pension plans are also structured as Group insurance policies where a homogenous group of lives are covered. Variants of Group insurance are employer-employee groups, lender-borrower groups (credit life), social sector groups etc.

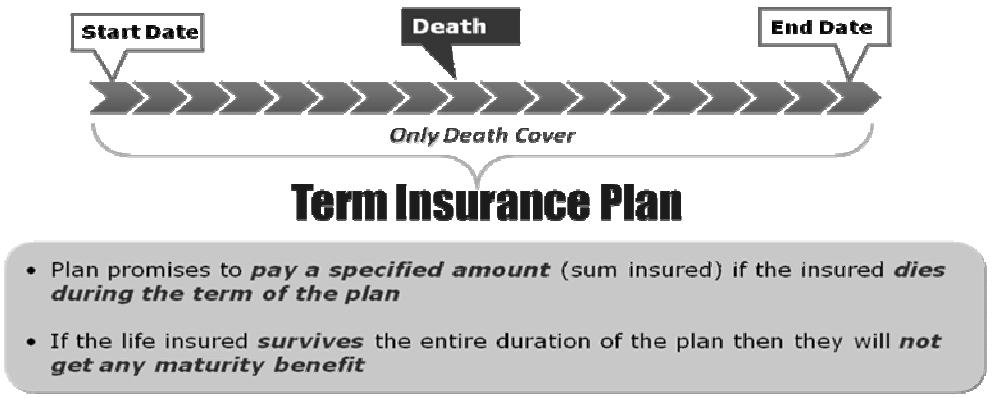
In order to effectively regulate the sector, the IRDA has issued various regulations for different types of life insurance products. These regulations stipulate the structure and broad features of different types of products with a view to ensuring protection of policyholders interests as well as robust development of the industry.

The broad features of different types of insurance are discussed below:

A. PURE PROTECTION INSURANCE

A pure protection plan is a simple risk cover insurance product where the sum assured becomes payable upon the happening of the risk event during the term of the policy. The two variants of a pure protection plan are:

1. **Term Insurance plan** – A term insurance plan provides a pure risk cover where the sum assured becomes payable upon death of the life assured during the term of the policy. Since there is only a risk cover, the premiums are usually low and affordable and the policy assures a financial security to the family members upon death of the life assured. The term of the policy is fixed and where the life assured survives the full term, no amount is payable. Some variants of pure protection plans also assure a return of some or whole of the premiums paid if the life assured survives the term of the policy. The benefit arising to the insurance company in such case is the income out of the premiums invested during the term.



2. **Health Insurance plan** – A health insurance plan provides a pure risk cover where the sum assured becomes payable upon the life assured being diagnosed of certain identified illness during the term of the policy. Health insurance is also popularly known as Medical Insurance or Mediclaim that covers medical expenses including hospitalization expenses. The type and amount of health insurance depends upon the scope of illnesses covered and the extent of expenses required to be covered. Health insurance benefits are also available as riders in group insurance plans.

While life is very uncertain, a person may not stay healthy & fit throughout their life. Therefore it is prudent to have health cover at every stage of life. If a major illness like heart failure is diagnosed & the funds for treatment cannot be immediately arranged. It may lead to loss of life. If the family resorts to costly personal loans for treatment & the life of the person cannot be saved then the family could incur huge debts. Having health insurance cover can help to overcome this problem.

The age of a person at the time of taking the health cover is very vital. Usually health plans are annually renewable policies, the cost will increase as the person gets older, regardless of the age of the policyholder when the policy commences.

Some of the critical illnesses that are usually covered under a health insurance plan are:

- Blindness
- Stroke
- Major organ transplant
- Multiple Sclerosis
- Paraplegia
- Arota Surgery
- Kidney failure
- Heart attack
- Cancer
- Coma

The list of illnesses differs between various health plans of different insurance companies and the premium would also differ according to the illnesses covered.

A. PROTECTION + SAVINGS INSURANCE:

Life insurance is usually a long term contract and thus is used world over as an effective investment instrument. In Protection cum Savings insurance products, in addition to getting a pure term insurance cover, the policyholder is also able to leverage long term savings. Life insurance plans are an excellent choice for providing for Protection needs, Long term goals such like children's education and marriage, retirement and others.

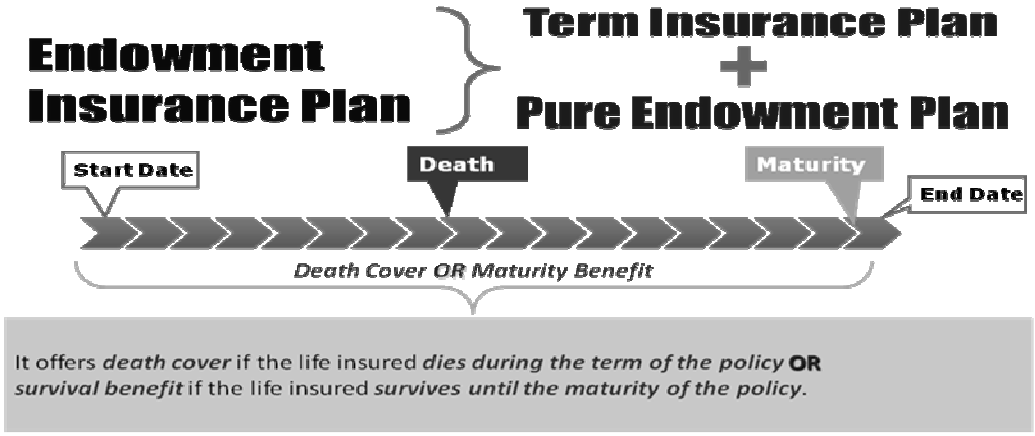
In such plans, the premium payable is divided into two parts:

- Premium for life coverage – provides financial protection in case of death
- Premium for savings element – Is invested by the insurance company on behalf of the policyholders.

The returns earned from investment are set-off against the expenses and the surplus is shared among policyholders in the form of bonuses. Here the investment risk is borne by the Insurance Company.

1. Endowment Insurance

An endowment insurance offers death cover if the life insured dies during the term of the policy and also offers a Survival benefit if the life insured survives until the maturity of the policy.



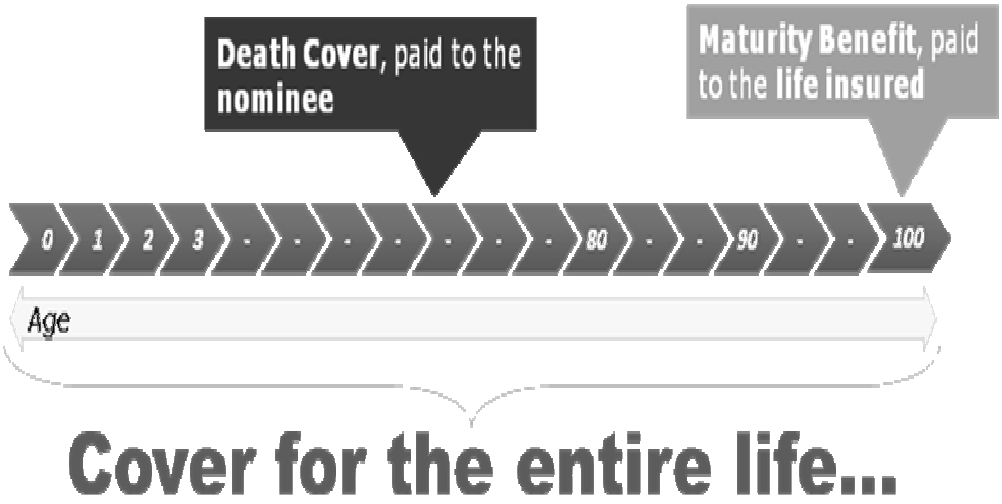
Some of the key features of an Endowment insurance plan are -

- If the life insured ***survives*** the entire term of the plan, then a ***specified amount*** is paid to him/her on ***maturity*** of the plan
- If the life insured ***dies*** before the maturity of the plan, then the ***death cover benefit*** is paid to the ***nominee/beneficiary***
- ***Savings element:*** After deducting the death cover charges & administration charges from the premium, the remaining amount is invested by the insurance company. The returns earned are later paid back to the life insured in the form of bonuses.
- ***Goal-based investment:*** Helps in accumulating money for specific plans like a child's higher education or marriage, etc.
- Some insurance companies also allow ***partial withdrawal*** or ***loans*** against these policies
- There are different variants under this plan –

- ***Higher death cover*** than the maturity benefit
- Maturity benefit is double the death cover, known as a double endowment insurance plan

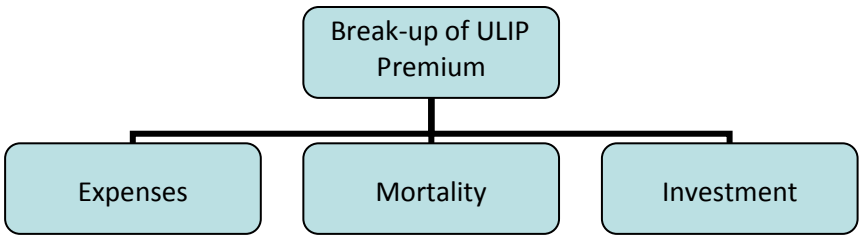
2. Whole of Life Insurance

A term insurance plan with an *unspecified period* is called a *whole life plan*. Some plans also have a *savings* element to them. The insurance company declares bonuses for these plans based on the returns earned on investments. As the name of the plan specifies, this plan *covers the individual* throughout their *entire life*. On the *death* of the life insured, the *nominee/beneficiary* is paid the *sum insured* along with the *bonuses accumulated* up until that point in time. During the individual's lifetime they can make *partial withdrawals* to meet emergency requirements. An individual can also take out *loans* against the policy. Although, in case of Whole Life Plans, sum assured is payable only on death, some insurers pay the sum assured when *life insured completes a certain age*. For example, 80 years, 90 years, 100 years, etc.



3. Unit Linked Insurance Plan

A Unit Linked Insurance Plan or 'ULIP' as it is popularly known is basically a combination of insurance as well as investments, similar to a protection cum savings plan. While a part of the premium paid is utilized to provide insurance cover to the policy holder the remaining portion is invested in various equity and debt schemes. A fund is created from a pool of premiums collected from policyholders and the fund is used to invest in various market instruments (debt and equity) in varying proportions similar to mutual funds. The significant difference between a protection cum savings plan and a ULIP is that the investment risk in a ULIP is borne by the policyholder (similar to a Mutual Fund), whereas the risk is borne by the Insurance company in the other case. The Policy holders can select the type of funds (debt or equity) or a mix of both based on their investment need and risk appetite. ULIP policy holders are allotted units and each unit has a net asset value (NAV) that is declared on a daily basis. The NAV is the value based on which the net rate of returns on ULIPs are determined. The NAV varies from one ULIP to another based on market conditions and the fund's performance.



Investment fund options offered by ULIPs			
Equity Fund	*Debt Fund*	*Balanced Fund*	*Money Market Fund*
This fund invests major portion of the money in equity and equity related instruments	This fund invests major portion of the money in Government Bonds, Corporate Bonds, Fixed Deposits etc.	This fund invests in a mix of equity and debt instruments	This fund invests money mainly in instruments such as Treasury Bills, Certificates of Deposit, Commercial Paper etc.

Features - ULIP policy holders can make use of features such as top-up facilities, switching between various funds during the tenure of the policy, reduce or increase the level of protection, options to surrender, additional riders to enhance coverage and returns as well as tax benefits.

Types - There are a variety of ULIP plans to choose from based on the investment objectives of the investor, his risk appetite as well as the investment horizon. Some ULIPs allocate a larger portion of the invested capital in debt instruments while others purely invest in equity. Again, all this is totally based on the type of ULIP chosen for investment and the investor preference and risk appetite.

Charges - Unlike traditional insurance policies, ULIP schemes have a list of applicable charges that are deducted from the payable premium. The notable ones include policy administration charges, premium allocation charges, fund switching charges, mortality charges, and a policy surrender or withdrawal charge. Some Insurer also charge "Guarantee Charge" as a percentage of Fund Value for built in minimum guarantee under the policy.

Risks - Since ULIP returns are directly linked to market performance and the investment risk in investment portfolio is borne entirely by the policy holder, one needs to thoroughly understand the risks involved and one's own risk absorption capacity before deciding to invest in ULIPs.

4. Variable Insurance Plan

Variable life insurance is a permanent life insurance policy with an investment component. Variable universal life insurance can help meet the needs of those who want life insurance protection with the potential to build cash value. The policy has a cash value account, which is invested in a number of sub-accounts available in the policy. A sub-account act similar to a mutual fund, except it's only available within a variable life insurance policy. A typical variable life policy will have several sub-accounts to choose from, with some offering upwards of 50 different options.

The cash value account has the potential to grow as the underlying investments in the policy's sub-accounts grow - at the same time, as the underlying investments drop, so may the cash value. The appeal to variable life insurance lies in the investment element available in the policy and the favorable tax treatment of the policy's cash value growth. Annual growth of the cash value account is not taxable as ordinary income. Furthermore, these values can be accessed in later years and, when done properly through loans using the account as collateral, instead of direct withdrawals, they may be received free of any income taxation.

Similar to mutual funds and other types of investments, a variable life insurance policy must be presented with a prospectus detailing all policy charges, fees and sub-account expenses.

A. Pure savings and Pensions

Pure savings and Pension plans address the risk of living too long. In the age of medical advancement where the mortality rates have declined and life span has increased significantly, it is important that the individual saves enough to meet his financial needs during the age when his earning capacity diminishes. In the Indian context, with the growth of the Indian economy, the nuclear family system is fast spreading and therefore old aged parents are left to fend for themselves. In order to mitigate the risk of not being able to meet financial needs during such old age, the savings and pension plans are effective tools.

These plans should be looked at two parts:

- Savings or accumulation stage – Deferred Annuity Plans. Under the deferred annuity plan, the policyholder contributes a small amount on a monthly/quarterly/ annual basis and on maturity, the sum assured is used to buy a pension plan (immediate annuities) that will provide a monthly income throughout retirement. These plans are best when bought at a young age as the corpus depends upon the period of accumulation.

  The term of the policy is called deferment period. During this period, the insurance company will invest the lump sum amount on behalf of the policyholder and earn returns on it. The maturity of the policy is called vesting where the accumulated corpus will be used to pay a regular annuity to the policyholder.

  At the time of vesting the policyholder can decide whether to buy the immediate annuity plan from the same insurance company or some other life insurer of his choice. This option to choose the pension provider is known as the open market option.

  At the time of vesting the policyholder will also have the choice of selecting the type of annuity plan that he would like from the annuity options available to him. The annuity payout will depend on the type of annuity chosen and the rates prevailing at the time of vesting

  The deferred annuity plans are available both in traditional and ULIP forms. In India the deferred annuity plans are largely driven by tax benefits.

Payout or annuity stage – Immediate Annuity Plans

An annuity is a series of regular payments from an annuity provider (insurance company) to an individual (called the annuitant) in return for a lump sum (purchase price) or installment premiums for a specified number of years. Annuities are usually sold by life insurance companies. They may be purchased by a single lump sum payment or under a deferred annuity plan. The premium (purchase price) may be made by the person who is to be the annuitant or another annuity purchaser such as the annuitant’s employer, other personal benefactor or a pension scheme.

The tax laws in India stipulate that upon vesting of a deferred annuity plan, only 1/3rd of the vested amount can be paid out as a lumpsum and the balance should be necessarily paid out only as annuities.

Some of the types of immediate annuities available in the market are:

- Life Annuity
- Life Annuity with returns
- Joint Life Annuity
- Guaranteed Annuity
- Increasing Annuity

PROPOSAL FORM

The Insurance policy is a legal contract between the Insurer and the Policyholder. As is required for any contract there is a proposal and an acceptance. The application document that is used for making the proposal is commonly known as the 'Proposal Form'. All the facts stated in the Proposal form becomes binding on both the parties and failure to appreciate its contents can lead to adverse consequences in the event of claim settlement.

The Proposal form has been defined under IRDA (Protection of Policyholders' Interests) Regulations, 2002 as "it means a form to be filled in by the proposer for insurance 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 decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted.

Explanation: "Material" for the purpose of these regulations shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the insurer."

While the IRDA had defined the Proposal form, the design and content was left open to the discretion of the Insurance company. However based on the feedback received from policyholders, intermediaries, Ombudsmen and Insurance companies, the IRDA felt it necessary to standardise the form and content of the Proposal Form. Thus the IRDA has issued the IRDA (Standard Proposal form for Life Insurance) Regulations, 2013. While the IRDA has prescribed the design and content, it has provided the flexibility to the Insurance companies for seeking additional information. The Proposal form carries detailed instructions not only for the Proposer and the Proposed Life Insured but also to the Intermediary who solicits the policy and assists in filling up the form.

It also requires the Proposer and the Proposed Insured to declare the correctness and authenticity of the information provided in the form. In addition, the Intermediary is required to certify that he has explained the features of the policy, including terms and conditions, premium requirements, exclusions and applicable charges to the Proposer.

It is pertinent to mention here that the Proposal form gains utmost importance in any insurance contract, as the insurance company offers a cover on the basis of information provided in the Proposal form. Through the Proposal form, the Insurer seeks to elicit all material information of the Proposer and the Proposed Insured, which includes name, age, address, education, income and employment details of the Proposer, medical history of the Proposed Insured and his family members, income details, any existing life insurance cover on the Proposer as well as Proposed Insured. The Information sought in the Proposal form is important for an insurance company to assess the risk that can be underwritten and also to comply with other regulatory requirements such as the 'Know Your Customer' norms.

The IRDA regulations divide the Proposal form into the following broad sections:

Section A – contains details of the Proposer;

Section B – contains specialized/additional information which may vary based on the product;

Section C – contains suitability analysis which is highly recommended;

Section D – contains details of the product proposed.

Some of the Insurers also have online versions of the Proposal form, through which an Insurance policy can be proposed online by the Proposer on the website of the Insurance Company.

The Intermediary plays a very vital role in executing the Proposal form. It is the responsibility of the intermediary to not only explain the features and benefits of the product but also explain the significance of the information sought in the Proposal form and thus help the Proposer appreciate the essence of material information.

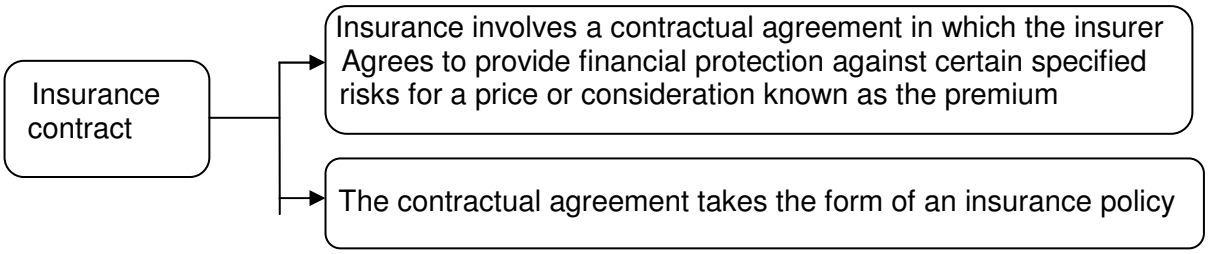
This is where the doctrine of “Uberrima fides” becomes very important. The Insurance Company relies on the information provided in the Proposal form for taking a decision on acceptance of the risk and issuing the Insurance policy. In the event it is discovered later that the information provided was incorrect or any material fact was concealed in the Proposal form, the Insurance Company may deny paying benefits under the Policy. Insurance litigations in the country are predominantly on the premise of rejection of claim due to non-disclosure of material facts and there are numerous cases which have reinforced the principle of “Uberrima fides”.

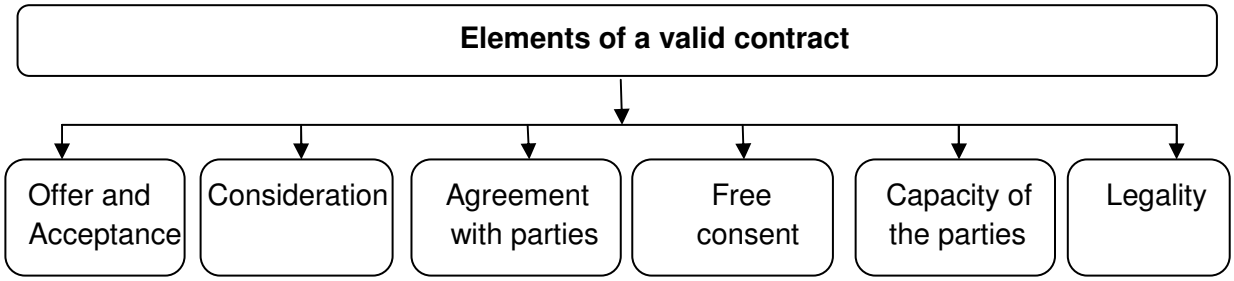
POLICY CONTRACT AND DOCUMENTATION

An Insurance Contract is known as a contract of 'Uberrimate Fides' or a contract based on 'utmost good faith', which means both the parties must disclose all material facts. Insurance contract is regulated by guidelines, rules, regulations, notifications and circulars of IRDA though not defined anywhere. It is a Intangible product. In return for the price (premium), the insurance companies issue the policies which are stamped and legally enforceable document. This insurance document is basically a promise to pay for covered loss according to its terms and conditions.

Policy contract has the same meaning as stated u/s. 10 of Indian Contract Act, 1872, “All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void. Nothing herein contained shall affect any law in force in, and not hereby expressly repealed, by which any contract is required to be made in writing or in the presence of witnesses, or any law relating to the registration of documents”.

A Policy Contract needs to necessarily have all the ingredients as mentioned under Indian Contract Act, the prominent amongst them are communication, acceptance, consideration etc. However, unlike any other contract, an Insurance Contract commences only on communication of acceptance. Mere silence to the proposal doesn’t complete the contract. There has to be an acceptance to the proposal which should be communicated.





In a contract of insurance the insurer undertakes to protect the insured from a specified loss and the insurer receives a premium for running the risk of such loss. Insurance Contract entered into by mis-representation of facts, coercion or fraud, will not hold good in Law and the party in default will not enjoy the benefits under the same.

IRDA (Protection of Policy holders' Interest) Regulations, 2002, under clause 6 stipulates the matters to be included in a Life Insurance Policy Contract.

As per Regulation 6, A Life insurance policy shall clearly state:

(a) the name of the plan governing the policy, its terms and conditions;

(b) whether it is participating in profits or not;

(c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;

(d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

(e) the details of the riders attaching to the main policy;

(f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;

(g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value.

(h) the age at entry and whether the same has been admitted;

(i) the policy requirements for (a) conversion of the policy into paid-up policy, (b) surrender, (c) non-forfeiture and (d) revival of lapsed policies;

(j) contingencies excluded from the scope of the cover, both in respect of the main policy and the

riders;

(k) the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan;

(l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and

(m) the address of the insurer to which all communications in respect of the policy shall be sent;

(n) the documents that are normally required to be submitted by a claimant in support of a claim under t*(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)*

he policy.

(2)While acting under regulation 6(1) in forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period or cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

(3)In respect of a unit linked policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

(4)In respect of a cover, where cover premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before insurance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon possible.

The Policy contract is approved by the IRDA. The IRDA has advised that the language of the policy contract should be simple, unambiguous, clear and consistent for better understanding of common man.

Guidelines on Insurance Repositories and electronic issuance of Policy contract, 2011 is a major breakthrough in Insurance arena, where procedures have been laid down for appointment of Insurance repositories and electronic issuance of policy contract. Despite the regulation, most of the Insurance Companies are yet to fully avail the fruitfully benefit of such advanced technology, which would not only benefit the Insurance company but also the Insured from operational and servicing view point.

Though the Insurance Contract is of utmost significance in the life of an Insured who avails the same to cover his life, health, old age and investment, it is given least importance and is not even being perused completely to know its features and benefits, thus resulting into various issues of mis-selling, which causing hindrance to the growth of Insurance Industry.

LESSON ROUND UP

- In order to effectively regulate the sector, the IRDA has issued various regulations for different types of life insurance products.
- A pure protection plan is a simple risk cover insurance product where the sum assured becomes payable upon the happening of the risk event during the term of the policy.
- A term insurance plan provides a pure risk cover where the sum assured becomes payable upon death of the

life assured during the term of the policy.

- A health insurance plan provides a pure risk cover where the sum assured becomes payable upon the life assured being diagnosed of certain identified illness during the term of the policy.
- In Protection cum Savings insurance products, in addition to getting a pure term insurance cover, the policyholder is also able to leverage long term savings.
- An endowment insurance offers death cover if the life insured dies during the term of the policy and also offers a Survival benefit if the life insured survives until the maturity of the policy
- A term insurance plan with an *unspecified period* is called a *whole life plan*. A Unit Linked Insurance Plan or 'ULIP' as it is popularly known is basically a combination of insurance as well as investments, similar to a protection cum savings plan.
- Variable life insurance is a permanent life insurance policy with an investment component.
- Pure savings and Pension plans address the risk of living too long. In the age of medical advancement where the mortality rates have declined and life span has increased significantly, it is important that the individual saves enough to meet his financial needs during the age when his earning capacity diminishes.
- The Insurance policy is a legal contract between the Insurer and the Policyholder. As is required for any contract there is a proposal and an acceptance.
- The application document that is used for making the proposal is commonly known as the 'Proposal Form'.
- Policy contract has the same meaning as stated u/s. 10 of Indian Contract Act, 1872.
- A Policy Contract needs to necessarily have all the ingredients as mentioned under Indian Contract Act, the prominent amongst them are communication, acceptance, consideration etc.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. Explain the broad features of Pure protection plans of life insurance.
2. Explain sec 2(11) as amended by the Insurance Laws (Amendment) Act,2015.
3. Distinguish between: Endowment Scheme and Pure Insurance Scheme.
4. What are ULIPS? Explain its features and importance.
5. Explain the features of the Term Assurance Policy. Comment on the relevance of such policy to a self-employed person, who has limited income with no material savings and who is the sole breadwinner of the family.
6. What are the matters to be included in a Life Insurance Policy Contract under IRDA (Protection of Policy holders' Interest) Regulations, 2002
7. Write a short note on the Proposal form under IRDA (Protection of Policyholders' Interests) Regulations, 2002
8. Write a brief note on Variable insurance plans.
9. Write a brief note on Policy Contract and Documentation.
10. State whether the following insurance contracts are legally enforceable:

    (a) A life insurance agent knows that an applicant for life insurance is addicted to alcohol. The

agent deliberately omits this information from the application to the insurer. The policy is issued. Later, the insurer denies claim on the basis of concealment of facts.

(b) Ram Prabhakar took a life insurance policy on his life. Four months later, he expired. The death certificate named the deceased as Ram prabu.

Lesson 9
GENERAL INSURANCE - PRACTICES AND PROCEDURES – FOCUS CLAIMS

LESSON OUTLINE

- Introduction
- Meaning of claim
- Claim settlement process in general insurance
- Claim settlement procedure for
- Motor insurance
- Fire insurance
- Marine insurance
- Health insurance
- Methods of claims settlement in general insurance
    - Repair
    - Replacement
    - Reinstatement
- Claims Management in general insurance
- Underinsurance
- Condition of average
- Recovery in insurance contracts
- Salvage
- Role of IRDAI in claim settlement
- Role of Insurance Ombudsman in claim settlement
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

The settlement of claims constitutes one of the important functions in an insurance organization. Indeed, the payment of claims may be regarded as the primary service of insurance to the public. It is the purpose for which an insurance contract is entered into. The proper settlement of claims requires a sound knowledge of the law, principles and practices governing insurance contracts and ,in particular, a thorough knowledge of the terms and conditions of the standard policies and various extensions and modifications thereunder.

In addition, the prompt and fair settlement of claims is the hallmark of good service to the insuring public. It is equally important that claims negotiations should be on the basis of patience, tact and courtesy. In this chapter we will

- Study the principles and practice of general insurance claims
- Understand the legal procedures and documentation to be followed for processing a claim

Explain the settlement practice by IRDAI and Ombudsman in case of dispute

INTRODUCTION

Concept of claim with reference to the insurance contract differs from the angle of the parties to the contract. The insurer is under an obligation or responsibility to perform the contract as per the terms of promise made. The insured is in an advantageous position once the premium as demanded by the insurer is paid. The payment of insurance premium and acceptance of the contract by the insurer creates contractual obligation upon the parties to perform some of the duties before or after the claim is made or on happening of event or the loss is suffered by one of the parties to the contract.

The settlement of claims constitutes one of the important functions in an insurance organization. Indeed, the payment of claims may be regarded as the primary service of insurance to the public. It is the purpose for which an insurance contract is entered into. The proper settlement of claims requires a sound knowledge of the law, principles and practices governing insurance contracts and ,in particular, a thorough knowledge of the terms and conditions of the standard policies and various extensions and modifications thereunder.

MEANING OF CLAIM

Claim is a right of the insured to receive the amount secured under the policy of insurance contract. It is the consideration of the insurance contract. It is a promise made by the insurer to pay the compensation to the insured on happening of some uncertain event resulting in loss or damage to asset insured. It is the pecuniary interest in the insurance contract. It is the insurance amount that is incorporated in the policy document of insurance contract. The claim is a right of the insured in all classes of the insurance contract. The payment of consideration is linked to the insurable interest of the insured. The insurable interest of the insured or the beneficiary under the insurance contract makes the insurance contract a valid contract. The claim payment and compensation payable as indemnity to the insured are related and are synonyms in the claims management of the insurance policy. The payment of premium is one set of promise whereas promise to pay for the loss suffered by the insured is the second set of promise and form reciprocal promises and considerations for one another.

Claims are to be paid either to the insured or the nominees of the insured by the insurer under the agreement or the terms of the contract of insurance. The important terms of the insurance contract and payment of the insurance claims are the payment of insurance claim either on happening of event or on the date of maturity.

Nature of claims and requirements in the settlement of claims are different for Life and General Insurance. The procedure for handling of claims varies according to the types of cover, the amount of claim whether it is a personal or commercial claim. Claims process is the procedure of handling claims and differs from case to case.

One of the most important principle of insurance i.e. principle of Indemnity, is the cornerstone of general insurance. The need to be compensated, or at least indemnified, for actual loss or damage suffered is the very basis of insurance. What if the unthinkable occurs-a fire takes place, there is an accident, a burglary or an illness occurs? What if...? Contemplation of the negative aspects makes a prospect introspect on the need for adequate insurance cover. But once the policy is availed of, the most important aspect is the speed and ease with which the insured is compensated or indemnified in the event of a claim.

That is why, claims servicing is the second face and even more important face of marketing. It is the actual delivery of the product – tangible delivery of an intangible service, or promise.

Servicing of customers at the time of claim is the most important and vital aspect of any insurance service. A satisfied customer is the best public relations officer of an insurance company. An insured having suffered a loss, is always in a damaged or vulnerable condition; alleviation of some of the suffering by ensuring speedy processing and settlement of the claim is the best and most excellent aspect of any insurance contract. Here in this lesson, we will discuss various aspects of claim settlement under different general insurance policies.

CLAIM SETTLEMENT IN GENERAL INSURANCE

General insurance is basically an insurance policy that protects you against losses and damages to assets and properties and from liabilities loss exposures, other than those covered by life insurance. For more comprehensive coverage, it is vital for you to know about the risks covered to ensure that you and your family are protected from unforeseen losses.

The coverage period for most general insurance policies and plans is usually one year, whereby premiums are normally paid on a one-time basis, in advance.

The risks that are covered by general insurance are:

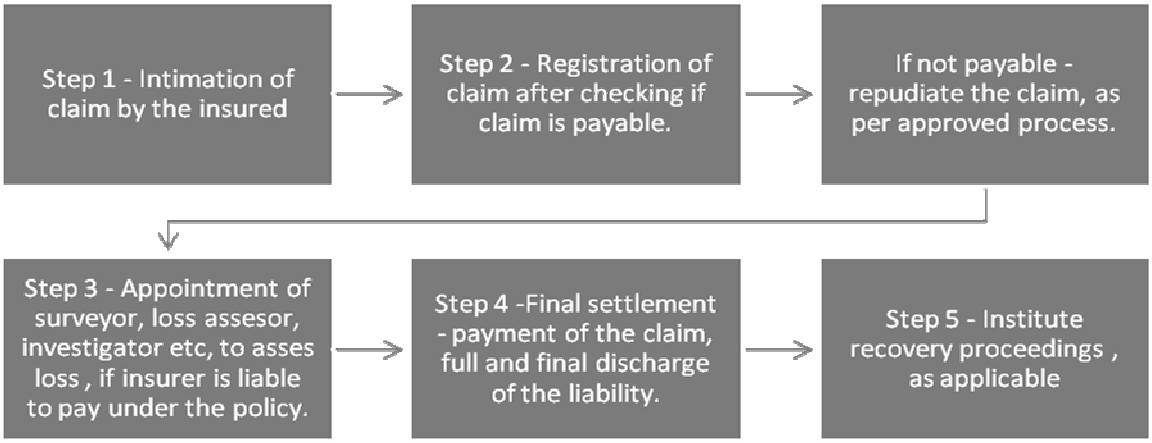
1. Property loss, for example, stolen car or burnt house
2. Liability loss arising from damage caused by yourself to a third party
3. Accidental death or injury

The main products of general insurance includes

1. Motor insurance
2. Marine insurance
3. Fire insurance / House owners insurance
4. Personal accident insurance
5. Medical and health insurance
6. Travel insurance

NATURE OF CLAIMS AND REQUIREMENTS IN THE SETTLEMENT OF GENERAL INSURANCE CLAIMS:

The general procedure for seeking claim settlement is same in most forms of General Insurance. The graphical presentation of claim settlement is as given below:



The procedure in respect of claims under various classes of General insurance follows a common pattern and may be considered under three broad headings –

- Preliminary stage
- Investigation stage
- Settlement stage

The various steps as shown above is explained below:

Step 1 – Preliminary Stage:

Intimation/Submission of the Claim by the Insured / Notice of Loss

It is most essential that insurers receive early notification of the loss. The time limits within which notice of loss shall be given by the insured are provided for in policy conditions. Some policies provide for immediate or forthwith notification whereas others require notice to be given as early as practicable after the loss. The purpose of an immediate notice condition is to allow the insurer to investigate a loss at its early stages. It would also enable the insurer to suggest measures to minimize the loss and to take steps to protect salvage.

Undue delay in notification would adversely affect the insurers position. Therefore, non-compliance with these provisions will relieve the insurer of liability if the non- compliance materially affects the insurers position. However, whether there is delay in notification or not or whether the delay is material will be ultimately decided by the Courts based on the facts of individual cases.

Procedural issues

On receipt of intimation of loss or damage insurers check that:

1. the policy is in force on the date of occurrence of the loss or damage;
2. the loss or damage is by a peril insured by the policy;
3. the subject matter affected by the loss is the same as is insured under the policy; and notice of loss has been received without undue delay.

The insured would intimate the insurance company of the occurrence of a peril or risk which has caused loss of or damage to the insured property

Step 2 – Evaluation/Registration of Claim / Investigation and Assessment

On receipt of the claim form duly completed from the insured, the insurers decide about investigation and assessment of the loss. If the loss is small, the investigation to determine the cause and extent of loss is done by an Officer of the insurers (upto Rs.20,000). Sometimes even this may be waived and the loss settled on the basis of the claim form only.

The investigation of larger or complicated claims is entrusted to independent professional surveyors who are specialists in their line. The practice of assessment of loss by independent surveyors is based on the principle that since both the insurers and insured are interested parties, the opinion of an independent professional person should be acceptable to both the parties as well as to a court of law in the event of any dispute.

The appointment of a surveyor is intimated to the claimant. The surveyor is furnished with all relevant claim papers such as claim form, copy of policy, etc. However, many a times, surveyor is appointed and survey is

carried out immediately on receipt of notice of loss, that is, even before claim form could be issued.

The insurer would briefly initiate process check –

I. Whether the policy has been issued by the insurer

II. Whether the policy is in existence

III. Whether correct premium has been received by the insurer

IV. Whether the peril causing loss/damage is an insured peril

If the insurer is not satisfied and the necessary elements of insurance are not present, it may repudiate the insurance claim and intimate the insurer about the repudiation. In some cases, the insurer may ask for some other inputs about the insurance claim which he thinks necessary for processing the claim further. If on receipt of the additional input, the insurer is not satisfied, he may repudiate the claim and intimate the insured about the repudiation of claim. Only after getting satisfied about the claim, the insurer initiates the next step for claim processing.

Step 3 – Appointment of surveyor/loss assessor/investigator etc.

The appointment of a surveyor is intimated to the claimant. The surveyor is furnished with all relevant claim papers such as claim form, copy of policy, etc. However, many a times, surveyor is appointed and survey is carried out immediately on receipt of notice of loss, that is, even before claim form could be issued.

The insurer would immediately arrange for surveyor to be appointed who would look into the circumstances of the loss, assess the actual loss suffered in money terms and that which can be indemnified in terms of the contract, advise the insurer regarding compliance of the various terms conditions and warranties under the contract etc.

The loss assessor has also to advise the client on various aspects of loss mitigation, limitation, salvage. Loss investigation including forensic investigation and analysis may also come under the purview of a professional investigator.

Acid tests applied by the surveyor of the various principles – insurable interest, utmost good faith, proximate cause and of course contribution, help in deciding ultimately, if a claim is payable as well as quantum payable.

If the claim is not paid within the same financial year in which it occurred, then the surveyor's assessment would enable the adequate provisioning for the claim in its financials.

Step 4 – Settlement of claims

The insurer would ensure claims are settled on the receipt of the final report from the surveyor, generally within the TAT (Turn around time) stipulated by various regulations and committed by the insurance company.

The claim is processed on the basis of:

(i) the claim form;

(ii) independent report from surveyors, legal opinion, medical opinion, etc., as the case may be;

(iii) various documents furnished by the insured; and

(iv) any other evidence secured by the insurers

(v) Final & full satisfaction discharge is a must. Otherwise claimant can go to court for payment of additional amounts after realizing the claim cheque. There are many case laws saying that the discharge voucher was obtained by the insurer due to misrepresentation, undue influence, etc.

If the claim is in order, settlement is effected by cheque. The payment is entered in the claims register as well as in the relevant policy record. Appropriate recoveries are made from the co-insurers, if any.

Before effecting payment, it is essential to decide whether the claimant is entitled to receive the claim monies. For example for payment of fatal claim under personal accident insurance, probate or letters of administration or succession certificates have to be produced by legal heirs. If the property insured under a fire policy is mortgaged to the bank, then according to the agreed bank cause, claim monies are to be paid to the bank, whose receipt will be a complete discharge to the insurers. Similarly claims for Total Loss on vehicles subject to hire purchase agreements are paid to financiers. Marine cargo claims are paid to the claimant who produces the marine policy duly endorsed in his favour.

Step 5 – Recovery

Recoveries may be in the form of salvage or from third parties under subrogation rights. Recoveries of salvage are to be entered in the claims register. After settlement of claim, the insurers under the law of subrogation, are entitled to succeed to the rights and remedies of the insured and to recover the loss paid from a third party who may be responsible for the loss under respective laws applicable. Thus, insurers can recover the loss from shipping companies, railways, road carriers, airlines, Port Trust Authorities. For example, in the case of non-delivery of consignment, the carriers are responsible for the loss. Similarly, the Port Trust is liable for goods which are safely landed but subsequently missing.

For this purpose, a letter of subrogation duly stamped is obtained from the insured. The letter is worded along the following lines :The next step for the insurance company, in certain cases is initiating process for recovery from the third person who is party – eg in marine cargo transit claims – recovery proceedings, as per applicable statutes are initiated against carriers. In motor third party liability claims – awards are settled with victims of any motor accident and action instituted against the owner of the vehicle for recovery.

Claim Procedure for Motor Insurance

(a) Motor Vehicle Accident Claims

Under Motor Insurance , claims generally arise when:

- The insured's vehicle is damaged or any loss has incurred
- Any legal liability is incurred for death of or bodily injury or damage to the property of a third party caused due to the usage of insured vehicle.

After the insured submit his claim form and the relevant documents, the insurer appoints a surveyor to inspect the vehicle and submit his/her report to the insurance company. Insured also get the details of the surveyor's report. In case of major damage to the vehicle, the insurer arranges for a spot survey at the site of accident.

The insured can undertake repairs only on completion of the survey. Once the vehicle is repaired, the insured should submit duly signed bills/cash memos to the insurance company. In some cases, companies have the surveyor re-inspect the vehicle after repairs. In such a scenario, the insured should pay the workshop/garage and obtain a proof of release document (this is an authenticated document signed by you

to release the vehicle from the garage after it is checked and repaired).

Once the vehicle has been released, insured should submit the original bill, proof of release, and cash receipt from the garage to the surveyor. The surveyor sends the claim file to the insurance company for settlement along with all the documents and Finally, the insurance company reimburses the insured.

In case of an accident, the insurance company pays for the replacement of the damaged parts and the labor fees.

The costs that the insured has to bear include:

A. The amount of depreciation as per the rate prescribed

B. Reasonable value of salvage (to be discussed separately)

C. Voluntary deductions under the policy, if the insured have opted for any

D. Compulsory excesses levied by the insurer

In the insured uses the cashless repair facility, the claim money is paid directly to the workshop or garage. Otherwise, the amount of claim is paid to the insured.

(b) Third Party Insurance Claim

In the event of a third party claim, the insured should notify the insurance company in writing along with a copy of the notice and the insurance certificate. The insured should not offer to make an out-of-court settlement or promise payment to any party without the written consent of the insurance company. The insurance company has a right to refuse liabilities arising out of such promises.

The insurance company will issue a claim form that has to be filled and submitted along with:

Copy of the Registration Certificate

Driving license

First information report (FIR)

After verification, the insurance company will appoint a lawyer in the defense of insurer and the insurer should cooperate with the insurance company, providing evidence during court proceedings. If the court orders compensation, the insurance company will then do it directly.

All Third Party claims are settled through MACT (Motor Accidents Claims Tribunal).

(C) Vehicle Theft Claims

In the event of theft of vehicle, the insured should lodge the First Information Report (FIR) with a police station immediately, inform the insurance company and provide them with a copy of the FIR. He should also submit the Final Police Report to the insurance company as soon as it is received and Extend full cooperation to the surveyor or investigator appointed by the company. After the claim is approved, the Registration Certificate of the stolen vehicle has to be transferred in the name of the company and the insured needs to submit the duplicate keys of the vehicle along with a letter of subrogation and an indemnity on stamp paper (duly notarized) to the insurance company.

If there is a dispute regarding the claim settlement between the insured and the insurer, how is the dispute resolved?

The most common form of dispute that arises between the insured and the insurer is about admission of

liability or the size of the claim. Disputes regarding claim amounts, where the insurer has agreed to cover the claim under the policy, are referred to an arbitrator. If the decision of the arbitrator is disputed by either party, the Consumer Forum or the Civil Court could be approached.

Claim Settling Process (Fire and Marine Insurance)

1) Intimation to Insurance Company: The insured must give immediate intimation to the insurance company regarding the loss, within the time frame of the policy conditions. The necessary details like the day, date, time and causes of fire and in case of marine insurance, ship and voyage taken should be mentioned.

On receipt of the claim intimation, the first step is to verify the following:

2) Assessment of the loss: The insured makes an assessment of the actual loss. Such assessment is required to fill the claim forms correctly in respect of the loss of goods or property.

3) Claim Form – On receipt of the claim intimation, the insurer will forward a claim form. Claims forms generally vary with the class of insurance. The insured must fill all possible details in the claim form, with regards to the time of loss, cause of loss, place and extent of loss, circumstances when loss took place etc. He must lodge the claim form within 15 days of the fire to claim compensation.

For example, in case of marine insurance, the insured should lodge a claim with the following documents:

1. Original Insurance Policy
2. Copy of Bill of Lading
3. A copy of commercial Invoice
4. A copy of packing list
5. Survey repot
6. Claim Bill

Delay in submission of claim form may result in non-acceptance of the claim.

4) Evidence of Claim: Along with the claim form, the insured must send certain proof of fire and other records, if available and if necessary. The evidence should enable the insurance company to determine the amount of loss.

5) Scrutinization: The claim form along with the supporting evidence is verified by the insurance company. The company scrutinizes for (a) policy in force at the time of loss (b) coverage of the policy (c) subject matter of insurance (d) adequacy of the notice of loss. The insurance company then appoints the surveyors to conduct an assessment of the actual loss. In case of major losses, specialist- licensed surveyor are deputed.

6) Survey: After the receipt of the form, and necessary verification, the insurance company appoints the surveyors to assess the actual loss. The surveyors conduct the necessary investigations. They investigate into the cause of fire, the actual amount of property lost and other relevant details. The surveyors then make the report of their findings and assessment of the loss. The insured has to provide the required documents to substantiate the extent of loss. In case the cause of loss is not established, it is for the insured to prove that the loss or damage has occurred due to insured peril.

7) Landing Remarks: In case of marine insurance, the insured should obtain landing remarks, from the port

authorities, if survey report is not obtained.

8) Appointment of the Arbitrator: On agreement of the claim amount between the insured and the insurer, the claim is settled. Otherwise, there may be a dispute regarding the amount of claim. In such a case, an arbitrator is appointed, acceptable to both the parties, to settle the amount of the loss.

9) Settlement of Claims: If there is no dispute between the two parties, as to the amount of loss, the insurance company then makes necessary payment to the insured. In case of marine insurance, the amount of money is paid to India Exporter in Indian rupees. If the claimant is not a resident of India, payment maybe made in foreign currency.

i. Thus, the insurers will pay for: if the property is damaged, the amount of such damage,

ii. if the property is destroyed, the value of such property, subject to sum insured.

iii. the insurers may at their option, reinstate or replace such property or an part thereof.

Therefore, the extent of indemnity is subject to two main limitations:

(a) Value of the subject matter of insurance affected, taking into account the following factors:

i. value at the time of loss

ii. value at the place of loss

iii. the real or intrinsic value excluding any sentimental value

iv. depreciation it betterment

v. prospective profit or other consequential and indirect losses are excluded

(b) The sum insured under the policy for the affected item, such as

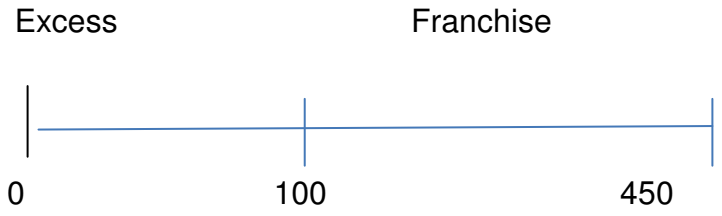
i. Under valued policies on such properties like works of art, the value is based on valuation certificate and stated in the policy is taken into consideration.

ii. Under Reinstatement Value policies, new replacement value is taken into account

iii. Under policies, subject to contract price clause, the liability is determined with reference to the price mentioned in the contract sale.

Limits on Claims

The limits on claims may be *excess* or *franchise.* The motto behind fixing these limits is to restrict the small claims and the total amount of claims. When the loss exceeds the excess limit, the full amount of is paid under franchise clause, and the balance is paid under the excess clause.



If the claim made is 90, nothing shall be paid. If the claim is 300, then 200 will be paid under excess clause, and if the loss exceeds 450, the total loss will be paid, under franchise clause.

Health Insurance Claim Settlement Procedure

In Health insurance mainly two types of claims are raised

1. Claims pertaining to cash less facilitated by the TPAs (Third Party Administrators)
2. Reimbursement of medical expenses

Claim procedure for cashless health insurance

1. For availing the cashless facility, first the insured visit the hospitals which are covered in the network of insurance Company.
2. Hospital obtains details from the customer and verifies the details along with the insurance details and send the intimation to the insurance company
3. On receiving the intimation from the hospital, the insurance company either approve the claim and authorize the hospital to carry out the treatment under cash less scheme. In some cases, the insurance company may ask for some additional information and even deny for the claim.
4. After getting the necessary authority from the insurance company, the hospital carry out the treatment without any deposit and get the settlement of bills from the insurance bills. Here it is pertinent to mention that the liability of insurance company is limited only the amount insured and if the bill for treatment is more than the amount insured, the balance needs to be recovered from the customer

Claim for Reimbursement of medical expenses

In the cases where the customer does not use the cashless health insurance, he raises the claim for reimbursement of medical expenses incurred.

SETTLEMENT OF INSURANCE CLAIMS

(a) Repair & Replacement

The insurer has the option of repairing and/or replacing the damaged or destroyed property. Only conditions would be that the cost of repair/replacement will not exceed the sum insured, repair or replacement may not be exact. It may be partial repair and partial replacement.

(b) Replacement

Usually in total or constructive total loss cases.

Total loss of machinery insured under Fire policy due to fire accident. The subject matter is totally destroyed and the insurer, subject to applicable terms and conditions (depreciation, average clause, applicable liability) agrees to replace the same.

Constructive Total Loss occurs where the entire subject matter of insurance eg entire consignment of goods in transit, are effectively lost, by virtue of the fact that they are inaccessible to insured and the cost of recovery and/or salvage would be more than the cost of the goods itself.

(a) Repair

The compensation by the insurer would be in the form of cost of repairs to the subject matter damaged by the insured peril, subject to the maximum level of indemnity (sum insured) under the policy.

In property policies, for eg. Fire or engineering policy this is usually done usually after surveyor assesses the loss and submits his report indicating the net liability of the insured towards the cost of repairs.

In marine policies, where, goods need to be repaired or loss minimized in transit – repairs would include costs of segregation, conditioning etc as part of the efforts of insured or his agent in minimizing losses.

(b) Reinstatement

One method of settlement is reinstatement of the insured to the position he was in prior to the loss occurrence. In many property claims, however, what sounds like an anamoly – 'new for old' is practiced. Here new items are replaced in place of damaged ones even if the original items were not new.

Claims Management in General Insurance

1. Underwriting and claims settlement are the two most important aspect of the functioning of an insurance company. Out of any insurance contract, the customer has the following expectations:
    i. Adequate insurance coverage, which does not leave him high and dry in time of need, with right pricing.
    ii. Timely delivery of defect free policy documents with relevant endorsements / warranties / conditions / guidelines.
    iii. Should a claim happen, quick settlement to his satisfaction?
2. Unlike life insurance, where all policies necessarily result in claims – either maturity or death – in general insurance not all policies result in claim. Approximately around 15% policies in general insurance result in claim. The claim settlement in general insurance thus has their own peculiarities and therefore need proper handling. Also how 15% policy holders are attended is of great importance. The services being rendered will determine the attitude of the customers. How the services being rendered are perceived by the customer? That also needs to be kept in mind.
3. In the present liberalized scenario, with cut-throat competition being the order of the day, the insurance companies have to go much beyond the handling of claims. The following aspect needs to be kept in mind.
4. General insurance being a market driven service industry, the customer has to be kept satisfied. With so many options available, a customer once lost is most likely a loss forever. Claim settlement can be used as a marketing tool. Brining in a new customer is much more costly than retaining the existing ones.
5. In a de-tariffed market, pricing will be the key factor. Proper claims management - quick settlement at optimal cost will help keep the price competitive.
6. A dissatisfied customer is a bad publicity. It has all the potential to damage the reputation of the company. It is an accepted fact that most of the customers complaint relate to claims. It should be the endeavour of any insurance company to ensure that such complaints do not occur in the first place and in some cases if they do occur it is attended promptly, efficiently and transparently.
7. IRDA guidelines on 'protection of policyholders' interest' stipulate certain obligation on the part of insurance company including time limit for claim settlement. This is a regulatory requirement and insurance company personnel at every level must understand its implication.
8. Delayed claim settlement generally result in higher claims cost. Claims cost is a very important factor vis-à-vis profitability. The delay in submission of survey reports is a very important reason for

delay in claim settlement. The surveyors are duty bound as per IRDA regulations to submit report within a stipulated time. The insurance company should analyze about take necessary steps and put the systems in place for ensuring the timely settlement of insurance claims.

9. Claims files must be monitored as they progress. A little time spent thinking clearly right from the beginning will avoid lot of unnecessary and time consuming patch-ups and straightening out later on. Unpleasant decisions conveyed timely with proper justification of the decision is better than procrastination which is bound to create more problems and unpleasant situations.
10. Proper underwriting (u/w) is essential as defective u/w results in complication at the time of settlement of claims. Defective U/w may saddle the companies with unwanted claims. Various court judgments and consumers forum awards bear testimony to the same. Any defect / ambiguity in the documents issued invariably goes against insurance companies. It is therefore of utmost importance that the client is made aware in very clear terms about what exactly is covered and what is not. There should be a strong system of audit for examining the documents being issued.
11. Lot of time / energy / money is spent when claim cases go to Ombudsman / Consumer Forum/ Court. Besides, adverse comment bring bad name, when the insurance companies are held liable. Insurance companies are invariably at the receiving end. The “watch and wait” attitude must change. There is a need to find out why so many cases go to consumer forum or the ombudsman and what should be done about it.
12. Claims-settlement have social service angle which must be met. In times of natural calamity lot of bad publicity comes to insurance company for delay in settlement of claims. This is in spite of the fact that in such situation insurance companies goes out of their way to settle claims. In any case claims relating to the assets of weaker section needs to be attended on priority. So do the health / medical related claims.

In view of the above, it is necessary that

1. Insurance companies should have a corporate claims management philosophy. Managing claims involves not only claims processing but goes on to cover the entire gamut of claims management – strategic role, cost monitoring role, service aspect as also the role of people handling the claim.
2. Out of the total outgo on account of claims it is estimated that around 10 to 15 % is because of leakages, frauds and inflated claims. In absolute terms this will be a quite substantial amount. If this can be effectively checked, the benefit can be passed on to the customer by way of reduced premium rates.
3. Claims reserving is also an important part of the overall claim management process. Adequacy of claims reserving is important for any insurance company to meet its claim obligation. In fact in a study in USA of the insurance companies going “bust” 34% (highest) was on account of insufficient reserve / premium. The analysis of reserve and the process that goes into making the same and its comparison with past experience can help address such important concerns as
    - Company’s likely future obligations on account of claims and its ability to meet them.
    - Solvency aspect and assessing the true picture of the financial health.
    - Analysis of claims trend can help to timely initiate remedial action. e.g. restricting a particular class of business.
    - Effectiveness of loss control measure.
    - Average time being taken for the settlement of a claim and the claim settlement ratio and how it compares with other operators in the market.

UNDERINSURANCE

A situation wherein the owner of a property or the person suffering a health condition does not have enough insurance to cover the value of the item or the health care costs may be termed as underinsurance. An uninsured individual knows that he lacks the security of insurance. An underinsured individual finds out about his lack of insurance coverage only after he files a claim.

For example, Mr. A believes that the health insurance cover provided by his workplace is more than adequate. Then, one day, he falls seriously ill. His family rushes him to hospital only to learn that the employer-provided medical insurance comes with a high deductible, limited annual benefits and exemptions on specific treatments. Thus, an underinsured person has insurance, but not enough.

Causes of Underinsurance

Underinsurance may be caused by many factors depending upon the nature and type of insurance. It ranges from a failure to update a policy in a timely manner to an underestimate of reconstruction or replacement value. Failure to report new construction or additions to the property or a decision not to purchase sufficient insurance due to cost could also lead to underinsurance problems. Relying on the health insurance problem by the employer may also be a reason of underinsurance. Even in many cases, cost cutting measure also a reason of underinsurance.

Consequences of Underinsurance

The dangers of underinsurance are just too high. If your business and personal assets are not adequately covered or if you have high deductibles and exemptions on your health insurance, footing out-of-pocket expenses can become a huge hurdle. If you have inadequate life insurance, you family would suffer the financial consequences when you are no more. Remember, being underinsured is as bad as being uninsured is—this is a lesson that we all must learn.

CONDITION OF AVERAGE IN INSURANCE POLICY

The doctrine of average – or average clause is always applied in indemnity policies – primarily in property claims – fire and engineering. At the time of taking the policy the insured has to consider the value of the risk or subject matter of insurance-sum insured. He must ensure that the adequate value has been declared and insured. If, at the time of loss, it is found that the sum insured is less than the actual value of the subject matter, then the proportionate or rateable portion of the claims would be payable. The insured would therefore be his own insurer for the difference

Fixing of adequate sum insured is also important from the point of view of the banks or financial institutions who may have advanced money on the security of the insured property. It is sometimes found that the banks or financial institutions do not concern themselves with the adequacy of the sum insured so long as it is sufficient to cover the money advanced by them or at best the full value of the property on which they have advanced money. Invariably in such cases they find the problem only after happening of a loss when the claim amount is suitably adjusted for underinsurance and the full indemnity is not available due to the inadequacy of the sum insured.

Eg. If the value of stocks which have been insured are actually Rs. 10 lac, but insurance premium has been paid on a sum insured of Rs.5 lac only- underinsurance is 50%. Hence the loss amount indemnified would be reduced by 50%.

Under average clause, the claim is calculated as

Claim amount = Actual Loss x Stock insured/Total Loss, where

Actual Loss = Total Loss - Stock salvaged or stock saved

Examples on Condition of Average Calculation under Fire Insurance Policy

Generally, claim payments under fire insurance policy is done either on 'Turnover basis', or under 'Output' basis. Turnover is used as the index of business activity and therefore as the measure of loss, in most of the consequential loss policies. Under the turnover basis, for the computation of claim amount, in the case of underinsurance, first the loss of gross profit is measured by ascertaining the ratio of gross profit to turnover and applying that ratio of gross profit to shortage in turnover.

Thus, every unit of production earns its due proportion of gross profit, and that the loss of gross profit can be measured by ascertaining the rate of gross profit per unit of production and applying it to the shortage in the number of units produced.

The wording "output" is used in the same sense as turnover. Output is defined as the quantity of commodity produced at the premises measured in units of litres, tons, kg etc.

The rate of gross profit is defined as the rate of gross profit per unit earned on the output during the financial year immediately before the date of damage.

Example:

5000 radio sets are produced and sold @ Rs.1000/ per set, the selling price of each radio set is made up of cost of production (70%), Standing charges (20%) and net profit (10%).

Settlement of a straight forward loss claim on "output" basis is as follows:

Sum Insured		₹12,00,000
Sum of Net Profit + Insured Standing charges (Gross Profit)		₹15,00,000
Rate of Gross profit ₹1500000/5000		₹300 per unit
Standard Output	5,000 units	
Output during the Indemnity period	2,500 units	
Shortage in Output	2,500 units	
Clause (a)	₹300 × 2,500 =	₹7,50,000
Clause (b) Additional Expenditure		₹1,00,000
₹1,00,000 X N.P and Insured SC 15,00,000		1,00,000
N.P. and all S C 15,00,000		8,50,000
Saving in Insured Standing Charges		10,000
		₹8,40,000

Average

Rate of Gross Profit × Annual Output = Insurable Amount

₹300 × ₹5000 = ₹5,00,000

Sum Insured = ₹12,00,000

$$= \frac{12,00,000 \times 8,40,000 - Rs.6,72,000\ (Claim\ amount\ payable)}{15,00,000}$$

After a fire, when the turnover is reduced, the variable expenses may also be reduced in the same proportion in which case the insured suffers no loss on this account.

RECOVERY IN INSURANCE CONTRACTS

Under subrogation, the insurer is subrogated to the rights and remedies that the insured enjoys against third parties who are responsible for the loss. The insured, who under the duty of the assured clause, is required to protect right of recovery against persons responsible for the loss, surrenders the same on being compensated; again the principle of indemnity restricts him from benefiting and making a profit, by recovering from the third party as well.

All transits are usually done under a contract of afreightment – bill of lading air way bill, goods consignment note, railway receipt post parcel receipt etc. These are negotiable and freely assignable, together with the invoice and insurance policy they can be assigned and usually are used for discounting with banks etc. A number of statutes come into play, particularly in cargo insurance- Marine Insurance Act, Carriage of Goods by Sea Act, Carriers Act, Railways Act, Port Trusts Act, Bailees Act. etc.

Each statute specifies action to be taken, and the time limit/jurisdiction etc under which action can be taken by the parties to the contract of affreightment.

Insurable interest in cargo insurance is of utmost importance at the time of claim occurring, as the consignee who is in possession of the negotiable documents is the owner of the goods and would institute action under the appropriate statute, for recovery against the transporter.

Primarily in Marine insurance (cargo), the insurer pursues the rights of recovery, on being subrogated post claim settlement. The insurer initiates action by way of negotiating or filing a suit for recovery of compensation in civil courts, against the transporter. Therefore, the current owner of the goods, at the time of loss, should initiate action for recovery on being intimated the same by the transporter. Especially in case of transit by sea, intimation may come weeks after the loss has occurred, e.g. When the ship has sunk or been captured by pirates.

PAY & RECOVER

Pay and recover is the parlance used, generally in motor accident compensation cases, where award is pronounced by the Motor Accident Claims Tribunal (MACT).After payment of the claim to the injured party or his legal heirs etc. The insurer can initiate action against the erring party- e.g. the owner of the insured vehicle.

MODES OF RECOVERY

1. **Excess/deductible –** That portion of the claim which is to be borne by the insured is called an excess or deductible.
2. **Subrogation –** Rights and remedies preferred against the third party.
3. **Contribution –** This occurs when the insured property is insured by more than 1 insurer- in such cases, recovery would be made by the lead insurer from the co insurer.

4. **Reinsurance –** Reinsurance is the most common method of risk transfer – where the risk is re insured with reinsurers by the insurance company and after the claim the same is recovered from them after payment to insured.

SALVAGE IN INSURANCE CONTRACTS

- Salvage is also a form of recovery in any claim. In most property claims, including transit insurance claims, damaged property can be disposed off for either lower or scrap value, this is done to reduce the financial impact of claims. Hence, most insurers advise the surveyors to complete the net assessment by valuing the salvaged value of the damaged property as well. Especially in total loss cases, the insured may abandon the wreck or damaged property in favour of the insurer who would thereafter sell the same and credit the sale proceeds to claims account.

Motor Claims Case

A formal claim for the loss sustained by the Complainant, Mr. Ramesh, due to the damage caused to his vehicle, was made by him on 11.9.98 and reminders sent to the National Insurance Company on 12.1.99 and 16.1.99 for settlement of the claim. The driver of the vehicle who had nothing to do with the accident did not hold a valid license. However, even after one year after the occurrence, the claim was repudiated by Company vide their letter dated 18.8.99.

Aggrieved by this repudiation of his claim the Mr. Ramesh filed Complaint before the District Forum, Shillong on 17.2.2000 which was dismissed on 7.9.00 being beyond the Forum's pecuniary jurisdiction, with liberty to approach the proper Forum. Thereupon a complaint was filed before this Commission alleging *"deficiency in service"* on the part of NIC and claiming an amount of Rs.674721, besides interest and damages.

Questions to introspect:

1. Can the Insurance Company repudiate a claim made by the owner of the vehicle which is duly insured with the Company, solely on the ground, the driver of the vehicle who had nothing to do with the accident did not hold a valid licence?

Answer

No, the company takes this ground for rejecting the claim. According to Section 149 of the Motor Vehicles Act, 1988 the State Commission opined, does not come to the aid of the Insurance Company in repudiating a claim where driver of the vehicle had not contributed in any manner to the accident.

However, as per Section 149(2) (a) (ii) of the Motor Vehicles Act empowers the Insurance Company to repudiate a claim wherein the vehicle in question is damaged due to an accident to which driver of the vehicle who does not hold a valid driving license is responsible in any manner. Therefore, this section does not empower the Insurance Company to repudiate a claim for damages which has occurred due to acts to which the driver has not, in any manner, contributed i.e. damages incurred due to reasons other than the driver." To sum up, in view of the law laid down by the Hon'ble Supreme Court in the judgments cited above, the Commission was completely satisfied that, having failed to discharge the burden of proving that the license of the driver of the insured vehicle was ineffective and thereby having failed to prove that there was any breach of the conditions of the insurance policy by the Complainant, NIC's repudiation of the insurance claim is unsustainable.

Further, as the accident did not occur owing to any fault of the driver, the policy condition relating to effective driving license is non-operative. This further leads us to conclude that there was *negligence and deficiency in service* on the part of the Insurance Co. by not settling the Complainant's claim. Therefore, the Commission

recommended to set aside the Repudiation of the Complainant's claim by NIC. NIC is to now settle the Complainant's claim under the comprehensive policy of insurance. As NIC was deficient in its services and as its negligence has caused loss and injury to the Complainant this is required to be compensated by NIC.

Health Insurance Case

The insured Mr. Mohanlal Tiwari was having mediclaim and accident policies since 1988 with the insurer (United India Insurance Company) and had renewed the same from time to time. His mediclaim policy was expiring on 6-2-2002 and he therefore paid renewal premium by cheque on 7-1-2002 which was debited from his account on 9-1-2002. However, by letter dated 15-1-2002, he was informed by the respondent No.2 that, after going through the record, it had decided not to renew his policy, advising him to renew his policy with some other **insurance** company.

The insured raised the following issues in defense before the Court against the company:

- ✓ It was contended that the company's action of excluding the diseases acquired during the period of the cover while renewing the policy, was arbitrary, unfair and violative of Article 14 of the Constitution.
- ✓ It was also contended that the refusal to renew the mediclaim policy on the ground of high claim ratio after having accepted the premium was also arbitrary, unfair and unjustifiable at law.
- ✓ Reference was made to Section 9 of the Health Insurance Act, 1994 of Ireland to illustrate that a registered undertaking was restrained thereunder from terminating or refusing to renew a health insurance contract without consent of the other party.
- ✓ Reliance was also placed on a circular-letter dated 18-12-1998, at Annexure "I" to that petition, of the National Insurance Company Ltd., showing the directions issued on the basis of the General Insurance Corporation Circular dated 13th June 1988, which required that in case of renewal without a break in the period, the policy was to be renewed by including the diseases contracted during the period of expiring policy.
- ✓ health insurance contract is not related to the category of life contracts. A life contract would obviously include the natural process of dying and a health insurance contract would obviously include what may be inevitable illness, which perils would be covered by the insurance.
- ✓ A policy of health insurance is for insuring against the risk of disease. One is a policy for life while the other for a healthy life. Even in a health policy, though under an annual contract on payment of annual premium, the assured must have a right of renewal subject to reasonable conditions, because, the policy is not intended to be for a term certain, but meant to cover the risk of disease for life so long the renewal premium is paid in time, as per the renewal clause.
- ✓ The contract of health insurance, like that of life insurance made in consideration of an annual premium, is an insurance for a year with an irrevocable offer to renew upon payment of the agreed renewal premium.
- ✓ Following aspects clearly emerge from the above Clauses 1.1, 4.1, 4.2, 4.3 and 7 of the mediclaim insurance policy and Clause 11 of the prospectus of the mediclaim insurance policy that : (i) the cover for the diseases which are not excluded from the first year of the cover would continue even in the renewal years if the renewal premium was paid in time; (ii) even if the insured contracts any disease which is not excluded from the existing cover, it will be continued to be covered in the subsequent year, if the renewal premium is paid in time; (iii) the disease covered under the policy will not be excluded during the continuance of the cover.

- ✓ Afortiori, the renewal could not be refused if insured paid the renewal premium in time.
- ✓ In the context of the renewal clause 5.9 of the policy and clause 11 of the prospectus, it would be most significant to refer to the circular letter dated 18th December 1998, at Annexure "I" to the Special civil Application No. 9425 of 2002, which totally derails the argument canvassed on the basis of the cancellation clause in clause 5.9 of the policy to the effect that the insurer has a contractual privilege to refuse to renew even when the insured is paying renewal premium in time as stipulated in the mediclaim insurance scheme or even to cancel the cover. This circular-letter is based on the GIC's letter No. Tech/A/185/2(6) dated 30th June 1988 which clarified the position in case of renewal, if there was a claim under the expiring policy. It was emphasized that the mediclaim policies which are renewed without break in the policy period and without enhancing the "sum insured" may be renewed, including the diseases contracted during the expiry period. The circular was issued by the National Insurance Company Limited, noticing that, in certain instances, the operating offices while renewing the policies, were excluding the illness for which a claim was made by the insured under the existing policy.
- ✓ The circular summarizes how to deal with different situations which may arise during renewal of insurance in the following terms :
- ✓ "Different situations which may arise during the renewal of insurance and how to deal with them are summarized below :-
- ✓ (1) In case of renewal without a break in the period the policy will be renewed including the disease contracted during the expiring policy period.
- ✓ (2) If there is a break, the fresh policy must specifically exclude the disease contracted during the expiring policy period and during the break period and it should be mentioned in the schedule of the policy specifically.
- ✓ (3) If an insured is already covered under an insurance policy, say, a group mediclaim, and wants to take an individual policy, the same may be issued upto the identical sum insured on the same terms and conditions if there is no break.
- ✓ (4) If a person is insured with another subsidiary and wishes to renew with us, the same should be considered only after ascertaining the claim status and exclusion under the previous policy.
- ✓ In case the claim status revealed is adverse or there is a continuing illness or an impending illness, such cases should be advised to continue with the same subsidiary and should not be accepted."
- ✓ 34.1 The circular-letter dated 18th December 1998 based on the GIC's letter of 13th June 1998 also provided norms in respect of enhancement of sum insured. One such norm is that enhancement should be allowed only at the time of renewal. Requests for enhancement of sum insured in case of persons below 60 years were to be acceded to, based on a declaration that the insured has not contracted any illness or disease if the amount of enhancement did not exceed ₹50,000=00. In case of persons above 60 years, necessary test reports and other formalities were required. Paragraph 5(c) of the circular letter, inter alia, provided that the disease for which claim has been lodged under the previous policy and of which the insured is not completely recovered, should also be specifically excluded "so far as enhancement of sum insured is concerned".
- ✓ 34.2 It, therefore, clearly follows that the diseases contracted during the period of existing policy cannot be excluded on renewal of the cover so far as the basic sum insured is concerned, when the renewal premium is paid in time.
- ✓ Final Order:

- ✓ For the foregoing reasons, since the grounds given for refusing to renew the mediclaim insurance policies of petitioners Nos. 2 and 3 are arbitrary and also against the contractual terms, the Special Civil Application No.9425 of 2002 is partly allowed, by holding that the refusal of renewal of the mediclaim insurance policy of the petitioners No.2 and 3 was arbitrary and illegal, and it is directed that the respondents insurance companies will renew their respective policies from the date on which they expired, on payment of the renewal premium payable by them under the Scheme, without excluding the diseases that may have been contracted by them during the period of their existing policies for the concerned year. Rule is made absolute accordingly with costs.

Marine Insurance Case:

Question

The Ashoke on a voyage from Mumbai to Singapore carried 5000 containers with tea. Freight of ₹100 per container was payable on delivery. The ship owner took a freight insurance value policy of ₹6,00,000 at premium of 3% of Sum Insured, subject to Institute Voyage Clause. 140 containers were damaged by fire and 130 washed overboard due to heavy weather.

i. Determine the claim payable applying the franchise clause on voyage policy.

ii. Calculate the claim if there is damage of 140 units by fire.

iii. Calculate claim under an unvalued policy of Sum Insured for Rs. 4,00,000 and premium @ ₹15000.

Answer

Determine the claim payable applying the franchise clause on voyage policy.

Claim under valued policy: Gross freight lost ÷ Insured value x Gross freight at risk

= 270 / 5000 x 6,00,000 = 32,400 (payable)

Claim payable: ₹270 x 100 = ₹27,000 as claim exceeds 3 % of 6,00,000.

Claim only for loss of 140 containers:

140/5000 x 100 = 2.8%, which is less than franchise @3 %. Hence, not payable

Claim under unvalued policy of Sum Insured for Rs. 4,00,000 with premium @₹15000.

Insurable value of freight = Gross freight at risk + Insurance premium

= 6,00,000 + 15,000 = 6,15,000

If insurable value of ₹6,15,000 is insured for ₹4,00,000, then loss of

₹27,000 will be payable for 27,000 × 400/615 = ₹17,560.

Note:

Franchise is an example of deductible, like excess, but the difference is that, in a franchise agreement, if the loss exceeds the franchise limit (3% in the given case), the whole loss is payable. On the other hand, if the loss is below the franchise limit, nothing is payable, like in the case of excess. But in the excess agreement, when the loss exceeds the excess limit, the loss amount in excess of the limit is only payable.

Case Study

Hemant Patel, a real-estate broker, lived in Delhi with his wife and two children. He owned a bungalow in Karol Bagh which was insured with Elite Insurance Company, New Delhi, for Rs 35 lakhs. On Dec 31st 1999, Hemant went to the local club with his family to attend a New Year party. When they returned home in the early hours of the next day, they found that their house had been burgled and many valuables had been taken. While the police investigation was going on, the insurer sent his surveyor to look into the cause of the loss, the compliance of the insured with the terms of the policy, and the amount of loss suffered by the policyholder. During the course of investigation, the surveyor observed significant discrepancies in the statements given by the insured. These discrepancies pertained to the list of items reported to have been stolen by the insured and the mismatch between the true value of these items and the amount supposedly involved in the burglary. When the surveyor submitted his report to the insurance company, he mentioned that the financial condition of the insured was not good before the burglary and he had increased the insurance coverage on his house just a few days before the burglary took place. Hemant's claim form was therefore rejected by the insurance company on grounds of fraud. Hemant filed a lawsuit against the insurance company.

Questions for Discussion:

1. Was Hemant eligible to receive the claim amount for the reported loss that he had suffered? Why do insurers make payments for suspicious claims?
2. What are the precautions that a loss adjuster has to take while handling claims for loss caused by theft?

LESSON ROUND UP

- General insurance is basically an insurance policy that protects you against losses and damages other than those covered by life insurance.
- The risks that are covered by general insurance are Property loss, for example, stolen car or burnt house, Liability arising from damage caused by yourself to a third party and Accidental death or injury.
- The general procedure for seeking claim settlement is same in most forms of General Insurance.
- In vehicle insurance, the insured submit his claim form and the relevant documents, the insurer appoints a surveyor to inspect the vehicle and submit his/her report to the insurance company. Insured also get the details of the surveyor's report. In case of major damage to the vehicle, the insurer arranges for a spot survey at the site of accident. In the event of a third party claim, the insured should notify the insurance company in writing along with a copy of the notice and the insurance certificate.
- Total loss of machinery insured under Fire policy due to fire accident. The subject matter is totally destroyed and the insurer, subject to applicable terms and conditions (depreciation, average clause, applicable liability) agrees to replace the same.
- Constructive Total Loss occurs where the entire subject matter of insurance e.g. entire consignment of gods in transit, are effectively lost, by virtue of the fact that they are inaccessible to insured and the cost of recovery and/or salvage would be more than the cost of the goods itself.
- In general insurance not all policies result in claim. Approximately around 15% policies in general insurance result in claim.
- Claims-settlement have social service angle which must be met.
- A situation wherein the owner of a property or the person suffering a health condition does not have enough

insurance to cover the value of the item or the health care costs may be termed as underinsurance.

- Insurable interest in cargo insurance, is of utmost importance at the time of claim occurring, as the consignee who is in possession of the negotiable documents is the owner of the goods and would institute action under the appropriate statute, for recovery against the transporter.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1.Explain the general procedure of settlement of claims in General insurance policies.

2. How are health insurance claims settled under
   - Reimbursement of medical expenses and
   - Reimbursements of medical expenses
3. What do you mean by underinsurance? Explain.
4. Write short notes on following:
   (A) Claim procedure for motor insurance
   (B) Condition of average in insurance policy
   (C) Recovery in insurance contracts
   (D) Salvage in insurance contracts.

Lesson 10
GENERAL INSURANCE - PRACTICES AND PROCEDURES – FOCUS UNDERWRITINGS

LESSON OUTLINE

- Essentials of a Contract as applicable to Insurance Contract
- Application of Principles of Insurance in General Insurance contracts
- Classification of General Insurance
- Structure of Insurance Policy
- Conditions & Warranties
- General Insurance documents
- Main objectives of Underwriting
- Underwriting process
- Disclosure - terms and conditions
- Lesson Round Up
- Self - Test Questions

LEARNING OBJECTIVES

Underwriting basically refers to the process of selecting, classifying and pricing applicants for insurance. The Underwriter is the person who evaluates a proposal and decides to accept or reject an application that comes for insurance. Based on the evaluation done, a decision is to be taken as to the acceptance of proposal or otherwise. If it is to be accepted, at what price and on what terms, conditions and coverages and price. This process ends with the issue of policy documents. Generally insurance companies have internal guide rates and standard policy documents, for routine risks which are typically “High frequency, low severity risk” and do not require much of an underwriting expertise & skill. But the aggregate of simple risk across the company, and the likely financial consequences needs monitoring.

However, for “low frequency high severity risk” e.g. liability, aviation, etc. or unusual risk, or risk with every high sum insured, etc. the underwriting process is more complex. In this chapter we will study the underwriting practices and procedures for general insurance policies, usually followed by insurance companies.

INTRODUCTION

ESSENTIALS OF A CONTRACT AS APPLICABLE TO INSURANCE CONTRACTS

An insurance policy is like any contract, a legal document and enforceable in a court; the provisions of the Indian Contracts Act, 1872 are applicable to insurance contracts as well.

Therefore the essentials elements of a valid contract of insurance would be-

1. OFFER AND ACCEPTANCE

The first requirement of a binding insurance contract is that there must be an offer and an acceptance. The applicant for insurance fills out the application and pays the first premium. This step constitutes the offer. The company may then accept the offer and issue the policy or reject the application. In most cases, the applicant makes the offer and the company accepts or rejects the offer. An agent merely solicits or invites the prospective insured to make an offer, However, an offer, intended to create legal relations, must be communicated to the offeree either by words or by conduct.

The phrase 'insurance is the subject matter of solicitation' is very commonly seen and heard -what this indicates is that insurance is sought by the person who wants to buy it from the insurer. It is to be solicited or purchased by the consumer. In other words, insurance selling should be advisory in nature and must not be forced upon for purchase. It must be remembered that "Customer's participation in availing the insurance products and services are purely on voluntary basis.

This means that the insurance company is providing you insurance against a risk on your request/solicitation, i.e. the company agreed to sell you its insurance policy after you solicited or asked for such a sale. In legal terms, insurance is a product that should not be pushed by a seller, but should be bought or sought by a buyer.

The proposal is made by the insured and accepted by the insurer.

2. AGREEMENT BETWEEN THE PARTIES –

The acceptance of the proposal by the insurer together with the premium is expressed in the form of a contract – the insurance policy; together with the clauses is the basis of the agreement between the parties. The consent of the parties must be free and in total agreement. That is to say, the parties must not have been threatened, unduly influenced, deceived or misled in a manner which would nullify their agreement. There must be "Consensus ad idem" that is genuine meeting of minds.

Further, there must be evidence of the intention or consensus of the parties to enter into a contractual relation. This may be provided by the formal procedure of making the promise under seal, or it may be by the existence of consideration. The application is the evidence of the intention from the applicant's point of view, while a policy bond is the evidence of the contract of insurance, issued by the insurance company after all the formalities are completed.

3. CONSIDERATION

The premium paid by the insured for the contract is the consideration for the company and in return, for the insured, the security and assurance given by the insurance company for compensation on the happening of the contingent event is the consideration to support the contract for the insured policyholder.

4. CAPACITY TO CONTRACT

The parties must be recognized by the law as having the **CAPACITY TO CONTRACT**. All aspects regarding the capacity to contract, age, mental capacity and understanding etc as defined in the Indian Contracts Act, 1872 is applicable.

5. LEGALITY OF OBJECT

The subject-matter of the contract must be Legal and Possible. In other words, the purpose of agreement must be lawful or for a legal purpose, enforceable at law and not for anything that would be contrary to public policy or public interest. Further, the performance of the contract should also be certain and should not be impossible.

If one of these essentials is missing, the contract is void, voidable or unenforceable, depending upon the circumstances. A void "contract" is a contradiction in terms for it never can be a contract. A voidable contract is valid but, at the option of one of the parties,

APPLICATION OF PRINCIPLES OF INSURANCE IN GENERAL INSURANCE CONTRACTS

An Insurance policy is a contract, which is legally enforceable, if properly executed, in a court of law. However, in addition to these essentials, as discussed above, the fundamental principles of insurance are also applicable to the contract of insurance, as discussed in earlier chapters. To recapitulate, the following principles of insurance are applicable to general insurance:

1. Principle of Uberrimae fidei (Utmost Good Faith),
2. Principle of Insurable Interest,
3. Principle of Indemnity – with corollaries
    i. Principle of Contribution,
    ii. Principle of Subrogation,
4. Principle of Loss Minimization, and
5. Principle of Causa Proxima (Nearest Cause).

To recap, it is important to note that while an application of insurance is being processed, the relevant principles of insurance applicable must be tested before the issuance of policy. The principle of Utmost Good Faith mandates disclosure of all material facts pertaining to the risk, which are likely to influence the decision of the company in the issuance of the policy. The information may pertain to ownership, condition of the risk, and other related information etc. On the other hand, the Indemnity principle lays emphasis on compensation of actual losses. Following indemnity, the principle of Subrogation and Contribution become automatically applicable. In other words, it means that the insurance company becomes eligible for the right of recovery of the losses after paying compensation to the insured, from the party who is responsible for the loss. The Contribution principle asserts the right of the insurance company for a rateable compensation from other insurance companies, if in case, the risk is insured by more than one insurance company. And lastly, the principle of proximate cause identifies the most direct, efficient and dominant cause of loss for payment of compensation.

Additionally, in the chapter on risk management, it was noted that insurance is a method of risk transfer, where many share the losses of a few. The whole concept of insurance is pooling and spreading the risk..

The main point to be noted here is that the loss should be *fortuitous, or accidental*, the loss should not be

inevitable. At the same time, it is to be noted that all losses cannot be insured. There can be many uninsurable losses or perils, such as losses arising out of war or a warlike action or rebellion and nuclear risks are generally excluded by all insurance because these losses are unpredictable and are often catastrophic in nature. Similarly insurance companies also exclude normal wear and tear, gradual deterioration, and damages due to insects etc, because these are inevitable, non-accidental and are normal losses.

BROAD CLASSIFICATION OF GENERAL INSURANCE BUSINESS

General Insurance or Non- Life insurance, based on the Indian Insurance Act, 1938, is broadly classified into–

1. Fire 2. Marine 3. Miscellaneous

Another classification is Traditional and Non – Traditional business, the former being fire and marine, motor, burglary insurance etc.

The most practical classification of general insurance is -

Broadly Classified as

1. Property insurance – all types of property is covered, provided the value can be converted into pecuniary terms , thus forming the sum insured under the policy.
2. Liability Insurance- Liability arising out of various contracts-employees liability, liability arising out of defective products, accident liability e.g. motor accidents
3. Health and Accident /casualty insurance- health and personal accident insurance
4. Insurance of interest – e.g. one can insure one's interest in a property e.g. rental income from a property etc.

All the different types of general insurance policies will be discussed in the subsequent chapters. However, the primary function of a general insurance contract is to provide indemnity and security, an assurance that, in the event of any loss, the contract would indemnify the insured.

STRUCTURE OF THE POLICY

The insurance contract is evidenced by a policy, the offer having come from the proposer in the form of a proposal. The proposal form elicits certain information about the proposer/insured, the subject matter of insurance and the experience or claims history, on the basis of which the terms and conditions of the contract would be decided and policy issued.

As the insured would like to avail of insurance for matter that he wants to have insured, it is necessary that he discloses all material facts about the same and his disclosures must be genuine and not misrepresented.

Policy Structure or key elements

i. **Heading** – The name of the insurer and other particulars regarding the issuing office- the name of the policy etc.

ii. **Preamble** – This contains relevant information regarding the subject matter of insurance, the locations, identity, value, and period of insurance required etc. The policy also contains the signature of an authorized official, who is empowered to accept the offer of the proposer and issue a policy.

iii. **Schedule** – This contains the details of the risk insured in a tabular form with regards to the value of the risk, sum insured coverage required, location of the risk etc.

iv. **Operative or insuring clause-** States the peril(s) which are to be insured against. The perils requested for cover are only to be covered.

Exclusions – States the various conditions under which the policy will not pay.

v. **Conditions & Provisions**

These describe the various conditions which must be followed or eschewed by the insured and may be quite detailed, depending on the nature of the risk and the extent and duration of cover required.

The conditions mention under what circumstances the policy would pay and the precautions safeguards to be taken by the insured, e.g. duty of assured prescribes that the insured must take all those steps necessary to mitigate the loss, as if he was not in fact insured. Other terms and conditions would relate to arbitration, duty to disclose material facts including any amendment/alteration in the risk or subject matter of insurance. There are certain clauses such as cancellation, arbitration, jurisdiction etc which are recommended in every contract.

Conditions can be either:

- Express conditions
- Implied conditions

Express conditions

Generally express conditions are those that require the insured to do something – e.g. in cargo insurance transit by road during monsoon. There are two types of express conditions,

i. General conditions, which are applicable to all policies of that class and are therefore, printed on the policy document.

ii. Special conditions, which are applicable only to that specific policy. The special conditions are thus handwritten or typed or rubber-stamped on the policy. (e.g. ,type of packing, compulsory excess, unloading survey, etc.)

Implied Conditions

Implied conditions are those, which are so basic and material that their existence forms the very basis of the policy and cannot be In the absence of express conditions, the insurance contract is subject to implied conditions, which relate to

i. Good faith

ii. Insurable interest

iii. Subject matter of insurance

iv. Identification of the subject matter

Implied conditions can be expressed in a policy explicitly, or can be modified or excluded by the express conditions.

All conditions whether expressed or implied are the *operative clauses* of a policy. They are recited as conditions to be fulfilled by the insured for assuming the right to recover under the policy.

Conditions can be of three types:

- Conditions precedent to a contract
- Conditions subsequent to a contract
- Conditions precedent to a liability

Conditions Precedent to a contract

Conditions precedent to a contract are those which are there prior to entering into a contract, which may be material to the contract being executed by either party. These conditions must be satisfied before risk is transferred to the insurer and include payment of premiums, requirements to provide information, absence of overlapping insurance, etc;

The recent Insurance Act 2015 has proposed the following changes to conditions precedent.

Section 11 of the 2015 Insurance Act, which will come into force on 12 August 2016, only applies to terms which relate to a particular type of loss or a loss at a particular location or time. It states that insurers cannot rely on non-compliance with these terms to "exclude, limit or discharge" their liability, provided that the policyholder is able to show that the non-compliance with the particular term could not have increased the risk of the loss which actually occurred, in the circumstances in which it occurred.

This is a major change to the current law. Much has been made of Section 11 in its application to warranties, but it has the potential to apply to all policy terms including conditions precedent. Under the existing law a failure to comply with a condition precedent provides an insurer with a complete defence to a claim, regardless of whether that failure was the cause - or even a cause - of the loss being claimed. Section 11 of the Act effectively introduces a type of causation requirement, ensuring that a breach of a policy term must be related to the particular loss in question before an insurer can decline a claim.

Conditions subsequent to a contract

Whereas, conditions subsequent are those conditions, due to the occurrence of a material event which may require the insurer to avoid the contract. In other words, conditions subsequent to policy incepting, like discovery of a fraud or gross misrepresentation which alters the basic circumstances under which the contract was accepted.

Conditions precedent to Insurers' liability

These conditions include those that must be satisfied before an insurer becomes liable to pay the claim and include claim notification requirements, an obligation to take reasonable precautions to minimize the risk of loss, etc.

Rules of interpretation of a policy

Like any other contract, disputes do arise regarding liability, quantum, extent and duration of cover,

especially in cases where the insurer may have earlier repudiated the claim. It follows therefore, that interpretation of the policy document, is of paramount importance even at the time of inception and during the currency of the policy and not only in a court of law.

The policy document being a standard document, drafted by the insurer, the benefit of doubt is always in favour of the insured, as a principle of natural justice. This is as per the contra proferentem rule which states that where the contractual language is capable of alternative interpretations, it will be construed or translated in favour of the insured, who accepts the standard contract.

Briefly, the following rules are applied-

Printed and written portion of the policy is to be construed together as far as possible.

- In case of contradiction, the written portion over-rides the printed portion.
- The policy is to be interpreted as a whole.
- The words in the policy are to be given their plain, ordinary and popular meaning.
- Technical words are to be given their strict technical meaning.
- The ordinary rules of grammar shall apply.

INSURANCE DOCUMENTATION

1. Proposals

As has been mentioned earlier, insurance is the subject matter of solicitation, i.e. the offer or proposal for insurance has to come from the insured. The proposal forms for most products have been designed, over the years, to conveniently and comprehensively, obtain information from the insured which would be material to underwriting the policy.

The basic principle of *utmost good faith* comes into operation here. The insured should at the start of the contract divulge all material information about the subject matter; this would enable the insurer to decide the terms of cover and the rating and help avoid any disputes in the future in the event of a claim.

The owner's pecuniary interest in the subject matter of insurance establishes that the loss if any would adversely affect him financially; this serves to prove *the insurable interest that the proposer has in the property to be insured.*

The policy of insurance is a personal contract, and thus if the insured wants to transfer the interest in the policy, he can only do so with the consent of the insurer. The transfer of rights can be made through assignment of the policy. Assignment means transfer of the rights to another person usually made through a written document.

When the property on which insurance has been obtained, is sold the existing policy might be transferred to the buyer of the policy, with the permission of the insurer. However, marine cargo policies are freely assignable as together with the invoice and contract of affreightment i.e. – B/L, AWB. GCN or RR they form negotiable instruments that can be discounted at banks.

The proposal form is therefore the foundation of the insurance contract. In other words, if is also said that a proposal is the basis of insurance contract. It contains all the relevant information about-

i. Generic details about the insured/proposer – name, address etc. Important not only for incorporating on the policy form but also checking KYC diligences under the anti money laundering laws and for checking moral hazards etc.

ii. Specific details about the subject matter to be insured-this may be a line or two, if a single machinery, or a single shipment of goods by road; it may run into pages in case it contains details about projects which are to be insured-e.g. hydro electric project, oil rigging platform etc

iii. Details regarding the value to be sum insured; duration of insurance covered required.

Almost all general insurance policies are for 1 year; specific voyage policies can be shorter for the transit duration only. Project polices can be longer than 1 year – till the project is commissioned and operative.

2. Policy

The policy schedule is the document which together with various clauses, warranties and conditions forms the contract.

Naturally, this would include such details as name address, nature of business, policy number etc. Other more particular information detailed in the policy schedule would be

1. Full details and description of the subject matter to be insured.
2. Sum insured based on value of the sum insured. The basis of valuation and the adequacy of the sum insured is to be measured and specified clearly to avoid dispute in future in the event of a claim.
3. Period of insurance
4. Premium
5. The terms and conditions which details the actual cover eg. in marine cargo policies whether the cover is under ICC (A) or ICC (B) etc.
6. The various clauses which attach to the policy schedule and which are applicable to the contract would be listed on the policy schedule as well to clearly specify the nature and extent of the cover which is being issued.

   It is advisable to discuss with the insured, especially in case of insurance of high value risks , the exact words and clauses which attach to the policy and that define the cover.

   E.g. in case of project policies etc- it may be necessary to clarify what is testing period. It may be necessary to advise that when the plan becomes operational, post testing period, project insurance cover should be replaced by operational cover like fire policy.

3. Certificate of insurance:

These are usually given in marine transit insurance under open policies and also for motor insurance. In motor insurance they are mandatory as it confirms that there is insurance cover in existence for the vehicle plying on public roads. They are less detailed than a policy and not stamped , but essentially give the same information regarding insurance

4. Cover note

These are documents that are issued immediately to prove that insurance cover is existing and valid for 60 days from the date of issue. Mostly used in motor insurance and transit insurance , particularly for import covers by sea. The cover note in marine insurance would be valid for duration of transit.

5. Endorsements

An endorsement is issued subsequent to the issue of policy, whenever there is a need.

There may be instances, when during the currency of the policy, certain changes may be advised by the customer. E.g. Change in location, correction of name or other details of subject matter insured. There may be instances of increase in the value to be insured, inclusion of extra covers or deletion of covers etc.

In such cases, the insurer would, on being so solicited by the insured customer, issue an endorsement which would reflect the changes or amendments and would thereafter form part of the policy document. This is particularly relevant, in the event of a claim, as the damaged property may have been the subject matter of the endorsement- which details would not be available in the original policy.

Generally endorsements are issued for such alterations as

1. Change in insurable interest
2. Cancellation of insurance
3. Change in the value at risk
4. Change in the location or situation of risk
5. Reduction or addition to the risk.
6. Change of the insured as when a transfer of interest or assignment of interest is made.
7. Some times an endorsement is also issued to correct a typographical error in the policy already issued.

6. Renewal Notice

While it is not obligatory to issue renewal notices reminding insured that the policy is due for renewal, it is recommendatory as an excellent customer service initiative.

It is well known that getting a new customer is much more difficult and time consuming than retaining an old one. With much less effort one can cash in on their loyalty and ensure that policies are renewed year after year. Further, it is important to note that an Insured should intimate any alteration of risk before renewal of the policy.

WARRANTIES

Warranties are an extension of the terms and conditions contained in the clauses which attach to the policy schedule. As explained, the insured proposes insurance of a particular property and completes a proposal. Based on the same and customary trade conditions and practices, as well as underwriting experience, the insurer would stipulate certain warranties or conditions, which help the minimize chances of loss.

Warranty is a statement by which the insured undertakes to do or not do a particular thing or fulfill a condition, or whereby he affirms or negates the existence of a particular state of facts which affect the incidence of a claim.

Warranties can either relate to facts existing at the time of the contract or relate to the future. It is an undertaking given by the insured either voluntarily or at the instance of the insurer about something that will determine the insurability of the risk.

For example, in a Marine Cargo policy, a warranty may read “Warranted that the consignments are

transported in closed trucks covered by tarpaulins " in case goods are being moved during monsoons, or seaworthiness of the ship, or a legal route.

UNDERWRITING

Underwriting is defined as the "process of selecting, classifying and pricing applicants or insurance" by George E Rejda. Underwriting is necessary to deter and detect adverse selection of risks. Underwriting is the process by which an insurance company decides whether to issue requested insurance and, if it decides to issue it, on what terms and conditions and at what price. Selection and classification are elements of underwriting. Underwriters are known as 'gate keepers' for insurers

Underwriting is the heart of the insurance business. Underwriters can be of two categories, namely:

***Staff Underwriters**

The Staff Underwriters are those who are generally stationed at the Head office and are more concerned with drafting of underwriting policy and guidelines. Some of their important duties include:

- Formulation of Underwriting Policy,
- Evaluation of experience,
- Research and development of coverages and policy forms,
- Review and revision of rating plans,
- Preparation of underwriting guides and bulletins,
- Conduct of underwriting audits,
- Participation in industry associations and bureaus and
- Education and training
- Formulation of Underwriting Policy

*** Line Underwriters:**

The Line Underwriters are those who are generally stationed at the Branch offices and are more concerned with the implementation of the underwriting guidelines. Some of their important duties include:

- Selection of insured's
- Classification,
- Determination of proper coverage,
- Determination of the appropriate rate /premium
- Producer and policyholder service.

On the whole the basic function of underwriting is to determine as to the following:

- Who will be an insurance company's customer?
- What the company's products will be?
- At what price those products will be sold?

Thus, underwriting management sets the company's guidelines in order to make optimal use of the company's available capacity and avoid adverse selection. Therefore, to summarize, underwriting is

concerned with the selecting Insured's, pricing coverage, determining policy terms and conditions, monitoring underwriting decisions, so as to ensure a profitable book of business, so as to avoid adverse selection.

Main objectives of Underwriting

1. To reduce the possibility of adverse selection against the insurer.
2. Prudent underwriting reduces the chances of Physical, Moral, and Morale hazards.
3. Underwriting helps in determining the expected loss potential of the proposed insured and selecting a price in line with this expected loss.

UNDERWRITING PROCESS

The underwriting process follows a series of stages, at the end of which the status of a risk is decided. It is only after the risk has been weighed and all possible alternatives evaluated that the final underwriting is done. When a proposal for insurance is received, the underwriter has four possible courses of action:

- Accept the risk at standard rates
- Charge extra premium depending on the risk factor
- Impose special conditions
- Reject the risk.

There are different types of hazards which can influence his decision to accept or reject a risk-

i. Physical hazards

These are hazards that affect the physical characteristics of whatever is being insured. For example a building made of wood represents a higher level of physical hazard than one made of brick.

ii. Moral hazards

These hazards refer to the defects that exist in a person's character that may increase the frequency or the severity of loss. Such a character may tend to increase the loss for the company.

iii. Morale (attitudinal) hazard

These hazards reflect attitudinal hazards namely indifference or carelessness about potential loss which is more evident from the personality traits, carelessness, poor management, accident-prone, adverse past loss experience.

iv. Financial hazards

If the value of the risk is beyond the capacity of the insurer he may reject the risk, or share the same.

v. Regulatory hazards

These hazards refer to the regulatory interventions which the Regulatory Authorities insist of the companies to follow at the time of underwriting, which may relate wither to the policy coverage or pricing. For example low premiums, broad coverage, and issuance of non-cancelable policies are some of the interventions which the underwriters may have to necessarily comply with.

Underwriting Decisions

The decision of the underwriters with regards to issuance of policy can be categorized as under.

The underwriter can either accept a proposal, reject it or accept it with certain modifications. Some of the modifications that can be made are:

- Hazard incidence can be reduced: For loss prevention and minimization, underwriters can recommend certain changes that will safeguard against physical hazards. For example, installing sprinkler systems and better fire-fighting equipment in offices will reduce damages in case of fire.
- Changing rating plans and policy terms: Sometimes a proposal that seems unacceptable at one rate may become a desirable business under another rating plan or with Special Conditions such as 'compulsory excess'.
- Facultative reinsurance can be used: When the business is not covered by the insurer's reinsurance treaty or the amount of insurance needed exceeds the net treaty capacity, the underwriter can transfer that excess to a facultative reinsurer.
- Factors to be considered for Underwritng decisions in General Insurance

The factors influencing underwriting decisions in some of the general insurance policies are summarized below for more insights.

FIRE INSURANCE POLICY UNDERWRITING

i. Fire Underwriting Factors

- To assess fire hazard, factors to be considered are (COPE) that is **C**onstruction, **O**ccupancy, **P**rotection and **E**xternal Exposures. Construction categories from underwriters point of view include
  - Code 1. Frame
  - Code 2. Joisted Masonry
  - Code 3. Non-Combustible
  - Code 4. Masonry Non-Combustible
  - Code 5 Modified Fire Resistive
  - Code 6. Fire Resistive

    The code 6 is the best from the underwriter's point of view
- Other minor construction considerations include age of the building, height, openings and divisions, fire stops (Firewall). Occupancy can be either Single occupancy or Multiple occupancy. Occupancy affects the frequency and severity of losses. Fire insurance rating depends upon sources of Ignition, Combustibility of Contents and Damageability, Hazards in a property risk (house keeping, heating and air-conditioning equipment, common electrical equipment and lighting and smoking materials). Fire protection may be private or public, which consists of three elements: Prevention, Detection - Smoke and heat detectors, Alarm, Sprinkler systems and Extinguishments. Fire Exposures depend upon number of floors, openings in between floors, dimensions of corridors and rooms, location of five hydrants and the length of hose reels, maintenance of electrical wiring equipment and fire escape route.

MOTOR INSURANCE POLICY UNDERWRITING

Private Passenger Automobile Underwriting Insurance Factors

- The underwriting factors for automobiles or vehicles especially with regards to liability risks are very complicate in nature due to unpredictability in the number of third party claims, accidents by young

and inexperienced drivers or drunken drivers, badly maintained vehicles and due to bad roads. Besides the following factors are also to be considered by the underwriters in issuance of auto policies which include:

- Age of operators
- Age and type of automobile
- Use of the automobile
- Driving Record
- Territory
- Gender and Marital Status
- Occupation
- Personal Characteristics
- Physical condition

Commercial Automobile Underwriting Practice factors

Commercial vehicles are more exposed to risk and hence the unerwriitngs factors in addition to mentioned above include:

- Weight and type of vehicle
- Use of Vehicle: use for own purposes or for hire
- Radius of Operation:
- 'Local': radius of 50 miles, 'Intermediate': radius of 51 to 200 miles, 'Long distance' : excess of 200 miles

Vehicles are generally classified into different categories based on the function and need such as 1. Trucks 2. Food Delivery 3. Specialized delivery 4. Waste Disposal 5.Farmer's 6. Dump and Transit Mix trucks and trailers 7.Contractor's equipment

PROFESSIONAL INDEMNITY INSURANCE POLICY LIABILITY UNDERWRITING

Users of professional services may financially suffer, or sometimes become victims of professional negligence. Generally professionals include Advocates, Doctors Chartered Accountants etc. Hence, it is important that these policies are to be underwritten very carefully. Professional indemnity cover is also available to insurance brokers and agents on account of whose wrong advice to their clients, may be facing repudiation of a genuine claim from an insurer.

Commercial General Liability Underwriting Factors

Products and Completed Operations Exposures or risks include manufacture, distribution or sale of an unsafe, dangerous or defective products. On the other hand liability of products or completed operations is related to negligence. Therefore, the underwriting factors cover also calls for an understanding of the history of the product, history of defects and history of claims for defective products.

DISCLOSURE OF TERMS AND CONDITIONS

Proper disclosures of terms and conditions are very important for the Insurance contracts. An insurer should make utmost efforts to ensure that all important terms and conditions are disclosed properly. Insurance

Companies should also ensure that the customer is made aware about the important clauses of the insurance agreement.

The policy schedule usually gives the most relevant information and summarizes information pertaining to risk, value, period of insurance, premium and cover details. The clauses which attach and form part of the policy are many and varied and would be attached to the policy schedule, depending on the type of policy.

FACTORS CONSIDERED FOR FIXING OF SUM INSURED IN GENERAL INSURANCE

1. AVERAGE CLAUSE

It has been described before, that the insured knows best about the property which he would like to insure. Hence, in his own best interest, while completing the proposal form, he must declare the full value of the property. In the event of a partial loss, the value to the extent it is underinsured would have to be borne by the insured. He would be his own insurer for that portion of the property damaged, which has not been insured because of inadequacy in value insured.

Fixing of adequate sum insured is also important from the point of view of the banks or financial institutions who may have advanced money on the security of the insured property. It is sometimes found that the banks or financial institutions do not concern themselves with the adequacy of the sum insured so long as it is sufficient to cover the money advanced by them or at best the full value of the property on which they have advanced money. Invariably in such cases they find the problem only after happening of a loss when the claim amount is suitably adjusted for underinsurance and the full indemnity is not available due to the inadequacy of the sum insured. Average clause enumerates that - If the property insured shall at the breaking out of any insured peril be collectively greater than the sum insured thereon, then the insured shall be considered as being his own insurer for the difference, and shall bear a rateable proportion of the loss accordingly. Every item, if more than one, of the policy shall be separately subject to the condition.

Since the purpose of the insurance is to place the insured in the same financial position in which he was at the time of loss, it is necessary that there should be no under-insurance and the sum insured be adequate.

Points to be noted:

- The sum insured is always fixed by the proposer.
- It is the limit of Insurer's liability under a policy.
- It is the amount on which the rate is applied to determine the premium payable for the insurance.
- The sum insured should represent the actual value of the property to be insured. Insuring for higher value than the actual value gives no advantage to the insured as payment of claim, if, any, is subject to the principle of indemnity.
- Insuring for value lesser than the actual value makes the insured self insurer for the difference and claim, if any, is subjected to 'average' clause whereby he is penalized for under-insurance.
- In case of joint ownership of any property, the insured can get the claim only in respect of his share. He could, however, insure full value of the property on behalf of other co-owners as well in which case the claim, if any, is paid to each co-owner to the extent of their insurable interest.

2. MARKET VALUE

This is determined by the amount at which property of the same age and condition can be bought and sold. This value takes into account both depreciation due to age and appreciation due to inflation. For determining

the sum insured for buildings, apart from excluding the value of land and plinth, the present cost of construction of similar building should be taken and then the depreciation for age and usage deducted.

3. Reinstatement Value

In fire insurance the principle of indemnity can be modified in the case of building, machinery and other fixed assets where , subject to the sum insured representing the value of similar new property, it can be insured under 'Reinstatement Value' clause.

In case of reinstatement value policy, the basis of loss settlement is the value of new property without taking any depreciation into account. This type of insurance enables the owner to replace his property without any financial strain on his own resources and is quite commonly taken by industrialists and building owners.

DUTY OF ASSURED CLAUSE

All policies have a duty of assured clause- this spells out that the duty of the assured is, to behave as if he was not insured. Hence, in the event of a peril operating, he or his agent have to take all necessary steps to avert losses/ mitigate the damages caused due to peril..

DURATION OF COVER CLAUSE

Particularly in transit insurance, where insured requires that warehouse to warehouse cover be issued - the duration of cover is defined as the from the time the goods leave the place of storage, and continue through transshipment till the goods reach final destination, or on the expiry of a certain period of time after the goods are discharged – 60/15/7 days depending on whether transit is by sea/air or road.

It is often a point of contention whether loading risks are covered, as damages often take place on loading. Peculiarly, only in Inland Transit (C), which is an extremely limited cover, are loading risks insured. In other policies, it is expected that additional premium be charged and the cover specifically mentioned-"loading risks covered' on the policy schedule.

Transhipment – in the ordinary and customary course of transit is covered. The emphasis is that it should be in the *ordinary and customary course* of transit. Any other deviation or detour should be informed, prior to such instance, to the insurer. This is because the underwriting conditions have altered and the new risk environment should be evaluated in terms of risk acceptability and premium to be charged.

DEDUCTIBLES

A deductible is that portion of the amount of an insured loss, which the insured agrees to pay. It is common in almost all types of insurance policies to stipulate a definite amount of money, which is to be borne by the insured. The insurer becomes liable for any amount beyond the deductible amount stated in the contract. It is a provision by which a specific amount is subtracted from the total loss payment and are usually found in auto, property and health insurance. *Deductibles are not used in life insurance because the death of an insured is always a total loss*. It is also not used in personal liability insurance because even for a small claim, the insurer must provide a legal defense.

Deductibles may be either compulsory or voluntary. Voluntary deductibles will fetch a discount in the premium. (also known as 'excess').

EXCLUDED LOSSES

Most insurance policies differentiate between direct and indirect loses; they do not cover indirect losses arising out of the peril, even though the peril itself is covered under the policy. Like, for example in case of

loss due to fire, losses arising as a result of fire fighting, viz. breaking windows, making holes on the roof, are also considered as direct loss. But loss of income due to interruption in business as a result of the fire is considered as indirect loss. If the assured wants to be covered against the indirect losses, he must obtain separate policy for the same.

Proximate cause should be established for any claim to become liable and the insurer to accept liability, in case the proximate cause is an insured peril. In case the policy is a named perils policy the onus would lie on the insured to prove that the insurer is liable by virtue of the fact that the loss happened because of operation of one of the named perils.

Obviously, as a commercial contract the elements of a legal contract are contained in the insurance policy; again in an idealistic world, the policy terms and conditions, as accepted at the time of purchasing the contract would later not be negated. However, this is not practically what happens. Therefore, it is of the utmost importance that both the parties to the contract should be of one mind- or consensus ad idem should be established at the start.

COINSURANCE

Where the amount of insurance on large industrial complexes is substantial, it is possible for the insured to interest different insurers in the risk for varying proportions of acceptance, so that the total is covered. The practice is for each insurer to issue a policy with a specification or schedule giving a description of the property insured, with the "co-insurance clause" included therein.

Survey of the risk, rating, collection of premium and preparation of the specification is carried out by the "leading office", that is the office carrying the largest share in the business.

All co-insurances are agreed upon prior to the issue of the original policy.

In the event of a claim all policies would ***contribute equally***. In case, in rare instances where two policies are extant for a same risk, both would contribute in proportion of their interest in the sum insured at the time of claim. Notably, the polices would contribute in a manner to ensure that the ***insured is indemnified*** and not benefitted from the loss. In marine cargo claims, subrogating to the rights and remedies enjoyed by the insured against the carrier or third party , illustrates the practical application of the principle of subrogation.
Example: 'A' insured his house against fire with X for Rs.50000 and with 'Y' for Rs. 75000. Fire broke out in the building and a loss of Rs.40000 occurs. 'A' may file a suit against both the insurers or against one only.

The liability of each insurer is determined by applying the following formula:

$$\frac{\text{The sum insured with an insurer} \times \text{Loss}}{\text{The total sum insured with all insurers}}$$

$$\text{Liability of X} = \frac{50{,}000 \times 40{,}000}{1{,}25{,}000} = ₹16{,}000$$

$$\text{Liability of Y} = \frac{75{,}000 \times 40{,}000}{1{,}25{,}000} = ₹\ 24{,}000$$

It has to be noted that a life insurance is a contingent contract, and as such the principle of contribution will not apply to life policies. If the same life has been insured more than once, all the different amounts will become payable in full.

The following conditions must be satisfied for the applicability of the principle of contribution or coinsurance or collective insurance:

1. The same subject matter is insured with more than one insures
2. The policies must cover the same peril.
3. The assured must be the same person in all the polices.
4. All the policies must be in force at the time of loss.
5. Each insurer has to pay to the insured his share of loss only.

The main postulate in underwriting all general insurance products is presence of mind and application of basic common sense. At every instance, a brief scan of one's surroundings would showcase an opportunity to provide protection and evaluation of the surrounding circumstances and environment reveal the conditions which affect the property (potential risk) and the possibility of loss (potential risk/peril.)

Underwriting is the application of one's common sense, experience and then knowledge in the common interest of the insurer and the insured.

LESSON ROUND UP

- An insurance policy is like any contract, a legal document and enforceable in a court; the provisions of the Indian Contracts Act, 1872 are applicable to insurance contracts as well.
- Losses arising out of war or a warlike action or rebellion and nuclear risks are generally excluded by all insurance because these losses are unpredictable and are often catastrophic in nature.
- The primary function of a general insurance contract is to provide security, an assurance that, in the event of any loss, the contract would indemnify the insured.
- Generally express conditions are those that require the insured to do something – e.g. in cargo insurance transit by road during monsoon.
- Implied are those , which are so basic and material that their existence forms the very basis of the policy and cannot be In the absence of express conditions.
- Certificates of insurance are usually given in marine transit insurance under open policies and also for motor insurance.
- Warranties are an extension of the terms and conditions contained in the clauses which attach to the policy schedule.
- The underwriting process follows a series of stages, at the end of which the status of a risk is decided and decision with regards to issuance of policy is taken.
- It is only after the risk has been weighed and all possible alternatives evaluated that the final underwriting is done.
- Proper disclosures of terms and conditions are very important for the Insurance contracts. An insurer should make utmost efforts to ensure that all important terms and conditions are disclosed properly.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. What do you mean by underwriting? Explain the process of underwriting in insurance.
2. What are the essential features of a valid insurance contract?
3. What are the principles applicable in general insurance contracts?
4. Write a short note on objectives of underwriting.
5. Explain the key elements in general insurance policies.
6. It is usually said that “Underwriting is the heart of insurance operations”. Explain.

Lesson 11
GENERAL INSURANCE PRODUCTS

LESSON OUTLINE

- Introduction
- Property Insurance
- Fire and Engineering
- Marine Insurance (Hull and Cargo)
- Motor Insurance
- Business Interruption
- Liability Insurance (Public, Products, Professional, Directors & Officers etc)
- Personal Lines (Health, Accident, Travel, Residential Premises etc.)
- Rural and Agricultural
- Micro-Insurance
- Other Miscellaneous lines (Burglary, Bankers' Risks, Fidelity etc.)
- IRDA's latest Norms for E-Insurance Policies & E- Insurance Account
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

A very broad classification of insurance is life and non-life. A more rational classification would be life insurance and other than life or, general insurance products.

The primary facility of general insurance is the adaptability of insurance covers to suit every eventuality or to be customized to meet the needs of the proposer. There is a plethora of insurance products in every class of insurance; General insurance is broadly classified into:

1. Fire Insurance
2. Marine Insurance
3. Transit insurance
4. Miscellaneous insurance health insurance, liability insurance, fidelity insurance etc.

On the basis of functionality Insurance products are classified as

1. Insurance of Property and engineering
2. Insurance of persons
3. Insurance of Liability-
4. Insurance of Interests

This lesson has been prepared in order to enable the students to understand the

1. Meaning of general insurance products
2. Meaning and features of fire and engineering insurance
3. Concept of Marine insurance and its types
4. Meaning and features of different types of Liability insurance

INTRODUCTION

In today's age of consumerism, insurance requirements have expanded to keep pace with the increasing risks. Gone are the days when life insurances ruled the roost; today we have a wide assortment of risk coverage commencing from health insurance to travel insurance to theft insurance to even a wedding insurance. With affluence and spending capacity on the surge there is a growing trend to fulfill needs, deal with responsibilities and secure one's possessions, be it good health or wordly wealth.

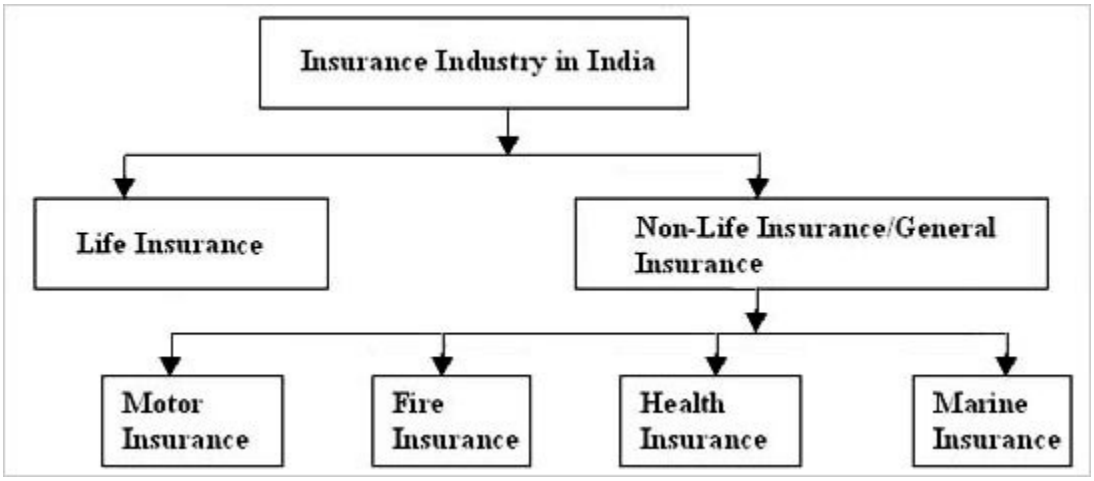
General insurance companies have willingly catered to these increasing demands and have offered a plethora of insurance covers that almost cover anything under the sun.

Any insurance other than 'Life Insurance' falls under the classification of General Insurance. It comprises of:
Insurance of property against fire, theft, burglary, terrorism, natural disasters etc

- Personal insurance such as Accident Policy, Health Insurance and liability insurance which covers legal liabilities.
- Errors and Omissions Insurance for professionals, credit insurance etc.
- Policy covers such as coverage of machinery against breakdown or loss or damage during the transit.
- Policies that provide marine insurance covering goods in transit by sea, air, railways, waterways and road and cover the hull of ships.
- Insurance of motor vehicles against damages or accidents and theft
- All these above mentioned form a major chunk of non-life insurance business.

General insurance products and services are being offered as **package policies** offering a combination of the covers mentioned above in various permutations and combinations. There are package policies specially designed for householders, shopkeepers, industrialists, agriculturists, entrepreneurs, employees and for professionals such as doctors, engineers, chartered accountants etc. Apart from standard covers, General insurance companies also offer **customized or tailor-made policies** based on the personal requirements of the customer.

Classification of Indian Insurance Industry



1. **Motor Insurance-** insurance purchased for cars, trucks, and other road vehicles. Its primary objective is to provide protection against physical damage resulting from traffic collisions and against liability that could also arise there-from.
2. **Fire Insurance –** losses insured are against fire and special allied perils such as , storms, floods, tempests, earthquakes, inundations, lightning strikes, land subsidence, including losses on account of business interruption, delays in start up , loss of profits or consequential loss etc
3. **Health Insurance-** is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. Depending on the type of health insurance coverage, either the insured pays costs out-of-pocket and is then reimbursed, or the insurer makes payments directly to the provider.
4. **Marine insurance –** covers the loss or damage of ships, cargo, terminals, and any transport or cargo by which property is transferred, acquired, or held between the points of origin and final destination.. Marine insurance branch deals with Cargo and Hull insurances.
5. **Insurance of Property and engineering –** fire and engineering, auto insurance, aviation and the like including cargo and hull
6. **Insurance of persons -** Casualty and Accident- personal accident products, Health
7. **Liability-** all liability lines including motor third party liability, workmen's compensation, product and public liability etc.
8. **Interests –** Fidelity guarantee, bankers blanket indemnity etc

The primary facility of general insurance is the adaptability of insurance covers to suit every eventuality or to be customized to meet the needs of the proposer. There is a plethora of insurance products in every class of insurance; a customer centric service industry, insurers are increasingly adapting products and processes to satisfy and even delight customers.

PROPERTY INSURANCE

FIRE POLICIES

Insurance of property means insurance of buildings, machinery, stocks etc against Fire and Allied Perils, Burglary Risks and so on. Goods in transit via Sea, Air, Railways, Roads and Courier can be insured under Marine Cargo Insurance. Hulls of ship and boats can be insured under Marine Hull Insurance. Further, there are specialized policies available such as Aviation Insurance Policy for insurance of planes and helicopters. Thus Property Insurance is a very vast category of General Insurance and the type of cover that you need depends upon the type of property you are seeking to cover.

Package or Umbrella policies

There are package or umbrella covers available which give, under a single document, a combination of covers. For instance there are covers such as Householders Policy, Shopkeepers Policy, Office Package policy etc that, under one policy, seek to cover various physical assets including buildings, contents etc. Such policies, apart from seeking to cover property may also include certain personal lines or liability covers. Make sure you understand the complete details of cover and exclusions contained in the policy you are considering. Package or Umbrella covers could have common terms and conditions for all sections as also specific terms for specific sections of the policy.

Fire Insurance

A fire insurance is a contract under which the insurer in return for a consideration (premium) agrees to indemnify the insured for the financial loss which the latter may suffer due to destruction of or damage to property or goods, caused by fire, during a specified period. The contract specifies the maximum amount , agreed to by the parties at the time of the contract, which the insured can claim in case of loss. This amount is not , however , the measure of the loss. The loss can be ascertained only after the fire has occurred. The insurer is liable to make good the actual amount of loss not exceeding the maximum amount fixed under the policy.

A fire insurance policy cannot be assigned without the permission of the insurer because the insured must have insurable interest in the property at the time of contract as well as at the time of loss. The insurable interest in goods may arise out on account of (i) ownership, (ii) possession, or (iii) contract. A person with a limited interest in a property or goods may insure them to cover not only his own interest but also the interest of others in them. Under fire insurance, the following persons have insurable interest in the subject matter:-

(a) Owner

(b) Mortgagee

(c) Pawnee

(d) Pawn broker

(e) Official receiver or assignee in insolvency proceedings

(f) Warehouse keeper in the goods of customer

(g) A person in lawful possession e.g. common carrier, wharfinger, commission agent.

The term 'fire' is used in its popular and literal sense and means a fire which has 'broken bounds'. 'Fire' which is used for domestic or manufacturing purposes is not fire as long as it is confined within usual limits. In the fire insurance policy, 'Fire' means the production of light and heat by combustion or burning. Thus, fire, must result from actual ignition and the resulting loss must be proximately caused by such ignition. The phrase 'loss or damage by fire' also includes the loss or damage caused by efforts to extinguish fire.

The types of losses covered by fire insurance are:-

- Goods spoiled or property damaged by water used to extinguish the fire.
- Pulling down of adjacent premises by the fire brigade in order to prevent the progress of flame.
- Breakage of goods in the process of their removal from the building where fire is raging e.g. damage caused by throwing furniture out of window.
- Wages paid to persons employed for extinguishing fire.

The types of losses not covered by a fire insurance policy are:-

- loss due to fire caused by earthquake, invasion, act of foreign enemy, hostilities or war, civil strife, riots, mutiny, martial law, military rising or rebellion or insurrection.
- loss caused by subterranean (underground) fire.
- loss caused by burning of property by order of any public authority.
- loss by theft during or after the occurrence of fire.
- loss or damage to property caused by its own fermentation or spontaneous combustion e.g. exploding of a bomb due to an inherent defect in it.
- loss or damage by lightening or explosion is not covered unless these cause actual ignition which spread into fire.

A claim for loss by fire must satisfy the following conditions:-

- The loss must be caused by actual fire or ignition and not just by high temperature.
- The proximate cause of loss should be fire.
- The loss or damage must relate to subject matter of policy.
- The ignition must be either of the goods or of the premises where goods are kept.
- The fire must be accidental, not intentional. If the fire is caused through a malicious or deliberate act of the insured or his agents, the insurer will not be liable for the loss.

Types of Fire Insurance Policies:-

- **Specific policy**:- is a policy which covers the loss up to a specific amount which is less than the real value of the property. The actual value of the property is not taken into consideration while determining the amount of indemnity. Such a policy is not subject to 'average clause'. 'Average clause' is a clause by which the insured is called upon to bear a portion of the loss himself. The main object of the clause is to check under-insurance, to encourage full insurance and to impress upon the property owners to get their property accurately valued before insurance. If the insurer has inserted an average clause, the policy is known as "Average Policy".
- **Comprehensive policy**:- is also known as 'all in one' policy and covers risks like fire, theft, burglary, third party risks, etc. It may also cover loss of profits during the period the business remains closed due to fire.
- **Valued policy**:- is a departure from the contract of indemnity. Under it the insured can recover a fixed amount agreed to at the time the policy is taken. In the event of loss, only the fixed amount is payable, irrespective of the actual amount of loss.
- **Floating policy**:- is a policy which covers loss by fire caused to property belonging to the same person but located at different places under a single sum and for one premium. Such a policy might cover goods lying in two warehouses at two different locations. This policy is always subject to 'average clause'.
- **Replacement or Re-instatement policy**:- is a policy in which the insurer inserts a re-instatement clause, whereby he undertakes to pay the cost of replacement of the property damaged or destroyed by fire. Thus, he may re-instate or replace the property instead of paying cash. In such a policy, the

insurer has to select one of the two alternatives, i.e. either to pay cash or to replace the property, and afterwards he cannot change to the other option.

Engineering Insurance

The rapid industrialization of our country has led to increasing use of machines in industry. Though use of machinery results in increased production capacities, in the event of accident and breakdowns, they can be potential sources of financial loss and could even result in the closure of business.

In spite of proper care and maintenance of machinery, mishap may yet occur. Sometimes the extent of damage may be quite high and may also lead to fatal or non-fatal injuries to human beings nearby.

The remedy for such losses is offered by means of the pecuniary protection given under Oriental's engineering insurance policies.

The various engineering policies offered by us may be divided under the following three major heads:

1. Project Insurance
2. Operational Machineries Insurance
3. Business Interruption Insurance

Project Insurance:

Before an industry is set up, it involves project planning, financing, procurement of land, land levelling and earthwork, excavation of land, placing orders and procurement of machineries from various places, storing these machineries and other equipments connected with the project in safe conditions, erecting the equipments as per a planned schedule and finally testing and commissioning the erected plant and machinery for their rated capacity.

The engineering policies, recommended at the project stage can be any one of the following three covers:

1. Erection All Risks (also know as Storage Cum Erection Insurance)
2. Contractors (Construction) All Risks Insurance
3. Contractor's Plant and Machinery Insurance

Operational Machineries Insurance

After the completion of testing and commissioning and commencement of commercial production, the machineries that are installed and working in a specified premises can be covered under any of the following policies (depending upon the nature and type of plant and machinery):

1. Machinery Breakdown Insurance
2. Boiler And Pressure Plant Insurance
3. Electronic Equipment Insurance
4. Civil Engineering Completed Risks Insurance
5. Deterioration Of Stocks Insurance - Refrigeration Plant (Stock) Policy

Business Interruption Insurance (Consequential Loss Insurance)

Following property damage, due to break down of the machinery / electronic equipment or explosion of a boiler covered under the respective material damage policies, there may be an interruption in the operations

and leading to loss of gross profits during such interruption periods. Such loss of gross profit is covered under business interruption policies:

This insurance covers additional cost of working also, to resume production.

MARINE INSURANCE :

A contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the insured, in the manner and to the extent thereby agreed, against transit losses, that is to say losses incidental to transit. A contract of marine insurance may by its express terms or by usage of trade be extended so as to protect the insured against losses on inland waters or any land risk which may be incidental to any sea voyage.

Scope

Transportation of goods can be broadly classified into three categories:

1. Inland Transport
2. Import
3. Export

In simple words the marine insurance includes

A. Hull insurance which is concerned with the insurance of ships (hull, machinery, etc
B. Cargo insurance which provides insurance cover in respect of loss of or damage to goods during transit by rail, road, sea or air.

Hull Insurance

There are various types of policies issued to cover different types of ships/boats depending on their function and usage of the vessel.

Sundry vessels

There are separate policies designed for fishing vessels, Sailing vessels, inland vessels (barges, pontoons, flats, floating cranes, tugs , ferries, passenger vessels etc Other types of insurance include covers for jetties, wharves etc and vessels plying in inland waters such as lakes, rivers canals etc.

Liners/Tankers/Bulk carriers/Dredgers

There are many types of vessels and policies have been designed to cover all these types of vessels- but primarily depend on the function and area of operation for the premium rating etc. They may be known as sundry vessels and rating of premium and cover is contained in a separate tariff. These policies are issued based on the areas of operation, the season and are annual policies insuring the hull(ship bottom) and

machinery (ships engine etc). Insurance cover is for the actual vessel and contents, as well as for third party liability for property and lives and pollution hazards associated with the perils encountered in the areas of operation.

Marine Insurance Clauses are designed for hulls and cargo insurance and because of the very nature of the trade – (travelling across the globe) have spread across the world and are universally accepted.

The main clauses are developed by a number of organizations around the world but primarily the institute of London Underwriters and American Institute of Marine Underwriters. These clauses are universally used in marine insurance the world over, though they may be translated into various languages.

Hulls are usually protected by the

1. **Institute Time Clauses Hull** – for ships and machinery and liability for a period of one year usually.
2. **Institute Voyage Clauses** – for ships, machinery and liability for a specific voyage.

These are named perils policies – that is loss or damage to the property insured caused by any of the perils **named** are covered. E.g. Fire, explosion, violent theft, jettison, piracy, breakdown or accident , contact with airplanes or similar objects, bursting of boilers, accidents in loading , unloading, shifting or discharging cargo, caused due to negligence of the master of the ship or his crew, collision liability etc

War and Strike risks:-

All marine policies exclude damage arising from war or warlike conditions and strikes. For this a separate cover has to be taken and is applicable to all vessels covered under the Indian Merchants Shipping Act, 1958.

Freight Cover

Freight is the primary reason for the shipping industry- plying all over the world conveying garangutan shiploads of goods to various countries around the world. Therefore, the ship owner has an insurable ineterst in the freignt and is enabled to insure the same through the Institute Time /Voyage Clauses (Freight).

There are numerous other polices and operations which may be insured under marine hull insurance – Ship Repairers liability, ship breaking insurance, Off shore Oil and Gas units policies – even the transport of oil through pipe lines is covered under hull policies.

CARGO POLICIES

Cargo policies insure goods in transit , whether by air, sea, road/rail or by post or courier.

SPECIFIC /VOYAGE POLICIES

Cargo in transit may be covered as a specific instance or if there are routine transport of cargo an annual cover may be availed of. Specific voyage policies are, exactly as named, policies insuring a single transit of goods from one place to another.

The usual practice, when seeking to u=insure the consignment, i to bring a copy of the invoice and the bill of affreightment (by sea – bill of lading; air – airway bill, road, lorry receipt or goods consignment note or by rail railway receipt and post – parcel receipt)

This specifies the value of the goods declared to the transporter and together with invoice forms negotiable instruments which lay claim to ownership.)

Specific voyage policies are generally issued only for the duration of the transit and till the goods reach the final destination given in the policy, in the customary time. The cover would incept from the time the goods leave the warehouse (WH) and continue to the final destination warehouse.

Hence the term WH to WH cover.

It is to be noted that insurance cover should be sought before the voyage/transit actually commences. The transit can be multi modal and be covered in a single policy eg. Goods are moving from Nagpur to Birmingham, UK by sea. The transit from Nagpur to Mumbai, or any other port, by road and thereafter by sea till UK and further from Birmingham by road/rail is all insured under a single policy.

OPEN COVER/OPEN POLICY

These policies are generally issued where there are frequent transits of materials requiring to be insured, sometimes at short notice.

Open Cover

Usually, importers /exporters of goods who have frequent consignments in transit and cannot specify from or to which country the goods are transported and the individual terms of contract may avail this. Generally, when banks finance such transactions they issue a letter of credit and using this as a basis the insured may seek an annual cover.

Each consignment is thereafter separately declared to the insurer, premium paid and a certificate of insurance issued.

Open Policy

Commonly used to insure routine inland transit of goods, open policy requires that a certain sum of premium, based on the annual turnover of goods transported, is paid and monthly or fortnightly declarations, declaring the value of goods transported declared. The premium is replenished at regular intervals, based on the value of the consignments declared, always ensuring that each consignment is adequately insured – that is the value declared should be as per invoice (cost, insurance and freight- CIF + 10%) In the event of a claim, in marine policies as well, which are agreed value policies, proportionate value of the goods insured would be considered while assessing loss.

Earlier, a special declaration policy, for higher annual turnovers , with greater discounts , used to be given but this is not so prevalent nowadays.

Difference between Open Policy & Open Cover			
	Open Cover	**Open Policy**	**Remarks**
1.	Generally for export and import consignments	Primarily used for domestic shipments	
2	Unstamped-usually a letter. Every consignment is usually insured by means of a certificate of insurance which is stamped.	Stamped-legally enforceable	Policy being stamped may be upheld in a court of law in case of disputes. The certificate of insurance issued for covering each consignment is stamped - stamp duty being recovered along with

			premium, is computed according to the Indian Stamp Act.
	Premium amount fluctuates from consignment to consignment, hence open cover letter is basically an assurance of cover – similar to a held covered letter. Details of premium, sum insured, incorterms etc are given in the individual certificates.	In open policy the sum insured is fixed and premium is collected in advance. Against this premium for regular consignments are adjusted till premium deposit advance is exhausted or replenished.	

Special Storage Risks Insurance

This policy insures the goods lying in railway yard or carriers godown pending final delivery to destination, usually pending clearance by the consignee. These policies are usually given in conjunction with open policies / special declaration policies. They are specialized niche policies and usually given to insured's who have been customers of the company for some time. The cover would terminate with the delivery of goods to consignee / payment for the consignment being made to the consignor whichever is earlier.

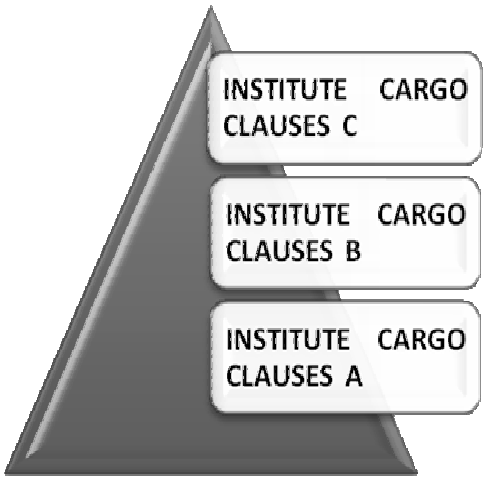
Duty Insurance

Transit polices also ensure the duty component separately. In certain cases , especially when goods are being transported by sea, the duty may not have been assessed or arrangement made for payment. In the event that the imported wants that the value of duty to be incurred when the cargo lands, is top be insured, he would arrange to take a duty policy. All terms and conditions as per cargo policy would apply – the only condition being that premium should be computed on the assessable duty value and paid before the goods land.

CARGO CLAUSES

The actual details of the covers which are used are governed by the **Institute Cargo Clauses(**sending by sea**)**

1. **Institute Cargo Clauses – A/B/C –**



Both ICC- B & C are named perils polices whereas ICC(A)- is All risks.

In named perils policies only loss or damage to the property insured due to named perils is covered and the onus of proof lies on the insured that the loss occurred due to the occurrence of an insured peril.

ICC (C) covers the following risks/perils-

i. Fire or explosion
ii. Vessel or craft being overturned , capsized stranded grounded or sunk,
iii. Overturning or derailment of the land conveyance
iv. Collision with an external object other than water
v. Discharge of cargo at a port of distress
vi. General average sacrifice,
vii. Jettison of cargo

ICC(B) also covers , in addition to the above-

i. Earthquake, lightening, or volcanic eruption
ii. Washing of cargo overboard
iii. Entry of sea, lake or river water into vessel, hold, container etc etc
iv. Total loss of any package lost overboard whilst loading or unloading from vessel or craft.

ICC (B) covers additionally on the payment of extra premium the following-

i. Theft pilferage non delivery(TPND)
ii. Fresh and rainwater damage
iii. Hook damage, oil damage, heating and sweating etc
iv. Breakage and leakage and bursting and tearing of bags etc.

ICC (A) covers all accidental loss or damage to property other than losses cause dby excepted perils/occurrences.

The onus of proof lies on the insurer to prove that loss occurred as per the excepted peril, in the event of dispute.

INSTITUTE CARGO CLAUSES (AIR)/INLAND RAIL & ROAD & REGISTERED PARCEL-SENDINGS BY POST.

As mentioned earlier all types of cargo transit insurance is classified as marine cargo insurance. Different clauses govern the types of covers issued for various transit.

1. **AIR CARGO** – Institute CARGO CLAUSES (Air- excluding sending by post)) are attached to policy schedule which seek to insure transit of cargo by air. Attached clause would be the Institute War & Strike clauses (Air) as losses caused by war and strikes etc are not insured
2. **POST** – Transit insurance by post is also covered. There are no specific clauses designed but usually if by Road/Rail the Inland Transit Clauses (Road/Rail) are used. It is sometimes advised , in case of valuable parcels, to declare the value to postal authorities so that the same is insured.

How to select the sum insured?

The sum insured or value of the policy would depend upon the type of contract. Usually, in addition to the contract value 10/15% is added to take care of incidental cost.

How to claim?

The following steps should be taken in event of a loss or damage to goods insured :

1. Take immediate steps to minimize loss.
2. Inform nearest office of the insurance company or claim settling agent mentioned on the policy.
3. In case of damage to goods whilst on ship or port , arrange for joint ship survey or port survey.
4. Lodge monetary claim with carrier within stipulated time period.
5. Submit duly assigned insurance policy/certificate along with the original invoice and other documents required to substantiate the claim such as :
    a. Bill of Lading / AWB/GR
    b. Packing list
    c. Copies of correspondence exchanged with carriers.
    d. Copy of notice served on carriers along with acknowledgment/receipt.
    e. Shortage/Damage Certificate issued by carriers.
6. Survey fees is to be paid to the surveyor appointed by the insurance company. This fees will be reimbursed along with the claim if the claim is otherwise admissible.

MOTOR INSURANCE

There has been a sudden rise in the motor accidents in the last few years. Much of these are attributable to increase in the number of vehicles. Every vehicle before being driven on roads has to be compulsorily insured. The motor insurance policy represents a combined coverage of the vehicles including accessories, loss or damage to his property or life and the third party coverage. Persons driving vehicles may cause losses and injuries to other persons. Every individual who owns a motor vehicle is also exposed to certain other risks. These include damage to his vehicle due to accidents, theft, fire, collision and natural disasters and also injuries to himself. In 1939, motor vehicle act came into force in India and compulsory insurance was introduced by motor vehicle act to protect the pedestrians and other third parties.

DEFINITION

A motor insurance policy is a mandatory policy issued by an insurance company as part of prevention of public liability to protect the general public from any accident that might take place on the road. The law mandates that every owner of a motor vehicle must have one motor insurance policy.

Motor insurance policy is a contract between the insured and the insurer in which the insurer promises to indemnify the financial liability in event of loss to the insured.

Motor Vehicles Act in 1939 was passed to mainly safeguard the interests of pedestrians. According to the Act, a vehicle cannot be used in a public place without insuring the third part liability.

According to Section 24 of Motor Vehicles Act, “No person shall use or allow any other person to use a motor vehicle in a public place, unless the vehicle is covered by a policy of Insurance.”

Classification of Motor Vehicles

As per the Motor Vehicles Act for the purpose of insurance the vehicles are classified into two broad categories such as.

1. Private cars:

(a) Private Cars - vehicles used only for social, domestic and pleasure purposes

(b) Private vehicles - Two wheeledi) Motorcycle / Scooters ii) Auto cyclesiii) Mechanically assisted pedal cycles

2. Commercial vehicles

(1) Goods carrying vehicles

(2) Passengers carrying vehicles

(3) Miscellaneous & Special types of vehicles

The risks under motor insurance are of two types:

(1) Legal liability due to bodily injury, death or damage caused to the property of others.

(2) Loss or damage to one's own vehicle\ injury to or death of self and other occupants of the vehicle.

BASIC PRINCIPLES OF MOTOR INSURANCE

Motor insurance being a contract like any other contract has to fulfill the requirements of a valid contract as laid down in the Indian Contract Act 1872.

In addition it has certain special features common to other insurance contracts.

They are:

- Utmost good faith
- Insurable interest
- Indemnity
- Subrogation and contribution
- Proximate cause

All of these principles have already been discussed in detail in earlier chapters. But for the student's convenience, we will be discussing these here again:

Utmost good faith

The principle of Utmost good faith casts an obligation on the insured to disclose all the material tracts. These material facts must be disclosed to the insurer at the time of entering into the contract. All the information given in the proposal form should be true and complete. e.g. the driving history, physical health of the driver, type of vehicle etc. If any of the mentioned material facts declared by the insured in the proposal form are found inappropriate by the insurer at the time of claim it may result in the claim being repudiated.

Insurable Interest

In a valid insurance contract it is necessary on the part of the insured to have an insurable interest in the subject matter of insurance. The presence of insurable interest in the subject matter of insurance gives the

person the right to insure. The interest should be pecuniary and must be present at inception and throughout the term of the policy. Thus the insured must be either benefited by the safety of the property or must suffer a loss on account of damage to it.

Indemnity

Insurance contracts are contracts of indemnity. Indemnity means making good of the loss by reimbursing the exact monetary loss. It aims at keeping the insured in the same position he was before the loss occurred and thus prevent him from making profit from insurance policy.

Subrogation and Contribution

Subrogation refers to transfer of insured's right of action against a third party who caused the loss to the insurer. Thus, the insurer who pays the loss can take up the assured's place and sue the party that caused the loss in order to minimise his loss for which he has already indemnified the assured.

Subrogation comes in the picture only in case of damage or loss due to a third party. The insurer derives this right only after the payment of damages to the insured. Contribution ensures that the indemnity provided is proportionately borne by other insurers in case of double insurance.

What Motor Insurance covers:

The damages to the vehicle due to the following perils are usually covered under OD section of the Motor Insurance policy:

(a) Fire, Explosion, Self- Ignition, Lightning
(b) Burglary/Housebreaking / Theft
(c) Riot & Strike
(d) Earthquake
(e) Flood, Storm, Cyclone, Hurricane, tempest, inundation, hailstorm, frost
(f) Accidental external means
(g) Malicious Act
(h) Terrorism acts
(i) While in Transit by Rail/ Road, Inland waterways, Lift, Elevator or Air
(j) Land slide / Rock slide

What Motor Insurance excludes:

The following contingencies are usually excluded under the Motor Insurance Policy:

- Not having a valid Driving License
- Under Influence of intoxicating liquor/ drugs
- Accident taking place beyond Geographical limits
- While Vehicle is used for unlawful purposes
- Electrical/Mechanical Breakdowns.

Why to buy Motor Insurance Policies

Motor insurance gives protection to the vehicle owner against (i). damages to his/her vehicle and (ii). pays for any Third Party Liability determined as per law against the owner of the vehicle. Third Party Insurance is a

statutory requirement. The owner of the vehicle is legally liable for any injury or damage to third party life or property caused by or arising out of the use of the vehicle in a public place. Driving a motor vehicle without insurance in a public place is a punishable offence in terms of the Motor Vehicles Act, 1988.

Important points to consider when buying motor insurance policies

Insured value/sum insured: If you are buying a policy against loss/damage to your vehicle, you must ensure that your vehicle is adequately insured as it will affect the amount you can claim in the event of loss/damage. For a new vehicle, the insured value will be the purchase price while for other vehicles, the insured value is the market value of the vehicle at the point you apply for the insurance policy.

- **Under-insurance** – If you insure your vehicle at a lower sum than its market value, you will be deemed as self-insured for the difference, i.e. in the event of loss/damage, you will only be partially compensated (up to the proportion of insurance) by your insurance company.
- **Over-insurance** – Should you insure your vehicle at a higher sum than its market value, the maximum compensation you will receive is the market value of the vehicle as the policy owner cannot 'profit' from a motor insurance claim.

Duty of disclosure: You should disclose fully all material facts, including previous accidents (if any), modification to engines, etc. When in doubt as to whether a fact is relevant or not, it is best to ask your insurance company. If you fail to disclose any material fact, your insurance company may refuse to pay your claim or any claim made by a third party against you. In such cases, you are personally liable for such claims.

Price: The price you pay for your motor insurance will depend on the type of policy selected. The insurance premium charged by your insurance company is the standard minimum rate in accordance with the Motor Tariff. However, in addition to the standard minimum rate, your insurance company may impose additional premiums known as loadings to the premium payable in view of higher risk factors involved such as age of vehicle and claims experience.

No-claim-discount: The premium payable may be reduced if you have no-claim-discount (NCD) entitlement. NCD is a 'reward' scheme for you if no claim was made against your policy during the preceding 12 months of policy. Different NCD rates are applicable for different classes of vehicles. For a private car, the scale of NCD ranges from 25% to 55% as provided in the policy.

Transfer of ownership: In case of any sale of vehicle involving transfer of policy, the insured should apply to the insurer for consent to such transfer. The transfer is allowed, if within 15 days of receipt of application, the insurer does not reject the plea. The transferee shall apply within fourteen days from the date of transfer in writing to the insurer who has insured the vehicle, with the details of the registration of the vehicle, the date of transfer of the vehicle, the previous owner of the vehicle and the number and date of the insurance policy so that the insurer may make the necessary changes in his record and issue fresh Certificate of Insurance.

Excess: Also known as a 'deductible'. This is the amount of loss you have to bear before your insurance company will pay for the balance of your vehicle damage claim. The types of excess applicable are as follows:

- **Compulsory excess of RM400:** If your vehicle is driven by a person not named in your policy or a person named in your policy who is under the age of 21, the holder of a provisional (L) driving license or the holder of a full driving license of less than two years.
- **Other excess:** applicable at the discretion of your insurance company and in some cases, no excess is imposed. You can negotiate with your insurance company on this excess.

TYPES OF MOTOR INSURANCE POLICIES

The All India Motor Tariff governs motor insurance business in India. According to the Tariff all classes of vehicles can use two types of policy forms. They are form A and form B. Form A which is known as Act Policy is a compulsory requirement of the motor vehicle act. Use without such insurance is a penal offence. Form B which is also known as Comprehensive Policy is an optional cover.

1. Liability only policy – This covers third party liability and / or death and property damage. Compulsory personal accident covers for the owner in respect of owner driven vehicles is also included.
2. Package policy – This covers loss or damage to the vehicle insured in addition to 1 above.
3. Comprehensive policy- Apart from the above-mentioned coverage, it is permissible to cover private cars against the risk of fine and / or theft and third party/ theft risks.

Every owner of motor vehicle has to take out a policy covering third party risks but insurance against other two risks is optional. When insurance policy covers third party risks, third party who has suffered any damages, can sue the Insurance company even though he was not a party to the contract of insurance.

Insurance policies for the vehicles subject to the purchase agreements, lease agreements and hypothecation are to be issued in the joint names of the hirer and owner, lease and lessor, owner and pledge respectively. In case of policy renewal a notice of one month in advance before the date of expiry is issued by the insurers. The notice gives the details of premium payable for renewal.

Transfer of ownership

In case of any sale of vehicle involving transfer of policy, the insured should apply to the insurer for consent to such transfer. The transfer is allowed, if within 15 days of receipt of application, the insurer does not reject the plea. The transferee shall apply within fourteen days from the date of transfer in writing to the insurer who has insured the vehicle, with the details of the registration of the vehicle, the date of transfer of the vehicle, the previous owner of the vehicle and the number and date of the insurance policy so that the insurer may make the necessary changes in his record and issue fresh Certificate of Insurance**.**

Insurer's Duty to Third Party

It is obligatory on the part of the insurer to pay the third party since, the insurer has no rights to avoid or reject the payment of liability to a third party. The duties of the insurer towards a third party are provided in section 96(1). The court determines the third party liability and accordingly compensation is paid. The liability is unlimited.

Cancellation of Insurance

The insurer may cancel a policy by sending to the insured seven days notice of cancellation by recorded delivery to the insured's last known address and the insurer will refund to the insured the pro-rata premium for the balance period of the policy. A policy may be cancelled at the option of the insured with seven days notice of cancellation and the insurer will be entitled to retain premium on short period scale of rates for the period for which the cover has been in existence prior to the cancellation of the policy. The balance premium, if any, will be refundable to the insured.

Double Insurance

When two policies are in existence on the same vehicle with identical cover, one of the policies may be

cancelled. Where one of the policies commences at a date later than the other policy, the policy commencing later is to be cancelled by the insurer concerned. If a vehicle is insured at any time with two different offices of the same insurer, 100% refund of premium of one policy may be allowed by canceling the later of the two policies. However, if the two policies are issued by two different insurers, the policy commencing later is to be cancelled by the insurer concerned and pro-rata refund of premium thereon is to be allowed.

Calculation of Premiums

In the case of Comprehensive Insurance Cover, for the purpose of premium, vehicles are categorized as follows:

Private Car

This is used for personal purposes. Private cars are lesser exposed than taxis, as the latter is used extensively for maximum revenue. The premium is computed on the following basis

1. **Geographical area of use:** Large cities have higher average claim costs followed by suburban areas, smaller cities, and small towns or rural areas. In India, the geographical areas have been classified into Group A and Group B.

2. **Cubic capacity:** The more the cubic capacity, the higher the premium rate.

1. **Value of the vehicle:** The premium rate is applied on the value of the vehicle. Owner has to declare the correct value of the vehicle to the insurer. This value is known as the Insured's Estimated Value (IEV) in motor insurance and represents the sum insured.

Two-wheeler

It is used for personal purpose only. Premium is calculated on cubic capacity and value of vehicle. Theft of accessories is not covered, unless the vehicle is stolen at the same time.

Two wheeler insurance provides mandatory personal accident cover of Rs. 1 lakh to the insurer. This accident cover can also be opted for passengers. It also protects against legal liabilities arising due to third party's injury/death or damage caused to its property.

Commercial Vehicle

This is the vehicle used for hire. For goods carrying commercial vehicle, premium is calculated on the basis of carrying capacity i.e. gross vehicle weight and value of the vehicle. For passenger carrying commercial vehicles, premium is calculated on the basis of again carrying capacity i.e. number of passengers and value of the vehicle. Accessories extra, as specified. Heavier vehicles are more exposed to accidents since the resultant damages they incur are more. Similarly, vehicles with higher carrying capacity expose more passengers to risk. Therefore heavier vehicles attract higher premium rate.

Claim Settlement-Motor Insurance

Claim arise when

(1) The insured's vehicle is damaged or any loss incurred.

(2) Any legal liability is incurred for death of or bodily injury

(3) Or damage to the third party's property.

The claim settlement in India is done by opting for any of the following by the insurance company

a. Replacement or reinstatement of vehicle

b. Payment of repair charges

In case, the motor vehicle is damaged due to accident it can be repaired and brought back to working condition. If the repair is beyond repair then the insured can claim for total loss or for a new vehicle. It is based on the market value of the vehicle at the time of loss. Motor insurance claims are settled in three stages. In the first stage the insured will inform the insurer about loss. The loss is registered in claim register. In the second stage, the automobile surveyor will assess the causes of loss and extent of loss. He will submit the claim report showing the cost of repairs and replacement charges etc. In the third stage, the claim is examined based on the report submitted by the surveyor and his recommendations. The insurance company may then authorize the repairs. After the vehicle is repaired, insurance company pays the charges directly to the repairer or to the insured if he had paid the repair charges. Section 110 of Motor Vehicle Act, 1939 empowers the State Government in establishing motor claim tribunals. These tribunals will help in settling the third party claims for the minimum amount

Business interruption insurance

Commercial coverage that reimburses a business owner for lost profits and continuing fixed expenses during the time that a business must stay closed while the premises are being restored because of physical damage from a covered peril, such as a fire. Business interruption insurance also may cover financial losses that may occur if civil authorities limit access to an area after a disaster and their actions prevent customers from reaching the business premises. Depending on the policy, civil authorities' coverage may start after a waiting period and last for two or more weeks.

Business interruption coverage is a tightly constructed part of broader commercial insurance policies. This coverage is most commonly found in commercial property insurance policies and business owner's policies (a package policy for small businesses, often referred to as a "BOP").

There are four critical elements to business interruption insurance:

1. It is only triggered in three limited circumstances:
   (a) There is physical damage to the premises of such magnitude that the business must suspend its operations.
   (b) There is physical damage to other property caused by a loss that would be covered under the company's insurance policy, and that damage totally or partially prevents customers or employees from gaining access to the business.
   (c) The government shuts down an area due to property damage caused by a peril covered by the company's insurance policy that prevents customers or employees from gaining access to the premises.
2. Even after a covered event, most policies have a waiting period of several days before business interruption coverage comes into play. Once it is in play, the coverage is not retroactive to the day of the event.
3. Coverage is limited. Specifically, after the waiting period expires, coverage is provided for lost net income, temporary relocation expenses (designed to reduce overall costs), and ongoing expenses such as payroll that enables businesses to continue paying employees rather than laying them off.
4. Coverage is not open-ended. Coverage is available only for as long as it is necessary to get the business running again, and usually not longer than 12 months. In addition, the business is required to prove all business interruption losses to its insurer.

LIABILITY INSURANCE

In our lives, we often encounter situations where someone caused any harm. Whether it is property, material, spiritual, moral, labor, etc. And after that comes up is such a thing as a "liability insurance".

Liability insurance is a part of the general insurance system of risk financing to protect the purchaser (the "insured") from the risks of liabilities imposed by lawsuits and similar claims. It protects the insured in the event he or she is sued for claims that come within the coverage of the insurance policy.

There are several types of liability insurance, the most basic.

(1) Public Liability insurance

This policy covers the amount which the insured becomes legally liable to pay as damages to third parties as a result of accidental death, bodily injury, loss or damage to the property belonging to a third party. The legal cost and expenses incurred in defending the case with prior consent of the insurance company are also payable subject to certain terms and conditions.

One can insure more than one unit situated in different locations under a single policy.

The policy offers a benefit of Retroactive period on continuous renewal of policy whereby claims reported in subsequent renewal but pertaining to earlier period after first inception of the policy, also become payable.

In Public Liability Policy, the sum insured is referred to as Limit of Indemnity. This limit is fixed per accident and per policy period which is called Any One Accident (AOA) limit and Any One Year (AOY) limit respectively. The ratio of AOA limit to AOY limit can be chosen from the following :

(a) 1:1

(b) 1:2

(c) 1:3

(d) 1:4

The AOA limit which is the maximum amount payable for each accident should be fixed taking into account the nature of activity of the insured and the maximum number of people who could be affected and maximum property damage that could occur, in the worst possible accident in the insured's premises.

In the case of Public Liability Insurance Act 1991, the AOA limit should represent the paid up capital of the company subject to maximum of Rs.5 crores. The AOY limit is fixed at 3 times the AOA limit (Max.Rs.15 Crores).

(2) Product Liability insurance

This policy covers all sums (inclusive of defence costs) which the insured becomes legally liable to pay as damages as a consequence of:

(a) accidental death/ bodily injury or disease to any third party.

(b) accidental damage to property belonging to a third party.

arising out of any defect in the product manufactured by the insured and specifically mentioned in the policy after such product has left the insured's premises. The policy offers the benefit of retroactive period on continuous renewal of policy whereby claims reported in subsequent renewal but pertaining to earlier period after first inception of policy, also become payable.

The policy can be extended to cover liability arising out of judgments or settlements made in countries which operate under the laws of U.S.A or Canada (which is an exclusion under the policy) by opting for the North American Jurisdiction Clause.

The policy can also be extended to cover Limited Vendors Liability for named or unnamed vendors. Limited vendors liability means liability arising out of the sale and distribution of named insured products by vendors with original warranties and instructions of use of the product specified by the manufacturers.

In Product Liability Policy, the sum insured is referred to as Limit of Indemnity. This limit is fixed per accident and per policy period which is called Any One Accident (AOA) limit and Any One Year (AOY) limit respectively. The ratio of AOA limit to AOY limit can be chosen from the following:

a. 1:1
b. 1:2
c. 1:3
d. 1:4

The AOA limit which is the maximum amount payable for each accident should be fixed taking into account the nature of product covered and the maximum number of people who could be affected and maximum property damage that could occur, in the worst possible accident after sale of the product.

(3) Professional Liability Insurance

This policy is meant for professionals to cover liability falling on them as a result of errors and omissions committed by them whilst rendering professional service.

The policy offers a benefit of Retroactive period on continuous renewal of policy whereby claims reported in subsequent renewal but pertaining to earlier period after first inception of the policy, also become payable. Group policies can also be issued covering members of one profession. Group discount in premium is available depending upon the number of members covered.

The policy covers all sums which the insured professional becomes legally liable to pay as damages to third party in respect of any error and/or omission on his/her part committed whilst rendering professional service. Legal cost and expenses incurred in defence of the case, with the prior consent of the insurance company, are also payable, subject to the overall limit of indemnity selected.

Only civil liability claims are covered. Any liability arising out of any criminal act or act committed in violation of any law or ordinance is not covered.

4. Directors and Officers Liability Insurance (D&O)

This cover is suitable for those Directors & key officers who are in a decision -making position. These directors and officers in pursuance of their duties may take some actions which may be in violation of certain statutes or Indian Laws.

Provides cover to the following:

1. Against any loss that the Organization may incur, on account of mistaken actions taken in their individual capacity as Directors & Officers in pursuance of their duties under Memorandum and Articles of Association.
2. Against loss arising from claims made against them by reason of any wrongful Act in their Official capacity.

3. Legal costs & expenses incurred with the written consent of the insurers arising out of prosecution (criminal or otherwise) of any Director / officer and attendance at any investigation, examination, inquiry or other proceedings by the authority empowered to do so.
4. Expenses incurred by any shareholder of the Company in pursuance of a claim against any Director / Officer, which the Company is legally obliged to pay, pursuant to an order of a Court.
5. Provide indemnity to the estate of, legal heirs or legal representatives of the Director / officer in the event of the Director / officer becoming insolvent.
6. Lift(Third Party) Insurance: Designed for owners of passenger lifts in building to cover third party liabilities for personal injuries or property damage arising out of the use and operation of lifts including their machinery, plant, doors, safety devices or other appliances.

PERSONAL INSURANCE

Health Insurance

A systematic plan for financing medical expenses is an important and integral part of a risk management plan. With rising health care costs, it was no longer possible for an individual to meet the heavy cost of treatment involving hospitalization.

The reasons for rise in health care costs are:

(a) Increase in medical treatment costs.

(b) Technological advancements in medical equipment.

(c) High labour costs.

Definition

"Health insurance is an insurance, which covers the financial loss arising out of poor health condition or due to permanent disability, which results in loss of income."

A health insurance policy is a contract between an insurer and an individual or group, in which the insurer agrees to provide specified health insurance at an agreed upon price (premium). It usually provides either direct payment or reimbursement for expenses associated with illness and injuries. The cost and range of protection provided by health insurance depends on the insurance provider and the policy purchased.

Health Insurance Policies

The health insurance policies available in India are:

(a) Mediclaim policy (individuals and groups)

(b) Overseas Mediclaim policy

(c) Raj Rajeshwari Mahila Kalyan Yojna

(d) Bhagyashree Child Welfare Policy

(e) Cancer Insurance Policy

(f) Jan Arogya Bima Policy

Mediclaim policy (individuals and groups)

Mediclaim policy is offered to individuals and groups exceeding 50 members. It covers the hospitalization for

diseases or sickness and for injuries. Under group medi-claim policy, group discount is allowed to groups exceeding 101 people. The medical expenses will be reimbursed only if the insured is admitted in the hospital for a minimum duration of 24 hours. Cost of treatment includes consultation fee of doctors, cost of medicines and hospitalization charges. Health insurance in India is available at very economical rates. It is very popular among professionals like Chartered accountants, Advocates, Engineers etc. It is very suitable for self-employed persons because it covers risks against several general and serious diseases.

Overseas Mediclaim Policy

In 1984, the Overseas Mediclaim Policy was developed. This policy will reimburse the medical expenses incurred by Indians upto 70 years of age while traveling abroad. The premium will be charged based on their age, purpose of travel, duration and plan selected by the insured under the policy. This policy is provided is provided to businessmen , people going on holiday tour, traveling for educational professional and official purposes.

Raj Rajeshwari Mahila Kalyan Yojna

It is a personal accident policy offered by an insurance company for the welfare of women. It is offered to women residing in rural and urban areas. Women between 10-75 years of age are eligible for this policy irrespective of their occupation and income level.

Bhagyashree Child Welfare Policy

It is offered to girls between 0-18 years. The age of the parents of the girls shouldn't be more than 60 years. It provides coverage to one girl child in a family who loses her father or mother in an accident.

Cancer insurance policy

It is designed for cancer patients aid association members. The persons insured under this policy will pay premium to their association along with the membership fee. This policy will offer coverage to the insured in case he develops cancer. All the expenses incurred for treatment of cancer not exceeding the sum insured will be paid directly to the insured person.

Jan Arogya Bima Policy

This policy provides medical insurance to poorer section of the people. This policy covers illness like heart attack, jaundice, food poisoning, and accidents etc. that requires immediate hospitalization.

New Rules to Standardize Health Insurance Sector by IRDA

Insurance sector is regulated by Insurance Regulatory Development Authority (IRDA) of India in our country and the organization has introduced several new rules to standardize this sector aiming to increase convenience of insurance holders.

In order to avoid misunderstandings and ambiguity of the insurance policies, the regulatory body has defined guidelines to standardize health insurance practices in the country. It has laid some rules which are required to be used as mandatory clause in the documentation of each and every health insurance policy.

Some of the guidelines framed by IRDA insurance include critical illness, pre-existing diseases, hospitalization etc. Regulatory body has defined these terms and health insurance companies are required to be used same words while framing policy wordings for each and every policy. the body has defined pre-existing disease 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 to prior to

the first policy issued by the insurer" and hospitalization as "A minimum stay for 24 hours in the hospital". Further, hospital has been defined as more clearly as "A hospital should have 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".

These new guidelines laid down by the IRDA insurance regulatory body aims to decrease the frauds and to increase satisfaction among insurance policy holders. The other main reason of laying these rules is to increase the trust between insured and insurer in order to facilitate development of this sector. With these simplified rules, insurance seekers will be able to understand different clauses of the policy and will help them to buy suitable policy meeting their needs.

FUTURE OF HEALTH INSURANCE

During the last 50 years, India has made considerable progress in improving its health status. Still it is in a developing stage. The increasing health care costs in the country are likely to contribute to the development of more health insurance products. Health insurance is not at the present recognized as a separate segment in Indian insurance industry. Privatization of insurance industry has encouraged the development of this segment but Health insurance in India has indeed a long way to go.

Personal Accident Insurance

Personal Accident is an insurance cover wherein, in the event of the person sustaining bodily injuries resulting solely and directly from an accident caused by EXTERNAL, VIOLENT & VISIBLE means , resulting into death or disablement

Events covered under Personal Accident Insurance

Personal Accident insurance covers but not limited to an accident may include events like:

- Rail / Road / Air Accident.
- Injury due to any collision/fall.
- Injury due to Bursting of gas cylinder.
- Snake-bite, Frost bite/Dog bite.
- Burn Injury, Drowning, Poisoning etc.

Scope of cover & benefits available under Personal Accidental cover

Personal Accidental policy covers accidental death, loss of limbs, permanent total and partial disablement as selected and granted by the insurance companies based on the underwriting norms. On payment of additional premium, medical expenses reimbursement can also be covered under personal accident insurance. These expenses are payable, in case, if the claim is admitted under the basic policy cover

Age limits under personal accident cover

This Policy is available to persons between the age of 5 and 70 years (Male & Female). In case of Family Package covers, the age of children should be between 5 to 19 years.

Factors affecting Sum insured under personal accident insurance

Sum insured is based on various factors namely:

(a) Income from gainful employment,

(b) Type of occupation,

(c) Age as on date of proposal,

(d) Period of insurance

(e) Conditions prevailing at the place from where the proposal is made etc.

Travel Insurance

Travel insurance coverage is usually limited to the period of your travel. However, some insurance companies may offer various combinations of protection to cater to the specific needs of customers, including long-term annual policies for a frequent traveler. Travel insurance can be purchased for you and/or your family to insure against travel-related accidents, losses or interruptions, such as:

(a) Personal accident

(b) Medical-related expenses

(c) Loss of travel or accommodation expenses due to cancellation or curtailment of the journey

(d) Losing your passport

(e) personal liability

(f) delayed baggage

(g) travel delays

(h) Hijacking

Home insurance, also commonly called hazard insurance or homeowner's insurance (often abbreviated in the real estate industry as HOI), is a type of property insurance that covers a private residence, such as a condominium or renters' insurance or home or multiple unit buildings (duplex, triplex or quadplex so long as the owner lives in one of the units). It is an insurance policy that combines various personal insurance protections, which can include losses occurring to one's home, its contents, loss of use (additional living expenses), or loss of other personal possessions of the homeowner, as well as liability insurance for accidents that may happen at the home or at the hands of the homeowner within the policy territory. If a home does not meet the underwriting guidelines of a standard homeowners policy (such as more than 15-20 year old shingled roof, 20-30 year old heating system, no central heating, etc) the residence could qualify for a limited coverage dwelling policy (DP).

Homeowners policy is referred to as a multiple-line insurance policy, meaning that it includes both property insurance and liability coverage, with an indivisible premium, meaning that a single premium is paid for all risks. Standard forms divide coverage into several categories, and the coverage provided is typically a percentage of Coverage A, which is coverage for the main dwelling.

The cost of homeowner's insurance often depends on what it would cost to replace the house and which additional endorsements or riders are attached to the policy. The insurance policy is a legal contract between the insurance carrier (insurance company) and the named insured(s). It is a contact of indemnity and will put the insured back to the state he/she was in prior to the loss. Typically, claims due to floods or war (whose definition typically includes a nuclear explosion from any source), amongst other standard exclusions (like termites), are excluded. Special insurance can be purchased for these possibilities, including flood insurance. Insurance should be adjusted to reflect replacement cost, usually upon application of an inflation factor or a cost index.

The home insurance policy is usually a term contract — a contract that is in effect for a fixed period of time. The payment the insured makes to the insurer is called the premium. The insured must pay the insurer the

premium each term. Most insurers charge a lower premium if it appears less likely the home will be damaged or destroyed: for example, if the house is situated next to a fire station or is equipped with fire sprinklers and fire alarms; if the house exhibits wind mitigation measures, such as hurricane shutters; or if the house has a security system and has insurer-approved locks installed. Perpetual insurance, a type of home insurance without a fixed term, can also be obtained in certain areas.

Agriculture and Rural Insurance

India's heart beats in the rural segment where more than half of our population lives and toils to enrich our country. Agriculture and rural insurance schemes are very important for the people living in the rural sectors. These schemes provide the economic security to the people against the perils such as floods, fire, etc.

AGRICULTURE INSURANCE COMPANY OF INDIA LIMITED [AIC] was incorporated on 20tl' December, 2002 to exclusively cater to the insurance needs of the farming community, with Authorised Share Capital of ₹1500 crore and Paidup Share Capital of Rs. 200 crore, contributed by the following:

(a) General Insurance Corporation of India [GIC] - 35%

(b) National Bank for Agriculture and Rural Development [NABARD] - 30%

(c) National Insurance Company Ltd. [NIC] - 8.75%

(d) The New India Assurance Company Ltd. [NIA] - 8.75%

(e) Oriental Insurance Company Ltd. [OIC] - 8.75%

(f) United India Insurance Company Ltd. - [UII] - 8.75%

AIC commenced its business on 1st April 2003 and, at present, the Company has a country-wide network of 17 Regional Offices at State Capitals, with its Registered and Head Office at New Delhi.

National Agricultural Insurance Scheme (NAIS)

National Agricultural Insurance Scheme (NAIS) is the Government sponsored crop insurance scheme under implementation in the country since Rabi 1999-2000 season as part of risk management in agriculture with the objective of providing financial support to the farmers in the event of failure of crops as a result of natural calamities, pests and diseases. Agriculture Insurance Company of India (AIC) Ltd. is the Implementing Agency of the Scheme. The scheme is available to all the farmers – loanee and non-loanee both - irrespective of their size of holding. It envisages coverage of all the food crops (cereals, millets and pulses), oilseeds and annual commercial/horticultural crops, in respect of which past yield data is available for adequate number of years.

The premium rates are 3.5% per cent (of sum insured) for bajra and oilseeds, 2.5% for other Kharif crops; 1.5% for wheat and 2% for other Rabi crops. In the case of commercial/horticultural crops, actuarial rates are being charged. At present small and marginal farmers are entitle to subsidy of 10% of the premium charged from them which is shared equally by Centre and State Governments.

The scheme is operating on the basis of ‘Area Approach’ i.e. defined areas for each notified crops – block, tehsil, mandal, firka, circle, gram panchayat etc. Presently the scheme is implemented by 24 States and 2 Union Territories. During the last twenty five crop seasons (i.e. from Rabi 1999-2000 to Rabi 2011- 12), 1930 lakh farmers have been covered over an area of about 2919 lakh hectares insuring a sum amounting to about Rs 256065 crore under the scheme. Claims to the tune of about Rs. 25001 crore have been paid/payable against the premium of about Rs. 7565 crore benefiting about 518 lakh farmers (upto Rabi 2011-12 season).

Modified National Agricultural Insurance Scheme (MNAIS)

The ongoing NAIS has been reviewed and modified to make it more farmers friendly. It has been launched as a pilot in selected States / UTs. In addition to payment of claims for yield loss on area approach basis (as under NAIS), its other features include:

i. Unit area of insurance reduced to village/village panchayat level for major crops

ii. Minimum number of CCEs required to be conducted at village / village Panchayat level reduced to four (except groundnut crop)

iii. Threshold yield based on average yield of the preceding 7 years excluding upto 2 calamity years declared by concerned government/authority

iv. indemnity payment for Prevented sowing/planting risk

v. coverage of Post harvest losses due to coastal cyclone

vi. On-account payment upto 25% advance of likely claims as immediate relief

vii. Minimum Indemnity Level (IL) is raised to 70%

viii. Uniform seasonality disciplines both for loanee & non-loanee farmers

ix. Private sector insurers apart from Agriculture Insurance Company (AIC) of India, are also permitted to implement the scheme with the aim of creating a competitive market for crop insurance to enable the farmers to insure their crops at reasonable premium rates.

Crop Insurance and Weather based Crop Insurance

Crop insurance is a means of protecting the agriculturist against financial losses due to uncertainties that may arise from crop failures/losses arising from named or all unforeseen perils beyond their control.

Weather Based Crop Insurance aims to mitigate the hardship of the insured farmers against the likelihood of financial loss on account of anticipated crop loss resulting from incidence of adverse conditions of weather parameters like rainfall, temperature, frost, humidity etc

Micro Insurance

Micro insurance is the protection of low -income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Low-income people can use micro insurance, where it is available, as one of several tools (specifically designed for this market in terms of premiums, terms, coverage, and delivery) to manage their risks.3

In India, it is often assumed that a micro insurance policy is simply a low -premium insurance policy. This is not so. There are a number of other important factors. Low-income clients often:

(a) Live in remote rural areas, requiring a different distribution channel to urban insurance products;

(b) Are often illiterate and unfamiliar with the concept of insurance, requiring new approaches to both marketing and contracting

(c) Tend to face more risks than wealthier people do because they cannot afford the same defences. So, for example, on average they are more prone to illness because they do not eat as well, work under hazardous conditions and do not have regular medical check -ups;

(d) Have little experience of dealing with formal financial institutions, with the exception of the National Bank of Agriculture and Rural Development (NABARD) Linkage Banking programme;

(e) Often have higher policyholder transaction costs. Thus a middle -class, urban, policyholder can send a completed claims form to an insurance company with relative ease: a quick call to the insurance company, receipt of the claims form by post, and then return of the form by post. For a low-income policy holder, submitting a claims form may require an expensive trip lasting a day to the nearest insurance office (thereby losing a day of work), obtaining a form and paying a typist to type up the claim, sending in the claim, followed by a long trip back home. Aside from the real costs of doing this, the low –income policyholder may be uncomfortable with the process; clerks and the other officials are often haughty with such low-income clients and can make clients feel ill at ease.

(f) Designing micro insurance policies requires intensive work and is not simply a question of reducing the price of existing insurance policies.

Other Miscellaneous Insurance

Burglary Insurance

Burglary Insurance is one of the major classes of business underwritten in the miscellaneous department and accounts for a sizeable portion of the department's premium income.

For the business house Burglary insurance is as essential as Fire insurance, as it enables them to recoup the losses suffered by them consequent on burglary or house breaking. In addition to the burglary policy, other types of policies giving wider covers have also been devised by the burglary department. The main types of policies are as follows:

(i) Business Premises Policy,

(ii) Private Dwelling Policy,

(iii) Jewellary and Valuable Policy,

(iv) All Risk Policy, and

(v) Money in Transit Policy

DEFINITIONS

Burglary:

The criminal law of the country does not speak of an offence called burglary. Hence it becomes necessary for the insurers to lay down in the policy the definition of the term. As normally understood burglary is:

(a) Theft of property from the premises following upon felonious entry of the said premises by violent and forcible means.

(b) Theft by a person in the premises who subsequently breaks out by violent and forcible means provided there shall be visible marks made upon the premises at the place of such entry or exit by tools, explosives, electricity or chemicals. Use of force may be against property and person.

Theft:

Indian Penal Code in Section 378 defines theft as follows: "whoever intending to take is honestly any movable property out of the possession of any person without the consent of that person or of any person having for that purpose authority, moves that property in order to such taking is said to commit theft."

House-breaking:

The word in practice is equal to 'Burglary'. Section 445 of the Indian Penal Code has laid down a definition of

the term.

A person is said to commit housebreaking who commits house trespass if he effects his entrance into the house (or any part of it), or if being in the house (or any part of it) for the purpose of committing an offence, or having committed an offence therein he quits the house, such entrance or exit being made by use of force in one of the six ways as described in the Indian Penal Code.

Robbery:

Section 390 of the Indian Penal Code laid down, "If in order to the commission of or in committing of the theft or in carrying away property obtained by theft, the offender, for that end, voluntarily causes (or attempts to cause) to any person death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint".

Dacoits:

Section 391 of the Indian Penal Code states dacoits as "where five or more persons conjointly commit or attempt to commit a robbery or are present and aid such commission or attempt, every one of them is said to commit dacoits"

Coverage:

Business premises are generally covered against burglary and house breaking only. Mere theft without the use of force and violence is not covered, robbery and dacoits being aggravated forms of theft.

It also covers risk of holdup. Burglary and house breaking fall within the scope of this cover. Under policies issued for private dwellings, the contents are covered against burglary, house-breaking and theft risks. Similarly Jewellery and valuables are also insured in the same manner.

Money in Transit:

Policies, as a matter of rule, cover robbery, hold-up and dacoits in addition to burglary, housebreaking and theft.

Business Premises Insurance Policies:

Policies issued to business premises cover stock-in-trade, goods in trust or on commission, fixtures and fittings, tools of trade such as typewriters, calculators and other similar property and cash and currency notes in locked safe against the risk of burglary and house-breaking.

Loss or damage to contents or to any part of the building caused by burglary or any attempt therefore is also covered. In regard to stock-in-trade and other goods the policy may be issued on full value basis or on "first loss" basis.

A "First Loss" 'Policy insures the property up to a specified amount only which is calculated to be the maximum likely loss on any one occasion. This type of policy is taken where a total loss is a physical impossibility.

First loss policies are usually taken for bulk commodities. The amount insured is always specified as a certain percentage of the full value, say, 10% or 12.5% of the full value.

The amount of premium-loss reinsurance was Rs. 16.60 crores by New India in 1994-95. It has got profit of Rs. 12.12 crores in that year.

Cash-in-Safe Insurance:

The cover includes only when the cash is secured in a safe and is granted only if the safe is burglar proof and is of an approved make and design. Safe which is permanently installed in the premises is a better risk than a safe which can be shifted. The cover is granted subject to the following two clauses.

(a) The loss of cash obstructed from the safe following the use of the key to the said safe or any duplicate these of belonging to the insured is not covered unless such key has been obtained by violence or through means of force.

The use of force need not necessarily be against the person or an individual. It can be against property as well. Thus cupboard is removed after forcing open the cupboard, the loss is covered by the policy.

(b) A complete list of the amount of cash in safe should be kept secure in some places other than the safe and the liability of the insurer is limited to the amount actually shown by such records.

All Risks (Jewellery and Valuables) Insurance:

Policies under this form of insurance cover risks in respect of jewellery, plate, watches, personal ornaments and other valuables. Loss or damage by any accident or misfortune including fire, theft, robbery from the person, defective settings or fastening and accidental damage are thus covered. The policies do not, however, cover loss or damage:

(i) Occasioned by or in consequence of war, invasion, act of foreign enemy, hostilities, civil war, noting, rebellion, revolution, insurrection, military or usurped power, riot, civil commotion, earth-quake or other convulsions of nature; (ii) caused by or arising from any process of repairing, restoring or renovating any property insured;

(iii) Due to moth, wilder, wear or other deterioration or inherent defect in any property insured. The insurance is applicable in all places within the geographical limits provided for in the policy.

Exclusions:

The exceptions peculiar to a burglary (business premises) policy are:

(i) Loss or damage where any member of the insured's household or his business staff is concerned as principal or accessory or resulting from any act committed by any other person lawfully on the premises wherein the property may happen to be;

(ii) Loss or damage which can be insured against by a fire or a plate glass or a motor insurance policy;

(iii) loss of or damage to deeds, bonds, bills of exchange, promissory notes, cash, treasury, bank notes, cheques, securities for money, stamps, stamp collections, books of accounts, manuscripts, documents of any kind and medals and coins, unless specially mentioned and agreed to be covered.

Extension under the Policy :

An extension of the policy frequently sought is in respect of riot and strike damage which is a common exclusion in all policies. Riot as included in the policy is deemed to mean riot as defined in the Indian Penal Code.

Extension (Infidelity of Employees) :

The normal policy does not cover loss to the insured arising through the acts of dishonesty by the employees entrusted with the carrying of the money.

The policy is extended at additional premium to cover any loss to the insured of the property insured by any act of fraud or dishonesty committed by the employees or employees carrying the property. This is known as 'Infidelity Extension'.

Fidelity Insurance

Fidelity insurance protects organizations from loss of money, securities, or inventory resulting from crime. Common Fidelity claims allege employee dishonesty, embezzlement, forgery, robbery, safe burglary, computer fraud, wire transfer fraud, counterfeiting, and other criminal acts.

These schemes involve every possible angle, taking advantage of any potential weakness in your company's financial controls. From fictitious employees, dummy accounts payable, non-existent suppliers to outright theft of money, securities and property. Fraud and embezzlement in the workplace is on the rise, occurring in even the best work environments.

Liabilities covered by crime insurance usually fall into two categories, although many polices combine both types of coverage:

- **Money and security coverage** pays for money and securities taken by burglary, robbery, theft, disappearance and destruction.
- **employee dishonesty coverage** pays for losses caused by most dishonest acts of your employees, such as embezzlement and theft

IRDA's latest Norms for E-Insurance Policies & E- Insurance Account

Insurance Repository services launched a provision to open e-Insurance accounts in 2013 but failed due to low awareness level among the customers. But now IRDA has issued a notification regarding 'regulations for Issuance of electronic insurance policies and submission of electronic proposal form of insurance policies with effect from 1st October, 2016.

"Insurance Repository" means a company which has been granted a certificate of registration by IRDA for maintaining the data of insurance policies in Electronic Form on behalf of the Insurers. The Insurance Repositories provide the ease of holding insurance policies issued in an electronic form.

The main objectives of IR are:

1. To provide insurance policy-holders a facility to keep insurance policies in electronic form .
2. To provide policyholders a facility for changing, modifying and revising the insurance policies online.
3. To act as a single stop for policy servicing needs.
4. To bring about the efficiency and transparency in the issuance and maintenance of insurance policies.

Issuance of Electronic Insurance Policies w.e.f October, 2016

- Every insurer shall issue electronic insurance policies that fulfill the below given criteria in terms of Policy Sum Assured (or) Premium.
- Issuance of Electronic Term insurance policy is mandatory, if the sum assured is equal to or more than Rs 10 lakh (or) single/ annual premium is more than Rs 10,000.
- It is mandatory to issue all motor insurance & individual overseas Travel insurance policies in an electronic form.

- Individually Health insurance policies with sum assured of equal to or more than ₹5 lakh (or) annual premium is more than Rs 10,000, policies have to be issued electronically.

Issuance of E- Insurance Policies: IRDA's Latest Norms & Criteria			
SNo.	**Type of Insurance Policy**	**Sum Insured (in Rs) Equal to (or) exceeding**	**Single or Annual Premium (in Rs) Equal to (or) exceeding**
1	Pure Term Insurance Policy (excluding Term Policy with ROP)	10 Lakh	10,000
2	Other than Term Policy (including Term Policy with ROP)	1 Lakh	10,000
3	Pension Policies	NA	10,000
4	Immediate Annuities	NA	10,000
5	General Insurance Policies (except Motor Insurance)	10 Lakhs	5,000
6	Individual Health Insurance	5 Lakhs	10,000
7	Motor Insurance	**All Policies**	
8	Individual Personal Accident Insurance	10 Lakhs	5,000
9	Individual Domestic Travel Insurance	10 Lakhs	5,000
10	Individual Overseas Travel Insurance	**All Policies**	

LESSON ROUND-UP

(1) Fire Insurance is taken for losses against fire and special allied perils such as , storms, floods, tempests, earthquakes, inundations, lightning strikes, land subsidence, including losses on account of business interruption, delays in start up , loss of profits or consequential loss etc

(2) Fire Policy covers: cover against lightning, explosion/implosion, aircraft damage, riot, strike and malicious damage, storm, cyclone, typhoon, hurricane, flood and inundation, impact damage, subsidence and landslide including rockslide, bursting and/or overflowing of water tanks, apparatus and pipes, missile testing operations, accidental leakage from automatic sprinkler installations, bush fire etc but does not cover a certain amount known as “excess” under the policy. Loss or damage caused by war and warlike operations, nuclear perils, pollution or Contamination, electrical/mechanical breakdown, burglary and housebreaking are excluded.

(a) Marine insurance includes

(b) Hull insurance which is concerned with the insurance of ships (hull, machinery, etc

(3) Cargo insurance which provides insurance cover in respect of loss of or damage to goods during transit by rail, road, sea or air.

(4) Motor insurance policy is a contract between the insured and the insurer in which the insurer promises to indemnify the financial liability in event of loss to the insured.

"Liability insurance" Liability insurance is a part of the general insurance system of risk financing to protect the purchaser (the "insured") from the risks of liabilities imposed by lawsuits and similar claims. It protects the insured in the event he or she is sued for claims that come within the coverage of the insurance policy. There are several types of liability insurances which includes Public Liability insurance, Product Liability insurance, Professional Liability Insurance, Directors and Officers Liability Insurance (D&O) ,Lift(Third Party) Insurance.

(5) “Health insurance is an insurance, which covers the financial loss arising out of poor health condition or due to permanent disability, which results in loss of income.”

A health insurance policy is a contract between an insurer and an individual or group, in which the insurer agrees to provide specified health insurance at an agreed upon price (premium).

(6) IRDA had formulated new rules for standarizing health Insurance in India.

(7) Personal Accident is an insurance cover wherein, in the event of the person sustaining bodily injuries resulting solely and directly from an accident caused by external, violent & visible means , resulting into death or disablement

(8) National Agricultural Insurance Scheme (NAIS) is the Government sponsored crop insurance scheme under implementation in the country since Rabi 1999-2000 season as part of risk management in agriculture with the objective of providing financial support to the farmers in the event of failure of crops as a result of natural calamities, pests and diseases. Agriculture Insurance Company of India (AIC) Ltd. is the Implementing Agency of the Scheme. The scheme is available to all the farmers – loanee and non-loanee both - irrespective of their size of holding. It envisages coverage of all the food crops (cereals, millets and pulses), oilseeds and annual commercial/horticultural crops, in respect of which past yield data is available for adequate number of years.

(9) Crop insurance is a means of protecting the agriculturist against financial losses due to uncertainties that may arise from crop failures/losses arising from named or all unforeseen perils beyond their control.

(10) Fidelity insurance protects organizations from loss of money, securities, or inventory resulting from crime. Common Fidelity claims allege employee dishonesty, embezzlement, forgery, robbery, safe burglary, computer fraud, wire transfer fraud, counterfeiting, and other criminal acts.

(11) Insurance Repository services launched a provision to open e-Insurance accounts in 2013 but failed due to low awareness level among the customers. But now IRDA has issued a notification regarding 'regulations for Issuance of electronic insurance policies and submission of electronic proposal form of insurance policies with effect from 1st October, 2016.

SELF-TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

1. What do you mean by General Insurance? What are the various categories of General Insurance? Explain.
2. What is fire insurance? What are the exigencies, which fire insurance generally, covers?
3. Explain engineering insurance in detail.
4. What do you mean by Marine Insurance? Explain different types of Marine insurance.
5. What do you mean by Motor Insurance? Explain different forms of Motor Insurance.
6. What do you mean by liability insurance? Explain different types of liability insurance.
7. Explain the crop and micro insurance in India.
8. What are the new norms formulated by IRDA for health insurance.
9. Why IRDA had made it mandatory for Insurance companies to issue E-insurance policies and to open E-Insurance Account.
10. Mr Arun took a fire policy on his house covering fire,flood and earthquake. He mentioned in his application that the house is provided with smoke alarm, and sprinkler for fire detection and control but he did not mention that they were not in working condition for more than a year. The house was damaged very badly in a unexpected earthquake. Can Mr Arun maintain his claim for damage not withstanding certain misrepresentation.

Lesson 12
Ethics and Corporate Governance Framework for Insurance Companies

LESSON OUTLINE

- Concept of ethics and corporate governance in insurance
- Corporate governance in insurance companies
- Financial statement of insurance company
- Protection of policy holders
- Concept of treating customers fairly (TCF)
- Disclosure norms in websites of insurance companies
- Actuarial and other certifications
- Lesson Round Up
- Self Test Questions

LEARNING OBJECTIVES

Corporate Governance is understood as a system of financial and other controls in a corporate entity and broadly defines the relationship between the Board of Directors, senior management and shareholders. In case of the financial sector, where the entities accept public liabilities for fulfillment of certain contracts, the relationship is fiduciary with enhanced responsibility to protect the interests of all stakeholders. The Corporate Governance framework should clearly define the roles and responsibilities and accountability within an organization with built-in checks and balances.

The importance of Corporate Governance has received emphasis in recent times since poor governance and weak internal controls have been associated with major corporate failures. It has also been appreciated that the financial sector needs to have a more intensive governance structure in view of its role in the economic development and since the safety and financial strength of the institutions are critical for the overall strength of the financial sector on which the economic growth is built upon. As regards the insurance sector, the regulatory responsibility to protect the interests of the policyholders demands that the insurers have in place, good governance practices for maintenance of solvency, sound long term investment policy and assumption of underwriting risks on a prudential basis.

In this chapter we will study about corporate governance and ethical practices in insurance companies.

CONCEPT OF ETHICS AND CORPORATE GOVERNANCE IN INSURANCE

Ethics, also known as **moral philosophy**, is a branch of philosophy that involves systematizing, defending and recommending concepts of right and wrong conduct. The term comes from the Greek word ethos, which means "character". Following ethics in business is fundamental to the long term success of any business. While success may come in the short term by businesses resorting to unethical means, in the long run doing the right thing will bring in success.

Corporate Governance

Corporate Governance may be defined as a set of systems, processes and principles which ensure that a company is governed in the best interest of all stakeholders. It is the system by which companies are directed and controlled. It is about promoting corporate fairness, transparency and accountability. Corporate Governance involves regulatory and market mechanisms and the roles and relationships between a company's management, its board, its shareholders and other stakeholders and the goals for which the Company is governed.

Principles of Corporate Governance

(a) Rights and equitable treatment of shareholders – Companies must encourage values and systems that respect rights of shareholders and help shareholders exercise those rights. Communicating the rights and encouraging shareholders to participate in meetings is very important

(b) Interests of other stakeholders – Other stakeholders include Customers, Employees, Investors, Creditors, Suppliers, Regulators, Communities, Policy makers etc. The Governance must ensure that the Company grows after taking care of the interests of the stakeholders

(c) Roles and responsibilities of the Board – The Board needs to be segregated from the management and the roles and responsibilities of the members of the management team including the CEO must be clearly defined. Management must be required to be accountable to the Board who must monitor their performance. While management runs the Company, the Board oversees it. The Board must have qualified and competent persons to evaluate the management performance

(d) Disclosure and transparency – this is a cardinal principle of Corporate governance and includes public disclosures as appropriate, internal communications, other external communications etc. Such a disclosure mechanism must enable all stakeholders to take an informed decision

Corporate Governance in insurance companies

Insurance sector have to protect the interests of the policy holders demands that the insurers have in place, for this it is important to have an good governance practices for maintenance of solvency, sound long term investment policy and assumption of underwriting risks on a prudential basis. The emergence of insurance companies as a part of financial conglomerates has added a further dimension to sound Corporate Governance in the insurance sector with emphasis on overall risk management across the structure and to prevent any contagion and to ensure financial stability.

The Insurance Regulatory and Development Authority of India (IRDAI) has outlined in general terms, governance responsibilities of the Board in the management of the insurance functions under various Regulations notified by it covering different operational areas. It has now been decided to put them together and to issue the comprehensive guidelines for adoption by an Insurer. In the light of changes brought in by the Companies Act, 2013, the existing guidelines on Corporate Governance practices of insurers are being

revised . These revised Guidelines shall replace the existing guidelines on Corporate Governance issued by the Authority and shall take effect from FY 2016-17.

Objectives of the Guidelines

The objective of the guidelines is to ensure that the structure, responsibilities and functions of Board of Directors and the management of the company recognize the expectations of all stakeholders as well as those of the regulator. The structure should take steps required to adopt sound and prudent principles and practices for the governance of the company and should have the ability to quickly address issues of non-compliance or weak oversight and controls. These guidelines therefore amplify on certain issues which are covered in the Insurance Act, 1938 and the regulations framed there under and include measures which are additionally considered essential by IRDAI for adoption by insurers.

The guidelines accordingly address the various requirements broadly covering the following major structural elements of Corporate Governance in insurance companies:-

1. Governance structure
2. Board of Directors
3. CEO
4. Key Management functions
5. Role of Appointed Actuaries
6. External audit – Appointment of Statutory Auditors
7. Disclosures
8. Relationship with stakeholders
9. Interaction with the Supervisor
10. Whistle blower policy

Significant Owners, Controlling Shareholders

IRDAI prescribes a minimum lock-in period of 5 years from the date of certificate of commencement of business of an insurer (R3) for the promoters of the insurance company and no transfer of shares of the promoters is permitted within this period without the specific approval of the Authority.

Section 2 (7A) of the Insurance Act, 1938 has prescribed the ceiling of Foreign Investment in Indian Insurance Companies at 49%, subject to the Indian Insurance Company being Indian owned and controlled. The manner of computation of Foreign Investment to satisfy this requirement is specified in the Rules and Regulations issued by the Government and IRDAI from time to time.

Explanation to sub-clause (b) of clause 7A of Sec 2 of the Insurance Act, 1938, which defines

‘Indian Insurance Company’ provides that the expression “control” shall include the right to appoint a majority of directors or to control the management or policy decisions including by virtue of their shareholding or management rights or shareholders agreements or voting agreements.

Therefore, it has to be demonstrated through express provisions in the agreements between the promoters/ shareholders and/ or the Articles of Association of the Insurance companies that the ownership as well as control does not lie with foreign entities but ultimately rests with resident Indian citizens at all times.

The Insurance Act, 1938 stipulates prior approval of the IRDAI for registration/transfer of shares, exceeding one per cent and /or which involve holding of share capital, after such transfer, in excess of 5 per cent of the paid-up capital of the company. The Board of Directors of the company shall ensure that the registration of shares is in compliance with the above provisions of the Act, Regulations and circulars issued by IRDAI from time to time.

Conflicts of interest

1.Where it is proposed to enter into a contract or arrangement with Related parties as defined in Companies Act 2013, the disclosures by Directors and necessary approvals as required under Sections 184, 177(4)(iv) and 188 of Companies Act 2013, read with the relevant Rules there under, shall be obtained. 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.

The Board of Directors of an insurer shall formulate a Policy on Related Party Transactions laying down the following:

(a) Definition of Transactions in the ordinary course of the insurance business giving examples specific to the insurance company.

(b) Method of determination of arm's length pricing

(c) List of items requiring approvals from various authorities, Audit Committee, Board, Shareholders etc.

(d) Any other matter relevant to the Related party transactions

The Policy shall be reviewed by the Board on an yearly basis. In the case of insurance cover given by the insurance company to the group companies, price/ premium quoted by the companies under F&U guidelines should be considered as arm's length.

2. Auditors, Actuaries, Directors and Key Management Persons shall not simultaneously hold two positions in the insurance company that could lead to conflict or potential conflicts of interest.

3. The Board should ensure ongoing compliance with the statutory requirements on capital structure while planning or examining options for capital augmentation of the Company.

GOVERNANCE STRUCTURE

(a) General

Insurers in India are yet to go public and get their shares listed on the stock exchanges. The composition of the Boards of the Public Sector Undertakings in the insurance sector is also laid down by the Government of India. It is relevant to observe here that the Corporate Governance requirements of companies listed in the Stock Exchanges have evolved over time and are outlined in SEBI (Listing Obligations and Disclosure Requirements) Regulations 2015. As the listing requirements are available in public domain they are not being repeated. The Authority advises all Indian Insurance Companies to familiarize themselves with Corporate Governance structures and requirements appropriate to listed entities. The companies, even if unlisted, are also well advised to initiate necessary steps to address the extant "gaps" that are so identified to facilitate smooth transition at the time of their eventual listing in course of time.

(b) Chairman of the Board

The insurance companies presently could have different structures with the Board of Directors headed by a Executive or Non-executive Chairman with distinct oversight responsibilities over the other Directors and Key Management Persons. It is expected that whatever form is taken, the broader elements of good Corporate Governance are present.

(c) Groups and Conglomerates

The governance structure of the insurer could also be influenced by its association with an insurance group or a larger financial/ non-financial conglomerate. Insurers who are a part of a financial group could also be subject to the regulatory requirements on governance policies and practices established for the group level and implemented uniformly across the group.

Board of Directors Insurance Companies should ensure that the board of directors should be competent and qualified so as to drive the strategies in a manner that would sustain growth and protect the interests of shareholders in general and policy holders in particular. The size of the Board in addition to being compliant with legal requirements (where applicable), should be consistent with scale, nature and complexity of business. The size and composition should ensure that they collectively provide knowledge, skills, experience and commitment.

The board of directors are been elected or nominated through expected shareholders from various areas of financial and management expertise with appropriate qualification and experience that is appropriate to the company. The following parameters should be taken care while deciding board of directors:

(a) The Board of Directors and Key Management Persons should understand the operational structure of the insurer and have a general understanding of the lines of business and products of the insurer, more particularly as the insurer grows in size and complexity.

(b) The Board of Directors of an insurer belonging to a larger group structure/ conglomerate should understand the material risks and issues that could affect the group entities, with attendant implication on the insurer.

(c) The Board of Directors of an insurer belonging to a larger group structure/ conglomerate should understand the material risks and issues that could affect the group entities, with attendant implication on the insurer.

(d) The Board of Directors is required to have a minimum of three “Independent Directors”.

However, this requirement is relaxed to ‘two’ independent directors, for the initial five years from grant of Certificate of Registration to insurers.

(e) An appointment letter shall be issued to the Independent director laying down the terms and conditions, including his duties, responsibilities, sitting fees, etc.

(f) As required under Section 149 of the Companies Act, 2013, there shall be at least one Woman Director on the Board of every Insurance company.

Role and Responsibilities of Board of Directors

The following are the roles and responsibilities of Board of Directors:

(i) Overall direction of the business of the insurance company, including policies, strategies and risk management across all the functions

(ii) Projections on the capital requirements, revenue streams, expenses and the profitability taking into consideration expectations of the shareholders and the policyholders.

(iii) Obligation to fully comply with the Insurance Act and the regulations framed there under, and other statutory requirements applicable to it.

(iv) Addressing conflicts of interest.

(v) Ensuring fair treatment of policyholders and employees

(vi) Ensuring information sharing with and disclosures to stakeholders, including investors, policyholders, employees, the regulators, consumers, financial analysts and/or rating agencies.

(vii) 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

(viii) Developing a corporate culture that recognizes and rewards adherence to ethical standards.

Fit & Proper criteria and Deed of Covenants to be signed by Directors

The directors of insurers have to meet the fit & proper criteria , at a minimum, which relate to integrity demonstrated in personal behavior and business conduct, judgment and financial soundness. The fit and proper requirements seek to ensure that the Director should not have been convicted or come under adverse notice of the laws and regulations involving moral turpitude or of any professional body. This declaration has to be renewed on an yearly basis. In order to ensure that there are no gaps in understanding the roles and responsibilities, the Guidelines also requires every Director to sign a Deed of Covenant with the company.

Disclosures about Meetings of its Board of Directors and its Committees

- As per the provisions of the Companies Act,2013 and the Secretarial Standards issued by the ICSI insurers shall ensure compliance from time to time as regards conduct of the meetings of the board of directors and its committee. All insurers shall disclose the following in the Director's Report .Number of meetings of the Board of Directors and Committees mandated under the Guidelines, in the financial year
- Details of the composition of the Board of Directors and Committees mandated, setting out name, qualification, field of specialization, status of directorship held etc.
- Number of meetings attended by the Directors and members of the Committee
- Details of the remuneration paid, if any, to all directors (including Independent Directors)

Control Functions

The Board shall be responsible for the oversight over the control functions of an Insurer. For insurers within a group, appropriate and effective group-wide risk control systems should be in place in addition to the control systems at the level of the insurer. It is essential to manage risks appropriately on a group-wide basis as well as at the level of the insurer. The Boards of the respective insurers are required to lay down requisite policy framework to ensure that such risks are adequately addressed.

Constitution of Committees

With a view to providing adequate Board time for discharge of the significant corporate responsibilities, the Board of Directors 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 BoardThe following Committees of Directors are mandatory for an insurance company:

(a) Investment Committee (formed under the Investment Regulations)

(b) Audit Committee

(c) Risk Management Committee

(d) Policyholders Protection Committee

(e) Nomination & Remuneration Committee

(f) Corporate Social Responsibility Committee (CSR Committee)

(g) With Profit Committee

The non-mandatory Committees (optional) are Asset Liability Management Committee, Ethics Committee.

(a) Investment Committee

Investment Committee shall comprise of a minimum of 2 non executive directors, the Chief Executive Officer, Chief Investment Officer, Chief Financial Officer, Chief Risk Officer and Appointed Actuary to oversee the performance of the Investment function of the Company. The Committee shall be responsible for laying down an overall investment policy and operational framework for the investment operations of the insurer. The policy should focus on a prudential Asset Liability Management (ALM) supported by internal control systems. The investment policy and operational framework is recommended by the Committee to the Board for approval and is also responsible for a period review of the investment policy in line with the market changes.

(b) Audit Committee

Every Insurer shall constitute an Audit Committee as per Section 177 of the Companies Act, 2013 and the committee shall comprise of a minimum of three directors, majority of whom shall be Independent Directors. It shall oversee the financial statements, financial reporting, statement of cash flow and disclosure processes both on an annual and quarterly basis. It shall set-up procedures and processes to address all concerns relating to adequacy of checks and control mechanisms. The Chairperson of the Audit Committee should be an Independent Director of the Board with an accounting/finance/audit experience and may be a Chartered Accountant or a person with a strong financial analysis background. The Committee shall be directly responsible for the recommendation of the appointment, remuneration, performance and oversight of the work of the auditors (internal/statutory/Concurrent).

(c) Risk Management Committee

The sound management of Insurance company is dependent on how well various risk are managed in the organization for which the risk management committee is formulated.. The Chief Risk Officer of the Company shall be responsible for risk management and attends the meetings of the Committee. This committee reviews risk registers prepared by the concerned functions with the help of CRO and the status of action plans to mitigate the risks. Committee should maintain an aggregated view on the risk profile of the company for all categories of risk including insurance risk, market risk, credit risk, liquidity risk, operational risk, compliance risk, legal risk, reputation risk etc. Policyholders Protection Committee is responsible for overseeing the interests of Policyholders of the Company. Normally this Committee is headed by an independent director though not mandatory, since the Committee represents Policyholders interests. The general agenda items include review of Customer complaints and Claims performance of the Company. All mandatory committees shall meet 4 times in a year and not more than 4 months shall elapse between two meetings.

(d) Policy Holders Protection Committee

As per Protection of Policy holder's Interest Regulations,2002 it is mandatory to hold the policy holders protection committee to protect the interest of policy holders. Therefore adoption of sound and healthy market practices in terms of sales, marketing, advertisements, promotion, publicity, redressal of customer grievances, consumer awareness and education is essential. The committee is required to report the nature of complaint on monthly basis to IRDAI. The committee is headed by a Non-Executive Director along with an expert/representative of customers as an invitee to enable insurers to formulate policies and assess compliance.

(a) Nomination & Remuneration Committee

As per the provisions of Section 178 of the Companies Act,2013 insurance companies have to constitute two independent committees for nomination and remuneration separately but can be merge after the approval of board of directors and intimating the Authority within a period of 180 days from the date of issue of these guidelines. The committee shall scrutinize the declarations of intending applicants before the appointment/reappointment/election of directors by the shareholders at the General Meetings. The committee on behalf of board of directors and shareholders decides the remuneration packages and any compensation payment for the CEO, the Executive Directors, Key Management Persons of the Insurance Company.

(b) Corporate Social Responsibility Committee (CSR)

(c) For all Indian Insurance Companies, a CSR Committee is required to be set up if the Company earns Rs 5 Crores or more the net profit during the preceding financial year as per the Section 135 of the Companies Act, 2013. The CSR Committee shall formulate a CSR policy and get it approved by the Board, Constitution of CSR Committee will be as per Companies Act, 2013.Asset Liability Management committee (optional) is responsible for reviewing the asset liability management position and strategy of the Company and advise the company appropriately. Since this is an optional committee, some insurance companies have included this item in Board Investment Committee or Risk management Committee.

(d) The responsibility of Ethics Committee includes monitoring compliance programs of the company, acting as a channel for whistleblower complaints, advising the effectiveness of the compliance structure etc. In some insurance companies, these functions are clubbed with the Audit Committee.

Role of Appointed Actuary

The Guidelines also lay down the role of an Appointed Actuary. He shall also fulfill the 'fit and proper' criteria and accordingly confirm that he is 'fit and proper' in writing to the insurer before he is appointed. He has the responsibility of informing the Board of any non-compliance or a likely non-compliance within his knowledge. In case he feels the Board does not take any action, he has to inform IRDA. The Appointed Actuary is expected to provide expert or technical advice to the management on matters such as solvency margin requirements, financial condition testing, identification of material risks and management etc.

Statutory auditors

The firm of statutory auditors of insurance companies will have to possess a track record of at least 15 years. One of the partners must have a qualification on Systems Audit. A cooling off period of 3 years is given between 2 audit tenures with the same insurer. Further one statutory auditor cannot work with more than 2 insurance companies at a time. The board of directors should ensure that the statutory auditors are compliant with the regulatory requirements and there are no conflicts of interest in their appointment.

Disclosure requirements

The following disclosure requirements have been prescribed along with annual financial statements:

(a) Quantitative and qualitative information on the insurer's financial and operating ratios, namely, incurred claim, commission and expenses ratios

(b) Actual solvency margin details vis-à-vis the required margin

(c) Policy lapse ratio for life insurers

(d) Financial performance including growth rate and current financial position of the insurer

(e) Description of the risk management architecture

(f) Details of number of claims intimated, disposed of and pending with details of duration

(g) All pecuniary relationships or transactions of the Non-Executive Directors vis-à-vis the insurer

(h) Details of the board composition

(i) Number of meetings of the Board and committees held during the year and the details of directors who attended

(j) Details of remuneration paid to Independent directors

(k) Any other matters, which have material impact on the insurer's financial position.

Outsourcing Arrangements

All outsourcing arrangements of an Insurer shall have the approval of a Committee of Key Management Persons and should meet the terms of the Board approved outsourcing policy. The Board or the Risk Management Committee should be periodically apprised about the outsourcing arrangements entered into by the insurer and also confirmation to the effect that they comply with the stipulations of the Authority as well as the internal policy be placed before them. An insurer shall not outsource any of the company's core functions other than those that have been specifically permitted by the Authority.

Whistleblower Policy

Insurers are well advised to put in place a "whistle blower" policy, where-by mechanisms exist or employees to raise concerns internally about possible irregularities, governance weaknesses, financial reporting issues or other such matters. These could include employee reporting in confidence directly to the Chairman of the Board or of a Committee of the Board or to the Statutory Auditor. The Policy illustratively covers the following aspects:

(i) Awareness of the employees that such channels are available, how to use them and how their report will be handled.

(ii) Handling of the reports received confidentially, for independent assessment, investigation and where necessary for taking appropriate follow-up actions.

(iii) A robust anti-retaliation policy to protect employees who make reports in good faith.

(iv) Briefing of the board of directors.

FINANCIAL STATEMENT OF INSURANCE COMPANY

The Financial statements of Insurance Company are prepared in accordance with the Insurance Regulatory and Development Authority *(*Preparation of Financial Statements and Auditor's Report of Insurance Companies*)* Regulations, 2002.

According to the Regulations, an insurer carrying on life insurance business is to comply with the requirements of Schedule A of the above said regulations and an insurer carrying on general insurance business is to comply with the requirements of Schedule B of the above said regulations. It is also Provided that this sub-regulation shall apply, *mutatis mutandis,* to reinsurers, until separate regulations are not made. The report of the auditors on the financial statements of every insurer and reinsurer shall be in conformity with the requirements of Schedule C, or as near thereto as the circumstances permit.

Schedule A of the regulation contains following parts

(1) PART I of Schedule A the regulation contains 'Accounting principles for preparation of financial statements' and while preparing the Financial Statement for the insurance companies in India, these principals are to be followed.

(2) PART II of Schedule A of the regulation contains the details of Disclosures which are forming part of Financial Statements in the Insurance Company.

(3) PART III of Schedule A of the regulation contains General instructions for preparation of Financial Statements

(4) PART IV of Schedule A of the regulation contains the Contents of Management Report

(5) PART V of Schedule A of the regulation contains the formats for Preparation of Financial Statements of a life insurance company. It provide that a life insurance company shall prepare its Revenue Account [Policyholders' Account], Profit and Loss Account [Shareholders' Account] and the Balance Sheet in Form A-RA, Form A-PL and Form A-BS respectively. The formats of the accounts are prescribed in this Part and accounts are to be prepared in the format or as near thereto as the circumstances permit.

Similarly Schedule B of the regulations contain Part I, Part II, Part III, Part IV and Part V which contains the above stated information about General Insurance companies. As per the above said Regulations, following financial statements are to be prepared by Insurance companies:

(a) Form of Revenue Account (Policyholders account) *

(b) Form of Profit and Loss Account (Shareholders account) *

(c) Form of Balance Sheet (Policyholders and Shareholders) *

(d) Schedules to Financial statements *

(e) Notes to accounts giving the significant accounting policies and actuarial assumptions

(f) Disclosures on regulatory actions taken by any enforcement authority

(g) Details of directorships, if any, held by persons in charge of management

(h) Ageing analysis of policyholders unclaimed amounts

(i) Details of payments made to Statutory Auditors

(j) Summary of related party transactions

(k) Key accounting ratios

(l) Receipts and payments account for the year

(m) Report of the management

(n) Performance of unit linked funds of the company

*For each line of business separately, such as Participating, Non-participating, Linked, Pension etc.

Important aspects of the Financial Statements of Insurance Companies

Insurance is an invisible trade. Being an intangible product, it embodies a pledge of protection. By default, insurance transaction relates to assumption of risk—that is reflected in collection of premium—and later paying off claims as and when arise and set aside some money as a residual for future servicing to policyholders. Its quality depends on a visible assurance of the ability to redeem this pledge, as much as on the intrinsic worth of the protection provided. It may sound simple but in reality, it is far more complex. Insurance companies are balance-sheet-driven businesses. Investors use balance sheets to evaluate a company's financial health. In theory, the balance sheet provides an honest look at a company's assets and liabilities, enabling investors to make a determination regarding the firm's health and compare results against the firm's competitors. Because assets are better than liabilities, companies want to have more assets and fewer liabilities on their balance sheets.

The *sine qua non* of insurance operation is to service the capital adequately and appropriately. If the adequacy of servicing relates to the probability of increase in shareholder's value, its appropriateness concerns claims paying ability for which the capital is deployed.

Insurance industry is capital intensive and claims sensitive. Adequacy of capital for a successful insurance operation is a must. Capital is a scarce commodity and it comes at a cost. Since debt capital appearing on the balance sheet involves constraint and cost, insurers often tend to increase their net worth to transact insurance business in a frequently competitive market by taking recourse to 'Off-Balance Sheet Capital' obtained through reinsurance and further down the line by retrocession.

The complexity to read the balance sheet of an insurance company arises because of its significant reliance on 'Off-Balance Sheet Capital'. Regulatory compliance requires an insurance company to arrange first a proper risk transfer mechanism which is known as reinsurance facility for shedding off the additional exposure beyond its limit of retention on any one risk. This is known as 'Off-Balance Sheet Capital' as this is a kind of capital that is not visible on the balance sheet but remains obscured that provides financial strength to the company to assume more risks to augment its business.

PROTECTION OF POLICY HOLDERS

Protection of Policy holders is a very important aspect in the insurance business. IRDA have provided 'Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002' provide for protection of the interest of policyholders. These regulations aimed to protect the policy holders from undue inconvenience, fraud and similar matters. The above stated Regulations apply to all insurers, insurance agents, insurance intermediaries and policyholders. The above stated regulations provides for following for protecting the interests of Policy holders.

A. Protection measures relating to Sale of Policy i.e. Point of Sale

(1) A prospectus of any insurance product should clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product should be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to all the riders put together shall exceed 30% of the premium of the main product.

(2) 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.

(3) Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately.

(4) Where, for any reason, the proposal and other connected papers are not filled by the prospect, a certificate may be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract.

(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by:

- the Authority
- the Councils that have been established under section 64C of the Act and
- the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.

B. Protection measures relating to Proposal for insurance

(1) Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document. It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.

(2) Forms and documents used in the grant of cover may, depending upon the circumstances of each case, be made available in languages recognised under the Constitution of India.

(3) In filling the form of proposal, the prospect is to be guided by the provisions of Section 45 of the Act. Any proposal form seeking information for grant of life cover may prominently state therein the requirements of Section 45 of the Act.

(4) 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 cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded, where the insurer claims that the proposer suppressed any material information or provided misleading or false information on any matter material to the grant of a cover.

(5) Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer shall draw the attention of the proposer to it and encourage the prospect to avail the facility.

(6) Proposals shall be processed by the insurer with speed and efficiency and all decisions thereof shall be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

C. Grievance redressal procedure

Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same along-with the information in respect of Insurance Ombudsman shall be communicated to the policyholder along-with the policy document and as maybe found necessary.

D . Protection measures relating to life insurance policy

(1) A life insurance policy shall clearly state:

(a) the name of the plan governing the policy, its terms and conditions;

(b) whether it is participating in profits or not;

(c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;

(d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

(e) the details of the riders attaching to the main policy;

(f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;

(g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value.

(h) the age at entry and whether the same has been admitted;

(i) the policy requirements for (a) conversion of the policy into paid up policy, (b) surrender (c) non-forfeiture and (d) revival of lapsed policies;

(j) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;

(k) the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan;

(l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and

(m) the address of the insurer to which all communications in respect of the policy shall be sent.

(n) the documents that are normally required to be submitted by a claimant in support of a claim under the policy.

(2) While acting under regulation 6(1) in forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection,when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

(3) In respect of a unit linked policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

(4) In respect of a cover, where premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before issuance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon as possible.

E . Protection measures relating to General insurance policy

(1) A general insurance policy shall clearly state:

(a) the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance;

(b) full description of the property or interest insured;

(c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;

(d) period of Insurance;

(e) sums insured;

(f) perils covered and not covered;

(h) any franchise or deductible applicable;

(i) premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;

(j) policy terms, conditions and warranties;

(k) action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;

(l) 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;

(m) any special conditions attaching to the policy;

(n) provision for cancellation of the policy on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured;

(o) the address of the insurer to which all communications in respect of the insurance contract should be sent;

(p) the details of the riders attaching to the main policy;

(q) proforma of any communication the insurer may seek from the policyholders to service the policy.

(2) Every insurer shall inform and keep informed periodically the insured 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.

F. Protection measures specified for Claims procedure in respect of a life insurance policy

(1) A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.

(2) A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible**,** shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

(3) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

(4) Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

(5) Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

G. Protection measures specified for 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 indication 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 be so done within 72 hours of the receipt of intimation from the insured.

(2) 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 the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where, in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report.

(3) 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, 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 original 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.

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

(5) On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under

the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.

(6) Upon acceptance of an offer of settlement as stated in sub-regulation (5) by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

H. Measures providing for Policyholders' Servicing

(1) An insurer carrying on life or general business, as the case may be, shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters, such as:

(a) recording change of address;

(b) noting a new nomination or change of nomination under a policy;

(c) noting an assignment on the policy;

(d) providing information on the current status of a policy indicating matters, such as, accrued bonus, surrender value and entitlement to a loan;

(e) processing papers and disbursal of a loan on security of policy;

(f) issuance of duplicate policy;

(g) issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and

(h) guidance on the procedure for registering a claim and early settlement thereof.

I. General Measures providing for Policyholders' Protection

(1) The requirements of disclosure of "material information" regarding a proposal or policy apply, under these regulations, both to the insurer and the insured.

(2) The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties.

(3) The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy.

(4) Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.

TREATING CUSTOMERS FAIRLY

What does "Treating Customers Fairly" means?

The Treating Customers Fairly (TCF) principle aims to raise standards in the way financial institutions carry on their business by introducing changes that will benefit consumers and increase their confidence in the financial services industry. This is a customer centric initiative aimed at improving the image and reputation of financial institutions by recognizing the Customers as one of the key stakeholders carefully and giving

them the deserved treatment. This assumes most importance in the financial services industry keeping in mind that the customers park their hard earned money with them and depend on them based on the expected level of servicing. Moreover, a small dissatisfaction could lead to an irreparable damage to the institutions as well.

Financial Services Authority ('FSA'), UK, has introduced this as a Code for compliance by the Financial institutions. Specifically, TCF aims to:

- help Customers fully understand the features, benefits, risks and costs of the financial products they buy.
- minimise the sale of unsuitable products by encouraging best practice before, during and after a sale.

In fact, Treating Customers Fairly is an integral part of Principle 6 of "Principles of Business" published by FSA, which states that a firm must pay due regard to the interests of the customers and treat them fairly. The retail regulatory agenda of FSA aims to achieve an effective and efficient market by treating the customers fairly. This is aimed to achieved through a focus on:

- capable and confident consumers
- providing simple and understandable information to consumers
- well managed and adequately capitalised firms which treat the customers fairly
- risk based and proportionate regulation

FSA has identified the following as the outcomes from customer perspective as a result of adopting the principle of TCR – financial institutions should be focused on trying to achieve these outcomes

Desired Outcomes expected upon adoption of TCF

The firms which have adopted TCF are expected to deliver the following outcomes:

Outcome 1: Consumers can be confident that they are dealing with firms where the fair treatment of customers is central to the corporate culture (RIGHT CULTURE).

Outcome 2: Products and services marketed and sold in the retail market are designed to meet the needs of identified consumer groups and are targeted accordingly (RIGHT TARGET).

Outcome 3: Consumers are provided with clear information and are kept appropriately informed before, during and after the point of sale (RIGHT INFORMATION).

Outcome 4: Where consumers receive advice, the advice is suitable and takes account of their circumstances (RIGHT ADVICE).

Outcome 5: Consumers are provided with products that perform as firms have led them to expect, and the associated service is both of an acceptable standard and as they have been led to expect (RIGHT GUIDANCE).

Outcome 6: Consumers do not face unreasonable post-sale barriers imposed by firms to change product, switch provider, submit a claim or make a complaint (RIGHT AFTER SALES SERVICE).

Outcome 1 – Consumers can be confident that they are dealing with firms where the fair treatment of customers is central to the corporate culture - RIGHT CULTURE

TCF seeks to bring about a cultural change in the way financial institutions operate by embedding the

requirements with the organization and not looked at another compliance requirement. The principle should be injected into the corporate genes so that it becomes a way of life. As such, the principle is expected to be driven from the top, demonstrable commitment from senior management of such financial institutions (also called as "firms"). FSA have encouraged firms to think about TCF using the product life-cycle approach, and this has raised cultural questions about connectedness and consumer focus within firms. TCF should be reflected in the approach taken to human resources and reward within an organisation as well as the front line business areas. It should be taken into account when corporate strategy is determined and when standard form consumer contracts are drafted. Senior management and the board should receive management information that enables them to assess whether customers are being treated fairly. Putting consumers at the centre of the corporate culture means that TCF, rather than simply being about process, should translate into practical outputs in the shape of fair outcomes for consumers

Firms should make TCF an integral part of their business culture. TCF is a continuous process – it is not something that firms can implement and then forget about.

Outcome 2: Products and services marketed and sold in the retail market are designed to meet the needs of identified consumer groups and are targeted accordingly - RIGHT TARGET

There are two elements in this principle:

(a) Designing the products keeping the needs of the targeted consumer groups

(b) Targeting the consumer groups in respect of whom the product has been designed

Any product or service is designed keeping a customers' needs in mind. Unless a product delivers a value, it has no meaning. Some of the customers' needs which insurance products address are as follows:

(a) Coverage of risk of untimely death of the breadwinner, resulting in stoppage of income for the family(Term Life Insurance or Whole Life Products address this need)

(b) Provision for financial needs at various stages in life cycle, such as marriage and education needs of children (Endowment and Money back products typically fulfill this need apart from covering risk of death

(c) Risk of accident to a vehicle (Motor insurance)

(d) Risk of fire accident or damage to due to floods and natural calamities to property (Fire Insurance, Comprehensive Household insurance etc.)

(e) Risk of hospitalisation and financial needs during medical emergencies (Health Insurance Policies and Critical Illness Riders)

(f) Risk of living longer and therefore need for money to support the prolonged living (Annuity or Pension Policies which provide for periodic payments after active years in one's life)

The second element speaks about delivering products to the right groups. There is no meaning in designing a product and but not delivering to the right segment. In fact, after designing the product intended for the target groups, if efforts are not taken to deliver the product to the intended market segment, it could result in the risk of the product being sold to unsuitable segment.

For example, a Pension product being sold to a person who has already attained age, say, 65. A Pension product can be sold only to a person during his active years when he saves for his post retirement income. If it is sold to a person who has already attained age 65, there is a clear mismatch between the product sold and the targeted segment.

Outcome 3: Consumers are provided with clear information and are kept appropriately informed before, during and after the point of sale (RIGHT INFORMATION)

This outcome is aligned to Principle 7 which states that a firm must address the information needs of the client and communicate in such way that it is clear, fair and not misleading. The information needs of the client are require to be addressed at 3 points of time – before, during and after the point of sale.

Information required before the point of sale

At this point, the knowledge of consumer needs to comprise of all those facts, data and any other information which is relevant to the customer to enable him to arrive at the decision as to whether the proposed product suits his needs or not. This comprises of the following:

(a) Awareness about the needs of the consumer

(b) Assessment of the financial capacity of the consumer to pay the premium

(c) Knowledge about the product benefits which suits his needs

(d) Costs and charges – both direct and indirect and its impact on the benefits under the policy and circumstances when the costs and charges could increase or come down

(e) Terms and conditions, including exclusions or circumstances under which a benefit is not payable or reduced benefit is payable

(f) Options available to the consumer under the product. For example, Paidup value, surrender, partial withdrawals etc. under an Unit linked life insurance policy

(g) Obligations of the consumer under the proposed product. For example, obligation to pay the premiums on time for continued benefit

Information required at the point of sale

Once the customer decides to purchase an insurance policy, the documentation of the customer's needs and requirement takes place.

Usually, under a life insurance policy, the knowledge of the consumer is verified by means of a "Benefits Illustration" document which is required to be signed before the consumer proceeds with purchasing an insurance policy. This is an excel sheet which lists down year on year the premiums payable under a life insurance policy, with the corresponding benefits for each year. Thus, customer understanding is first confirmed in writing.

Then, the Consumer is required to fill in an application form for insurance (also called Proposal form in insurance), where he fills the information required about the subject matter to be insured (which is the life assured in the case of life insurance).

Since insurance is based on the principles of *"ubberimae fidae"* (utmost good faith), the consumer is expected to disclose all the questions asked in the proposal form sincerely and truthfully. Any misstatement or concealment of any material fact in the proposal form could lead to a repudiation of policy benefits later. Therefore, knowledge on the part of the Proposer (applicant) that he needs to carefully disclose all the material facts within his knowledge about the subject matter of insurance becomes very critical.

In Life insurance, there are questions concerning status of health of the life assured which needs to carefully replied. Most litigations in life insurance and health insurance today happen due to non disclosure of health status correctly in the proposal form.

The distributor who sells the policy, usually the agent, plays a critical role here in bringing this point to the knowledge of the consumer and assist him in filling the form. In case the agent does not do his duty properly here, it could cost the consumer in the form of cancellation of policy benefits.

Information after the point of sale

While providing information to the consumer at the point of sale is critical, the responsibility of the insurance companies does not stop there. In fact, information after the point of sale is equally important. Since insurance is a service, the various touch points of insurers in the customer's insurance life cycle assumes a greater importance.

The information required after the point of sale could comprise the following:

(a) Information on various benefits which accrue from time to time, e.g. Bonus declared in Participating Policies

(b) Periodic information, not more than yearly frequency, on the performance of funds in the case of unit linked insurance policies

(c) Market information in respect of funds of various unit linked insurance policies

(d) Periodic reminders about the premium payment ahead of the due dates

(e) Informing customers upon change in status of the policy, such as Lapsed, paid up, reinstatements etc.

(f) Claims related information after intimation about a claim. Assisting the consumer in getting the claim settled. In fact, this is the most important stage after the point of sale where consumers require lot of information in getting the policy benefits. Insurance companies must take care to furnish the required information

Outcome 4: Where consumers receive advice, the advice is suitable and takes account of their circumstances (RIGHT ADVICE).

Since insurance is one of the products in managing finance and risks, a wholistic approach towards advising the customers on selection of the product which suits the needs of customers is critical. The advice must be unbiased keeping the customers' interests in mind and the distributors interests. For example, a distributor may recommend products which pays him maximum remuneration. It must be remembered that a right advice could increase a salesman's future income as a satisfied customer refers other customers.

The test to find whether the advice is right to check whether the product sold reflects the customer's needs, priorities and circumstances. While the distributor has the primary responsibility of delivering the right advice, insurance companies can check with consumer directly, after the sale is made, as to whether the product purchased by the consumer has fulfilled his needs and that he is satisfied with the sales process.

Outcome 5: Consumers are provided with products that perform as firms have led them to expect, and the associated service is both of an acceptable standard and as they have been led to expect (RIGHT GUIDANCE).

The above outcome has the following elements:

(a) Performance of products sold as per what has been promised at the point of sale

(b) Delivery of acceptable service standards as promised at the point of sale

This principle addresses the Policyholders Reasonable Expectations arising out of what customer has been

lead to believe by the Insurers and their representatives when a product was sold. This emphasizes the importance of integrity in business. Business Integrity is just delivery of "Promise only what you can deliver" and "Deliver what you have promised". If integrity is comprised, reputation of the Company's brand is at stake and ultimately threatens the entity's existence.

In Unit Linked Life insurance policies, a portion of the premium paid by the consumer is invested in stock market linked securities which are subject to the vulnerabilities of stock market. Fairness to customer assumes a lot of importance in such policies. It is possible that the consumer would have invested in such policies with the expectation (which was set by the insurer and distributor at the point of sale) that the insurance policy may deliver a reasonable return over a period of time. Under such circumstances, if due to a fall in the stock markets, if the customer experiences a fall in the fund value of his investments, the delivery by the insurance company could fall short of the expectations. On the other hand if the customer has been given a fair chance and reconciled himself at the point of sale that there is a risk of erosion in the fund value due to downfall in stock markets, the expectation is set right.

As already pointed out in the earlier section, even an unintentional misstatement or non disclosure about the health status of a consumer in the proposal form could lead to repudiation (non payment) of policy benefits. This could severely impact the fundamental policyholder expectation, which is payment of the intended policy benefit for which the insurance policy was taken.

Similarly expectation in service could be impacted if for example the turnaround time for delivery of a service is unreasonable.

Outcome 6: Consumers do not face unreasonable post-sale barriers imposed by firms to change product, switch provider, submit a claim or make a complaint (RIGHT AFTER SALES SERVICE)

This principle is intended to make life easier to the Policyholder on the after-sales service expected by him from the insurance company.

For example, in India portability* of Health insurance policies was a pain area for consumers. Insurance companies used to disallow transfer of the credits earned by a Policyholder (e.g. "No claims bonus") under a Health Insurance Policy, upon the consumer changing the insurance company. Under the new Health Insurance Regulations, IRDA have mandated transfer of the credits to the new insurer.

*Portability" means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer or from one plan to another plan o f the same insurer, provided the previous policy has been maintained without any break

Similarly, the claims process must be kept simple from consumer's perspective. Here consumer includes the "Nominee" or the "Legal heir" who receives the policy benefit upon death of the life assured. Since a claimant may not have even knowledge about the insurance or the processes related to claims settlement, extra care needs to be taken by the insurance companies in handling the claims. Usually, the pain areas from customer angle are the exclusion of claims, i.e. non payment of claims on the ground that the particular circumstance under which the claim is made is not covered. For example, under health insurance policies, pre-existing illness is a pain area for policyholders. The attempt of insurance companies must be ensure that a fair interpretation of the policy clauses is given under such circumstances when a claim is excluded. The benefit of doubt, if any, must be given to the Policyholder or his or her nominees or legal heirs.

To measure the progress of the outcomes the following measures are to be taken:

- Findings from any TCF or other relevant thematic work;

- Findings from our day-to-day supervision of individual firms: as part of our supervisory work, we will continue to challenge firms and their senior management on how they satisfy themselves they are treating their customers fairly, including through use of their management information; and we will also assess the nature and level of TCF risks within the firm, looking at a range of available indicators;.
- Our Financial Capability Baseline survey (and its repeats), which is an important source of intelligence on financial literacy and consumer behavior, helping firms and us to target their and our efforts on TCF;
- FSA consumer research, including mystery shopping exercises or generic consumer research;
- Relevant data provided directly to us by firms or the Financial Ombudsman Service (FOS), for example complaints data.

Consumer responsibility

The Financial Services and Markets Act (FSMA) 2000 of UK states that 'consumer protection' objective must have regard to 'the general principle that consumers should take responsibility for their decisions'. An efficient retail market relies as much on capable and confident consumers as it does on firms who treat their customers fairly. However, this does not in any way understate the responsibilities of insurance companies and their intermediaries in ensuring that the customers are given their due treatment as per the principles enshrined above.

For example, in spite of a consumer having clearly understood the impact of the investing in an Unit linked insurance policy, a complaint is preferred for unsuitable sale, the customer should take the responsibility of the decision taken by him after considering the risk factors.

In addition to this broad legal basis for qualified consumer responsibility, FSMA goes further in recognising that, for financial services, it is only reasonable toexpect consumers to exercise responsibility for their decisions if we address some of the inherent difficulties in the market. Specifically, FSMA states that appropriate consumer protection must have regard not only to the principle of consumer responsibility, but also to:

- the needs that consumers may have for advice and accurate information;
- the differing degrees of experience and expertise that consumers may have in relation to
- different kinds of products or services; and
- the differing degrees of risk involved in investments or other transactions.

The customer responsibilities include the following :

- read advertisements and other material carefully;
- engage properly with the firm and provide accurate information, raising questions if uncertain
- about any aspect;
- read any suitability letter and ensure that it properly reflects the discussion;
- use cooling off periods to consider whether to go ahead;
- review financial needs on a regular basis and consider taking further advice when
- circumstances change; and
- complain to the firm if they perceive unfair treatment.

If consumers do all these things, then they will have maximised their chances of:

- making a good decision that is in their own best interests;
- protecting themselves against any improper or poor quality behaviour by the firm; and
- putting themselves in a position to tell as good and persuasive an account as possible of their own actions and thought processes to a court or ombudsman, should any dispute over the transaction go that far.

The FSA's approach to these issues is that it is reasonable that, where a firm fulfils all its obligations and treats the customer fairly, then even if a transaction turns out to be disappointing for the customer this should not be blamed on the firm. Otherwise fear of unpreventable liabilities would deter business to the detriment of firms and customers. Furthermore, the absence of reasonable care on the part of the customer might be a relevant consideration when a complaint against a firm by a consumer is being considered by the firm, by the FOS or by the courts. Put simply, if customers fail to take reasonable care they may find that they reduce the protection they can expect under the law. But, in a strictly legal sense, consumer actions cannot be described as responsibilities. And when considering complaints, firms need to examine the circumstances of the individual case carefully. **An attempt to shift responsibility onto the consumer just on the basis that he or she has not read the written contract will often be simplistic and will not be treating the complaint fairly.**

TCF and principles-based regulation

To meet the optimum level to treat the Customers fair, TCF initiative is the principle-based approach to regulation. The principle based approach helps to align good business practice in firms and market. TCF Principles meets with our won statutory objectives. Instead of framing new rules as part of the TCF initiative, the firm's senior management can focus on the principles and the outcomes for consumers which have to be achieved.

TCF initiative have used example based approach to improve the fair treatment like , publishing case studies and of statements of good and poor practice, to help firms to interpret the meaning of relevant principles which facilitates easy understanding.

The Principles are themselves rules. some detailed rules will remain and compliance with them will remain an important aspect of treating customers fairly. More principles-based approach poses challenges for the staff as well as for firms. In particular, it is important that the supervisors have the tools they need to help facilitate firms' efforts to implement TCF and to form the types of judgement that more principles-based regulation requires.

On the basis of TCF initiative, FSA have imposed a number of penalties in relation to inadequate system and controls, misspelling, poor handling of complaints etc. FSA will take enforcement action against firms if there is significant risk to customers and improper attempt to deliver on TCF.

Along with FSA, the office of the Fair trading also working towards the mission of making markets to work well for customers.

Transparency in dealings – Disclosures required by Insurance Companies

One of the methods to promote fairness in dealings with customers is appropriate disclosures to customers about an insurance company's key operational parameters. Since a Policyholder parks his funds with insurance companies for a longer term and some of the benefits payable to policyholder depends on the performance of the insurance company, it is but equitable to provide the customer with appropriate

information from time to time about the insurance company key metrics. Some of the measures to promote transparency in dealings as required by Indian regulations are listed down here:

Disclosure norms in websites of insurance companies

IRDA requires insurance companies to publish the following in their websites periodically:

(a) Financial statements, viz., Revenue Account, Profit & Loss Account, Balance Sheet, Premium, Commission, Operating Expenses, Benefits paid

(b) Share Capital and shareholding pattern

(c) Investments

(d) Fixed Assets

(e) Analytical ratios

(f) Valuation of net liabilities and main parameters of valuation

(g) Geographical distribution of business

(h) Related party transactions

(i) Board of Directors and Key persons

(j) Solvency margins

(k) Claims data

(l) Grievances data

Publication in News Paper

Insurers have also been required to publish the Balance Sheet, Profit & Loss Account, Revenue Account and Key Analytical Ratios on an half yearly basis in at least one English daily newspaper circulating in the whole or substantially the whole of India and in one newspaper published in the regional language of the region where the registered office is situated or in Hindi. The publication should be in font size of atleast 10. The publication must be made within 2 months from end of the half year period or within 15 days from the date of approval by their Board of Directors, whichever is earlier.

ACTUARIAL AND OTHER CERTIFICATIONS

Who is an actuary?

An actuary is an expert who applies mathematical and statistical methods for assessment of financial and other risks relating to various contingent events and for scientific valuation of financial products in the fields of insurance, retirement and other benefits, investments etc.

The Job

The Actuary designs insurance & pension plans. Also determines insurance premium rates and contract provisions for each type of policy offered, compiles data relating to rates of mortality, sickness, injury, retirement and property loss from accident, theft, fire or any other hazard. On the basis of data thus collected, he/she analyzes insurances' claims from Corporation or Company. Also evolves new types of attractive policies ensuring greater business. An Actuary works in Insurance Companies, Banks, Stock Exchanges and other financial institutions controlled by Govt. & Private bodies.

An Actuary's *skills are used* by the office of an insurance company to:

(1) Design an insurance product and set its price

(2) Select the right people for insurance products.

(3) Minimise the amount of losses for the company by reinsuring the company's insurance policies with another insurer (called reinsurers)

(4) Maximize the profits for the company and thus protect the customers' amounts kept with the insurance company for a number of years etc.

(5) Prepare on a given date a summary of the company's liabilities (commitments)

(6) To determine the adequacy of the reserves.

(7) To certify the solvency of the Insurance Company.

He looks into the future financial prospects of an insurance company. The liabilities are expected death claims and other benefits payable by an insurer to the policy holders (purchasers of insurance contracts) in the future. The Actuary's certificate indicates that the company is (not) solvent and can (not) meet varying payments due at any time in future. For others it is not easy to find whether an insurer is solvent or not. For an actuary, it is that difficult a job as he can use his professional skills to walk into the future and see how much income comes to the fund and how much expenses and benefit payments go out of the fund every year in future.

The Required Traits to be an Actuary

I. One must have a natural problem solving ability

II. Be able to see situation from different vantage points,

III. Develop lateral thinking.

IV. Practical Outlook

V. Probing curiosity & business sense with highly developed inter personal Communication skills

VI. An Aptitude for Mathematics

VII. Deep knowledge of Statistics & Commerce

Insurance Regulatory and Development Authority (Appointed Actuary) Regulations, 2000 prescribe that an insurer registered to carry on insurance business in India shall, appoint an actuary, who shall be known as the 'Appointed Actuary' for the purposes of the Act.

A person shall be eligible to be appointed as an appointed actuary for an insurer, if he or she shall be-

(a) Ordinarily resident in India;

(b) A Fellow Member of the Actuarial Society of India;

(c) An employee of the life insurer, in case of life insurance business;

(d) An employee of the insurer or a consulting actuary, in case of general insurance business;

(e) A person who has not committed any breach of professional conduct;

(f) A person against whom no disciplinary action by the Actuarial Society of India or any other actuarial professional body is pending;

(g) Not an appointed actuary of another insurer;

(h) A person who possesses a Certificate of Practice issued by the Actuarial Society of India; and

(i) Not over the age of seventy years.

An insurer shall seek the approval of the Authority for the appointment of appointed actuary, submitting the application in Form IRDA-AA-1 and the Authority shall, within thirty days from the date of receipt of application, either accept or reject the application for appointment of Actuary. It is provided that before the rejecting the application, the Authority shall give an opportunity of being heard to the insurer and if an insurer does not receive approval within thirty days of the receipt of such application by the Authority, the insurer shall deem that the approval has been granted by the Authority.

An insurer, who is unable to appoint an appointed actuary, shall make an application to the Authority in writing for relaxation of one or more conditions mentioned and the Authority shall, on receipt of the application communicate its decision to the insurer within thirty days of receipt of such application.

It is also provided that a life insurer shall not carry on business of insurance without an appointed actuary.

An appointed actuary shall cease to be so, if he or she has been given notice of withdrawal of approval by the Authority on the following grounds:-

(a) that he or she ceases to be eligible in accordance of the regulations or he or she has, in the opinion of the Authority, failed to perform adequately and properly the duties and obligations of an appointed actuary under these regulations. The Authority shall give an appointed actuary a reasonable opportunity of being heard, if he or she has been given a notice of withdrawal of approval by it. If a person ceases to be an appointed actuary of an insurer otherwise than on the grounds mentioned in sub-regulation (1), the insurer and the appointed actuary shall intimate the Authority the reasons therefor within fifteen days of such a cessation.

Powers of Appointed Actuary

- Access to all information or documents in possession, or under control, of the insurer if such access is necessary for the proper and effective performance of the functions and duties of the AA;
- Seek any information from any officer or employee of the insurer;
- To attend all meetings of the management including the directors of the insurer and have the right to speak and discuss on the matters that relates to:
  - (i) actuarial advice to the directors
  - (ii) affecting the solvency position of the insurer
  - (ii) affect the ability of the insurer to meet the reasonable expectations of policyholders
- To attend the meeting of the insurer at the insurer's annual accounts or financial statements are to be considered

Duties and obligations of Appointed Actuary

In particular and without prejudice to the generality of the foregoing matters, and in the interests of the insurance industry and the policyholders, the duties and obligations of an appointed actuary of an insurer shall include:--

(a) rendering actuarial advice to the management of the insurer, in particular in the areas of product design and pricing, insurance contract wording, investments and reinsurance;

(b) ensuring the solvency of the insurer at all times;

(c) complying with the provisions of the section 64V of the Act in regard to certification of the assets and liabilities that have been valued in the manner required under the said section;

(d) complying with the provisions of the section 64 VA of the Act in regard to maintenance of required solvency margin in the manner required under the said section;

(e) drawing the attention of management of the insurer, to any matter on which he or she thinks that action is required to be taken by the insurer to avoid--

(i) any contravention of the Act; or

(ii) prejudice to the interests of policyholders;

(f) complying with the Authority's directions from time to time;

(g) in the case of the insurer carrying on life insurance business,--

(i) to certify the actuarial report and abstract and other returns as required under section 13 of the Act;

(ii) to comply with the provisions of section 21 of the Act in regard to further information required by the Authority;

(iii) to comply with the provisions of section 40-B of the Act in regard to the bases of premium;

(iv) to comply with the provisions of the section 112 of the Act in regard to recommendation of interim bonus or bonuses payable by life insurer to policyholders whose policies mature for payment by reason of death or otherwise during the inter-valuation period;

(v) to ensure that all the requisite records have been made available to him or her for the purpose of conducting actuarial valuation of liabilities and assets of the insurer;

(vi) to ensure that the premium rates of the insurance products are fair;

(vii) to certify that the mathematical reserves have been determined taking into account the guidance notes issued by the Actuarial Society of India and any directions given by the Authority;

(viii) to ensure that the policyholders' reasonable expectations have been considered in the matter of valuation of liabilities and distribution of surplus to the participating policyholders who are entitled for a share of surplus;

(ix) to submit the actuarial advice in the interests of the insurance industry and the policyholders;

(h) in the case of the insurer carrying on general insurance business to ensure, --

(i) that the rates are fair in respect of those contracts that are governed by the insurer's in-house tariff;

(ii) that the actuarial principles, in the determination of liabilities, have been used in the calculation of reserves for incurred but not reported claims (IBNR) and other reserves where actuarial advice is sought by the Authority;

(i) informing the Authority in writing of his or her opinion, within a reasonable time, whether,--

(i) the insurer has contravened the Act or any other Acts;

(ii) the contravention is of such a nature that it may affect significantly the interests of the owners or beneficiaries of policies issued by the insurer;

(iii) the directors of the insurer have failed to take such action as is reasonably necessary to enable him to exercise his or her duties and obligations under this regulation; or

(iv) an officer or employee of the insurer has engaged in conduct calculated to prevent him or her exercising his or her duties and obligations under this regulation.

Absolute Privilege of Appointed Actuary

(1) An appointed actuary shall enjoy absolute privilege to make any statement, oral or written, for the purpose of the performance of his functions as appointed actuary. This is in addition to any other privilege conferred upon an appointed actuary under any other Regulations.

(2) Any provision of the letter of appointment of the appointed actuary, which restricts or prevents his duties, obligations and privileges under these regulations, shall be of no effect.

INSURANCE AND LOSS SURVEYORS

Insurance Surveyors and Loss Assessors (Licencing, Professional Requirements and Code of Conduct) Regulations, 2000 provides rules for Insurance Surveyors and Loss Assessors in India.

Application for, and matters relating to, grant of licence

Every person who is an individual and intending to act as a surveyor and loss assessor in respect of general insurance business shall apply to the Authority for grant of licence in FORM–IRDA-1-AF as given in the Schedule to these regulations.

The Authority shall, before granting licence, take into consideration all matters relating to the duties, responsibilities and functions of surveyor and loss assessor and satisfy itself that the applicant is a fit and proper person to be granted a licence. In particular and without prejudice to the foregoing, the Authority shall satisfy itself that the applicant, in addition to submitting the application complete in all respects:-

(a) satisfies all the applicable requirements of section 64UM read with section 42D of the Act and rule 56A of the Insurance Rules, 1939;

(b) possesses such additional technical qualifications as may be specified by the Authority from time to time;

(c) has furnished evidence of payment of fees for grant of licence, depending upon the categorisation;

(d) has undergone a period of practical training, not exceeding 12 months, as contained in Chapter VII of these regulations; and

(e) furnishes such additional information as may be required by the Authority from time to time.

The Authority on being satisfied that the applicant is eligible for grant of licence, shall grant the same in FORM-IRDA-2-LF as given in the Schedule to these regulations and send an intimation to the applicant together with an identity card mentioning the particular class or category of general insurance business namely, fire, marine cargo, marine hull, engineering, motor, miscellaneous and loss of profit for which the Authority has granted licence and the licence shall remain valid for a period of five years from the date of issue thereof, unless cancelled earlier.

A surveyor and loss assessor, whose licence has been cancelled or suspended for any reason, may submit an application for issuance of licence, after the expiry of three years from the date of such cancellation or suspension, and, such an application shall be treated as a fresh case, and, accordingly, the applicant shall satisfy all the requirements of sub-regulation (2).

A surveyor and loss assessor shall be subject to categorisation as specified in Chapter V of these regulations.

A licence issued, before the commencement of these regulations, by the Controller of Insurance or his authorised representative shall be deemed to have been issued in accordance with these regulations.

Corporate Surveyors and Loss Assessors

Where the applicant is a company or firm, the Authority shall be satisfied that all the directors or partners, as the case may be, possess one or more of the qualifications specified in section 64UM(1)D(i) of the Act and none of such directors or partners, as the case may be, suffers from any of the disqualifications mentioned in section 42 D of the Act read with Section 42(4) of the Act. The applicant referred to in (1) shall apply in FORM-IRDA-3-AF as given in the Schedule to these regulations. The Authority on being satisfied that the applicant is eligible for grant of licence, shall grant the same in FORM-IRDA-4-LF as given in the Schedule to these regulations, and, all the provisions of regulation 3 above, shall apply mutatis mutandis to corporate surveyors.

DUTIES AND RESPONSIBILITIES OF A SURVEYOR AND LOSS ASSESSOR

A surveyor and loss assessor shall, for a major part of the working time, investigate, manage, quantify, validate and deal with losses (whether insured or not) arising from any contingency, and report thereon, and carry out the work with competence, objectivity and professional integrity by strictly adhering to the code of conduct expected of such surveyor and loss assessor.

(2) The following, shall, inter alia, be the duties and responsibilities of a surveyor and loss assessor:-

(i) declaring whether he has any interest in the subject-matter in question or whether it pertains to any of his relatives, business partners or through material shareholding;

Explanation: For the purpose of this clause 'relatives' shall mean any of the relatives as mentioned in Schedule IA to the Companies Act, 1956;

(ii) maintaining confidentiality and neutrality without jeopardising the liability of the insurer and claim of the insured;

(iii) conducting inspection and re-inspection of the property in question suffering a loss;

(iv) examining, inquiring, investigating, verifying and checking upon the causes and the circumstances of the loss in question including extent of loss, nature of ownership and insurable interest;

(v) conducting spot and final surveys, as and when necessary and comment upon franchise, excess/under insurance and any other related matter;

(vi) estimating, measuring and determining the quantum and description of the subject under loss;

(vii) advising the insurer and the insured about loss minimisation, loss control, security and safety measures, wherever appropriate, to avoid further losses;

(viii) commenting on the admissibility of the loss as also observance of warranty conditions under the policy contract;

(ix) surveying and assessing the loss on behalf of insurer or insured;

(x) assessing liability under the contract of insurance;

(xi) pointing out discrepancy, if any, in the policy wordings;

(xii) satisfying queries of the insured/insurer and of persons connected thereto in respect of the claim/loss;

(xiii) recommending applicability of depreciation and the percentage and quantum of depreciation;

(xiv) giving reasons for repudiation of claim, in case the claim is not covered by policy terms and conditions;

(xv) taking expert opinion, wherever required;

(xvi) commenting on salvage and its disposal wherever necessary.

(3) A surveyor or loss assessor shall submit his report to the insurer as expeditiously as possible, but not later than 30 days of his appointment.

Provided that in exceptional cases, the afore-mentioned period can be extended with the consent of the insured and the insurer.

CATEGORISATION OF SURVEYORS

A surveyor and loss assessor shall be categorised, as mentioned in sub-regulation (3), based on the following criteria:

(i) professional qualifications;

(ii) training undergone;

(iii) experience as a surveyor and loss assessor and any other relevant professional experience;

(iv) any other criteria, as may be specified by the Authority from time to time.

(1) The categorisation shall consist of allocation of one or more specified departments of insurance business, based on the factors mentioned above and shall include categorisation of the surveyors and loss assessors into three categories, viz., Category A, Category B and Category C.

(2) Every surveyor and loss assessor, whether a company or firm or an individual, shall be eligible to carry on the work as a surveyor or loss assessor, as per the categorisation specified in the licence.

CODE OF CONDUCT FOR INSURANCE SURVEYOR AND LOSS ASSESSOR

Every surveyor and loss assessor shall-

(1) behave ethically and with integrity in the professional pursuits. Integrity implies not merely honesty but fair dealings and truthfulness;

(2) strive for objectivity in professional and business judgment;

(3) act impartially, when acting on instructions from an insurer in relation to a policy holder's claim under a policy issued by that insurer;

(4) conduct himself with courtesy and consideration to all people with whom he comes into contact during the course of his work;

(5) not accept or perform survey works in areas for which he does not hold a licence;

(6) not accept or perform work which he is not competent to undertake, unless he obtains some advice and assistance, as will enable him to carry out the work competently;

(7) carry out his professional work with due diligence, care and skill and with proper regard to technical and professional standards expected of him;

(8) keep himself updated with all developments relevant to his professional practice;

(9) at all times maintain proper record for work done by him and comply with all relevant laws;

(10) assist and encourage his colleagues to obtain professional qualifications, and, in this behalf, provide

free article ship and/or practical training for a period of twelve months;

(11) maintain a register of survey work, containing the relevant information, in FORM-IRDA-11 as given in the Schedule to these regulations, and shall keep important records of the survey reports, photographs and other important documents for a period three years and furnish the same and such other specified returns, as and when called for by the Authority or by any investigating authority or the insurer;

(12) disclose to all parties concerned his appointment, where the acceptance or continuance of such an engagement may materially prejudice, or could be seen to materially affect the interests of any interested party. As soon as a conflict of interest is foreseen, every surveyor and loss assessor shall notify all interested parties immediately and seek instructions for his continuance;

(13) not disclose any information, pertaining to a client or employer or policy holder acquired in the course of his professional work, to any third party, except, where consent has been obtained from the interested party, or where there is a legal right or duty enjoined upon him to disclose;

(14) neither use nor appear to use, any confidential information acquired or received by him in the course of his professional work, to his personal advantage or for the advantage of a third party.

LESSON ROUND UP

- IRDA's Corporate Governance guidelines are applicable to Insurance companies in addition to the applicable provisions of the Companies Act, 1956.
- The Committees mandatory for an insurance company are Investment Committee (formed under the Investment Regulations), Audit Committee, Risk Management Committee, Nomination & Remuneration Committee, Corporate Social Responsibility Committee (CSR Committee), With Profit Committee and Policyholders Protection Committee.
- The non-mandatory Committees (optional) are Asset Liability Management Committee, Ethics Committee,
- The Appointed Actuary is expected to provide expert or technical advice to the management on matters such as solvency margin requirements, financial condition testing, identification of material risks and management etc.
- The Financial statement of an Insurance Company are prepared in accordance with the
- The Insurance Regulatory and Development Authority (Preparation of Financial Statements and Auditor's Report of Insurance Companies*)* Regulations, 2002.
- Insurance industry is capital intensive and claims sensitive. Adequacy of capital for a successful insurance operation is a must. IRDA have provided 'Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002' provide for protection of the interest of policyholders.
- The Treating Customers Fairly (TCF) principle aims to raise standards in the way financial institutions carry on their business by introducing changes that will benefit consumers and increase their confidence in the financial services industry.
- One of the methods to promote fairness in dealings with customers is appropriate disclosures to customers about an insurance company's key operational parameters
- An actuary is an expert who applies mathematical and statistical methods for assessment of financial and other risks relating to various contingent events and for scientific valuation of financial products in the fields of insurance, retirement and other benefits, investments etc.
- Insurance Surveyors and Loss Assessors (Licencing, Professional Requirements and Code of Conduct) Regulations, 2000 provides rules for Insurance Surveyors and Loss Assessors in India.

SELF TEST QUESTIONS

(These are meant for re-capitulation only. Answers to these questions are not to be submitted for evaluation)

(i) What are the corporate governance guidelines issued by IRDA for insurance companies?

(ii) Explain the schedules prepared in the financial statements of an insurance company.

(iii) Explain the desired outcomes expected upon adoption of TCF.

(iv) Protection of Policy holders is a very important aspect in the insurance business. Explain the provisions for protection of the interest of policyholders provided by IRDA.

(v) Write short notes on:

(a) Duties and obligations of appointed actuary

(b) Duties and responsibilities of a surveyor and loss assessor

(c) Disclosure norms in websites of insurance companies.

PROFESSIONAL PROGRAMME

INSURANCE LAW AND PRACTICE

Open Book Examination in Elective Subjects (Paper-9.3) in Module-III of Professional Programme (New Syllabus) Examination

Professional Programme (New Syllabus) offers five elective subjects in Module III, as mentioned herein below, out of which a student has to opt only one subject to study and qualify that suits his aptitude, interest, ability and career goal:

1. Banking Law and Practice
2. Capital, Commodity and Money Market
3. Insurance Law and Practice
4. Intellectual Property Rights-Law and Practice
5. International Business -Laws and Practices.

There is Open Book Examination (OBE) in all the above five elective subjects from June 2014 onwards. However, in all other subjects/modules of Professional Programme (New Syllabus), students would continue to be examined as per traditional pattern of examinations.

This is to inculcate and develop skills of creative thinking, problem solving and decision making amongst students of its Professional Programme and to assess their analytical ability, real understanding of facts and concepts and mastery to apply, rather than to simply recall replicate and reproduce concepts and principles in the examination.

In OBE, the candidates are allowed to consult their study material, class notes, textbooks, Bare Acts and other relevant papers, while attempting answers, as per the requirement of questions. The emphasis throughout is in assessing the students' understanding of the subject, applying their minds, rather than the ability to memorise large texts or rules or law.

Unlike a conventional/typical examination, which assesses how much information candiates have been able to store in their minds, the success in this type of examination depends on the candidate's ability to understand the question, identify inherent issues, application of various techniques, laws, principles, etc. while solving answers with the help of supporting reference material.

Broad pattern of Question Paper for OBE is as follows:

- Each question paper would contain Six questions carrying 100 marks
- Question No.1 will be of 50 marks based on case study ranging between 3000-4000 words.
- Question No.2 will be of 30 marks based on study of regulatory framework related to the subject.
- Question No.3-6 will be of 5 marks each covering important topics of the syllabus.

Candidates are not allowed to consult their fellow examinees or exchange their study material/notes, etc. with each other in the examination hall.

Candidates are prohibited to bring in any electronic devices, such as laptop, tab, I pad, palmtop, mobile phone, or any other electronic device/ gadget at the examination hall/room. However, they are permitted to use their own battery operated noiseless and cordless pocket calculator with not more than six functions, twelve digits and two memories.

PROFESSIONAL PROGRAMME EXAMINATION (NEW SYLLABUS)
ELECTIVE PAPER (9.3)
INSURANCE LAW AND PRACTICE

Open Book Examination ***PRACTICE TEST PAPER***

Time Allowed: 3 hours *Maximum Marks: 100*

Note: Attempt all questions.

Attempt all questions. All questions are compulsory

Question No. 1

Read the case study and answer all questions given at the end of the case:

Ashwini, aged 30 years, was employed as a supervisor in a bank. On 4th June, 2012, he took two life endowment insurance policies on his life for Rs.50,000 each from Prudent Life Insurance Co. Ltd. Each policy had a different maturity term and period. Both the policies had accident claim benefit of an equivalent amount, viz. in the case of death of the insured due to an accident, the amount payable by the insurer would be twice the amount of the sum assured. Ashwini made his wife Smt. Asha as his nominee under the policies and also the legal assignee, since the couple had no issues then.

On 31st May, 2014, Ashwini while going to his office on his two-wheeler was involved in a head-on collision with a motor car coming from the opposite direction and was severely injured. He was admitted to a hospital, but succumbed to the injuries and died in the hospital on the morning of 2nd June, 2014.

Smt. Asha filed a claim under the policies with the insurer for payment of the sum assured together with the accident benefits. The company, after processing the claim, informed her on 15th July, 2014 that they were rejecting the claim on the ground that Ashwini, while taking the policies, had suppressed material facts.

The insurer indicated that Ashwini did not mention in the proposal form, the fact of an earlier ailment of having suffered from para-typhoid in June – July, 2010 and having been away from his employer on medical leave between 6th June, 2010 and 5th July, 2010.

The nominee filed a complaint on 18th August, 2014 with the District Consumer Forum stating that the repudiation of the claim was not justified. The insurer reiterated its argument that the on-mention of the previous ailment to it was a suppression of material facts and affected the fundamental nature of the contract. The District Consumer Forum on consideration of the arguments before it held in favour of the insurer agreeing with it that the deceased had suppressed material facts at the time of the proposal.

Smt. Asha, not accepting the decision of the District Consumer Forum, filed an appeal with the State Forum. Her counsel contended before the Forum that even if the deceased had suffered from para-typhoid less than two years prior to obtaining the policies and did not give the necessary information in the proposal form, it did not amount to a material suppression of facts. His main argument was that the cause of death was the accident with the motor vehicle and the cause had no nexus whatsoever with the alleged ailment. Thus, there was no suppression of facts.

The State Forum after hearing the arguments of both the parties, allowed Smt. Asha's appeal and held that the cause of death was accident and not illness. The non-mention of the fact of illness and hospitalisation did not amount to any non-disclosure of material facts. The Forum granted the relief asked for and directed the

insurance company to pay Smt. Asha Rs. 2,00,000 under the policies. The decision taken on 6th January, 2015 also entitled the nominee with interest at 9% per annum from the date of filing the claim, viz. 18th August, 2014.

From the information given above, answer the following questions —

(a) Was the State Forum justified in its conclusion in terms of the conditions of life policies issued by Indian insurance companies ? Give reasons for your answer. Cite relevant case law, if any. *(10 marks)*

(b) If Ashwini had died on account of an illness, and not in an accident, will the decision of the State Forum be different? Give reasons. *(10 marks)*

(c) What are the provisions of the Insurance Act, 1938 regarding the time-limit beyond which the terms of a life insurance policy cannot be questioned? *(10 marks)*

(d) What do you mean by 'guaranteed surrender value' in a life policy? *(10 marks)*

(e) Can a discontinued life insurance policy be revived by the insured and if so under what circumstances and on what terms? *(10 marks)*

Question No. 2.

Answer all the following questions

(a) Anil, an individual, has taken with Urban Insurance Co. Ltd, a fire policy against his residential property, for a sum assured of Rs.3,00,000. The cover lasts till the end of September, 2015. On 20th May, 2015, an accidental fire takes place and the entire building is gutted and damaged. Anil prefers a claim with the insurance company. The claim is rejected on the ground of negligence on Anil's part. Representations made by Anil to the insurer against such a rejection were not successful.

What options are left to Anil to proceed further in this regard ? Discuss. *(5 marks)*

(b) Explain the maxim caveat emptor. Does this apply to insurance contracts? *(5 marks)*

(c) Explain the concept of 'treating customers fairly' with respect to policy servicing in insurance business. *(5 marks)*

(d) What do you understand by condition of 'average' in a fire insurance contract? How does this operate? Explain. *(5 marks)*

(e) How does 'insurance' differ from 'hedging'? *(5 marks)*

(f) State the exclusions as regards a fire insurance policy. (5 marks)

Question No. 3. Why do insurers insure 'pure risks' only? Define 'risk' and distinguish between 'pure risk' and 'speculative risk'. *(5 marks)*

Question No. 4. Explain the concept of trust in life policy. *(5 marks)*

Question No. 5. Describe the rules of interpretation of a policy. *(5 marks)*

Question No. 6. What are the liabilities that require a compulsory cover under a policy of motor insurance? Discuss. *(5 marks)*