BBA-203

INSURANCE AND RISK MANAGEMENT

DIRECTORATE OF DISTANCE EDUCATION

SWAMI VIVEKANAND

SUBHARTI UNIVERSITY

Meerut (National Capital Region Delhi)

CONTENTS

SYLLABUS

BBA-I Semester-II Year

INSURANCE AND RISK MANAGEMENT

BBA-203

Course Code: BBA 203 N		
Course Credit: 04	Lecture: 04	Tutorial: 1
Course Type:	Core Course	
Lectures delivered:	30 L + 10 T	

End Semester Examination System

Maximum Marks Allotted	Minimum Pass Marks	Time Allowed
70	28	3 Hours

Continuous Comprehensive Assessment (CCA) Pattern

Tests	Assignment/ Tutorial/ Presentation/class test	Attendance	Total
15	5	10	30

Course Objective:

This course introduces the concept of risk and techniques of identifying, measuring and managing it. In this context, insurance as a risk management tool is discussed with references to its role, functions and basic principles as applicable to different classes of insurance. The course aims to provide the students with a broad understanding of risk and insurance as a means to manage it. This forms the foundation to facilitate the students in their further studies on insurance.

UNIT	Content	Hours
I	**Introduction and Scope of Insurance :** Historical perspective, Conceptual Framework, Meaning and Nature of Insurance, Classification of Insurance Business viz., Life Insurance and General Insurance.	8
II	**Fundamental principles of insurance-** Utmost good faith, Insurable Interest, Indemnity ,Proximate cause, Subrogation, Contribution	12
III	**Financial Aspects of Insurance Management** Role of Financial Institutions, Insurance Companies, Financial Market, Structure and functions, Important Life Insurance Products and General Insurance Products, Determination of Premiums and Bonuses, Various Distribution	12
	Channels	
IV	**Risk Management and Underwriting** Risk, Uncertainty, Peril, Hazard, Classification of risk, Meaning, Scope & Objective of Risk Management, Role of Actuaries- Product framing, Re-insurance, Preparation of Insurance Documents, Policy Conditions.	10

V	**Insurance Laws and Regulations** Insurance Act 1938, Life Insurance Corporation Act 1956, IRDA Act 1999, Consumer Protection Act 1986, Code of Conduct in Advertisement, Tax Benefits under Life Insurance Policies	10

Course Outcomes

1. Demonstrate knowledge of insurance contracts and provisions, conceptual framework of insurance, classification of Insurance and employee benefit plans.
2. Describe the financial market and its function, determination of premium and bonus and distribution channels.
3. Demonstrate knowledge of common insurance policies, reinsurance and preparation of documents, Demonstrate competency in assessing the types of risks facing financial institutions, corporations, organizations and individuals and recommending insurance policy coverage accordingly.
4. Able to explain the purpose, structure and functions of insurance regulations.

Text Books

- Mishra M.N.- Insurance Principle & Practice (Sultan Chand & Company Ltd., NewDelhi), 2016
- George, E. Rejda, Principles of Risk Management and Insurance, Pearson Education, 2017

Reference Books

- Vaughan, E. J. and T. Vaughan, Fundamentals of Risk and Insurance, Wiley & Sons, 2013
- Gupta P. K., Insurance and Risk Management, Himalaya Publishing house, 2018

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UNIT

1

HISTORY AND DEVELOPMENT OF INSURANCE

STRUCTURE

1.1. WHAT IS INSURANCE?

Insurance is perceived by the common man as a risk protection measure. It is an arrangement by which individuals exposed to certain contingencies get compensated financially when there is a loss.

In technical terms, insurance, is a means of **protection** against monetary loss from any kinds of **peril.** Fire, floods, breakdowns, lightning, earthquakes, etc., are called perils. These perils though accidental occurrences, affect the value of economic assets. A human life is also considered as an **income generating asset,** exposed to perils like **sickness, disabilities or early death.**

The well-insured man has a certain **peace of mind.** He can feel **secure** in the knowledge that neither he nor his family will have to bear the **entire loss** arising out of a sudden misfortune. He knows that if his factory or house burns, or his property is damaged, his insurance company will indemnify him for all or part of the loss, according to his policy, both he and his family gain a feeling of **security** in knowing that his life insurance company will pay money to the family to make up, at least in part for the loss of his income, if he dies early.

1.2. SEARCH FOR SECURITY

Mankind is always in search of security against the risks arising out of the **environment.** Creating a fire, selecting a cave or sharpening an implement all gave pre-historic man a means of livelihood as well as security. With the progress of civilisation, the feeling of security was further strengthened by certain social arrangements such as **community, tribes and other groups.** Living in groups has always been a source of emotional and physical security for mankind.

As people moved to fresh pastures, tribes began to break up, and living in groups did not provide enough protection. They dispersed as **family units,** engaged in more **trade and commerce** and, in their pursuit for **accumulation of wealth,** had to face more contingencies and risks and, consequently, more chances of loss. With progress in civilisation, development of nations and growth in commerce and maritime trade, they had to face more risks and the need for financial security was increasingly felt. There is no way of knowing **who** will incur a loss, **when** a loss may happen or **what** would be the magnitude of the loss. Insurance was conceived to play its role here. Human ingenuity developed the concept of **collective cooperation,** where the **loss of the affected few can be shared by many,** based on the principle of insurance.

1.3. INSURANCE – EARLY DAYS

The **Sumerian** civilisation, known for its highly developed business practices, could provide relief to travellers and traders when they were exposed to threats like robbery and piracy. By 2000 BC, the **Babylonians,** as well as the ancient **Hindus,** were familiar with the essentials of **Bottomry** or **Respondentia** as indicated by the provisions in the **Codes of Hammurabi** and **Manu.** Here, money was borrowed during the voyage, and the ship was mortgaged to secure the repayment of principal and interest on safe arrival at the destination. The hypothecation of the ship, with or without cargo, is called Bottomry, and that of its cargo alone, is Respondentia. The trader is **absolved** of his debt with the principal and interest, should the loss occur during the voyage.

By about 900 BC, **Phoenician** traders, the most skilful shipbuilders and navigators of their time, had some form of protection when a ship on its voyage met with total wreck.

The **Romans** formed **Collegia,** organisations to provide money for funeral celebrations, which included elaborate and costly burial ceremonies. A member paid an entrance fee and periodical payments, and the Collegia provided an assured fund for a decent burial. They were also familiar with the practice of census, and compiled records of births and deaths for study.

In **England,** the medieval ages saw **Guilds** developing as a form of mutual insurance against losses from fire, shipwreck, and other causes. These Guilds gradually exercised wider functions. They offered relief to their members and went further to care for the family of a member after his death. In the 17th century, **friendly Societies** emerged, and took over the functions of the Guilds in connection with payments due to sickness or death. They were working on the principles of mutual insurance.

In **India,** some kind of insurance was practiced during the ancient Vedic times. Manu and Kautilya refer to a levy of special charges on merchandise carried from place to place, to ensure their safe carriage and protect the traders from heavy losses. The **joint family system,** which was the backbone of our society till recently, was a kind of insurance providing such security to the family members.

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1.4. INSURANCE – MODERN FORM

Insurance in the modern form came into practice mainly to cover the **risks at sea** and their disastrous consequences. The origins for this form are found in certain practices adopted by the **Italian merchants** in the 14th century when a group of merchants used to agree to bear each others' risks among themselves. Later, the practice spread to the London merchants. The very word 'policy' indicating the insurance contract comes from the Italian **polizza,** a promise.

LLOYD'S COFFEE HOUSE

During the 17th century, London was the centre of world commerce and ships from London sailed to all parts of the world. But the perils and threats faced in the sea were of great concern to the merchants. They used coffee houses as their meeting places to share information and concerns. Thus an obscure coffee house opened by **Edward Lloyd** by 1680 became world famous for its association with **marine** insurance and the shipping industry by developing further the **concept of sharing the risk.**

Lloyd's Coffee House was visited by ship-owners, merchants and other businessmen interested in marine trade and commerce. Thus it became more a place of business than a coffee house. Here, the practice of **underwriting** evolved. The word **underwriter,** denoting the person who takes the risk and promise to pay as agreed came into use. The merchants became **underwriters** because, when several of them had written their signatures **one under the other,** at the foot of an insurance policy, it meant that if the insured ship was lost, each underwriter would bear a stated proportion of the loss.

Lloyds has done much to spread the practice of insurance throughout the world. Today, Lloyds is a well-known society of underwriters, all of whom accept risks for their clients. The individual members are grouped into **syndicates** of varying sizes and each syndicate is managed by an underwriting agent. Originally, Lloyds was exclusively for marine insurance. Nowadays, **risks of every description** are accepted by the Lloyds underwriters, who are known for their willingness to insure unusual risks (Edith Rudinger).

The Great Fire in London in 1666 was an eye-opener to the need for protection from **fire.** With the spread of industrialisation, railways and other transport systems in the nineteenth century, **motor, personal accident** and other lines of insurance were developed and adopted.

On the **Life** side, **Annuities** were the first to be conceived on a scientific basis. Annuities are annual payments to be received during the lifetime of a person. **Lorenzo Tonti,** who lived in the middle of the 17th century, pioneered a scheme where a certain number of persons contributed a specific sum to a fund. At the expiry of each year, the interest on this fund was divided among the survivors of the subscribers, until the last survivor received the whole interest. These **Tontine Schemes** provided a large amount of data which later became the basis for Life Insurance.

The earliest available records of a life insurance policy, as we know it today, are on the life of one **William Gybbons** of London, effected on **18th June 1583.** The policy, for a term of 12 months, was underwritten by sixteen individuals. It is believed to be the first life policy ever issued and also the first known case to be taken to the court for settlement.

Individual underwriting gave way, over time, to corporate underwriting. The **first Life Insurance company registered in England** was **'The Hand-in-Hand Society'** established in 1696, followed by **'The Mercer's Company'** in 1698. The oldest Life Office recognized by the British Government by a **Royal Charter** was **'The Old Amicable Society'** which transacted business from 25th March **1706.**

In **1752, Benjamin Franklin** helped to establish the first Life Insurance Company in American colonies.

1.5. MORTALITY TABLE AND ACTUARIAL SCIENCE

The basic requirement of the science of life insurance is precise knowledge about the rate at which members of a group will die at a given age and from year to year. This information can be arranged with the help of past records of deaths. It is assumed that the same experience will be repeated in future. Such data and its study emerged as a new science in the horizon of knowledge.

Towards the close of the 15th century, the British Government started compiling and publishing such data about deaths. **Edmund Halley,** the famous astronomer known for his calculations on the orbit of the comet which bears his name, collected vital information from the city of Silesia which maintained a record of births and deaths including the ages of the dead. Edmund Halley presented before the Royal Society in 1693 his **'Degrees of Mortality of Mankind'** based on the vital statistics he could obtain.

The **Theory of Probability** based on the **Law of Large Numbers** and their mathematical application to the past experience of records of death, enabled the scientists to arrive at approximations of **life expectancy.** This led to the foundation of **Actuarial Science.** With the establishment of the **Institute of Actuaries** in 1848 in England, **Actuarial Science** became a systematic effort for arriving at premium rates and assessment of risk and future liabilities. Life insurance in the modern form gained more and more acceptance with the development of The Theory of Probability and Actuarial Science and the entry of corporate bodies in the field of insurance.

1.6. INSURANCE IN INDIA

Insurance activity in its **modern form** started in India in 1818. A British company, the **Oriental Life Insurance Society** was formed to afford relief to the distressed relatives of Europeans. The company treated Indian lives as sub-standard and charged extra premium.

Indian minds open to progressive ideas were keen to establish companies to extend the benefits of insurance to Indian householders and businessmen. In this respect, the contribution of **Raja Ram Mohan Roy,** a great social reformer of India, to the development of life insurance, is significant. He is well known for his valiant efforts in abolishing the evil practice of 'sati'. Concerned about the plight of the desperate widows and orphans, he made a fervent appeal to the 'native gentlemen' to be kind enough to institute life insurance as a provision 'for the maintenance of poor widows.'

The failure of the **Albert Life Insurance** organisation in August 1869 sent shock waves among the policy holders. Another premier company, **European Assurance Society** followed with a crash, resulting in heavy losses to Indian policy holders. The disappointment and dejection caused by the failure of these two companies provided the impetus for floating Indian companies by Indians for insuring Indian lives at the same rate as the European lives in India. Thus, in **1870,** the first Indian company, **Bombay Mutual Life Assurance Society,** came into existence to offer life insurance in India, irrespective of colour or creed. The seven earnest men who founded the society, in order to dispel all doubts and distrust, offered that, if in the first two years a policy became

a claim, they would, from their pockets, make good the shortfall up to ₹ 5000. No claim was registered till 1874, and by that time, the company had enough money to settle the first claim.

The **Hindu Family Annuity Fund** was started in Calcutta in 1872, by Pandit Ishwar Chandra Vidyasagar, a well known social reformer and educationist. The objective was to give financial help to Hindu widows and orphans through annuities.

In 1874, the **Oriental Government Security Life Insurance Company Ltd.** was established in Bombay by a distinguished Actuary, D.M. Slater. Sir Phirozshah Mehta was one of its founder members. While Bombay Mutual was cautious in its approach, Oriental was aggressive in business development. The strategies they adopted in product development, fixation of premium and providing information to policy holders soon made them the market leader.

By 1892, another Indian company, the **Indian Life Insurance Company Ltd.,** was registered in Karachi by some citizens of Goa settled there. The company introduced the novel idea of electing a policyholders director to the board. The manager and the directors of this company worked without any remuneration until it was firmly established. A similar spirit of sacrifice was found among its clerks and canvassers too, and the company became a leading Indian life insurance company.

Another milestone in the history of insurance in India was the formation of **'Bharat'** in Lahore in 1896. The company came to be recognised as a 'thoroughly well-managed life office'. 'Bharat' quoted reduced premiums for assurances donated to charities. It also ventured to invest in electricity supply companies, which gave power to many cities in Punjab. In the following year, **Empire of India** came into existence in Bombay. The company was known for its prudent management and, in spite of its lower premium rates, could declare bonus in 1902, at its first valuation itself.

The last two decades of the 19th century witnessed the concurrent growth of **mutual aid associations** working on the principle of insurance. These were small, sectarian groups formed mainly on community lines to take care of the economic needs of their members in distress.

Swadeshi Movement

The Swadeshi spirit sweeping the country in the beginning years of the 20th century saw rapid growth in insurance. The movement gave impetus for the formation of new companies in various parts of the country. The **United India Life Assurance Company** was floated in 1906 in Madras. The **National Insurance Company** was founded in Calcutta. The **Hindusthan Co-operative Insurance Society** was another great insurance company established in 1907, in Calcutta. This company was born in the room where Gurudev Rabindranath Tagore lived. The national fervour and awareness among Indian entrepreneurs about the potentiality of the insurance business, led to the establishment of many more companies. Notable among them were **'General'** and **'Co-operative Assurance'** in Lahore, **'India Equitable'** in Calcutta and **'Bombay Life'** in Bombay.

In the wake of the Swadeshi movement, a large number of **provident societies** of various kinds, offering insurance type of protection also came up. But most of these companies went into liquidation soon as they were not organised on sound business principles.

1.7. EFFORTS BY THE STATE

There was a demand for the state to enter the sphere of insurance to pursue its duties as a welfare state. The idea was shelved due to opposition from some quarters. The death of a Post Master in harness leaving his family in pathetic

circumstances aroused the public opinion for a **Government sponsored scheme of insurance** to make provision for the security of the families of the Government employees. It prompted the Government in 1883 to introduce life insurance in the **Postal Department** on an experimental basis. It was a pioneering step not only in the field of insurance but also in the recognition by the State of its responsibility for the welfare of its employees and their families. The success of the scheme led to gradual extension of it to other Government departments ultimately to the employees of local municipalities and teachers of Government aided schools (since 1995 to sections of rural people also).

The Mysore State Government, in 1891, took the initiative to provide cheap insurance to its employees. The scheme, known as **Official Branch Insurance,** was compulsory for all permanent employees of the government. In 1916, it was expanded to offer insurance to residents of Mysore State in the name of **Public Branch Insurance.**

1.8. GENERAL INSURANCE

The general insurance industry in India can trace its roots to the **Triton Insurance Company Limited,** established by the British in Calcutta in 1850. Marine insurance was the only business handled initially. It was followed by fire insurance. The delayed development of general insurance in this country was due to the limited progress made in commerce and industry under the British regime.

The **Swadeshi Movement** in 1905, the **Non-Cooperation Movement** of 1919 and the **Civil Disobedience Movement** of 1929 gave impetus to the establishment of industries and commercial houses. Life insurance companies too began branching out to fulfill the needs of non-life insurance. When several cotton fires in Bombay exposed the merchants to heavy losses and foreign insurers charged higher rates to cover the risks, the Indian trading community felt the need to form an Indian company. **The Indian Mercantile,** the **first Indian General Insurance Company,** was born in 1907. The company started transacting life insurance in 1933.

More and More Companies

The year 1912 is remembered for the first legislation on Insurance in India. In the same year, **Western India** and the **Industrial and Prudential Company** were formed. The post war effects did not deter Sir Dorab Tata from establishing the **New India Assurance Company** which commenced business first in general insurance. Pandit K. Santhanam endeavoured to form **Lakshmi** with the support of Lala Lajpat Rai and Pandit Motilal Nehru. **Andhra Insurance, Indian Mutual, South India Cooperative, United India** and **Prithvi** were a few other companies which came to occupy prominent positions in the industry. The period also saw eminent Indian actuaries guiding the insurance companies on sound business and scientific lines.

The vast potential in India attracted foreign companies to establish their branches in the country. Commencing their business first in general insurance, they later extended to life insurance. Most successful among them were **Sun Life of Canada, Royal London** and **Prudential of England.**

1.9. GOVERNMENT CONTROL

The rapid and indiscriminate growth in the number of insurance organisations as mutual associations, provident societies and joint stock companies also led to certain malpractices in the industry, calling for government's intervention. The provisions under the existing acts were inadequate to control them. So, **The Indian Life Insurance**

Companies Act and **The Provident Insurance Societies' Act** were passed in **1912.** The necessity of actuarially based premium tables, periodical valuations, submission of accounts and keeping certain deposits with the government were some of the important steps introduced, and these provisions brought some control over the industry. Yet, mushrooming growth and unhealthy rivalry between the companies were manifesting in heavy initial lapses of policies. The extravagant cost of procuring business and not reporting it in the revenue account raised doubts as to whether the companies would be able to honour their contracts. Another evil practice sweeping the industry was excessive rebating in premium rates. Complacency in settling death claims was prevalent. The surge of patriotism and the spirit of sacrifice pervading the sphere of insurance in the early years were slowly receding and commercial interests started dominating. Extensive supervision and regulation from the government was the need of the hour.

The Act was amended in 1928, as a partial measure to address immediate problems. On the basis of a survey report by a Special Officer and feedback from the public, a new Act was passed in 1938 which came into effect from 1st July 1939. **The Insurance Act 1938** was a comprehensive piece of legislation covering both **Life and Non-Life branches** and providing strict state control over insurance business. The new Act created the post of Superintendent of Insurance. He was granted executive powers to call for information, verify the documents and cause action wherever necessary. Rebating was made illegal. The Act had various provisions with regard to registration, capital structure, deposits, voting rights, representation for policy holders, valuation, investments, accounts, control over expenses standardisation of forms, agency appointment, their remuneration, etc. These helped in weeding out the weak elements. However the administration of the law soon revealed shortcomings in the system. The stringent provisions could not deter the unethical practices followed. The investment of insurance funds in 'sister' concerns became a common feature. The industry was also suffering from insurance frauds. Various amendments were passed between 1939 to 1945 to check malpractices.

In spite of the setbacks, public interest in insurance was increasing, and leading companies were making steady progress. When the country got independence and the partition brought riots and heavy killings, the insurance companies rose to the occasion and managed the flood of claims, even waiving strict proofs for death and title. They did their best to meet the commitments. Many companies had their own majestic buildings in metro cities. Put together, insurance companies were the largest estate holders in the country.

The Insurance Act was amended in 1950 to provide adequate control on expenses, excessive remuneration, investments, etc. The Superintendent of Insurance was re-designated as Controller of Insurance with more powers. The Life Insurance Council and General Insurance Council were set up.

The industry on its own also adopted a Code of Conduct which unfortunately remained only as a dead letter. Another dangerous trend emerged in 1954. When New India reduced its premium rates, a 'rate' war followed, causing serious repercussions. The rate war was followed by a 'bonus' war, with companies resorting to interim valuations and declaring higher bonuses to attract more business. The indiscipline and malpractices by unscrupulous insurers led to an intensified demand for nationalisation.

1.10. NATIONALISATION

The country embarked upon the First Year Plan on April 1, 1956. Planned economic growth on the socialistic pattern was the slogan of the times. The demand for nationalisation was gaining momentum to provide massive funds for economic

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development and also to save industry from the malignant practices of the insurers. A few more cases of mismanagement by insurers hastened the decision to nationalise life insurance in 1956.

The Ordinance nationalising 245 life insurance companies was promulgated by the President on **19 January 1956.** On the same day, in his broadcast to the nation, **C.D. Deshmukh,** the Finance Minister, asserted that it was a 'further step in the direction of more effective mobilisation of the peoples' savings'. He pointed out that 'the misuse of power, position and privilege that we have reason to believe occurs under existing conditions is one of the most compelling reasons that have influenced us in deciding to nationalise life insurance.' He summed up by saying that as a measure conceived in a genuine spirit of service to the people, nationalisation would give material assistance to the Five Year Plans, and introduce into the lives of the millions in the rural areas a new sense of awareness of building for the future **'in the spirit of calm confidence which insurance alone can give.'**

Deshmukh also gave his concept of an ideal insurance company. 'Firstly, it must be conducted with utmost economy and with the full realisation that the money belongs to the policyholders. The premium must be no higher than is warranted by strict actuarial considerations. The fund must be invested so as to secure the maximum yield for the policy holders that it may be possible to secure, consistent with the safety of the capital. It must render a prompt and efficient service to its policy holders and by its service make insurance widely popular. Finally, the management must be conducted in a spirit of trusteeship.' With such great expectations, the **Life Insurance Corporation of India** came into being on **September 1, 1956** formed by an Act of Parliament with a capital contribution of ₹ 5 crore from the Government of India. Thus it became the only public sector company which could carry on life insurance business. Postal Life Insurance, Army Group Insurance, Air Force Insurance Funds and schemes administered by state governments were the exceptions.

LIC – Its Track Record

LIC, set out with clear objectives, grew steadily and spread the message of insurance to the farthest corners of the nation. From a new business of ₹ 329 crore sum assured under 9.5 lakhs policies procured during the period of 16 months from 1.9.56 to 31.12.57, LIC progressed to the new business of ₹ 91,213 crore under 170 lakhs policies in the year ending on 31st March, 2000. The first premium received reached ₹ 4,959 crore compared to ₹ 13 crore in 1957. Its rural business was significant, representing 16.7% of the total number of policies. The bonus rates were on the rising curve. As a learning organisation, it took periodical steps to reorganise its functions and, by empowering the staff, could take the range of services nearest to the policyholders.

It was able to break new grounds in extending group and social security schemes to the weaker sections. It has a vast network of 2048 branches; 100 divisions and seven zonal offices spread over the country. Its marketing force consisted of over 19,000 development officers and 8 lakh full-time and part-time agents.

The vast premium income mobilised by LIC helped the nation in economic development, especially in building up infrastructure. In 1999-2000, its accumulated investment in infrastructure was ₹ 1,17,888 crore, helping the country in improving the quality of the people at large through the enhancement of basic amenities like potable water, drainage, housing, electrification and transport.

LIC has made notable contributions to the development of the equity market. It has participated in the establishment of institutions like NSC, IDBI, UTI and NIA. LIC has taken advantage of Information and Technology and initiated measures for the convenience of the policyholders.

GIC – The Four Subsidiaries

The general insurance business was only ₹.24 crore by way of premium in 1951. It rose to ₹ 130 crore at the time of nationalisation in 1971 when 108 private general insurance companies' were amalgamated into four public sector general insurance companies with General Insurance Corporation of India as the holding company. The four subsidiaries were, National Insurance Co. Ltd., New India Assurance Co. Ltd., Oriental Insurance Co. Ltd., and United India Insurance Co. Ltd. They operate through 2699 branches, 1360 divisional offices and 92 regional offices. The Indian general insurance market today is of about ₹ 20,000 crore as gross annual premium out of which 73% is earned by public sector companies. A peep into the share of different branches of business as at the end of March 2006 indicates that contribution from motor insurance was 43% followed by fire at 18%, marine at 6%, engineering at 4% and the rest, 18%.

The 'Slow' Progress

Despite all these achievements, the progress of the insurance industry in this country was very slow compared to world standards. By 2000, of the 100 crore people in India, hardly 25 crore were covered by life insurance. The share of insurance funds in household savings was 12.8% during 2000-2001.

There are two traditional ways to measure the role of insurance in the economy. **Insurance density** shows the average annual per capita premium within a country, converted from local currency into US dollars. In 2000, India occupied a very low position with $8.5 (2.4 non-life and 6.1 for life) compared to Malaysia $140.4 (62.3 and 78), South Korea $1,022.8 (262.3 and 760.5), South Africa $490.9 (77.9 and 413.0) and China $13.3 (5.0 and 8.3).

The other index, **insurance penetration,** is the ratio of annual gross insurance premium to the gross domestic product (GDP). The country's life insurance premium was mere a 1.39% and for non-life, it was still lower, at 0.6 per cent. The comparative figures for other countries are: Malaysia (2.16 and 1.72), South Korea (8.39 and 2.89), South Africa (13.92 and 2.62) and China (1.02 and 0.61). In 1999, in the global insurance market, the US accounted for one-third of the total premium and Japan had 21.29 per cent share. India could account for a mere 0.36 per cent only. So, the insurance industry, even in the nationalised set up, could not make the desired progress in keeping pace with international standards.

1.11. INSURANCE REFORMS

Following **global trends** and with the objective of complementing the reforms already initiated in the financial sector, the Government of India appointed the **Malhotra Committee** in **1993** to evaluate the Indian insurance industry and suggest reforms. The reforms were aimed at 'creating a more efficient and competitive financial system suitable for the requirements of the economy, keeping in mind the structural changes currently underway and recognising that insurance is an important part of the overall financial system where it was necessary to address the need for similar reforms....'

In **1994,** the Committee submitted its Report. The Committee felt that despite overall growth of insurance, several lines of business have not been sufficiently developed and there is a vast untapped potential. The complacency in the Public Sector Units was reflecting in their insufficient responsiveness to customer needs, high costs, instability of marketing networks, restrictive labour practices, excessive lapsation of life policies, and serious lags in technology. The Committee concluded that the industry should be **opened up.** Competition would result in reaching out to various segments with **appropriate products and better customer service.**

Reforms Committee on Postal Life

The performance of Postal Life was reviewed by the Committee and the proposal to convert it as a corporate body and treat it along with other insurers was also considered. Postal Life Insurance, run by the Central Government is operated through a vast and well established network of post offices all over the country. Postal Life has been making steady progress over the years. Compared to LIC, premium charged was lower, bonus declared was always higher; its lapse ratio was insignificant and claims settlement efficient, as observed by the Committee. Considering all these and other advantages flowing from the present system, the Committee felt **not to disturb** it and suggested to expand its activities. The committee, in its report, recommended that. **'PLI should be permitted to transact life insurance in the rural areas among the general public and suitably strengthened for this purpose. It is to continue as part of the Postal Department and not to be brought under the control of the proposed Controlling Authority'.**

The recommendations were accepted, PLI was restructured by the Government and in March 1995 PLI came out with special insurance plans (RPLI) and extended its operations to more people **in rural areas.**

1.12. IRDA FORMED

Based on their recommendations, the Insurance Act was amended in 1999 to allow private companies to operate. The **Insurance Regulatory and Development Authority** (IRDA) was established as a corporate body replacing the Controller of Insurance to protect the interests of the holders of insurance policies and to **regulate, promote and ensure orderly growth** of the insurance industry. The IRDA was empowered to frame regulations and has since come out with many regulations and circulars relating to various spheres, ranging from registration of companies to training of intermediaries, product design, accounting standards, investment norms and advertisement rules.

There were other reasons also for opening of the insurance sector in our country. India as a member of **WTO,** (formed to promote free trade among member nations) had to yield to the pressures of WTO regulations. Apart from criticism about the tapping of insurance potential, the Government had to take efforts for **funding the long term infrastructure projects** in the country which alone ensure long term economic growth. Such funds can be generated only through insurance.

In the Liberalised Environment

The exclusive privilege enjoyed by LIC and GIC to do life/non-life insurance business stood removed as amended by the IRDA Act 1999. The four subsidiaries of GIC became individual corporate bodies and **GIC was converted into a national Re-Insurer** to assume the risks of other insurance companies. **Postal life** continued as an integral part of Postal Department.

IRDA opened up the market in August 2000 with the invitation for registration of new companies. **Foreign capital was allowed with a limit of 26 percent of ownership.** As at the end of September 2012, there are fifty two registered insurers—24 in Life, 27 in Non Life and one Re-Insurer. LIC is the only public sector company among the Life Insurers. The six non-life public sector undertakings include **Export Credit Guarantee Corporation of India (ECGC)**specializing in export credit insurance and **Agricultural Insurance company of India Ltd (AIC)** underwriting only agricultural risks. There are three 'stand alone' non-life private insurers covering health risk exclusively. Over the decade **the insurance penetration and insurance density** have improved significantly.

Table 1.1: IRDA Annual Report 2011-12 Insurance Penetration and Density in India

Year	Life		Non-Life		Industry	
	Density (USD)	Penetration (percentage)	Density (USD)	Penetration (percentage)	Density (USD)	Penetration (percentage)
2001	9.1	2.15	2.4	0.56	11.5	2.71
2002	11.7	2.59	3.0	0.67	14.7	3.26
2003	12.9	2.26	3.5	0.62	16.4	2.88
2004	15.7	2.53	4.0	0.64	19.7	3.17
2005	18.3	2.53	4.4	0.61	22.7	3.14
2006	33.2	4.10	5.2	0.60	38.4	4.80
2007	40.4	4.00	6.2	0.60	46.6	4.70
2008	41.2	4.00	6.2	0.60	47.4	4.60
2009	47.7	4.60	6.7	0.60	54.3	5.20
2010	55.7	4.40	8.7	0.71	64.4	5.10
2011	49.0	3.40	10.0	0.70	59.0	4.10

* Insurance density is measured as ratio of premium (in US Dollar) to total population.
* Insurance penetration is measured as ratio of premium (in US Dollars) to GDP (in US Dollars).
* The data of Insurance penetration is available with rounding off to one digit after decimal from 2006.
Source: Swiss Re, Various Issues.

Since opening up of Indian insurance sector for private participation India has reported increase in insurance density for every subsequent year and for the first time reported a fall in the year 2011 Insurance penetration which surged consistently till 2009, slipped in the consequent second year on account of slower rate of growth in the life insurance premium as compared to the growth of Indian economy.

The share of Indian life insurance sector in global life insurance market stood at 2.30 per cent during 2911 as against 2.54 per cent in 2010. There was a decline of 8.5 per cent of life insurance premium, during 2011-12. In non-life sector, the share in global premium was 0.62 per cent slightly higher than the previous year.

Among the Asian countries Taiwan, Hong Kong, South Korea, Japan and Singapore are ahead of us. (Source IRDA Report 2012)

The Changing Scenario

The decade following the set up of IRDA witnessed significant changes and developments in Indian insurance. Some of them are summarized below.

- Reaching out to more and more people through innovative products is the main benefit. The insurers have flooded the market with an array of new products. **Unit Linked Insurance Plan,** a market oriented policy found wide acceptance among the people. It is a kind of plan where the returns are linked to the yield in the stock market. During 2003 to 2007 when there was buoyancy in the stock market this product introduced in various formats ruled high, bringing in large flow of first premium income. The market share of Linked business in the first premium underwritten was nearer to 43%. A global crisis affecting Indian stock scenario followed and the high growth shown in the sales of ULIP could not be sustained.
- **Health insurance is emerging today as one of the most promising segment** within non-life sector. There is increased awareness about the benefits of Health insurance especially in urban areas and the industry is responding with a variety of products.. **Portability** of medi claim within the non-life insurers is now permitted and serves as an additional value. Though medi claim is within the domain of non-life sector, combinations of

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life products with the features of health care promoted by Life-insurers are also in the market.

- IRDA has also launched a new scheme called **MICRO INSURANCE**, to expand the coverage among rural and low income segments. A new class of distributors called Micro Insurance agents has been created. There has been a **steady growth** in the design of products catering to the needs of the poor at affordable premium rates. and number of people insured as individuals as well as members of groups under this scheme has increased **substantially**.
- Insurance **intermediaries** is another area where major changes are taking place. Prior to liberalisaton agency was the only source through which insurance business was solicited and procured. After opening of the sector the distribution channel has been widened to include **Corporate Agents. Brokers, and Banks (Bancasurance)**. Recently, **Distance marketing and use of Referrals** also have been approved to ensure a wider distribution of insurance products...

Over the years there has been a shift **away from the individual agency channel**. The share of intermediaries other than individual agents in the new business premium procured has been significant and growing year by year.

1.13. THE SOCIAL AND ECONOMIC BENEFITS OF INSURANCE

Insurance plays an important role in the social and economic life of the country.

Builds Business Confidence

Insurance encourages **risk taking** in a controlled way. On the business front, it minimises the worries and increases initiative. Entrepreneurs, especially the young ones, are motivated to venture more willingly and more freely in their activities with the hope that the unknown consequences of an unprecedented event will be taken care of.

Mobilises Savings for Economic Development

Insurance companies mobilise savings on a big way and invest them mainly in **infrastructure,** providing basic amenities like housing, electricity, transport, communication and water supply. In a developing country, insurers play a major role in investment, providing valuable capital for further business growth.

Security to Individuals

Insurance encourages thrift and a systematic way of saving for a desired sum in the future. At the same time, it guarantees the full face value of the desired sum. To depend entirely on savings as a means of providing for the future may prove disastrous if death or disability intervenes before accumulating the fund. Life insurance serves as a hedge against such possible failure. The benefits extended by life insurance keep families together and help them to carry out their cherished dreams.

Contribution to Social Stability

In a society where social security systems are either absent or inadequate, insurance can fill up the gap to the most possible extent. It reduces the financial burden on the state. The insurers handle the social responsibilities of the state through group schemes for the benefit of weaker sections.

Better employer-employee relations, favourable credit terms to borrowers, minimum disruption to business on the death of the key employee, are some of the host of benefits made available through insurance.

There is a shift in our understanding and approach to insurance today. It is not a mere provision for indemnification. It is viewed as an effective tool for risk management. Life insurance is perceived as personal financial planning. This is discussed in the next chapter.

SUMMARY

- Insurance is ensuring security. The concept is as old as mankind. The modern idea of Insurance originated in Marine Insurance. The developments in England were reflected in India also.
- The Swadeshi Movement encouraged Indians to start their own companies. The first Indian company was established in 1870. The mushroom growth of business necessitated insurance regulation and periodic amendments.
- In 1956, Life Insurance was nationalized, followed by nationalization of non-life companies in 1973. As a part of financial reforms, the industry was opened in 2000.
- As several new operators have started operations, new marketing channels are opening up, and new products are offered.
- Insurance brings peace and prosperity to homes. It encourages entrepreneurship and provides massive funds for infrastructure and industrial growth.

REVIEW QUESTIONS

1. Human life is exposed to perils. Name a few of them.
2. Through insurance the loss of a few can be shared by many. Comment.
3. Describe how the risks at sea enabled the insurance concept to develop.
4. Explain the role played by Lloyds in spreading the insurance practices.
5. Postal Insurance was not brought under the control of IRDA. Why?
6. Trace the history of insurance legislation in India.
7. Discuss the causes that led to the nationalization of life insurance.
8. What are the aims and objectives of IRDA?
9. Do you agree with the following statements? Give reasons.
   (*i*) A well insured man has a certain peace of mind
   (*ii*) Search for security led us to collective cooperation
   (*iii*) The joint family system is a kind of insurance
   (*iv*) Insurance reforms are not required at all
   (*v*) Insurance penetration has not improved after liberalization.
10. What are the changes/trends and/developments happening after liberalisation?

FURTHER REFERENCES

- Visit the following websites to have current information about insurance:
- **http://www.irda.gov.in Insurance Regulatory and Development Authority** is an autonomous apex statutory body which regulates and develop the insurance industry in India.
- **http://www.lifeinscouncil.org/ Life Insurance Council** – Forum for development and coordination of the life insurance industry.
- **http://gicouncil.in General Insurance Council** – The council represents the collective interests of the non-life insurance companies in India.
- **http://iib.gov.in/Insurance Information Bureau** – Reliable, timely and accurate data is collected, processed and disseminated by an independent body.

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UNIT

2

RISK MANAGEMENT AND THE ROLE OF INSURANCE

STRUCTURE

Our lives are enriched by nature's bounty all around us. But, along with nature's gifts, which help us lead comfortable and happy lives, risk too is omnipresent. It pervades all aspects of our lives, making us uneasy about its occurrence and outcome.

In fact, we manoeuver through life in a world fraught with manifold risks. The pressures of modern living make a risk-free environment seem impossible. The work place, particularly the factory, is full of various risk factors. Even well-protected homes are not free from risks.

In insurance and risk management, the challenge is to evaluate the likelihood of risks that can befall individuals as well as industrial and commercial concerns, and the probability of their adverse financial impact, and then explore ways to either avoid or manage these risks, or minimise their effects.

2.1. RISK AND HUMAN BEHAVIOUR

There are wide variations in people's response to risk. Some are adventurous, and wantonly invite risk by taking up challenging activities and occupations. On the other hand, some people rarely venture out of their comfort zones. There are still others who, though afraid, are prepared to take calculated risks and may go ahead provided there are enough safeguards. This variation is also seen in people's appetite for business. It is a historical fact that, right from ancient times, merchants would brave heavy risks at sea to navigate their ships to far off countries, to trade their goods, and bring wealth and glory to their homeland.

What is Risk?

The term **risk** is generally used to refer to a **situation** where the outcome is **uncertain** and there is a **possibility of loss.** The loss is **random** in nature. It occurs by **chance,** and may happen to **any body** and **any property.** It is **not intentional.** In insurance, the term is also identified with the **peril** which may cause the loss.

The word 'peril' is used to describe any **event,** such as fire, flood, earthquake etc., which could lead to economic loss. The **uncertainty** about its happening, its **frequency** and its **severity,** is referred to as risk. Thus, risk has also been defined as the **inability to accurately predict** the effects of future events.

2.2. RISK MANAGEMENT

To the layman, risk means **exposure to danger.** The process of managing risk is called **Risk Management.** It is defined as 'the identification, analysis and economic control of risks that threaten the assets or earning capacity of an enterprise.' The importance of Risk Management has been recognised, and organisations now employ risk managers to specifically manage the risk. The **Risk Management** process involves the following important steps:

1. Identify all potential and significant risks
2. Evaluate the cause, frequency and severity of losses
3. Develop and select methods to manage the risk
4. Implement the method chosen
5. Monitor performance on an on-going basis

This general framework applies to individual risk management too.

Risk Identification

Risk Identification involves considering the range of possible risks, their likelihood and the possibility of adverse consequences in terms of monetary losses. The losses may be due to damages to property, inability to operate business, an unexpected legal liability, default of creditors, sudden death of personnel, or disability arising out of injury, sickness, etc.

Risk Evaluation

Risk Evaluation means analyzing the risks in terms of their frequency, and the severity of losses; and assessing the potential impact of an event liable to cause risk, if it occurs.

Risk Control

Risk Control is the development of an appropriate mechanism to minimise losses. The cost of the response should not be more than the potential cost of the risk.

Risk Avoidance

Risk Avoidance is the elimination of the risk itself, by avoiding those processes or activities that may cause the risk. For example, if a person does not drive a car, the possibility of motor liability can be avoided. However, in day to day social or business life, it is not always possible to avoid all possible risks, as this would curtail one's activities and progress. Therefore, this method has its own limitations in risk management.

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Risk Reduction

Risk Reduction includes methods which attempt to reduce the possibility of risk, as well as lowering the potential loss. It also includes safety and preventive measures.

Risk Retention

Risk Retention involves keeping the risk with oneself and dealing with it. Depending on the level of the risk, its probability and severity, a conscious decision is taken to create a fund and bear the losses. This is the easiest and cheapest way to deal with small losses, and to avoid costly and time-consuming legal procedures in claim settlements. Under certain circumstances, such as losses due to war or warlike operations, it is also the only alternative.

A recent development amongst businesses which are large enough to take care of their losses, is to form a captive organisation or set up a wholly-owned subsidiary, and pass on the risks to this entity. This may also happen when the companies do not want to share strategic information with outsiders.

Risk Transfer

Risk Transfer is transferring the responsibility of the losses to someone else. The most common method of Risk Transfer is to **INSURE** risks.

Consider the following scenarios which could come up in our day to day lives. While travelling in a vehicle, it could collide with a car and cause damage to it, or injury to a person. Or, while being moved from one location to another, our household goods are damaged in transit. Lightning could strike a house, causing it to collapse; household goods are lost in theft or robbery; the doctor makes a wrong diagnosis or an error in prescription, or an error during surgery; sudden illness leads to heavy medical expenses; disability or sudden death of the head of the family causes loss of income to the growing family; a commercial venture faces losses consequent to the breakout of a fire in the workplace, accidents occur, causing injury; consignments are lost or damaged in transit; the human element fails in discharging its duties — the possibilities are endless.

Such situations are possible in everyone's life. It is impossible to know who will face a risk, and when. The risk, when it strikes, can be devastating, either for an individual or for a business. The risk can neither be avoided nor retained. In such cases, **INSURANCE,** as a risk transfer mechanism, would be the appropriate response.

Through the process of Insurance, the risk is transferred to an **INSURER** in exchange for the payment of a consideration called premium by the person seeking such a transfer of risk. Such a person is called the **INSURED** or the policy holder.

Insurance, as **a risk financing tool,** provides a convenient way to handle risks.

This insurer creates a common pool into which each policy holder pays a fair and equitable premium, according to the risk or loss he brings to the pool. The insurer estimates the cost of probable losses, spreads the losses of few over many, fixes the cost of the premium, receives the premium in the common pool, and pays the due claims to those suffering losses. The insurer also undertakes subsidiary services like advice on risk evaluation, loss control, loss prevention, etc.

While insurance is a tool of risk financing; it has to be understood that insurance does **not prevent** the risk, nor it can reduce the possibility that a loss will occur. It can only **reduce the financial impact** in the event of a loss.

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2.3. THE INSURER AND INSURABLE RISKS

Insurance cannot be availed to cover all kinds of risk exposures.

From the standpoint of the **Insurer,** the **Insurable Risk** must meet the following criteria:

- The risk must involve a loss that is capable of **financial measurement.** Insurance is applicable only to situations where **monetary compensation can be given,** following the loss.
- There must be some way to **determine** whether any loss has occurred, and how great this loss is. Data should be available, so that the loss can be calculated.
- There must be a **large number of similar, homogenous risks** to be covered. Historical data should be available, so that the probability of loss can be predicted. Only then can a reasonably close calculation of the **probability** of frequency and severity of the loss be made, and fair and economically feasible premium be charged.
- The possible loss must be **accidental and random** in nature, **beyond the control** of the Insured. There is risk only when there is **uncertainty** of the event.
- The person insuring must be the one who **stands to suffer** from financial loss (difficult to bear) when the risk occurs. The loss must be **severe** enough to cause financial hardship.
- The peril should not be **catastrophic** in nature, and should be unlikely to affect all the insured persons **simultaneously.** If a loss were to occur to a large number of insured persons at the same time, the claims may exceed expectations. In such a case, the insurer would not be likely to have adequate resources.

2.4. CLASSIFICATION OF RISKS

Risks can be classified according to their **origin** and **consequences.**

Pure Risks

Pure Risks are associated with **uncertainties** which may cause loss. In a pure risk situation, either a loss occurs or no loss occurs - there is **no possibility for gain.** These uncertainties may be due to perils such as fire, floods, etc., or may arise from human action such as theft, accident, etc. There are different types of Pure Risks:

- **Personal Risks:** These include early death, illness, accident and disability, insufficient income during retirement, unemployment, etc.
- **Property Risks:** Reduction in value of assets due to physical damage, fire, theft, etc.
- **Liability Risks:** The risk of legal liability for damages accruing to customers, suppliers, vendors, etc. Such risks are also connected with compensation payable to employees for injuries and other harm afflicted in the workplace.

These situations all come under the category of pure risks and are **insurable.**

Speculative Risks

Speculative Risks have three possible outcomes: **loss, no loss** or **gain.** Examples of such risks include the decision to invest in some shares, or betting on a horse in a race. The

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statistical techniques used in insurance cannot be applied to speculative risks. Further, these risks are deliberately taken with the hope of gain. Generally, speculative risks are **not** considered insurable.

Fundamental Risks

Fundamental Risks are **impersonal** in nature. They are present in nature and the economy, and are beyond the control of man. Their effect is **pervasive** and usually impacts a **large** group of people. Earthquakes, war, inflation, mass unemployment, etc., are examples of such fundamental risks. Generally, these risks are **not insurable** and it is left to the Government to deal with the effects of these events. However, in situations where the occurrences are **irregular** and the **impact** is **minimal,** the insurers can venture to **insure** these risks.

Particular Risks

Particular Risks have their origin in individual events which can be partially controlled. They occur due to the action of the individuals, for example, Meeting with an accident while crossing the road. These risks are **insurable** with **conditions.**

2.5. BUSINESS RISKS

There are various risks normally faced by an enterprise. Some of them can be grouped as under.

Market risks	:	loss occurring due to changes in fashion, style technology, demand and supply.
Price risks	:	loss due to changes in output and input prices/loss due to forced buying or selling certain investments.
Credit risks	:	loss arising out of defaults by vendors/customers.
Interest rate/Exchange rate risks	:	loss caused by adverse interest exchange rate movements.
Operational risks	:	risks developing out of business operations manufacturing processes and rendering customer services.
Strategic risks	:	risks involved due to uncertainty in organizations objectives and goals.
Legal risks	:	penalties—sanctions imposed by Regulatory bodies.

The list is not exhaustive. Business risks also include such types of risks as *reputational risks* and *environmental risks.* There is also overlapping among the groups of risks mentioned.

Besides, there are risks which are peculiar to the business concerned. Each industry has its own risk profile. A Life insurance company faces *Actuarial risk* when there are experiences of wide negative deviations from the Mortality Rates they follow.

A Banker is exposed to *liquidity risk* when there are sudden and simultaneous heavy withdrawals. .

These *financial risks* also called as *dynamic risks* are of speculative nature.

From the insurer's point of view these risks are **not considered as insurable risks.**

While *Pure risks* such as **fire, accidents, physical damage to assets, consequential losses, legal liabilities, theft, sudden death, disability** etc (not

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of speculative nature) can be transferred to an insurer the other financial risks have to be managed by **business itself through its risk management strategies** and complying with the provisions set out by the Regulatory bodies.

In the recent past a new concept, **ENTERPRISE RISK MANAGEMENT** has emerged calling for an **integrated and holistic approach** towards all the risks faced by a company. With proper risk management in its place an enterprise can minimize its capital requirement (also called Risk-Based Capital) and maximise its earnings, Discussion of this new concept is beyond the scope of this book. However it can be stated here that in developed countries, insurance companies are also venturing out to offer **package insurances** combining the **pure and speculative risks** to the extent possible and subject to the regulations in force.

2.6. LEVEL OF RISK AND INSURANCE

Risks vary in terms of both their **frequency** and their **severity.** The response to the risk also varies with the type of the risk.

When the risk is of **High Frequency** and **Low Severity,** the element of **uncertainty** is **reduced,** and the risk can be borne by the individual or the enterprise. When the frequency is **high,** expected claim cost will be high too, and hence the premium will be almost equal to the potential loss, discouraging people from going in for Insurance. So, insurance is not a solution in such cases. The individual or the business should avoid or minimise such risks.

When the risk is characterized by **High Frequency** and **High Severity,** the extent of uncertainly is removed. Due to the high severity, the individual or business should take every possible step to avoid such risks. The insurance company would not come forward to accept the transfer of this type of risk.

When the risk is of **Low Frequency** and **Low Severity,** the individual or the company can bear the risk themselves and meet the losses from their own funds. If desired, the insurer can combine many such cases and offer a **comprehensive package** of insurance covering these risks.

When the risk is of **Low Frequency** and **High Severity,** the individual or the concern will be unable to bear the consequences. The element of unpredictability will also come up. Hence, the risk can be **transferred** to the Insurer for **sharing with others.** Insurance is the most appropriate response in these situations.

2.7. INSURANCE AS A RISK TRANSFER MECHANISM

Three basic principles form the foundation for the risk transfer mechanism of Insurance:

- Sharing the losses
- Law of large numbers
- Equality of risk

Sharing the Losses of the Unfortunate Few by Many

A large number of people who face the same risks are **grouped together** and the risk suffered by a few is **spread** over this group. A **fund** is created, into which all those who face a similar risk will each put a small sum of money. This fund will be adequate to compensate the economic loss suffered by the few. This concept of **spreading risks,** together with the **Theory of Probability** and **Law of Large Numbers,** forms the basic **economic** principles of Insurance.

The Probability Theory is a mechanism for measuring the likelihood of an occurrence. This likelihood is measured on a scale from 0 to 1, where 0 represents impossibility and 1 denotes certainty. Where the probability lies on the range from 0 to 1 is an indication of how likely the event is.

Utilizing the Law of Probability, the likelihood of future events are estimated based on the knowledge of what has happened in the past under similar conditions.

For example, consider that there are 10,000 houses in a township. The value of each house is ₹ 5 lakhs (each has a similar exposure to risk). In the past, there have been two fire accidents every year, on an average, and the damage was to the tune of ₹ 4 lakhs in most of the cases. In such a situation, each of the owners of the 10,000 houses can contribute ₹ 80 each, creating a pool of ₹ 8 lakhs, which can be distributed to the unfortunate two affected house owners.

Objective probability is a probability for which there is historical evidence and common experience to support the decision. The likelihood of future event is estimated based on the past experience. Historical information may not always be available for decision making. Here the individual must rely on his own estimate of a situation and the likelihood of various possible outcomes. Such an estimate or 'educated guess' is called **subjective probability**.

Probability is not the same as risk. It is an helpful tool to define a risk. There are other factors which have impact on the risk. As stated earlier two individuals in the same environment may have a different approach towards a risk and may behave differently. **Subjective risk** is defined as uncertainty based on an individual's mental condition or state of mind. **Objective risk** is the relative variation of actual loss from expected loss. It can be statistically calculated. This objective risk declines as the number of exposures increases and its **measurement** enables an insurer to predict the risk more accurately.

Law of Large Numbers

This mathematical law is extremely useful for an insurer. It states that, as the number of exposure units increases, the more closely the actual experience will approach the expected (the probable) experience. The **larger** the sample, the greater would be the **likelihood** that the frequency of occurrence will **coincide with the average frequency** that can be established by theoretical calculation.

For example:

A coin has two sides and each side has an equal chance (50:50) of falling face up when it is tossed. If the coin is tossed 100 times, the outcome may be that the coin landed on its head 60 times. As we continue tossing the coin, the more the number of times it is tossed, the closer the outcome will be to 50:50. The larger the number of trials, the closer the **actual** experience will be to the **probable** experience.

Consider again the example given earlier for insuring a township of houses against fire. As the number of houses under observation increases, the greater is the degree of accuracy the insurer will have in predicting the proportion of a houses that will burn.

The law of large numbers has **dual** application in insurance. The insurer must have a sufficiently large volume of historical data so that the prediction can be more accurate. Once the estimate is worked out, a large number of contracts must be entered into, to avoid possible losses due to small numbers.

Equality of Risk

The loss incurred by the unfortunate few is paid out of the common fund created by contributions from the individuals or the enterprises in the group. This contribution,

in Insurance terminology, is called 'Premium'. **Equity** demands that each member of the group should contribute a premium which should be commensurate with the risk that individual or business brings into the fund. The risk is not uniform in quality or quantity. This process of fixing the appropriate contribution adequate to meet the risk is done on the basis of **Actuarial** or **Mathematical Principles.**

In Life Insurance, the mathematical laws of the **Theory of Probability** and the **Law of Large Numbers** are applied to the **Law of Mortality, to arrive at** the premium, the measure of the contribution.

Mortality Table

The Mortality Table 2.1 represents a record of observed death rates in the past. It is arranged in a form to show the probabilities of death and survival at each age. A Mortality Table can be described as a **'generation passing through time'.** Future mortality is estimated on the basis of past mortality data. The greater the number of exposures in a group of similar risk, the closer the estimated number will be to the actual experience.

Table 2.1 A Typical Mortality Table

Age (X) at the beginning of the year	*Number of people living at the beginning of the year (lx)*	*Number of people dying during the designated year (dx)*	*Yearly probability of surviving (px) (1–qx)*	*Yearly probability of dying qx (dx/1x)*
0	10,00,0000	41800	0.995820	0.004180
20	97,54,159	18533	0.998100	0.001900
30	95,79,898	16573	0.998270	0.001730
40	93,77,225	28319	0.996980	0.003020
50	89,66,618	60166	0.993290	0.006710
60	80,84,266	129995	0.983920	0.016080
70	62,74,160	247892	0.960490	0.039510
80	32,74,541	323656	0.901160	0.098840

(1980 Standard Ordinary (CSO) Male Lives)

The Mortality Rate is the most important concept on which the science of life insurance is built. It is the rate at which people die, at any particular age, in any given population, with reference to the people living at that particular age, in that given population. In essence, it is the ratio between the number of people dying at age x and the number of people living at age x.

Adequate Premium For Risk—an example

As per Table 2.1, at the age of 30, out of the 95,79,998 people living in the beginning of the year, 16,573 may die during the year before they reach the age of 31 years. The mortality rate is 0.001730. If the survivors at this age (95,79,998) contribute ₹ 173 each, the amount so collected (₹ 165,73,39,654) would be enough to pay ₹ 100,000 to the dependents of the 16,573 who die during the year. So, a premium of ₹ 173 (without adjusting for interest for expenses) would be fair and adequate at age 30 for an insurance coverage of ₹ one lakh, provided a large number of people at that age come together to take insurance.

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2.8. INSURANCE SOLUTIONS

So based on the concept of collective cooperation and applying the three principles explained insurer enables the humanity to manage the risks to which it is exposed. How the insurer offers solutions to manage certain risks are described here, briefly. Detailed discussion are to be found in the following chapters

Risk of premature death: Life is uncertain. The average life expectancy may be say, 65 years. That does not mean that every one will live certainly upto 65 years. Mortality Table tells that some people die at young ages. If a person dies while still in employment, the family will experience sudden discontinuance of earnings leaving them in distress. In such cases a **Life insurance product** will provide a **cash asset** called **Sum Assured** or **annuities** payable to the family to take care of their future needs, in return to the smaller amounts paid by the deceased as **premiums**.

Life insurance plans are available in endless variety. Benefits payable on death may vary according to the terms of the plan chosen and options availed. Temporary coverage for **short duration** is available under **Term assurance** at low cost. Full sum assured is payable on the unfortunate death of the person during the term. The risk cover may be extended for a further period, by renewing the policy and paying the premium based on the insured's present age.

A traditional **Whole life** policy ensures maximum death coverage at low premium. The premium is payable for the whole life of the person who desires such protection or up to the period chosen. An **Endowment** type covers insurance protection as well as savings for the future which may serve as an emergency fund or retirement income.The risk cover would be for a fixed period. A market oriented **Unit linked** plan is a hybrid product which invests a part of the premium in a fund chosen by the policyholder. Thus while it is helpful in managing the risk of premature death it also serves as a means of wealth creation.

Life insurance offers protection in a variety of ways. When a partner dies the partnership has to be dissolved and the capital brought in by the partner has to be returned.. Under **Partnership insurance** offered by Life insurer this risk can be managed. The agreement with the insurer will enable the remaining partners to pay off the part of the capital out of the sum assured paid by the insurer and continue their venture. Similarly the risk of loss that may happen due to the sudden demise of a key employee can be managed through **Key man insurance**.

Risk of Disability: When disability strikes it may be temporary or permanent. The person may become unemployed due to injury or sickness. There is cessation of income. **Disability insurance** purchased from an insurer separately as a policy or as an adjunct to the existing one will assure guaranteed income to manage the cost of recovery and other expenses.

Risk at old age: In the personal risk management, retirement planning is now given its important place. People during their working years, dream of financial independence and comfortable and healthy life in their old age. While a **Medi claim** policy can take care of their anxieties about health, **Annuities or Personal Pension Plans** can relieve them from their worry for uninterrupted income. The Annuities or Pensions assured by the insurer are available till their lifetime. The Surveys reveal that women tend to live longer than men. **Joint Life Annuities** offered by the insurer makes annuities available to the survivor also, thus managing the risk of old age for both husband and wife.

Risk of liability and physical damages: A legal liability may arise out of individual's actions or failure to exercise sufficient care such that another person or property is affected. Legal liability may arise out of the ownership of the business property, manufacturing processes, distribution of products or in rendering professional services. It may also be consequent to the provisions in the contract. If an individual /organization is legally responsible for personal injury or physical damages suffered by others it may result in payment of **compensation,** sometimes very heavy. There are many **liability insurance** coverages designed and offered by non-life insurers to manage such risks faced by individuals and organizations.

Main types of perils which can cause damages to property are **fire, lightning, tornado, earthquake, flood and accident. Also theft and burglary.** In insurance, the term 'accident' has a wide meaning. It is any loss causing event that is, unforeseen and unintentional. These and other risks which may happen at home, in the farm, factory, office or while on the move in land or over seas are managed by **transferring** such risks to insurer under various plans. **Fire and Marine** are major types of insurances. **Auto insurance** covers risk and liability arising out of ownership and operation of a vehicle. The risks in the agricultural front are managed through **agricultural and cattle insurance** where unexpected heavy losses are compensated. All these and other aspects of insurance are discussed in detail in subsequent following chapters.

2.9. INSURANCE AND INDEMNITY

Insurance is not indemnity. However, it is **based on the principles of indemnity.** Most general insurance contracts provide indemnity in the sense that they compensate and put the insured person back into the same position that he or she was in, prior to the loss. In general insurance, the monetary value of the subject matter of insurance can always be arrived at either by purchase value or by mutual agreement. If the property is damaged, the insurer will pay an amount which will be equal to and **not more than the value** of the property just before the occurrence of the loss. This principle is strictly observed because it would be against public policy if insured persons were able to make a profit out of a peril.

Under **life insurance,** however, such an evaluation of human life is impossible. Life insurance contracts are **not contracts of indemnity.** They are for **agreed values.**

This leads to the question, then, what can be the basis for life insurance? The basic purpose of life insurance is to provide protection to the family. Three methods of determining the maximum amount of protection that life insurance can provide have emerged, and found acceptance with insurers. They are the **Human Life Value Approach,** the **Needs Approach** and **Capital Needs Analysis.**

Human Life Value

The Human Life Value concept is based on the theory of the 'economic value of man' (human capital) contributed by economists in the eighteenth century. In 1942, S.S. Huebner developed a framework to assess the 'insurable value' of an individual. The Human Life Value concept recognises the individual as the creator of value, and the family as an economic unit organised around such an individual. The HLV is defined as the present value of the family's share of the breadwinner's future earnings. It is the amount the family would lose forever, if the head of the family dies prematurely.

An Example (in ₹)

Annual Earnings (net)	1,80,000
To deduct:	
Income Tax	5100
Personal Expenses and Self Maintenance	30000
Social Needs	10000
Total	45100
Balance Income devoted to the family per annum	134900
Earning span of Life (balance 25 years)	34900 × 25
	= 3372500
Present value today discounted at 5%	1901280
Present value today discounted at 7%	1572124
Present value today discounted at 8%	1440057

Thus, if an individual aged 35 earns ₹ 1,80,000 per annum and ₹ 1,34,900 is devoted to the family, and he will retire at age 60 (working expectancy of 25 years), he should be worth ₹ 14,40,057 today, by discounting the stream of future income to be used for supporting the family, using the rate of interest as 8%. This amount represents the present value of ₹ 1,34,900 payable every year, should he die prematurely.

This is the minimum life cover he should have for the benefit of the family. It simply means that if the family were to place ₹ 14,40,057 in a financial institution, earning an interest of 8%, and draw ₹ 134900 every year, it would get ₹ 1,34,900 every year up to the end of 25 years.

So, to the extent possible, this income flow has to be capitalized in the Life Insurance Policy. It is true that at least two of the assumptions made in the above simplified example are unrealistic: constant future income and unchanged future personal maintenance cost. The effect of inflation on earnings and expenses are also ignored. However, this simplified example is sufficient to illustrate the concept of Human Life Value.

The next step is to suggest a suitable plan for the proposer at the premium rate affordable to him.

The Human Life Value will be higher at younger ages, and lowest (almost zero) at the point of retirement. Hence it may happen that for his current income, a young person cannot afford the premiums needed to cover his full HLV. The need for the death cover (apart from the size of cover) will also be high, due to lack of other savings at a young age. Therefore, the plan offered should be of the low premium high cover type, like 'Whole Life' to enable maximum death cover to be achieved.

As the age advances and the career / business steadies, the HLV can be more and more correctly estimated: Owing to increase in income, further premiums can also be afforded. Hence, the initial deficit in death cover can be made up by the time the person reaches 35-40 years. Unlike the policies offered at younger ages, the subsequent policies should be with savings orientation like Endowment, Money-back, Unit Linked Plans etc. so that they can form the basis for a retirement provision also. The insurance planning should be such that there may not be any need for further death cover beyond age 40, in view of the high premium rates, as also the possibility of the person being uninsurable at a higher age, owing to physical impairment.

Purchasing Life Insurance on the basis of Human Life Value is just plain justice where a dependent family is involved. It is an ethical duty. HLV provides the economic rationale for the life insurance purchase decision.

Needs Approach

The other method for estimating the amount of life insurance to own is the Needs Approach. Under this method, the various family needs that must be met in the event of the death of the breadwinner are analyzed and the amount of money needed to meet these needs is determined. The amount of financial assets and existing life insurance is then subtracted from the total amount needed. The difference is the amount of life insurance that should be purchased. The most important family needs are the following:

- Clearance Fund: Amount required immediately to meet funeral and the expenses connected with the last illness, installment debts, taxes, etc.
- Re-adjustment Income: Income for a one or two year period to give the family time to adjust its living standard to a different level.
- Income during the dependency period: Income required until the children become self-supporting, the youngest reaching age 18. This is reduced if the spouse is working.
- Life-income to the surviving spouse - especially if he or she is older and not employed.
- Special needs: Special needs include redemption of mortgages, educational fund for the children and emergency fund to meet unexpected events.
- Retirement needs: Additional amount needed after retirement age.

After identifying the needs (cash needs, income needs and special needs) and the financial objectives of the family and their priority, the next step is to determine the amount of income or other benefits that are available from other sources, like Provident Fund and pension, investment income, current life insurance coverage, expected inheritances, etc, towards meeting these needs.

The amount of additional life insurance to be taken may be determined on the basis of the difference between the funds required to meet these needs and those available.

The major advantage of the Needs Approach is that it is a reasonably accurate method for determining the amount of the insurance to own, when specific family's needs are recognised. The Needs Approach, however, has certain shortcomings. The future needs may change, when the basic assumptions are no more valid. This approach also ignores inflation, and preservation of estate assets for the heirs, such as the children. However, this method is considered more practical from the viewpoint of sales.

Capital Need Analysis

Capital Need Analysis (CNA), also called Capital Retention Approach, is another method of estimating the amount of life insurance to own. Unlike the Needs Approach, which assumes liquidation of life insurance proceeds, the Capital Retention Approach preserves the capital needed to provide income to the family. The income producing assets are then available for distribution later to the heirs. The steps are:

1. Prepare a personal balance sheet short-listing all assets and liabilities.
2. Determine the amount of income producing assets.
3. Decide the amount of additional capital needed to meet the financial goals.
4. Arrive at the amount of insurance that is needed to ensure this additional capital.

Capital need analysis is a simple method and is easy to understand. Unlike other methods, it ensures preservation of capital. It also has a partial hedge against inflation. Under this method, a larger amount of insurance will be required, with consequent high cost.

SUMMARY

- Man has always been in search of security. He wants protection from perils like flood, breakdowns, lightning, earthquakes, etc. Perils are accidental and cause monetary loss. The damage and the economic loss caused is considered as risk. The risk is a chance or possibility of danger to an income-generating asset.
- Insurance provides protection against the risk (of economic loss).
- Human life is also exposed to perils like sickness, disability or early death.
- Risk can be avoided - but not always. Risk can be managed. Risk can be handled by minimizing it or transferring it. Risk transfer is the mechanism of Insurance. Insurance companies make it possible for millions of people to put certain sums of money together to protect each other from large losses. Insurers work out the risk-sharing on the principles of the Theory of Probability and the Law of Large Numbers.
- The Mortality Rate is an important concept used in life insurance. Generally, insurance is based on indemnity (except for life, and disability, accident). In life insurance, the concept of Human Life Value can be applied to decide the amount of insurance.
- A well-insured person is assured a certain peace of mind.

REVIEW QUESTIONS

1. What is meant by Risk Management? Describe the steps in Risk Management.
2. Insurance is a risk transfer mechanism. When it is felt necessary and how it works?
3. Distinguish between
   (*i*) Personal risks and Property risks
   (*ii*) Pure risks and speculative risks
   (*iii*) Fundamental risks and Particular risks.
4. How the Probability theory is useful in measurement of risk?
5. State with reasons. whether the following statements are TRUE or FALSE?
   (*i*) Response to risks will vary with the individuals
   (*ii*) Financial risks are insurable.
   (*iii*) When the risk is of low frequency and of high severity insurance is most appropriate
   (*iv*) Life insurance contracts are not contracts of indemnity.
   (*v*) The concept of Human Life Value can be applied to decide the amount of insurance.
6. Discuss how the Life insurer offers solutions for the risks faced in life.
7. Explain the following concepts in brief—
   (*i*) Equality of risk
   (*ii*) Law of large numbers
   (*iii*) Capital need analysis.
   (*iv*) Enterprise risk management
   (*v*) Captive insurance organization
8. Objective Probability and Subjective Probability—How they are different? Relate their application to insurance.
9. What are the ideal characteristics of insurable risks?

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UNIT

3

RISK MANAGEMENT AND THE ROLE OF INSURANCE

STRUCTURE

Insurance is understood as a **risk transfer mechanism** where persons facing **similar** insurable risks are brought together to protect themselves by **pooling** the risks and **sharing** the losses. **Insurance companies** make this possible through insurance **contracts.** They are governed by laws enacted by Government and regulations issued by the Authority which is empowered exclusively to do so by legislation.

3.1. INSURANCE DEFINED

'The aim of all insurance,' says Porter 'is to make provisions against dangers which beset human life and dealings. Those who seek it endeavour to avert disaster by **shifting possible losses on to the shoulders of others,** who are willing for pecuniary consideration, to take risk thereof, and in case of life insurance, they endeavour to assure to those dependent on them a certain provision in case of their death or to provide a fund out of which their creditors can be satisfied.'

Based on the decision given in the case of the Prudential Insurance Company Inland Revenue Commissioner (1904 2 K.B. 658), E.R. Hardy Ivamy, one of the early authors on the subject of Insurance, felt that, 'in the wider sense, the contract of **insurance means a person called Insurer undertaking to return for the agreed consideration, called the Premium, to pay to another person, the Assured a Sum of money or its equivalent, on the happening of a specified event.'**

The landmark case of *Lucena vs Craufurd* (1806) had made it more clear and simple to understand what insurance is. 'Insurance is a contract by which one party

in consideration of a price paid to him **adequate to the risk,** becomes **security to the other** that he shall not suffer loss, damage or prejudice by the **happening of the perils specified** to certain things which may be exposed to them.'

These observations in their compass introduce the concept of **risk transfer** and qualify insurance as a kind of **indemnity.** They bring out the following basic features of insurance, in general.

- It is a provision against the dangers caused by certain events.
- The event involves an element of uncertainty.
- The event is of a character that is adverse to the interests of the person effecting the insurance.
- An amount is assured, on the happening of the event, to mitigate the losses in return for an amount called premium, as consideration adequate to meet the risk.

A Definition by Bunyon

Lord Bunyon has provided a workable definition which is often quoted for **Life Insurance** contracts. 'A contract of life assurance is that in which one party agrees to pay a **given sum** on the happening of a particular event contingent upon the duration of life in consideration of the **immediate payment of a smaller sum** or certain equivalent **periodical payments** by another.'

The difference between this definition for life insurance and the observations made above is obvious. All insurance contracts excepting life insurance, (including personal accident, sickness insurance) are contracts of **indemnity.** The life insurance contract is **not** a contract of indemnity. It is the provision to pay an **agreed sum** on the happening of the event. Further, in life insurance, which is also viewed as an instrument of **savings and investment** the contract may provide for a fund in the future on attaining a specified age or surviving a stipulated period; this event is **not adverse** to the interests of the person insured.

3.2. INSURANCE BUSINESS AS CLASSIFIED IN THE INSURANCE ACT, 1938

The term 'Insurance' has not been defined in the Insurance Act 1938. However it has classified the insurance business as **Life, Non-Life** or **General,** and **Re-insurance,** and elucidates the features and boundaries of the contracts which are coming under those broad categories.

'Life insurance means,' the Act says, 'the business of effecting contracts of insurance on human life. It covers 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 which includes:

- granting of disability and double or triple indemnity accident benefits
- granting annuities upon human life and
- granting of superannuation allowances payable out of any fund....'.

The definition of life insurance in terms of the provisions of the Act is wide enough to include a policy where the payment of the amount is assured in the event of the life assured attaining a **specified age.** It also covers plans with the element of **investment only** which would enable the insured to raise funds in the future for himself or for the benefit of his dependents.

A life policy may also provide for certain additional benefits in the event of an accident. A policy exclusively against **accident** only, does not however come under

life insurance business. Such policies can be issued only under the general insurance category.

General insurance in terms of the Act includes **fire, marine** and **miscellaneous** insurance which can be carried on **singly** or in **combination** with one or more of them.

Fire insurance means contracts of insurance against loss by fire and other incidental occurrences customarily included under fire insurance. Similarly, **marine** insurance means contracts to provide insurance for vessels, cargoes and freights and also to other risks incidental and arising out of such transit and customarily covered under marine insurance policies.

Miscellaneous insurance is the business not covered in the above three categories. This includes accident, motor insurance, health, travel, aviation, liability, engineering, burglary and theft, fidelity, credit, contractors' risk, consequential loss, etc.

While referring to **Reinsurance,** the regulations define **'cession'** as the unit of insurance passed to a Reinsurer by the insurer and **"retention"** as the amount of risk which an insurer assumes on his own account. A cession may be the whole or portion of single risks.

What is a Contract?

Insurance has been described as the **business of effecting contracts.** Let us examine how an insurance contract conforms to the basic elements set out in **The Indian Contract Act 1872.**

A contract is an **agreement enforceable at law.** To make the agreement enforceable following points should be considered:

1. There must be at least **two parties** – one who gives the promise and the other, receiver of the promise.
2. There should be unrevoked **offer** and unqualified **acceptance.**
3. **Consideration** – something, lawful, real and not illusory, furnished at the desire of the promisor which moves from one party to the other in return for what the other party gives.
4. **Free consent** – the persons to the contract agreeing upon the entire content of the agreement in the same sense.
5. **Competent to contract** – a person is competent to enter into contract if he/she is of the age of majority completing 18/21 years, of sound mind and is not disqualified by any law.
6. **Lawful objective** – permitted and not forbidden by law; not immoral or opposed to public policy.

A **valid** contract satisfies all the legal requirements and thus is enforceable by law.

A contract that has no legal force from the moment of its making is termed as **void.** An illegal contract is void. Certain contracts that are at common law contrary to public policy are also void.

A **voidable** contract is one in which a party has the right to avoid his obligations under the contract. This may arise through misrepresentation, mistake, nondisclosure and undue influence. It is a contract which, though valid when made, is set aside subsequently.

3.3. INSURANCE AS A CONTRACT

The above principles which govern contracts in general are applicable to insurance contracts as well. While insurance is solicited, a **proposal** is obtained duly filled in by the prospect indicating the type of insurance cover desired by him. Though it is called a proposal form giving the meaning of an offer, it is only a statement providing the

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insurer with the material facts required for the assessment of the risk. It is therefore, an **invitation to offer,** expecting to know from the insurer the terms and conditions on which the insurance may be offered.

After considering the proposal and the report from the Medical Examiner, if any, the insurer makes an **offer** intimating the terms of insurance cover and the amount of premium required as consideration.

The proposer is now called upon to indicate his unqualified consent and pay the premium signifying his **acceptance.** In case the deposit amount, as consideration, sent along with the proposal is **adequate** to cover the first risk premium, the insurer assumes the risk **straightaway.** Taking it as an unqualified acceptance, the insurer proceeds to adjust the amount as first premium and issues the receipt. When the proposal is so accepted it becomes a **promise.**

The **consideration** is the **premium** paid by the proposer and the **sum assured** payable by the insurer on the happening of the event insured against.

The contract is between a **legally competent** person (major, of sound mind, not legally disqualified) and the insurer licensed by IRDA. The proposer should have **legal 'interest'** on the subject matter of insurance.

In the transaction, the insured is expected to **disclose every material information** required by the insurer and the insurer also should observe the plain duty of explaining the implications so that when the contact is entered into, both the parties are of the **same mind.**

Thus, all the principles laid down in the Indian Contract Act are observed in the formation of the insurance contract.

3.4. INSURANCE – A SPECIAL CONTRACT

Insurance is a special type of contract having distinct features. It is **technical** in nature. The terms are **fixed by the Insurer** and the proposer seldom participates in drafting the contract. Usually the insurer's offer is on a take-it or leave-it basis.

It is **conditional.** The Insurer's obligation to pay the sum assured depends upon the performance of certain acts by the insured.

It is a **unilateral** contract. The insurer promises to provide cover in return for the payment of a premium. As long as the premiums are paid, the insurer is legally bound to honour the promise. The policy holder, on the other hand, does not promise the premium and cannot be compelled to pay the premiums.

It is **aleatory** as opposed to commutative. In a commutative contract there is an exchange of equivalent values. In an aleatory contract, the element of chance enters and one party may receive much more in value than he or she gives under the contract. If the contingent event does not occur, nothing is payable in the case of non-life contracts.

It is a contract of **indemnity,** subject to certain exceptions. The insured person should not be paid more than the actual loss. Life insurance, accident and disability insurance are exceptions.

Most importantly, it is a contract of utmost good faith - *uberrima fides.*

3.5. UTMOST GOOD FAITH

The principle of utmost good faith is considered to be the 'rock foundation' on which an insurance contract has to be built. This doctrine is applicable to **all classes of insurance.**

In ordinary business transactions, the normal rule is that the party to the contract is under a duty not to make any misrepresentation concerning the subject matter of the

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contract to the other. The duty, if at all, is negative in nature, namely not to induce the other party to get him into the contract by fraud or misrepresentation. Beyond showing ordinary good faith, there is **no positive** duty to tell the whole truth in relation to the subject matter of the contract. Each has to make such independent enquires as he may think prudent. In other words, the maxim **'caveat emptor'** which means, **'let the buyer beware',** applies.

In a contract of insurance, however, there is the implied condition that each party must **disclose material facts** which he **knows or ought to know,** at the time of entering into the contract or when he is under duty to make the disclosure. This type of contract is called ***uberrima fides,*** the contract based on Utmost Good Faith.

Why is this 'Duty to Disclose' Made a Condition in Insurance?

The observations made by Lord Mansfield, who is remembered as the father of the English Commercial and Insurance Law, are worth recalling.

> Insurance is a contract upon speculation. The special facts upon which the contingent chance is to be computed lie more commonly in the **knowledge of insured only.** The underwriter **trusts** the insured's representations and **proceeds upon confidence** that he does not keep back any circumstance in his knowledge to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if did not exist. The keeping back such circumstance is a **fraud** and, therefore, the policy is *void.* Although the suppression should happen through mistake without any fraudulent intention yet still the underwriter is deceived and the policy is void; because the risk run is really **different from the risk understood** and intended to be run at the time of the agreement. . .Good Faith forbids **either party,** by concealing what he privately knows, to draw the other into a bargain from his ignorance of the fact and his believing the contrary.
>
> *Carter v Boehm* (1766)

The rationale behind this legal position is further explained in the statement of Scrutton LJ: '.... as the underwriter knows **nothing** and the man who comes to him to insure knows **everything,** it is the **duty of the assured,** the man who desires to have a policy, to make a **full disclosure** to the underwriters, without being asked, of all the material circumstances, because the underwriters know nothing, and the assured knows everything.'

The Doctrine of Good faith implies:

1. The insurer is in the 'risk business', speculating on the event insured against.
2. The knowledge about the material circumstances or facts which can influence the event to happen is mostly in the possession of the proposer.
3. Unless the proposer fully and positively discloses them, the proposer cannot assess the nature and scope of the risk properly and fix adequate premium.
4. Non-disclosure will mislead the insurer and can be construed as fraud, making the contract void.
5. Insurance being technical in nature, **the obligation of good faith is equally applicable to both the insured and the insurer.**

What is a Material Circumstance or a Material Fact?

'Every circumstance is material which would influence the judgement of a **prudent insurer** in fixing the premium, or determining whether he will take the risk.' It includes every material circumstance which is **known** to the assured and every circumstance which in the ordinary course of business, **ought to be known** by him. So the duty of making the disclosure is not confined to such facts as are within the **actual** knowledge of the assured. It extends to all material facts which he **ought** in the ordinary course of business to have known. Where the facts would have been discovered by the

assured **if he had made reasonable enquiries,** he cannot escape the consequences of not disclosing them.

Facts which need not be disclosed: There are circumstances which, in the absence of enquiry, need not be disclosed. The Marine Insurance Act 1963, in Sec. 20(3) gives a short description of them. Quoted in various legal disputes, they are applicable to all kinds of insurance. They are, the circumstances,

- Which diminish the risk
- Which are known or presumed to be known to the insurer in the ordinary course of business
- As to which the information is waived
- The disclosure of which is unnecessary by reason of any express or implied warranty

Facts of public knowledge and facts which could be or should be referred from the details already furnished need not be disclosed. But courts have also established that waiver cannot be **easily presumed.** Actual knowledge is not essential, if the insurer believes that he had the means of knowing the fact.

Time for 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 a material fact, or in consequence of which a fact previously immaterial becomes material, must be at once communicated to the insurers.**

It is usual in life insurance to insert an additional clause in the declaration appearing in the proposal form to the effect that any change affecting general health, family history, financial position, etc., has to be intimated to the insurer. This duty continues till the acceptance by payment of the first premium and commencement of the risk. **After the contract comes into force, there is no duty to inform the insurer about any changes** in the nature of the risk. The duty to disclose again arises, in life insurance, when the policy lapses for default in payment of premiums and the assured wants to revive the policy. In general insurance, where the risk is covered on short term basis, the duty to disclose revives when the policy ends, and has to be renewed for a further period.

3.6. EFFECT OF NON-DISCLOSURE

Proposal – the Basis

The insurer seeks to know the material facts from the proposer through a proposal. It is in a questionnaire format prepared by the insurer to elicit all information necessary for a proper evaluation of the risk. Questions vary with the kind of insurance and the parties to the contract. In life insurance, the risk is assumed on the health of the proposer. Hence the questions would be on age, health, habits, occupation, etc. Facts about income, insurance needs, present level of insurance, are also asked to rule out any malafide intention to get undue advantage out of the contract.

The proposal form usually concludes with a **declaration** by the proposer to the effect that the statements made by the proposer are **true in every particular** and that he agrees that shall be the **basis** of the contract and that if any untrue averment is there, the contract shall be **null and void,** and the premiums paid may be forfeited. The **policy is also issued** with a recital that the proposal and the personal statement and allied forms shall form the basis of the contract. By such stipulations, all the

representations take the characteristics of **warranties.** By turning representatives into warranties, the insurer gets an advantageous position.

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3.7. REPRESENTATIONS, WARRANTIES AND CONDITION – THEIR EFFECT

A **representation** is a statement made during the negotiations over a contract. A representation induces the other party to enter into a contract. It must be true and if it is false or fraudulent, the contract is **voidable** at the option of the other party. He can sue for damages or cancel the contract proving how he has been misled. Every information given by a proposer, in the proposal form and allied forms is considered as a representation.

In practice, the duty in furnishing the correct information can be further **modified or strengthened** by **mutual agreement** in the contract. A stipulation that the statements should be accurate in **every particular,** may be agreed as a part of the contract. Then the accuracy of the statements become a **condition precedent** to the validity of the contract. Now the statements are called **warranties** and **any inaccuracy** in the statement, **irrespective of its materiality,** can make the contract **invalid.**

In the case of representations, the Insurer would have to establish that the misrepresentation was of a material fact to entitle the Insurer to avoid the contract. A representation needs only be **substantially** correct. **It need not be strictly and literally true.** But a warranty, when incorporated in the policy, either expressly or by reference, must be complied with **strictly and literally.** If the statement is false or inaccurate, the Insurer can avoid the contract whether the statement relates to a **material fact or not.** In insurance law, a warranty is treated as a **condition** in any other contract and must be **exactly** complied with. A mere mis-representation in the proposal can make the contract invalid.

In other words, when the answers given to the specific questions put in the proposal are made **basic** to the contract, by the declaration, the **exact fulfillment** of them is made a condition for the enforceability of the contract. The Insurer can repudiate the contract for any untrue averment found in the statements. The insurer is relieved of the burden to **ascertain or prove** the materially of the statement and its relevance to the risk assessment.

This legal practice was originally conceived as a measure to protect the insurers from adverse selection. By **adverse selection,** we mean the tendency of persons with a higher than average risk or chance of loss to seek insurance at average rates. If such a tendency is not controlled, it would lead to higher than expected claim levels and affect the solvency of the insurer. In practice, the provision was used by insurers to deny even justifiable claims in many cases.

When referred to the Courts, the judges came out with adverse comments but could not enforce the insurers to pay. In his judgement Viscount Haidane said: 'The result may be technical and harsh, but if the parties have so stipulated, we have **no alternative** sitting as a court of justice, but to give effect to the words agreed on.' Dawsons Ltd V. Bonnin (1922) (Motor Insurance).

Commenting on the vulnerability of the insured in such cases, Swift J expressed his anguish: 'Sorry I am for him. There is **nothing I can do** to help him. The law is quite plain.' (Mackay vs London General Insurance Co. Ltd - 1935)

It is relevant to quote here the observations made by Lord Leonard (in the case of Anderson Vs Fitzgerald (1853) Life Insurance). Referring to the effect of the clauses introduced in the policy of life insurance, he observed, that 'unless they are fully explained to the parties, will lead to a number of persons to suppose that they have

made a provision for their families by an insurance on their lives and by payment of perhaps a very considerable proportion of their income, when in point of fact, from the very commencement the **policy was not worth the paper upon which it is written'.**

In England, such outspoken comments in judicial proceedings led to the implementation of the self **Code of Conduct** among insurers. In 1977, the British Insurance Association (BIA) and Lloyds drew up a statement of **Non-Life Insurance Practice** which they recommended to their members. In so far as non-disclosure and misrepresentation, the Code provides that except where **fraud, deception or negligence is involved,** an insurer will not **unreasonably repudiate** liability to indemnify a policyholder on the grounds of breach of warranty (with exception for marine and aviation insurance).

A similar kind of Code of Conduct was issued by the **Life Offices' Association,** stating that insurers should not unreasonably reject the claim **except on fraud, negligence and non disclosure of material nature, especially when the matter was outside the knowledge of the proposer.**

In India, Section 45 of the **Insurance Act** has placed restrictions on the insurers' right in repudiating claims under Life Insurance Policies.

3.8. SECTION 45 – THE INDISPUTABILITY CLAUSE

Section 45 is a provision quoted often in insurance cases. The section states that 'no policy of life insurance, shall, after the **expiry of two years** from the date on which it was **effected,** be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer or referee, or friend of the insured or in any other document leading to the issue of the policy was inaccurate or false, unless the insurer shows that such a statement was on a **material matter** or suppressed facts which it was material disclose and that the policy holder **knew** at the time of making it that the statement was **false** or that it **suppressed facts** which it was material to disclose.'

This section applies to **life policies only.** Policies of general insurance which are generally renewable every year do not come under the purview of this section. Known as **'indisputability clause'** this section has to be read and understood in **two parts.** The first part implies that 'a policy can be called in question within two years from the date on which it was effected on the ground that any statement leading to the issue of the policy was **inaccurate or false.'** As per the second part, when the policy is questioned after a period of two years, **three conditions** are applicable. They are:

1. the statement must be on a material matter or must suppress facts which it was material to disclose;
2. the suppression must be fraudulently made by the policy holder; and
3. the policyholder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose. (*LIC of India vs Janakiammal AIR 1968 Mad 324*).

The **onus** of proving that the assured has failed to perform the duty of disclosure referred to above **lies on the insurers.**

Illustrations

'A' had been treated, a few months before he submitted a proposal for the insurance of his life with the insurance company, by a reputed physician for ailments such as anaemia, shortness of breath and asthma. 'A' did not disclose in his answers to the questions that he suffered from those ailments. He also made a statement that he had not been treated by any doctor for any such serious ailments. It was held that 'A' was

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guilty of **fraudulent suppression of material fact** and the policy issued to him null and void. The repudiation of claim was upheld. (*Mithoolal Nayak vs LIC of India AIR 1962 SC 814*)

In the cited case, the Supreme Court also held that when the contract is bad on the ground of fraud, the party who has been guilty **cannot ask for the refund** of the money paid under the contract.

In another case (*LIC of India vs Janakiammal AIR 1968 Mad 324*) where the repudiation of claim was set aside it was held:

> An insurer could avoid a contract of insurance after the expiry of a period of the two years mentioned in Sec. 45 of the Act only on the ground of suppression of illness which **affects the expectation of life** of the insured, and not mere temporary or **trivial illness**, and unless the disease he was suffering from is clearly established and it is also established that the disease would have a material bearing on the insurability of the policy holder, the policy cannot be invalidated.

The proof of **deliberate** fraud and **not mere constructive** fraud is also necessary. A misrepresentation is a fraud when it is deliberately made with an intent to **deceive** the other party or to **induce him to enter into a contract under favorable terms.**

The 'Effected Date'

The phrase used in this section relates to a date from which the contract becomes **effective by way of acceptance and commencement of risk.** Sometimes the risk may be backdated to suit the convenience of the life assured, generally to get the benefit of lower age. The 'effected' date will not refer to that date. Similarly, it will not also refer to the date of issue of the policy when the document is formally signed and delivered.

The Bombay High Court observed in Khamele v. LIC (1971) "the phraseology used in Sec. 45 of the Insurance Act relates to a date from which the policy of insurance that is a contract of insurance, becomes effective and such date would be the **date of acceptance of the proposal** from which the risk on the life of the proposer is covered."

If there has been any ante dating to suit the convenience of the policyholder, the 'effected date as per Sec.45 would mean the date **on which contract comes into existence**. Similarly, it will not refer to the date on which the policy is formally issued.

Where a Policy has Lapsed and is Revived

The Courts have also made it clear whether the revival of lapsed policy constitutes a new contract or not. As per the operative part of Section 45, the period of two years for the purpose of the section has to be calculated from the date on which the policy was **originally** effected'. (*Mithoolal Nayak vs LIC of India AIR 1962 SC 814*)

Death within Two Years – Decision after Two Years

It has also been held that this section would apply to every case where the repudiation of claim is made more than two years after the policy was effected, irrespective of **whether the insured died before the expiry of two years or not.** The date of death or date of intimation of death are irrelevant. (*LIC vs Janakiammal AIR 1968 MAD 324* following *Mithoolal Nayak vs LIC 1962 (SC)).*

Within Two Years - Warranty Applicable?

The above statutory provision is a clear indication that the doctrine of warranty **will not apply after the expiry of two years.** So it would appear that the insurer can, **during the two-year period,** repudiate a liability if he can prove that certain facts, material or not, were suppressed either **innocently or intentionally** by the insured.

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However, the recent trend of court decisions interpreting warranties as representations makes it evident that their breach does not avoid the contract unless it is proved that the breach increased the chance of loss to the insurer or the non disclosure was consciously made by the insured.

In *All India General Insurance Co., Ltd vs S.P. Maheshwari (AIR 1960 MAD 484)* the court held that **even within two years,** only misrepresentation which is material in the sense of having **some effect upon life expectation, whether direct or indirect,** should be allowed in defence for avoiding the contract by the insurer. A 'simple disorder or trivial disposition' has to be distinguished from an illness which causes material change in health. In *LIC vs Sakuntala Bai, (AIR 1975 AP 68)* where LIC repudiated the claim within two years, non disclosure by the life assured of having **suffered from indigestion** was held to be not a suppression of **material fact affecting the validity of the contract.**

In these cases, the fraudulent intention could not be proved. There was no relation between the cause of death and the disease suppressed. The fact suppressed, the courts feel, should not be a trivial one, and must have an impact on longevity and life expectation, directly or indirectly. In a contract of insurance, the questions are framed by the insurer. The construction should be fair and reasonable and it should not be a trap against the insured. So, wherever there is ambiguity, the courts lean towards protecting the policyholders.

3.9. INSURANCE – IS IT A WAGER?

When a person aged 25 is asked to pay ₹ 23 every year, as long he is living, as against the promise made by an insurer to pay ₹ 1000 on his death whenever it happens, we call it a Whole Life Policy (without profits). Will you call it a wager?

What is a Wager?

'A wagering contract is one involving two parties, each of whom stands to win or lose something of value according to the result of some future event; neither party can have any interest in the contract except his stake. In general, gaming and wagering contracts are by statute null and void, and no action can be brought to recover any money paid or won under them.' In other words, wager is a gamble on an event which is uncertain.

As per Sec 30 of the Indian Contract Act, 'Agreements by way of wager are void.'

Insurance and Gambling – Features Compared: 'Uncertainty' is the only thing which is common to a wagering contract and Insurance. But unlike in gambling, nobody wins or makes a profit in insurance; only the economic loss is compensated to a certain extent. The loss is shared by a group - by pooling the risk. The risk is not created as in the case of gambling; in insurance, it already exists and has to be taken care of. In fact, as Prof. Huebner pointed out only when a person is not insuring is he gambling with his life.

The most important difference is the **interest** in the subject matter of Insurance without which all contracts of insurance are unenforceable. We call it **Insurable Interest. The existence of Insurable interest distinguishes insurance from wagers and other ordinary contracts.**

Insurable Interest is of great importance in Insurance, especially in its three leading branches namely, Marine, Fire and Life Insurance. The evolution of law in this subject has its historical significance. In the early years, especially in the 18th century, wagering policies become very common, and it was the practice of unscrupulous businessmen to insure other people's ships and merchandise and to secure insurance money in the event of loss or destruction at sea. In the absence of insurable interest,

life insurance was in the nature of gambling. The lives of eminent persons were insured by unconnected parties for heavy amounts. This practice went to ridiculous levels and there were a series of court decisions on these wagering contracts. Legislation had to intervene, first in 1745 by the Marine Insurance Act, and later in 1774 by the Life Insurance Act, to establish insurable interest as the basis of insurance contract without which it is not valid.

Since then, English courts strictly enforce the provisions on Insurable Interest. In India, we are more guided by these legal provisions as well as the court decisions.

3.10. WHAT IS INSURABLE INTEREST?

The Insurance Act does not define insurable interest whereas the Marine Act 1963 has defined it to a limited extent.

The definition given by Lawrence J in *Lucena vs Craufurd (1806)* has become the basis for the legal provisions enacted later in England. He said 'A man is interested in a thing to whom **advantage may arise or prejudice happen** from the circumstances which may attend it...To be interested in the preservation of a thing, is to be so circumstanced with respect to it and to have **benefit from its existence prejudice, from destruction.**'

Mac-Gillivary in his monumental book on insurance law has given a definition, as follows: 'where the assured is so situated that the **happening of the event** on which insurance money is to become payable would, as a **proximate cause,** involve the assured in the **loss or diminution of any right** recognized by law or in any **legal liability,** there is an insurable interest in the happening of that event to the **extent of the possible loss or liability....**'

The Insurable Interest must involve the loss of a **legal right,** or involve a legal liability and must be legally valid and subsisting. The interest must be **definite and capable of valuation in monetary terms.** That leads us to the concept of **indemnity** which is the controlling principle of all insurance contracts excepting life insurance. A person can insure only when he has **pecuniary interest** in the subject matter.

The Subject Matter

In case of most of the branches of **property insurance,** the subject matter of insurance is a **physical** subject exposed to certain perils and the assured will suffer financially if the subject matter is lost or damaged by such perils. This relationship gives rise to insurable interest on the subject matter. So also in **burglary** insurance.

In the case of a **personal accident** – it is also the physical object, limbs of the body – and the assured's relation to it and the **probability of suffering** that constitute insurable interest.

The 'Event'

In the case of **liability** insurance, the definition is broadened to include the **event** insured against. The event must be one by the happening of which the assured would suffer. Responsibility to third persons by the happening of an accident, or by the insolvency of the debtor, are instances of such cases.

Ownership, Possession and Contractual Relationship

In the case of property of goods, insurable interest may be based on **ownership.** Such ownership may be sole or joint. It may be absolute or limited; the ownership may be legal or based on **equity.**

The insurable interest may be found on **contractual obligations.** Thus, a bailor on contract has insurable interest for the safety of the goods belonging to others. Principal and Agent, Vendor and Vendee, Mortgageor and Mortgagee, Landlord and Tenant, Principle and Surety, Surety and Co-surety are some other contractual relationships which may give rise to insurable interest. Apart from any question of legal right or contractual titles, sometimes, **mere possession,** if lawful, may be sufficient to give an insurable interest.

The interest may not be a direct one but only a collateral interest, which means a prospective advantage derived from the continued safety of the subject matter. Thus a **profit** or remuneration which has already been ascertained at the date of insurance can also come under the purview of insurable interest.

In Life Insurance

Life Insurance is not a contract of indemnity. We cannot put a value on human life. However if insurable interest is not made as a condition, life insurance may be exploited, by unscrupulous elements. Taking lessons from the past, English law has presumed insurable interest in Life Insurance only in three cases:

1. Every man/woman has insurable interest on his/her own life.
2. A woman has insurable interest on the life of her husband.
3. A man has insurable interest on the life of his wife.

A person has insurable interest in his own life to an **unlimited extent.** By insuring his life, it is presumed he can protect his estate/family from the loss of future earnings as a result of his early death. Though the law recognizes insurable interest on one's own life to an unlimited extent, the insurer may not accept a cover disproportionate to his income.

As a wife normally depends on her husband for support, it can be presumed that she has insurable interest in him.

An husband has insurable interest in his wife's life. The service and help rendered by wife was thought of as the basis of insurable interest for a husband to take a policy on his wife. But the Court of Appeal in England held that no such interest **need be proved** and the interest can be presumed on **broader grounds.**

All these three eventualities form an **exception to the general rule** laid down in English Act 1774 to the effect that insurable interest must be based on **pecuniary interest.** In the above three circumstances, interest is much higher than the pecuniary value and is incapable of valuation. **In other cases, pecuniary value must be present;** it must be definite and capable of valuation; it must be founded on legal obligation; and mere moral obligation is not sufficient.

As per English Law,

> **A parent has no insurable interest in the life of the child qua child.** It is the parent's obligation to maintain a child. So insurable interest cannot be claimed in respect of money spent for his education and maintenance. Nor does a child have an insurable interest in the life of the parent qua parent. When the Life Insurance is effected on the life of some other person than the assured and not being his wife or her husband, a pecuniary interest must be present and the assured cannot recover more than the value of his interest at the time the contract was made.

We follow the practice set out by English Law and their courts. A parent is not considered to have insurable interest in the life of the child and the child in respect of his/her parents' life.

In our society, maintaining the parents is deemed as obligation. When the parent is aged or infirm, they have a right to maintenance and an order can be passed under 125 of the Code of Criminal Procedures 1973. If the child is adopted, such right is given a statutory form. Therefore, we can presume that a parent has a pecuniary interest on the child – but such pecuniary interest is not present unless the parent is unable to maintain himself or herself. If the parent is affluent, such pecuniary interest does not arise. When the parent is not able to maintain herself/himself, financing a policy on the child's life is a problem. Our socio-economic structure is different. Our Insurance Act 1938 does not define insurable interest. We have only Sec 30 of the Indian Contract (about Wager contracts) to guide us. So it is felt by many, that this question of insurable interest of parent on the child and child on the parent needs a review.

(Refer: Discussion on Insurance on minor lives - Page 84)

In USA, where insurable interest is not defined in statute, public policy governs the issue. Not only a pecuniary interest but also a sentimental interest in the life insured or closeness of relationship is deemed sufficient to prove insurable interest.

Other Relatives

It follows as practiced in England, that insurable interest in the case of other relatives (brothers, sisters, uncles, aunts, etc.) cannot be presumed, unless there is **pecuniary interest.**

The following are other cases where pecuniary interest founded on a right or obligation which would be recognized by law or equity can give rise to Insurable Interest:

Employer–Employee

An **Employer** has insurable interest on the life of his employee. He can undertake to provide benefits to the family of the employee in the event of death. Thus he can effect Group Insurance on the lives of employees. The employer can also effect Keyman Insurance on employees who are found valuable and contributing for the success and profitability of the company.

'An **employee** has an insurable interest in the life of the employer arising out of contractual obligation to employ him for a stipulated period at fixed salary' – Hebdon vs West (1863). In the said case, a promise to engage the plaintiff for 7 years could give rise to valid insurable interest. Similar promises like notice period before the termination of service, can provide valid insurable interest.

Debtor-Creditor

A **creditor** has insurable interest in the life of his debtor to the extent of the debt and interest. It is considered because, in the event of death of the debtor while the loan is yet to be paid, the chances of recovery may be affected.

Partners

A **partner** has insurable interest in the life of his co-partner to the extent of the capital brought in by the latter.

A **surety** has valid insurable interest in the life of the Principal, as well as co-surety. This arises out of the obligation founded on the contractual obligations.

Re-insurance

An insurance company has insurable interest on the lives assured in their books. This enables them to go in for reinsurance whenever needed.

Insurance on Minor Lives

The policy at a young age will get the benefit of lower premium. It will give an opportunity as well to build up a sizable fund for future education or start-in-career purposes. But the child is not legally competent to enter into a contract and the parent has no insurable interest on the child. To circumvent this difficulty, insurers enable the parents to sign the proposals on behalf of their minor children with the condition that the policy will automatically vest on the children on attaining major status, and become their property. If risk is covered and unfortunately death occurs in the meanwhile, the amount is paid to the beneficiaries, i.e. parents who receive it as the legal heirs of the estate of the minor.

The Time for Insurable Interest

In all branches of General Insurance, excepting marine insurance, the insurable interest should exist at the time of effecting the policy and on the date of claim as well. In the case of Marine Insurance, the Act provides that:

'The assured must be interested in the subject matter insured at the time of loss, though he need not be interested, when the insurance is effected.'

Life Insurance is not a contract of indemnity - so the courts have viewed that in life insurance, the insured must have an insurable interest at the time when the policy is **effected.** It is immaterial whether or not he later ceases to have such interest. So insurable interest need not exist at the time of claim. (*Dalby vs India & London Life Assurance Co. 1854*)

There are two more important legal principles which relate to General Insurance as contracts of indemnity. A brief description of them is given here. They will be discussed in more detail along with the type of general insurance under study.

Subrogation

This is a corollary to the principle of indemnity. The principle of insurance is that an insured person should not be allowed to profit from a loss. If the Insured has any right of action to recover the loss from any third party, who is primarily responsible for the loss, the Insurer after settlement of the claim is entitled to avail himself of these rights to recover the loss from such third party. So, when the insured has such legal rights, subrogation arises as a **natural consequence** and the rights are transferred to the insurer. This ensures that the insured does not receive more than indemnity.

Contribution

This is also supplementary to the principle of indemnity. Contribution is the right of an Insurer who has paid a loss under a policy to recover a **proportionate amount from other insurers** who are liable for the same loss. It comes into operation where there are two or more policies on the same event. The cost of providing indemnity is shared by the insurers. The total payment will be no more than indemnity across the policies.

Proximate Cause

The classic definition of proximate cause runs as follows:

'Proximate cause means the active, efficient cause that sets in motion a train of events which brings about a result, without the intervention of any force, started and

working actively from a new and independent source.' *Pawsey and Co. vs Scottish Union and National Insurance Co. (1907)*

When there is a loss, besides proving that the loss is within the cover, the insured must also prove that the loss was proximately caused by an insured peril. The proximate cause does not, however, mean the last cause or nearest in time but the dominant or effective cause (Privy Council).

The doctrine of proximate cause is common to all branches of insurance.

When the loss is due to a **single event** the proximate cause has be attributed to that event for the loss. In case where the loss occurs as a **chain of events** in succession with one event setting of the other it may be difficult to prove the exact cause of loss.

In *Smith vs Cornhill Insurance (1938)* the assured who was injured in motor accident, fell into water in a dazed condition and thereupon died of shock. It was held that here death was proximately caused by motor accident.

In a similar case (*Issitt v Railway Passengers Association*—1989), where the insured died after an accident, followed by cold and pneumonia it was held that death was due to accident.

It may happen that the actual peril that has caused the loss is caused by another peril. In case any one of them is insured and the other is not it leads to complications.

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SUMMARY

- The concept of sharing the risk takes the form of a legal contract governed by Acts and regulations. An Insurance Contract has distinguishing features. The principle of utmost good faith makes risk sharing possible. The principle of insurable interest keeps it different from gambling. Law has provisions to see that insurance is built on utmost good faith. It also ensures that innocent policy holders are protected. Insurance excepting life insurance, accident disability and health cover is a contract of indemnity. The principle of indemnity is that an insured person should not be allowed to make a profit from a loss. The insurer will indemnify only when the loss is due to the happening of the insured event.

REVIEW QUESTIONS

1. What is the role of premium in an insurance contract?
2. Lord Bunyan in his definition for life insurance has distinguished it from other insurance contracts. How?
3. How the Insurance Act 1938 has categorized insurance in India?
4. What are the essential features of a legally valid contract?
5. How the legal requirements of a valid contract are satisfied in a life insurance contract?
6. Distinguish between:
   (*i*) Aleatory contract and Commutative contract
   (*ii*) Void and Voidable contracts
7. The principle of Utmost Good faith arises because 'the underwriters know nothing and the prospect knows everything. Explain.
8. What is a material fact? When the duty to disclose ends?
9. Examine the following statements, their application to an insurance contract and legal effects:
   (*i*) A representation when found false or fraudulent can make a contract voidable at the option of the other party.
   (*ii*) Statements made in the proposal for insurance are in the form of representations.

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(iii) Warranties are disclosures which must be strictly and literally true and any untrue statement will make the contract void, legally invalid.

(iv) The Declaration at the end of proposal gives the effect of warranties to the statements in the proposal.

10. Section 45 of the Insurance Act, known as the Indisputability Clause. Gives protection to the innocent policyholders. Discuss with the support of case laws.

11. State with reasons whether the following statements are TRUE or FALSE:

(i) In the case of a life policy the doctrine of warranty is not applicable after two years from the date of acceptance of risk.

(ii) Insurable interest is required to prevent gambling.

(iii) A husband has insurable interest in his wife's life.

(iv) Subrogation supports the principle of indemnity.

(v) A creditor can seek insurance on the life of his debtor.

12. Whether minors are competent to contract? If not, why and how insurance policies are issued in favour of minors?

13. In life insurance insurable interest is required to be present:

(i) At the inception

(ii) At the tome of claim

(iii) Throughout the term of the contract

14. Define proximate cause and explain how it influences insurer's decision in claim settlement.

15. Mr. Amar has submitted a proposal on 12.2.2007. Amount towards first premium was paid on 14.2.2007 The risk was accepted on 28.2.2007. The policy document was formally issued on 10.3.2007 and delivered on 15.3.2007. What is the 'effected date' of the policy in terms of sec. 45 of the Insurance Act?

16. Mr. Kamal took an 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.

CASE STUDY: THE CASE OF THE HYPOCHONDRIAC

Shri. S. took a policy in February 1954. He died within two years, in August 1955. The insurer investigated the claim and found that he had consulted a doctor, and had taken medicine on various occasions in 1952, 1953 and 1954. In the proposal for the question: Have you within the past five years consulted any medical man for any ailment not necessarily confining to your house? the response given was 'NO'.

The insurer repudiated the claim alleging that the insured had deliberately suppressed facts about his illness which was a material fact. When the issue was taken to court, the insurer could prove that the insured had been taking medicines and injections but not that he was suffering from any particular disease.

The doctor who gave evidence about the medicines taken also stated, that 'the deceased was usually of neurasthenic type, that his condition was almost normal .... occasionally took medicines from him and used to make much fuss about even small ailments, and he would be quite upset over such small ailments.'

The Court observed:

> Indeed it would appear that the deceased was suffering from slight hypochondria. The fact that a hypochondriac used to take medicines or injections now and then, cannot be held to show that he was suffering from any particular ailment. After all placebo has a definite place in medical treatment...

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There are many persons with varying degrees of hypochondria, who imagine that they are suffering from all sorts of diseases and go on taking medicines whether they are necessary or not. They cannot be said to be suffering from any ailment or to be receiving any treatment for any ailment and in such cases, the policy cannot be avoided by merely referring to the fact that they have been taking some medicines...

The judgement was in favour of the claimant.

LIC of India vs Janaki Ammal AIR 1968 MAD 324

Also refer LIC of India vs Shakuntala Bai AIR 1975 AP 68

Hypochondria: an abnormal condition characterised by a depressed emotional state and imaginary ill health, referable to the physical condition of the body or one of its parts.

Placebo: a substance having no pharmacological effect but given to a patient who supposes it as a medicine and takes it.

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UNIT

4

FINANCIAL ASPECTS OF INSURANCE MANAGEMENT

STRUCTURE

4.1. THE ROLE OF FINANCIAL INSTITUTIONS

A financial institution (FI) is a company engaged in the business of dealing with financial and monetary transactions such as deposits, loans, investments, and currency exchange. Financial institutions encompass a broad range of business operations within the financial services sector including banks, trust companies, insurance companies, brokerage firms, and investment dealers. Virtually everyone living in a developed economy has an ongoing or at least periodic need for the services of financial institutions.

How Financial Institutions Work

Financial institutions serve most people in some way, as financial operations are a critical part of any economy, with individuals and companies relying on financial

institutions for transactions and investing. Governments consider it imperative to oversee and regulate banks and financial institutions because they do play such an integral part of the economy. Historically, bankruptcies of financial institutions can create panic.

Types of Financial Institutions

Financial institutions offer a wide range of products and services for individual and commercial clients. The specific services offered vary widely between different types of financial institutions.

Commercial Banks

A commercial bank is a type of financial institution that accepts deposits, offers checking account services, makes business, personal, and mortgage loans, and offers basic financial products like certificates of deposit (CDs) and savings accounts to individuals and small businesses. A commercial bank is where most people do their banking, as opposed to an investment bank.

Banks and similar business entities, such as thrifts or credit unions, offer the most commonly recognised and frequently used financial services: checking and savings accounts, home mortgages, and other types of loans for retail and commercial customers. Banks also act as payment agents via credit cards, wire transfers, and currency exchange.

Investment Banks

Investment banks specialise in providing services designed to facilitate business operations, such as capital expenditure financing and equity offerings, including initial public offerings (IPOs). They also commonly offer brokerage services for investors, act as market makers for trading exchanges, and manage mergers, acquisitions, and other corporate restructurings.

Insurance Companies

Among the most familiar non-bank financial institutions are insurance companies. Providing insurance, whether for individuals or corporations, is one of the oldest financial services. Protection of assets and protection against financial risk, secured through insurance products, is an essential service that facilitates individual and corporate investments that fuel economic growth.

Brokerage Firms

Investment companies and brokerages, such as mutual fund and exchange-traded fund (ETF) provider Fidelity Investments, specialise in providing investment services that include wealth management and financial advisory services. They also provide access to investment products that may range from stocks and bonds all the way to lesser-known alternative investments, such as hedge funds and private equity investments.

4.2. FINANCIAL MARKET

Definition: Financial Market refers to a marketplace, where creation and trading of financial assets, such as shares, debentures, bonds, derivatives, currencies, etc. take place. It plays a crucial role in allocating limited resources, in the country's economy. It acts as an intermediary between the savers and investors by mobilising funds between them.

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Functions of Financial Market

The following are the functions of the financial market.

- It facilitates mobilisation of savings and puts it to the most productive uses.
- It helps in determining the price of the securities. The frequent interaction between investors helps in fixing the price of securities, on the basis of their demand and supply in the market.
- It provides liquidity to tradable assets, by facilitating the exchange, as the investors can readily sell their securities and convert assets into cash.
- It saves the time, money and efforts of the parties, as they don't have to waste resources to find probable buyers or sellers of securities. Further, it reduces cost by providing valuable information, regarding the securities traded in the financial market.

The financial market may or may not have a physical location, i.e. the exchange of asset between the parties can also take place over the internet or phone also.

4.3. LIFE INSURANCE—TRADITIONAL PRODUCTS

The purpose of a business organisation is to create value and deliver it to the satisfaction of its customers. When the customers buy 'products' they are only buying benefits and values from the offering made by a company. Life insurance as a service industry, offers various sets of value satisfactions in their products. Risk cover and systematic savings are the **core services** combined in different forms and offered to meet the insurance needs of the customer.

Insurance companies differentiate their products by adding auxiliary benefits and attributes to these **core services,** and marketing them. While buying an Endowment Policy from an insurance company, the proposer gets not a mere legal contract assuring a sum as it is common under the said type of policy but also other **attributes accompanying the policy** like easy facility for payment of premiums, timely reminders, quick withdrawals and loans, hassle free settlement of claims and a range of customer services which differentiate it from the similar endowment policies offered by other companies.

The insurance gets more **value added** when sold by a professional and service minded agent, and the buyer perceives it as a better product compared to the same plan from the same company sold through another agent.

4.4. LIFE INSURANCE PRODUCTS—HOW THEY EVOLVED

In the beginning, life insurance operated to cover only the **risk of death** during a short period. Since the risk of death increases with age, resulting in increase in premiums payable, the need for long-term insurance with uniform premium was felt. From this, the concept of **whole life,** where the premium was payable throughout life, was developed. The uniform rate, which included a savings element, led to the accumulation of a 'reserve', as the premium collected in the early years would be in excess of the amount required to cover the risk. Thus, the concept of **savings with risk cover** was born. Insurance plans which, besides offering death cover during the specified term, provided a **maturity benefit** also at the end of the term, were designed.

The insurance companies made conservative estimates in fixing the premium rates. When the experience was found more favourable than the assumptions made,

the insurer **shared the benefit** with the policy holder in the form of 'bonus'. Thus, the concept of with – **profit policy** was evolved. In due course, when the policy holders began to expect bonus as a matter of right, insurers started **deliberately charging an extra amount** for the payment of bonus and offered distinct with-profit policies. To meet the needs of the interest-sensitive customers, variations came up offering the sum assured in **quicker installments. Combining mutual fund concept** insurers designed **market related** products which are gaining more and more acceptance today.

With improvement in longevity, 'living too long' was also felt as a risk in the modern society and **'annuities'** were developed, promising to pay a series of payments above a certain age, to take care of the needs in old age. The advent of industrialisation brought **group insurance** to extend the beneficial coverage of insurance at a moderate cost to certain groups who assemble together with a common purpose and are engaged in economic activity.

Thus, today we have a wide range of life insurance products to suit the various needs and preferences of the customers.

4.5. TERMINOLOGY

Every business has its own 'language'. In Life Insurance too, there are certain fundamental terms used to indicate the features and benefits of its products.

Sum Assured is the amount secured on death or on survival and due for payment as per the conditions of the policy.

It is **death benefit** when it is paid on the happening of the death during the term of the contract.

It is called **survival** or **maturity benefit** when it is settled at the end of the term.

Premium is the amount that each individual has to pay in order to secure the given sum assured.

The person applying for the policy is known as **Proposer.**

Proposal is the form in which the application is made for insurance and the **Policy** is the document provided by the insurer as evidence to the contract entered into.

The individual whose life is insured (on whose death the amount is payable) is **Life Assured.** The person who is the legal owner of the policy is known as **Policy Holder, Policy Owner.**

4.6. PRODUCT CLASSIFICATION

Life Insurance Products can be broadly classified into five groups:

1. Individual Assurances—Traditional Plans
2. Individual Assurances—Market Oriented Plans
3. Annuities—Personal Pension Plans
4. Riders—Additional Benefits
5. Group Insurance—Group Superannuation Schemes

The individual assurances can be further grouped as **Participating and Non-Participating** (also known as **With Profit and Without Profit)** policies. Participating policies are eligible for share in the profits of the company. The share called **Bonus** is payable along with the sum assured. The premiums rates for these plans are higher than the Non-Participating policies. **Guaranteed Additions** is an innovation substituting with-profit policies. The guaranteed additions will be payable

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along with the sum assured and the rate is guaranteed at the outset when the policy is taken. After the liberalisation of Indian Insurance, **market related products** are replacing with-profit policies and the plans with guaranteed additions.

4.7. INDIVIDUAL ASSURANCES—TRADITIONAL PRODUCTS

Term Assurance

The main purpose of taking life insurance is to provide financial **protection** to the beneficiaries. The Term Assurance fulfills this objective. It is used to replace the income lost when the wage earner dies a premature death. It is also helpful to cover the expenses associated with death (funeral, medical bills, tax payments, debt clearance, etc.).

Term Assurance is for a limited number of years. The plan gives **pure insurance protection.** It pays **death benefit only.** The face amount called Sum Assured is payable if death occurs **during** the stipulated period. It has **no maturity value.**

The main characteristic of the plan is its **low cost.** High risk is covered at a low premium, especially at younger ages. So the insurers are more careful while accepting the risk under this plan. The proposers whose health, lifestyle, family history, occupation and other factors suggest that they are normal alone are considered for term assurance. The need for such insurance cover is also taken into account. As the age factor is critical for the assessment of risk, standard age proof is insisted upon. Proposals are evaluated on the basis of medical reports, including special reports, if required.

Initially, insurers were offering this product for a very short term. With continuous improvement in mortality, the plan is now made available for longer durations of ten and fifteen years, and even more. However, the insurer fixes a limit to the age at maturity (generally 60 years) and the maximum sum assured that can be given.

Uses

Term assurance is useful for a person who strongly feels that the family should be protected but finds his/her current income is limited. He can choose this plan which can give him maximum protection at low cost. It is also appropriate when the need for protection is temporary. This non-expensive plan is also desired where the person has drawn a large amount of loan to promote his business or to meet his personal needs.

Limitations

The main limitation is that it has no maturity value and the protection is limited to a number of years. As the premium covers risk of death only and does not include any savings element, no reserve or cash value accumulates, and on termination by voluntary surrender or at the end of the period, no amount is available to be paid.

Term assurance purely works on the basic principle of insurance – pooling the risk and sharing. A person who pays premium for fire insurance does not claim a return of fire insurance premium if his house was not burnt down during the period insured. But he does not feel it strange when he demands a return of premium on his surviving the term in life insurance. He feels as though he has lost the money in the deal.

The premium becomes heavy as the age increases due to high incidence of risk. The prospects at advanced ages consider the premium as costly and prohibitive.

Insurance salesmen are also eager to recommend other kinds of policies which have an in-built savings component and offer cash value. They can get higher commissions. Due to these factors, limitations and rather, perceptions, people do not prefer term assurance unless circumstances compel them to go for it.

Considering consumer reactions, preferences and pressure from Consumer Action Groups, insurers have introduced attractive variations in Term Assurance by changing the price components and benefit patterns. Some of them are described as follows.

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Term Assurance with Return of Premiums

Besides the death cover, this scheme offers an amount equivalent to the total premiums paid on surviving the term. The plan gives a psychological satisfaction to the customer that, when he survives the term, he will receive back at least all the premiums paid, though not with interest.

The plan accumulates cash value after a minimum period, say, five years, which means that the policy holder is eligible to receive an amount if he terminates the contract after five years.

Family Income Policy

The benefit of life cover can be paid in **two ways**—as a lump sum to repay debits, meet expenses, and invest in future earnings, or as a **replacement income.** In the latter type, it is termed as Family Income Policy, providing an income from the date of death until a certain age or for a set period of years from the date of commencement of the policy. This plan would appeal to those whose family responsibilities call for a monthly income to be paid to the surviving spouse and children. Combining both the benefits, a Family Income Policy can also offer **a lump sum on death and a monthly income for a fixed period.**

Increasing Term Assurance

This is a product which starts with a given sum assured and increases automatically every year at a fixed rate, say 10%. This feature would be helpful in meeting the increased cost of living due to inflation. The cover can also be increased if a particular event (like getting married, having children) takes place at the option of the policy holder. Premium will increase accordingly.

Decreasing Term Assurance

Decreasing term Assurance has a provision to meet a specific need. The variance is designed to protect the repayment due on a mortgage where the capital outstanding is reducing steadily during the term due to periodical repayments. The sum assured is adjusted during the term to reflect the periodical repayments, although the premium will normally remain level throughout the term (or limited to a period). This Term Assurance is usually called **Mortgage Redemption Assurance.** For example, when a housing loan is granted, banks insist on insurance cover under this plan, so that on untimely death of the person to whom the loan is granted, the property after adjustment of the claim amount passes to the legal heirs, and not the debt. This is most suitable as a **collateral security.**

Convertibility

Convertible Term Assurance is another type of Term Assurance with the option to convert the policy, after a period, into a Whole Life or Endowment Policy (policies with savings element) which have cash values. The advantage of this type of Term Assurance is that when the policy holder wants to convert the contract, he can do so **without medical examination,** regardless of the state of health at that time. The premium would be enhanced from the date of conversion depending upon the date of conversion, the plan and term to which it is converted. This option is normally to be

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exercised five years from the commencement. The plan is suitable for those who have chosen a career promising high income in future years, but today find it difficult to pay the high premium for plans with saving elements.

4.8. WHOLE LIFE PLANS

When the need for insurance protection is felt over one's entire life time, Term Assurance with limited period may not be found adequate. In such cases, Whole Life Assurance, which provides the face amount upon the insured's death **regardless of when it happens** is ideal. It is protection for life time for the whole life. Some may need insurance cover even beyond 65 or 70 years and want to provide a substantial amount to the surviving wife, children or for charity when death occurs. A Whole Life Plan is appropriate when such life insurance protection is needed.

As the sum assured under the Whole Life Policy is payable whenever death occurs, and is not restricted to any period, it is also referred as Term Assurance with **unspecified term.** But there are other features which distinguish it from a Term Plan. Whole Life Policy combines **protection and savings** and a cash value develops during the period as a by-product, because of the components in the premium and the premium paying method. This **cash or reserve** value can be surrendered or borrowed upon after a minimum number of years, which benefit is not available in Term Assurance.

The premium is payable during the whole of the lifetime of the policy holder, till death, when the sum assured will become payable. Under the **Limited Payment Whole Life,** the policy holder can have a restricted paying premium period, enabling him to pay all the premiums during his productive years. If the life assured survives the premium paying period, the policy will continue in force with no further premiums to be paid.

The provisions under the Whole Life Plan are being continuously reviewed by the insurers. In the Mortality Table which is the basis for premium calculation, age 100 is normally taken as the terminal age. Insurance companies take it as though all die by that age and calculate the premium. So, in all fairness, they should pay the amount to those persons who live to that age. So, Insurance companies stop collecting the premium by that age and also start paying the claim when they reach 100. Now, companies are further relaxing the conditions, and stipulate that under a Whole Life Policy, premiums are payable for 35 years or till age 80 which ever is more (death not intervening). When 'the policy holder, under these conditions, reaches age 80, the sum assured becomes payable.'

Whole Life policies can be taken with participation in profits. **The bonus rates for Whole Life are usually higher** than the rates declared for other types of policies. Under Limited Payment Plan, the policy continues to participate in profits even after the expiry of the premium paying period.

Convertibility can be made available in Whole Life Assurance also. The plan can operate as Whole Life for the first five years and can be converted into an Endowment (with maturity benefits) at the end of the period, if so desired. This plan is suitable for a young man with heavy family responsibilities, at present having a small income but with definite prospects of higher income in the near future. As his financial capacity increases and family needs get defined, he can adjust the term to suit his convenience.

Uses and Limitations

The Whole Life Plan is presented as the best form of life insurance for family protection. In the later years, a substantial amount may also be available as loan from the reserve

values of the policy to meet the family needs. Yet the traditional Whole Life policy is criticised for its long term and the low rate of return on the savings component. To overcome this criticism, insurers have introduced Whole Life Plans with a variety of premium paying patterns and options and benefits.

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4.9. ENDOWMENT PLANS

In the United States, the Whole Life, with its variations, is the most popular plan widely sold. Endowment Assurance takes its place in India. This is because, in the Indian perspective, life insurance is not a mere risk cover but also a long-term savings plan – a plan which is semi compulsory in nature and where the money saved is safe. Till 1999, Endowment Assurance accounted for more than 70% of the total products sold. But the scenario is changing.

Endowment Plan has both death and survival benefits. It promises to pay the sum assured on the death of the insured during a fixed term of years, and settle the amount at the end of the term if the insured survives the term. The first part, assuring death benefit, we know is Term Assurance. The second part of the promise for survival or maturity benefit is known as **Pure Endowment.**

A **Pure Endowment Policy** is for a term of years and the sum assured is payable only if the life assured **survives** to the end of the term. Premiums are payable throughout the term and the premium depends only on the **term and not on the age. It does not cover risk** and the premium has the elements of investment and expenses only. Yet it is offered as a life insurance product. The product may serve the object of a bachelor or a spinster interested in preserving income for old age and not for any cover on early death. **Savings on tax** may also be the motive for the individual opting for this plan, who may be otherwise **not insurable.**

The definition given in the Insurance Act (Sec. 2) includes the business of effecting any contract upon human life where the money is payable on the happening of any **contingency upon human life** as life insurance. Hence by its terms and conditions, Pure Endowment can also be taken as a **life insurance product.** Moreover, understanding the concept of Pure Endowment is very relevant in insurance as most of the plans are combinations of Term Assurance and Pure Endowment in varying degrees.

An Endowment Plan is nothing but a **combination of Term Assurance and Pure Endowment.** The concept can be explained in another way:

Suppose a person wants to have a **given sum at the end of a specific period.** Towards that objective he makes certain contributions every year to accumulate at a compound rate of interest to reach that amount. If he survives the term, he will have the sum at the end of it. If, however, he dies before the end of the term, his savings plan would be incomplete, leaving a gap between the amount accumulated and the targeted amount.

The life insurance company steps in here and offers **to make up the deficit** in return for a small premium to meet the risk. It is a **decreasing term assurance,** provided by the insurance company where the amount at risk payable as a deficit decreases every year and becomes nil at the end of the term. The effect is that the savings accumulation equal to the sum targeted is available at the end of the term and the full sum desired to be had at the end of the term is payable to the beneficiaries if death occurs earlier.

Uses of Endowment Plan

Endowment Assurance takes care of many anxieties and concerns in life. Provision for financial protection to the family, funds in future to meet education, marriage expenses, and income after retirement, etc., can all be planned under this

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Assurance. It is a semi-compulsory, systematic savings plan carried through the active years to have a secured future for the family. Salespeople find it easy to explain, and proposers find it simple to comprehend.

4.10. VARIATIONS

Many products have evolved combining Term Assurance and Pure Endowment in varying degrees. **A Double Risk** plan will assure **twice the sum assured on death and a single sum assured on survival.** It is a combination of two Term Assurance elements and one Pure Endowment element.

When the plan assures a **single sum assured on death and twice the sum on survival,** called **Double Endowment,** evidently it has two Pure Endowment and one Term Assurance parts.

Fixed Term Endowment is another variation of Endowment. The sum assured under this plan is available **only at the end of the selected term.** However, no further premium is required to be paid if the life assured dies earlier. It satisfies certain needs which would arise in the future, like marriage expenses. Since the sum assured is payable only on the expiry of the term, the premiums are lower than those payable under an ordinary Endowment Plan.

Fixed Term Annuity is rather an extension of this Endowment. The sum assured at the end of the term is paid in ten (or specified) equal half yearly installments. It is designed to meet educational needs. The premium is little lower than the former.

An Endowment type of plan is also offered on two lives. It is called **Double Cover Joint Life Endowment Plan** and is ideally suitable for a working couple. The policy is issued on the lives of the **husband and wife.** In the event of death of one of the lives assured during the selected term, the basic sum assured is paid to the other life and future premiums are waived under the policy. However, the policy continues on the life of the surviving person and the sum assured is again paid on the date of maturity or in the event of earlier death. If one or both survive to the maturity date, the basic sum assured is paid.

Joint Life Plan is also available to **partners in business** with a difference. Here, the contract will come to an end at the time of the first death with the payment of the basic sum assured. The plan is not eligible for any further benefit.

4.11. MONEY-BACK PLANS

'Get periodical returns and stay insured for the full sum assured' goes the punch line for this Plan which is also a variation of Endowment Assurance. It has a different pattern in the payment of the sum assured. The face amount is paid in installments at periodical intervals during the currency of the policy.

An example: In a 20 years' plan, the payment is paid in four installments, viz. 20% of the sum assured each at the end of 5th, 10th or 15th years and the balance 40% with vested bonus at the end of the 20th year, i.e. on maturity. In case of death at any time during the 20 years' term, the full sum assured is paid along with bonus attached and **without deducting** any installment which has already been paid. The bonus is reckoned on the full sum assured, irrespective of the installments paid.

On analysis, we will find a Money Back Plan, a **series of Pure Endowments embedded within a Term Assurance for the whole period.** Thus the 20 years' plan described above is a mix of a Term Assurance of 20 years for the full sum assured and a series of Pure Endowment Plans for different periods (20% of sum assured for 5 years, 20% of sum assured for 10 years, 20% of sum assured for 15 years and 40% of sum assured for 20 years).

This is considered as a good plan of assurance for a person who, in addition to a full cover for the protection of the family, wants periodical payments to coincide with any needs that may arise during the term, like education of the child, or marriage. The plan also satisfies the people who feel that the return on the investment aspect of Life assurance is inadequate and better value to their money can be had by investing in other avenues. No doubt the premium is relatively high under these plans.

Insurance companies differentiate in the Money-back Plans offered by them. The installments and the patterns of payments may be designed differently so that the benefits are not comparable with similar products of other companies.

4.12. PLANS FOR CHILDREN—ON THE LIVES OF PARENTS

Insurance means substituting economic power. The loss of income to the family due to sudden death, is compensated to certain extent by Life Insurance. So, people who earn money and have a dependant family can go for Insurance. If the concern is to ensure that the money is ready when the child needs it most, to join professional courses, or seek admission in overseas universities or have a head start in a promising career, these can be accomplished by the parents having adequate coverage **on themselves,** which build up a fund for future and also ensures that the goals like higher education are met in the event of untimely death.

Certain specific Plans like Fixed Term Endowment or Educational Annuity Plans are available when the Sum Assured together with bonus or unit additions are payable at the end of the selected term either in lump sum or in installments. The money would be useful to reach higher education expenses even in the absence of the parents. Premiums under this type plan are payable for the selected term which would coincide with the age of the child, when a lump sum would be handy. The sum assured is paid on the stipulated date even if the life assured dies earlier. But the future premiums would be waived.

4.13. CHILDREN'S PLANS—ON THE LIVES OF CHILDREN

They are designed mostly to **start as saving schemes adding risk cover at a later stage.** The cover for death is normally provided from 7 years onwards. As children are not competent to enter into a contract the parents take insurances on the lives of their minor children. The risk on the life of the child commences from the policy anniversary after certain years, called **Deferred Date.** The time gap between the commencement of the policy and the commencement of risk is called the **Deferment Period.** If the child dies before the deferred date, the premiums paid will be returned. In case of death of the child after the Deferred Date and before the end of the term, the claim will be paid to the parents as beneficiaries.

These policies are issued with conditions that the title will **automatically pass on** to the child on attaining majority, called **vesting age.** After the **Vesting Date** (which is the policy anniversary after the vesting age) the child becomes the owner of the policy. The benefits under these policies are normally designed to be payable as **staggered payments to meet the educational expenses of the children.** On payment of additional premiums, based on the life of the proposer, the parent, further premiums can be **waived** in case of death of the parent during the deferment period.

At present, insurers waive medical examination if the child is below 10 years. For risk plans or when the sum assured is heavy or the age is above 10 or when the proposal indicates any abnormality, full medical reports and special reports as per the company's practice will be required. Insurers will also insist on matching insurance on the lives of the parents. Practices followed by insurance companies in their offer of Children's plans vary widely. Children's Policies are becoming popular for the following reasons:

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- A forced savings habit starts at early age and over a long term it is possible to build up a big amount for education, marriage, estate creation, start in life, etc.
- Insurance cover is available without medical examination from the risk date and a life cover is continued at low premium.
- Tax benefits can be availed either in child's account or parents account.

There cannot be any substitute for the love and affection and care showered on the children. But giving them a financial support when they need it more will go a long way in giving them edge in the competitive world and realise their dreams. They will feel proud of their parents and emotional bondage would be stronger. Children's plans serve these needs.

4.14. PLANS FOR SPECIAL CHILDREN

When a child is born with some **disorder, physical or mental challenge,** it needs special attention from its parents. A special plan to secure the future of such children provides payment of the part of sum assured (20%) to the child on the death of the parent-proposer and the balance as annuity payments, say for 15 years, certain, and thereafter for the life of the child. The payment will be made to the child directly or to the nominee as a measure of much needed financial support in the absence of the parent. The premium will be computed taking the age of the life assured (parent), age of the dependent child for a whole life plan with limited premium paying period. In case of the unfortunate death of the dependant child, the premium can be returned or the policy can be made proportionate paid up as the need for the Plan ceases.

When the permanent disability conforms to the norms specified under Government rules the premium paid can rank for special Income Tax benefits as deductions from the income of the life assured.

4.15. HEALTH PLANS

What the Act says

The Insurance Act has included 'health' under Miscellaneous insurance to be transacted by **non-life insurers**. IRDA in its Regulations on Registration of Insurance companies have classified insurance industry as under.

- Life insurance business consisting of linked business, non-lnked business or both

Or

- General insurance business including health insurance business (or health cover)

IRDA in its Regulations have also stated that 'health insurance business' or 'health cover 'means the effecting of contracts, which provide sickness benefits or medical, surgical or hospital benefits, whether in-patient or out-patient, **on an indemnity, reimbursement,** service, prepaid, hospital or other plans basis, including assured benefits and long-term care.

Life Insurers and Health Insurance

The longevity of an individual has increased to a great extent. The cost of medical/ hospitalisation has become unaffordable to many. So the life insurers who are already in the business of covering risks exposed to human life, feeling that they can also meet

the needs of the people in providing additional financial support. ventured offering plans with additional benefits on health cover. But these plans are not on reimbursement basis meeting the actual medical expenses **as such plans can be granted only by non-life insurers.** Life insurers plans provided **Lump sum benefits irrespective of actual medical expenses incurred.** The benefits are paid out in **fixed percentages of sum assured** ranging from 100% to 10% as decided at the outset when the policy is taken.

IRDA is encouraging life and non-life insurers coming together to offer combinations in products. A new breed of products called **'combi products'** is emerging. Combining Term assurance from a life insurer and Medi claim policy from a non-life insurer a new integrated, **Health plus Life Combi product** is offered to the insured as one plan. To work out this 'partnership' **a memorandum of understanding** is agreed between the two insurers on administration of the policy. There is transparency in the premium to be charged and flexibility in continuing the policy. The Lead insurer facilitates the issue, service and claim settlement relating to the policy. The unique advantage to the policy holder is the facility to have both the benefits, term assurance and medi claim under a single policy through the services of the lead insurer.

4.16. NEW GENERATION PRODUCTS UNIT LINKED–VARIABLE LIFE AND UNIVERSAL LIFE CHANGING NAMES

Unit Linked Insurance was introduced in United Kingdom, in 1950, by Unit Trusts. It was a hybrid product combining the features of investment and insurance. Life insurance companies saw its potential, developed it and started selling it successfully. Its popularity spread to Netherlands and Canada. It was offered in United States in 1976 with a change in name as **Variable Life Insurance (VLI).** This product called **Unit Linked Insurance Plan** in India was first floated by The Unit Trust of India in collaboration with LIC of India. Later, life insurance industry adapted it as an attractive product combining wealth creation and risk cover. The features, benefits and uses of this product and its positioning in the market as defined by IRDA are discussed in the next chapter, in detail.

Universal Life Insurance was another new plan which was first conceived as variation of Whole Life Plan. With **flexibility in premium payments and adjustability in death cover.** Introduced in 1979, it became very popular in USA, and later in UK also. Under this plan, the policy holders can pay 'premiums of whatever amount and whenever they desire subject to company's rules on minimums and maximums. While regulating its launching in India IRDA changed its name as **Variable Insurance Product** and also stipulated the features to be incorporated in it. The circular and the guidelines issued make it clear that-

- Every VIP policy shall have a policy account. It will be credited with premium net of all charges.
- Only level regular premiums are permitted. Single premium or limited premiums shall not be allowed.
- The premium shall be shown separately as risk premium, charges, commission and policy components.
- The guaranteed rate and bonus shall be applicable to the balance of the policy account.
- Top–up premium (increasing the premium) is allowed throughout the term.
- The policy provides guaranteed mortality cover. The policy holder shall be offered flexibility of changing the sum assured during the currency of the term subject to insurability and minimum sum assured. Such change will be effective from the next policy anniversary.

- Sum assured chosen by the policy holder together with the balance in the policy account shall be payable as death benefit.
- The benefit payable on maturity shall be the balance of money in the policy account plus the terminal bonus, if any.
- Only traditional plans, either participating or non-participating, on non-linked platform can be offered as Variable Insurance Products.
- The sum assured shall at least be ten times annualised premium. The minimum policy term shall be five years.
- All Variable Insurance Products shall have a lock-in period of three years. No partial withdrawal is permitted. Loan can be availed.
- A statement of policy account shall be sent to the policy holder at least once in a year.

4.17. PRODUCT DIFFERENTIATION

Combining Term Assurance, Whole Life, Pure Endowment and also adding the elements of Annuities (to be discussed later), insurers evolve different schemes to suit the needs of various market segments.

All insurers do not offer all types of plans. It depends on how the company positions itself in the market. A company viewing insurance as a unique means of protection may offer mostly Whole Life policies from a very early age with different terms for payment of premiums. Another company, considering it as a instrument to get more value for money can concentrate on market linked policies, linking the products to capital markets. Insurers, considering the changing circumstances, may also reposition themselves from time to time and offer products with different benefits and payment patterns.

Postal Life Insurance

Life Insurance plans are also offered through post offices. Postal Life Insurance is the oldest insurance organisation in the country. It was established in 1884 by the Government of India and it is managed by the postal department of the government. Initially it was to cover only telecom department employees, but slowly extended to all Central and State government employees, public sector employees and other government related organisations. **Postal insurance does not come under IRDA regulations.**

Products Offered

Scheme for Physically Handicapped, Whole Life Assurance Scheme, Endowment Assurance Scheme, Convertible Whole Life Assurance Scheme, Anticipated Endowment Assurance Scheme, Joint Life Endowment Assurance Scheme for married couples, Children's Policy are policies currently issued by them. The other special features related to Postal Life Insurance are:

- Limit of sum assured minimum ₹ 20,000 maximum ₹ 10,00,000.
- All policies and loan documents are exempt from stamp duty.
- Premium can be paid at any post office.
- Premium eligible for income tax rebate.
- Non-medical policies are issued up to ₹ 1,00,000.
- Physically handicapped persons can insure up to ₹ 1,00,000.
- Convertible Whole Life Policies can be converted into Endowment Assurance.
- Nominations and assignments can be made at any time.

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- Easy loans against policies after completion of 3 years. It will attract interest at 10% p.a.
- Bonus is paid on paid up policies also.
- Unlike other insurance companies, there is no agency system in vogue.

The Government of India accepted the recommendations of the Reforms Committee and amended the rules in 1995 to extend its operations in rural areas. Accordingly Postal Department came out with Rural Postal Life Insurance (RPLI) scheme with certain restrictions in the existing plans offered.

Among the extra advantages enjoyed by Postal Insurance are low cost of operation and exemption of stamp duties. Products are marketed with the punch line 'low premium-high bonus'.

SUMMARY

- Life insurance plans offer a myriad of benefits. The fundamental benefit is the economic protection given on early death. Later, it extended to 'living benefits,' providing funds for future needs. Term Assurance, Whole Life and Endowment are the basic plans and variations came in by combining them in different ways. The premium collection and benefit pattern can change depending upon the needs and convenience of the buyers. For people, who are 'interest sensitive', money-back was introduced. 'With Profit' is another variation which offers participation in profits. More and more flexibility in plans is the order of the day.

REVIEW QUESTIONS

1. Discuss the role of Financial Institution and Financial Market.
2. What are the core services offered in a life insurance product? What are the attributes added to it to make it attractive?
3. Term Assurance covers only death risk. Discuss the variations in the product, its convertibility and explain how the plan is useful to an young man?
4. How Whole Life Plan is different from Term Assurance? Enumerate its benefits.
5. Endowment Plan is a combination. Elaborate.
6. Explain the features of a Money-back Plan. How does it serve the needs of a young family?
7. What are the plans best suited to promise an assured future for children? Explain the benefits offered.
8. Head of family feels insurance is not a good investment. How would you advise him to go for a traditional policy?
9. Health insurance is now offered by Life insurer in a distinct form. Discuss the initiative.
10. Needs are changing. Variable Life Assurance is a new generation plan. Explain.
11. Discuss the role of Postal Life in the Indian insurance industry.

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UNIT

5

LIFE INSURANCE PRODUCTS MARKET RELATED PLANS

STRUCTURE

Life insurance covers mainly the risk of death. It does not cover the effect of inflation and fall in currency value of the sum assured which is promised at the outset of the contract. Mostly, Life Insurance contracts are for the long term, and the claim amount when payable may become inadequate to meet the needs, due to erosion in money value. This is the major criticism against Life Insurance Plans.

The premiums in life funds, when invested collectively, as per regulation norms, normally get a yield of 5 to 6% per year. This is because of the cautious approach of the insurers and also the mandatory provisions in investing the fund. Life insurers holding the money in trust for the benefit of the policyholders hesitate to invest in speculative ventures. Investment norms stipulate a significant portion to be invested in development of infrastructure and Government securities. Safety rather than yield is the guiding factor in their investment pattern. Hence the insurers are not able to offer high return to the policyholders.

The buyers of insurance who were confident of investing elsewhere and getting better return started feeling it would be ideal to go for Term Insurance only with the insurers and invest the balance in the capital market. **Buy Term Assurance—Invest the Difference** (BTID) became the trend. Yet, the common people with their limited knowledge about investment avenues and aversion to risk, could not reach the capital market and their dissatisfaction with the insurers continued.

5.1. THE RISE OF MUTUAL FUND AND UNIT LINKED PLANS

The concept of **Mutual Fund or Unit Trust** was first introduced in UK, and became popular among the public. Various funds depending upon the needs of the people and their ability to take risk were developed, and the common people could invest in various financial services and avenues through this investment vehicle. Mutual Funds pool the funds of investors to buy stocks, bonds, and other financial instruments and create a diversified portfolio of investments. Mutual Funds started promoting schemes with a limited insurance coverage also. The success and popularity of Mutual Funds enabled the insurers to combine the concept of mutual fund with life insurance cover and introduced Unit Linked Insurance Plans also known as Variable Life Insurance (VLI).

The basic working of unit linked insurance is similar to Mutual Fund. The amount paid by the policyholder after deduction of the premium for pure risk coverage (Term Assurance) for the current year and the expenses, is invested in Funds **opted by the policy holders.** They accumulate with investment earnings and get higher yield compared to traditional policies. From the insurer's point of view, they are interested to introduce the unit linked product, as there are no guarantees in the plan, and the capital requirement in launching or servicing such plans is also lower. The customers are happy as they able to get better returns and find transparency and flexibility built in the scheme.

In India, The Unit Trust of India and LIC Mutual Fund were permitted to float Unit linked plans in collaboration with LIC. The maximum saving and cover under these plans and their tenure were very much restricted. Reviewing their limited success Malhotra Committee felt that life insurance industry should develop and market such plans for longer terms and with uniform risk cover.

Basic Plan and the Premium

A policy term has to be chosen with the minimum of five years. If it is Whole Life the term should be taken as 70 minus age at entry. The premium can be single or annualized premium.

Insurance cover and Investment

The plan has two components –Term insurance cover and investment part. There are front-end and back-end charges made on the premium collected.

Adjustment of Premium

The risk premium, called **mortality charge,** is levied in the beginning of every month, as per the table enclosed with the policy.

Investment Options

The premium paid by the client, after adjusting for risk cover and any charges, is utilized to buy units in the funds chosen by the policyholder.

The policyholder is given the option to choose the investment pattern for the premium paid and the units are allotted in his favour. The company should provide different types of investment strategy **(Equities, Debt, Balanced, etc.)** with minimum and maximum percentage of investments in each fund.

The documents should contain enough details, and the intermediary should be given adequate training to explain the features of these funds, so that the proposer makes an informed decision on the investment option. The policy holder can select and allocate the premium among various types of funds depending upon his needs and ability to take risks.

Types of Funds

Broadly, the following types of funds are offered to the policyholders for investment of their money after meeting the cost of insurance.

Equity/Growth Funds

These funds are invested more in the equity shares of companies with the hope of earning high returns. The shares/stocks are traded in the stock market. The fund has a speculative outlook. Over a long term, the investment in this fund may appreciate more in value compared to other financial instruments.

Debt/Income Funds

They are also called **Bond Funds.** They are mostly in Government Securities and safe Corporate Bonds. These funds give steady and decent income but the capital may not appreciate much.

Secured Funds

Investment in government/government guaranteed securities.

Balanced Funds

As the name indicates, this fund consists of both equity and debt instruments in the proportions desired.

Money Market/Liquid Funds

The instruments of this fund are of short term nature like treasury bills, commercial papers, inter bank call money, etc. They provide moderate income depending upon the interest rates prevailing in the market. The capital is safe.

Investment as Units and Net Asset Value: The investment in these funds is denoted as units. The units are allotted at the price computed by the **Net Asset Value** of the underlying assets of the fund opted by the client. It is typically computed by a formula:

$$\frac{\text{Market/Fair Value of Investments + Current Assets} - \text{Current Liabilities}}{\text{Number of outstanding units in the Fund on the day of purchase of units}}$$

If the unit price is less, the client gets more number of units. Each time the insured pays the premium, more units are allotted to his account.

Flexibility: The product is made more flexible and adaptable to put the policyholder in control of his policy. The policyholder can switch between funds. Certain **free switches** are allowed. When it exceeds free switches, charges for switching from the funds are made.

Funds exceeding the basic premium can also be paid as **top-up premium.** Consequently enhancement of risk cover is also permitted. After a lock-in period **withdrawals** subject to maintenance of minimum levels are allowed.

Charges: There are certain charges accompanied with the product for its administration. IRDA wants them to be made clear, specific, simple and easy to understand.

Allocation charge is the percentage of the premium appropriated from the premium total. The balance is known as **allocation rate** to purchase the units for the policy.

In the first year the company may include **initial managerial expenses.**

Fund management charge is the percentage of the value of the assets appropriated from the net asset value (around 1% per annum).

Policy administration charge may be a fixed amount or a percentage to cover administrative expenses in keeping the policy in the books.

Switching charges are made when they go beyond the number of free switches. It is expressed as a flat amount per each switch (say ₹ 100).

Partial withdrawal charge is a flat amount levied at the time of part withdrawal.

Surrender charge is levied at the time of surrender as a percentage of the fund or a percentage of accumulated premiums.

Besides, the insurer may also charge for expenses when other services like change in sum assured, premium redirection, are desired.

The charges are made by **cancelling the appropriate number of units** from the policy holder's fund.

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5.2. IRDA REGULATIONS

Over years IRDA has come out with directions and guidelines to regulate this unique product and position it as a plan of long term nature with standardized life coverage The objective is to protect customer's interests and see that there is transparency in operations at the point of sale of the product and during the term of its service .as well According to IRDA the following features are to be incorporated in the design of the product.

- Individual products to have a minimum policy term of five years ULIPs, other than single premium products, to have a minimum premium paying term of five years.
- All products including pension/annuity must have a minimum sum assured payable on death.
- Minimum lock-in period is five years. This stipulation is applicable even to top-up premiums. During this stipulated lock-in period no residuary payments on policies which have lapsed /surrendered / discontinued are to be made.
- No partial withdrawal is allowed within the lock-in period of five years.
- The insurer shall evenly distribute the overall charges over the lock-in period.
- All top up premiums made during the continuance of the policy must have a component of insurance cover.
- ULIP pension/annuity products shall offer a minimum guaranteed return of 4.5% per annum or as specified by IRDA from time to time.

Transparency

IRDA stipulates that the insurer should give **adequate training** to their agents so that they can explain the features of the product well to enable the proposer to make an **'informed decision'.** As the investment risk is entirely passed on to the policyholder, the company should provide **periodical statements** to the policyholder on the performance of the funds so that he can exercise the options if found necessary. The qualitative information furnished should enable the policyholder to adapt to changing circumstances and have enough **risk cover and increasing investment value.**

ULIP Under Whose Jurisdiction?

ULIP is an hybrid instrument combining both insurance and investment and ULIP account for considerable share of insurance business. Securities and Exchange Board of India {SEBI} felt that ULIP as a financial instrument which covers investment aspects ULIP should have their prior approval before launching in April 2010, SEBI moved to ban Life insurers from selling ULIPs. Soon IRDA asserted that issue of ULIPs is clearly within their domain and advised the insurers to ignore the order of SEBI. To clarify the position, the Central Government, in June 2010 came out with an Ordinance promulgating that issue of ULIPs will continue to be regulated by IRDA .Amendments to RBI, SEBI and Insurance Acts were made. The Government also said that a high level committee chaired by the Finance Minister would sort out all issues of jurisdiction regarding hybrid products.

ULIP and Mutual Fund

Though the concept of mutual fund is used in building up ULIP, its structure and working are different from a mutual fund product. In mutual fund, the investment amount is decided by the fund house whereas the premium in ULIP is the contribution decided by the policy holder and can vary over the term of the policy.

A minimum of risk level is assured in ULIP. It is mandatory as per IRDA instructions. Life insurance coverage is not available in a mutual fund, though some funds provide it as a value addition.

Also, the expenses in mutual fund are prescribed by SEBI (Securities and Exchange Board of India) unlike ULIP where the charges are determined by the insurer subject the approval of IRDA. In ULIP, the policy holder can switch over the funds with one or two switches free of cost in a year. In mutual fund expenses related to entry and exit loads have to be borne by the investor.

ULIP enjoys tax benefits under Section 80C. When the benefits are paid they are tax-free (Section 10 (10D)). In mutual fund, tax benefits are available only for specified investments and the rules related to short term and long term capital gains are applicable. The heavy allocation charges in the early period of ULIP put it poor in comparison to an equity linked investment with tax benefits for the first 3 or 4 years.

Disclosing the portfolio of investment to the investor every quarter, is mandatory in mutual fund. In ULIP it is not mandatory but IRDA wants insurers to keep their policy holders informed about the performance of the funds periodically, through their statements and also educate their policyholders on the risk factors on an ongoing basis.

ULIP and with Profit Policy

A with profit or participating policy provides, apart from the risk amount, an additional benefit by way of share in the surplus in the company called bonus. Premium receipts from these products are mostly invested in government securities and corporate bonds. The conservative investment philosophy of the insurer as well as the directions under Insurance Act and IRDA would constrain the insurer from venturing out to the equity market. So, the bonus rates are not attractive compared to the returns offered by ULIPs. The contributions from ULIPs are invested in market oriented securities (as per the investment pattern offered by the insurer and desired by the insured and subject to statutory provisions) and returns are naturally higher.

ULIP and Traditional Plans—Flexibility

Compared to a traditional product, ULIP is more transparent and has high liquidity. The insured has the option to park the savings element of his premium in the type of investment desired by him. ULIP has more flexibility. Unlike the money-back policy where the payments are at fixed intervals, ULIP allows withdrawals whenever needed. For instance, in a 20 year policy the insured may opt to withdraw amounts at the year 12 and 15 to meet educational expenses of his daughter and allow the rest to accrue to form a fund to buy annuities at his old age. In financial planning, ULIP can serve to provide various benefits offered by traditional plans like whole life endowment, money back, children's plans and pension plans in one platform.

With the rise in income levels, awareness about the capital market and also need for financial planning, Unit Linked Policies are gaining greater acceptance. It is true that Unit Linked Policy has changed the face of life insurance today, providing a new direction to the life insurance business.

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SUMMARY

- Unit Linked is the latest arrival among the plans in which the death benefit and cash value vary according to the investment experience. The investment is according to the option made by the insured. The plan it is felt is an hedge against inflation and gives a better value to the money. But the investment risk is entirely maintained by the insured. IRDA has come out with instructions to be followed in the product design and promction of this product in Indian market. Universal life is yet to find its place in insurance products.

REVIEW QUESTIONS

1. Trace the origin and development of the concept of Unit Linked Plan.
2. What are the essential features of ULIP?
3. IRDA's stipulations have been designed to ensure transparency in the plan offered and also to protect the interests of the policyholder. Comment.
4. Describe briefly the nature of funds to be chosen by the policyholder.
5. There are certain charges which accompany the Unit Linked plan. Name them and explain.
6. Distinguish between:
   (*i*) ULIP and Traditional
   (*ii*) Endowment with Profit Plan
7. State with reasons whether the following statements are TRUE or FALSE:
   (*i*) There is no flexibility in the structure of ULIP
   (*ii*) In ULIP, the risk of investment is passed on to the policyholder.
   (*iii*) There is no death benefit in ULIP.
   (*iv*) The policyholder, in the long run, can expect a better return on his Unit Linked Policy.

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6

LIFE INSURANCE PRODUCTS Annuities-Pension Plans Riders-Business Insurance

STRUCTURE

The overall objective of life insurance as a personal financial planning tool is to provide future income security. When a person reaches old age, he may cease to be employed or get less engaged in his work for wage or compensation. Yet the need for income is there so long as he is living. Annuity, recognised as a life insurance product, takes care of this need.

6.1. ANNUITIES

Annuity is the 'reverse' of life insurance. Life insurance gives protection from the risk of dying too young. Annuity takes care of when one lives **'too long'**. Though the functions are different, both are based on the principle of 'pooling the risk.' Premium or annuity both are computed on the probability of death and survival as evidenced by the mortality table.

An annuity in the ordinary sense, is purchase of an 'income'. It involves conversion of capital into income, the principal into an annuity. When an annuity is purchased, the insured pays a capital sum as **consideration** for a promise from the insurer to make a series of payments, called **annuities,** as long as he lives. The person who receives a periodical payment under an annuity is called the **annuitant.**

The annuity depends upon the **age, sex, and type of annuity.** The older person receives a greater annuity compared to the purchase price he has made, as the probability of his survival will be low. A man will withdraw more annuity than a woman of the same age, as the life span of women is longer than that of men. When annuity payments are guaranteed for a minimum number of payments, the annuity will be lower compared to the annuity ceasing on death without such guarantee.

The annuities can be broadly classified as **Immediate** and **Deferred.**

An Immediate Annuity is an annuity purchased with a single premium called Consideration for Annuity Granted (CAG) where the first annuity payment is due immediately. For example, if the annuity is payable monthly, the first payment, in Immediate Annuity, starts one month from the purchase date, and if it is to be paid annually, one year from the purchase date. The installments are paid quarterly, or half yearly, in the same manner.

A Deferred Annuity, on the other hand, is an annuity that can be purchased by a single premium or by periodical payments of premiums with the commencement of annuity payments **deferred to a later date.**

Immediate annuities are purchased mostly by persons who have **just retired or are nearing retirement.** They pay a lump sum from their terminal benefits received from their employer. Deferred annuity is generally opted by people a few years before their retirement, for providing retirement income and also for availing tax advantage. It has an **accumulation period** during which the annuity fund values accumulate. The liquidation as an annuity starts normally at age 60 or 65. If the purchaser dies during the accumulation period, the insurer pays all or portion of the annuity cash value.

Pure Life Annuities

A Pure Life Annuity provides **lifelong income** to the annuitant. The payments continue as long as the annuitant is alive and terminate on the annuitant's death. No more payments are made after the annuitant dies. This type of annuity provides maximum income for a given purchase price. It is ideally suitable for the persons who need maximum life income and who have no dependents.

However, because of the risk of ceasing the annuities on earlier death and forfeiting the amount, this type of annuity is not preferred by many people. There is a popular misconception that only the interest portion is paid by the insurer as annuity and so stopping the annuity on death without any death benefit is felt as 'unjustified'.

6.2. HOW THE ANNUITY WORKS

The annuity installment actually includes three elements: (*a*) **principal,** (*b*) **investment income** and (*c*) **survivorship or insurance benefits.**

The amount attributable to each of the three elements in any annuity installment can be computed and explained.

To illustrate, assume an annuity of ₹ 1,000 per year issued to a man aged 60, with the first payment due one year from the date of issue. The cost of the annuity will be ₹ 7,552.87 arrived at on the basis of 10% interest and the applicable mortality table. This has to be paid as a single premium. If the annuity were to be purchased one year later (at age 61) the single premium would be ₹ 7,437.71. Thus in the first year, ₹ 115.16 of the original capital has been **liquidated.**

Segregation of the first ₹ 1,000 annuity installment into principal, interest and survivorship benefit would be calculated as follows, **exclusive of expenses:**

Initial Investment	₹ 7,552.87
Add: Interest assumed (10%)	₹ 755.29
Total Amount Available	₹ 8,308.16
Less: Annuity Payment	₹ 1,000.00
Amount remaining without Survivorship benefit	₹ 7,308.16

Note: The cost of annuity at age 61 will be ₹ 7,437.71 but a sum of ₹ 7,308.16 only is available. How is the deficiency of ₹ 129.55 replenished? Not all the 60-year-old annuitants will survive the one year period to collect their ₹ 1,000. **Those who die will**

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release their investment to be spread among the survivors. Each survivor's share will amount to ₹ 129.55, which is the deficiency in the fund available at the beginning of the 2nd year.

Thus, the first annuity payment of ₹ 1,000 is divided as follows:

Interest Income	—	₹ 755.29 (₹ 7,552.87 @ 10%)
Capital Liquidation	—	₹ 115.16 (₹ 7,552.87 – ₹ 7,437.71)
Survivorship Benefit	—	₹ 129.55 (₹ 7,437.71 – ₹ 7,308.16)
		₹ 1,000.00

Each successive year, the **survivorship benefit will increase, whereas interest income and capital liquidation will decrease.** For example, the annuity payment for the second year will consist of:

Interest Income	—	₹ 743.77 (₹ 7,437.71 (@ 10%)
Capital Liquidation	—	₹ 119.74 (₹ 7,437.71 – ₹ 7,317.97*)
Survivorship Benefit	—	₹ 136.49 (₹ 7,317.97 – ₹ 7,181.48+)
		₹ 1,000.00

*₹ 7,317.97 is the cost of annuity at age 62.

+₹ 7,181.48 is the amount remaining from the initial fund plus interest after ₹ 1,000 payment is made.

Based on the article 'Annuities in Investment Portfolio - An Overview' by T.V. Ramarao Yogakshema - Jan. 1989 (LIC).

Emphasis added

There are reasons involving mortality and interest factors which compel insurers to have **conservative assumptions** in fixing the annuity rates.

Those who purchase annuities enjoy better mortality compared to the lives under life insurance policies and they are far superior to the population as a whole. Experience has also confirmed that the annuitants have a longer span of life. Mostly, proposers who are confident of their health seek annuities and enter the pool of risk to avail the premium at average rates. There is an element of **self selection** which in the insurer's point of view is an **'adverse selection'** affecting their calculations. Because of the higher life expectancy of annuitants insurers have to use **special mortality tables** to calculate annuity rates. As there is continuous improvement in mortality rates, there is a **mortality cushion** in life insurance policies. In the case of annuities it is quite the **reverse**. The improvement goes against their calculations!

The interest factor presents another problem. The interest rate once presumed cannot be changed during the term of the contract, i.e. once the annuity starts. The market rates of interest are decided by the demand and supply of money and the policy of monetary authority. In 1950-51 the rate on government securities was 2.79% and the rate on time deposit was 1.31%. These rates gradually rose to 6.11% and 10% in 1980-81 and stood at 11.60% and 10.00% in 1986-87. Insurers, on the basis of increasing trend, revised the annuities and passed on the benefits to the new annuitants. In the late eighties and nineties, the rates were coming down and after liberalization and interlinking with the world economy the downward trend persisted. Now, with the reverse trend, insurers have to offer lower rates of annuities. In a contract for long term, insurers have to be cautious in their rate assumptions.

Faced by these constraints, the Insurers strive to make the annuity fair and equitable. Yet, most people are hesitant to buy annuity because it promises no or little return if they should die shortly after the annuity commences. So insurers today offer various **options** to make the annuity attractive to the buyers.

Life Annuity with Refund of Purchase Price: Under **installment refund option,** the annuitant receives life long annuity and if he dies before receiving income payments equal to the purchase price, the payments are continued by the insurer in favour of the beneficiary **until the total income payments equal the purchase price.** The other alternative is **cash refund option** where, on death of the annuitant before receiving total payments equal to the purchase price, **the balance is paid as a lump sum** to the beneficiary.

Life Annuity with Return of Purchase Price: In case of death of the annuitant, the **purchase price is refunded.** The annuity rate obviously will be low compared to the type of annuities described above. This kind of annuity will be suitable for persons who prefer lifelong income and also like to provide for their dependants.

Guaranteed Annuity: These Annuities are called **Life Annuities Certain.** Income payments are guaranteed for a certain number of years, usually 5, 10, 15 or 20 years. If the annuitant dies before receiving the guaranteed number of payments, the remaining number of payments are paid to the named beneficiary, i.e. **up to the guaranteed period.** If the annuitant survives the guaranteed period, he will continue to receive the income **lifelong.** This option is used when a person wants an income to be provided to his dependent as well, in the event of his early death. As the payments are guaranteed, the annuity rates are lower than the rates paid under Pure Life Annuity.

Joint Life and Survivor Annuity: This type of annuity finds its most common use with the husband and wife. On the first death, the income will continue unchanged or reduced by an agreed percentage either immediately or after a minimum period from the commencement of the annuity. This is similar to the **family pension scheme** offered by employers. The survivor **will have lifelong pension.** The option of annuity certain can also be made under this annuity.

Escalating Annuity: Escalating Annuity assures the income payments **increasing** by a fixed percentage each year, e.g.: 1/2/3% of the original annuity. This is helpful in managing the effect of inflation. The disadvantage is that annuity payments will be lower in the first years compared to a level annuity.

Variable Annuity: Like the variable life assurance, the annuity is linked to the value of investments backing the annuity. It is also called Unit Linked Annuity. The purpose is to provide a hedge against inflation. The basic assumption as in the case of variable life insurance, is that in the long run the return on common stocks and investments keep pace with inflation. During the accumulation period, the premium collected each year after deducting expenses (as in the case of life assurance) will be utilized to **buy units at the current unit value.** At the vesting date the insurer starts to pay the income as **units.** During the liquidation period, the units remain constant but **their value will change** depending on the **net asset value** of the stock in the annuitant's portfolio. Like in the case of life assurance, the annuitant choses the fund for investment. Transfer among funds permitted is by insurers during accumulation or liquidation periods. Some insurers promise guaranteed minimum death benefit during the accumulation period establishing certain age limits.

Combination Annuity: It is **partly fixed and partly variable.** It takes out some of the uncertainty about the income. Fixed and variable annuity may be fixed as 50/50 or 75/25 depending on the individual's needs. Variable annuity like Immediate or Deferred annuity can have any option in settlement (life annuity, annuity certain, capital protected annuity, etc.).

Annuity enjoys **tax benefits at the accumulation period.** During liquidation, the **annuity is taxed as income.** But after retirement and as a senior citizen, the impact of tax may not be much.

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Annuity, whatever may be the type, has certain common benefits. The income is certain. The annuitant may spend it without fear of outliving it. It provides immunity from pressures to withdraw and spend it, thus enhancing one's ability to be independent and maintain self respect.

6.3. PERSONAL PENSION PLANS

A pension scheme is based on the deferred wage concept. Pension is considered as part of a wage packet which has been deferred and channeled into provision for retirement. The employer, instead of paying immediately as salary or wages, develops it as a fund and pays it to the employee as a retirement benefit.

It is estimated that in India only 11% of the employees in the organised sector enjoy this benefit of provision for pension. The changing socio-economic scenario, increasing longevity, urbanisation, disintegration of joint families, ushering in of nuclear families have made provision for **financial security in old age a pressing need.** Insurers have developed Personal Pension Plans especially for those who are self employed and who can appreciate the need for making old-age provision.

Personal Pension Plans (PPP) are nothing but Annuities with added features. They can be equity linked, with or without guaranteed returns. The options given under Annuities are available here also. The major benefit and feature is the **long term** it provides to the policy- holder (35 to 40 years) to accumulate, so that a big sum available as a corpus from which lifelong pension can be drawn. On the vesting date, the date on which the pension has to start a part of the accumulated sum can be **commuted, tax free.** A Term Assurance Rider can be added to assure death benefit if death occurs before the vesting date. On early death, the premiums will be returned with interest as provided in the contract. The insurers also offer additional sums on death, depending upon the mortality experience and interest earned in the market. The product when approved by authorities (IRDA - CBDT) as a pension plan will be eligible for tax benefits.

In developed countries, a retirement security is referred as **'three legged stool'**—social security, employer pension schemes and individual savings. In our country, social security schemes are almost nil and benefit under employer's pension plan is available to a few only. The Personal Pension Plan seems to be the only hope for the ageing population.

Rider Benefits

Rider is an **optional benefit** available to the policyholder **at an additional cost.** In the 'pre liberalisation period' the benefits under the products were predefined and offered as **packages.** The customer had to choose the plan closest to his needs. The recent trend is to offer a **basic plan with add on benefits** to suit the **exact needs** of the customer. These add on benefits at extra cost are called Riders. They introduce an element of flexibility much desired by the buyers. There are at least five rider benefits which are popular today in the insurance market.

Accident Benefits

Accident benefit is the most popular rider. Under this rider, an insurer undertakes to pay a specified amount as an additional benefit, should death be caused by an accident. The specified amount may be equal to or less than the sum assured under the basic plan as per the extent of the benefit opted. The benefits are subject to certain eligibility criteria and conditions. Generally, the accident benefit is payable if the insured's death was caused, **directly** and **independently of all other causes,** by an **accidental bodily injury** and death occurred within the **days specified.** Deaths due to

- war, riot related accidents,
- self inflicted injuries (suicide),
- accidents resulting from aviation activities, in any capacity other than as a passenger in an approved aircraft flying between established airports, and
- accidents resulting from criminal activities

are certain exclusions mentioned in the contract. This benefit, which can be given only when the occupation is not accident prone, may not extend beyond 65 or 70 years of age of the life assured.

Disability Benefit: When the policyholder suffers **total and permanent disability arising out of accident** this benefit is provided by way of periodical payments with a lump sum at the end of the term of the basic plan or on earlier death. The disability must arise before the policy anniversary on which the nearer birthday of the life assured is 65/70 and it must be the result of an accident and must be total and permanent and such that there is no work, or occupation or profession that the life assured can do or follow to earn or obtain any wages, compensation or profit.

As per the policy conditions, the loss of sight of both eyes or amputation of hands at or above the wrists or amputation of both feet at or above the ankles or amputation of one hand at or above the wrist and one foot at or above the ankle, will be deemed to constitute total and permanent disability.

The disability must have arisen due to the accident within the days specified in the policy. The life assured will get a percentage (10%) of the sum assured every year till maturity/death which ever is earlier. At maturity/death the balance is paid in a lump sum to the policyholder/nominee.

Income Benefit: This benefit provides for **regular financial support to the family** in case of premature death. In addition to the lump sum on death, a percentage of the basic sum assured (1% every month) is paid till the end of the term. This rider is designed to appeal to young men (and women) who have a young family to support. A monthly income is paid to the surviving spouse/children until a certain age or for a set period of 10, 15, 20 years from the date of policy issuance.

Critical Illness Benefit/Major Surgical/Minor Surgical Assistance Rider: Critical illness includes malignant cancer, coronary artery bypass surgery, heart attack, kidney failure, stroke and major organ transplant. If the policyholder is affected with a critical illness, after the lien period referred to in the policy and subject to other conditions mentioned, the amount assured under this rider will be payable. The proof of diagnosis should be as per the standard stipulated by the company. Bills proving hospitalization treatment or purchase of medicine will not be insisted upon.

Similarly, financial assistance is given in the event of major or minor surgery, after obtaining the discharge report. No bills are required. These riders are different from the yearly renewable **Mediclaim policies** offered by general insurance companies which are availed to get reimbursement of medical expenses subject to certain limits.

These riders are new to India. No reliable data has been built up so far to charge appropriate premium for them. Hence companies prefer many restrictions on this rider, and the premiums charged now are subject to review after a period set by the company.

Term Assurance Rider: Term assurance offers pure risk cover at the cheapest premium. When additional protection is needed to cover the risk for certain period ex. loan temporarily raised for business or family expenses, the policyholder can opt for this benefit for a limited period at a very nominal cost.

Premium Waiver Benefit Rider: This benefit ensures relief from payments of premiums in case of disability arising out of accidents. Future premiums on the policy will be waived. This rider is eminently suitable under a children's plan. When

the parent dies during the minority of the child, future premiums will be waived and the policy will be treated as in force.

Guaranteed Insurability Rider: Guaranteed Insurability is another innovative rider option given by certain insurers. The policyholders can avail increase of cover (upto 50%) at specified periods without any medical examination or submission of additional proposal.

Mass Customisation: Thus with four or five basic plans and six riders, hundreds of options can be offered and customize the product to suit the needs and purse of every one. Some options can be added or withdrawn at the will of the policyholder. Some can be taken only from the commencement of the basic plan and once withdrawn, can be added only on satisfying again the **eligibility criteria.** As provided for basic plans, the riders also have terms and conditions like **maximum sum assured, maturity age, term, total cover, etc.**

IRDA, in their endeavor to regulate and see that the riders do not overshadow the basic plans and 'mis-selling' do not occur, have stipulated that: the premium on all riders, relating to health or critical illness shall not exceed 100% of the basic premium of the main policy and the premium on all the other riders put together should not exceed 30% of the basic premium. These limits may be changed by IRDA depending on the experiences and the benefits desired by the policyholders.

6.4. LIFE INSURANCE FOR BUSINESS

Keyman Insurance

In business circles, Keyman Insurance is now becoming a part of **risk management.** The scheme is very popular in USA. The purpose of taking Keyman Insurance is to protect the company against the premature death of a valuable employee whose technical knowledge, skills, services and influence contribute in large measure to the stability and profitability of the company. He may be an able technician, financial wizard or business strategist. The sudden loss of such a Keyman will create a vacuum in the company. An equally capable person has to be brought in or trained over a cost. In the meanwhile, the setback would cause a loss of profits. Keyman Insurance is helpful in overcoming these difficulties.

The employer has insurable interest on the life of an employee for the service rendered. The premium paid under this insurance can be **fully treated as business expenses.** To avoid misuse of these provisions, IRDA has set certain ground rules and the Income Tax Act has placed some restrictions. Briefly these are as follows:

- The firm should not be a proprietory company and the Keyman's share in the capital of the company should not be more than 25%. The details about the Keyman's share in the capital structure have to be given. His family members' share (inclusive of his share) should not be above 50%.
- The data about the Keyman, his age, qualifications, experience, salary and service conditions, age of retirement, etc., have to be furnished to decide whether he holds the unique position of the Keyman in the company. There can be more than one Keyman in the company contributing their expertise in different fields.
- The company should also furnish its track record, profits made in the last 3 years and state the contribution of the Keyman to it. Audited accounts

of 3 years, along with Memorandum and Article of Association, have to be submitted.

- Further, the company should have a resolution passed by the company's board, deciding to go for insurance cover in the name of the specific person as a Keyman for the sum assured and term and premiums decided. They should also authorize a person to negotiate and sign the proposal on behalf of the company.

The **quantum of insurance,** linked to the profitability of the company will be decided taking into various factors like

- The **annual compensation package to the Keyman:** It can be upto ten times of his income.
- The **gross profits of the company** (before depreciation and taxation) for the last three years. Two times of the average may be the maximum.
- The **net profit of the company** for the last three years - five times of the average net profit may be allowed.

The permissible insurance may be arrived at on the basis of the above three methods. If the company has identified more than one Keyman and decides to go for Keyman insurance for more than one individuals the sum total under this scheme should be **within the overall limit** arrived on the basis of profitability.

The Procedure: The proposal has to be signed by the authorized person and the Life Assured. Full medical reports along with special reports if any on the Life Assured have to be submitted. A high level marketing official in the insurance company would be required to give a report. When accepted, the policy will be issued with an endorsement (for which consent from the company's Board is necessary) stating that in the event of the employer leaving the company, the policy will be surrendered to the insurance company for a value or assigned absolutely in favour of the employee/Life Assured. Nomination is not allowed and riders like accident benefit cannot be added.

The premium paid can be treated as expenses, **but the benefit when received will be treated as revenue and taxed.** The Finance Bill of 1996 has made very clear provisions about the premiums paid for and the proceeds received from Keyman insurance policy.

6.5. PARTNERSHIP INSURANCE

The need for Partnership Insurance is realized today. When a partner dies and the share of the deceased partner has to be paid out of the partnership funds, it will have a serious effect on the firm. Life Insurance can take care of this contingency and relieve the partnership of this paralyzing effect.

A partnership has an insurable interest in the life of each partner, if an agreement exists between them that the survivors will purchase the interest of the deceased partner. The extent of Insurable Interest would be the amount of purchase money required to be paid in respect of the share of the deceased partner.

The policy can be taken as a **Joint Life Plan:** The sum Assured should not exceed the capital amount including goodwill (with the minimum of ₹ 25000). **Individual policies** can also be taken on the lives of all the partners with the sum assured not exceeding the capital to the credit of the partners' account (including the goodwill).

The firm should authorize a person to sign the proposal on behalf of the company with the partners as lives assured. The agreement must also provide for the express understanding that the money available from insurance would be available to settle the claim of the deceased partner and treat the premiums paid as business expense of the firm.

The insurer would also require copies of Income Tax returns and audited accounts or statement of the capital account of the partners.

Nomination is not allowed in policies issued under partnership assurance. In the case of dissolution of the firm for any reasons other than death of any of the partners insured, the policy can be surrendered to the insurer for cash value or made paid up and such paid up policy can be absolutely assigned in favour of any of the insured. Assignment is permitted only in such cases. Necessary endorsement incorporating these conditions will be placed in the policy with the consent of the firm.

The insurer may insist on other restrictions and conditions, like minimum sum assured, maximum term, maximum maturity age, etc.

It is claimed that the premium paid for Partnership Insurance can be treated as expenses incurred wholly and exclusively for the purpose of the business, under Sec. 37 (1) of the Income Tax Act. But the matter is not entirely free from doubts. Hence the insurer **does not accept responsibility for benefits under IT Act** and leaves it to the firm and their tax consultants.

Plans for Keyman Insurance and Partnership Insurance

Different plans were offered and accepted by insurance companies to cover the Keyman and the partners. Specific products like Limited Endowment were suggested by the insurers. IRDA in their recent circular (Jan 06) have come out with the advice 'that all insurers are strictly to ensure that where the premium for the insurance on the life of an employer is paid by the employer or where the premium on the life of a partner is paid by another partner or by the partnership firm, the scope of cover is not wider than **term assurance.'**

SUMMARY

- Annuity is the reverse of traditional life insurance. It covers the risk of living too long. Periodic payments are assured during the lifetime. Types of annuities vary with the time when it begins, mode of payment of premium, mode of annuity payment, the number of lives covered, refund options, etc. Personal pension plans are based on annuities. Riders are additional benefits offered at extra cost. They are helpful in meeting the specific needs of a customer. There are products in insurance to help businessmen to save their business from the impact of early death of the Keyman/partner.

REVIEW QUESTIONS

1. 'Annuity is the reverse of life insurance'. Explain the basic difference.
2. State with reasons whether the following statements are TRUE or FALSE:
   (*i*) Annuity is an insurance which takes care when a person lives 'too long'.
   (*ii*) Annuity would be the same irrespective of age.
   (*iii*) Immediate Annuity is purchased with a single premium.

(*iv*) The mortality rate of annuitants (those who purchase annuities) is found higher compared to others.

(*v*) A Pure Life Annuity provides a life long income.

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3. A retired officer who desires to purchase feels that it would be unfair on the part of the insurer to stop payment on his death and pay no more to his dependents. How would you convince him?
4. Describe a Joint Life Annuity Certain for 15 years. How it is an ideal economic solution for aged couple?
5. Define the elements with which an annuity is built. How the insurer strive to make it attractive?
6. Escalating Annuity provides hedge against inflation. Comment.
7. 'Financial security at old age is a pressing need'. Discuss the role of a Deferred Annuity in meeting this need.
8. A Rider is an optional benefit at an additional cost. Describe the usefulness of some important riders.
9. How the Keyman Insuranceis structured? What are the requirements called for?
10. When a partner dies it has a paralyzing effect on the firm? How a Partnership relieves the strain? What is the procedure and also state the conditions insisted by IRDA?

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UNIT

7

UNDERWRITING SELECTION OF LIVES

STRUCTURE

The process of selecting and classifying applicants for insurance, charging appropriate premium and documenting the contract is referred as underwriting.

Underwriting is one of the primary functions of an insurer. It involves activities of processing the new applications received, called **new business**. Every application is evaluated according to the established guidelines. This essential function through **fair and consistent risk selection** ensures that the insurer remains financially strong to meet the legitimate claims.

In the early days when Life Insurance was in its embryonic stage, selection of lives was made by interviewing the applicant by the Board of Directors of the Insurers. The person seeking for insurance has to appear before the Board and the selection is made by judging the health of the person by mere appearance. In latter years, a physician was invited to sit in the Board to advise the Directors. Mere declaration by the proposer and his appearance were the criteria for selection.

With the increase in volume of business, it was not found possible to interview each and every one of the applicants. It was also felt that medical examination is desirable before selecting for insurance. The proposal form was also enlarged to have more information about the proposer. Based on the proposal, the observations of the

medical examiner and the report obtained from the sales representative a scientific assessment of risk was developed.

The word 'underwriting'

The process of assessment and acceptance is called **'underwriting'**. The name 'underwriting' was used when Marine Insurance was first transacted in **Lloyds Club in London**. The person accepting the risk would **sign under the details** of the risk to be insured, expressing his willingness to accept the share of risk for consideration specified. So the word 'Underwriting' used for acceptance of risk in marine came into vogue in other branches of insurance also. The person processing the risk is called **'Underwriter'**.

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7.1. MORTALITY TABLES

Underwriting in life insurance is particularly concerned with mortality rates. **Mortality Table** a landmark in the development of life insurance provides reliable information about the most important factor in the assessment of risk – the probability of death.

There are two main classes of Mortality Table, depending upon on the **sources of data** from which they are compiled:

1. **Census Mortality Table:** The experience is based on the **general population.** It is constructed on the basis of census enumeration and registered births and deaths and expressed for the 10 year period ex. (1941-50), (1951-60), etc.
2. **Insured Lives Mortality Table:** The table is based on the experience of **insured lives.** These are constructed by Life Insurance Companies from their own office data. They give more precise picture of the Insured lives. It is also referred as **Select Mortality Table.**

The Census Mortality Tables include deaths among those lives who are 'substandard', too poor to insure or uninsurable and show **higher mortality** than the table followed by the Insurer.

With the development of **Actuarial Science,** Actuaries and Medical Team joined together to initiate **Medico-Actuarial Investigations** to collect more information which would be helpful in assessment of risk.

Indian Experience

The earlier study of mortality on Indian lives was made by Standard Life Insurance. It was based on the Indian experience of the Company's policyholders during 1870-85. Oriental Insurance Company conducted periodical investigations and published Mortality Tables. The **Oriental Mortality (1925-35)** Table was modified and adopted by LIC of India in 1956. During the last four decades, LIC has conducted five investigations and the fifth one was done during **1994-96.** The current mortality rate used in the industry today relates to this period. This Select Mortality Table refers to the experience of lives selected after due care by the Insurer. The premium rates are based on them.

The Objective of Selection

Insurance is based on pooling of risks. Similar risks have to be grouped together and the cost is shared. On the principle of **'Equality of Risk'**, one should share the cost of risk depending upon the risk he is bringing into the group. The objective of risk assessment is to verify this, in such a way that the mortality of the group selected is not worse than the predetermined rates as evidenced by the current Mortality Table followed.

If it is not done in a fair manner, it will result in **'adverse selection'**. The company may receive a large number of impaired lives, and the company may not be able to meet the claim cost resulting from the increase in the number of deaths. The lives which are healthy may be attracted towards other companies which are stringent in their selection. In a competitive environment, such trends will be more prevalent.

It may be argued that the Census Mortality Table, which covers all lives in the country, can be adopted and the system of selection of lives can be dispensed with. But the Census Mortality is always higher than the Mortality Table followed by the Insurer. The premium will be high and resisted by healthy lives. Healthy lives may postpone insurance till some impairment sets in and those whose health is not so good may be brought in by the field personnel who face lower resistance from them. The insurer will experience **'adverse selection'**, and be left with more impaired lives impacting unfavorably in the claim experience. The suggestion to follow the Census Mortality Table can be successful only when insurance is made compulsory and the Sum Assured is decided by a pre-determined scheme and not left to the option of the Life Assured.

The Information Gap

There is one more dimension to it. The customer knows less about the product. Despite the efforts to make the terms simple and readable, the insurance contract continues to be technical and complex. The customer goes defensive and in his anxiety to secure the most favourable terms, may not disclose all that he knows about his insurability especially if the Insurer does not ask for it. The personal interests of the sales force may not align completely with the Insurer in getting adequate information to assess the risk and decide appropriate premium. **The challenge before the Insurer is, without being too cautious, to obtain sufficient information at reasonable cost and make proper assessment of risk.** Otherwise, adverse selection may cause mechanism breakdown.

Sources of Information

The information needed for selection of lives and assessment of risk is obtained from the following main sources, viz.,

1. The **proposal form** and the personal statement filled by the proposer
2. The **Report by the Medical Examiner**
3. The **Confidential Report from the Agent** who solicited the business

In addition to these, a Special Report is obtained from the officials of the company wherever the underwriter feels more information is required about the health, financial position, habits, and insurable interest of the proposer.

7.2. PROPOSAL – ITS SCRUTINY – LEGAL ISSUES

The proposal is designed by the Insurer by be presented to the prospect, the potential buyer for his consideration of the insurance cover applied for. Depending upon the type of the policy it contains the details of the information necessary for assessment of risk and issue of policy.

Proposal forms are not uniform in their content or in the order of information furnished. They vary with the companies, but often the proposal consists of information about the proposer's:

- name, sex, residence, date of birth, occupation, educational qualification, income, object of insurance, nature of insurance sought, the riders to be attached, history of previous insurance, name of the beneficiary/nominee;

- physical impairments, if any, present physical condition, details about the illnesses, diseases, injuries, surgical operations experienced, medical consultations made, absence from work due to prolonged illness, health condition of the family members, life style, personal habits, avocations and hobbies, etc.

When the life assured is different from the proposer, the second part known as **personal statement** would relate to the *life assured* as the risk cover is on the life assured. In the case of female lives, additional questions on pregnancy, child birth, insurance on husband's life have to be furnished. Normally age proof of the life assured will be enclosed with the proposal.

The proposal form, at the end contains a declaration stating that all the information given is true in every particular and, along with the declaration, forms the **basis of the contract.** Incorrect statements will nullify the contract. As the proposal is an important document it has to be filled up personally by the proposer. If the answers are in a language different from the questions, a separate declaration has to be obtained from the person who explained the questions to him. If the proposer is illiterate the declaration from the third party should state that the questions were explained to the proposer and the answers have been truthfully recorded.

Information Not Recorded

As agreed by the proposer, in the declaration, the proposal forms the basis of the contract. The Insurer also in the preamble of the policy dcument refers it as the basis of the agreement. Hence the underwriter takes all care to scrutinise the information, responses and details provided in the proposal and proceed to evaluate the risk. There should not be any ambiguity in the answers recorded. Dots, dashes, question marks and blank spaces have to be followed up and any additional information needed has to be pursued. Otherwise, it would be deemed as **waiver** and the Insurer at a later stage would find it difficult to dispute the claim on the grounds of misrepresentation or suppression of facts. IRDA (Protection of Policy holders' Interests) Regulations, 2002 states:

'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 cover.'

The underwriter is expected to process the proposals with 'speed and efficiency' and as per IRDA norms to communicate the decisions within a reasonable period not exceeding **15 days** from the receipt of the proposals.

Insurable Interest

The underwriter must verify whether the proposer has the insurable interest to effect the policy, and the amount of coverage applied for is appropriate. If insurable interest is not present at the time of submission of proposal, the contract is void and so the proposal has to be rejected. The insurable interest has to be present at the time of issue of policy, regardless of whether it continues to exist or not. An amount of insurance that seems to be excessive in relation to the insurable interest may indicate anti selection.

Identity and Proof of Residence

Years back, the banking industry was alerted against money laundering, the inflow of money acquired through illegal means to approved financial channels. Banks, under The Prevention of Money Laundering Act 2002 (PMLA) were advised to institute KYC (Know Your Customer) norms to check the tendency effectively. The Insurance industry received Guidelines on Anti-Money Laundering (AML) Programme from IRDA which became effective from 1st August 2006. The documentation of permanent address

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and current address is now mandatory for all the new contracts. As required by the PMLA rules, satisfactory evidences to establish the identity and the residing place have to be submitted along with the proposal.

Prohibition of Rebate

Insurance Rules 1939 by Rule 12 thereof prescribe that in the proposal it shall be clearly indicated that an offer or acceptance of any rebate (other than specified in the prospectus) is an offence under Sec. 41 of The Insurance Act. The underwriter is not expected to verify whether any rebate has been offered in the field. However he must check that the proposal is received through the channel licensed by IRDA and the legal provision about the prohibition of rates invariably finds its place in the printed form.

Commencement of Risk

Receipt of premium as consideration is the pre-requisite for commencing the risk. The Act under Sec. 64VB stipulates that no insurer shall assume the risk unless and until the premium payable or the deposit as required is received in the prescribed manner. So the underwriter should verify whether the deposit amount is received along with the proposal and shall not commence the risk without it, when the proposal is found acceptable.

7.3. MEDICAL REPORTS

The medical examiner authorised by the insurance company, verifies the identity of the person presenting for medical examination and makes a record of his/her age, weight, height, chest girth and other vital particulars in his medical report. He also gives his findings on the clinical signs of the cardiovascular, digestive, uro-genital and central nervous systems and other aspects of health. In the light of the information furnished by the proposer in the personal statement, the second part of the proposal form, he makes further investigation wherever necessary and indicates his general **observation** and **opinion** about the **insurability** of the person.

If there are adverse points, further special reports may be called for to make a more correct evaluation of the proposer's health. Depending on the findings and also the type of plan, term, age at entry, age at maturity and sum assured under consideration, the underwriter may call for laboratory tests and special reports like ECG, TELE, blood reports. The underwriter may ask for a **statement from the attending physician** for a history of any health condition observed.

7.4. AGENT'S CONFIDENTIAL REPORT

An agent is supposed to have personal knowledge about the proposer's health, physical impairments, lifestyle, occupational duties and income. The agent's confidential report furnishes information on all these aspects and also his comments on the reason for insurance and the insurability of the life to be assured. It is also the practice of the insurer to call for **special reports from the designated officials** wherever the sum assured involved is high and the age is advanced.

7.5. UNDERWRITING SET UP

The underwriting or the new business department responsible for underwriting activities works under the leadership of the chief underwriter. The staff under him are trained to have a wide range of knowledge on matters like products sold, the

underwriting philosophy of the company, marketing distribution system and guidelines for underwriting. They are acquainted with medical information about the impact of various diseases on longevity. They need not be physicians as insurability involves not only good health but other factors as well. But every insurer will have an expert panel consisting of medical specialists **(medical referees)** who are appraised of the medical actuarial investigations and the expectations from the life insurance industry. They **guide** the Underwriter of the Insurer in assessing the risk and fixing the premium and also placing clauses and conditions especially in high risk cases.

Two Major Steps

The risk assessment or selection of lives involves two major steps:

1. **Assessing the level of risk that is present:**
   - Deciding whether to accept or decline
   - Fixing the premium payable which would be adequate, equitable and not excessive.
   - Decide whether any specific policy endorsement is necessary.
2. **Complete documentation and set up records for future service and reference.**

7.6. CLASSIFICATION OF RISKS

The Underwriter, by inspecting the risk classifies it under three groups:

1. **Standard lives** insurable at normal premium rates;
2. **Substandard or impaired lives** insurable at higher than normal premium rates; and
3. **Uninsurable lives.**

Standard life is also called First Class Life or Average Life. Standard lives are those who can be accepted at the premium rates published by the Company in the manual given to the field-force for soliciting insurance business. There is no universal definition for it. Each company can have its own norms, which may change also over time.

A company normally has the following assumptions for considering a life assured as a Standard one.

- The life to be assured should be healthy
- Not having any physical deformity
- Without any bad habits
- Not engaged in hazardous avocation/occupation/activities in regular duty or as a hobby
- Not having any past history of ailment/surgery
- Currently not undergoing treatment for any illness
- Not residing in a polluted, hazardous location
- Is of right build

The assumptions may change based on research and experience.

Substandard lives are called **'impaired'** lives and clearly they are 'unhealthy lives'. But it is a relative term. How 'unhealthy' depends upon the long-term prognosis of the impairment. **Prognosis** is the medical term used often in Life Insurance. It means, 'a forecast of the probable course of a disease, especially, of the possibility of the recovery', whereas **diagnosis** is determining the identity of the illness present.

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7.7. RISK AND HAZARD

Hazard is the status of the risk. It is the condition which may create or increase the chance of loss in the risk proposed for coverage. It is the underwriter's role to assess the level of risk by examining the hazards that have an effect on the risk. Hazards come in two forms:

Physical Hazard means the physical characterizes that have effects on the risk. **Moral Hazard** indicates the attitude of the proposer towards the risk. There is a close link between them.

A trained underwriter looks into every proposal and connected papers, inspects the material facts provided therein and checks the hazardous nature of the factors that affect the risk to know whether they are within the underwriting parameters set by the company. Some of these factors, which influence the mortality rate and have a bearing on the level of risk, are discussed below in brief. They are called **'factors of insurability'**.

Age

Age is an important factor which has its impact on the risk. Life Insurance is correlated with age. The date of birth decides many things in Life Insurance like:

1. Whether the proposer is a major or competent to enter into contract
2. Whether the proposer can be given the particular plan and term applied for and the Sum Assured asked for
3. Whether the terms regarding the minimum/maximum entry age/maturity age are complied with
4. Most important – the **premium rate** to be charged.

Besides indicating the life expectancy, age is also a strategic factor in evaluating certain impairments. For instance, underweight has great significance in younger age, and overweight at advanced ages. When certain diseases like diabetics set in young ages, they are considered more serious.

Proof of Age: Insurers always insist upon a proof of age at the time of submission of the proposal itself. Extract from municipal records, school or college certificates, or certified extracts from service records in respect of a proposer employed in government/ quasi government or public sector undertakings are considered to be reliable and called **Standard Age Proofs**.

When such standard proofs are not available, insurers may consider other non-standard age proof and accept them. But certain restrictions regarding Plan, Term, Sum Assured, Maximum Maturity Age are imposed. Exercising caution, the Insurer may sometimes raise up the premium in such cases.

If the age is not admitted at the time of issue of policy, it would be incumbent on the Life Assured to give proof of age as early as possible. There is also a possibility of age proving higher or lower when it is submitted later. The Insurer has the discretion to modify the terms, if there is difference in age. As age is an important material fact, the Insurer has **legal right** to insist upon the age proof before settlement of the claim, if it has not been admitted earlier. If the actual age is very much different from the one admitted on the commencement of risk, and fraudulent intention is proved, the Insurer can also avoid the contract.

Sex

Mortality experience has proved that **females live longer**. Some Insurers charge **lower premium rates for females**. Collaboration with foreign insurers has brought this practice to India also in recent times. But there are other important considerations, like childbirth, and diseases peculiar to the female sex, which the underwriter looks into while assessing the risk on a female life.

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Build

Build includes height, weight and distribution of the weight. Once, the appearance was the sole criteria for selection. A bad build or faulty constitution, with a background of unfavorable family history or history of personal illness may point out increased risk. Degenerative diseases of heart, blood vessels and kidney associated with overweight increase the likelihood of death at all ages. Additional mortality due to overweight is at an **increasing rate in later life**.

Chest girth in relation to height and chest expansion on expiration assumes special importance when one is found underweight. Girth of **abdomen in relation to chest** girth has special significance in overweight cases.

Family History

Longevity of parents, brothers, and sisters is also a factor in assessing the risk. So the age and health position of the living and age at death and cause of death of those who are deceased have to be furnished. These have a bearing on risk especially when the applicant shows signs of cardiovascular diseases or diabetes. The adverse family history is considered more seriously in the case of younger lives. For example, if there are two or more early deaths in the family, below age 60, because of cardiovascular or lung diseases, and the proposer is young, the proposal has to be viewed critically.

Personal History

The current physical condition, the past health record and the lifestyle of the life to be assured are studied from the information given in the **Personal History**. Insurers have developed a standard questionnaire to gather information which has a bearing on the longevity of the proposed insured. If the answer is 'yes' the proposer has to give further details like the nature of illness, whether fully recovered or still under treatment. Hospital reports may be called for. The questionnaire when filled will reveal the past, present illness, chronic or otherwise, any accident in the past, its severity, the degree of permanent impairment, incapacity, absence due to sickness, and habits.

Table 7.1 Personal History – Part of the Proposal

Personal History	*Yes/No*	*If Yes – Give Details*
(*a*) During the last five years did you consult a Medical Practitioner for any ailment requiring treatment for more than a week?		
(*b*) Have you ever been admitted to any hospital or nursing home for general check up, observation, treatment or operation?		
(*c*) Have you remained absent from your place of work on grounds of health during last 5 years?		
(*d*) Are you suffering from or have you ever suffered from ailments pertaining to liver, stomach, heart, lungs, kidney, brain or nervous system?		
(*e*) Are you suffering from or have you ever suffered from diabetes, tuberculosis, high blood pressure, low blood pressure, cancer, epilepsy, hernia, hydrocele, leprosy or any other disease?		
(*f*) Did you ever have any bodily defect or deformity?		
(*g*) Did you ever have any accident or injury?		

(h) Do you use or have you ever used 1. alcoholic drinks 2. narcotics 3. any other drugs 4. tobacco in any form		
(i) What has been your usual state of health?		
(j) Have you required or at present availing/ undergoing medical advice, treatment or tests in connection with Hepatitis B or AIDS related condition?		

Physical Condition – Medical Aspects

Physical condition is a basic and significant factor in the assessment of risk. Besides height and weight, there are other determinants which a competent medical examiner alone can bring out. When such medical information is found to be critical for assessment of risk, the underwriter would require a medical report from the medical examiner authorised for the purpose.

When the person to be insured is presented to him, the medical examiner verifies the identity, inspects the proposal submitted by him, takes measurements like blood pressure pulse rate, etc., and proceeds to examine the important systems of the body. Summing up, he gives his opinion about the **insurability** of the person. Typically, the questionnaire will be as follows:

Table 7.2 A Section of the Medical Report

Has the Proposed Insured Ever had Any Known Indication of or Been Treated for Any Disorder of:	*Yes*	*No*
A. The heart, blood vessels, such as heart murmur, poor circulation, phlebitis, stroke, heart disease, heart attack, angina, chest pain, or high blood pressure?		
B. The chest, lungs, nose, and throat, such as asthma, chronic bronchitis, or emphysema?		
C. The digestive system, including stomach, intestines, gall bladder, liver or pancreas, such as ulcer, colitis, hepatitis, or bleeding?		
D. The kidneys, urinary bladder, reproductive organs, such as sugar, albumin, pus, or blood in urine?		
E. The nervous system, eyes, ears, such as dizziness, seizure, paralysis, mental or nervous disorder, impairment of sight or hearing?		
F. The glandular system, blood such as diabetes, thyroid, anemia, leukemia, disorder of breast or skin?		
G. Acquired Immune Deficiency Syndrome (AIDS), persistent lymph gland enlargement, unusual infections, any other immune system abnormality, or had a positive test related to AIDS?		
H. Musculoskeletal system, such as arthritis, sciatica, amputation, injury, pain or defect of the neck, back, bones, or joints?		
I. Any other illness, disease, operation under observation, taking mentioned above?		
J. Is any individual proposed for coverage currently under observation, taking medication, or receiving treatment?		

The personal history furnished by the proposer, the medical report from the medical examiner and special reports, are studied by the underwriter to verify whether there is any abnormality affecting the expected mortality of the proposed insured. The defects and disabilities, whether chronic or acute, and their bearing on longevity, are enquired into. **Wherever necessary he seeks expert guidance from the medical referees.**

Through experience, study and observation, a keen underwriter develops an ability to sense the possible adverse points, seek additional information and evaluate the risk. In this process, he is helped by the **Numerical Rating System** which makes risk assessment more objective and faster. The system will be discussed later in this chapter.

Mental factors are difficult to assess. Certain mental faculties would have deteriorated because of age or other impairments. Insurers do not have adequate statistical information on the effect of mental factors on health. Yet, they are relevant because persons who are too weak to take care of themselves, with substantial cognitive impairments, are **clearly uninsurable.**

Occupation

There are three kinds of hazards which are common in occupations. Workmen engaged in direct operation in certain industries have **health hazards** due to inhaling of dust, poisonous gases, or contact with chemical toxins. Abnormalities in temperature, exposure to heat, air pressure and radiation or strenuous nature of work itself may also pose health hazards.

Accident is a common hazard in industries like mining, quarrying or construction industries. Occupation may present an **environmental** hazard too. Exposure to irregular living, temptation to use drugs, indulge in excessive liquor may be present in some careers related to the entertainment or amusement industry. Wherever the occupation seems to be hazardous, the underwriter will call for an occupation questionnaire to know the exact nature of duties and make a due assessment of risk.

Thanks to advancements made in safety engineering, industrial medicine, and various safeguards taken now, there is a decline in occupational hazards. The living conditions of the workers have also improved. Due to increased attention given to safe working environment, the extra ratings charged for certain occupations have been reduced or eliminated over the years. Extras charged for certain occupations are also removable when the life assured returns to normal duties.

However, Insurers are careful in considering **additional benefits like disability, accident cover, etc.,** for such occupations and have made provisions to exclude or limit these risks. If the proposer has at the time of proposal any intention to take up an hazardous occupation, the policy is issued subject to a suitable endorsement.

7.8. HABITS, HOBBIES AND AVOCATIONS

Use of tobacco in any form, chewing or smoking or using a pipe is considered as a hazardous habit. Studies have proved that smoking and use of tobacco leads to higher mortality. They also aggravate many other health problems. Most Insurers treat tobacco users as substandard group and verify the extent of use of tobacco and their impact on their health, by putting the applicants to a Nicotine Test. Insurers are cautious in this respect, as they want to know not only the present use of tobacco, but also whether they used in the past and discontinued, as the damage might have already been caused to their health.

Insurers also seek information about the habit of using **intoxicating beverages and drugs**. Moderate use of alcohol is considered normal. But moderate consumption of alcohol or use of tobacco may tend to be only partial

information revealed in the proposal. If it is later found that heavy use led to the death, and the claim is disputed, the courts may question why Insurers did not investigate at the time of underwriting itself when the claimant takes a stand that the use of tobacco and drugs has already been mentioned. It is legally considered as waiver by the Insurer. So, wherever such habits are mentioned, **even as moderate or mild,** the insurer has to be cautious in treating such cases as standard.

Resorting to **hazardous sports and avocations** in their leisure time may be a hobby for some people. Activities like mountain climbing, car racing, gliding, sky diving are some such hobbies. They present increased mortality due to additional hazard. Insurers charge extra in such cases or endorse with conditions excluding risk of death resulting from the involvement of the hazardous activity.

Race, Nationality, Residence, Travel and other Factors .

In the past, Insurers considered other socio-economic and geographical risk factors also in assessing the risk. Today, they are ignored, and the rates are the same for all the residents in the country as a whole. It is true that there are variations in mortality within a country or region due to factors like climate, standard of public health, style of living, medical facilities, etc. A recent study made in the United States, by the Harvard University, found a wide range in the life expectancy among the Americans, the highest being 91 years in New Jersey and the lowest 58 years among natives of South Dakota. The study was based on race, location, population density, per capita income and homicide rates. The study found that Asian American women in America have a high life expectancy of 86.7 years.

In India too, there is a wide variation in mortality rates depending upon geographical location. As per a study published by the Ministry of Health, Government of India, the life expectancy in India varied from 59 (males – Assam) to 75 (females – Kerala) years. But Insurers in their underwriting do not go by the race, residence or region with the hope that their effect in selection will be taken care when the Inured are in large numbers covering all states. So the policies are now issued free from restrictions as to travel and residence.

War and Aviation

When the nation is at war, impending or actual, war risks are normally excluded. Insurers insert a war clause in their contracts which are typically cancelled at the end of the war period. In case of death due to hostilities between the nations only the premium will be refunded. The purpose of the war clause is to **control adverse selection.**

In practice, the defence personnel are issued policies without payment of extra premium, except for such categories in the Army like paratroopers, gliders, mine sweepers, mine layers, navy working in submarine, etc., where special questionnaires are obtained, risk assessed, and appropriate extra premiums are collected or conditions imposed.

The flight for paying passengers in a regularly scheduled plane flying between established airports is not considered as hazardous and no extra is charged. But flying in a commercial or private aircraft is considered as more risky. Personnel engaged in military flying and civil and commercial flying are treated on the basis of the duties they have to attend.

7.9. FINANCIAL UNDERWRITING

Financial Status, as evidenced by the proposer's present income, source of income and permanency of such income is also a strategic factor in underwriting. It

is verified primarily to find out the motivation for the proposed insurance. **The need for insurance, the proposed beneficiary, the estimated economic value of the person, the amount of insurance requested, its relation to income** are looked into to rule out that the purchase is not speculative.

Insurers do not have any uniform formula or rigid rules to follow in respect of financial underwriting. In practice Underwriters have a **factor table** to guide them in financial underwriting in ordinary cases. The Sum Assured is determined by multiplying the proposer's annual income by a factor that is a function of age. The following are certain parameters followed generally by insurance companies:

Table 7.3 Parameters Allowed by Insurance Companies

Age	*Total Insurance*
18-35	20 times of the annual income
36-50	15 times of the annual income
51-60	10 times of the annual income
61 and above	On merit

The existing insurance is also taken into account, while deciding the maximum insurance that can be granted. The above formula is only a **guideline and not a fixed standard**.

While a smart insurance salesperson relates the sum proposed to the proposer's HLV and NEEDS, the underwriter reconciles with the age and other risk factors. How much premium a person can afford is another determinant. Ten percent of income may be the threshold and the underwriter can consider premium up to thirty percent as affordable.

When the proposer wishes to take out insurance on other lives more stringent criteria is followed. In such cases the Insurer would like to know the insurable interest, the purpose of insurance and the extent of the economic loss the proposer may suffer in case of early death of the life proposed.

The law gives unlimited insurable interest on one's own life. But the Insurers consider factors like financial status, need for insurance and dependency while deciding the maximum Sum Assured that can be allowed. The insurer is also concerned about the **conservation of business**. When the premium is affordable and reasonably related to the income, there is more likelihood that the policy is kept in force and not lapsed. This leads us to a discussion on Moral Hazard.

Moral Hazard

In addition to the precaution taken in limiting the sum assured to one's capacity to pay the premium and the need for insurance, the insurer will check other aspects also to rule out Moral Hazard. Unlike physical hazard, moral hazard relates to mental attitude and behaviour of the proposer. It arises when the **likelihood of distorting information** by the proposer is suspected. Such distortion may range from a **deliberate fraud** to make undue gain on death, to a suppression of information fearing harassment by enquiries by the Insurer. Disclosure of certain personal family particulars may be considered by some as embarrassment.

Besides the Insurance disproportionate to the Income, the following **situations** will put the Insurer on guard against Moral Hazard.

Insurance at Advanced Age

The insurable value and the need for insurance vary with the life cycle. As the age advances the concern for protection from early death comes down. Unless the

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individual has large assets and there is need to provide liquid assets to clear tax and other obligations on death, high insurance cover at older age is considered as indicating moral hazard and it has to be underwritten with caution by the Insurer.

Insurance on Female Lives and Children

When proposals are made on female lives without independent income and there is no apparent need for insurance (like tax benefit) moral hazard is not ruled out especially when large sums are applied for. The Sum Assured when granted will be related to the insurance cover the husband has on his own life. Similarly, the insurer consider covers for children, provided the parents have suitable insurance programme and all children are insured to comparable amounts.

Outstation Party

There is a possibility of Moral Hazard when a proposer is medically examined at a place other than his usual place of residence. It is possible that the proposer wants to avoid the medical examiner in his area who is aware of the adverse health conditions of the proposer.

Nominee not Nearest Dependent

Moral Hazard is suspected when the policy monies are payable to a person who is not the nearest dependent of the life to be insured. The beneficiary mentioned may be financing the policy. There is also a possibility that the insurance itself a contributing factor in insured's death.

Moral Hazard Reports

When the amount proposed is large or the proposer is in advanced age, it is the practice of the insurers to collect Moral Hazard Reports from their own designated officers to verify the genuineness of the need and to rule out Moral Hazard. When Moral Hazard is suspected as present, no amount of extra premium can be sufficient to meet the hazard. It has to be **rejected** outright.

7.10. RATING METHODS

When the underwriting information about the proposer has been collected, they are **evaluated** to find whether the risk is **acceptable,** conforming to the **standard risk** or to be treated as **substandard** or **declined**. In a few cases, it is also postponed so that the condition or impairment is settled. The system adopted by the company should enable the underwriter to measure the risk as accurately as possible and assess the **combined effects,** when more than one problem is present. The procedure should be **equitable** and also **simple** and **not expensive** to work upon.

Judgment Rating

The life insurance industry was for a long time depending on the judgment method in evaluating risk. Each risk exposure was individually evaluated and the rating was decided by the underwriter's judgment. Medical experts, Actuaries and departmental people used to apply their collective wisdom and experience and decide when the cases are complex and more unfavorable factors are present. This method even today is applied in marine insurance when risks are diverse and also in case of health insurance underwriting. This method tends to be subjective and also time consuming. To obviate these drawbacks, the industry evolved comparatively a more scientific method of appraisal called **Numerical Rating System.**

Numerical Rating System

The collective investigation made by medical societies who had special interest in life insurance and the actuaries in USA and other countries led to the mobilisation of valuable data which formed the basis of their Numerical Rating System. Various factors of insurability, the impact of each of these factors on longevity and their combined effects were all studied. Values were assigned to each of these factors and to their effect when two or more factors were interrelated. **Average mortality is taken as 100%. Debit points are given to unfavorable factors and credit points to favorable factors**. Combining the points the net rate is arrived at. The rate over 100 is termed as **Extra Mortality Rate** (EMR). Insurers have comprehensive handbooks called **Rating Manuals**. These are frequently updated and kept strictly confidential. Extra mortality classes are formed with specified ranges for each group. In most insurance companies, the ratings range from 75 to as high as 500. Ratings within 75-125 are considered as standard. A proposal which involves a rate in excess of the standard limit is treated as substandard and **appropriate rating up of premium** is done depending upon the classification into which EMR falls or declined.

The systematic procedure used in this Rating System is based on two assumptions:

- The **hypothesis of unchanging mortality** which means the Extra Mortality Rate (EMR) for a given impairment **continues to be the same** during the entire duration of policy.
- **The addition of specific Rates of Extra Mortality Rates,** which takes it as a simple rule that when there is more than one impairment the total extra mortality rate of the said risk is the **sum total of extra mortality ratings of the separate impairments**. In underwriting parlance this is called Lyndquists's Rule.

In practice, the insurance has to **modify** the assumption taking into account the **interaction of various impairments co-existing**. In some cases the ratings may be increased further. (For example, heart murmur associated with raised BP and overweight where the combined effect will have more impact on mortality). The net rating may also come down due to the presence of some favorable factors. A keen underwriter will have the demographic and socio-economic factors also in his mind while assessing a risk. Due weight is also given to the competence of the medical examiner and the agent.

So, judgment may still have its influence on rating, though the subjective factor is minimized in the Numerical Rating System. This system has enabled the underwriter to evolve a uniform procedure for assessment, faster underwriting and building up of new statistics for continuous review of the method.

The Company's **'underwriting philosophy'** has its effect on assessment of risk. A company may position itself to sell more Whole Life or Term Assurances policies from the very young age or its marketing may be focused on selling Unit Linked Policies where the risk cover may not be much. A company may sell more micro insurance in rural areas or concentrate on marketing high premium plans for the urban elite. The underwriting philosophy may vary accordingly. When the company is able to accumulate faster reserves in its policies and is able to avoid adverse selection, it can venture more in its evaluation of risk assessment in the competitive environment.

Professionalism in Selling: The agent, as the first line marketing intermediary is always considered as the **'Primary Underwriter'** in life insurance. He should be a competent professional with a high degree of knowledge. While presenting the proper plan to meet the identified needs of the proposer, he should not encourage any adverse selection, but follow the code of ethics in selling. Such a competent and knowledgeable agency force will make the job of the underwriter easier. Insurers encourage such agents by providing them guidelines for their 'field underwriting'.

Use of Computers in Underwriting: Information Technology and the use of computers have greatly helped the insurers in their underwriting. Answers to various queries in the proposal and the data available in the allied documents (medical reports, etc.) become the inputs for the computers. The computer in effect does the normal underwriting in most of the cases and the underwriter just reviews and confirms the decisions. Programmes are developed to evaluate various disorders and suggest further requirements necessary to make a final assessment. The electronic underwriting has made the assessment, quick, consistent and inexpensive.

Rating Substandard Lives: Generally, the numerical ratings up to 125 are considered as **normal** and these lives have to pay the scheduled premium published in promotion literature. They are called 'first class', 'average', and 'normal' or 'standard' lives. Others are placed in the appropriate classes in accordance with the extra numerical ratings. Such lives are offered modified terms of acceptance. They include:

Flat Extra Premium: When the extra mortality as measured by the system seems to be constant, independent of age, a **constant extra** premium is charged to compensate the additional expected mortality. The method suits well when the occupation or avocation is hazardous and when the proposer has certain physical defects or deformities. Specific **standard extras** for certain impairments are even made available along with the scheduled rates of premium. Such extras may be levied throughout the term or charged for certain initial years and removed thereafter.

Extra Percentage of Premium: A special Mortality Ratings Table is developed for each substandard class which takes into account the incidence and the intensity of risk depending on the important factor of age. The premium is quoted including the **extra percentage** given in the Table. The insurer may also vary the extra premium according to the type of plan.

Restrictive Clause: The other method of treatment of a substandard life is to **limit the death benefits** under certain circumstances. If the death occurs due to a specified hazard (For example, hazardous occupation, pregnancy), death benefit may only be equal to the refund of premiums paid. Charging extra premium is avoided.

Restrictive Lien: This is the method where the death benefit is graded, with the amount payable increasing each year after a fixed period and reaching the full death benefits at the end of the restrictive term. This method is called **Decreasing Lien Method.** For example, a decreasing lien of ₹ 500 per 1000 Sum Assured for 10 years would mean that in the first year, the death benefit would be only ₹ 500. In the second year, the death benefit would be reduced by ₹ 450 (₹ 550 is payable) and so on and at the end of 10 years, the lien would become Nil and thereafter, the full Sum Assured (₹ 1000) is payable as death benefits. This method is more appropriate when underwriter feels that the extra mortality will wear off after certain years warranting no extra premium.

Modification of Coverage: The Underwriter after evaluation of risk may offer a different and more limited form of coverage. The limitation may be a lower Sum Assured, shorter period or a different plan even. If the applicant agrees to the modifications, the policy is issued.

Postponement – Rejection. When the applicant is in the period of convalescence or the risk presented is not a settled one (losing much weight in the near past) the insurer may postpone the consideration for a short period.

When the risk fails to meet the norms of the insurer even at the extreme substandard level, it is **declined.** The insurers keep a track of the declined cases to keep away their reentry by manipulation in future.

Insurance on Female Lives – Underwriting Aspects

Underwriting risks on female lives has its history. Considering the social, economic and other factors and lack of adequate medical attention to women folk in India, it was the general practice among Indian insurers to charge an extra premium for female lives. In addition a lien was also imposed for some initial years. In 1956, when life insurance was nationalised, LIC of India, as a progressive measure, chose to liberalise the conditions. The experience was shocking. There was a spurt in early claims where female lives were involved. Though the general mortality rate among women was lighter, the experience of mortality among insured women was found to be higher due to the presence of **moral hazard**. So, LIC had to reframe the conditions for accepting female lives and re-impose certain restrictions. With the improvement in the experience there has been steady liberalisation of underwriting of female lives by the Corporation.

The general approach of the present insurers in selection of female lives is governed by the following factors:

- The element of **replacement of earning capacity**—the life insurance considered as substitution of economic power
- The **need for insurance**
- The **special risks** involved in female lives
- The **financial and moral hazard**
- The **socio economic background** of the proposer.

In the national scene women are emerging as equal partners. There has been a fast growth in the employment of women especially in the service sector. In general, they have a greater longevity than men. Insurance consciousness among them has also very much improved. So the insurers today, have a duty to consider female lives on equitable terms.

Broadly, female lives are grouped under following segments while considering insurance:

Women with earned income, by virtue of employment in institutions or from professions such as doctors, lawyers, chartered accountants, architects, etc., are considered at par with men. Amount of maximum insurance and other conditions are the same as applicable as in the case of men. Certain insurers also have the practice of charging lower premium to the lives belonging to this sector.

Women with unearned income from investments or property constitute the other segment which has a strong desire to have life insurance to save income tax and also as a measure of wealth management. In such cases, insurers insist on authentic proof to show their income for the last three years to decide the maximum insurance that can be given to those lives.

Married Women-Housewives: Insurers were very cautious in insuring these lives as they do not have their own income and due to the involvement of moral hazard. They insisted on adequate insurance of the husband as a pre-requisite. Today the role of the housewife is not confined to core domestic duties alone. She is helpful to her children in their educational pursuits, assists her husband in his business endeavors and engages in various activities and their 'economic value' cannot be under estimated. So, the insurers are quite liberal now in considering their cases provided there is enough income in the family to support the premium.

There are **self-employed women** like vegetable vendors, fisherwomen, agricultural laborers, milk-maids, etc., regularly employed or marginally employed. Insurers consider cover on their lives on certain approved plans and up to a maximum limit fixed by them.

At present insurance to **pregnant ladies** is not allowed during their advanced pregnancy – say after twenty four weeks of pregnancy. Plans with higher elements

of term assurance may not be considered. Proposals from pregnant ladies with past history of complications would be accepted with a single extra or with lien or restrictive clause limiting the risk covered.

A **widow** earning her own livelihood desirous of insuring for the protection of her children may be regarded as eligible for insurance.

Insurance on Minor/Major Children – Juvenile Insurance

A life insurance policy on the life of a child can be issued on the application of a parent or a person responsible for the support of the child. Underwriters impose some restrictions.

Deferred Risk Plans are issued from a very young age, with risk commencing at a later age, say, 7 years. They are subject to the insurance on parents and adequacy of income. A limited amount is also allowed on the young children without insisting on insurance on the parents' lives. There are medical requirements up to a maximum limit of insurance fixed by the insurer and up to a certain age. Where the sum assured is high or when the application indicates that the child has a health problem, the coverage may be subject to medical examination or a report from the child's physician at the commencement or at the deferred date when the risk commences.

Risk premium plans are allowed to boys and girls whose age nearer birth day is 12 years and more (as per the common practice) subject to the following conditions:

- The life to be assured should have a properly developed physique.
- Family history, personal history of health and medical reports are satisfactory.
- Sum Assured should not exceed insurance on parents, lives and subject to adequacy of their income. A limited amount may be considered without insisting insurance on parents.
- In cases of **major children,** (aged 18 and above and below 25) with no income of their own but dependent on their parents for financing the policy, adequate insurance on parents' lives would be insisted upon. Underwriters would consider whether all the children in the family are similarly insured.

Children's Plans may include **premium waiver benefit,** which assures waiving payment of premiums if the applicant dies (parent) prior to the attainment of age, say 18, the vesting age under the policy. For this benefit the underwriter would require evidence of insurability of the applicant and charge modest additional premium.

Insurance for Handicapped

Proposals on the lives of persons with physical impairments (handicapped persons) are considered only when they are **gainfully employed,** have adequate income of their own and sufficient precautions are taken to avoid accidents. The physically handicapped persons are classified into various groups depending upon the description of the deformity due to congenital defect or accident or underlying diseases. A special questionnaire (deformity questionnaire) is called for. Minor impairments like loss of fingers etc., are ignored and **no extra** for impairment is charged, provided the impairment will not, in any way, affect the normal movement and the policy is issued at standard rates. Other proposals are considered with suitable extra premiums and with certain restrictions.

7.11. NON-MEDICAL UNDERWRITING

Today, substantial new business is done under Non-Medical Scheme. Non-Medical does not mean waiving medical information. It only denotes that the physical examination of the proposed by an authorised medical examiner is dispensed with. Medically related questions are sought from the applicant and also from the field worker. Experimented first by United Kingdom towards the end of the nineteenth century, the concept stood

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the test of time and the limits have been gradually increased. In USA, one company has raised the limits even to $1 million.

There are many reasons for accepting proposals under the Non-Medical Scheme. The first motivation was the experience which revealed that hardly **less than 10% of the medically examined cases brought out adverse features**. This percentage is still less, especially when life insurance is sold actually in the 'prime market', viz., within the age group of 21-45 years. By dispensing with medical examination for such identified groups the insurers can **save the expenses**. The fees payable to the medical examiners will be substantially reduced. Even the slight increase in the claims can be compensated by the savings in medical fees and other expenses.

There is a **shortage of medical examiners especially in rural areas** and the insurers find it difficult to have a wide network of medical examiners. Insurers are able to avoid this problem and facilitate large scale selling of insurance through non medical underwriting.

Safeguards

Insurers have safeguards to see that mostly standard lives are covered under this scheme. Besides getting a proposal with additional questions and detailed report forms from the field workers, insurers also impose certain restrictions. Non-Medical Insurance is not available beyond certain age (35 years). In special circumstances, like professionals and salaried employees of government public sector or reputed concerns it may extend up to 45 years. Other safeguards include **limitations or restrictions on maximum term, Sum Assured, maturity age, type of plan, etc.** In the case of any adverse information as found in the proposal or report from the field workers, the Insurers can always call for medical examination for considering the risk. Companies also have 'sample checking' system to see that the scheme is not misused.

Documentation

When the Underwriter decides to accept the risk, the next step is to 'assume' the risk. It is done by accepting the deposit amount already received as the first premium under the policy. In view of Section 64 VB of the Insurance Act, 1938, the risk of the insurance company commences only on the payment of the premium. A contract cannot be valid and complete without consideration. The premium in an insurance contract is acknowledged as consideration and issue of premium receipt signifies commencement of risk. **The First Premium Receipt** gives particulars of the Policy No., Date of Commencement of Risk, Plan and Term, Premium Mode, etc., and also the next due date for the premium.

Proposal is the **basis** of the contract. When the contract is finalised, the policy is issued as an **evidence** of the contract. It is the underwriter's job to see that the life insurance policy is issued according to the terms accepted.

IRDA has issued instructions on the matters to be stated in the Life Insurance Policy. As it is an evidence of a long term contract, the particulars should be clearly and correctly stated to avoid any misinterpretation in future.

A Life Insurance Policy consists of the following parts:

(*a*) **The Heading**	The name and address of the Insurer – its corporate office – issuing office.
(*b*) **The Preamble**	The intention of the parties to the contract. Proposal is taken as the basis of contract. The Insurer acknowledges the receipt of the first premium.
(*c*) **The Operative Clause**	The mutual obligations and responsibilities are stated here. The Policy holder has to pay the pre-

mium and the Insurer agrees to pay the benefits on the contingency provided the conditions are satisfied.

(*d*) **The Proviso** — The conditions and privileges related to the contract are enclosed and endorsements which are part of the contract are appended.

(*e*) **The Schedule** — Address of the Policy holder. Details of the Contract, the Policy No., Sum Assured, Riders, Date of commencement, Plan and Term, Age, Premium Mode, Date of Maturity, To whom the amount is payable. Special Conditions, etc., are given.

(*f*) **The Attestation** — Stamped and signed on behalf of the Insurer.

The IRDA regulations state that while sending the policy document to the Insured, the Insurer should allow 15 days' **free look period/cooling off period**. The Insured, he/has when disagrees with the terms and conditions of the policy, has the option to return the policy and claim refund of the premium paid, subject only to deduction of a proportionate risk premium for the period of cover and the expenses incurred by the Insurer on medical examination of the proposed and stamp duty charges.

SUMMARY

- Underwriting is the process of risk assessment. The insurability of a risk, the level of risk, the premium adequate to meet the risk and other terms and conditions necessary to assume the risk are decided by studying the factors of insurability as provided in the proposal, medical report, agent's report and other allied forms. Among the methods of underwriting, Numerical Rating is scientific and found practically more useful. Risks are graded and insurable. risks are accepted with appropriate premium and conditions. Acceptance leads to commencement of risk and documentation. In assessment of risk the proposal serves as the basis and the policy issued is the evidence to the agreed terms.

REVIEW QUESTIONS

1. What is meant by 'underwriting? How the term evolved and got its present meaning?
2. What is the objective of risk assessment?
3. What do you understand by the following terms?
   (*i*) Extra Mortality Rate
   (*ii*) Occupational Hazard
   (*iii*) Adverse selection
   (*iv*) Standard age proof
   (*v*) Underwriting philosophy.
4. Describe briefly the operations of Numerical Rating System.
5. Distinguish between Lien and Restrictive Clause.
6. Discuss the legal issues involved in scrutiny of a proposal.
7. Write a short note on the factors affecting the insurability.
8. What are the sources available to an underwriter?
9. How the Moral Hazard is assumed? Explain briefly the types of cases where moral hazard is suspected?
10. Explain the usual safeguards adopted under Non-Medical Scheme.
11. Discuss the treatment given to substandard lives.
12. How an underwriter categorises female lives and consider their proposals?

13. What are the restrictions generally imposed while underwriting lives on children?
14. Explain the various aspects of a policy document.
15. Discuss the need for financial underwriting.

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CASE STUDY

COMMENCEMENT OF RISK – UNCONCLUDED CONTRACT – CASE APPLICATIONS

Case 1

Mr. AKD aged 47 years, on 31 March 2000, submitted a proposal for ₹ 20 lakh and paid ₹ 84,110 as initial deposit towards half yearly premium. He suddenly expired on 7-6-2000. On the claim being made, the wife of the deceased was informed that the contract was unconcluded and the legal heirs were entitled to get the refund of the deposit amount only.

The Insurer contended that the medical reports submitted along with the proposal revealed that the health of the deceased was substandard and their higher office, after verifying the reports proposed to give insurance provided the proposer was ready to pay ₹ 27 per 1000 Sum Assured as extra premium. This was informed to the proposer when he visited the office on 2-6-2000 to enquire about the proposal. He submitted a request to the insurer to consider a fresh policy under Endowment for a term of 10 years and quote the terms. Within 5 days he died.

The general rule is that the contract of insurance will be concluded only when the party to whom an offer has been made accepts it unconditionally and communicates his acceptance to the person making the offer. Whether the final acceptance is that of assured or insurers however depends simply on the way in which negotiations for insurance have progressed.

Case 2

Mr. N submitted a proposal for ₹ 10000 and a life insurance policy with the date of commencement as 28-9-1973 was issued. The premium installments were payable in half yearly mode in March and September. The premium was initially fixed at ₹ 329.10; however because of loss of teeth, the rate of premium was increased by 2% extra so as to make a total of ₹ 339.10, half yearly. This was mentioned in the policy. Subsequently, amounts of ₹ 329.10 were paid to the insurer in respect of the installments falling due up to September 1974. Each time the insurer accepted the amounts.

It was open to the insurer to have refused to accept the payment of premium installment if it was deficient, but the amount of ₹ 329.10 was accepted and the insured was accommodated by allowing him time to make the deficiency good.

Mr. N expired on 8-12-1974. Can the insurer deny the claim on the ground that inasmuch as the premium paid is deficit, the insurer is not bound to pay the claim?

Discussion

What are the underwriting issues involved?

How and what steps can be taken to avoid such unpleasant litigation in future?

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ANNEXURE I

Indian Assured Lives Mortality (1994-96) (modified) Ultimate

Age	Mortality rate	Age	Mortality rate
0	0.001630	33	0.001246
1	0.000960	34	0.001308
2	0.000670	35	0.001387
3	0.000620	36	0.001482
4	0.000470	37	0.001593
5	0.000420	38	0.001721
6	0.000380	39	0.001865
7	0.000400	40	0.002053
8	0.000400	41	0.002247
9	0.000400	42	0.002418
10	0.000380	43	0.002602
11	0.000450	44	0.002832
12	0.000530	45	0.003110
13	0.000650	46	0.003438
14	0.000713	47	0.003816
15	0.000770	48	0.004243
16	0.000823	49	0.004719
17	0.000873	50	0.005244
18	0.000919	51	0.005819
19	0.000961	52	0.006443
20	0.000999	53	0.007116
21	0.001033	54	0.007839
22	0.001063	55	0.008611
23	0.001090	56	0.009433
24	0.001113	57	0.010294
25	0.001132	58	0.011025
26	0.001147	59	0.011951
27	0.001159	60	0.013073
28	0.001166	61	0.014391
29	0.001170	62	0.015904
30	0.001170	63	0.017612
31	0.001171	64	0.019516
32	0.001201	65	0.021615
66	0.022724	83	0.139067
67	0.025617	84	0.151077
68	0.028823	85	0.162298
69	O.032372	86	0.174149
70	0.036294	87	0.186638
71	0.040623	88	0.199775

Age	Mortality rate	Age	Mortality rate
72	0.045392	89	0.213560
73	0.050639	90	0.227995
74	0.056404	91	0.243072
75	0.062728	92	0.258782
76	0.069655	93	0.275109
77	O.077231	94	0.292031
78	0.085502	95	0.309522
79	0.094519	96	0.327549
80	0.104331	97	0.346073
81	0.114992	98	0.365052
82	0.126553	99	0.384436

Source: IRDA Annual Report. For discussion on Mortality Table ref. Chapter 2, 8 and 9.

Mortality Rates of Annuitants in LIC of India, LIC A (96-98) Ultimate

Age	Mortality Rate	Life Expectation	Age	Mortality Rate	Life Expectation
20	0.000919	57.45	42	0.002053	36.70
21	0.000961	56.50	43	0.002247	35.77
22	0.000999	55-56	44	0.002418	34.85
23	0.001033	54.61	45	0.002602	33.93
24	0.001063	53.67	46	0.002832	33.02
25	0.001090	52.72	47	0.003110	32.11
26	0.001113	51.78	48	0.003438	31.21
27	0.001132	50.84	49	0.003816	30.32
28	0.001147	49.89	50	0.004243	29.43
29	0.001159	48.95	51	0.004719	28.56
30	0.001166	48.01	52	0.005386	27.69
31	0.001170	47.06	53	0.006058	26.84
32	0.001170	46.12	54	0.006730	26.00
33	0.001171	45.17	55	0.007401	25.17
34	0.001201	44.22	56	0.008069	24.35
35	0.001246	43.28	57	0.008710	23.55
36	0.001308	42.33	58	0.009397	22.75
37	0.001387	41.38	59	0.010130	21.96
38	0.001482	40.44	60	0.010907	21.18
39	0.001593	39.50	61	0.011721	20.41
40	0.001721	38.56	62	0.011750	19.64
41	0.001865	37.63	63	0.012120	18.87

NOTES

Age	Mortality Rate	Life Expectation	Age	Mortality Rate	Life Expectation
64	0.012833	18.10	88	0.132652	5.28
65	0.013889	17.33	89	0.141924	5.01
66	0.015286	16.56	90	0.151539	4.76
67	0.017026	15.81	91	0.161495	4.52
68	0.019109	15.08	92	0.171794	4.29
69	0.021534	14.36	93	0.182436	4.07
70	0.024301	13.67	94	0.193419	3.87
71	0.027410	12.99	95	0.204746	3.68
72	0.030862	12.35	96	0.216414	3.50
73	0.034656	11.72	97	0.228425	3.33
74	0.038793	11.13	98	0.240778	3.17
75	0.043272	10.56	99	0.253473	3.01
76	0.048093	10.01	100	0.266511	2.86
77	0.053257	9.49	101	0.279892	2.72
78	0.058763	9.00	102	0.293614	2.59
79	0.064611	8.53	103	0.307679	2.46
80	0.070802	8.08	104	0.322087	2.33
81	0.077335	7.66	105	0.336836	2.19
82	0.084210	7.26	106	0.351928	2.05
83	0.091428	6.88	107	0.367363	1.89
84	0.098988	6.52	108	0.383139	1.70
85	0.106891	6.19	109	0.399258	1.45
86	0.115136	5.87	110	0.415720	1.08
87	0.123723	5.56			

NOTES

ANNEXURE II

A MODEL PROPOSAL FORM

BRANCH OFFICE:..... DIVISION:.....

[.....FOR OFFICE USE ONLY.....]

PROPOSAL NO.	:	INWARD NO.	: .....
IDENTITY NO.	:	DT. OF RECEIPT	: .....
POLICY NO. ALLOTTED	:	AGENCY CODE	: .....
NO. OF UNITS ALLOTTED	:	DEV. OFFICER'S CODE	: .....
AMOUNT PAID	:	IS AGENCY INFORCE?	: .....
AMOUNT PAID ON	:	AGENCY INFORCE UPTO	: .....
TRANSACTION NO./DATE	:	IS LICENCE INFORCE?	: .....
CASHIER'S INITIAL	:	LICENCE INFORCE UPTO	: .....

ALL ANSWERS TO BE FILLED IN BLOCK LETTERS. ANSWERS MUST BE GIVEN IN WORDS/ STROKES OF PEN OR DOTS WILL NOT BE ACCEPTED AS REPLIES.

AMOUNT PAID BY CASH/CHEQUE/DD:
DRAWN ON;

(NAME & ADDRESS OF THE BANK) ..... BANK DRAFT/CHEQUE NO.: .....

AMOUNT: ₹ ..... (IN WORDS) ₹ .....

1. (*a*) (*i*) NAME IN FULL OF LIFE TO BE ASSURED : .....

(*ii*) IF MINOR, NAME OF THE PROPOSER : .....

(*iii*) RELATIONSHIP WITH THE LIFE TO BE ASSURED : .....

(*b*) (*i*) ADDRESS (FOR COMMUNICATION) : .....

TEL. NO. : ..... E-MAIL ADD : .....

Proof Submitted : .....

(*ii*) PERMANENT ADDRESS : .....

(*c*) NOMINEE'S DETAILS

NAME : ..... DATE OF BIRTH/AGE : .....

RELATIONSHIP WITH LIFE TO BE ASSURED: .....

ADDRESS : .....

(*d*) APPOINTEE (IF NOMINEE IS MINOR) : .....

NAME : ..... DATE OF BIRTH/AGE : .....

RELATIONSHIP WITH NOMINEE : .....

ADDRESS : .....

NOTES

2. PLAN DETAILS

MODE OF PREMIUM PAYMENT: SINGLE PREMIUM/YEARLY/HALF-YEARLY/ QUARTERLY

(*a*) SUM ASSURED UNDER BASIC PLAN : ₹ ..... (in words)

₹ .....

(*b*) ACCIDENT BENEFIT SUM ASSURED : ₹ .....

(*c*) CRITICAL ILLNESS RIDER SUM ASSURED : ₹ .....

(*e*) FUND SELECTED BOND/SECURED/BALANCED/GROWTH FUND (See information below)

INVESTMENT PATTERN OF THE FUNDS

Fund Type	*Investment in Government/Government Guaranteed Securities/ Corporate Debt*	*Short-term investments such as money market instruments (including Govt. Sec & Corporate Debt)*	*Investment in Listed Equity Shares*	*Details and objective of the fund for risk/return*
Bond Fund	Not less than 80%	100%	Nil	Low risk
Secured Fund	Not less than 65%	Not more than 85%	Not less than 15% and not more than 35%	Steady income – Lower to Medium risk
Balanced Fund	Not less than 50%	Not more than 70%	Not less than 30% and not more than 50%	Balanced income and growth - Medium risk
Growth Fund	Not less than 20%	Not more than 40%	Not less than 60% and not more than 80%	Long term Capital growth—High risk

(*f*) OTHER DETAILS:

PLAN NO.	DOB OF LIFE ASSURED	AGE	TERM	MODE	AGE PROOF

OCCUPATION	ANNUAL INCOME	SOURCES OF INCOME	SEX

RURAL/URBAN	FIRST/SUBSEQUENT

NOTES

DISTRICT	TALUKA	VILLAGE

3. DETAILS OF EXISTING POLICIES INCLUDING UNIT-LINKED POLICIES (INCLUDING POLICIES SURRENDERED/LAPSED DURING LAST 3 YEARS)

POL. NO.	INSURANCE COMPANIES FROM WHERE THE PREVIOUS POLICY/ POLICIES HAVE BEEN PURCHASED WITH ADDRESS (IF PREVIOUS POLICIES ARE FROM LIC OF INDIA, GIVEN NAME OF BRANCH D.O.)	TABLE AND TERM	SUM ASSU-RED ON MAIN PLAN	TERM ASSUR-ANCE RIDER SUM ASSURED	CRITICAL ILLNESS RIDER SUM ASSU-RED	MODE	AMOUNT OF ACCIDENT BENEFIT TAKEN	YEAR OF ISSUE	WHETHER ACCEPTED AS PROPO-SED AT ORDINARY RATES IF NOT THE TERM OF ACCEPTANCE	MEDICAL OR NON-MEDICAL	WHETHER INFORCE FOR FULL SUM ASSURED	IF NOT, GIVE DUE DATE OF LAST PREMIUM PAID OR DATE OF SURREN-DER

4. (*a*) HAS ANY POLICY ON LA'S LIFE LAPSED OR SURRENDERED DURING THE LAST 3 YEARS?

   (*b*) HAS A LIFE INSURANCE PROPOSAL ON THE UFE OF LIFE TO BE ASSURED EVER BEEN

   (*i*) WITHDRAWN/DEFERRED/DROPPED/DECLINED : YES/NO

   (*ii*) ACCEPTED WITH EXTRA PREMIUM OR LEIN : YES/NO

   (*iii*) ACCEPTED ON TERMS OTHERWISE THAN THOSE PROPOSED : YES/NO

5. FAMILY HISTORY

MEMBER	LIVING		DEAD		
	PRESENT AGE	STATE OF HEALTH	YEAR OF DEATH	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS					
SISTERS					
WIFE/HUSBAND					
CHILDREN					

NOTES

6. PERSONAL STATEMENT REGARDING HEALTH OF LIFE TO BE ASSURED

Personal history	Answer 'Yes' or 'No'	If 'Yes' give full details
(*a*) During the last 5 years did you consult a Medical Practitioner for any ailment requiring treatment for more than a week?		
(*b*) Have you ever been admitted to any hospital or nursing home for general check up, observation, treatment or operation?		
(*c*) Have you remained absent from place of work on grounds of health during the last 5 years?		
(*d*) Are you suffering from or have you ever suffered from ailments pertaining to Liver, Stomach, Heart, Lungs, Kidney, Brain or Nervous system?		
(*e*) Are you suffering from or have you ever suffered from Diabetes, Tuberculosis, High Blood Pressure, Cancer, Epilepsy, Hernia, Leprosy or any other disease ?		
(*f*) Do you have bodily defect or deformity?		
(*g*) Did you ever have any accident or injury?		
(*h*) Do you use or have ever used (1) Alcoholic drinks: (2) Narcotics: (3) Any other drugs: (4) Tobacco, in any form:		
(*i*) What has been your usual, state of health?		
(*j*) Have you ever received or at present awaiting/undergoing medical advice/ treatment or tests in connection with Hepatitis B or AIDS related condition?		
(*k*) Are you wearing glasses? If so, power of glasses:		
(*l*) (*a*) Missing teeth if any, if so number missing (*b*) Are you wearing well fitting denture? If so, for how many teeth?		

7. PHYSICAL MEASUREMENTS OF LIFE TO BE ASSURED (IN CASE OF NON-MEDICAL): Ht.(in cms.) ..... Wt.(in kg.) .....

8. TO BE ANSWERED IF LIFE TO BE ASSURED IS A MARRIED FEMALE:

(A) Are you pregnant now?	Date of fast delivery	Have you had any abortion or miscarriage or Caesarean section? If so, give details.	Date of last Menstruation

(B) Husband's Full Name	His Occupation	His Annual Income

(C) Details of Husband's Insurance:				
POLICY NO.	INSURANCE COMPANIES FROM WHERE THE PREVIOUS POLICY/ POLICIES HAVE BEEN PURCHASED WITH ADDRESS (IF PREVIOUS POLICIES ARE FROM LIC OF INDIA, GIVEN NAME OF BRANCH/D.O.)	SUM ASSURED	TABLE AND TERM	PRESENT STATUS OF THE POLICY

9. WHETHER THE TERMS AND CONDITIONS OF THE PROPOSED PLAN HAVE BEEN EXPLAINED TO YOU BY THE AGENT

   YES/NO

10. HAVE YOU UNDERSTOOD FULLY THE TERMS AND CONDITIONS OF THE PLAN YOU PROPOSE TO TAKE?

    YES/NO

11. DO YOU AGREE THAT ON ATTAINMENT OF AGE OF MAJORITY BY THE LIFE TO BE ASSURED, THE POLICY WILL VEST IN HIM ABSOLUTELY? (Applicable in case of life to be assured is minor)

    YES/NO

NOTES

DECLARATION

I _____ the proposer/the person whose life is herein before being proposed to be assured, do here by declare that the foregoing statements and answers have been given by me after fully understanding the questions and the same are true and complete in every particular and that I have not withheld any information and I do hereby agree and declare that these statements and this declaration shall be the basis of the contract of assurance between me and the ABC Insurance Corporation of India and that if any untrue averment be contained therein the said contract shall be absolutely null and void and all moneys which shall have been paid in respect thereof shall stand forfeited to the Corporation.

Notwithstanding the provision of any law, usage, custom or convention for the time being in force prohibiting any doctor, hospital and/or employer from divulging any knowledge or information about me concerning my health or employment on the grounds of secrecy, I, my heirs, executors, administrators and assignees or any other person or persons, having interest of any kind whatsoever in the policy contract issued to me, hereby agree that such authority, having such knowledge or information, shall at any time be at liberty to divulge any such knowledge or information to the Corporation.

And I further agree that if after the date of submission of the proposal but before the issue of the First Premium Receipt (*i*) any change in my occupation or any adverse circumstances connected with my financial position or the general health of myself or (*ii*) if a proposal for assurance or an application for revival of policy on my life made to any office of the Corporation or with any other life insurer is withdrawn or dropped, deferred or accepted at an increased premium or subject to a lien or on terms other than as proposed I shall forthwith intimate the same to the Corporation in writing to reconsider the terms of acceptance of assurance. Any omission on my part to do so shall render this assurance invalid and all moneys which shall have been paid in respect thereof shall stand forfeited to the Corporation.

I hereby give my consent for undergoing medical examinations/tests including test for HIV as required by the Corporation.

I further declare that I have discussed my financial standing with the agent/intermediary.

I have been informed about the risk profile of the ULIP plan(s) and fund(s). In consultation with the agent/ intermediary, I have taken a personal and independent decision in an informed manner to go for the Plan and Fund which I have chosen.

I understand that if I have deposited 'application money' as a token consideration under this proposal for insurance, the closing NAV of the date of completion only will be applied for allotment of units.

Dated at ..... on the ..... day of 200

Signature of Witness

Name .....

Occupation .....

Address .....

.....

Signature or Thumb impression of the person whose life is proposed to be assured or the proposer (if different from the life to be assured). When life to be assured is a minor, Proposer's signature is required.

In case form is filled up/signed in a language different from that of the Proposal Form:

Declaration by the person filling in the form:

"I hereby declare that I have fully explained the above questions to the proposer / the Life to be Assured in ..... language and I have truthfully recorded the answer given by the proposer / Life to be assured."

Name of the Declarant: ..... Signature: .....

Address of the Declarant: .....

.....

.....

Declaration by the Proposer/Life to be assured:

"I certify that the contents of the form and documents have been fully explained to me, by Mr/Ms: ..... and I have understood the significance of the proposed contract.

Signature or thumb impression of the person whose life is proposed to be assured or the Proposer:

.....

In case the Proposer and/or the Life to be assured is/are illiterate, the thumb impressions of the Proposer / Life to be assured should be attested by a person of standing whose identity can easily be established, but unconnected with the Corporation and this declaration should be made by him/ her.

"I hereby declare that I have fully explained the above questions and contents of the proposal form to the proposer / life to be assured in ..... language, and that the proposer / life to be assured has affixed his / her thumb impression above after fully understanding the contents thereof."

Name of the Declarant: ..... Signature: .....

Address of the Declarant: .....

.....

.....

DECLARATION BY PARENT/GUARDIAN (IN CASE LIFE TO BE ASSURED IS A MINOR)

"With reference to the proposal for ₹ ..... on the life of my son/daughter, I hereby agree and undertake that if under the policy that may be issued, any payment is received by me by way of surrender, partial withdrawal or for any other reasons whatsoever before the policy has vested in life assured, I shall utilize the moneys hereby received for the benefit of the minor or his estate".

Signature of Parent/Guardian: .....

Signature of witness: .....

Name: .....

Occupation: .....

Address: .....

NOTES

SUMMARY OF SECTION 45 OF INSURANCE ACT, 1938

No policy of life insurance shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policyholder and that the policyholder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose.

Note: "Material" shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the Corporation.

Insurance Act 1938 under Section 41

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept in rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.

Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the Insurance agent satisfies the prescribed conditions establishing that he is a bonafide Insurance Agent employed by the insurer.

(2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

N.B. Rebate of premiums shall be allowed only in accordance with the details given in the prospectus or table; of premium rates or, as the case may be, the relevant document, and that an offer or acceptance of any other rebates shall be an offence under Section 41 of the Insurance Act, 1938.

For Medical Cases only

"I certify that the Proposer has signed/Put his/her thumb impression in my presence, after admitting that all the answers to Questions Nos. 6 and onwards of this form have been correctly recorded."

_____

Signature or Thumb impression of the Life Proposed

N.B. Signature or thumb impression should be Affixed in the presence of Medical Examiner.

_____

(Signature of the Medical Examiner)

Model: Agents Report/Moral Hazard Report

Branch : ..... Date of Expiry : .....

Licence No. : ..... Proposal No. : .....

Agent's Code Number and Name : .....

Particulars of Club Membership : .....

Name of Life to be Assured : ..... Age : ..... Sum Proposed: .....

Name of the Proposer : ..... Age: .....

(If Life Assured is minor)

Occupation of Life to be assured/Proposer :

1. (*a*) How long to you know the life to be assured / Proposer? :
   (*b*) Are you related to him/her ? If so, give details
   (*c*) What is Educational Qualification of Life to be assured/Proposer
2. (*i*) Give details of income of Life to be assured/Proposer :
   (*ii*) What income proof is verified by you for details in (*i*) above?
3. (*i*) What is the General State of Health of Life to be Assured :
   (*ii*) Does the Life Assured has any physical deformity / impairment?
   (*iii*) Do you have any knowledge of life to be assured having suffered from any illness or undergone operation hospitalization or medical investigation?
4. Did you discuss with life to be Assured the status of previous policies and are you satisfied that no policy has lapsed in last 3 years?
5. Are you aware of any proposal (or revival of any policy) of life to be assured having deferred, declined, dropped, accepted with extra?
6. Are you aware of anything in occupation, financial/Social position of proposer his/her habits or any other circumstances which might likely to add to the risk?
7. (*a*) Mark of identification of Life to be Assured: .....
   (*b*) Physical Measurements : Height (in cm): ..... Weight (in kg): .....

I hereby declare that the foregoing statements are true and correct to the best of my knowledge and belief.

Dated at ..... on the ..... day of .....

Agent's Signature and Stamp

To be filled by Sales Supervisor/Marketing Official

I am satisfied with the identity of the party and on the basis of my independent enquires, I hereby declare that the foregoing statements are true to the best of my knowledge and belief.

Dated at ..... on the ..... day of .....

Name and Designation: ..... Signature .....

NOTES

NOTES

ABC INSURANCE CORPORATION OF INDIA LTD

XYZ-Risk cum Savings Policy (with Profits) (with Accident Benefit)

ABC Insurance Corporation of India Ltd having received a Proposal and Declaration and the first premium from the Proposer and the Life Assured named in the Schedule and the said Proposal and Declaration with the statements contained and referred to therein having been agreed to by the said proposer and the Corporation as basis of this assurance do by this policy agree, in consideration of and subject to the due receipt of the subsequent Premiums as set out in the Schedule, to pay the Sum assured together with such further sum as may be allocated by way of Bonus, but without interest at the office of the Corporation where this policy is serviced to the person or persons to whom the same is payable in terms of the said Schedule, on proof to the satisfaction of the Corporation of the Sum Assured having become payable as set out in the Schedule, of the title of the said person or persons claiming payment and of the correctness of the age of the Life Assured stated in the Proposal if not previously admitted.

And it is hereby declared that this Policy of Assurance shall be subject to the Conditions and Privileges printed on the back hereof, and that the following Schedule and every endorsement placed on the Policy by the Corporation shall be deemed part of the Policy.

Divisional Office Schedule Branch Office

Policy No. Date of Commencement	Table and Premium Paying Term	Sum Assured ₹	Due date and Mode of Payment	Instalment Premium Payable ₹	Proposal No. & Date

Nominee under Section 39 of the Insurance Act, 1938	Date of Birth
Name and Address of Proposer and Life Assured	Age of Life Assured
	Whether Age Admitted
	Date of Last Payment

Payment to be made and events on the happening of which they are to be made.	1. On Life Assured surviving the premium paying term	Sum Assured together with accrued bonus
	2. On life Assured's death before the end of the stipulated Premium Paying Term	Sum Assured together with accrued bonus
	3. On Life Assured's death after the end of the stipulated Premium Payment Term	Sum Assured
To Whom Sum Assured Payable	The Proposer or his Assigns or Nominees under Section 39 of the Insurance Act, or Proving Executors or Administrators or other legal Representatives who should take out representation to his Estate or limited to the moneys payable under this Policy from any Court of any State or Territory of the Union of India.	
Period during which premium payable	Till the stipulated date of Last Payment or previous death of the Life Assured.	
Dates when premium payable	On the stipulated due date in	
Special Provisions		

Signed on behalf of the Corporation at the above mentioned Branch Office.

Date

Examined Authorised Signatory

8

PRICING IN LIFE INSURANCE PREMIUM SETTING

NOTES

STRUCTURE

The Premium is the price paid for the risk undertaken by the Insurers. Legally speaking, it is the **consideration** that moves from the proposer to the insurer in exchange for their promise to pay the Sum Assured on the happening of the contingent event. It has been defined as **'price paid adequate to the risk'** in a court case (Lucena vs Crawfurd). From the underwriter's point of view, it is the **contribution** which should be **equitable and commensurate with the risk** the insured brings into the pool of risk. IRDA stipulates that it should be **fair,** to be certified so by the Actuary who designs the insurance product. No doubt, the consumer thinks that the premium is the **cost** he pays which should be commensurate with the **value** received.

What is an adequate, fair and equitable premium?

The premium to be charged under a Life Insurance Contribution depends on the following factors:

1. The rate of mortality—the probability of the insured event occurring.
2. Expected yield on the investment mix.
3. Operational Expenses—Taxes, Selling, Issuing, Maintaining the policy.
4. Loading to cover for contingencies like rate of inflation, profit margin, etc.
5. Assumption on withdrawals/lapses.
6. Additional loading in the case of guaranteed additions/with profit policies.
7. The benefits pattern promised under the plan.

The possibility of event occurring is ascertained from the **Mortality Tables,** which show the probabilities of death at designated ages. **Morbidity Tables** show probabilities on critical illness, disability, accidents, etc. These tables serve as the main basis for construction of premium rates for life and health insurance.

8.1. MORTALITY TABLE—RISK PREMIUM

In India, the Oriental Insurance Company started its mortality investigations periodically from the year 1897 onwards. Their table relating to the period 1925-35 was considered as more reliable and adopted by LIC with modifications. LIC of India had their own investigations, five times, since 1956. Their latest study relating to the period 1994-96 is in current use. The mortality rates, as shown in that table, for certain ages are given in Table 8.1.

Table 8.1

Age	Mortality Rate
20	0.00100
30	0.00117
40	0.00205
50	0.00524
60	0.01307

The mortality rate for age 30 is shown as 0.00117. It means if there are 1,00,000 people aged 30, out of them 117 may die during the year before they reach 31 years of age. So if all the 1,00,000 persons aged 30 are insured for ₹ 1,00,000 each, an insurer would expect to pay 117 death claims in this group for a total claim payment of ₹ 1,17,00,000. The insurer can collect ₹ 117 from each of them and pay the claims from this pool.

The contribution of ₹ 117 each for one lakh cover (₹ 1.17 for ₹ 1000 Sum Assured) is **just adequate to cover the risk for the group.** This is called **Risk Premium** - the premium to cover one year risk under Term Assurance where **only death benefit** is assured. The risk premium is assessed just by multiplying the sum assured with mortality factor. For example, 1000 × 0.00117 = ₹ 1.17 for 1000 Sum Assured. For an endowment type of policy, where the maturity value as a living benefit is also assured, additional amount as the investment component is built in the premium.

IRDA vide their Regulations 5 (Assets, Liabilities and Solvency Margin of Insurers) made it clear that unless the insurer has constructed a separate table based on his own experience made available through the efforts of Actuarial Society of India, with the concurrence of the Authority (IRDA), mortality rates/morbidity rates prescribed by them have to be used. Accordingly LIC (1994-96) Ultimate Table and LIC (1996-98) Annuitants' Table are prescribed for computing rates on life insurance and annuity products respectively.

There is no morbidity table on the Indian experience. Life insurers use the tables provided by the Re Insurers with adjustments wherever necessary. Now, on the request of IRDA, the Actuarial Society of India has suggested a standard table to be used which has been communicated by IRDA to all insurers for pricing critical illness assurance as a stand alone product or as a rider.

Interest Earned—Pure or Net Premium

Premium is collected in the beginning of the year - **in advance.** The claim payments are spread over the entire period of one year. Assuming that all the claims are paid at the end of the year (though unrealistic), the insurer need not have ₹ 1,17,00,000 at the beginning of the year. If the insurer is able to earn interest at 5% an amount of ₹ 1,11,420 would be adequate, to be invested in the beginning of the year (the present value at 5% being 0.95238) to pay the claims. To the extent of the **expected interest earnings,** the premium charged is now **reduced.** The premium so arrived is called **Pure or Net Premium.**

Loading—Office Premium

In bringing people having homogeneous risk together to pool their risks and share the claim cost, the insurer has to incur **expenses - marketing and policy maintenance expenses.**

Marketing and other expenses for procuring business, namely commission and remuneration in respect of the policy are very heavy and take away substantial portion of the first year premium.

Policy maintenance expenses depend the manner in which they are analysed by the insurer, as fixed and variable expenses and as premium related or policy related expenses. Ex commission payable is related to the premium; medical fees and stamp fees relate to the size of the policy. Administrative expenses depend on number of policies. The cost of sending a premium notice is the same whether the sum assured is ₹ 1 lakh or ₹ 1 crore.

Besides the cost involved in procuring and maintaining the policy, the insurer has to provide for **unexpected contingencies, inflation, etc.** A reasonable allowance for **profit** to the stakeholders of the company has also to be made. When these amounts are added to the net rate the insurer arrives at **Office Premium**.

This premium is further tuned depending upon the mode preferred by the company - yearly or quarterly. The premium so adjusted is the **Tabular Premium**. It is expressed as **annual premium — for ₹ 1000 Sum Assured for the designated age** and given in the promotional literature.

Level Premium

The illustration given is for one year Term Assurance. When the survivors in the group move to the next year, they have to pay higher premium as the risk is increased. Life Insurance is taken for longer terms. As the premium increases every year, the policy holders may feel it more burdensome at some stage and tend to discontinue. Among the policy holders, who discontinue, more will be in good health. Those in poor health have reason and motivation to continue. This results in **adverse selection**. The population left with the insurer is not the same for which the mortality rates are assumed. Thus the calculation will go awry and the claims not manageable.

Further, charging different premiums every year may also be expensive and difficult to administer. Single premium payable in the beginning of the term can be one solution. But it is not popular. This has led to the concept of **Level Premium,** *i.e.* charging the same premium throughout the term. The **natural premium** payable every year, as described above, is adjusted for the interest earned and other factors and **uniform premium** is computed. It is the mathematical equivalent of the increasing yearly renewable term premiums for the same period. **As a result, the premiums paid in the early years will be more than adequate to settle the claims and less than adequate in the later years.** The excess paid in the early years accumulates in the **Life Fund** with interest and at any point, this amount along with future premiums would be **sufficient** to enable the insurer to pay death claims that may arise in the remaining period.

Benefit Pattern—Term and Endowment Plans

The basic premium will vary according to the payment benefits and privileges assured under the Plan. The Term Assurance is the cheapest as it extends death benefit only. The Term Assurance with return of premiums will have higher premium rate to enable the insurer to return an amount equivalent to the premiums received on survival of the term.

In Endowment Assurance, which is more common, the Sum Assured is payable on death during the term and also on maturity when the policy holder survives the term. In such cases, the premium will have **two components,** one for the 'Term' aspect and the second for the 'Endowment' aspect termed as savings element. This part can also called as 'Pure Endowment Component'.

Most of the plans are combinations of Pure Endowment and Term Assurance in varying degrees. The premium charged is according to the **benefits delivered** under these two types. Under Endowment type of plans (also in Whole Life Plans) reserves accumulate, due to level premium system and savings element. This enables the insurer to grant loans against such reserve value and also offer surrender value when the

contract is terminated after a minimum period. So, the premium is more in these cases corresponding to the benefits. It is still higher in Money Back type of plans where the survival benefits are settled in quick installments.

For products with an investment component, pricing includes assumption about the investment growth. **Longer the span** the premium money is invested the **larger the sum grows.** Investment earnings have a much greater impact on long term products like whole life insurance, than short term products.

The life insurance premium may have a **bundled or unbundled** structure. Bundled premium is a pricing structure where the insurer presents the product as a package of benefits for a specified premium. Unbundled means is disclosing to the customer the breakdown of the various components of the premium - as in the case of Unit Linked Plan.

Guaranteed Additions and Participating Policies

Innovative products introduced by the insurers include plans offering guaranteed additions to the Sum Assured. These additions are paid along with the Survival Benefits or on death. The addition will be at a predetermined rate of ₹ X per Thousand for Sum Assured for every year elapsed. Participating Insurance Policies (called With Profits in India) give policy holders the right to share in the surplus fund. This distributable surplus is paid to policy holders as bonus every year after valuation. The insurer has to provide specific allowances in the premium for including guaranteed additions or bonus as additional benefits.

Withdrawals/Terminations—Their Effect

The level premium is charged with the assumption that the policy will run its full term, if the contingency not intervening. The insurer has heavy marketing and other policy issue expenses, in the first year, which are spread over the full term. So if the premium is stopped it is a loss to the insurer also. People having good health only may drop, while those with bad health may continue, resulting in adverse selection. So the insurer takes into account the possibility of lapses and their effect also while fixing the premium.

Fair Premium—IRDA Stipulations

The IRDA Notification stipulates that when insurers wish to introduce a product, they should mention in the application (to IRDA) clearly the **'Pricing Assumptions'** and show how premiums are arrived at. They must also cover the relevant areas discussed above. In the case of Unit Linked Policies expenses/charges relating to allocation, fund management, administration, switching off, withdrawals also have to be stated. The premium table for the particular plan has to be submitted to IRDA and also be available in the website. The appointed Actuary should certify that premium tables are workable, and sound, and **'the assumptions are reasonable and premium rates are fair.'**

Valuation

The practice of charging level premium, we discussed, creates excess fund in the earlier years, which with interest earned on it along with future premiums **should be** able to meet the future liabilities. So it is necessary for the insurer to verify at any given point of time, whether the excess is sufficient to clear the estimated liability in the future. The process of such verification is called **valuation.** It enables the insurer to see whether he is **solvent** or not. It is an actuarial process involving complex calculations evolved by actuarial science. IRDA requires insurance companies to make valuations as on 31 March **every year.**

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All the premiums received by the insurer are held as a fund. The amounts are invested as per norms by the insurer. The fund mainly consists of the premium income and the interest income on its investment. Out of this is paid are claims and expenses. The balance fund held by the insurer is called **Life Fund** of the company.

Surplus - Bonus

The insurer assumes a certain rate of interest, rate of morality and expenses while charging the premium. There are also other assumptions like taxes, inflation rate, etc. Valuation verifies the actual experience with these assumptions and expectations. If the experience is found to be favourable, the fund will show a **surplus**.

The insurer also collects more premium from the with profit policy holders, which has to be invested and returned to the policy holders as additions to their sum assured. The insurer is required to maintain **separate** funds, in respect of participating and non-participating policies. Separate valuations have to be made annually in respect of these funds. The insurer has to distribute not less than **90% of the surplus,** arising out of the with profits policy holders fund to those with profits policy holders. The law stipulates that not more than 10% of the surplus of this fund can be distributed to the share holders.

Distribution of Bonus

The valuation surplus so accrued is distributed by declaring bonus for the with profit policies. The bonus may be **simple and reversionary** as ₹ 'ex' per thousand sum assured attached or vested to the sum assured payable either on death or maturity. Every year, when the bonus is declared it is added to the sum assured. This is a popular method, called Simple and Reversionary.

In a **compound and reversionary** system the bonus will be added to the existing sum assured including bonus attached to it earlier and the rate per bonus will be calculated on this amount inclusive of existing vested bonuses. Some insurers use the surplus to offer cash value of bonus or reduce the premium continuously as and when the bonuses are declared every year.

Insurers insist on a minimum period to pass from the commencement before adding bonus. The bonus rates may also vary, taking into the **type of plan,** (Whole Life, Endowment, Money Back, etc.) term and sum assured. The present trend is to give guaranteed additions during the first five years and then declare and add bonus from the sixth year onwards.

Final Additional Bonus

A one time bonus called **Final Additional Bonus** or Terminal or Loyalty bonus is chosen by insurers to provide incentive to policy holders to continue their policies. It is paid as an additional sum on maturity. The death claim may also be eligible for it if the policy has been kept in force for a long time, say 15 years and more.

Interim Bonus

Bonus is declared for the policies which are in the books of the insurer as on the date of valuation. But valuation takes time, three to six months to complete. Policies which were on the books on the date of valuation are also eligible for bonus additions. For such policies interim bonus is given normally, not necessarily at the rate of bonus declared in the previous valuation.

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SUMMARY

- Premium is the consideration paid by the insured. Mortality, interest, expenses and some more factors are considered in setting the premium. Level premium is the uniform premium charged, and found convenient to both the insured and insurer. It results in creating a reserve under the policy. Office premium is given in the promotional literature. All the premiums are received by the insurer in Life Fund. Valuation is done every year and the surplus is distributed as bonus. The insurer has to distribute not less than **90% of the surpluses,** arising out of the with-profits policy holders' fund to those with-profits policy holders. Interim bonus is given for the policies which become eligible in the inter valuation period.

REVIEW QUESTIONS

1. How is a net premium is different from a risk premium?
2. The possibility of lapse also an influence in computing the premium. Discuss.
3. Level premium is advantageous to the insured and the insurer. Elaborate.
4. How does a surplus arise? How is an interim bonus/final additional bonus justified?

9

DISTRIBUTION CHANNEL MARKETING INTERMEDIARIES

STRUCTURE

The world over, insurance is sold and not bought. Insurance which are compulsory under law are few exceptions. Between the insurer and the buyers there are a number of intermediaries performing the functions of spreading the awareness about insurance and bringing large sections of people under insurance coverage. As distribution is the 'key' to insurance penetration, IRDA has introduced a variety of intermediaries to work as per their regulations and guidelines. They are called Agents, Corporate Agents and Brokers. The list is expanding. This set of marketing intermediaries, helping the insurers in fulfilling their objectives of reaching out to various market segments, is called the **distribution channel.**

9.1. AGENTS

Traditionally, **tied agency** is the **preferred** mode of distribution for selling life insurance. The company which has branches all over the country will attract local people to become their agents. The agents will be selected from various segments in society and thus the company will be able to cover entire sections of the society.

Insurance is a complex product, **intangible in nature,** which is basically a 'promise' by the insurer to cover the contingent event. So, eventually it requires personal selling effort, an interaction with the prospect, creating **confidence** and trust in his mind. A study by the Life Insurance Marketing and Research Association (LIMRA), conducted amongst 27 million US households, indicated that 76 per cent would prefer to buy insurance **only after face-to-face discussion** with an intermediary.

As it is a long term contract, the assured also desires **after sales personal service**. Though the reputation of the insurance company and the nature of the product are determining factors, the **influence of the agent,** leads to the ultimate decision in buying insurance. Hence the insurance companies found the arrangement of having local individuals as their representatives ideal and adequate to market their products. Today's scenario is changing. Corporate bodies and institutions are also in the field as agents to help the insurer tap the extensive potential.

Insurance agent, as per Insurance Act 1938 is a 'person licensed under the Act to solicit or procure insurance business which includes servicing the policies for their renewal or revival'. The agent works for commission as remuneration. The remuneration pattern and the agent's right to receive renewal and even hereditary commission on fulfilling certain conditions have also been provided under law. The Act under its section 42 has provisions to deal with the **licensing, appointment** and other matters relating to agents.

IRDA has framed and issued IRDA (Licensing of Insurance Agents/Licensing of Corporate Agents) Regulations stipulating **minimum educational qualifications, training,** etc., to be complied with while enrolling agents and also a **code of conduct** to be observed by the agents. The aim is to create a **competent field force with financial integrity,** which can endeavor to sell insurance on the basis of needs and assure efficient servicing to the policyholders.

Licensing of Agents — Important Provisions

The applicant for insurance can be an individual, or a firm, company, bank, cooperative society, panchayat or local authority, Non Government Organisation or any other organisation approved by IRDA. The agent who is not an individual is called a **corporate agent.** In terms of these provisions a license will **not be** issued if the person

- Has not completed 18 years of age, is a minor.
- Found to be of unsound mind.
- Found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or an abetment of or attempt to commit any such offence.
- Found guilty of or knowingly participating in or conniving at any fraud, dishonesty or misrepresentation against an insurer or insured.

Further the person (individual or corporate insurance executive), **must.**

- Have passed at least 12th standard for appointment—in area with a population of 5000 or more, and 10th standard - in other areas (considered as rural) ; and
- Have undergone training in an institution approved by IRDA for at least 50 hours and passed the test conducted by the Insurance Institute of India or any other body recognised by IRDA.

An agent can work for **one insurance company—Life or Non-Life.** An agent can choose one life and one non-life company to work for. Such an agent is called a **Composite Agent.** The applicant who wants to become a composite agent has to complete 75 hours of training. There are relaxations in training for those who are qualified in certain specialised areas of study.

The **license** is issued by the designated persons of the companies authorised by IRDA. The license is issued on behalf of IRDA and is valid for **three years.** The fee charged is ₹ 250. It has to be **renewed every three years.** If it is not renewed the agent will lose his right to do further business.

Code of Conduct

The IRDA Regulations have also provided a code of conduct for the agents while soliciting insurance and servicing their policies. Briefly they are:

Dos

An agent shall:

- Always carry the **identity card** issued by the company and introduce himself as the agent of the company. A copy of the license should be with him to be shown if demanded.

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- Disclose the scale of commission **if asked for.**
- Disseminate information on the range of products of his company.
- Take into account the prospect's needs and suggest suitable product.
- Indicate the correct premium.
- Explain the nature of questions in the proposal form and the importance of disclosing material information.
- Make all enquiries about the proposer and submit his Confidential Report.
- Communicate acceptance or rejection of the proposal by the company.
- Secure and submit to the company the documents required..
- Ensure the premiums are remitted in time and nomination is kept up to date.

Don'ts

An Agent shall not:

- Solicit or procure insurance business without holding a valid license.
- Induce a prospect to submit wrong information.
- Offer different policy terms other than quoted in the promotional literature.
- Interfere with any proposal introduced by any other agent.
- Cause the termination of an existing policy to effect a new proposal.
- Demand or receive any share from the beneficiary for the service rendered.
- Behave in a discourteous manner.

After opening of the insurance sector and establishing IRDA, different categories among agents have been approved/revived.

Chief Agent

Section 2(5A) of the amended Insurance Act has reintroduced and approved 'chief agent' as a person not being a salaried employee of an insurer, who in consideration of commission -

- Performs any administrative function for the insurer and
- Procures life insurance business for the insurer by employing or causing to be employed, insurance agents on behalf of the insurer

Special Agent

Section 2(17) has approved a 'special agent' as one who procures life insurance business for the insurer, in consideration of commission, whether wholly or in part by employing or causing to be employed insurance agents on behalf of the insurer. He is not authorised to do any administrative function.

Special Agents can work in the life insurance business, **not in the general business.**

Corporate Agents

Corporate Agency is a valuable addition to the intermediaries in insurance. It enables the insurer to take advantage of the presence of a large number of firms, corporations, societies, etc., who are in contact with people in the normal discharge of their activities and utilize their presence and services for canvassing insurance products. Through the corporate agents the insurer can get quick access to certain business segments and sell to high net worth individuals and increase their market share.

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The corporate agents who have a vast client base and know their minds and have earned their confidence can sell suitable products. They may find it fits well with the other financial services they extend to their customers. From the customer's point of view better advice about the products and better service may be available to them from the corporate agents who look more professional.

The word 'corporate' does not mean that the agency is 'impersonal' in nature. Under the corporate agency also only individuals solicit business, but they do it on behalf of their organisations after getting trained and appointed as in the case of individual agents. Corporate agents are also tied with one life and/or with one non-life insurer. The commission within the overall limit prescribed in law is paid to the corporate agency and it is upto the agency to reward the persons representing them.

The concept of **Corporate Agency** was introduced in IRDA Regulations (Licensing of Insurance Agents) 2000 and the scope was further widened and more specific provisions for corporate agents were stipulated under IRDA (Licensing of Corporate Agents) Regulations 2002. IRDA came out with another set of instructions in July 2005 in order to streamline the system of appointment of corporate agents and highlight the need to sell insurance contracts, which are highly technical in nature, only through people **approved by IRDA** found to be competent for that purpose. The provisions include:

- Companies, Firms, Banks, Co-operative Societies, Panchayats, NGOs, Micro lending institutions and Non-banking finance companies (or any other organisation, on getting approval from IRDA) can be appointed as corporate agents.
- The applicant for corporate agency should normally be an organisation whose principal business is other than distribution of insurance products. Insurance distribution should be a subsidiary activity.
- Organisation wanting to be the corporate agent should have soliciting and procuring insurance as one of its objectives in their basic business documents.
- In exceptional cases, granting corporate agency can be considered for exclusively doing insurance distribution. Such an organisation should be a public limited company with a minimum capital base of ₹ 15 lakh and should be owned/managed by insurance professionals.
- They have to nominate their partner (in the case of a firm), director (in the case of a company), or one or more of their officers or employees as corporate insurance executive/s satisfying the qualifications set out in the regulations. This **insurance executive** would be required to undergo the training and pass the test as in the case of individual agents. The license in their case will be issued at the corporate level of the company by a person specially designated for that purpose.
- To utilise their presence in various areas and segments and procure insurance business, this chief corporate insurance executive can have **'specified persons'** to work under him. They should have the minimum qualifications like the individual agents, attend the training and pass the test. They will be given certificates instead of licenses at the cost ₹ 500.
- The chief insurance executive and other specified persons should be whole time employees and at least one of them should have insurance qualifications. No other persons like 'referral providers', 'lead generators', etc., are involved in soliciting and procuring insurance business.
- A corporate agency can work for one life and one non-life company. The manner of their working should clearly indicate that they are representing the

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insurance company who appointed them. When the agency's relationship with the insurer is terminated, the corporate agent can enter into an agreement with any other insurer after getting approval from IRDA.

- The commission paid should be within the framework given in law and no extra premium should be paid nor extra collected from the proposer.
- The corporate agents have to observe the code of conduct like other individual agents. Not more than 50 per cent of premium of total premium shall come from one person/one organisation/one group.
- Every corporate agent should furnish periodical statistics about the business done, audited accounts and any other data stipulated by IRDA to their insurer.
- These provisions and other instructions given in the circular are meant to ensure that only qualified and competent people sell the insurance products in the market.

9.2. BROKERS

Introduction of brokers is a new experience in India. While the concept has been there for a long time it was only in October 2000 that Broker as an alternative mode of distribution was approved by IRDA through their Regulations.

Brokers are customer focused and place their clients' interest uppermost. They acquaint with the risk management philosophy of their client, familiarise with their business and suggest appropriate insurance cover and terms. As they are authorised to do business with **more than one insurer,** they can negotiate for the most beneficial pricing and terms. To the insurer they provide the required underwriting information to make a proper assessment of risk. They also assist in paying premiums and settling claims. They do a host of other services related to insurance consultancy and risk management. They receive their remuneration from the insurer.

IRDA Regulations provide for three kinds of Brokers. The **Direct Broker** is authorised to canvass business and place the same with insurers, on terms that are standard or negotiated. He can deal with **both life and general insurance**. The **Re Insurance broker** is authorised to place reinsurance business of clients who are **insurers,** with **reinsurers**. The **Composite broker** is authorised to handle both direct and reinsurance business as well. The Composite broker is expected to have more data base on reinsurance covers available internationally and information including the solvency ratings of reinsurers. The Regulations provide:

- An individual, a firm, a company, a co-operative society or any other person recognised by IRDA can act as an insurance broker.
- The applicant must have necessary **infrastructure**—office space, equipment, trained manpower, etc. Among the employees at least two of them should have necessary qualifications to conduct insurance business.
- The applicant must satisfy the **capital/deposit requirements** which vary with the type of the broker. The requirement of capital is ₹ 50 lakh for a direct broker, ₹ 200 lakh for a reinsurance broker and ₹ 250 lakh for a composite broker.
- The broker has to appoint a Principal Officer, who is responsible to conducting the affairs of the broking company in a professional manner and as per rules laid down by IRDA. He must be a whole-time employee serving as an interface between the customer and the insurer and a link between the Regulator and the broking company. The Principal Officer would have undergone 100 hours' training and passed the test conducted by the National Insurance Academy or any other institution approved by IRDA.

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- The fees payable for the license is ₹ 25000 for a direct broker, ₹ 75000 for a reinsurance broker and ₹ 125000 for a composite broker. The license is valid for three years, to be renewable on payment of fees depending on the remuneration received during the preceding year.
- The broker should abide by the code of conduct laid down by IRDA.
- The broker must take out a Professional Indemnity cover.
- Audited accounts have to be maintained and submitted to IRDA.

IRDA has powers to inspect the premise, cause investigation on complaints and if found warranted can suspend/cancel the license.

The broker is expected to work with utmost good faith, care and diligence, keep the information about the clients confidential, avoid conflict of interest and be ethical in their transactions.

9.3. BANCASSURANCE

Banks have now been approved to distribute insurance products and is becoming increasingly popular as an alternative channel. The term Bancassurance covers a wider spectrum of insurance activities. Bancassurance had its origins in France where the concept first emerged in the 1970s. It is now deeply rooted in Europe, especially in France, Spain, Belgium, and Italy where banks distribute more than 50 per cent of the life insurance policies sold. In Asia, it is gaining momentum in Malaysia, Taiwan, Indonesia and Singapore.

Bancassurance works broadly on the following models:

Corporate Agency: Product of an insurance company distributed by a bank as corporate agent by the bank staff (not more than one Life insurance company and not more than one General insurance company).

Referral Arrangement: A bank allows agents/marketing staff of insurance companies to use their database/infrastructure for selling insurance products.

Joint Ventures: A bank and an insurance company enter into a strategic alliance and form an insurance company with risk participation by both.

Brokerage: Selling the insurance product of more than one life insurance company or more than one non-life insurance company by a bank.

In India, the issuance of government notification under Banking Regulation Act (1949) for banks to undertake distribution of insurance products paved the way for bancassurance. The IRDA notification on Corporate Agency Regulations in October 2002 allowed banks to act as a corporate agents, of one life insurance company and one general insurance company.

Indian banks have a vast network of branches across the length and breadth of the country. There are more than 65000 branches in India and deposits with banks constitute 50 per cent of domestic savings in India. Given the vast potential available through banks, insurance companies are varying with each other in involving banks including Grameen banks functioning in remote villages, in insurance marketing.

Most of the bancassurance relationship in India started with a 'referral' type arrangement, where bank staff provide leads to an insurance company marketing team, in return for which the banks receive fees. Today, the system of corporate agency has become popular with the banks. Insurers have now tie-ups with a large number of public sector, private sector and foreign banks to have access to various geographical regions and customer segments.

At present RBI allows the banks (including subsidiaries, state, district, urban and even non-banking financial companies) to act as insurance agents on fee basis subject to eligibility criteria mentioned in the circulars. As corporate agents they are governed by IRDA rules. Referral arrangement with banks in life insurance has also been approved by IRDA (vide their circular dated 14-2-2003) where there is no relationship as an agent. IRDA has stipulated the scales of referral fee payable in such cases.

9.4. MICRO INSURANCE AGENTS

A new class of agents called micro insurance agents is arriving on the scene. They are specifically appointed to sell micro insurance products. While the individual, corporate agents and brokers can sell micro products, NGOs (Non-Government Organisations), SHGs (Self-Help Groups) or MFI (Micro Finance Institution) are authorised to sell **only micro products designed for rural people.** These groups who have access to the rural masses and have their confidence and trust will be appointed by the insurer by entering into a **deed of agreement** with them specifying clearly the terms and conditions. They are given 25 hours training by the insurer in local language and remunerated as outlined in the regulation.

9.5. MORE AND MORE CHANNELS EMERGING

The opening of insurance sector has enlarged distribution of insurance products from the earlier single channel system of tied agency to a multiple channel setup comprising of individual agents, Corporate agents, Brokers and Bancassurance and Micro Insurance. No doubt the new channels have helped the industry to sell insurance every year in a massive way and penetrate into many new segments.

Distance Marketing

With the advent of information age, new innovative systems of marketing have evolved. The use of internet, web based selling, e-marketing, telecalling, mobile, SMS etc., have brought revolutionary changes in reaching out to more people and making the buying of insurance easy. The extensive use of informational technology by the insurers has made it necessary to IRDA to intervene and come out with regulations on the use of this channel called **Distance Marketing.**

A large number of entities operating in different field of activities are holding information about the clients which have been built up through their contacts and goodwill. This database is a rich resource which would be of immense use to the insurers. The database when shared with the insurer can be helpful to reach various segments according to their time and convenience. The value of **referrals** has been recognized in insurance and much advantage is now taken from sharing information from such database.

IRDA while appreciating the value and support which can be received from distance marketing and referral system is anxious that under both these modes of distribution **only licensed personal/entities are involved and there is no scope of remuneration other than the commission permitted under the Act.** IRDA is also anxious that there is **no mis selling or pressure selling** while adapting these modes. Some of the important provisions notified by IRDA are given below:

Distance marketing includes every activity of solicitation (including lead generation) and sale of insurance products through following modes:

- Voice mode, which includes telephone-calling;
- Short Messaging service (SMS);
- Electronic mode which includes e-mail, internet and interactive television (DTH);
- Physical mode which includes direct postal mail and newspaper & magazine inserts; and,
- Solicitation through any means of communication other than in person.

For the purpose of solicitation through distance marketing insurers and brokers have to engage **only their employees who have undergone statutory training.** Corporate agents can use their Specified persons The services of **Telemarketer,** an entity new to the insurance marketing can be utilized subject to certain conditions stipulated by IRDA.

Tele caller and the **Authorised Verifier** employed by the Telemarketer for the purpose of solicitation of sale over telephone calls shall be **trained** as specified by IRDA and shall clear post assessment test.

Standardized script should be used to explain the features and benefits of the product and sale shall be finalized only on receiving the consent in **explicit terms** The insurer shall preserve **all records of the entire process of solicitation and concluding of sale** and security of the data is assured.

Under Referral arrangement where the insurer has agreement with the referral company to share their data base for distribution of insurance products it should be registered with IRDA and approval obtained. Among the eligibility criteria the main provision states that **the referral company is not in any of the business of extending loans and advances, accepting deposits, trading in securities on its own or on the accounts of the customers.** It should have no linkage , direct or indirect with the transaction or distribution of insurance business To be specific the referral company's role is **only to provide the information** about their customers. The insurer as well as the referral company have to keep full records of their transactions for each batch of referral data including sales completed and remuneration paid.

Opening additional channels and broadening the distribution of insurance products leads to many benefits. The insurer is not only able to sell more at less cost, but gets more feedback from the market, to develop suitable products. Thus product innovation and customisation is possible. The more committed sales force ensures customer retention, less lapses and ultimately leads to more customer satisfaction. The insurer has to manage so that there is no conflict of interests between these alternative modes of distribution.

Insurance selling requires personal interaction and advice from a reliable and competent intermediary. In fact, the person who meets the proposer and gets the proposal from him is called 'primary underwriter'. He/she should be the person who is selected, trained, appointed and given license for that purpose. His knowledge should be updated periodically. In all of their regulations, guidelines IRDA has not compromised on these aspects. In their circular in March 2003 they made it emphatically made it again very clear:

'No insurer shall distribute the product through any person who is not licensed as per the provisions of Insurance Act, 1938 for the purpose of soliciting and procuring insurance business.'

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SUMMARY

- Distribution is the 'key' to insurance marketing. For a long time agency was the only mode of distribution in India. Now a multi-channel distribution system has been introduced including agents, corporate agents, brokers and micro insurance agents helping the insurer to reach out to various segments. IRDA has come out with regulations and guidelines to ensure spread of business on desired lines.

REVIEW QUESTIONS

1. Historically, distribution in India was totally agent-based. Comment.
2. Corporate agency – How does the system work?
3. Broker system and their potential. Discuss.
4. Comment on the role of bancassurance in widening the market for insurance.
5. Insurance Agency can provide employment in a massive way.Insurance agency can be a life time carrier. Discuss.
6. Code of Conduct for agents has become necessary to enforce discipline in the industry. How?
7. How the guidelines issued by IRDA can check misselling in Distance Marketing?
8. Micro Insurance Agents is a new class of agency force. How the scheme is structured to reach out to the rural masses?
9. In life insurance marketing intermediary serves as a 'primary underwriter'. Discuss the importance of the role.

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UNIT

10

PRINCIPLES AND PRACTICE OF GENERAL INSURANCE

STRUCTURE

Insurable Risk

Insurance is meant to protect a person or property from insurable risk. The term risk connotes uncertainty about the occurrence of an event (peril) that may cause loss. In insurance parlance, the subject matter of insurance is called **risk**. A building with a good deal of wood and woodwork is a bad risk and a concrete building is a good risk. Hazard means conditions which create or increase the chance of loss by a **peril**. Hazard may either be physical or moral. **Physical hazard** relates to property insured and **moral hazard** relates to the insured person's character. A contract of insurance has four dimensions, viz., subject matter of insurance, peril that causes the damage (say fire), the unfortunate happenings and the resultant financial loss. Some of the concepts dealt with in the earlier chapters are repeated here more specifically in the context of marine, fire and motor insurances with appropriate examples.

Insurance Contract

The insurance contract, like any other contract, is governed by the general principles of the law of contract as described in the Indian Contract Act. The essential elements of a contract including insurance contract are

- Offer and acceptance
- Consideration
- Agreement between the parties
- Capacity of the parties to contract and
- Legality of the contract

An offer is made by the insured on duly submitting a proposal and acceptance is made by the insurer usually by the issue of a cover note or policy. The acceptance is valid only on payment of premium (Insurance Act 1938, Sec. 64VB).

Premium is the consideration received by the insurer and promise to indemnify is the benefit received by the insured. Legally speaking the consent must be based on common intention and understanding and the parties to contract should be competent to contract, have attained age of majority, possess sound mind and not otherwise disqualified by the law. The contract should be for lawful purpose. The Insurance Act

stipulates that all insurance contracts should be in writing, duly stamped. It must conform to the legal principles, of insurable interest, utmost good faith and indemnity.

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Insurable Interest

The insured person's interest in the subject matter of insurance is of utmost importance and loss or damage to it should make the insured suffer. In an insurance contract lack of insurable interest will render the contract void. There must be a property right or interest, or potential liability capable of being insured and that property right, etc., must be the subject matter of insurance. The insured must have a legal relationship to the subject matter and stand benefited by its safety. The interest may be by ownership, or as trustee or bailee or creditor. But, at the same time, the beneficiary of a will cannot claim insurable interest in the property that he may inherit through the will. The principle of insurable interest and the principle of indemnity are interdependent. The loss or damage should be amenable to measurement in terms of money. The insured cannot recover more than the amount of insurable interest. A fire policy is so worded that it covers not only the insured's own goods but also goods held in trust or fiduciary capacity. A garage proprietor has insurable interest in the vehicles entrusted to him for repair. Insurable Interest may arise on account of liability to third party or legal liability to pay compensation to employees. Shipowners may incur liabilities to third parties, harbours, docks and cargo owners, for negligent navigation. And even the damaged ship may create legal liability to others and hence shipowners have insurable interest by law. An insurance company has insurable interest in its underwriting and hence it can reinsure the risk. In case of marine cargo insurance, insurable interest is required only at the time of loss and not necessarily at the time of issue of policy. But in all other branches of insurance it is required both at the inception of contract and at the time of loss.

Assignment

Assignment means transfer of legal right of a person on an asset to another person. Insurable interest can be acquired as a beneficiary of an assignment. Assignment of the subject matter of insurance does not automatically result in assignment of insurance policy although transfer of rights may lead to assignment of the policy. But it is subject to limitations imposed on the policyholder by the policy conditions. Assignment may be absolute or conditional and accordingly the rights of assignee will vary. Consequent to the assignment the insured can direct the insurance company to pay the claim amount to a specified person who may be an outsider but the insured will be required to give discharge to the insurer for such payment.

All insurance contracts are personal contracts. A fire policy is issued only after the insurer is satisfied about the bonafides of the insured. Generally speaking, fire and accident policies are considered as personal contracts and the insurer's consent is required for the assignment. The policy can therefore be assigned to the new owner only with the consent of the insurer. Motor insurance is granted only to an insured who can be relied upon to take proper care of the motor vehicle. The assignment therefore requires the consent of insurer, and the transferor should apply to the insurance company. If within fifteen days insurer does not intimate his refusal, the assignment is valid and enforceable. The insurer is entitled to refuse the transfer and if so the insured should be informed accordingly within fifteen days. The position in respect of assignment of personnel accident policies is not settled in law. In practice, assignment of 'death benefit' by the insured to a specified near relation is allowed. Material alteration in the risk vitiates the policy. But in case of assignment in favour of the bank, material alteration in the risk, does not invalidate the policy or assignment. However, the bank is required to notify the insurer of any material alteration initiated by it.

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Utmost Good Faith

In all commercial contracts good faith shall be observed and good faith means absence of fraud or deceit. Legally speaking, a commercial contract will be nullified if one of the parties has committed fraud or deceit. Utmost good faith arises at the proposal stage, during the operation of the policy and continues at every renewal. It hinges on full disclosure of material facts by the insured. Insurance contracts are inherently fiduciary in nature and built on trust. The proposer knows and ought to know all relevant information about the risk proposed which the insurer in the normal course is not expected to know. The duty of utmost good faith implies that a proposer must disclose to the insurer all material facts relevant to the proposed insurance. The duty applies not only to material facts which he knows but also extends to material facts which he ought to know. Normally contracts are governed by the dictum 'caveat emptor' but insurance contracts are governed by principles of 'uberima fides'.

In a fire insurance contract the material facts for example, can be the construction classification and location of the building or in case of goods stored, whether they are hazardous or extra hazardous in nature. Likewise in marine insurance, material facts constitute method of packing, its strength and quality and the exact nature of goods; such as new machinery or second hand, etc. It may be the roadworthy condition of a motor vehicle in motor insurance or the precise nature of goods covered under a burglary policy that constitutes material facts. The fact that another insurer had declined to accept the proposal or refused to renew the policy or accepted the risk at extra premium constitutes material facts and so also information on past losses sustained by the proposer.

However, in the absence of specific inquiry by underwriters, the proposer has no obligation to disclose the information such as: facts which are well known (large scale riots in the area of operation) or inherent risk in the nature of property insured which is a common knowledge (e.g., petrol, camphor, etc.). But it is possible for the insurer to call the insured's action as inadequate disclosure, if he fails to disclose a material fact just because the proposal form which contained many questions did not cover that particular fact. When the proposer has said that the ship is expected to sail on a particular day and it sailed another day, the contract remains unaffected. But a mistake in the identity of ship will affect the validity of insurance. Intentional suppression and fraudulent misrepresentation render the contract void. However, innocent misrepresentation based on belief or expectation is treated differently from misrepresentation of facts. The principle of good faith applies not only to insured but also to the insurance company. While insuring a property if the insurer knows that it has already been destroyed (e.g., a ship on high seas) but it is not known to the proposer then the insurer will be held liable for breach of good faith.

Warranty

Warranty usually relates to the physical aspect of risk. Breach of warranty may or may not increase the risk. It is usually inserted in the policy to protect the insurer and thereby any breach thereof will be held against the insured. In general law warranty is not equivalent to guarantee. But in insurance law, warranties and conditions are treated on the same footing. A simple statement that electrical installations or machinery are properly maintained or they are in conformity with regulations is a warranty in fire insurance and any lapse in this regard will adversely affect the insured. The statement such as 'goods are packed in double gunny bags', or goods are shipped by a 'first class steamer', are considered as warranties. They can be expressed or implied in nature, but must be complied with as otherwise a breach of warranty will make the contract voidable. The proposal form contains several statement in the form of declaration. The legal effect of the declarations is to convert the statements into warranties.

NOTES

Indemnity

A contract of insurance promises to indemnify the insured against financial loss. Indemnity means security or protection against loss or damage. Insurance provides compensation for loss or damage only to the extent of actual amount of loss. In insurance contract indemnity is based on insurable interest and hence compensation is only to the extent of insurable interest. The objective is that the insured after getting the claim amount should neither be better off nor worse off as a result of the loss. The need to apply the principle of indemnity is that if it is possible to make a profit out of the insurance, then people may be tempted to misuse it for pecuniary benefit.

Financial Aspects of Indemnity

The insurance company may pay the insured the value of the property at the time of its destruction or monetary value of damage or reinstate or replace such property or any part thereof. The method of valuation is not defined in the insurance policy, but in practice it is **'Market Value'**. 'Market Value' would mean the price at which similar property could be normally purchased. For insurance purposes, market value is arrived at after deduction of appropriate depreciation on the value of the property based on age, usage, wear and tear and maintenance. The claim amount payable under the policy is worked out, according to the nature of property. In the case of a building, it is generally replacement value and in respect of plant and machinery it is current reinstatement value, calculated on the estimated normal useful economic life of the machine with appropriate depreciation thereon. As far as traders' stocks are concerned, it is replacement cost and in a manufacturing unit it is cost of raw materials, cost of labour and overheads incurred, but not inclusive of profit.

Indemnity in Marine Insurance

In marine policies the principle is applied in a modified form. Both marine cargo and marine hull policies are issued as **valued policies.** Valued policies will clearly indicate the agreed value of the insured property. The price of goods on the high seas may fluctuate while in transit and it may go up in the country of destination. Hence the market value of goods is difficult to determine when they are lost in mid-ocean. In the circumstances the concept of agreed value is applied which includes the cost of the goods, freight, insurance and other incidental charges plus a reasonable percentage of profit.

Marine hull policies are issued as valued policies. The vessel may be old, but to a ship owner it is valuable from the point of view of earning capacity. In a valued policy the insured amount remains constant throughout and the value cannot questioned subsequently, except where there is a suspected fraud. Excessive over-valuation of cargo might allow the insurer to re-open the value, but not for hull, as the insurer is expected to know its value when the proposal is accepted.

In motor insurance, both in case of physical property and legal liability to third party, principles of indemnity are applied and if there is a total loss then the basis will be sum insured or the value the vehicle, whichever is less. Third party death or bodily injury, damage to property of third party and workmen's compensation in common law are deemed to be unlimited.

Salvage

Property which is partially saved from loss or damage is called salvage. If a motor car is damaged to such an extent that it is not worthwhile to repair it, because the cost of repairs would exceed the sum insured or its value, the insurer would in such cases settle it as a total loss and take over the salvage for scrap value. If the salvage is left

with the insured, to that extent he would be asked to pay the value to the insurer or an appropriate deduction will be made in the claim amount. If the injured has received the whole or part of his loss from a third party who was responsible for causing the loss, then to that extent, the indemnity provided by the insurer will be reduced.

Subrogation

Subrogation may be defined as the transfer of rights and remedies of the insured to the insurer who has indemnified the insured in respect of the loss. Subrogation principle arises from the principle of indemnity. If the insured recovers his actual loss from two sources, viz. insurer and the third party responsible for loss he would be making a profit that would defeat the object of the principle of indemnity. If the insurer is not allowed subrogation rights, then the wrong-doer would escape liability, although responsible for the loss. It is against public interest. Subrogation rights emanate through the policy condition that the insured shall render all necessary and reasonable assistance to the insurer to recover the loss from the third party who was responsible for the loss. In other words, the policy condition provides for subrogation of the insured's rights to the insurer. It is therefore very important for the insured to take care that the right of recovery of the insurer is not prejudiced or impaired in any way. The right of subrogation is implied in all contracts of indemnity. In other words, its application to contracts of indemnity is automatic without any express condition in this regard. The right extends to 'salvage' on settlement of the claim. There is no specific subrogation condition in motor policies and therefore, subrogation is under common law, as a corollary of the principle of Indemnity. However, subrogation rights do not arise when the claim is settled on **'ex gratia'** basis. The insurer by exercising subrogation right cannot recover more than what he has paid to the insured.

Contribution

Contribution may be defined as the right of an insurer who has paid a claim under a policy to recover a proportionate amount from other insurers who are also liable for the loss. If the insured has more than one policy on the same subject matter with more than one insurer, then each insurer will indemnify only a proportion of the loss. While the insured can recover his full loss within the sum insured from any one of the insurers who have insured the risk, the insurer who had paid the claim in full has the right to recover proportionate contribution from other interested insurers. Contribution principle will apply only when the subject matter of insurance is common to all policies.

Proximate Cause

The object of insurance is not to provide indemnity for all losses but only for such losses that are caused by insured perils. If stocks are burnt, then the cause of loss is fire which is covered under a fire policy and hence the claim is payable. The cause may be an insured peril or an uninsured peril, and it is therefore important to determine the cause of loss to decide whether the claim is payable or not. But in actual situation, the loss may be the result of two or more causes, acting simultaneously or one after the other, then, it becomes necessary to chose the most important, the most effective, and the most powerful cause which has brought about the loss. This cause is termed as the proximate cause, and all other causes are considered as remote. The proximate cause should be the cause which is most closely and directly connected with the loss. The legal doctrine of proximate cause is clear in theory but in actual practice, its fraught with difficulties in interpretation. If out of many causes for the loss if one is insured peril then the other causes may be ignored. On the other hand, if concurrent causes include an excepted peril the claim will be rejected and in such a case, if the results of the operation of insured peril can be clearly separated from the effects of the excluded

peril, the insurer has the liability under the policy. Where a number of causes operate one after the other and the original cause happens to be an insured peril, there is liability under the policy. The insured has to prove that the loss was proximately caused by an insured peril. The onus get shifted to the insurer if it is argued that the loss was caused by an excepted peril and in which case it has to prove that accordingly.

SUMMARY

- Insurance is a contract between the insurer and insured.
- The law of contract will apply which means there should be offer, acceptance, consideration, legal purpose, and capacity to contract.
- Insurance contract is governed, in addition, by principles of insurable interest, utmost good faith, and indemnity.
- Disclosure of materials facts is vital to contract.
- Insurance contract is governed by law of indemnity.
- General insurance contract in certain cases are on agreed value basis, although in most cases they are on simple indemnity basis.
- Proximate cause is a simple concept but complex in its application.
- Proximate cause for the loss or damage is critical in deciding claim payment.

REVIEW QUESTIONS

1. What are essential elements of a contract?
2. What are the special features of an insurance contract?
3. What is insurable interest and why it is very important in an insurance contract?
4. Write short notes on: Utmost good faith, indemnity, subrogation, contribution, proximate cause, material facts.
5. What is insurable interest and why it is important to the insurer?
6. What is Subrogation and what is the purpose of adding this clause in a policy and how it is relevant to Indemnity clause?
7. Generally in a Commercial Contracts "Good Faith" is important but why in an Insurance contract it is "Utmost Good Faith".

APPLICATION QUESTIONS

Mr. Shyam purchased a new car and (*i*) took a shed on rent to park his car, and (*ii*) The car was financed by a bank. (*iii*) He appointed a driver for the car. (*iv*) The car was given to service station for car wash, after the car got stuck in a Marshy Land on a rainy day. Besides the owner, who among the four can have insurable interest on the car?

FURTHER REFERENCES

General Insurance Principles Practice

Practical Approach to General Insurance Underwriting.

General Insurance Business Operations and Decision Making

All by National Insurance Academy, Pune and Gengage Learning

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UNIT

11
FIRE INSURANCE

STRUCTURE

Introduction

Fire insurance activity originated in Germany to cover properties located in municipal towns. But it was after the great fire in London that regular fire insurance was introduced by the insurance companies. In India, fire insurance was introduced in the early eighteenth century. Initially it covered only fire risk and in due course for practical considerations and other compulsions, fire policy covered explosion, riot, strike, flood, etc.

Fire Risk

The risk of fire or fire peril is ever present in society in many forms. The purpose and scope of fire insurance is to provide financial protection against loss or damage to property caused by fire. It is a contract by which the insurer for a consideration (premium), agrees to indemnify the insured against the consequences of fire during the agreed period up to the amount stated in the policy.

The properties normally covered by fire insurance are buildings, furniture, fixtures and fittings, valuables in the buildings such as machinery, plant and equipment, accessories goods in factories, godowns, stock in trade with shops, hotels, etc.

Perils Covered

By convention and practice, fire policies provide comprehensive cover to many perils besides fire. The range of cover provided includes loss or damage caused by fire, lightning, explosion, implosion, riot, strike, malicious damage, terrorists' attack, cyclone, storm, hurricane, flood, inundation, subsidence, landslide, bursting of pipes and apparatus, bursting and overflow of water tanks, earthquake, etc., many of which are covered automatically and others on request on payment additional premium. Fire policy covers damage caused by fire from external sources and not destruction or damage caused by its own fermentation, natural heating or spontaneous combustion or burning of insured property by an order of the Public Authority. However, spontaneous combustion can be covered at extra premium. Industrial boilers are not covered by fire policy but the risk can be covered by Boiler Explosion Policy under Engineering Insurance.

Riot, strike, malicious damage and terrorist attack, for the purpose of insurance, will mean direct visible physical loss, destruction or damage by external violent means caused to the property. Fire policy will not include burglary, house breaking, theft, larceny or any attempt by any person taking part therein. The policy encompasses risk such as impact damages caused by rail/road vehicles or animals by direct contact. But if they belong to or are owned by the insured or any occupant of the premises or their employees while acting in the course of their employment, they are not covered. Destruction or damage caused by subsidence of part of the site on which the property stands or landslide/rock slide are covered. In other words, a wide range of perils are covered by fire insurance. The liability of the insurance company shall in no case exceed, in respect of each item, the sum expressed in the schedule of properties to be insured or the total sum insured. The total sum insured is arrived at on different modes of valuation, viz., market value and replacement value, agreed value, etc.

Exclusions

The policy does not cover the following under general exclusion clause:

1. 5% each of the claim on landslide and rock slide, lightning, storm, and subsidence and for other loss up to ₹ 1000.
2. Loss, destruction or damage caused by war.
3. Loss, destruction or damage directly or indirectly caused to the property insured by nuclear peril, missile testing.
4. Loss destruction or damage caused to the insured property by pollution or contamination.
5. Loss, destruction or damage to any electrical and/or electronic machine, apparatus, fixture or fitting arising from over-running, short circuiting or leakage of electricity.
6. Damage to goods in cold storage due to electrical or plant failure. But it can be covered on payment of extra premium.

General Conditions

There are a number of conditions attached to the policy and the following are some of the important conditions. The policy is voidable in the event of misrepresentation, mis-description or non-disclosure of any material particulars. This condition flows from the principle of utmost good faith. Material alteration in the property or any change in the nature of trade or manufacture, or of the occupation in such a way so as to increase the risk of loss or damage by the insured perils will make the policy voidable. The insured does not have any right to abandon damaged property whether the insurer takes possession or not. If the claim is fraudulent or any false evidences are produced by the insured to avail of a benefit under the policy, the insured loses all benefits under the policy. Similarly if the loss or damage is caused willfully by the insured or with his convivance, then all benefits under the policy will be forfeited. The insurer has the option to reinstate or replace the property that is lost or damaged instead of paying the amount of claim to the insured. This condition may be invoked when the insured is claiming a highly exaggerated amount of loss.

Average Clause

An insured is expected to insure his property for its full value. In the event of claim, if it is found that he has not covered the property for its full value, then the average clause will apply and he has to bear a portion of the claim. The condition states that the adequacy of sum insured will be checked against sum insured under each item as well as on the total sum insured. The implications of the average clause are explained in the example given below:

Value of property	₹ 1,00,000
Sum Insured	₹ 50,000
Loss (Amount claimed)	₹ 80,000
The amount payable	50,000 / 1,00,000 × 80,000 = ₹ 40,000

The **contribution** clause provides that in the event of there being more than one insurer covering the loss then all the insurers will contribute towards the claim amount in the proportion to the particular policy's sum insured bears to the aggregate sum insured under all the policies. If the loss is caused by a third party the insured is required to give assistance to the insurer to enable them to recover the loss from the third person responsible for the loss. The insured's rights of recovery against the third party are subrogated to the insurer, and this transfer of rights takes place even before the insurer pays the loss.

Tariff (Premium)

From 1.1.2007, rates of premium on different classes of risk is fixed by the individual insurance company and not by the tariff committee as hitherto. Premium is always recovered in advance and the risk cover commences only on payment of premium. The rate and amount of premium depends on class of construction of buildings, nature of risk, physical hazard, moral hazard, insured amount and add on cover.

Sum Insured

Certain risks can be added or deleted by mutual consent between the insurer and the insured. The amount to be insured is the decision of the policyholder. And if the property is over insured, *i.e.*, insured value of the property is more than its actual value, the insured will not get benefit of higher claim. But if it is under insured, average clause will apply and hence insured will be paid less. The sum insured is always decided by the insured. It is also the limit of insurer liability. When the subject matter of insurance is of high risk (more than normal) it will attract higher premium. If proper fire control measures are adopted, there will a discount on premium.

In a fire policy among many properties covered there may be certain items whose market value cannot be ascertained, e.g., curios, works of art, manuscripts, obsolete machinery, etc., and the sum insured for those articles is determined on agreed value basis. The procedure is similar to that of valued policies.

Long-term Policies

All fire policies are issued for 12 months period and renewed thereafter if required. Policies for a period exceeding 12 months shall not be issued except for dwelling house insurance.

Partial Insurance

It is not permissible to issue a policy covering certain portions of a building. However, the plinth and foundations or the foundation of a building may be excluded. So also policy covering only specified machinery (except boilers) or parts of machines or accessories thereof fixed in the same block/building cannot be insured. Where portions of a buildings and/or machinery therein are with different ownership, it is permissible for each owner to insure separately, but to the full extent of each person's interest on the building and/or machinery In such case, the insured's interest shall be clearly defined in the policy.

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Loading for 'Kutcha' Construction

Building(s) having walls and or roofs of wooden planks thatched leaves and, or grass hay of any kind, bamboo, plastic cloth, asphalt cloth, canvas, tarpaulin and the like shall be treated as 'kutcha' construction for rating. An additional premium shall be charged for such building(s) and/or contents thereof.

Cancellation of Policy

When a policy is cancelled at the request of the insured the premium shall be recovered at Short Period Scale of premium and the balance refunded. However, if it is cancelled at the option of the insurer, refund of premium shall be on pro-rata basis. In case a policy is cancelled on account of a government order on a building, pro-rata refund of premium may be allowed.

11.1. SPECIAL POLICIES

Floater Policy

Large industrial concerns and big traders usually have their stock of raw material and finished goods in various godowns at various locations. They would prefer one policy covering all stocks. Policies can be issued to cover stocks of the insured at various locations, on aggregate basis. Stocks in two or more godowns may be combined and declared for insurance purpose. Similarly, a manufacturing company's stocks in process, stocks in godowns and in the open yard can be covered under one sum insured.

Declaration Policy

In order to take care of frequent fluctuations in stocks/stock values, Declaration Policy can be issued subject to the conditions that monthly declarations based on the average of the highest value at risk on each day or highest value on any day of the month shall be submitted by the insured at the latest by last day of the succeeding month. If declarations are not received within the specified period, the full sum insured under the policy is be deemed to have been declared. Reduction in sum insured shall not be allowed under any circumstances.

Reinstatement Value Policy

Reinstatement value insurance is granted on fixed assets, viz., building, machinery etc. subject to certain conditions. When fire policy with the reinstatement value clause is issued, it provides that in the event of loss, the amount payable is the cost of reinstating property of the same kind or type, by new property. The basis of settlement differs from the basis under the standard fire policy where the losses are settled on the basis of market value, i.e., after making deductions for depreciations, etc. Under reinstatement value policy, what is paid against the claim is not the depreciated value of the building or machinery, but the cost of replacement of the damaged property by new property of the same kind.

Industrial All Risks Policy

This is a package cover designed for industrial concerns for their manufacturing and storage facilities with an overall sum assured of ₹ 100 crore. The policy provides cover for the following:

- Fire and special perils
- Burglary

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- Business Interruption (which is an optional cover)
- Machinery Breakdown/Boiler Explosion/Electronic Equipment (material damage)

Exclusions

Faulty design, building collapse, larcenary, war and nuclear peril.

Agreed Bank Clause

All policies in which a bank has a partial interest are to be made out in the joint name of the bank and owner or mortgager and the agreed bank clause be incorporated in the policy. The salient features of the clause are:

(*a*) The claim is payable to the bank whose receipt shall be a complete discharge and binding on all parties insured.

(*b*) Any notice under the policy is sufficient if given by or to the bank.

(*c*) Any settlement, compromise, etc., in relation to the dispute if made with the bank shall be valid and binding on all parties of insurance.

(*d*) Breach of condition of the policy (which relates to notification of material alterations in the risk) does not affect the interest of the bank unless breach is committed by the bank.

(*e*) Any alteration or increase in risk does not invalidate the insurance provided the bank notifies the same as soon as it comes to its knowledge and pays additional premium.

Proposal

(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) 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.

(4) Wherever the benefit of nomination is available to the proposer, in terms of 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.

(5) 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.

Cover Note

On receipt of a completed proposal form and/or inspection report, the cover note is issued, pending preparation of the policy document. The cover note is an unstamped

document issued to provide evidence of cover till the policy is issued. The cover note provides insurance against specified perils on the same terms and conditions of the impending policy.

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Policy

The printed policy which is known as standard fire policy is a stamped document, with detailed information of the property and contract. As and when need arises for a change in the policy, an endorsement document is issued to record changes such as alteration in risk, increase or decrease of sum insured, etc.

Matters to be stated in 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

(*g*) Any franchise or deductible applicable

(*h*) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated

(*i*) Policy terms, conditions and warranties

(*j*) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy

(*k*) 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

(*l*) Any special conditions attaching to the policy

(*m*) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured

(*n*) The address of the insurer to which all communications in respect of the insurance contract should be sent

(*o*) The details of the riders attaching to the main policy

(*p*) Proforma of any communication the insurer may seek from the policy holders to service the policy

(*q*) Fire insurance policy, for that matter any insurance policy issued by an Indian, insurance company, should conform to the conditions stated above which are prescribed by IRDA.

(2) Every insurer shall inform and keep the insured informed periodically on the requirements to be fulfilled by him 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.

11.2. CLAIMS

In the event of loss of property by insured peril, the insured shall submit the claim to the insurance company. The claims form shall contain the following information:

- Name and address of the insured
- Date of loss, time and place where the fire started

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- Cause of fire
- Details of the property damaged with description, value at the time of fire, value of salvage and the amount of loss
- Details of other policies on the same property giving the name of the insurer, policy number and sum insured.

Claim Procedure in Respect of a General Insurance Policy

In order to protect the interest of the policyholders, IRDA has prescribed the following norms and stipulations for the insurance company to follow:

(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 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 IRDA 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. 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 clays 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 decides to reject a claim under the policy, it has to be recorded in writing and communicated to the insured. He 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 case of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2 per cent above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

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11.3. SURVEYOR REPORT

If the amount loss is small, the insurer may depute an officer to survey the loss and decide on the settlement of the loss on the basis of the claim form and the officer's report. However, in case of large losses, an independent surveyor duly licensed by the IRDA is appointed to give a report on the loss. The loss survey report would generally deal with the following matters:

- Cause of loss
- Extent of loss
- Under-insurance, if any
- Details and value of salvage, and how it has been disposed of or proposed to be disposed of
- Details of expenses (e.g., fire fighting brigade expenses)
- Compliance with policy conditions and warranties
- Details of other insurance policies on the same property that is lost or damaged, and the apportionment of the loss and expenses among co-insurers

On the basis of the claim form and the survey report, a decision is taken about the settlement or otherwise of the loss.

In the event of any dispute regarding the amount of claim payable, not the claim itself, it shall be referred to arbitration as per the provisions of the Arbitration and Conciliation Act, 1996. Arbitration is a private method of dispute resolution and is faster and cheaper than a civil suit. When there is a dispute on the admissibility of the claim, then the dispute should be taken to the civil court and not arbitration. All notice and other communication to the company in the matter shall be in writing. On the settlement of loss under the policy, the sum insured shall stand reduced by the amount of claim paid if the insured does not reinstate the sum insured in the policy.

SUMMARY

- Fire insurance activity originated in Germany. But it was after the great fire in London that regular fire insurance was introduced by the insurance companies.
- The properties normally covered by fire insurance are buildings, furniture, fixtures and fittings, valuables in the buildings such as machinery, plant and equipment, accessories, etc., goods in factories, godowns, stock in trade in shops, hotels, etc.
- The range of cover provided is loss or damage caused by fire, lightning, explosion, implosion, riot, strike, malicious damage, terrorist attack, cyclone, storm, hurricane, flood, inundation, subsidence, landslide, bursting of pipes and apparatus, bursting and overflow of water tanks, earthquake, etc., many of which are covered automatically and others on request and on payment additional premium.
- Fire policy covers damage caused by fire from external source and not destruction or damage caused by its own fermentation, natural heating or spontaneous combustion or burning of insured property by an order of the public authority.
- The policy does not cover the loss, destruction or damage caused by war and nuclear peril, missile testing under General Exclusions Clause.

NOTES

- An insured is expected to insure his property for its full value. In the event of claim, if it is found that he has not covered the property for its full value, then the average clause will apply and he has to bear a portion of the claim.
- This contribution clause provides that in the event of there being more than one insurer covering the loss, then all the insurers will contribute towards the claim amount.
- In the event of any dispute regarding the amount of claim payable, not the claim itself, it shall be referred to arbitration as per the provisions of the Arbitration and Conciliation Act, 1996.
- Premium is always recovered in advance and the risk cover commences only on payment of premium. The rate and amount of premium depends on the class of construction of buildings, nature of risk, physical hazard, moral hazard, insured amount and add on cover.
- The amount to be insured is the decision of the policy holder. If the property is over-insured, *i.e.*, insured value of the property is more than its actual value, the insured will not get the benefit of higher claim. But if it is underinsured, average clause will apply, and hence the insured will be paid less.
- All fire policies are issued for 12 months period and renewed thereafter if required. Polices for a period exceeding 12 months shall not be issued except for dwelling house insurance.
- It is not permissible to issue a policy covering certain portions of a building.
- Besides Standard Fire Policy, special policies like Floater Policy, Declaration Policy, Reinstatement Value policies, Industrial All Risks Policy, are issued to meet specific needs.
- All policies in which a bank has a partial interest are to be made out in the joint name of the bank and owner or mortgager and the agreed bank clause be incorporated in the policy.
- The printed policy, which is known as standard fire policy, is a stamped document, with detailed information of the property and contract.
- As and when the need arises for a change in the policy, an endorsement document is issued to record changes such as alteration in risk, increase or decrease of sum insured, etc.
- In the event of loss of property by insured peril, the insured shall submit the claim to the insurance company. The claims form shall contain information: such as name and address of the insured, date of loss, time and place where the fire started, cause of fire, details of the property damaged, etc.
- If the amount loss is small, the insurers may depute an officer to survey the loss. In case of large losses, an independent surveyor duly licensed by the IRDA is appointed to give a report on the loss.

REVIEW QUESTIONS

1. What risks a standard fire policy cover?
2. What is the difference between condition and warranty in a fire policy? Give examples.
3. What are the exclusions in a fire policy? And what are the implications?
4. What do you mean by extension in an insurance policy? Give examples and explain.
5. What is the basis for valuation of subject matter of insurance in fire policy?

NOTES

6. State the Contents of the Survey Report on Fire Insurance Claims.
7. Mention the General Exclusions under the standard and special Perils Fire Policy.
8. Describe the Special conditions attached to a Fire Declaration Policy.
9. Which are the essential ingredients of Fire Insurance Contract in order to make it enforceable at Law?
10. What are the duties of the Insured in the event of a loss under the Fire Insurance Policy?
11. Describe the Procedure involved on receipt of claim intimation under a fire policy.
12. Mention the various 'add-on' which can be taken by the Insured on payment of extra premium under a fire policy?
13. Explain Briefly the contents of a fire policy.
14. Briefly Explain claim procedure in a fire policy.
15. Distinguish the Right of the Insurer and Insured to cancel a policy.
16. Detail the procedure for appraisal of, proposal for Fire Policy.
17. Detail the procedure for appraisal of Fire Insurance proposal of a trader in textiles.
18. What is floater policy? What are the properties covered in a floater?
19. A fire policy is a Personal Contact – give comments on its implications.
20. Write Short Notes On: (1) Declaration Policy, Reinstatement Value, Fire Policy, Industries All Risk Policy.

APPLICATION QUESTIONS

1. 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.

CASE STUDY A CASE FOR DISCUSSION – CASE I

A real life case is given below. Based on the data given, analyse the issues involved and the problems in settlement of claim. If you were to sit on judgment over the dispute what will be your approach? Give your decision and the reasons therefor.

FIRE INSURANCE PROBLEM IN CLAIM SETTLEMENT

The National Textile Corporation (Corporation) is running a textile unit at Coimbatore known as Omparasakthi Mills. M/s. Prabhu Textile is a partnership firm carrying on the process of doubling textile yarn on job-work basis. The Corporation had entered into an agreement with M/s. Prabhu Textiles on 04-11-1992 for converting the yarn into cheese form, get them doubled and convert into cones of 1.25 kg. Thereafter, it is to be tagged in marketable form. For this purpose, the corporation has taken insurance cover for the goods against risk by fire, lightning, etc., for a sum of ₹ 10 lakh. The Corporation sent to M/s. Prabhu Textiles 260 bags of yarn for conversion. In the relative gate passes and delivery notes, the value thereof was mentioned as ₹ 16,19,000. After conversion, M/s. Prabhu Textiles, redelivered 130 bags of yarn between 04-01-1993 and 12-01-1993. The rest of the 130 bags of yarn were in process of conversion with M/s. Prabhu Textiles. The value of the said yarn was ₹ 8,45,000.

On 17th January, 1993, a fire broke out in the factory of M/s. Prabhu Textiles. The corporation received the information at about 10.00 a.m. and their yarn partly in conversion and partly finished, was gutted in the fire. Hence, they lodged a claim with United India Insurance Co. Ltd. claiming ₹ 6,84,690 being the value of the goods lost in the fire.

The Insurance Company appointed a Surveyor and on the basis of the Surveyor's report repudiated the claim by holding that:

(*a*) the fire was not accidental

(*b*) the stocks were not available at the location

(*c*) the policy excluded losses due to theft

(*d*) Property was removed to other buildings, and the claim was, therefore, fraudulent.

The Corporation thereafter filed a case in the court.

II. In early hours of 17th January 1993 the Managing Partner of M/s. Prabhu Textiles Ltd. heard an alarm caused by the employees and found the factory premises on fire. A telephonic message was given to the fire service station and the police station. The fire was extinguished, but the entire stock of yarn had been burnt and no portion of the stock could be salvaged. Extensive damage was caused to the machinery and building. The police registered a case and after investigation arrived at the conclusion that fire must be due to electric short circuit.

Prabhu Textiles has also taken a separate policy of insurance with the insurance company covering the risk of loss to the stock of yarn in the factory premises for a sum of ₹ 5 lakh. It is submitted that on the date of incident in their premises the yarn belonging to the following mills was lying:

(*a*) 6,500 kg. of yarn worth ₹ 8,45,000 belonging to M/s. Omparasakthi Mills.

(*b*) 2.232 kg. of yarn worth ₹ 3,00,000 belonging to M/s. Lakshmi Mills Co.

(*c*) 6,788,200 kg. of yarn worth ₹ 5,10,394 belonging to M/s. Durairaj Mills.

The receipt of yarn from each party is evidenced by documents like RR3A and GP2 forms issued by the Central Excise Department as these are excisable goods. Similarly, when the party returns the yarn after doing the job-work, return is also evidenced by similar documents submitted to the Central Excise Department. It is pointed out that M/s. Omparasakthi Mills, Coimbatore, M/s. Durairaj Mills Pvt. Ltd., M/s. Pethanaicken Palayam Mills and M/s. Lakshmi Mills, Coimbatore, were regularly sending yarns to Prabhu Textiles for converting them into double yarn and packing them into cones. Records are maintained for receipts and returns as prescribed by the Central Excise Department.

A video film taken by the insured showed the broken window panels, burnt wires, damaged switch boards, smoke on the walls, development of cracks in the office room, the broken strewn pieces of asbestos sheets and cones of yarn, bent iron rods, ankles and grills, five burnt motors and 8 aluminium separators in between the spindles. The Surveyor appointed by the insurance company in his report, pointed out that the doubling frames have been subjected to severe fire attack. The ferrous parts have been blued by the heat and sagged completely. Aluminium parts have melted and fallen down as a blot and all the cables have been burnt to their bare conductors. The winding machine had been totally damaged and the stock of yarn had also been burnt without any room for salvage. They made a claim of ₹ 5 lakh from the insurance company.

The insurance company repudiated the claim on the ground that the fire was not accidental but intentional. For this decision reliance was placed on the report of the Surveyors, according to whom (i) the fire had occurred simultaneously in different portions of the premises and there was no continuity in direction and hence these different portions must have been simultaneously- set fire to; (ii) there were only 269 yarn cones in damaged condition and the remaining of them had been shifted, and (iii) M/s. Prabhu Textiles was in financial crisis.

III. Prabhu Textiles had four doubling machines and a cone winding machine which were purchased with the finances provided by the Tamil Nadu Investment

Corporation Ltd. The value of the said machinery was ₹ 14,37,198. Each doubling machine consists of 412 spindles and each spindle at its top has booster in which the spindle oil is poured and the quantum of oil at a particular level was required to be maintained throughout. It is stated that in the gear mobile oil and grease were required to be regularly applied. Further in the winding machine at least 15 litres of oil was required to be kept. It is pointed out that because of the spindle oil, mobile oil and grease the fire would spread quickly.

The Tamil Nadu Investment Corporation Ltd. which had provided the finance had also taken a policy of group insurance covering the loss by fire, etc., with the same insurance company in respect of the building and machineries of various concerns including that of Prabhu Textiles. The policy covers the risk to the building for a sum of ₹ 7,20,000 and machinery for a sum of ₹ 8,00,000 totalling ₹ 15,20,000. A claim was submitted ₹ 15 lakh to the insurance company. It was also rejected.

CASE STUDY A CASE FOR DISCUSSION – CASE II

A CASE OF FIRE INSURANCE CLAIM

1. Mr. Swami, the Owner of the building bearing Door No. 656, Trinadh Mahal, Vullithota Street, Rajahmundry, insured the building with the New India Insurance Company for ₹ 10,00,000/-. The Fire Policy was issued on 24.06.1996 which was valid from 24.06.1996 to 23.06.1997. As per the terms and conditions of the policy, if the property is destroyed or damaged by fire, lightening, explosion, riots and strikes, storm, cyclone, typhoon and floods, the Insurance Company will pay the insured value of the property destroyed or damaged. On 06.11.1996, the cyclone damaged the insured property and the owner i.e., Policy Holder accordingly, filed a claim of ₹ 5,00,000/- with the Insurance Company which was repudiated on 31.03.1997 on the ground that as per the Report of the Surveyor, the insured building was in a deteriorated condition and did not sustain any kind of loss on account of cyclone. Thus, being aggrieved, the owner filed the complaint before the District Consumer Court.
2. The Insurance Company filed its Counter-stating that as per the Surveyor's Report, the insured building was in a deteriorated condition with cracked walls, exposed bricks, country/tiled roof which had collapsed long time ago with some plants which were rooted inside the building premises. That the Policy was taken by Mr. Swamy long ago and was renewed by the Insurance Company from time-to-time, on utmost good faith. It was the duty of the policyholder to disclose the true condition of the building. Further the District Consumer Court had no territorial jurisdiction to deal with the Complaint as the Policy was issued at Visakhapatnam and the insured property is situated at Rajahmundry. Denying the allegations, the owners prayed for justice.

   District Consumer Court, after taking into consideration, the pleadings and the evidence led by the parties, dismissed the complaint.
3. Being aggrieved by the order passed by the District Consumer Court, Policy Holder filed the Appeal before the State Commission. The State Commission allowed the Appeal, set aside the Order of the District Consumer Court and directed the Insurance Company to pay the claim amount of ₹ 4,50,000/- together with compensation of ₹ 25,000/-. It was held that based on the facts and circumstances of the case and the fact that 06.11.1996 cyclone

was declared as a national calamity and that the Policy was an old Policy renewed time and again, there was no reason to disbelieve that the insured building was damaged due to cyclone.

Being aggrieved by the order passed by the State Commission, Insurance Company filed Revision Petition.

4. This Revision Petition was admitted limited to the point of quantum of compensation and the operation of the impugned order was stayed. Undisputed facts are that the respondents got their building bearing Door No. 656, Trinadh Mahal, Vullithota Street, Rajahmundry, insured with the New India Insurance Company for a sum of ₹ 10,00,000/- under Fire Policy on 24.06.1996 which was valid from 24.06.1996 to 23.06.1997. As per the terms and conditions of the Policy, if the property was destroyed or damaged by fire, lightening, explosion, riots and strikes, storm cyclone, typhoon and floods, the petitioner-Insurance Company will pay the insured value of the property destroyed or damaged. On 06.11.1996, the insured property was damaged on account of cyclone and the owner preferred a claim for ₹ 5,00,000/- which was repudiated by the Insurance Company on 31.03.1997 stating that their Surveyor stated in his Report that the building was in a deteriorated condition and did not sustain any kind of loss of account of cyclone.

CONTENTION OF THE INSURANCE COMPANY

5. Based on the Report of the Surveyor as well as the Affidavit filed by Shri. V.S.R. Prasad Rao, Chartered Engineer and approved Valuer and Loss Assessor, who was produced as a Third Party witness by the insurer, the Insurer contended that as per Survey Report, the building was in a deteriorated condition with cracked walls, exposed bricks, country/tiled roof which collapsed long ago with some plants which were well rooted inside the building premises. That since the Policy was being renewed from time to time, in utmost good faith, the insurer should have disclosed the condition of the building while getting the Policy renewed.

POLICYHOLDER CONTENTION

The detailed report of Shri. V.S.R. Prasad Rao, Chartered Engineer, stated that the building was damaged due to cyclone and it would require ₹ 6,00,000/- for the proposed repairs/renovation and alterations to the existing damaged building. It was reported by him that the building was damaged due to cyclone on 06.11.1996 which was a major one in the Godavary Delta area and wrecked havoc affecting over 7 lakh people. That the said cyclone was declared by the Government of India as a national calamity. He further cited Supreme Court Judgment which runs as under:

The Supreme Court of India in Dharamendra Goel v. Oriental Insurance Company Limited reported in (2008) has observed that the Insurance Company, after having accepted the value of the particular insured good, cannot disown that very figure on one pretext or the other when they are called upon to pay compensation. Hon'ble Supreme Court held that the Insurance Company, having put the value of the insured good itself at the time of renewal of the Policy, cannot put a different value when called upon to pay compensation.

Based on the above facts what will be your decision if you were to sit on judgment of the case. Give your decision with reasoned arguments.

NOTES

UNIT

12

MOTOR INSURANCE

STRUCTURE

Introduction

It is the fore-thought and vision of the underwriters that a motor insurance policy was designed by an insurance company as early as 1895. An act was passed in 1930 by the government of U.K. to cover third party liability. A similar act was passed in India by 1939 and later on a new act was substituted in 1988. At that time the number of vehicles in India was less and the accidents were few. Today the number of vehicles on the road is staggeringly large and the traffic has grown in menacing proportions. The Motor Vehicle Act 1988 (M.V. ACT) in the present day context, is an absolute necessity, and without compulsory insurance the position would have been precarious for motor accident victims. The necessity for motor insurance is felt by everyone, with the advent of large and powerful automobiles, and numerous road accidents. Motor insurance was devised to protect the owners' interest on automobiles against unforeseen loss or damage and also meet the liability for compensation to third party, in case of death or injury, or damage to third party property. The later part was called 'liability insurance' when it was introduced. The government brought in legislation making motor insurance compulsory, as the victims of road accidents were not able to get compensation, because of refutation of the claims on flimsy grounds, as well as the weak financial position of the persons liable.

The Motor Vehicles Act 1939 and the new Act of 1988 made motor insurance for third party liability compulsory and unlimited. The Act stipulates that no owner of a motor vehicle can use, cause or allow to use the vehicle in a public place without a valid insurance. The policy issued in terms of the Motor Vehicles Act makes it compulsory to cover liability towards injury/death to third party/persons, damage to third party property, injury/death to passengers in a public service vehicle, injury/death to workmen connected to the operation of the vehicle, viz., driver, conductor, ticket examiner and loadmen.

Risk Covered

Motor vehicle insurance covers a number of risks. It insures the motor vehicle owner against risk of liability for injury, or death of third parties, caused by the driver. It insures damage to the vehicle and its accessories, third party property, damage and death of, or injury to, the assured himself or spouse or driver. No insurer should deny third party liability cover to any motor vehicle having valid fitness certificate.

Compulsory Insurance

Section 146 of the M.V. ACT 1988 provides that no person shall use, except as passenger, or allow any other person to use, a motor vehicle in a public place unless the vehicle is covered by insurance complying with the requirements of the Act. This means that any mechanically propelled vehicle in use in a public place has to be compulsorily insured against liability risk, *i.e.*,

- Liability arising from death, injury or property damage to third parties.
- Liability arising from death or injury to workmen such as paid driver/cleaner/ conductor/ labourer engaged for loading or unloading, etc.
- Liability arising from death or injury to fare paying passengers traveling in the vehicle licensed to carry passenger.

Motor policies in vogue are of two types (A) Liability only policy and (B) Package Policy. Liability Policy covers only Act Liability as per Motor Vehicles Act. Package policy covers loss or damage to the vehicle besides third party liability.

Basic Principles of Insurance

Motor insurance contracts are subject to the basic principles of insurance. The owner of a motor vehicle has insurable interest in the vehicle. Although the owner has no insurable interest in any third party liability, Section 146 of the Motor Vehicles Act, 1988 makes it necessary. If a third party is injured in an accident, the damages payable to the third party would be a financial loss to the insured. Hence he needs to insure his liability to a third party. The principles of utmost good faith, indemnity, subrogation, contribution and proximate cause will also apply to motor insurance contracts. A bank or finance company has insurable interest in a vehicle, if the vehicle is purchased under a hire purchase agreement. Motor repairers have insurable interest as bailee in respect of loss or damage to customers cars which are in their custody for repairs.

Premium

For the purpose of premium rating the vehicles are classified as follows:

1. Private cars/two wheelers
2. Goods carrying vehicles
3. Passenger carrying vehicles
4. Miscellaneous and special type of vehicles.

Rating Factors

The premium rates are fixed based on the following factors depending on the class of vehicle:

1. Insured Declared Value (IDV).
2. Geographical zone in which the vehicle is plying.
3. Age of the vehicle.
4. Cubic capacity.
5. Gross weight capacity for goods carrying vehicles.
6. Licenced carrying capacity for passenger carrying vehicles (other than 3 or 4 wheelers with carrying capacity not exceeding 6 passengers.
7. Discount on premium is allowed for every year of 'no claim' which can go up to 50 per cent cumulatively and likewise premium is increased (loading) on the basis of adverse claim experience.
8. *Loading for adverse claims.* Insurers may load the third party tariff motor premium by 100 per cent if the claim experience of any individual owner is adverse as per the insurers' assessment. If the experience continues to be

bad, then a further loading of 100 per cent on the expiring premium can be charged. Insurers may not load the premium further.

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Insured Declared Value (IDV)

The value declared by the insured in the proposal is called IDV and it is deemed to be the sum insured for the purpose of tariff. The IDV is arrived at on the basis of manufacturer's listed selling price of the brand and model at the time of commencement of insurance/renewal and adjusted for depreciation. This valuation is applicable for the purpose of total loss/constructive total loss claims only.

Scope of Cover

The insurer will indemnify the loss or damage to the vehicle insured by fire explosion, self ignition, lightning, burglary, house breaking, or theft, riot and strike, earthquake (fire & shock) flood, typhoon, hurricane, storm, tempest, inundation, cyclone, hail storm, frost damage caused by accidental external means, malicious act by terrorist activity, vehicles whilst in transit by road/rail, inland water way, lift elevator or air, by landslide, rockslide and other liability besides third parties liability as per the provisions of the Motor Vehicles Act. The insurance policy is issued for twelve months only. There after it has to be renewed every year.

Exclusions

Motor policy will not cover (*i*) depreciation, (*ii*) wear and tear, (*iii*) mechanical or electrical breakdown, failure or breakages, (*iv*) damage to tyres, (*v*) damage or loss caused to the vehicle when driven under the influence of liquor or drugs.

General Exceptions

The company shall not be liable under this policy in respect of loss or damages:

1. Caused, sustained or incurred outside the geographical area.
2. Arising out of any contractual liability.
3. (*a*) Being used otherwise than in accordance with limitations as to use and/or without permit (*b*) Driven by other than a driver as stated in drivers clause.
4. Any consequential loss.
5. Arising from ionising radiations or contamination.
6. Caused by or contributed by or arising from nuclear weapons material.
7. In connection with war, invasion, the act of foreign enemy.

Geographical Zones

For the purpose of premium calculation, India is divided into three zones depending on the location of the office of registration of the vehicle.

1. Private cars, two wheelers, commercial vehicle with passenger capacity not more than 6.

Zone A :	Ahmedabad, Bangalore, Chennai, Hyderabad, Kolkata, Mumbai, New Delhi and Pune
Zone B :	Rest of India

2. Commercial vehicles excluding vehicles detailed above.

Zone A :	Chennai, Delhi/New Delhi, Kolkata, Mumbai
Zone B :	All other State capitals
Zone C :	Rest of India

Limit of Liability

Liability for all classes of vehicles will be unlimited for third party death and bodily injury and in respect of damage to property of third party as specified in the policy although the Act fixed it at ₹ 6000. However the tribunal may award a higher amount if considered appropriate. In case of personal accident for owner-driver, the insurer undertakes to pay compensation for bodily injury sustained by owner-driver of the vehicle in direct contact with vehicle insured or whilst traveling in it as a co-driver. The personal accident cover is compulsory under both **'Liability Only'** and **'Package'** policies. The owner of the insured vehicle with an effective driving license is called as owner-driver under this section. The owner-driver is provided with insurance cover while driving the vehicle including mounting into/dismounting from or traveling in the insured vehicle as a co-driver. The personal accident cover under this section is limited to maximum sum insured of ₹ 2 lakh per person. Damage caused by intentional acts, influence of alcohol or drugs are excluded. In case of death, compensation will be paid to the legal representatives directly. The compensation motor accident is payable even when the driver/owner of the vehicle is not at fault but only the victim. The amount is restricted to ₹ 50000 for death and ₹ 25000 for permanent disability. The claim is payable under the policy in accordance with Sec. 140(3) of the Act.

Motor Vehicles Act 1988 defines a hit and run motor accident as an accident arising out of the use of a motor vehicle, the identity of which could not be ascertained in spite of reasonable efforts. However in the case of hit and run, the claim is not on the insurance company since the vehicle is not identifiable. The claim application will be made to the designated authority in each district, who will pay after due enquiry. The amount is paid from a common fund known as 'solatium fund' which is maintained by the government out of contributions by insurance companies and governments. The amount payable is restricted to

1. ₹ 25,000 for death and
2. ₹ 12,500 for injury

Motor Accident

If a third person is injured in an accident, then the injured person is to be immediately moved to the hospital for treatment. After ensuring that the person has received medical treatment, the matter is to be reported to the police without delay. If any property (belonging to a third person) has been damaged as a result of the accident, the police is to be informed immediately. The insured policyholder should report the matter to the insurance company in writing. He should, in addition, obtain a claim form from the insurer and submit it duly filled to the insurance company with the supporting documents, viz., an estimate from reputed repairers in case the vehicle is damaged, copies of the FIR with the police, sketch of the accident site, driving license, RC book, fitness certificate, permit, and final bill from repairers and satisfaction note from the policyholder himself. The notice of claim if any, received by the insured from the third party, Motor Accidents Claims Tribunal or any court, is to be sent directly to the insurance company. It is not advisable for the insured to respond to the notice of claim. The insurance company will handle it provided the documents required are in order. It is not that the insured has no responsibility in this regard and in fact he should do all that is possible, to support the insurance company in its defence against the claim of the victim. But whatever the insured does should be with the consent and guidance of the insurer. The RC book, driving license and FIR copies should be submitted to the insurance company. In case of theft, the insured should report the theft to the insurance company, immediately in writing. The report should include a clear description of the incident, the date and time of the incident. The insured should report the theft to the police station as well. He must obtain a copy of the First Information Report from the police. If the vehicle is non-traceable then the insured must produce a certificate from the police to that effect. The insurance company will

settle the claim in cash on the basis of the latest market value or the 'estimated value' mentioned in the policy, whichever is less. The insurance company may appoint an investigator to examine the genuineness of the theft.

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Motor Accident Claim Tribunal

The Motor Vehicles Act of 1988 empowers the state governments to set up tribunals for adjudicating third party claims. The litigation cannot be taken to a civil court wherever a tribunal is set up. The aggrieved party has to move the tribunal either in the place of accident or his residence generally within a period of six months from the date of accident. However the time limit does not apply to accident victim strictly.

Lok Adalat

The pending cases with the tribunal where the liability under the policy is not in doubt are transferred to Lok Adalat. It is another claim settlement body which works on a simple and easy system and adopts conciliation methods for settlement of third party claims.

Survey

The insurer on receipt of the claim, depute an officer or the surveyor to investigate the accident and submit report to it. Based on such a report, the insurer can either opt for repairing, reinstating or replacing the vehicle or can pay the compensation in cash.

Cancellation of Policy

The insurance company may cancel the policy and so also the insured may also cancel a policy by giving seven days notice subject to the condition that the vehicle has to be insured elsewhere for at least 'Liability Only Cover'. The insurance company has to intimate about cancellation of insurance to the Regional Transport Authority.

Vintage Cars

According to the Tariff Regulations, the agreed value policy is issued only in respect of vintage cars and not for any other vehicle. In an agreed value policy, a specified sum or pre-determined sum agreed as the insured value of the vehicle is paid as compensation in case of total loss/constructive total loss of the vehicle. The claim is settled without any deduction for depreciation.

Concessions

A discount of 50 per cent on Own Damage premium is allowed in respect of vehicles specially designed for use of blind, handicapped and mentally challenged persons. Discount is also given to the Automobile Association members, vehicles with and theft devices and vintage cars.

Use of Vehicles Within Insured's Premises/Sites

In some cases, the insured may use a vehicle only in his premises/sites and not on the public roads. These vehicles are mostly used in production or manufacture activity and are not used on the public roads. In such cases discount is allowed on the premium. In these cases no Certificate of Insurance or cover note is issued by the insurance company to the insured.

Special Vehicles

Vehicles with electrical/electronic fittings, vehicles which use CNG/LPG fuel fibre glass fuel tanks and vehicles used for driving tuitions are subject to additional premium.

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Cover Note

Motor cover note is valid for a period of sixty days from the date of its issue and the insurance company has to issue a policy before expiry of the cover note.

Certificate of Insurance

An insurance policy is not effective for the purposes of the Act unless a certificate of motor insurance is issued. The certificate must contain important details of the relative policy.

Motor Third Party Pool Account

Several complaints have been received by IRDA regarding non-availability of motor third party insurance especially for commercial vehicles. However in view of adverse claim experience, insurers have been expressing difficulty to underwrite this business unless they are permitted to charge premium rates that they consider appropriate.

In view of the mandatory nature of motor third party insurance business IRDA has taken steps to monitor the rates, terms and conditions of cover. IRDA considers that all insurers registered to carry on general insurance business including motor insurance business should actively participate in providing such cover to vehicle owners at rates as notified by them.

In the circumstances, IRDA directed that all general insurers registered to carry on general insurance business (including motor insurance business) or general reinsurance business, shall collectively participate in a pooling arrangement to share motor third party insurance business underwritten by any of the registered general insurers in accordance with the following provisions. These arrangements are applicable to commercial vehicles only.

1. *Participation in pooling arrangement:* Every insurer registered to carry on general insurance business (including motor insurance business) or general reinsurance business shall automatically participate in the pooling arrangement with effect from 1.4.2007. This arrangement is applicable to commercial vehicles only.
2. *Underwriting insurers:* Every underwriting office of every insurer that is authorised to underwrite motor insurance business for the insurer shall also be authorised to underwrite motor third party insurance business that will be shared among all insurers through the pooling arrangement.
3. *Pooling mechanism:* The pooling of business among all insurers will be achieved through a multi-lateral reinsurance arrangement between the underwriting insurer and all the other registered insurers carrying on general insurance business (including motor insurance business) and general insurance reinsures.
4. *Participation in motor third party insurance pooled business:* The participation of General Insurance Corporation of India (GIC) in the pooled business shall be such percentage of the motor business that is ceded to it by all insurers as statutory reinsurance cessions under Sec. 101A of the Insurance Act. (Time being it is 20 per cent) The business remaining after such cession to GIC shall be shared among all the registered general insurers writing motor insurance business in proportion to the gross direct general insurance premium in all classes of general insurance underwritten by them in that financial year.
5. *Underwriting of business:* Underwriting offices of insurers shall follow the underwriting instructions of the General Insurance Council in the matter of procedures for underwriting and documentation and accounting and settlement of balances. The business shall be underwritten at rates and terms and conditions of cover as notified by the Authority from time to time.

No vehicle owner shall be denied third party insurance cover in respect of his vehicle which is holding a valid permit for use on public roads except on grounds of attempted fraud.

6. *Claims processing and settlement:* All claims in respect of third party death or injury or physical damage shall be processed for settlement in a speedy and efficient manner in accordance with the instructions of the General Insurance Council. For this purpose, the Council shall adopt a pro-active claims settlement policy adopting the most efficient claims processing practices possible.
7. *Administration of the Pooling arrangement:* The GIC shall act as the administrator of the pooling arrangement. It will act under the guidance of the General Insurance Council. For this purpose, the Council may establish such Committees of insurers as are necessary to operate the pooling arrangement and process and settle claims in the most efficient manner.
8. *Remuneration:* There will be no agency commission or brokerage payable in respect of motor third party insurance business. The underwriting insurer will be paid a reinsurance commission of 10 per cent on the premium ceded by it to all the other insurers and reinsurers. The GIC as administrator shall be paid a fee of 2.5 per cent of the total premium on motor third party insurance business in respect of the business underwritten for the pooled account. Each insurer shall bear the cost of hardware required to operate the pooling arrangement within its offices. The GIC will bear the cost of hardware necessary to administer the pooling arrangement in its offices. The cost of the operating software for the pooling arrangement shall be shared by all the insurers and reinsurers in the manner decided by the General Insurance Council. Each insurer shall bear the cost of travel of its executives to attend to the work relating to the pooling arrangement. However, any travel specifically to service a claim shall be recoverable as claims related expenses.
9. *Agreement:* The insurers and GIC shall enter into a multi-lateral reinsurance arrangement to give effect to this pooling scheme.
10. *Review:* The IRDA will review the operation of the pooling arrangement and the need for regulation of the premium rates and terms of cover and will issue such directions from time to time as may be considered necessary.

12.1. RECENT DEVELOPMENTS

Motor Insurance—Judicial Views on Third Party Claim

The Motor Vehicle Act compels the owners of the motor vehicle to take insurance for third party liability. There have been several instances of conflict, in interpretation of the Act and the policy conditions. The Supreme Court in its judgement on the Swaran Singh and National Insurance Company dispute, discussed the issues elaborately. Salient points of the judgement are given here.

Motor Vehicles Act

Motor Vehicles Act 1988 Sec. 2(10) deals with driving licence. Sec. 3 with necessity for driving licence, Sec. 4 on agelimit for the driver, Sec. 5 on the responsibility of owners of motor vehicles for contravention of sections 3 and 4. Sec. 14 on currency of licences to drive motor vehicles and Sec. 15. renewal of driving licences. Section 147 of the Act provides for requirements of policies and limits of liability.

Section 149 provides for the duty of insurers to satisfy judgments and award against persons insured in respect of third party risks. Section 149 postulates that in the event that a certificate of insurance has been issued or a judgement or award

in respect of any liability obtained by the insured, the insurer notwithstanding its entitlement to avoid or cancel or may have avoided or cancelled the policy, shall, subject to the provisions of this section, pay to the person entitled to the benefit of the decree any sum not exceeding the sum assured payable thereunder, as if the insurer were the judgement debtor, in respect of the liability, together with any amount payable in respect of costs and interest. If the amount which an insurer becomes liable under this section to pay in respect of a liability incurred by a person insured by a policy exceeds the amount for which the insurer would be liable under the policy, the insurer shall be entitled to recover the excess from that person.

Motor Vehicles Act 1988, *inter alia,* provides for compulsory insurance of vehicles in relation to the matters specified there. The provision for **compulsory insurance** indisputably has been made *inter alia* with a view to **protect the right of a third party.**

The relevant provisions of the Act indisputably are beneficient to the claimant. They are in the nature of **Social Welfare Legislation.**

Third Party Claim

The right of the victim of a road accident to claim compensation is a statutory one. He is a **victim of an unforeseen situation.** He would not ordinarily have a hand in it. The negligence on the part of the victim may, however, be contributory. He has suffered owing to wrongdoing of others. An accident may ruin entire family. It may take away the only earning member.

An accident may take place for variety of reasons. The driver of a vehicle may not have a hand in it. He may not be found to be negligent in a given case. Other factors such as unforeseen situation, negligence of the victim, bad road or the action or inaction of any other person may lead to an accident.

The Third Parties Rights against Insurers was enacted with a view to correct **injustice** of the assured **to the injured person** by way of denial or delay in payment of claim to the injured. In a case where the assured became bankrupt and if the injured person had not already obtained judgement and executed his claim for damages his only right was to move in the bankruptcy or the winding up of proceedings. In the circumstances the beneficial provisions of the English statutes were incorporated by the Parliament of India while enacting the Motor Vehicles Act, 1939 which has been replaced by the Motor Vehicles Act, 1988.

Furthermore, the insurance company with a view to avoid its liabilities is not only required to show that the conditions laid down under Section 149 (2) (a) or (b) are satisfied but further required to establish that there has been a breach on the part of the insured. By the provisions contained in the 1988 Act, a more extensive remedy has been conferred upon those who have obtained judgement against the user of a vehicle. **Breach** on the part of the insured **must be established by the insurer** to show that not only the insured used or caused or permitted to be used the vehicle in breach of the Act but also that the damage suffered flow from the breach.

Under the Motor Vehicles Act, holding of a **valid driving licence** is one of the conditions of contract of insurance. Driving of a vehicle without a valid licence is an offence. However, the question herein is whether a **third party** involved in an **accident** is entitled to the amount of compensation granted by the Motor Accidents Claims Tribunal although the driver of the vehicle at the relevant time might not have a valid driving licence but would be entitled to recover the same from the owner or driver thereof. There may be a case where an accident takes place without there being fault on the part of the driver. In such an event, the question as to whether a driver was holding a valid licence or not would become redundant.

If the person who has got the vehicle insured has allowed the vehicle to be driven by a person who is not duly licensed, the insurer has to satisfy the Tribunal or the Court that such violation or infringement on the part of the insured was wilful. If

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the insured has taken all precautions by appointing a duly licensed driver to drive the vehicle in question and it has **not been established that it was the insured who allowed the vehicle** to be driven by a person not duly licensed, then the insurance company cannot repudiate its statutory liability. The insurance company is, required to **establish the said breach by cogent evidence.** In the event, the company fails it cannot be absolved of its liability. The provisions of sub-sections (4) and (5) of Section 149 of the Motor Vehicles Act, 1988 may be considered as the liability of the **Insurer to satisfy the decree.**

The insurance company cannot shake off its liability to pay the compensation only by saying that at the relevant point of time the vehicle was driven by a person having no licence. Thus, where a liability has been established by a judgement, it is **not permissible to look beyond** the determination in order to establish the basis of the liability. If the insurer has been made to pay something which on the contract of the policy he was not bound to pay, it can under the proviso to sub-section (3) and under sub-section (4) recover it from the assured. It was said that the assured might be a man of straw and the insurer might not be able to recover anything from him. But the answer to that is that it is the insurer's bad luck. In such circumstances the injured person also would not have been able to **recover** the damages suffered by him **from the assured,** the person causing the injuries. The right to avoid liability in terms of sub-section (2) of Section 149 is restrictive. The Tribunal has power to direct them to satisfy the decree at the first instance and then direct recovery of the same from the owner. These two matters stand apart and require contextual reading.

In a case where the driver of the vehicle admittedly did not hold any licence and the same was allowed consciously to be driven by the owner of the vehicle by such a person, the insurer is entitled to succeed in its defence and avoid liability. But the driver possessing licence for one type of vehicle **found driving another type of vehicle,** met with accident, and if it is found that accident was caused solely because of some other unforeseen or intervening causes like mechanical failures and similar other causes having no nexus with driver not possessing requisite type of licence, the insurer will not be allowed to avoid its liability merely for technical breach of conditions concerning driving licence. A **learner's licence** is a licence within the meaning of the provisions of the Act. It cannot be said that a person holding a learner's licence is not entitled to drive the vehicle.

Minor and inconsequential **deviations** would not constitute sufficient ground to deny the benefit of coverage of insurance to the third parties. On all pleas of breach of licensing conditions taken by the insurer, it would be open to the tribunal to adjudicate the claim and decide the insurer to seek its remedy of reimbursement from the insured in the civil court.

Accident

'Accident includes negligence. It makes no difference that the accident was caused by the negligence of the assured (as opposed to his intentional act). In fact, one of the commonest causes of accidents is negligence, and an accident policy applies, excepted perils apart, whether the injury is caused by the negligent act of the assured himself or of a third party.' One must avoid the danger of construing that term accident as if it were equivalent to 'inevitable accident'. That a mishap might have been avoided by the exercise of greater care and diligence does not automatically take it out of the range of accident. Expressed another way, "negligence" and "accident" as used here are not mutually exclusive terms. They may co-exist.

Licence

In Section 3, the words used are **'effective licence'.** It has been differently worded in Section 149(2), *i.e.*, **'duly licensed'.** If a person does not hold an effective licence as

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on the date of the accident, he may be liable for prosecution in terms of Section 141 of the Act but Section 149 pertains to insurance as regard third party risks. A provision of a statute which is penal in nature *vis-á-vis* provision which is beneficent to a third party must be interpreted differently. The words 'effective licence' used in Section 3, therefore, cannot be imported for sub-section (2) of Section 149 of the Motor Vehicles Act. We must also notice that the words 'duly licensed' used in sub-section (2) of Section 149 are used in past tense.

A person's licence is ordinarily renewed and if the accident took place after the date of expiry of the licence, before renewal, it cannot be said that he did not have a valid licence, Section 14 in unequivocal term states that the licence remains valid for a period of **thirty days** from the day of its expiry.

Section 15 of the Act does not empower the authorities to reject an application for renewal only on the ground that there is a break in validity or tenure of the driving licence, and in the meantime the provisions for disqualification of the driver will **not be** applied and he cannot be said to be **delicensed.** The license shall remain valid for a period of 30 days after its expiry.

If a person has been given a licence for a particular type of vehicle, he cannot be said to have no licence for driving another type of vehicle which is of the same category but of different type and with a licence for driving a light motor vehicle one can drive either a car or a jeep and it is not necessary that he must have driving licence both for car and jeep separately.

The insurance company can deny the claim and take defence in terms of Section 149(2)(*a*)(*ii*) of the Motor Vehicles Act, 1988. If (*a*) driving licence produced by the driver or owner of the vehicle was a fake one; (*b*) driver did not have any licence whatsoever; (*c*) licence, although was granted to the concerned driver but on expiry thereof, the same had not been renewed; (*d*) licence granted to the drivers being for one class or description of vehicle but the vehicle involved in the accident was of different class or description; and (*e*) the vehicle in question was driven by a person having a learner's licence. But it is not so simple and straight forward in case of third party claim as indicated above.

A summary of findings by the Supreme Court is as under:

- (*i*) The Motor Vehicles Act, 1988 providing compulsory insurance of vehicles against third party risks is a social welfare legislation to extend relief by compensation to victims of accidents caused by use of motor vehicles.
- (*ii*) The breach of policy condition, e.g., disqualification of driver or invalid driving licence of the driver, have to be proved to have been committed by the insured for avoiding liability by the insurer. To avoid its liability towards insured, the insurer has to prove that the insured was guilty of negligence and failed to exercise reasonable care.
- (*iii*) The insurance companies must establish 'breach' and the burden of proof is on the insurance company.
- (*iv*) Even where the insurer is able to prove breach the insurer would not be allowed to avoid its liability unless the said breach is fundamental and contributed to the cause of the accident.
- (*v*) The question as to whether the owner has taken reasonable care to be determined in each case.
- (*vi*) If a vehicle at the time of accident was driven by a person having a learner's licence, the insurance companies would be liable to satisfy the decree.
- (*vii*) If the tribunal arrives at a conclusion that the insurer has satisfactorily proved his defence, the insurer is liable to be reimbursed by the insured for the compensation and other amounts which he has been compelled to pay to the third party.

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SUMMARY

- It is the fore-thought and vision of underwriters that the motor insurance policy was designed by an insurance company as early as 1895 while the act was passed in 1930.
- Motor insurance is to protect the owner's interest on automobiles against unforeseen loss or damage.
- The Motor Vehicles Act makes it compulsory to cover liability towards injury/death to third party/persons, damage to third party property, injury/death to passengers in a public service vehicle, injury/death to workmen connected to the operation of the vehicle, viz., driver, cleaner, conductor, ticket examiner, and loadmen.
- No person shall use a vehicle in a public place unless it is covered by a policy of insurance complying with the requirements of the Act.
- For the purpose of premium rating, the vehicles are classified as private cars goods carrying vehicles passenger, carrying vehicles, miscellaneous and special type of vehicles.
- The value declared by the insured in the proposal is called Insured Declared Value (IDV) and it is deemed to be the sum insured for the purpose of tariff. The IDV is arrived at on the basis of the manufacturer's listed selling price of the brand and model at the time of commencement of insurance/renewal and adjusted for depreciation.
- Motor Vehicles Act 1988 defines a hit and run motor accident as an accident arising out of the use of the motor vehicle, the identity of which could not be ascertained in spite of reasonable efforts. The compensation in such case of motor accident is ₹25,000 for death and ₹ 12,500 for injury.
- If a third person is injured in an accident, then the injured person is to be immediately moved to the hospital for treatment and after ensuring that the person has received medical treatment, the matter is to be reported to the police without delay and then reported to the insurance company in writing.
- The notice of claim if any, received by the insured from the third party, Motor Accidents Claims Tribunal or any Court, is better sent to the insurance company. It is not advisable for the insured to respond to the notice of claim.
- For adjudicating third party claims the litigation cannot be taken to a civil court wherever a tribunal is set up.
- An insurance policy is not effective for the purposes of the Act unless a certificate of motor insurance is issued. The certificate must contain important details of the relative policy.

REVIEW QUESTIONS

1. Explain briefly the scope of cover, extensions, exclusions and claim procedure in respect of Motor insurance?
2. Explain third party liability insurance and legal implications quoting court cases.
3. Discuss the Motor Pool arrangement and its implications for the insurance companies.
4. What is your understanding of the following:
   (*i*) Insurable Interest in Motor Insurance?
   (*ii*) Miscellaneous and special types of Vehicles-Name any five
   (*iii*) Commercial Vehicle
   (*iv*) Certificate of insurance

5. Write Short Notes on:
   (*i*) Necessity for third Party Insurance in Motor Insurance.
   (*ii*) Motor Accident Claim Tribunal.
6. Differentiate between of the following:
   (*a*) Geographical Area and Geographical Zone.
7. Deductible and deduction for depreciation.
8. What is the reason for allowing various discounts while underwriting Motor Insurance? Explain At least two discounts in use.
9. Analyze a Proposal Form for Commercial Vehicle underwriting explaining briefly the importance of information required.
10. Explain the concept of "Liability Without Fault". How much Compensation is paid for liability without fault claims?
11. What are three Major Losses Associated with i) Private Car ii) Truck and iii) Taxi and what are the insurance cover available for them?
12. What are the important factors considered in fixing premium for private motor car and truck insurance?
13. Detail the procedure for appraisal of proposal for private car?
14. What are various types of Motor Vehicles and how Insurance case of such vehicles are differently appraised by the insurer while underwriting?

APPLICATION QUESTIONS

1. Mr. Balu gave his car to a car mechanic to set right the break system which was not working. On his phone call he went to pick up the car. As the defect was rectified according to the mechanic, the mechanic to drove the car, while the owner was also in the car, on a test drive. It met with an accident and hit a pedestrian on the road, resulting in a claim. Will the insurance policy on the car taken by Mr. Balu will cover the risk.
2. The Insurer while changing the Tyre, the car slipped off the jack and injured him and it resulted in medical expenditure of ₹ 10,000/- is it a motor accident and considered eligible for claim?

FURTHER REFERENCES

1. Automobile Insurance – Georgesdionne and Others by Centre for Research on Transportation, Montreal.
2. Motor Accident Claims – Janak Rajjai – Universal Publishing.

CASE STUDY A CASE FOR DISCUSSION – CASE I

A real life case is given below. Based on the data given analyse the issues involved and the problems in settlement of claim. If you were to sit on judgment over the dispute what will be your approach. Give your decision and the reasons therefore.

MOTOR ACCIDENT—OWN DAMAGE CLAIM

Mr. Davinder Singh is the owner of the vehicle bearing No. HR-37A-5521. He got the said vehicle insured on 10.11.2003 for one year, i.e., up to 9.11.2004. It met with an accident on 20.4.2004 with a truck. The said vehicle was being driven by one Kulbir Singh. Upon investigation made in this regard by the insurance company, it was found that the licence bearing No. 6604/R-91-92 held by Kulbir Singh was not issued by the Licensing Authority at Solan. Hence the claim was rejected.

However, Mr. Davinder Singh claimed that the driver possessed a valid licence. He therefore filed a complaint petition under Section 12 of the Consumer Protection

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Act, 1986 before the District Consumer Disputes Redressal Forum complaining of deficiency in service for not paying the amount of claim which was covered by the insurance policy, which the insurer was bound to pay. The complaint was admitted, awarding a sum of ₹1,23,412 towards damages to the car and also a sum of ₹ 20,000 towards other heads, besides interest at the rate of 9 per cent per annum.

The insurance company preferred an appeal and it was dismissed by the State Commission. A revision application filed before the National Commission met with the same result. Hence it was taken to the Supreme Court of India.

A plea was taken by the insurance company that Kulbir Singh, the driver, was not possessing a valid driving licence at the time of driving the vehicle. When they scrutinized the driving licence, it was found that the driving licence had been issued by the DTO, Hoshiarpur on 23.11.1998. The original driving licence was issued by the Licencing Authority, Solan in 1991-92. There is no evidence on the file to the effect that the original driving licence had been issued by the Licensing Authority at Solan (H.P). Further, a report has been received on the back of the court summons to the effect that the original driving licence No. 6604/R-91-92 in the name of Kulbir Singh son of Amrik Singh had not been issued by the Licensing Authority, Solan (H.P.) as mentioned in the report.

The insurance company therefore contended

(*i*) that a fake licence cannot be renewed and that too by an authority which did not originally grant the same

(*ii*) indisputably, the complainant was the owner of the vehicle in question

(*iii*) it was comprehensibly insured

(*iv*) the vehicle, however, was being driven by Kulbir Singh who did not have an effective driving licence and in that view, the owner of the vehicle was not entitled to grant of any amount by way of compensation or otherwise

(*v*) The Motor Vehicles Act, 1988 was enacted to meet the social obligation in regard to a third party as a result a cover of insurance is mandatory

(*vi*) In terms of Section 149 of the Motor Vehicles Act, however, taking of an insurance policy in relation to damages which may be suffered by the owner of the vehicle was not compulsorily insurable

(*vii*) An insurance company may be held to be liable to indemnify the owner for the purpose of meeting the third party liability under of the provisions of the Motor Vehicles Act, but the same may not necessary for an insurance company to compensate the owner of the vehicle towards his own loss. A distinction must be made as regard the statutory liability of the insurer *vis-a-vis* the purport and object sought to be achieved by a beneficent legislation and a mere enforcement of a contract between the two.

It has been clearly stated by the policyholder in his affidavit that, when he employed the driver Kulbir Singh, he was possessing a valid driving licence issued by the Licensing Authority, Hoshiarpur. He also verified this driving licence issued by Licensing Authority, Hoshiarpur and also took his driving test and found that he was an efficient driver. There is no rebuttal evidence from the side of the opposite parties and hence we hold that the driver Kulbir Singh was possessing a valid driving licence when the accident took place and hence the insurance company had illegally repudiated the claim of the complainant.

The policyholder further submitted that:

(*i*) in terms of the insurance policy the owner was required to take only reasonable care to ascertain as to whether the driver had been possessing a valid licence or not

(*ii*) it was not possible for him to ascertain from the original Licensing Authority as to whether any licence had been issued by it or not

(*iii*) the duty of the owner is merely to take reasonable care in the matter as it is not expected that he would make a detailed inquiry in this behalf.

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CASE STUDY A CASE FOR DISCUSSION – CASE II

1. Mr. LAL had insured his vehicle LPT 709 bearing Reg. No. HR 39/7825 with the Oriental Insurance Company on 11.06.1996 for an amount of ₹ 4,03,405/-. The vehicle met with an accident by colliding with a truck on 19.02.1997 and was very badly damaged. The Surveyor appointed by the Insurance Company after inspecting the damaged vehicle assessed the loss at ₹ 2,76,500/- and after deducting the survey fee, the Insurance Company settled the claim with the Policy Holder by paying him ₹ 2,75,000/-. The vehicle which was totally damaged was also transferred in the name of the Insurance Company.
2. The policyholder after having accepted the claim paid by the Insurance Company filed a complaint against the Insurance Company before the District Consumer Court wherein he contended that since the vehicle which was totally damaged was only recently insured for ₹ 4;03,405/-. Being only about 8 months in use and since it has also been transferred in the name of the Insurer, he should be paid the entire insured amount of ₹ 4,03,405/-. He also stated that he had accepted the lesser amount in settlement of the insurance claim because he had to pay the financer who had loaned him money for the vehicle with interest for which he urgently required the money.
3. The Insurance Company, on the other hand, contended that since the Petitioner had voluntarily accepted the claim as full and final settlement in writing he could not now challenge it. The Consumer Court after hearing both parties and considering the evidence filed before it, accepted the complaint and ordered as under:

   "There is no dispute that the vehicle was treated as total loss and the registration of the said vehicle has been transferred in the name of respondent company. The said vehicle met with an accident on 19.02.1997, while the same was insured on 11.06.1996. The amount insured in the cover note is according to the market value and after six months, there cannot be a huge depreciation to the value of vehicle. There was no reason to assess the short value of the said vehicle. The complainant after taking the claim has filed the present complaint before this Forum, so the complainant cannot be said that he has taken the claim as full and final settlement. The immediate lodging of the complaint after taking the claim amounts protest against the claim. In the foregoing circumstances, we agree to the contention of the counsel of the complainant and we direct the respondent to make the payment of ₹ 4,03,405/- the sum assured along with interest @ 18 % per annum from the date after three months of the accident till the realization".
4. The Insurance Company filed an appeal before the State Commission which accepted the appeal primarily on the grounds that the settlement amount had been voluntarily accepted by the Policyholder and he could not then challenge it. The relevant part of the order of the State Commission is reproduced:
5. *"We have gone through the report of surveyor. He has given the reasons for assessing the market value. It was 1996 model. Moreover, respondent had accepted the amount as assessed by the surveyor i.e.,* ₹

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2,75,500/- without any objection and without any protest in full and final settlement of the claim. There is receipt on the file signed by the respondent which again shown that the respondent had agreed to accept ₹ 2,75,000/- on total loss basis for vehicle No. HR 39-7825. In the case of voluntary acceptance, it cannot be said that the same had been accepted under duress. The reasoning given by the District Consumer Forum that the amount is presumed to have been accepted under protest as complaint was filed immediately thereafter, cannot be said to a solid reason to state that the amount was accepted by the respondent under protest when the documents suggest that it was accepted without any protest and further he transferred the vehicle in favour of the appellant.

Therefore, we hold that the vehicle owner had accepted the amount voluntarily and without any duress or pressure in full and final settlement of claim and thereafter he was not competent to agitate that he was entitled to higher amount. The value assessed by the surveyor cannot be brushed aside without any solid reason.

He is also not entitled to any compensation for mental agony etc., because after accepting the amount voluntarily in full and final settlement, it cannot be said that he had accepted the same under coercion, duress or undue influence or he suffered mental pain and agony."

6. Aggrieved by the order of the State Commission, a revision petition has been filed by the vehicle owner. The Petitioner stated that he was compelled to settle the claim in order to pay back the money that he had taken from the financer to buy the vehicle on which interest was also being levied and also that he was losing his daily income because of the total loss of his vehicle on which he depended for his livelihood. Being illiterate, the Petitioner had put a thumb impression on the amount offered by the Insurance Company without fully understanding its import and this cannot be construed as voluntary acceptance. If indeed he had voluntarily accepted, he would not have immediately filed a complaint before the District Forum expressing dissatisfaction with the amount involved in the insurance settlement.
7. The Insurance Company stated that the Surveyor had correctly assessed the loss as per the market value of the vehicle at the time of the accident. The petitioner, therefore, cannot claim a higher amount than that offered to him for which detailed reasoning and calculation had been made by the Surveyor in his survey report.
8. The policyholder brought to the notice of the court that in a similar case (Dharmendra Goel vs. Oriental Insurance Company) The Supreme Court of India held that when an accident had happened to the vehicle during the validity period of the Insurance Policy and the owner has insured it for ₹ 3,54,000/-. So, the value of the vehicle on total loss basis cannot be assessed at ₹ 1,80,000/-. Particularly when the cost of the new vehicle was ₹ 4,30,000/-. The company's contention that within a span of seven months vehicle had depreciated from ₹ 3,54,000/- to ₹ 1,80,000/- was unacceptable.

If you were to sit on judgment of the revision petition what will be your decision and the reasons therefore.

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UNIT

13

ENGINEERING INSURANCE

STRUCTURE

Introduction

Construction companies, more particularly, engineering constructions and heavy industries, who manufacture and install machines, use huge plants and equipments, which are expensive. The loss arising out of machinery breakdown, damage to machines caused by unforeseen circumstances will cost the company heavily. The branch of Engineering Insurance was evolved recent times to protect the engineering companies against heavy loss. In Engineering Insurance, the insurer will indemnify the loss or damage to mechanical, electrical and electronic machines caused by insured perils and also consequential loss. This is a growing branch of insurance triggered by the increased pace of industrialization of our country. In the backdrop of economic liberalisation, privatisation and globalisation scope of coverage is large and varied.

Almost all the perils are covered excepting wear and tear and depreciation. Third party and public liabilities are also covered wherever necessary. In the absence of engineering insurance, contractors and builders of large projects, would have been left with no cover for certain risks and would have been forced to take several policies covering different risks exposing them to the complications of full disclosure, double insurance, contribution, etc. The following are the important types of insurance extended by insurers.

- Machinery Breakdown Insurance (MBD)
- Contractors All Risk Insurance (CAR)
- Electronic Equipment Insurance (EEI)
- Contractors Plant & Machinery Insurance (CPM)

- Boiler and Pressure Plant Policy (BP)
- Erection All Risks (EAR) Policy
- Marine cum erection (MCE) Policy.
- Machinery Loss of Profits (MLOP) and Advance Loss of Profits (ALOP) policies

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Basic Principles of Insurance

As in the case of other insurance, the basic principles of utmost good faith, insurable interest, indemnity, subrogation, contribution, and proximate cause will apply. Policies are generally issued on the project basis for the entire period. They can also be issued on annual basis and renewed every year till completion.

13.1. MACHINERY (BREAKDOWN) INSURANCE

Who can Insure?

Machinery Insurance cover is availed of by industrial manufacturing companies, tiny sectors, and any one who owns/holds electrical, electronic, mechanic and lifting equipment, boilers, motors, pumps, etc.

Scope of Cover

Any unforeseen physical loss or damage to the insured machinery whilst running, at rest or during maintenance due to an accident on account of

(*i*) internal causes like faulty material, defects in casting, faulty construction, faulty design, cracking, over-heating of parts, short-circuiting, electrical burn-outs, faulty erection, explosion, tearing apart on account of centrifugal forces and failure of operation of safety devices and

(*ii*) external causes like lack of skill, carelessness, sabotage, falling bodies, electrical overload, failure of other connected machinery and entry of foreign objects.

Exclusions

Loss/damage by fire and allied perils, war/nuclear perils, gradually developing flaws, defects or cracks, wear and tear, wilful act and consequential loss. Special exclusions are the policy excess, loss or damage to belts, ropes, chains, rubber tyres, dyes, moulds, blades, cutters, knives, all exchangeable tools, operating media and also loss or damage for which the manufacturer/supplier/repairer is responsible either by law or under contract.

Extensions

Cover is available for overtime, night work, work on public holidays, express freight, air freight, additional customs duty, escalation, etc., with payment of additional premium.

Sum Insured

The sum insured of the policy should be equal to the cost of replacement of the insured items by new property of the same kind and capacity, as otherwise Condition of Average (under-insurance) will apply in the event of claim.

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13.2. CONTRACTOR'S ALL RISKS INSURANCE

Who can Insure

Contractors' All Risks Insurance Policy is designed to protect the interests of contractors and principals in respect of civil engineering projects, like construction of buildings, bridges, tunnels, dams, housing developments, industrial buildings, power plants, offices, apartment, water treatment plants, airports, canals, roads, etc.

Scope of Cover

Loss or damage to the subject matter from any unforeseen or accidental cause including fire, lightning, explosion, impact, aircraft damage, flood, inundation, storm, cyclone, hurricane, earthquake, subsidence, rockslide, landslide, theft, burglary, riot and strike, lack of skill, negligence, malicious act, human error, collapse, impact, terrorism, etc. Cover can also be obtained for contract works, construction plant and equipment, construction machinery, surrounding property, cost of clearance of debris and third party liability. Cover commences from the date of first unloading of the machinery at the contractor's site or the commencement of work whichever is earlier and expires on the date specified in the policy or immediately when the contract work is taken over by the principal, whichever is earlier.

Exclusions

War/nuclear perils, wilful act or gross negligence, policy excess, faulty design, inventory loss, defective material, wear and tear, deterioration in normal atmospheric condition, rust, scratching of painted or polished surfaces, penalties, liability to insured's employees/workmen, etc.

Extensions

Cover maintenance period, maintenance visits, extended maintenance escalation and owner's surrounding property without any limit during maintenance.

Sum Insured

The sum insured will be the total of the estimates of possible outlay or outgo comprising contract price, materials or items supplied by the principal, any other additional item, landed cost of imported items at the construction site, construction plant and machinery, freight, increased replacement value and third party liability. Separate sum insured is to be mentioned in the policy for each item. If the sum insured is less than the actual value, Condition of Average for under-insurance will apply in the event of claim. Escalation in the cost of project can be covered on payment of additional premium.

13.3. ELECTRONIC EQUIPMENT INSURANCE

Who can Insure

Electronic Equipment Insurance Policy is availed of by the owner, hirer or financial institution depending upon the responsibility or liability in each case.

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Scope of Cover

The term 'Electronic Equipment' includes the entire computer system consisting of CPU, key boards, monitors, printers, UPS system, software, etc. Auxiliary equipment such as air- conditioning, heating and power conversion, etc., are also included under this term. Electronic equipment also includes electronic data processing equipment, electro-medical equipment, equipment for research and material testing, telecommunication and navigational equipment, computer system for production plant and machinery as well as signal and transmitting units, etc. Fire, lightning, explosion, damage due to smoke, soot, water, etc., mechanical, electrical and electronic breakdown, human error like fault, carelessness, negligent operation, theft, burglary, natural calamities like flood, inundation, storm, cyclone, earthquake, subsidence, landslide and rockslide are the perils covered. The coverage is limited to the cases of external data media (magnetic tapes, discs, etc.) and also reconstruction cost of data therein. In addition, the insurer will pay any extra expenditure incurred for the use of substitute EDP equipment.

Exclusions

Existing faults or defects, gradual deterioration, wear and tear, cavitation, erosion, corrosion, encrustation, maintenance cost, loss or damage to items of glass, porcelain, ceramics, valves, tubes, ribbons, fuses, exchangeable tools or consumable materials like lubricating oil, fuel, chemicals, etc., war/nuclear perils, manufacturer's/ dealer's guarantee, aesthetic defects such as scratches on paint, polish or enamel services and consequential loss of any kind. Cost arising from faulty programming, labeling or inserting, inadvertent cancellation of information or discarding data medium and from loss of information caused by magnetic files and consequential loss. Restriction imposed by public authorities concerning the reconstruction or operation of EDP equipment and repairing or replacing the whole or part of the damaged equipment.

Sum Insured

Cost of replacement of the equipment, amount required for restoring external data and the lost information. Additional expenditure for use of substituted EDP equipment is also permissible based on the amount agreed per day or per month as per policy.

13.4. CONTRACTORS' PLANT AND MACHINERY INSURANCE

Who can Insure

This policy may be issued to any contractor who may be using his plant and machinery at different projects, or any hirer or financial institution, depending upon the responsibility or liability in each case. The plant and machinery include escalators, loaders, dumpers, diving equipment, pile driving, handling equipment, site power generating plants, pumps, transformers, mixing plants, materials, compressors, bulldozers, road rollers, etc.

Scope of Cover

Fire, lightning, riot and strike, malicious damage, terrorism, explosion, subsidence, landslide, rockslide, storm, flood, inundation, earthquake and other convulsions of nature, breakdown of equipment, burglary, theft, faulty handling, dropping or falling, collision, impact and all kinds of unexpected accidental loss or damage to the equipment, whilst at work, at rest, whilst being dismantled or in the course of such operation being shifted, relocated, etc., at the erection site.

Exclusions

Electrical or mechanical breakdown, boiler explosion, replaceable parts such as bits, knives, ropes, belts, chains, etc., wear and tear, corrosion, transits outside the site limit, wilful negligence, war and nuclear perils and consequential loss.

Extensions

Third party liability, owner's surrounding property, clearance and removal of debris, express freight, overhead charges, holiday wages, overtime wages, air freight charges, etc.

Sum Insured

Sum insured for each item should represent the present-day replacement value of a similar new item including all freight, duty, taxes, cost of erection, etc. In the event of under-insurance, Condition of Average will apply for each claim.

13.5. BOILER AND PRESSURE PLANT INSURANCE

Who can Insure

The standard Fire Policy covers only the explosion of domestic boilers, and hence, a separate policy known as Boiler and Pressure Plant Policy has been devised to cover industrial and other boilers, economizers or vessels, machinery or apparatus in which steam is generated.

Scope of Cover

Damage to boilers and/or pressure vessels due to explosion or implosion, damage to insured's own surrounding property and third party liability for death or bodily injury or damage to third party property.

Exclusions

Fire and allied perils, war and nuclear perils, overload experiments or tests, gradually developing flaws, wear and tear, hydraulic tests, chemical explosion, wilful act, gross negligence, defects existing prior to inception of cover, manufacturer's/repairer's responsibility, consequential loss or liability.

Sum Insured

The sum insured of each item of boiler/pressure vessel must represent its current replacement value of similar new item including all expenses like duty, taxes, excise, freight, insurance and other incidentals. In case of under-insurance, Condition of Average will apply in the event of claim.

13.6. ERECTION ALL RISKS (STORAGE-CUM-ERECTION) INSURANCE

Who can Insure

The Storage-cum-Erection Insurance Policy, also known as Erection All Risks Insurance Policy, is issued to those concerned with erection of electrical plant and machinery and equipment and structures involving nil or very little civil engineering work.

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Scope of Cover

Any accident, fire, riot and strike, lightning, malicious damage, storm, tempest, flood and inundation, earthquake, act of God perils, tearing apart due to centrifugal forces, short-circuiting, faults in erection, lack of skill and carelessness, theft and burglary and damage to equipment during commissioning and testing till handed over to the principal.

Exclusions

War and nuclear perils, willful act and negligence of insured, cessation of work, inventory loss, wear and tear, gradual deterioration, rust, scratching of painted/ polished surface, breakage of glass, faulty design, defective material or casting, bad workmanship, files, drawing, packing materials, policy excess, liability to principal's/ contractor's employees for death or injury, etc.

Extensions

Owner's surrounding property, construction plant and machinery, cost of catalyst during hot test, civil engineering work for foundation, escalation, extended maintenance, dismantling increased replacement value, whilst in fabricator's premises and intermediary storage, third party liability, clearance and removal of debris, additional customs duty, air freight, extra charges, overtime charges, holiday wages, testing of second-hand machinery, terrorism, etc.

Sum Insured

The sum insured will have to represent the total estimated completed value of the project, comprising cost of plant, machinery, equipment, tools, accessories, etc., freight, handling and incidental expenses, customs duty, excise duty, taxes, cost of erection and cost of civil constructions. The sum insured is subject to adjustment at the end of the policy period based on actual values for freight, handling charges, customs duties and cost of erection. If there is under-insurance, Condition of Average will apply, in the event of claim.

13.7. MARINE-CUM-ERECTION (MCE) POLICY

Cover under a standard EAR Policy commences with the delivery of the first consignment of plant and machinery at the site of erection. This would mean a separate Marine Transit Policy for imported equipments and inland transit policy for indigenous equipment, both up to the project site. Under a composite marine cum errection policy, cover starts from the moment the equipments leave the manufacturers warehouse within the country or overseas and continues during the voyage to the port of entry, unloading at the port of entry, inland transit to the site of erection including incidental storage and thereafter during erection, testing and commissioning. The marine cover is against all risks of physical loss or damage as provided by the marine policy with the Institute Cargo Clauses (All Risks) attached. War, strikes, riot and civil commotion are additional perils which can be covered; but war risk additional cover is available only for the ocean voyage and not during land transit.

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13.8. MACHINERY LOSS OF PROFITS (MLOP) AND ADVANCE LOSS OF PROFITS (ALOP)

MLOP

Due to loss or damage to the machinery there are some consequential losses which are not covered by the machinery breakdown policy. The resultant damages may be heavy and the profits which otherwise would have accrued may not happen, and also additional expenses like fixed charges (standing charges) have to be incurred. These losses are payable under MLOP issued along with the machinery breakdown policy. The claim is admissible only after the machinery loss is established and become payable. However, the policy is subject to certain exclusions. In claim settlement professional surveyors who are experts in calculation of turnover, gross profit, net profit and standing charges, are appointed as the calculation involves complex working.

ALOP

It is in many respects similar to MLOP but this policy is issued when the industry or business has not recorded any profits due to delay in commissioning the project. Delay must be caused by direct physical loss or damage admissible under contractors all risk policy. The damage should have caused the delay in commissioning and consequently loss of profit. It is not a stand alone policy but taken in conjunction with other engineering insurance policies describes above.

13.9. RECAPTULATION OF COVERAGE, EXTENSIONS, AND EXCLUSIONS ERECTION ALL RISK INSURANCE/ CONTRACTORS ALL RISK POLICIES

Scope of the Policy

Location Risks	Fire, lightning, theft and burglary
Handling Risks	Impact from failing object, collision, failure of cranes or tackles
Operation Risks	Failure of safety devices, leakage of electricity, insulation failures, short circuit, tearing apart on account of centrifugal forces, explosion
Risk of Human Element	Carelessness, negligence, faults in erection, malicious damage, sabotage, strike, riots and terrorist activity
Acts of God	Earthquake, storm, tempest, hurricane, flood, inundation, subsidence, landslide and rockslide

Extensions

Surrounding property of the insured, Storage risks, earthquake, clearance of debris, and terrorism.

Exclusions

War/nuclear risks, willful acts, negligence cessation of work, wear and tear and faulty design. It does not include legal liability and so a separate policy is to be taken.

13.10. OTHER POLICIES

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Contractual All Risk Insurance (CAR)
Erection All Risk Insurance (EAR)
Contractors Plant & Machinery (CPM)
Machinery Breakdown Insurance (MBD)
Boiler and Pressure Plant Policy (BPP)
Electronic Equipment Insurance (EEI) Policies.

Table 13.1 Details of Cover in Nutshell in Respect of the Above Policies

Main Perils	*Material Damage*					
	CAR	*EAR*	*CPM*	*MBD*	*BP*	*EEI*
Fire, Lightning	Yes	Yes	Yes	No	No	Yes
Explosion/Implosion	Yes	Yes	Yes	No	Yes	Yes
Short circuit, other electrical causes	Yes	Yes	No	Yes	No	Yes
Earthquake, flood, inundation	Yes	Yes	Yes	No	No	Yes
Wind storm	Yes	Yes	Yes	No	No	Yes
Theft, burglary	Yes	Yes	Yes	No	No	Yes
Malicious acts	Yes	Yes	Yes	No	No	Yes
Negligence, human error lack of skill	Yes	Yes	Yes	Yes	No	Yes
Defective material, bad workmanship	No	No	Yes*	Yes*	No	Yes*
Faulty design	No	No	Yes*	Yes*	No	Yes*

*Subject to limitations as per policy terms.

SUMMARY

- Construction companies, more particularly, engineering constructions, and heavy industries, who are manufacture and install, machines use huge plants and equipments, which are expensive. The loss arising out of machinery break down, damage to machines caused by unforeseen circumstances will cost the company heavily. The branch of Engineering Insurance was evolved in recent times to protect the engineering companies against heavy loss. In Engineering Insurance, the insurer will indemnify the loss or damage to mechanical, electrical and electronic machines caused by insured perils and also consequential loss.
- **Machinery Breakdown Insurance:** Machinery Insurance cover is availed of by industrial/manufacturing companies, tiny sectors, and anyone who owns/ holds electrical, electronic, mechanic and lifting equipment, boilers, motors, pumps, etc. It covers any unforeseen physical loss or damage to the insured machinery.
- **Contractors' All Risks Insurance:** Contractors' All Risks Insurance Policy is designed to protect the interests of contractors and principals in respect of civil engineering projects like, construction of buildings, bridges, tunnels, dams, housing developments, industrial buildings, power plants,

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offices, apartments flats, water treatment plants, airports, canals, roads, etc., which covers loss or damage to the subject matter from any unforeseen or accidental cause.

- **Electronic Equipment Insurance:** Electronic Equipment Insurance Policy is availed of by the owner, or the hirer or financial institution depending upon the responsibility or liability in each case. The policy covers a wide range of risk, loss, and damages.
- **Contractors' Plant and Machinery Insurance:** This policy may be issued to any contractor who may be using the plant and machinery at different projects, or a hirer, or a financial institution, depending upon the responsibility or liability in each case. The plant and machinery include escalators, loaders, dumpers, diving equipment, pile driving, handling equipment, site power generating plants, pumps, transformers, mixing plants, materials, compressors, bulldozers, road rollers, etc.
- **Boiler and Pressure Plant Insurance:** The standard Fire Policy covers explosion of domestic boilers only, and hence a separate policy known as Boiler and Pressure Plant Policy has been devised to cover industrial and other boilers, economizers or vessels, machinery or apparatus in which steam is generated or their contents resulting from their own explosion/ implosion.
- **Erection All Risks (Storage-Cum-Erection) Insurance:** The Storage-cum-Erection Insurance Policy, also known as Erection All Risks Insurance Policy, is issued to those concerned with erection of electrical plant and machinery and equipment and structures involving nil or very little civil engineering work.
- **Marine-Cum-Erection (MCE) Policy:** Under a composite marine-cum-errection policy, cover starts from the moment the equipment leaves the manufacturer's warehouse within the country or overseas and continues during the voyage to the port of entry, unloading at the port of entry, inland transit to the site of erection including incidental storage and thereafter during erection, testing and commissioning.
- MLOP/ALOP policies cover loss of profit on account of machinery breakdown and delay in project execution respectively.

REVIEW QUESTIONS

1. Explain briefly the scope of cover, extensions and, exclusions in respect of (*i*) Machinery breakdown insurance, (*ii*) Contractors all risk insurance, (*iii*) Electronic equipment insurance, (*iv*) Contractors plant and machinery insurance, (*v*) Boiler and pressure plant policy, (*vi*) Erection all risk insurance, (*vi*) Marine cum erection insurance.
2. What are the purpose and scope of MLOP and ALOP Policies ?

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UNIT

14

HEALTH INSURANCE AND ACCIDENT INSURANCE

STRUCTURE

Introduction

Various healthcare programmes operating in India are as follows:

- State-run schemes for government and public sector employees
- Corporate sector health care programmes
- Hospitals run by govt./local bodies for the public
- Private health care schemes
- Community-based and self-financing programmes
- Micro-credit linked health insurance schemes

They take care of only a small section of the population that too in a perfunctory manner. A large majority are left without satisfactory arrangement. It is in this context that health Insurance becomes important.

In India, health insurance is provided mainly in the form of Mediclaim policy to the individuals or groups, association or corporate bodies. State owned insurance companies have covered so far about 2.5 million people of the country's population, through Mediclaim policy. The Mediclaim policy covers hospital care and domiciliary hospitalisation expenditure and on similar lines Group Medical Policy is also available. The advantage of the Group Mediclaim policy is risk pooling and on account of that the cost of insurance is less. The Mediclaim policy is well received by the Indian

population, in the urban areas. However, a major shortcoming of the plan is that while hospitalisation expenditure is covered routine outpatient care is not covered.

Life Insurance Corporation of India operates with plans like Asha Deep-I, Asha Deep-II and Jeevan Asha. These plans provide with insurance cover against four major ailments, viz., Cancer, Paralytic Stroke, Renal Failure and Coronory/Artery Disease. The age group covered is between 18 and 54 years. The insurance cover ranges from ₹ 50,000 to ₹ 3,00,000.

Unit Trust of India introduced the Senior Citizens Unit Plan in the year 1993. The scheme provide coverage for hospitalisation expenditure up to an amount of ₹ 500,000 for those investors (insured) after attaining 58 years of age. In order to join the scheme, an individual should be within the group of 18–54 years and has to pay a lump sum as premium. There are special policies for cancer patients. One is Cancer Medical Expenses Policy for members of Indian Cancer Society and the other for the members of Cancer Patients Aid Association.

In recent times, private sector insurance companies including exclusive health insurance companies have come out with their own version of the mediclaim policy, with innovative covers and added benefits. The product names also differ.

14.1. HEALTH INSURANCE—MEDICLAIM INSURANCE POLICY

Salient Features and Scope of Cover

The policy covers reimbursement of hospitalisation/domiliary hospitalisation expenses for illness diseases or injury sustained.

In the event of any claim becoming admissible under this scheme, the insurer will pay the insured person the amount of such expenses as would fall under different heads as mentioned below, and are reasonably and necessarily incurred by or on behalf of such insured person, but not exceeding the sum insured.

(*a*) Room, rent and boarding expenses payable to the hospital/nursing home.

(*b*) Nursing expenses.

(*c*) Surgeon, anaesthetist, medical practitioner, consultants, specialist's fees.

(*d*) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-rays, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and cost of organs and similar expenses.

Insurer's liability in respect of all claims admitted during the period of insurance shall not exceed the sum insured per person mentioned in the policy. The scheme provides for family discount in premium, cumulative bonus, and cost of health check-up details of which are given elsewhere. These facilities are subject to renewal of insurance without break.

Conditions

Hospital / Hospitalisation

Hospital/Nursing Home means any institution in India established for indoor care and treatment of sickness and injuries and which has been registered either as a hospital or nursing home with the local authorities and is under the supervision of a registered and qualified medical practitioner. Such a hospital/nursing home should have atleast 15 in-patient beds (in small towns atleast 10) with a fully equipped operation theatre of its own where surgical operations are carried out. There should be fully

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qualified nursing staff under its employment round the clock and fully qualified doctor(s) both day and night. Hospitalisation should be for a minimum period of 24 hours for admissible claims. However, the time limit is not applied to specific treatments, i.e., dialysis, chemotherapy, radiotherapy, eye surgery, dental surgery, lithotripsy (kidney stone removal), tonsillectomy, D&C taken in the hospital/nursing home. Here, even if the insured is discharged on the same day, the treatment will be considered for hospitalisation benefit.

Domiciliary Hospitalisation Benefit

Medical treatment for a period exceeding three days for illness/disease/injury which in the normal course would require care and treatment at a hospital/nursing home taken whilst confined at home in India under any of the following circumstances, may be paid: the condition of the patient is such that he/she cannot be removed to the hospital/ nursing home or the patient cannot be removed to hospital/nursing home for lack of accommodation therein. However domiciliary hospitalisation benefits shall not cover the expenses incurred for pre and post hospital treatment and those incurred for treatment of any of the following diseases:

- Asthma
- Bronchitis
- Chronic Nephritis and Nephrotic Syndrome
- Diarrhoea and all type of dysenteries including gastro-enteritis
- Diabetes Mellitus and Insipidus
- Epilepsy
- Hypertension
- Influenza, cough and cold
- All psychiatric or psychosomatic disorders
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis
- Arthritis, gout and rheumatism.

Excepted diseases may change from one insurance company to other.

Period of Cover

Health policies are issued for a period of twelve months and will cover any disease or illness affecting the insured during the period and also relapse of the disease within 45 days from the date of last consultation with the hospital/nursing home where treatment was taken. Occurrence of the same illness after a lapse of 45 days of discharge will be considered as fresh illness for the purpose of this policy. Further, medical expenses incurred during the Period up to 30 days prior to hospitalisation on disease illness/injury sustained will be considered as part of the claim. So also expenses incurred during period up to 60 days after discharge from the hospital will be considered as a part of the claim.

Exclusions

The insurer is not liable to make any payment in respect of any expenses incurred by the insured in connection with or in respect of diseases/injuries which are pre-existing at the inception of the policy. However, many insurers consider the payment if there was no claim in the initial few years as specified in the policy. So also any disease contracted by the insured person during the first 30 days from the commencement date of the policy will not be covered. During the first year of the insurance cover, the expenses on treatment of diseases such as cataract, benign prostate, hypertophy, hysterectomy for menorrhagia, or fibromyoma, hernia, hydrocele, congenital internal disease/defect,

fistula in anus piles, sinusitis and related disorders are not payable. If these disease and other than congenital internal disease/defect are pre existing at the time of proposal they will not be covered even during subsequent period of renewal too. If the insured is aware of the existence of congenital internal diseases/defect before inception of policy, it will be treated as pre-existing.

Injury or disease directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, warlike operations will not be covered. So also cost of spectacles and contact lenses, hearing aids, dental treatment or surgery of any kind unless requiring hospitalisation are not allowed. Convalescence, general debility, 'Run-down' condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/alcohol are excluded. All expenses arising out of any condition directly or indirectly caused due to or associated with any syndrome or condition of a similar kind commonly referred to as AIDS are not covered. Charges incurred at the hospital or nursing home primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the ailment, sickness or injury, for which confinement is required at a hospital/nursing home will not be considered. Expenses on vitamins and tonics unless forming part of treatment of injury or disease as certified by the attending physician are disallowed. Injury/disease directly or indirectly caused by or contributed to by nuclear weapons/materials, treatment arising from or traceable to pregnancy, childbirth including caesarean and naturopathy treatment are excluded.

Age Limit

This insurance is available to persons between the ages of 5 years and 80 years. Children between 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.

Family Discount

A discount of 10 per cent in the total premium will be allowed for family comprising of the insured and any one or more of the following:

(*i*) Spouse

(*ii*) Dependent Children

(*iii*) Dependant Parents

Claim

Preliminary notice of the claim with particulars relating to policy number, name of insured person in respect of who claim is made, nature of illness/injury and name and address of the attending medical practitioner/hospital/nursing home should be given to the insurance company within seven days from the date of hospitalization/injury/death. The final claim along with hospital receipts bills/cash memos, claim form and documents as listed in the claim form should be submitted to the Insurer within 30 days of discharge from the hospital. Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the insurer that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed timelimit.

Payment of Claim

All claims under this policy shall be payable in Indian currency. All medical treatments for the purpose of this insurance will have to be taken in India only.

Cumulative Bonus

The sum insured under the policy shall be progressively increased by 3 per cent in respect of each claim free year of insurance, subject to maximum accumulation for 10 claim free years of insurance.

Health Check-up

In addition to cumulative bonus, the insured shall be entitled for reimbursement of cost of medical check-up once at the end of block of every four underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1 per cent of the average sum insured during the block of four claims free underwriting years.

Period of Cover

Health insurance policy is issued for a period of one year and is subject to review. Continuation of insurance cover will be available if the renewal premium is paid in time. On continuation of insurance cover and timely remittance of premium the insured becomes eligible to following benefits from first day after renewal.

- Cumulative Bonus, if accrued
- Cost of health check-up, if due
- Payment for hospitalisation cost for diseases/illness/injury sustained even during first 30 days of renewal.

Delay of 7 days from the date of expiry of the policy is permitted in exceptional cases subject to Health Certificate from Medical Practitioner.

Extension

It is permissible to extend the cover for the hospitalisation expenses incurred by the insured of Indian origin in Nepal and/or Bhutan while on short visits to these countries. However, the insured would have to make a specific request to the insurer for such an extension.

14.2. THE TOP UP AND SUPER TOP UP MEDICARE POLICY

Purpose

At present Health Policies are available only for ₹ 5 Lakhs. Only few Companies offer upto ₹ 10 Lakhs for selected agegroups and hence Top UP facility is introduced for an increased amount of cover. It is also useful to employees having reimbursement scheme provided by their employer but inadequate for the need.

SPECIAL FEATURES

1. Room rent restrictions and cap on certain diseases removed. Pre and Post – Hospitalisation expenses covered only in Top Up Policy. 30 days waiting period and first two year exclusion clause for certain diseases deleted.
2. (*i*) Agelimit for coverage – 3 months to 80 years
   (*ii*) Policy can be issued both on individual basis and family basis
   (*iii*) Sum Insured available – Minimum ₹ 3 Lakhs Maximum ₹ 15 Lakhs
   (*iv*) Threshold Level – ₹ 2 Lakhs, ₹ 3 lakhs and ₹ 5 Lakhs at the option of policyholder.
3. An individual can take policy covering all his family members with separate sum insured and threshold level for insured persons or to cover all family members under one single Sum Insured.

4. The Top Up Policy pays Covered Hospitalisation Expenses for any Hospitalisation exceeding the Threshold Level opted up to the Sum Insured chosen The Covered Expenses includes Room Rent, ICU Charges, Specialists / Doctor Fees, Pre & Post Hospitalisation, Ambulance Charges. The proposer may or may not have regular Health Insurance Policy.
5. The Super Top Up Policy pays the amount by which the aggregate of covered hospitalisation expenses for one or more hospitalisation during the policy period exceeds the threshold Level opted.
6. **Threshold Level:** It is the level of expenses upto which the Top Up and Super Top Up Policies do not pay. When the covered expenses incurred exceed the Threshold Level, the Top up Policy pays the excess over the Threshold Level. Upto the Threshold Level, the insured may bear the expenses on his own or get reimbursed from any Primary Health Insurance Policy or Reimbursement Scheme.
7. **Sum Insured:** The maximum quantum available in the top up policy to the insured over and above the Threshold Level opted ; or the maximum amount received/reimbursable under any other Health Insurance Policy or Benefit Scheme whichever is higher.

The Sum Insured under the Policy will be available only if all limits of reimbursement under any Health Policy/Reimbursement Scheme have been exhausted. If a person takes TopUp Policy for Sum insured of ₹ 5 Lakhs with Threshold Level of ₹ 2 Lakhs.

The policy covers the hospitalisation expenses in excess of ₹ 2 Lakhs from ₹ 2,00,001 to ₹ 7,00,000.

Suppose ₹ 2,50,000/- is reimbursable under primary policy or under any reimbursement scheme, policy covers expenses from ₹ 2,50,001/- to ₹ 7,50,000/- even though the threshold level opted is ₹ 2 lakhs.

However, maximum liability will be sum insured chosen.

14.3. NEW INITIATIVES

Health Insurance is now a business of ₹ 10,000 crores as annual premium which was ₹ 2000 crores about ten years ago. But unfortunately it is not a healthy portfolio of any insurance company. In order to ensure healthy growth IRDA is trying to work good coordination between insurance companies, hospitals, third party administrators and the policyholders. The focus is on customers welfare, standardisation of procedures. Cover HIV/AID patients which is a growing menace, daycare coverage, dispensation of minimum 24 hours Hospitalisation, removing the Lacunae in group insurance, right premium to make it affordable to large section of population and at the same time viable to the insurers.

INNOVATIONS IN HEALTH INSURANCE: There are products available that provide Daily Hospital Cash benefit in the form of fixed daily allowance which could be used to cover the incidental costs associated with hospitalisation (like travel and stay costs of an attendant). These benefits are available either on standalone basis or as optional component of a packaged health insurance policy. Personal Accident policies, which can again be availed on standalone basis or as part of packaged product with health insurance, are also a useful supplement to the hospitalisation indemnity products.

14.4. PORTABILITY OF HEALTH POLICIES

Portability means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained by the insured for

pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

The IRDA examined at length various issues involved in the portability of health insurance plan and issued the circular for effecting portability of Health Insurance. Policies shall allow for credit gained by the insured for pre-existing condition(s) in terms of waiting period when he / she switches from one insurer to another or from one plan to another, provided the previous policy has been maintained without break.

Thus the policyholder will have option to switch over from one company to other instead of having to discard the insurance mechanism for health care of one company to purchase new policy from a different company at a high cost. The option will allow employees changing jobs to carry forward their insurance cover and, may be, even a conversion to an individual plan. As for insurers, this move will fuel competition among them and they will need to improve their offerings, pricing and service standards if they wish to match the consumer's expectations and retain the policyholders.

The entire database of the companies, including the claim details, to be shared with their counterparts, if requested by the counterpart within seven working days of such request. A time period of three days has been granted by the regulator to acknowledge portability applications.

14.5. THIRD PARTY ADMINISTRATOR (TPA)

Introduction

All these days, health insurance business was handled by the insurance company on its own, despite the fact that medical treatment is a complex professional matter and it calls for knowledge of disease, mode of treatment, details of drugs, possible complications in treatment of certain diseases, knowledge on hospitals/nursing homes and their competency, cost of treatment, etc. It also requires proper liaison with hospitals, patients and their wards. In USA and other developed countries insurance companies outsource this work to ensure perfection and convenience. It is in this context, a new breed of institution has emerged in India, who are known as third party administrators. The role and function of these organisations and the regulatory aspects are furnished hereunder.

Definition

According to IRDA Regulations, a Third Party Administrator (TPA) is one who is licensed by the IRDA and engaged, for a fee or remuneration as may be specified in the agreement with an insurance company, for the provision of health services. Health Services means all the services to be rendered by a TPA under an agreement with an insurance company in connection with health insurance business but does not include marketing of insurance business directly or through an intermediary. A company with a share capital of ₹ one crore and registered under Companies Act, 1956 can function as TPA. The primary object of the company is to carry on business in India as TPA in the health services not to engage in any other business. At least one of the directors shall be a qualified medical doctor, registered with the Medical Council of India. The Chief Administrative Officer or Chief Executive Officer of the company shall undergo appropriate training specified by IRDA and possess prescribed qualification. A single insurance company can engage more than one TPA, and the TPA can serve more than one insurance company.

Functions

The TPA should help the insured person at the time of admission to the hospital and provide cashless service so that the insured person need not pay any deposit to the hospital nor the hospital bill if it is within the insured amount. It should maintain full details of the claim, disease, age, sex, period, cost and follow the guidelines/directions that may be issued by the IRDA from time to time.

Code of Conduct

A TPA shall

(*i*) Establish its or his or their identity to the public and the insured/policy holder and the details of insurance company with which it has entered into an agreement.

(*ii*) Disclose the details of the services it is authorized to render in respect of health insurance.

(*iii*) Bring to the notice of the insurance company any adverse report or inconsistencies or any material fact that is relevant for the insurance company.

(*iv*) Render necessary assistance for settlement of claims.

(*v*) Maintain the confidentiality of the data collected by it in the course of its business.

14.6. GROUP MEDICLAIM POLICY

For Whom

The Group Mediclaim is available to any group/association/institution/corporate body of more than 100 persons provided it has a central administration point to manage the scheme and subject to a minimum number of persons being covered. The group should conform to IRDA definitions and its guidelines both for mediclaim and personal accident policies.

Details of the guidelines are given below:

- Employer - Employee group including dependants of the employees
- Pre-identified segments/groups where the premium is to be paid by the state/central government
- Members of a registered co-operative society
- Members of Registered Service Clubs
- Holders of credits cards, bank deposit customers, etc.

The group policy is issued in the name of the group/association/institution/corporate body with a list of employees/members including family members. The coverage under the policy is the same as under Individual Mediclaim Policy with the following differences:

- Cumulative bonus and health check-up expense are not payable
- Group discount in the premium is available
- Renewal premium is subject to bonus/malus clause
- Maternity benefit extension is available at extra premium

Group Discount

Group discount is allowed depending upon the total number of insured persons covered under the policy at the inception.

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Bonus/Malus

Low claim ratio discount is allowed on the total premium at renewal depending upon the level of low claims for the entire group (bonus). On the same basis of incurred claims loading is applied to the renewal premium for adverse claims experience (malus).

Maternity Expenses Benefit Extension

This is an optional cover which is available on payment of extra premium for all the insured persons under the policy. The option is to be exercised at the inception of the policy and it is subject to certain restrictive clauses.

Details of Insured Person

The insured is required to furnish a complete list of persons in the prescribed format indicating the sum insured and for each addition and deletion of name during the currency of the policy shall be intimated to the insurer. No change of sum insured for any insured person will be permitted during the currency of the policy. No refund of premium is allowed for deletion of insured person if he or she has been paid a claim under the policy.

IRDA Guidelines on Group Insurance Policies

Group insurance schemes are offered by insurance companies to certain classes of individuals, for the advantage of coverage at a moderate cost to the insured as well as the insurer. The organised sector offers good scope to the insurers to achieve sizeable business growth by designing various group insurance schemes. Most group insurance schemes pertain to employer-employee groups, but group insurance is also being sold to organisations where there is some commonality of interest. There are various aspects that are connected with group insurance: e.g., what shall constitute a 'group' in the context of group insurance, the market conduct that is supposed to be adopted by the insurers in canvassing group insurance schemes and fixing administration standards for group schemes. With a view to rationalise the approach to be adopted by insurers in dealing with various group schemes, guidelines have been issued by IRDA under section 34 of Insurance Act 1938 to be adhered to by all the insurers.

A: Definition of a Group

A group should consist of persons who assemble together with a commonality of purpose or engage in a common economic activity, like employees of a company. Non-employer-employee groups, like employee welfare associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add-on benefit, borrowers of a bank, professional associations or societies may also be treated as a group provided the president/secretary/manager/ group organiser in his capacity as organiser of the group has an authority from majority of the members of the group to arrange insurance on their behalf or is doing so as part of a necessary security for other matters, such as the life of bank borrowers. For employer-employee groups, the scheme may be either contributory or non contributory, and there will be no limit to the employer contribution. Where an insurer is not clear whether a particular group insurance proposal can qualify as per these guidelines, the insurer may refer the matter to IRDA with facts of the case for clarification.

No group should be formed with the main purpose of availing insurance. There should be a clearly evident relationship between the member and the group manager for services other than insurance. While a homogeneous group of persons may decide to buy a group insurance policy to achieve saving in cost, a person negotiating 'group' rates and then going round finding members to insure will not be considered as a legitimate group.

While it is not proposed to prescribe the minimum size of a group, through these guidelines, it is expected that insurers will exercise prudence in requiring a minimum group size. However, different criteria may apply to micro-insurance groups.

Though entry into or exit from the group may go on continuously, entry into the group insurance policy for individual members will be either from a well defined date such as the next anniversary of the policy or from the first of the following month or from a clearly identifiable event other than merely joining the group, such as date of commencement of employment or date of sanction of a loan, etc, subject to payment of premium in time. Insurance will, however, cease as soon as a member leaves the group except where it is agreed in advance to continue the benefit even after the member leaves the group, such as in the case of an employee who retires. In the case of travel related insurance, insurance may attach from the date of the travel subsequent to acceptance of risk and receipt of the premium.

B: Marketing of Group Insurance

An insurer may sell group insurance policies either directly or through an insurance agent or insurance intermediary.

An insurer shall not enter into any memorandum of understanding or marketing arrangement, or referral arrangement or any similar arrangement, howsoever described, for sale of insurance products with any person or entity not licensed under the Insurance Act. Any existing arrangement that is not in compliance with these guidelines should be terminated forthwith. However, this should not prejudice transactions upto the effective date of termination so long as it is not in violation of the provisions of the Insurance Act or Regulations. The IRDA may relax this condition in case of sale of micro-insurance products either on a case to the case basis or through a regulation on micro-insurance. This does not affect any arrangement made by the insurer with the group organiser or manager with regard to administration of the group insurance so long as there is no payment or reimbursement of expenses other than the commission that is legally payable.

C: Group Insurance Administration

The premium charged and benefits admissible to each member of the Group shall be clearly specified in the group policy and the administrator/group manager shall not have the liberty to vary the premium or benefits with regard to the individual members unless the same is a part of the change in the policy benefits and conditions by the insurance company or is made in accordance with a pre-determined basis of determining the sum insured such as the outstanding loan amount. In any case, such changes should be agreed to by the insurer.

Group discounts on premium are given for the benefit of the insured members of the group and should not be appropriated as additional remuneration by the agent or corporate agent or broker or group organiser or manager. Such discounts should be based on valid underwriting considerations such as the group size and shall be passed on to the members. Where a part or whole of the premium is paid by the group organiser, for example, the employer in respect of insurance of his employees, the discounts may be shared by those who paid the premium in proportion to the premium paid by them.

There shall be attached to each group insurance policy, a complete list of the persons insured thereunder. Where this is not feasible, in view of the large size of the group, a clear reference shall be made to a list maintained in the books of the group organiser or manager that cannot be subsequently manipulated, as being the list of persons insured.

Where an employer buys a group insurance policy as a service benefit for its employees and pays the premium in full or in part, the employer may be treated as the policy holder with the employees being treated as the beneficiaries. In such

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cases, the employer may issue confirmation of insurance protection to individual employees with clear reference to the group insurance policy and the benefits secured thereby. In respect of such group policies, the claims of individual persons insured thereunder may be processed through the employer.

In non-employer-employee cases, the individual group member would be treated as the insured beneficiary and the group organiser will be only the holder of the group policy. In such cases every care should be taken by the insurer in the matter of issue of certificate of insurance to the members of the group, who are truly the insureds. It is necessary that such a certificate contains information on the schedule of benefits, the premium charged and important terms and conditions of the insurance contract. The certificate shall also state the procedure to be followed to register a claim with the insurer including the full address of the office of the insurer where the claim should be registered. While the group organiser or manager may play a role in facilitating the registering and settlement of a claim, the insurer is totally responsible to ensure that the claim payment is made in the name of the insured member even if the cheque is sent to the group manager for administrative convenience.

For operational convenience, in respect of non-employer-employee groups, the insurer may provide the facility to the group organiser or manager to issue certificates of insurance to persons insured under the group, provided the underwriting guidelines for acceptance or rejection of such a risk do not require use of subjective judgement and can be easily programmed into a computer that will review acceptance and print the certificate of insurance. In such cases, the certificate forms shall be supplied by the insurer with in-built security features and in pre-numbered lots to the group organiser or manager. Utilisation and full accounting of the certificate forms should be independently checked by the staff of the insurer every time before furnishing a fresh lot of forms, either by personal verification or based on a certificate by the auditor of the agent.

Under any circumstances the insurer will be responsible for the certificate of insurance issued by a group organiser or administrator, in the certificate forms provided by the insurer.

The insurer shall remain responsible to ensure that all sales material and prospectus of the insurance plans are properly drawn up and comply with the regulations on insurance advertisements and disclosures and on protection of policy holders' interests.

The insurer shall conduct a surprise inspection of the books and records of the group organiser or manager at least once a year to ensure total compliance with these guidelines or require a certificate of such compliance from the auditors of the group organiser or manager, at least once a year.

The insurer shall be held responsible to the persons insured, in respect of the group policy in case of failure of the group organiser or manager to account for the business to the insurer, if the person insured can prove that he had paid the premium and secured a proper receipt leading him to believe that he was duly insured.

14.7. OVERSEAS MEDICLAIM POLICY

Introduction

The Overseas Mediclaim Policy was originally introduced in the year 1984, in order to provide payment of medical expenses incurred in respect of illness/accident suffered or sustained by Indian residents during their overseas trips. The insurance scheme has since been modified several times to provide for additional benefits like in-flight personal accident, loss of passport, etc. In the year 1991, an employment and study policy was introduced for Indian citizens temporarily living abroad.

Scope of the Policy

Overseas Mediclaim Policy covers medical expenses while a person is travelling abroad. The travel may be undertaken for business, holiday, employment or studies. This policy is also available for frequent corporate travellers. Overseas medical policy aims at providing financial support for medical treatments or operations for those who unfortunately fall ill or meet with an accident while abroad. This policy covers abnormally high medical costs in some overseas countries. The special feature of the policy is that while the premium is payable in Indian currency, the claim is settled in foreign currency.

Add-on Benefits under the Policy

Besides meeting medical expenses and repatriation cost additional benefits are available under the policy for the following eventualities:

- Personal Accident
- Loss of checked in baggage
- Delay of checked in baggage
- Loss of passport
- Personal liability

Premium Rate

The premium rates under the policy depend on the age of the proposer, period of visit, and country of visit.

Period of Cover

The policy can be issued for a period upto 180 days for business and holiday plan and an extension is allowed on original policy for further period of 180 days subject to declaration of good health by the proposer.

Eligibility Conditions

Age limit from: 6 months up to 70 years

The policy needs to be taken before departure from India

Travellers who are above 60 years of age and persons who are traveling to USA and Canada (above 40 years) need to submit a medical report (ECG, blood sugar, etc.) along with the proposal form at the time of taking insurance.

Claim Payment in Foreign Currency

All claims in overseas mediclaim policies and sometime in accident policies can arise in a foreign country. In such cases, the Reserve Bank instructions on payment of claims in foreign currencies are given in the RBI memorandum included in the marine chapter.

14.8. RECENT DEVELOPMENTS

Personal Accident Insurance

Scope of Cover

The purpose of personal accident insurance is to pay fixed compensation for death or disablement resulting from accidental body injury. The policy provides that, if at any time during the currency of this policy, the insured sustains any injury resulting solely and directly from accident caused by external violent and visible means, then

the insurer shall pay the insured or his legal representative(s), as the case may be, the sum assured, in the policy, for death, permanent disablement, partial disablement, etc.

In case of death, claim amount may be one time payment of the sum insured. Policies can also provide for payment to dependent children for education. In case of partial disablement payment can be one time or periodically till recovery. No compensation is payable in respect of death, injury or disablement of the insured if it is intentional self-injury, suicide or attempted suicide or suffered whilst under the influence of intoxicating liquor or drugs. Policy conditions stipulate that in case of death, written notice must be given before interment or cremation, and in any case, within one calendar month after the death. In the event of loss of sight or amputation of limbs, written notice thereof must be given proof of claims satisfactory to the company shall be furnished. The insurance company doctor shall be allowed to examine the insured person. No claim is payable if it is fraudulent or supported by fraudulent statement.

The insured shall give immediate notice to the insurance company of any change in business or occupation. The insured shall on tendering premium for the renewal of the policy give notice in writing to the insurer of any disease, physical defect or infirmity which has affected the insured since the payment of last premium.

Underwriting

The cover available is for 24 hours and on worldwide basis. In personal accident insurance, the risk factor is based on occupation. Generally speaking accidents at home, on the street, etc., are the same for all persons. But the risks associated with occupation vary according to the nature of work performed. For example, a teacher is less exposed to risk at work than an engineer working at a site where a building is constructed. Hence, occupations are classified into groups, each group reflecting, more or less similar risk exposure. Accountants, lawyers, teachers, bankers etc fall in one group, builders, and engineers working in site, veterinary doctors, drivers of motor cars, etc., in another group. Likewise manual labourers, machine operators, drivers of trucks or lorries and other heavy vehicles, are put in a third group. Lastly, persons working in mines, explosives, electrical installation with high tension supply, jockeys, circus personnel, etc., are of high risk category. The insurance company before issuing the policy elicits information on the following:

- Personal details, *i.e.*, age, height and weight, full description of occupation and average monthly income
- Physical condition
- Habits and pastimes
- Previous accidents or illness
- Selection of benefits and sum insured
- Declaration

The sum insured is decided by the insured but the insurer exercises some control. The sum insured is normally related to the average monthly income of the insured. Although it is difficult to specify the exact amount for which the cover could be granted (since the practice differs with insurers), it may generally be for an amount equivalent to 60 to 72 months earning of the insured. The age limit for the cover is between 5 years and 70 years. However, in case of persons who already have a cover, policies may be renewed after they complete 70 years but up to the age of 80, subject to a loading on the renewal premium. In case of fresh proposals from persons above 70 years but below 80 years, cover may be granted at normal rates plus loading. No medical examination is required for personal accident policies, whether fresh or renewal. Policies can be issued to cover the entire family subject to certain conditions. No claim bonus will be

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allowed up to 50 per cent of insured amount at 5 per cent of the amount for each year of no claim upto 10 years.

14.9. GROUP PERSONAL ACCIDENT POLICY

Group

Group policies can be issued where there is some common relationship among the persons to be insured and a central point for the administration of the insurance scheme exists. Accordingly, these policies can be granted to any one of the groups mentioned under group Mediclaim Policy.

Cover

The coverage is the same as under individual policy except that cumulative bonus and education grant do not apply. Reimbursement of medical expenses are available on payment of additional premium. So also war risk can also be covered by extensions. The sum insured is fixed separately for each insured person. Rates of premium applicable to named employees are based on classification of risks. Where it is not possible to obtain details of occupation for each insured person, the insurer use his discretion in applying the rates.

Claim

The claim form is designed to elicit information, among other things, on the following:

Personal details such as age, occupation, etc.

- Details of accident, nature of injuries, etc.
- Name and address of the attending doctor
- Medical certificate of the attending doctor (sometimes this is issued as a separate form)
- Details of other insurances to invoke contribution clause, if applicable and to check whether they had been disclosed in the proposal form
- The claim form shall be submitted to the insurer along with the medical certificate, medical examiner's report and death certificate.

14.10. ACCIDENT POLICY—JUDICIAL DEFINITION OF ACCIDENT

Accident insurance is a traditional product. The concept and meaning of the word accident has been dealt with by the courts both in India and abroad in several cases, knowledge of which is useful in interpreting the policy conditions. The following passage is based on several court decisions and will be helpful to the readers to appreciate the meaning and implications of accident in the context of insurance.

Mr. Gupta had taken Group Janata Personal Accident Insurance Policy for ₹ 3,00,000, from the National Insurance Company Ltd. The validity of the insurance cover was from 15th February, 2001 to 14th February, 2006. The insured, aged 37 years, died on 01st January, 2004, because of extreme cold wave. As the sum assured was not paid, the wife of the assured filed a case before the District Forum, Vaishali, Hajipur, Bihar. That complaint was dismissed by the District Forum by order dated 18th August, 2005, solely on the ground that the death of the assured due to cold wave would not be an accidental death. The State Commission, in appeal, confirmed that finding. Hence,

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a revision petition was filed before the national commission. The only question which required consideration was 'whether the death caused by "cold wave" was an "accidental death" for the purpose of insurance cover?' It was decided, for the purposes of insurance cover that death caused by 'cold wave' was accidental death.

In another case, a person who was on election duty in a village went to the bank of the river Gandak, flowing by the side of that village, to relieve himself. He came back deeply agitated and frightened, and reported to his colleagues that on the bank of the river he had encountered armed miscreants who threatened him with dire consequences if the polling team did not help and cooperate with them during the election. On the following day, at about 09.00 p.m. he developed pain in the chest and was sent to the village hospital. Thereafter he came back to the school and died due to heart failure at midnight. The insurance claim made by his wife on the accident policy was rejected. Hence, a writ petition was filed before the High Court. The Court allowed the writ petition and observed that the death of the insured was caused due to heart failure and the act of threatening by the armed miscreants was plainly covered by the expression 'external violent and any other visible means'. There can be no denying that the death was an accidental death caused by accidental means. The view expressed in the law of insurance that the words 'by violent external and visible means' add little if anything to an accident policy is to be accepted, then his death would attract the insurance cover. But even if a literal interpretation is given and the distinction between accidental result and accidental means is to be maintained, the unescapable conclusion is that the act of **threatening by the armed miscreants** was plainly covered by the expression **'external violent and any other visible means'.**

It was clearly an accident that triggered off the heart attack and thus resulted solely and directly in his death. In the light of the above, it plainly appears from any point of view (whether with or without maintaining the distinction between accidental result / and accidental means), that the death of Parshuram Singh, the husband of the petitioner, would be covered by the policy. The stand of the insurance company that his death was not covered by the insurance because there was no bodily injury on his person is plainly misconceived. 'In our opinion, the phraseology of the external visible injury used in the policy condition simply means death resulting solely and directly from accident caused by external violent and any other visible means.'

The word accident, or its adjective accidental, is no doubt used with the intention of excluding the operation of natural causes such as old age, congenital or insidious disease or the natural progression of some constitutional physical or mental defect; but the ambit of what is included by the word is not entirely clear. It has been said that what is postulated is the intervention of some cause which, is brought into operation by chance so as to be fairly describable as fortuitous. The idea of something haphazard is not necessarily inherent in the word; it covers any unlooked-for mishap or an untoward event which is not expected or designed, or any unexpected personal injury resulting from any unlooked-for mishap or occurrence. The test of what is unexpected is whether the ordinary reasonable man would have expected the occurrence, it being irrelevant that a person with expert knowledge, for example of medicine, would have regarded it as inevitable.

Even where there are no antecedent circumstances which can be separately visualised and described as 'an accident', the results to the victim may nonetheless be accidental. There were several decisions by different courts interpreting the word accident. Injury or death caused by lightning, sunstroke or earthquake has been held to be accidental. Similarly, where a man in the course of his work is exposed to excessive heat coming from a boiler and becomes exhausted or has to stand in icy cold water and sustains pneumonia or, having got overheated, is exposed to a draught resulting in pneumonia or sustains sub-acute rheumatism as a result of bailing out of a flooded mine, his injuries have been held to be accidental. So also it was held in another case that 'sunstroke though it may be a disease according to the classification of physicians,

is nonetheless an accident in the common speech of men. The suddenness of its approach and its catastrophic nature caused violent impact and death. In other cases an assured who took an over-dose of veronal in an attempt to cure ear ache, one who died from a dose of novocaine properly administered by a medical man, and a person who exerted force to open a jammed desk and contracted hernia, all recovered the claims under accident policies. At the same time, injury resulting from looking deliberately at a blow lamp at close range was not paid likewise, an aggressor, in a quarrel, who knows or ought to know that he will be in danger of bodily harm as a natural result of his conduct, cannot allege that the resulting injury was caused by accidental means.

Policies of liability insurance as well as property and personal injury insurance frequently limit coverage to losses that are caused by 'accident'. In attempting to accommodate the layman's understanding of the term, the courts have broadly defined the word to mean an occurrence which is unforeseen, unexpected, extraordinary, either by virtue of the fact that it occurred at all, or because of the extent of the damage. An accident can be either a sudden happening or a slowly evolving process like the percolation of a harmful substance through the ground. Qualification of a particular incident as an accident seems to depend on two criteria: (1) the degree of forseeability and (2) the state of mind of the actor in intending or not intending the result.

The courts have established a long line of cases which identify the essential characteristics of an accident as an event which was neither expected nor intended and which causes hurt or loss. From the aforesaid law developed in other countries and in this country, it is clear that the injury or death caused by lightning, sun-stroke or earthquake has been held to be accidental. Similarly, if a person working in icy cold water thereafter sustains pneumonia which causes his death, such death is also considered to be an accidental death. Similarly, if the assured is seized by a fit and drowns or falls in front of a train and is killed, death is due to external cause and is an accidental death. Death resulting from threats by miscreants is also considered to be an accidental caused by external violence and visible means. In substance, death which does not occur in the usual course or natural course of events, or events/causes which could not be reasonably anticipated, are considered to be accidental.

In a case arising under the Workmen's Compensation Act, the Supreme Court held that even if a workman died from a pre-existing disease, if this disease was aggravated or accelerated under the circumstances, the death would be considered as resulting from injury by accident. In taking this view, the Supreme Court noticed with approval a decision of the House of Lords.

Further, it is settled law that when two reasonable interpretations of the terms of the policy are possible, the interpretation which favours the insured is to be accepted and not the interpretation which favours the insurer. Further, the terms of the insurance policy are drafted one-sided by the insurance company. Therefore, in case the terms of the policy are vague, benefit should be given to the insured and not the insurer. The law on the subject is settled by the apex court.

SUMMARY

- In India, health insurance is provided mainly in the form of Mediclaim policy to individuals or groups, association or corporate bodies.
- The Mediclaim policy covers hospital care and domicilary hospitalisation expenditure. On similar lines, Group Medical Policy is also available.
- Private sector insurance companies, including one exclusive health insurance company, have come out with modified versions of mediclaim policy, with innovative and added benefits.

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- The scheme provides for family discount in premium, cumulative bonus, and reimbursement of cost of health check-up. These facilities are available only on renewal of health insurance without break.
- For the purpose of the scheme hospital/nursing home means any institution in India established for indoor care and treatment of sickness and injuries and which has been registered either as a hospital or nursing home with the local authorities and is under the supervision of a registered and qualified medical practitioner. Such a hospital/nursing home should have at least 15 in-patient beds and in small towns at least 10.
- Medical treatment given at home in India is an exception and permitted only when the condition of the patient is such that he/she cannot be removed to the hospital/nursing home, or the patient cannot be removed to hospital/ nursing home for lack of accommodation therein.
- The insurer is not liable to make any payment in respect of expenses incurred by the insured in connection with diseases/injuries which are pre-existing at the inception of the policy. However, many insurers consider the claim if there is no claim in the initial few years of the policy.
- Health insurance is available to persons between the ages of 5 years and 80 years. Children between 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.
- Preliminary notice of the claim with particulars relating to the policy number, name of insured person, is given to the insurance company within seven days from the date of hospitalisation/injury/death. The final claim should be submitted to the company within 30 days of discharge from the hospital.
- A Third Party Administrator (TPA) is one who is licensed by the IRDA and engaged for a fee or remuneration as specified in the agreement with an insurance company.
- TPA services do not include marketing of insurance business directly or through an intermediary. TPA is the link between insurer, insured and the hospital.
- TPA should have a share capital of ₹ one crore and be registered under Companies Act, 1956.
- The TPA should help the insured person at the time of admission to the hospital and provide cashless service so that the insured person need not pay any deposit to the hospital nor the hospital bill if it is within the insured amount.
- The Group Mediclaim is available to any group/association/institution/ corporate body of more than 100 persons provided it has a central administration point to manage the scheme and is subject to a minimum number of persons to be covered. The coverage and benefits under the policy are the same as under Individual Mediclaim Policy excepting that cumulative bonus is not payable. But group discount is available.
- In group insurance, the insured is required to furnish a complete list of persons in the prescribed format indicating sum insured. Each addition and deletion of names during the currency of the policy should be intimated to the insurer.
- Overseas Mediclaim Policy covers medical expenses, incurred while a person is abroad. The foreign visit may be undertaken for business, holiday, employment, or studies, and all are covered by the policy. While the premium is paid in Indian rupee, claims are settled in foreign currency.

- Besides meeting medical expenses and repatriation cost the policy covers personal accident, loss of checked in baggage, delay of checked in baggage, loss of passport, and personal liability.
- Age - limit for insurance cover is from 6 months to 70 years. A person who is travelling to USA and Canada (above 40 years) needs to submit a medical report (ECG, blood sugar, etc.) along with the proposal form at the time of taking insurance.
- The purpose of personal accident insurance is to provide fixed compensation for death or disablement resulting from accidental body injury.
- No compensation is payable in respect of death, injury or disablement of the insured if it is intentional self-injury, suicide or attempted suicide or suffered whilst under the influence of intoxicating liquor or drugs.
- The cover is available for 24 hours and on worldwide basis.
- In personal accident insurance, the risk factor is based on occupation.
- Generally speaking accidents at home, on the street, etc., are the same for all persons. But the chance of accidents on the job depends on occupation.
- Although it is difficult to specify the exact amount for which the cover could be granted it is generally for an amount equivalent to 60 to 72 months earning of the insured.
- The agelimit for the cover is between 5 years and 70 years and can be renewed up to 80 years.
- Group policies can be issued where there is some common relationship among the persons to be insured and a central point for the administration of the insurance scheme. The IRDA guidelines in this regard are to be followed.
- At present Health Policies are available only for a maximum of ₹ 5 lakhs. Hence, Top up facility is introduced for increased amount of cover.
- Sum Insured available in Top up is from ₹ 3 lakhs to ₹ 15 lakhs. Threshold Levels are – ₹ 2 Lakhs. ₹ 3 Lakhs and ₹ 5 Lakhs. Top up Policy pays the excess over threshold level.
- The Sum Insured under the Policy will be available only if all limits of reimbursement under a Health Policy/Reimbursement Scheme have been exhausted.
- Policyholders have option to switch over health insurance from one company to other, if they so desires and it is called portability.
- Portability means policyholder's right to switch from one insurer to another insurer without losing the credit gained by the insured for pre-existing conditions and time bound exclusions.

REVIEW QUESTIONS

1. Explain briefly the scope of cover, extensions, exclusions and claim procedure in respect of (*a*) Health insurance (*b*) Accident insurance (*c*) Group Health insurance (*d*) Group Accident Insurance (*e*) Overseas Medical policy.
2. Explain the role and functions and regulatory the aspects of third party administrator (TPA).
3. Explain the rationale of first year and second year exclusions:
4. A health Insurance Policy was issued for ₹ 3 Lakhs in 1996–1997. This policy was renewed continuously till 2002–2003. During this period a claim was also settled for a heart ailment.

The sum insured was enhanced to ₹ 7 Lakhs in the year 2003–2004. There was a claim for ₹ 7 lakhs in 2006 for a bypass surgery. Discuss the admissibility of the claim.

5. Explain risks if any, faced by an health insurance company?
6. Define the role of regulator (IRDA) in the context of policyholder's protection regulations and grievance redressal?
7. What are the special features of group health policy?
8. List out some of the standard exclusions referred to as general exclusions contained in most of the health insurance policies.
9. How can consumer protection be achieved in health insurance?
10. The risk of fraud is high in health insurance. Give a few ways in which such frauds can be curbed.
11. What are the Major Exclusions in a Health Policy?
12. Detail the procedure for appraisal of proposal for Health policy?
13. In Underwriting a Health Policy and Accident Policy which one call for more elaborate exercise.
14. Health conditions of a policyholder is assessed both in life insurance and health insurance. But what are the differences in the approach of the Life and General Insurer?

APPLICATION QUESTIONS

1. A boy while playing cricket hit the ball and it fell in the adjacent factory compound. While another boy went into the compound factory gates of which were open and there was no watchman. The boy after picking the ball while running back hit the boiler in hot condition and got burnt and injured, resulting in hospitalization and medical expenses of ₹ 10,000/-. Can his father claim the damage on his family medical insurance policy, which include his son?

FURTHER REFERENCES

1. Hospital and Health Insurance, by C. Charles, Anmol Publication (P) Ltd.

CASE STUDY A CASE FOR DISCUSSION – CASE I

A real life case is given below. Based on the data given, analyse the issues involved and the problems in settlement of claim. If you were to sit on judgment over the dispute what will be your approach. Give your decision and the reasons therefor.

MEDICLAIM POLICY - CASE OF PRE-EXISTING DISEASE

Smt. Saroj Sian, along with Balwinder Singh took a joint mediclaim policy from New India Assurance Company Ltd. bearing No. 350102/48/02/00382 dated 31-03-2003, for the period 31-3-2003 to 30-03-2004 for a sum of ₹ one lakh each. Premium of ₹ 3,274 was paid. At the time of taking insurance policy, she was not suffering from any kind of disease. Earlier, in the years 2000-01 and 2001-02, she had taken medical insurance policies from the New India Assurance Company Limited on payment of premium.

On 3-2-2004, she went to Fortis Heart and Multi Specialty Hospital with pain in the lower abdomen. There, she was examined by Dr. Rashmi Garg, Gynaecologist,

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who after medical check-up, advised her to undergo surgery for the removal of uterus. Accordingly she was admitted in the hospital on 6.2 2004 where some medical tests were conducted and she was discharged on 8-2-2004. At the time of discharge from the hospital, she had paid a sum of ₹ 14,177 to the hospital for medical investigation and tests.

Thereafter, she was admitted on 24-2-2004 to the Fortis Hospital where she under went surgery for removal of uterus and was discharged on 1.3.2004. She paid ₹ 51,594 towards surgery and ₹ 2,075 for medicines and medical investigation. New India Assurance Company Ltd. had a tie up with Raksh TPA Pvt. Ltd, which has having its offices across India for settling the medical claims of medical insurance policy holders of New India Assurance Company Ltd. She lodged a claim with Raksh TPA for reimbursement of ₹ 67,846 but ultimately her claim was rejected on 27.10.2005 on the ground that she had been suffering from the disease for the last 8 years, so it was pre-existing. Alleging deficiency in service, a case was filed in the court for ₹ 1,19,205.

The New India Assurance Co. Ltd contested the case and moved the court for proper adjudication on the plea that the claim was not payable as risks of such ailment were specially excluded. It was admitted that the complainant had purchased a medical insurance policy and also admitted the filing of the proposal form. It further admitted the purchase of other two policies during earlier period but stated that no policy was purchased during the year 2002-2003. As such, there was no continuation of the policy. It next stated that the policy holder had concealed the pre-existing disease, so the entire contract of insurance had become null and void and held that the claim is untenable. Ultimately her claim was rejected by stating the disease was pre-existing.

The insurance company further added that according to Clause 4.3 of the terms and conditions of medical claim insurance policy, during the first year of the operation of insurance cover, the expenses on treatment of disease such as cataract, benign prostate, hypertrophy, hysterectomy for menorrhagia or fybromyoma, were not payable if these disease were preexisting at the time of proposal. The copy of the insurance policy does not contain any such terms and conditions of medical insurance.

The policy holder argued that she had the pain of abdomen off and on for the last 8 years and irregular cycles with excessive flow (menorrhagia). Subsequently it was detected that the respondent was suffering from Adenocarcinoma uterus with fibroids, for which hysterectomy was performed. There was no evidence that she had knowledge of the disease in question for which she was operated upon by Fortis Hospital and later on lodged the claim. The existence of off and on abdomen pain or having irregular cycles with excessive flow is not such a serious disease to be taken notice because it happens with many ladies. It was only during check-up after 6.2.2004 that, it was detected that she was suffering from Adenocarcinoma of uterus with fibroids for which hysterectomy was performed. It is true that, in the proposal form with respect to the current medical insurance policy covering the period 31.3.2003 to 30.3.2004, she had stated that she was not suffering from any disease. She had rightly stated so because she had no knowledge that she was suffering from Adenocarcinoma of uterus with fibroids.

CASE STUDY A CASE FOR DISCUSSION – CASE II

NOTES

A CASE OF MEDICAL INSURANCE CLAIM

Sardar Kulbir Singh took a Mediclaim Policy from the National Insurance Company for the first time on 06.09.1994 for ₹ 1,00,000/- which was effective till 05.09.1995. Thereafter, he renewed the Policy and the last Policy was for the period 24.09.1997 to 23.09.1998 and the insured amount was enhanced to ₹ 2,00,000/-. Mr. Kulbir Singh suffered from some Cardiac problem and was admitted to Escorts Heart Institute and Research Centre, Okhla on 15.07.1998 and after necessary tests, had undergone three Artery bypass grafting on 15.07.1998 where he incurred an expense of ₹ 1,73,800/-. Thereafter he filed a claim with the Insurance Company. The Insurance Company repudiated the claim on twin grounds,

Firstly that the last Policy was obtained after a gap of 17 days as the earlier Policy had expired on 07.09.1997 and it was renewed on 24.09.1997 and secondly, that the respondent had suppressed the fact that he was suffering from Heart Problem while obtaining the Mediclaim Policy and as such, the case of Sardar Kulbir Singh falls squarely within the ambit of Exclusion Clause 4 of the Terms and Conditions of the Policy. Being aggrieved, Mr. Singh filed the complaint before the District Consumer Disputes Redressal Forum.

On being served, the insurance company filed its written statement stating that the rejection of the claim was made after thorough investigation of the case and after due application of mind. That while obtaining the Mediclaim Policy, Mr. Singh deliberately concealed the facts about his illness and fully knowing about his Heart Problem. He increased the insured amount from ₹ 1,00,000/- to 2,00,000/- surreptitiously. Based on the detailed Report of their Panel Doctor, Dr. Vinod Gandotra that the claim of the respondent was repudiated. Thus, denying the allegation made in the Complaint, prayed for dismissal of the complaint.

District Forum, after taking into consideration, the pleadings and the evidence led by the parties, allowed the complaint, holding the Insurance Company guilty of deficiency in service. The Company was directed to pay a sum of ₹ 1,73,000/- to the policy holder. Aggrieved by the order passed by the District Forum. The Insurance Company filed the Appeal before the State Commission, Delhi which has been partly allowed by the commission directing the Insurance Company to pay ₹ 15,000/- besides the actual claim of ₹ 1,73,000/- which shall include the cost of litigation also. Aggrieved by the Order passed by the State Commission. The Insurance Company has preferred Revision Petition.

Before the State Commission, two fold arguments were raised, one, that the Policy obtained by Mr. Kulbir Singh was not continuous because the last Policy was obtained on 24.09.1997, after a gap of 17 days as the earlier Policy had expired on 07.09.1997. The other submission was that Mr. Kulbir Singh was suffering from heart problem prior to the taking of the Policy and as such, the case of Mr. Kulbir Singh fell squarely within the ambit of Exclusion Clause 4 of the "Terms and Conditions" of the Policy. However, the Insurer did not press the first submission.

The Insurance Company contended that the Court have erred in holding that the Insurance Company had wrongly and without any justification repudiated the claim of Mr. Singh. It was submitted that the Insurance Company had repudiated the claim on the basis of the Report of the Panel Doctor who had specifically concluded in his Report that the disease for which the claim was filed was pre-existing as on the date of taking of the Insurance Policy. The Discharge Summary, in which it was recorded as under:

Resume of History – Mr. Kulbir Singh is a 58 year old gentleman who is a known hypertensive, known, diabetic, non smoker with pleasing personality. He had been having chronic stable angina on exertion for the 10 years which has been on an increase lately. There is no history of myocardial infarction in the past. He was advised further investigations.

INVASIVE CARDIOLOGICAL INVESTIGATIONS"

It was referred to Dr.Vinod Gandotra, a Panel Doctor of the Insurance Company. The said Doctor, after examining the Discharge Summary, came to the conclusion that the disease for which the respondent was suffering was a pre-existing disease and therefore, the claim was not tenable.

Dr. Vinod Gandotra, Panel Doctor, in his opinion, has reported as under:-

"I have gonethrough in details all the attached papers of abovesaid claimant Mr. Kulbir Singh who had undergone Hospitalization from 10.07.1998 to 21.07.1998 in Escorts Heart Institute with the complaints of Chronic Stable Angina on Exertion for the last 10 years. That has been increasing lately. No history of Myocardial Infarction. Known case of Diabetes Mellitus & Hypertension. During hospitalization after thorough examination & investigations including Coronary Angiography he was diagnosed a case of "CORONARY ARTERY DISEASE* TRIPLE VESSEL DISEASE* CHRONIC STABLE ANGINA* NIDDM* HYPERTENSION and for the same he was operated for BYPASS surgery on 15.07.1998 and managed afterward with the supporting Life Saving Medicines. Initially he visited OPD of EHIRC on 21.04.1998 when he was advised comprehensive Cardio Check-up and afterward he had Angiography on 11.06.1998 which confirmed the diagnosis of CAD – Triple Vessel Disease. He had Positive TMT & Stress Thallium.

This is a case of Chronic Stable Angina of 10 years with the aggravation of the symptoms which finally turned out CAD-Triple Vessel Disease and for the same he had Bypass Surgery. As per Policy Copies he was under Mediclaim Coverage since 06.09.1994 to 05.09.1994 & again from 08.09.1995 to 07.09.1997 in continuation and Renewal from 24.09.1997 i.e. with the Gap of 17 days. Thus, the present Policy would be considered as a Fresh & First Year Mediclaim Coverage. Thus claim is falling under Pre-existing disease. Claim is not tenable under the purview of Revised Mediclaim Policy & can be REPUDIATED as per terms and conditions (4.1) of Revised Mediclaim Policy on the ground of PRE-EXISTING DISEASES."

"4.1 such diseases which has been in existence at the time of proposing this insurance, pre-existing condition means any injury which existed prior to the effective date of this insurance. Pre-condition also means any sickness or its symptoms which existed prior to the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing disease will be considered part of the pre-existing condition."

Accordingly, it was a case of Chronic Stable Angina of 10 years with the aggravation of symptoms which finally turned out CAD – Triple Vessel Disease for which the Policy Holder had under gone bypass surgery. Hence, the claim filed by the Policyholder could not be entertained in view of the fact that the disease was pre-existing.

At this point policyholder raised the following issues:

No evidence was produced by the Insurance Company to show that the policyholder was suffering from Chronic Stable Angina since 1993, i.e., 10 years prior to the taking of the Mediclaim Policy for the first time in the year 1994. The Company did not produce the Proposal Form which was filled in by Mr. Singh in the year 1994 or in the year 1998 to show that he was guilty of suppression of any material fact. It is not disclosed in the Discharge Summary as to on whose

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information the Doctor had recorded the fact that the respondent was suffering from Chronic Stable Angina for the last 10 years. No reference has been made to any previous medical record in the Discharge Summary to show that the respondent was suffering from Chronic Stable Angina for the last 10 years.

The opinion of Dr. Vinod Gandotra, Panel Doctor of the Insurance Company was based on the Discharge Summary. He had not examined the person himself. The opinion recorded by Dr. Vinod Gandotra regarding the illness of the respondent is based on the discharge summary which itself was questionable. No concrete evidence has been produced to show that Mr. Singh was suffering from Chronic Stable Angina.

The policyholder suffered from heart problem only on 10.07.1998, which necessitated his admission in the Escorts Heart Institute where Artery Bypass Grafting was conduction on him on 15.07.1998. It shows that he developed CAD Triple Vessel Disease after 4 years of taking of the Policy. Even if, it is assumed that he was having history of Chronic Stable Angina Pain on Exertion for the last 10 years, the same does not go to show that imminent surgery was required and for that purpose the Policy was taken by the respondent.

It was not the case that Mr. Kulbir Singh was guilty of suppression of facts. The contention of insurance company is that there was pre-existing disease and it falls under Exclusion Clause 4 as the party was suffering from a pre-existing disease. The insurance company has failed to produce any evidence, whatsoever, except what has been stated in the discharge summary, to show that the respondent was suffering from Chronic Stable Angina.

If you were to sit on judgment over the case what will be your decision and on what grounds.

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UNIT

15

MISCELLANEOUS INSURANCE

STRUCTURE

15.1. MONEY IN TRANSIT INSURANCE

For Whom

This insurance is intended for industrial, manufacturing and business concerns which periodically draw from banks and other sources large sums of money for payment of salaries and for day-to-day requirements and also money in transit from one place to the other as is necessary for any client.

Scope

The policy covers loss of money in transit from one place to the other as specified, carried by any person authorised by the insured and caused by robbery, theft or any other fortuitous cause. The policy also provides indemnity for loss of money by burglary, house-breaking, robbery or hold-up whilst the money is retained in the insured premises. Money shall mean and include cash, bank draft, currency notes, coins, treasury notes, cheques, postal orders and current postage stamps. This definition may be enlarged by mutual consent.

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Exclusions

The main exclusions are war and nuclear perils, riot and strike, storm, tempest, flood, earthquake, shortage due to error or omission, money sent under contract of freight and consequential loss or legal liability of any kind.

Extension

Certain additional covers are permissible, like dishonesty or infidelity of cash carrying personnel, riot and strike, cash kept in safe in excess of 48 hours, moneys in till/counter during working hours or money for disbursement of wages, money retained overnight by personnel in locked steel cupboards or when the insured himself carries money and money in tills, counters, chests, drawers, cupboards, safes, etc., whether in transit or not, for both less than 48 hours and beyond 48 hours.

Premium

The policy specifies two limits, one, the limit to the amount of money carried in a single transit and the other, the estimate of the total amount of money that may be carried during the policy period. The premium rate is reckoned considering these two factors, in addition to the mode of carriage of money, manner in which it is carried, whether armed guards accompany the cash carrying personnel, places between which the money is carried, their location in relation to the neighbourhood, route through which the money is carried and distance over which the money is carried.

Liability

The insurer's maximum liability is restricted to such single carrying limit per event.

15.2. FIDELITY GUARANTEE INSURANCE

For Whom

This policy is issued in favour of an employer covering his employees. There should exist a vicarious liability on account of the employer-employee relationship. This policy is useful not only in respect of employees dealing with cash/accounts but also those who are responsible for stocks, like godown keepers, etc. This policy is not meant for principal to cover the acts of his contractor, sub-contractor, agent, etc.

Scope

This insurance provides indemnity to the employer for financial loss sustained as a result of dishonesty, default, negligence, misappropriation, forgery, embezzlement, larceny or fraudulent conversion of money or goods of the employer, committed by salaried employees in the course of performance of their duties. The cover granted is against a direct pecuniary loss and not a consequential loss. The loss should be in respect of monies or goods of the insured employer. The act should be committed in the course of the duties specified.

Condition

The policy does not cover any loss if not discovered within 6 months after the death, dismissal or retirement of the employee or if not discovered within 6 months after the date of expiry of the policy, whichever is earlier. If there is any mis-representation or mis-description or if there is any alteration in the condition of employment, no claim is

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payable. The policy will not cover more than one claim per employee. The policy needs two proposals one from the employer and the other from the employee.

Types of policies

1. Individual Policy, where only one individual is guaranteed.
2. Collective Policy, where a number of selected individuals are covered with separate sum insured for each.
3. Floater/Floating Policy, a schedule of names of employees are specified in the policy, but instead of individual sum insured, a single sum insured is floated over the whole group and the premium is loaded with floater extra per person.
4. Positions Policy, where instead of the individual names of employees, all the employees under a particular position or designation are covered with a single sum insured floating over the group.
5. Blanket Policy, where the entire staff is covered without showing the names or positions.

The premium depends upon the type of occupation, status of the employee, system of check and supervision. No Condition of Average is applicable.

15.3. HOUSEHOLDERS COMPREHENSIVE INSURANCE

For Whom

This is a package policy designed to meet the requirements of a householder by combining under a single policy a number of contingencies which are otherwise covered under separate policies. The insurer may allow Discount on the premium based on the number of risks covered.

Scope

There are ten risks that are covered by this policy.

- Fire and allied perils for the building and the contents thereof (compulsory)
- Burglary and house-breaking, larceny or theft of the contents in the building
- All risks cover for jewellery and valuables by any accident or misfortune anywhere in India
- Fixed plate glass against accidental damage
- Unforeseen and sudden physical damage caused by mechanical or electrical breakdown of domestic electrical, electronic or mechanical appliances, apparatus or gadgets
- Loss or damage to television set including antenna, VCR, VCP and connected equipments
- Loss of or damage to pedal cycle and legal liability to third parties
- Loss of or damage to personal baggage due to any accident or misfortune while travelling anywhere in India on official/personal work
- Personal Accident cover for insured, spouse and children
- Legal liability of the insured or his family members and also legal liability as per Workmen's Compensation Act and Common Law towards employees.

Exclusion

The policy is subject to certain general exclusions common to all sections, like war and nuclear perils, wear and tear and consequential loss. There are certain special exclusions applicable to each cover.

Condition

Likewise, there are general policy conditions applicable to all sections, like notice of loss, misrepresentation, reasonable care of property, claims procedure, contribution, fraud, indemnity, under-insurance, arbitration, etc., and a few specific conditions may also have been prescribed for each cover.

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15.4. SHOPKEEPERS' INSURANCE

For Whom

This policy caters to all the requirements of a small shopkeeper, whose property is valued at less than ₹ 10 lakh, by combining within a single policy a number of contingencies which are otherwise covered separately under different policies. A sectional discount in premium is granted by the insurer based on the number of coverages availed of by the insured.

Scope

The following are covered by a single policy

- Loss or damage to building and all contents therein excluding money and valuables by fire and allied perils (compulsory)
- Loss or damage to all contents excluding money and valuables by burglary and house-breaking excluding ordinary theft or larceny
- Loss of money in transit due to any accident or misfortune; loss of or damage money or valuables by burglary/house-breaking whilst contained in a burglar proof safe; and loss of money in cashier's till/counter in insured's premises by burglary, house-breaking or following assault/violence on insured or his employees
- Loss of or damage to pedal cycle and legal liability to third parties
- Loss of or damage to fixed plate glass in the insured premises
- Loss of or damage to neon sign/glow sign by accidental external means, fire, lightning, external explosion, theft, riot strike and malicious act
- Loss of or damage to personal baggage of insured or baggage in connection with trade, anywhere in India
- Personal Accident cover for insured/his employees
- Direct pecuniary loss of insured due to fraud or dishonesty committed by any salaried employee
- Legal liability for accidental death or bodily injury to any third party or accidental damage to their property during performance of any act in connection with the insured's business or liability to employees under the Workmen's Compensation act or at Common Law
- Business interruption due to operation of perils covered under Section-I above and subject to a claim admissible thereunder.

The premium depends upon the sum insured, the type and number of sections covered.

The scope of cover, terms, conditions, exceptions, etc., of the various policies when taken separately, apply to the corresponding sections of this policy also.

Television Insurance

This policy covers television set, apparatus and antenna including VCP/VCR with connected installations.

It indemnifies loss or damage by fire and allied perils, electrical risks, earthquake, burglary, theft and any accidental external means the Policy pays for material loss or damage to the insured items, third party liability to which the insured is legally liable and also for the breakage or collapse of the aerial fittings.

15.5. BANKERS' INDEMNITY INSURANCE

For Whom

This is a package policy, a combination of several specific covers, granted by the insurers to any bank. The policy provides indemnity for direct loss (of money/securities) sustained by the insured bank and discovered during the period specified in the policy. Money means currency, coins, jewellery, ornaments pledged with the bank, etc. Securities means air consignment notes, bank money orders, bills of exchange, bills of lading, certificates of deposit, certificates of shares/stocks, etc.

Scope

The policy affords cover to bank in respect of the following contingencies:

A: On premises: Any money/security lost/destroyed or otherwise made away with by fire, riot and strike, burglary, house-breaking, theft, robbery or hold-up whether within the premises or outside and whether caused by bank's employees or other persons.

B: In transit: Any money/security lost, stolen, misappropriated or made away with, whether due to fraud of the employees or otherwise, whilst in transit or in the hands of such employees.

C: Payments made in respect of bogus, fictitious, forged cheques, drafts, genuine cheques, drafts or fixed deposit receipts, travellers' cheques or gift cheques issued by the insured, bearing forged endorsement or the establishment of any credit to any customer on the strength of such documents whether received over the counter or through the clearing house or by mail. Bills discount and other credit facilities are excluded.

D: Dishonesty or criminal act of the employees resulting in loss of money/security whether committed singly or in connivance with others.

E: Fraud or dishonesty by the employees relating to any goods/commodities pledged or hypothecated to the insured and under the insured's control.

F: Loss by robbery, theft or other cause whilst in transit by registered insured post from the insured's office to the consignee.

G: Any infidelity or criminal act of appraisers.

H: Infidelity or criminal act of agents and contract employees engaged for various purposes.

Exclusion

Exclusions are earthquake, volcanic eruption subterranean fire or any other convulsions of nature, flood, inundation, hurricane, typhoon, storm, tempest, tornado, cyclone or atmospheric disturbance, war and nuclear perils, trading loss, wrongful act or default of any director or partner of the insured other than salaried employees negligence or omission of insured, consequential loss or liability, loss attributed to manipulation of or faulty computer programme, etc.

The sum insured for each of the contingencies has to be decided by the insured and that is the maximum liability of the insurer for any one loss. This is known as the basic sum insured.

Premium

The premium is based on the limit of indemnity, i.e., the basic sum insured and the total number of employees and branches of the bank. The sum insured is to be reinstated to the original figure after each claim settlement during the currency of the policy.

15.6. PUBLIC LIABILITY INSURANCE

For Whom

This policy is mainly granted to industrial risks of small, medium and mega size and also to non-industrial risks like hotels, clubs, public halls, pandals, airport premises, film studios, zoos, godowns, shops, etc.

Scope of Cover

The policy will indemnify the insured against all claims up to the limits specified, for which the insured shall become legally liable to pay as compensation for fatal accident, body injury to any person (not being a member of the insured's family) or engaged in the service of the insured or for any accidental loss or damage to property, not being property belonging to or in the custody of the insured or any person in the service of the insured. Such loss or damage may be caused by or through the fault or negligence of the insured or caused by the persons employed by the insured. All costs and fees for defending any claim for compensation will also be payable under the policy. The jurisdiction is Indian Union only.

Condition

For any claim to become payable under the policy, the loss should have occurred during the period of insurance and the loss should have been reported to the insurer during the policy period (from date of commencement to date of expiry of the current policy). The limit of liability specified in the policy will be reduced by the amount of each claim settled. There is no provision to reinstate the sum insured to the original figure even by payment of additional premium. Two important policy conditions are maintenance of proper records by the insured and forfeiture of benefits in the event of fraud, or misrepresentation.

Statutory Compulsion

The Government of India enacted the Public Liability Insurance Act 1991 to provide immediate relief by owners to persons for death or body injury or for damage to property of third parties due to any accident while handling hazardous substances exceeding certain quantity. It is on 'no fault' liability basis. The law has prescribed compulsory insurance for the liability.

15.7. PRODUCT LIABILITY INSURANCE

For Whom

Products like canned foodstuff, aerated waters, medicines, injections, animal/poultry feed, electrical appliances, mechanical equipment, acids, chemicals, gas

cylinders, etc., manufactured and sold to the public may, if they are defective, cause death, body injury or illness or damage to property. Apart from goods, the containers too can cause injury or damage. This policy is granted to manufacturers, dealers, vendors and such other agencies to provide indemnity/compensation in respect of legal liability arising out of manufacturing defect in the products.

Scope of Cover

The policy will indemnify the insured against all sums upto the limits of indemnity specified in the policy for which the insured shall become legally liable to pay compensation for accidental body injury or death or illness to any person not being a member of the insured's family or engaged in or upon the service of the insured and also for accidental loss of or damage to property not being property belonging to or in the custody or control of the insured or any member of the insured's family or any person who at the time of the accident is engaged in and upon service of the insured. Indemnity will be provided for anything harmful or damage caused by in any product or container thereof sold or supplied by the insured, in normal course of his business. In addition, all costs and expenses incurred with the consent of the insurer in defending any legal proceedings for enforcing any claim for compensation will be payable. The cover is world wide.

15.8. PROFESSIONAL INDEMNITY INSURANCE

For Whom

This policy is designed to provide insurance protection to professionals like registered medical practitioners, solicitors, advocates, lawyers, chartered accountants, architects, interior decorators, consultants in finance, management, etc. The policy provides for payment where the insured is held legally liable to pay by way of damages to third parties in respect of errors or omission of its employees, nurses, technicians or negligence in professional service rendered by the insured. The policy will also pay the cost of charges and expenses in defending any legal case against the insured, if done with prior consent of the insurer.

Conditions

The insured will have to choose the indemnity limits for any one accident or contingency in any one year and the liability of the insurer is restricted thereto during the policy period. No revision in sum insured is permitted during the currency of the policy. Reinstatement of sum insured to the original figure after any claim settlement is also not permitted. For any claim to become payable under the policy, the loss should have occurred during the period of insurance and the claim should have been reported to the insurer during the policy period or within such extended period as may be allowed under the policy. The limit of liability specified in the policy will get reduced by the amount of each claim settled. The insured should not admit any claim directly without insurer's consent.

15.9. BURGLARY INSURANCE

Burglary

Burglary means forcible entry/exit into a building with intention to commit theft but mere theft is not covered. Burglary also means theft following house breaking and

thefts committed by forcible entry into the premises and forcible exit out of the premises. The house breaking can be actual, i.e., breakage of window, doors, shutters, locks, etc., or constructive by forcible opening of the lock to enter the premises using a skeleton key.

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Meant for Whom

Burglary insurance is useful for business houses, industries, and other business organisations, like shops and warehouses.

Coverage

The properties held in the business premises, such as cash and valuables, stock in trade, raw materials, finished goods, goods held in trust or on commission by the proposer, furniture, fixture fittings, etc., can be covered. The perils or the risk covered are loss or damage to property by burglary and also attempted burglary when insured is held liable to making good any damage. Damage to premises caused by burglars is covered under the policy only if the insured is responsible for making good any damage.

Underwriting

The underwriting of burglary insurance is based on the details given in the proposal form. The acceptance/rating of the risk depends on the location of the premises, type of construction, nature of security provided in the building, whether the contents are vulnerable goods like liquors, electronic gadgets, garments, music systems, wrist watches, etc., value of the goods to be insured and whether they are heavy or bulky, light or small. Similar to the fire insurance underwriting, burglary insurance can offer policies on declaration or floater basis. Where substantial quantity of goods is at risk and it is considered improbable that the entire amount be burgled, the underwriter may grant a cover called first loss policy. Burglary insurance cover forms part of several package policies or special contingency policy.

Exclusions

1. War, Nuclear Peril, etc.
2. Involvement of insured or family members/persons lawfully in the premises
3. Losses recoverable under fire or plate glass policy
4. Jewellery, valuables, money, stamps, securities, etc., unless specifically insured
5. Loss by use of duplicate key unless it is obtained by assault, violence, threat
6. Where risk is increased due to material alterations
7. Where interest in insured property is passed on to another, otherwise by will or operation of law
8. Where the insured premises is left unoccupied for more than 7 days continuously.

15.10. TERRORISM INSURANCE

In view of growing menance of terrorism all over the world, more so in India terrorism insurance has assumed importance in recent times. A brief summary of the scope of insurance is given below.

1. Terrorism coverage is provided as an additional cover to all risks underwritten under fire, engineering and property section of miscellaneous classes of business. For Personal Accident Policies, Terrorism is an inbuilt cover.
2. Terrorism insurance underwritten by an insurer is managed by a pool and the pool is managed by GIC.

3. An act of terrorism means an act, including but not limited to the use of force or violence and the threat arising out of that by any person or group (s) of persons, committed for political, religious, ideological or similar purpose; including the intention to influence any government and to put the public or any section of the public in fear.
4. Terrorism cover is taken as add on cover by payment of additional premium at the option of the insured. The sum insured can include material damage and business interruption. The maximum aggregate loss payable is ₹ 1000 crores. Midterm inclusion of terrorism coverage is not allowed. Terrorism cover has to be taken only in conjunction with property or Engineering covers.
5. The exclusions are: Permanent or temporary dispossession of any building or plant or unit of machinery resulting from the unlawful occupation by any persons and burglary, house breaking, theft, larceny.

15.11. STUDENTS SAFETY INSURANCE SCHEME

Purpose

This policy is intended to be issued to the schools/colleges or any other educational institution for the ben[illegible] of the students/staff therein.

How to Join the Ins[illegible]nce Scheme

The school will ta[illegible] the policy on behalf of the students in the institution [illegible] subsequently collect premium from them by way of insurance fees.

It is important to note tha[illegible] [illegible]nts/staff on roll should be covered with[illegible] exception to provide cover under [illegible].

Scope of Cover

This policy provides cover for 24 h[illegible] student/staff (Teaching/[illegible]) against death, disability and hospital exp[illegible] arising out of accident only.

Basic Cover

Accidental death only – Settlement will be [illegible]00 [illegible] value for which the individual student/staff is covered und[illegible].

Optional Covers

1. Permanent Total Disability (PTD): I[illegible] esulting in PTD of hand, foot, eyes.
   E.g. PTD of both hand or both [illegible]
   PTD of one limb with one fo[illegible]
   PTD of one limb or one eye o[illegible]
2. Permanent/ Partial Disabil[illegible] esulting in PPD of hand, fo[illegible], [illegible].
3. Hospitalisation Expens[illegible] ospital resulting out of an accid[illegible] chosen.

Unistudy Care Insurance Policy

- It is a specially designed policy for college students, which not only takes care of personal accident cover but also support for continuing education in case of unfortunate accidental death of the parent/guardian.

- Sum insured can be opted upto ₹ 3 lakhs per parent/guardian for death partial total disability.
- It has an option to cover death of the student upto ₹ 2 lakhs payable to parent/guardian.

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Hospitalisation Benefits

(*a*) (*i*) Room, Boarding expenses as provided by the hospital/nursing home
(*ii*) If admitted in IC Unit.

(*b*) Surgeon anaesthetist, medical practitioners consultants specialists fees nursing expenses.

(*c*) Anaesthesia blood oxygen operation theatre charges, surgical appliances medicines and Drugs diagnostics materials and x-ray, dialysis, Chemotherapy, radiotherapy cost of pacemaker, artificial limbs and cost of organs and similar expenses.

The premium on student policies is very low.

SUMMARY

- **Money-in transit Insurance:** This insurance is intended for industrial, manufacturing and business concerns which periodically draw from banks and other sources large sums of money for payment of salaries and for day-to-day requirements and also money in transit from one place to the other as is necessary for any client.
- **Fidelity Guarantee Insurance:** This policy is issued in favour of an employer covering his employees. There should exist a vicarious liability on account of employer-employee relationship. This policy is useful not only in respect of employees dealing with cash/accounts but also those who are responsible for stocks, like godown-keepers, etc. This policy is not meant for a principal to cover the acts of his contractor, sub-contractor, agent, etc.
- **House holders' Comprehensive Insurance:** This is a package policy designed to meet the requirements of a house-holder by combining under a single policy a number of contingencies which are otherwise covered under separate policies. The insurer may allow discount on the premium based on the number of risks covered. There are 10 risks that are covered by this policy.
- **Shopkeeper Insurance:** This policy caters to all the requirements of a small shopkeeper, whose property is valued at less than ₹ 10 lakh, by combining within a single policy a number of contingencies which are otherwise covered separately under different Policies.
- **Television Insurance:** This policy covers television set, apparatus and antenna including VCP/VCR with connected installations.
- **Bankers' Indemnity Insurance:** This is a package policy, a combination of several specific covers, granted by the insurers to any bank. The policy provides indemnity for direct loss (of money/securities) sustained by the insured bank and discovered during the period specified in the policy.
- **Public Liability Insurance:** This policy is mainly granted to industrial risks of small, medium and mega size and also to non-industrial risks like hotels, clubs, public halls, pandals, airport premises, film studios, zoos, godowns, shops, etc.

  The policy will indemnify the insured against all claims up to the limits specified, for which the insured shall become legally liable to pay as compensation for accidental body injury to any person.

- **Product Liability Insurance:** Products like canned food stuff, aerated waters, medicines, injections, animal/poultry feed, electrical appliances, mechanical equipment, acids, chemicals, gas cylinders, etc., manufactured and sold to the public may, if they are defective, cause death, body injury or illness or damage to property. Apart from goods, the containers too can cause injury or damage. This policy is granted to manufacturers, dealers, vendors and such other agencies to provide indemnity/compensation in respect of legal liability arising out of manufacturing defect in the products.

  The policy will indemnify the insured against all sums upto the limits of indemnity specified in the policy for which the insured shall become legally liable to pay compensation for accidental body injury or death or illness.
- **Professional Indemnity Insurance:** This policy is designed to provide insurance protection to professional like registered medical practitioners, doctors, solicitors, advocates, lawyers, chartered accountants, architects, interior decorators, consultants in finance, management, etc.

  The policy provides payment where the insured is legally liable to pay by way of damage to third parties in respect of errors or omission or negligence in professional service rendered by the insured.
- **Burglary Insurance:** Burglary means forcible entry/exit into the building with an intention to commit theft. Burglary insurance is useful to factories, shops, residential premises. Risk depends on nature of premises, security arrangement nature of goods/objects insured. War, nuclear risk, involvement of insured and family members in the loss, are not covered by the policy.

  In view of growing menace of terrorism all over the world, more so in India Terrorism Insurance has assumed importance. Terrorism cover is taken as add on cover by payment of additional premium at the option of the insured. The maximum aggregate loss payable is ₹ 1,000 Crores. Terrorism cover has to be taken only in conjunction with Property or Engineering Covers. Terrorism insurance is managed by a pool.
- **Students Policy**
  1. Unpredictable risks are faced by students.
  2. Students policy covers risks and uncertainties
  3. The school will take the policy on behalf of the students and collect premium from them.
  4. Ensure all students/staff are covered without exception.
  5. The risks covered 24 hours basis happening anywhere in India.
  6. Basic Cover is accident death only and optional cover being permanent total disability and partial disability.
  7. A specially designed policy for college students takes care of personal accident cover and also support for continuing education in case of unfortunate accidental death of the parent / guardian.

REVIEW QUESTIONS

1. Explain briefly the scope of cover, extensions, exclusions and claim procedure in respect of (*a*) Money in transit insurance (*b*) Fidelity Guarantee insurance (*c*) Burglary insurance (*d*) Professional intedemnity insurance (*e*) Personal liability policy.
2. Explain and Elucidate: Indemnity in Product Liability Policy.
3. Professionals are becoming risk conscious. Explain the need for a suitable insurance for them.
4. What Risks are covered in a household insurance policy?

APPLICATION QUESTIONS

Mr. Kapoor Purchased a new washingmachine. But unfortunately it had a defect. And one month after purchase, it malfunctioned resulting in heavy leakage of water, which inundated, the whole house damaged carpet, furniture, and a few articles kept on the floor. The owner filed for damages. Discuss and decide.

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CASE STUDY - A CASE FOR DISCUSSION – CASE I

A real life case is given below. Based on the data given analyse the issues involved and the problems in settlement of claim. If you were to sit on judgement over the dispute what will be your approach. Give your decision and the reasons thereof.

Theft Claim

Mr. Nashemuddin, a vegetable merchant, running his business at Kauna Maidan, Munger, filed a complaint in the court against the insurance company as well as the Branch Manager, State Bank of India, Munger. (SBI) for the non payment of the claim against the loss suffered on account of theft of stocks. He contended that he had taken a cash credit facility from the bank for his wholesale business with a limit of ₹ 2 lakh and the bank got the stock insured with the National Insurance Company. The premium paid was debited to his account. It is his contention that his business was extended by hiring Stall No. 19, Raja Bazar Sabzi Mandi, Munger on 01-07-1992. The bank was informed about it on 03-07-1992. The bank renewed the insurance policy in question on 17-07-1992 itself.

On 07-12-1992 curfew was clamped in the entire Munger town and it continued till 13-12-1992. When the curfew was relaxed for two hours on 13-12-1992, the owners found that the entire stock of vegetables in the Stall No. 19 at Raja Bazar Sabji Mandi, Munger, had been looted away by miscreants. A complaint was lodged with police and the bank was informed accordingly. After things came to normalcy on 21-12-1992, he requested the bank to get his insurance claim finalized. On 15-01-1993, surveyor of the insurance company assessed the loss after inspecting the business premises at Stall No. 9, Raja Bazar Sabji Mandi. He was informed that all papers regarding the stock, purchase vouchers, sales records, etc were missing, along with the articles in the stall.

The claim was not settled and finally on 26 October 1993, the insurance company repudiated the claim on the ground that the stocks at Stall No. 9, Raja Bazar Sabji Mandi had no insurance coverage. However Mr. Nashemuddin contended that he had suffered loss due to gross negligence and deficiency in service on the part of the insurance company and in any case at the negligence of the officers of the SBI.

In the written version, the insurance company argued that the insurance coverage was taken for the business which was carried out at the Kauna Maidan, Munger, and there was no coverage for the business place at Stall No. 19, Raja Bazar Sabji Mandi. Therefore, the claim was rightly repudiated.

The bank had contended that Mr. Nashemuddin, proprietor of M/s. Kisan Traders was having a cash credit account with a limit of ₹ 2 lakh with the bank for the wholesale business in potatoes and onions located at Kauna Maidan, Munger, and the same was insured with the insurance company from time to time. Thereafter, at the time of renewal of the insurance policy, full details of the business places at Kauna Maidan and Stall No. 19, Raja Bazar were given to the agent of the insurance company. But the business at Stall No. 19 was not mentioned in the insurance policy for the reasons best known to the insurance company.

The District Consumers Forum, Munger, with whom a complaint was made, first took into consideration the submission of the State Bank of India that they had informed the insurance company that the insured had started his business at Stall No. 19, Raja Bazar. After talking into consideration the aforesaid fact, the FIR and the surveyor's report, the District Forum arrived at the conclusion that the ground given by the insurance company that place of business at Raja Bazar was not covered by the insurance was unjustified. The forum believed that stock of the vegetables was worth ₹ 2,42,000 but as the cash credit facility was only ₹ 2 lakh, the claim for more than two lakhs was not fit to be accepted. It therefore was ordered that insured is entitled to two lakhs with interest @ 18 per cent from the bank and insurance jointly and severally.

Against that judgement, the insurance company and the State Bank of India preferred an appeal before the State Commission for reasons of their own.

The surveyor report was taken into consideration that the purchase vouchers of the stocks claimed to have been looted. The vouchers established that the purchase was made by M/s. Kisan Traders, Raja Bazar Subji Mandi, Munger, and the total value of the goods as calculated by him was ₹ 2,42,011. The statement submitted with the bank indicated the stock as on 07-12-1992 at Raja Bazar was ₹ 2.40,000 and stock at Kauna Maidan was worth ₹ 1.90,000 for which no claim was made by the insured as it was not looted. After deducting ₹ 50,000 for the green vegetables and daily sales he arrived at the conclusion that stock roughly could be valued at ₹ 1,90,000. Thereafter, the surveyor arrived at the conclusion that stock can be divided into two equal parts and each shop would be having stock worth ₹ 95,000. Based on this calculation, the state commission awarded ₹ 95,000 in full settlement of the claim. Against the decision the parties went on appeal to the higher court.

CASE STUDY — A CASE FOR DISCUSSION – CASE II

Case of Burglary

1. M/s. On-Line Computers, PATNA were sanctioned a loan of ₹ 12,00,000/- on 22.06.2001 by The Bank of Maharastra for the business of Computer Institute with the terms and conditions that the plant and machineries, Computer etc., would be under hypothecation and they have to be comprehensively insured. On Line Computers purchased computer and its accessories worth ₹ 14,74,250/- and insured the said articles under Miscellaneous Accidents Policy and Coverage for Burglary and House Breaking for a sum of ₹ 15,00,000/- with the National Insurance Co. Limited. The policy was taken for the period from 31.07.2001 to 30.07.2002. Accordingly, policy dated 01.08.2001 was issued in the name of M/s. On-Line Computers and the premium amount was debited to the loan account.

   The Computer Firm lodged an F.I.R. with Shashtrinagar Police Station on 29.12.2001 alleging that theft/burglary was committed in the premises where the computers and its accessories were fitted. The Partner of the Firm informed about the theft to the Branch Manager, Bank of Maharashtra, Patna Branch. The Bank lodged a claim under the Insurance Policy with the Insurance Company on 29.12.2001. Spot Surveyor was appointed by the insurer who visited the spot and found the occurrence of theft to be true and recommended payment of the insured amount to the appellant. In spite of the computer institutes repeated demands and legal notice claiming ₹ 14,74,250/- with interest @17% which the Bank was charging, the Insurance Company

did not settle the claim. Thus, being aggrieved, the partner of the firm filed a Complaint before the State Commission alleging deficiency in service and slackness on the part the Insurance Company.

2. The Insurance Company argued that it got the information of the alleged theft from the Bank and Mr. R.P. Singh was appointed for preliminary survey who submitted a detailed Report on 16.01.2002. That the Surveyor assessed the value of the stock on the basis of market price at ₹ 7,70,000/-. Thereafter Mr. Chandra Shekhar Prasad was appointed as Surveyor for final survey, who submitted his Report on 28.07.2003. In his report, Mr. Chandra Shekhar Prasad had raised certain objection regarding the cash memo issued by one M/s. Retech Computer Centre and the final assessment of loss made by him was to the tune of ₹ 4,23,900/-. Thereafter, the Insurance Company appointed Mr. Ajay Kumar Ojha to verify the cash memo issued by M/s. Retech Computer Centre based on the objection raised by Shri. Chandra Shekhar Prasad, who, in his Report dated 24.05.2005, stated as under:-

"bill issued by a non-existing firm would be fabricated"

Further objection raised by the Insurance Company was that as per General Condition No. 9 of the Insurance Policy, all the benefits and rights occurring under the Policy are liable to be forfeited, in case the insured uses fraudulent means or device for obtaining benefit under the policy. That the Insurance Company did not take any decision in the matter in view of Condition No. 9 of the Insurance Policy. That whether the cash memos were genuine or fraudulent require detailed investigation and evidence which is possible only in a Civil Court and not before the State Commission. Thus, denying all allegations of deficiency in service and negligence, Insurance Company prayed for dismissal of the complaint.

The State Commission, after taking into account the pleadings as well as the evidence led by the parties, held that the Insurance Company was not justified in appointing second and third Surveyor as the first Surveyor, by a comprehensive report running into 27 pages, has dealt with every aspect of the matter and, after considering all the cash memos and details had assessed the loss at ₹ 7,70,000/-. The Insurance Company had failed to give any valid reason to discard the report of the first Surveyor and the same was binding. Appointments of subsequent Surveyors was bad both in law as well as on facts. Based on these findings, Complaint was allowed and the Insurance Company was directed to pay ₹ 7,70,000/- to the Policy Holder as assessed by the first Surveyor.

Insurance Company, being aggrieved by the order passed by the State Commission, has gone on Appeal.

The Arguments during the appeal are as under:

Facts of the case are not in dispute. The Computer Firm was sanctioned term loan of ₹ 12,00,000/- for running Computer Institute with the condition that plant and machineries of adequate worth will be under hypothecation and stocks to be comprehensively insured. The Firm purchased the computers and its accessories. The machinery and accessories were insured covering burglary and house breaking to the extent of ₹ 15,00,000/- for the period 31.07.2001 to 30.07.2002. After theft/burglary in the premises of the Computer Firm it lodged F.I.R. with the local Police Station on the same day and informed the insurer of the theft. Police, after investigation, found that the theft had taken place and filed its final report as untraceable. Policy holder thereafter filed a claim with the Insurance Company but in spite of several reminders and legal notice, they did not either settle the amount of payment nor repudiated the claim which lead to the filing of the Complaint.

The Insurance Company contended that the first Surveyor, Mr. R.P. Singh was a Spot Surveyor to conduct the preliminary survey. After submission of the report by the Spot Surveyor, Mr. Chandra Shekhar Prasad was appointed as the Surveyor who submitted his Report on 28.07.2003 and assessed the loss at ₹ 4,23,900/-. Because of some doubt as to the authenticity of the theft, the insurer appointed Mr. Ajay Kumar Ojha to investigate the matter. Shri Ajay Kumar Ojha submitted his report on 24.05.2005 to the effect that no theft had taken place and the purchase memos issued by M/s. Retech Computer Centre, Patna were fabricated bills. According to the insurer, the State Commission has erred in holding that there was no need to appoint either second or the third Surveyor. As against this, the policy holder submitted that the first Surveyor had, after a detailed investigation, assessed the loss at ₹ 7,70,000/- and that the Report of the first Surveyor was detailed and comprehensive running into 27 pages in which every aspect of the matter had been dealt with. The Insurance Company had failed to give any valid reason to discard the Report of the first Surveyor.

The Report submitted by the first Surveyor itself shows that it was a preliminary survey report for the theft committed at the premises of the Policy Holder. The State Commission opined that the appointment of the second Surveyor was bad in law is not correct. Since, the report submitted by the first Surveyor was a preliminary report, the Insurance Company was justified in appointing the second Surveyor. The second Surveyor had assessed the loss at ₹ 4,23,900/-. But in our considered view, the appointment of the third Surveyor was neither justified nor warranted in the given facts and circumstances of the case. The Insurance Company could not spell out the reasons as to the requirement of appointing the third Surveyor/Investigator. Nothing has been placed on the record justifying the appointment of Shri Ajay Kumar Ojha, Investigator in the face of the categorical findings recorded by the second surveyor assessing the loss at ₹ 4,23,900/-. Mr. Ajay Kumar Ojha, in his Report has relied upon certain letters which he allegedly received from Commercial Taxes Department, Financer Bank and State Bank of India, Hanuman Nagar and the Bank of Maharashtra, Patna, saying that the firm by the name M/s. Retech Computer Centre is not in existence. This apart, investigator has not stepped into the witness box to prove the Report. No one has appeared on behalf of the Insurance Company to prove the Report of Shri Ajay Kumar Ojha, Investigator.

Taking into account all these facts how you would decide the case if you were to sit on Judgment.

UNIT

16

REINSURANCE

NOTES

STRUCTURE

Purpose

The purpose and scope of insurance is based on the principle of spreading the risk and sharing the losses. The insurance companies underwrite numerous risks during the course of conducting their business. Occurrence of losses, frequency of losses, and the aggregate quantum of loss arising out of various insurance contracts are unpredictable. The insurer's capacity to meet the obligations and make the payment depends upon its financial position. Hence, the insurer goes for reinsurance which is the ultimate way of insuring the risks under their portfolio in the international reinsurance market. The prime function of reinsurance is to protect the assets of the insurer from those insurance risks that have the potential to impair its solvency. It also enables the insurer to underwrite novel risks where the perils are unknown and not easily predictable. Reinsurance is a mechanism evolved to help the direct insurer to tone down the quantum of losses devolving under direct insurance contracts arising out of catastrophic losses under a single policy or calamities that induce losses under various policies arising out of a single event, e.g., natural calamities, earthquake, flood or man made riots. Further fluctuation of the annual aggregate claims experience around the mean (average) claims experience, can be mitigated by utilising the reinsurance mechanism. Reinsurance is a method employed by the direct insurer to transfer the surplus business in excess of it's capacity to retain. As reinsurance is a form of insurance, many of the principles and practices applicable to the conduct of insurance business equally apply to reinsurance.

Reinsurance Contract

A reinsurance transaction (contract) is an agreement between two parties, called the ceding company, which is the direct insurer which agrees to cede and the reinsurer, who agrees to accept a certain fixed share of a risk, upon terms as agreed. Reinsurance was generally practiced through eighteenth century and had become well established by the beginning of twentieth century. All the early instances of reinsurance were effected by a method known as facultative. But as the need for cover expanded, following the growth of direct insurance, other methods of reinsurance were devised.

The facultative method is used based on per risk basis, *i.e.*, for reinsuring very large and complicated risks which will fall beyond the retention capacity of the ceding company, viz., direct insurer. The other method used in modern reinsurance is called

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the treaty method of reinsurance. This has come into universal use as the main tool of reinsurance and is used in all classes of business.

Facultative Method

Under this method, the reinsurer receives full information of each risk. The ceding company offers for reinsurance only those individual risks it is unable to absorb in entirety within its own retention limit and other standing reinsurance facilities (treaties). The reinsurer has the right to accept or decline the risk. The reinsurer may accept a part or the portion of the risk ceded by cedent (*i.e.*, the direct insurer). Thus the full amount ceded, can be subscribed by more than one reinsurer and together they may cover the full quantum of risk ceded. The ceding company will part with the direct premium collected by it, in proportion to the quantum ceded. For example, direct insurer collects a direct premium of ₹ X for covering a risk valued at ₹ Y. under facultative reinsurance and if 20 per cent of the risk is ceded for reinsurance, the cedent will pay 20 per cent of total premium to the reinsurer. When a claim arises under the direct insurance cover to the tune of ₹ Z, the ceding company will recover 20 per cent of the claim amount of ₹ Z from the reinsurer.

Treaty Method

Under this method of reinsurance, the ceding company is bound to cede all the risk as provided in the treaty and the reinsurer is bound to accept all the risk to be reinsured. This is an obligatory arrangement. The ceding company can exercise no option in withholding any particular cession (risk) from the reinsurer. The reinsurer too forgoes its rights to decline any reinsurance allotted (ceded) to it. There are two classes of treaty methods

(*a*) proportional

(*b*) non-proportional

Proportional

The proportional treaty provides for sharing of risks between the ceding company and the reinsurer, on lines similar to those under the facultative method. The ceding company will estimate the quantum of aggregate premium that may be generated in direct underwriting and that would be the quantum of premium shared with the reinsurer.

Non-Proportional

Under the non-proportional treaty method, the reinsurer will be responsible only for a loss which exceeds the agreed quantum of loss.

The variations in proportional treaties are:

Table 16.1

Facultative	*Treaty*
1. Reinsurer has the option to accept or decline any risk offered to it.	Reinsurer is obliged to accept all cessions within the scope of agreement.
2. Reinsurance is on case by case basis and complete details of risk offered are provided.	Any number of risks can be ceded within the scope of the treaty and no individual details are provided, except as agreed.
3. Mostly placed on proportional basis.	Placed both on proportional or non-proportional basis.
4. Cover commences and terminates along with the original policy.	Cover is usually annual or continued with provision for cancellation.

Quota Share Treaty

Under this the ceding company and reinsurer cede and accept respectively a proportion of all insurances in a specified class of business (like fire, motor, etc).

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Surplus Treaty

Here the reinsure will accept all amounts in excess of the retention limit of the direct insurer.

Auto Facultative or Facultative Obligatory Covers

The ceding company has the option to offer and the reinsurer has the obligation to accept.

Non-Proportional Treaties

Non-proportional treaties include different kinds of treaties known as excess loss covers, excess loss ratio and pool method. Excess loss cover means the reinsurance does not relate to the sum insured but to the loss exceeding the agreed limit in any one case. In excess loss ratio, when the loss exceeds a certain proportion of the premium income, it become operative and in the pool method, member companies pool their risk.

Retrocession Facultative

The principle of spreading of risk is first put into operation in direct insurance, then extended to reinsurance. A third dimension of spreading is attempted in a method of reinsurance, called retrocession. The reinsurer who accepts reinsurance under treaties, particularly surplus treaties, can choose to reinsure in the market, on portfolio basis. The retrocession (meaning further reinsurance offer of cessions accepted) may be subscribed by several players in the reinsurance market which might include the original direct insurer too. The subscribers to retrocession may not know the details of individual risks and their share in the claim loss under the portfolio may not be very big. But this method of retrocession involves clubbing of risks on a global basis and not merely on a regional basis, and provides scope for trading in reinsurance in terms of inward treaties and outward treaties to different market players.

16.1. PROCEDURE FOR REINSURANCE ARRANGEMENTS PRESCRIBED BY IRDA

General Insurance Company of India: GIC is the sole national reinsurer, providing reinsurance to the direct non-life insurance companies in India. The Corporation's reinsurance programme has been designed to meet the objectives of optimising the retention within the country, ensuring adequate coverage for exposure and developing adequate capacities within the domestic market. It is also the manager of the Third Party Motor Pool and Terrorism Insurance. GIC receives statutory cession on each and every policy issued by domestic insurers subject to certain limits and leads domestic companies' treaty and facultative programmes.

(1) The reinsurance programme shall continue to be guided by the following objectives:

(*a*) maximise retention within the country

(*b*) develop adequate capacity

(*c*) secure the best possible protection for the reinsurance costs incurred

(*d*) simplify the administration of business.

(2) Every insurer shall maintain the maximum possible retention commensurate with its financial strength and volume of business. The IRDA may require an insurer to justify its retention policy and may give such directions as considered

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necessary in order to ensure that the Indian insurer is not merely fronting for a foreign insurer.

(3) Every insurer shall cede such percentage (curently 10%) of the sum assured on each policy for different classes of insurance written in India to the Indian reinsurer as may be specified by the IRDA in accordance with the provisions of the Insurance Act 1938.

(4) The reinsurance programme of every insurer shall commence from the beginning of every financial year and every insurer shall submit to the IRDA their reinsurance programmes for the forthcoming year, 45 days before the commencement of the financial year.

(5) Within 30 days of the commencement of the financial year, every insurer shall file with the IRDA a photocopy of every reinsurance treaty slip and excess of loss cover cover note in respect of that year together with the list of reinsures and their shares in the reinsurance arrangement.

(6) The IRDA may call for further information or explanation in respect of the reinsurance programme of an insurer and may issue such direction as it considers necessary.

(7) Insurers shall place their reinsurance business outside India with only those reinsurers who have over a period of the past five years counting from the year preceding for which the business has to be placed, enjoyed a rating of at least BBB (with Standard and Poor) or equivalent rating of any other international rating agency. Placements with other reinsurers shall require the approval of the IRDA. Insurers may also place reinsurances with Lloyd's Syndicates taking care to limit placements with individual syndicates to such shares as are commensurate with the capacity of the syndicate.

(8) The Indian reinsurer shall organise domestic pools for reinsurance surpluses in fire, marine hull and other classes in consultation with all insurers on basis, limits and terms which are fair to all insurers and assist in maintaining the retention of business within India as close to the level achieved for the year 1999-2000 as possible. The arrangements so made shall be submitted to the IRDA within three months of these regulations coming into force, for approval.

(9) Surplus over and above the domestic reinsurance arrangements class wise can be placed by the insurer independently with any of the reinsurers complying with sub-regulation (7) subject to a limit of 10 per cent of the total reinsurance premium ceded outside India being placed with any one reinsurer. Where it is necessary in respect of specialized insurance to cede a share exceeding such limit to any particular reinsurer, the insurer may seek the specific approval of the IRDA giving reasons for such cession.

(10) Every insurer shall offer an opportunity to other Indian insurers including the Indian reinsurer to participate in its facultative and treaty surpluses before placement of such cessions outside India.

(11) The Indian reinsurer shall retrocede at least 50 per cent of the obligatory cessions received by it to the ceding insurers after protecting the portfolio by suitable excess of loss covers. Such retrocession shall be at original terms plus an overriding commission to the Indian reinsurer not exceeding 2.5 per cent. The retrocession to each ceding insurer shall be in proportion to its cessions to the Indian reinsurer.

(12) Every insurer shall be required to submit to the authority statistics relating to its reinsurance transactions in such forms as the IRDA may specify, together with its annual accounts.

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Inward Reinsurance Business

Every insurer wanting to write inward reinsurance business shall have a well-defined underwriting policy for underwriting inward reinsurance business. The insurer shall ensure that decisions on acceptance of reinsurance business are made by persons with necessary knowledge and experience. The insurer shall file with the IRDA a note on its underwriting policy stating the classes of business, geographical scope, underwriting limits and profit objective. The insurer shall also file any changes to the note as and when a change in underwriting policy is made.

Loss Provisioning

Every insurer shall make outstanding claims provisions for every reinsurance arrangement accepted on the basis of loss information advices received from brokers/ cedants and where such advices are not received, on an actuarial estimation basis.

SUMMARY

- Reinsurance is a method of spreading the risk, a way to improve the cash position at the time of claim settlement.
- As there are different products sold by insurance companies, reinsurance companies adopt several methods to provide reinsurance.
- Facultative Method provides reinsurance case by case.
- But in Treaty Method it is obligatory for the reinsurance company to reinsure all the ceding by the ceding insurance company.
- However, to suit ever-growing needs, the two basic methods have several variations.
- The reinsurer can insure its risk, which means reinsuring the reinsurance. This is known as retrocession.

REVIEW QUESTIONS

1. Discuss the purpose and benefits of reinsurance scheme.
2. Explain (*a*) Facultative Reinsurance, (*b*) Treaty Method of Reinsurance.
3. German Commercial Law states that "Reinsurance is the insurance of the risk assumed by the insurer? Discuss the role of Reinsurance in modern global economy faced with complex nature of risk demanding special types of covers?
4. What is proportional reinsurance? Explain with examples.
5. Give salient Features of IRDA Guidelines for Indian Reinsurance Companies? Is there is any Statutory obligation for direct insurer in India to confine their Reinsurance requirement with General Insurance Corporation of India?
6. In treaty methods there are two types:
   (*i*) Proportional and
   (*ii*) Non Proportional.
   Explain and Elucidate both.
7. What do you mean by Retrocession and Explain the Process?
8. Discuss the purpose and benefit of Reinsurance Scheme to the Insurer and Insured.

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UNIT

17

REGULATION AND SUPERVISION TWIN OBJECTIVES

STRUCTURE

17.1. THE NEED FOR REGULATION

Insurance policy is taken to provide protection from the adverse effects of the unpredictable events. In life insurance, it is also a long-term financial planning to provide fund for future needs. Insurance is an intangible product and the insurer makes only a promise to pay the secured amount on the happening of the event. If at the time of the claim the promise is not fulfilled, the insured has to face the adverse consequences that he thought he had insured against.

The insurance market operates on the principle of sharing the risk. If the applicants for insurance do not share the information required and pay the adequate premium the calculations will go awry and the insurers will have to quit the business.

Insurance is a business working on large numbers generating large volume of funds over time. These funds have to be invested prudently. The three objectives of

safety, yield and liquidity have to be balanced so that the policy holders' money is safe, they get maximum return and also receive their claims in time.

Every country, therefore, has its own regulatory measures, in some form or other, to see that the insurance business is done fairly, run by competent persons, does not result in loss leading to insolvency of insurers and most important, the legitimate interests of policyholders are protected.

From Controller to Regulator

Regulation of insurance business in India dates back to 1912 when The Indian Life Insurance Companies Act, the first statutory measure was passed. In 1928, the Indian Insurance Companies Act was enacted with provisions to enable the government to collect statistical information about both life and non-life insurance companies. Earlier legislation was consolidated and amended and the Insurance Act 1938 was passed with a view to protect the policyholders' interest and have detailed and effective control over insurers. In order to administer the Act an **insurance wing** in the government was established which was later looked after by an attached office under the **Superintendent of Insurance** and finally by the **Controller of Insurance**. The duties, powers and responsibilities of the Controller as regards the regulation of insurance business were defined in the Insurance Act.

When life insurance was nationalised and LIC was created in 1956 followed by the nationalisation of general insurance business in 1973 and creation of GIC, most of the functions of the Controller were taken over by these organisations.

The Malhotra Committee appointed to study and recommend for restructuring the industry suggested liberalising the insurance business. The committee also felt that the Controller of Insurance should be restored to its full statutory powers and suggested the establishment of the **Insurance Regulatory Authority** for that purpose. The recommendation was accepted by the government and the IRDA Bill as it finally came to be known was passed by Parliament in December 1999. The Insurance Act was also amended to open the sector and establish IRDA as the regulatory authority.

17.2. INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

The main objectives of Insurance Regulatory and Development Authority of India are to **regulate, promote and ensure orderly growth** of insurance.

This is a **corporate body** which has replaced *Controller of Insurance*. It consists of a Chairperson and not more than five whole-time members and not more than four part-time members, all 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.

It is advised by an **Insurance Advisory Committee** of not more than **25 members** drawn from social economic and research spheres. The Authority is empowered to make **regulations** vide powers vested in it under **Section 114** governing issues like Licensing of Agents and intermediaries, Solvency margin, Investments, Valuation, Business in Rural and Social Sectors, Advertisement Rules, Protection to Policy holders' interest, etc. Under **Section 34,** IRDA has also powers to issue **directions,** in the public interest, to prevent the affairs of any insurer being conducted in a manner detrimental

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to the interests of the policy holders or generally to secure proper management of any insurer.

The major Act, Insurance Act 1938 (Amended 1999) along with the Insurance Regulatory and Development Authority has various provisions to regulate and supervise the insurers.

Rules and regulations relating to the following areas are discussed briefly:

- Authorisation of insurers
- Solvency margin
- Investment norms
- Insurance accounting
- Introduction of new products
- Protection to policyholders
- Code of conduct
- Advertisement regulations
- Social obligations
- Supervision over administration
- Supervision over market conduct
- Consumer education

17.3. AUTHORISATION AND LICENSING OF INSURERS

As per law, life and general insurances should be handled by **separate companies**. A single company cannot do both. The applicant should be an Indian promoter. Foreign companies are not allowed. The Indian promoter can have a foreign partner.

The minimum paid-up capital for a life or general insurance company is ₹ **100 crore** consisting of equity shares (ordinary shares) only. Any **foreign participation should not exceed 26 per cent** of the paid-up capital. For a reinsurance company the minimum capital required is ₹ **200 crore.** In addition, in case of life business and general insurance business 1 per cent and 3 per cent respectively should be deposited with the Reserve Bank of India.

There are restrictions on the transfer of shares after registration, and also limits on percentage of share holding. A company while submitting application for registration should not propose an identical name with another insurance company. The sponsoring promoter company should have a good track record.

IRDA while considering the application will take into account all matters relating to carrying on the business of insurance by the applicant - their capital structure, infrastructure planned, level of actuarial and professional expertise, geographical spread of activities, distribution system, training programmes, nature of products to be promoted, proposed sales promotion, reaching out to rural areas, application of information technology, etc.

The approval for registration of an insurance company is valid for 12 months and it has to be **renewed every year**. Before renewal, IRDA can call for a certificate of soundness from an actuary if serious irregularities are noticed in the performance of the company. IRDA has powers to suspend, or cancel the registration after observing due process of law.

A life insurance company should have an **actuary** who will be known as 'appointed actuary'. His powers and duties have been prescribed by IRDA.

The appointment of key persons and key directors of the company needs to be reported to IRDA in the proforma given and approved by them. The key persons will include Chief Executive, Chief Marketing Officer, Appointed Actuary, Chief Investment Officer, Chief Finance Officer, Chief of Internal Audit. IRDA is concerned that the important posts are filled by 'proper and fit' persons.

17.4. SOLVENCY MARGIN

The solvency margin represents the amount by which the **value of the company's assets exceeds the amount of its liabilities.** It is a safety margin that insurers must maintain in order to protect the interests of the policyholders they have in their books.

The solvency margin has become necessary because of fluctuation in claims, adverse claim experience, losses in investment, fall in value of assets, inflationary pressures, high expenses, etc. It is also kept high to keep away frivolous players.

IRDA regulations contain elaborate guidelines on the solvency of insurance companies. Solvency in simple terms means ability of the insurer to meet the demands arising out of claims payment promptly and without any financial strain. This calls for efficient management of assets and liabilities. It depends on quality and adequacy of assets. The claims are not easy to predict and assess precisely. The actuaries use certain calculations and statistical methods, which are otherwise called actuarial methods, to project the claim in a realistic fashion.

The first step in deciding this solvency is to value the assets which usually consist of approved securities, approved investments, deposits, non-mandated investments and, miscellaneous assets. The book value, fair value and the adjusted value are arrived at for the assets. Liabilities largely consist of expected payment on policies. The kind of liabilities in life and general insurance vary. Section 64V of the Insurance Act governs the valuation of assets and liabilities and Section 64VA has provisions regarding the sufficiency of assets for calculation of solvency margin.

In life insurance it is the duty and obligation of the appointed actuary to ensure solvency of the insurer always and comply with the provisions of Sections 64V and 64VA of the Insurance Act. A statement on the maintenance of the required solvency for a life insurance company has to be **certified by the actuary, auditor in case of general insurance.**

17.5. INVESTMENT NORMS

Insurance companies receive the premiums from their policyholders and hold them in their funds. They have to meet their obligations - to settle the claims, maturity or death, as and when they arise. They also have to provide the promised yield to the policyholders and fulfil their reasonable expectations. Besides, they have to see that the premises on which the premium is computed are kept up in the investment activities. So investment operations are an important part of insurance business.

Safety, Liquidity and Yield

Investments are made primarily to earn an income by way of interest, dividend and capital gain. But at the same time, the investor shall take care of safety and liquidity of invested amount.

Safety means the return of amount invested with income expected thereon and liquidity refers to the ability to convert the investment into cash with least delay and loss. A prudent investor usually makes a reasonable compromise on return, safety and liquidity. It is because if one factor is highly attractive, it will adversely affect the other factors. An investment which enjoys highest rating for safety will always generate less income, and similarly an investment with very high return will carry high risk, i.e., less safety.

The insurer, especially in life insurance business, receives large funds and it is essential that these funds are judiciously invested with the combined objectives of safety,

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liquidity and maximisation of yield so that the policyholders' interests are protected and their investment in insurance are rewarded to the optimum level.

Infrastructure Needs

Insurance plays a major role in the economy. The long-term financing needed for building infrastructure is very much available in insurance. So, the world over, insurers park a good portion of their funds in infrastructure. The need is felt more in a developing country like ours where adequate infrastructure is yet to come up.

Investment Regulations

Insurance companies in India need to follow the investment regulations laid down under the Insurance Act 1938, Insurance Rules 1939, and the IRDA Investment Regulations 2001. The asset class is broadly classified into Government Securities, Approved Securities, Infrastructure and Social sector and Approved Investments. Limits have been prescribed for all these categories.

Funds in Life Insurance

The life insurer can have **three major lines of business—Life, Pension and General Annuity and Unit Linked Life Insurance**. The premium collected from these classes of business is to be invested in the respective funds. The policyholders' funds are further bifurcated into Participating and Non-participating funds. The initial capital brought and additional amounts injected by the share holders is termed as 'share holders fund'. Both these, Share holders' fund and Policyholders' fund (excluding the funds relating to Pension and General Annuity business and Unit Linked Life Insurance business) constitute **Controlled Fund**. Not less than 50 per cent of this fund has to be invested in government securities and approved securities. At least 15 per cent of it must be invested in infrastructure and social sector. Not exceeding 35 per cent of this fund can be invested in other investments subject to exposure norms. There are other conditions applicable to these investments limiting the exposure.

The investment norms for the monies collected under Pension and General Annuity stipulate 40 per cent to be invested in government and other approved securities and not exceeding 60 per cent in approved investments subject to prudential/exposure norms.

No minimum norms for investment in government securities have been provided for the funds collected under **Unit Linked Life Insurance** but investments in other than approved investments cannot exceed 25 per cent.

The funds of Unit Linked Policies should be invested in the assets which are marketable and as per the pattern desired by the policy holders.

The pattern of investment for General Insurance and Re-insurance is different with not less than 30 per cent in government securities and approved securities, at least 5 per cent in housing sector and investments in fire fighting equipments etc and not less than 10 per cent in infrastructure and social sector. Not exceeding 55 per cent can be invested in other investments subject to exposure norms.

IRDA has prescribed **standard formats** for reporting on investments. They are subject to inspection by IRDA. Guidelines have been issued on disclosure norms and valuation of assets and liabilities. Time to time IRDA has been issuing directions to the insurer on the composition of investment within the provisions of the Act.

17.6. ACCOUNTING AND FINANCIAL STATEMENTS

The insurer is expected to keep a separate account for each class of insurance business as prescribed by Section 11 of The Insurance Act 1938, Insurance Rules 1999

and Regulations issued by IRDA. Every insurer in respect of all insurance business shall prepare the following statements in the specified format as follows:

1. Balance sheet in accordance with the Regulations contained in Part I of the First Schedule and in the form set forth in Part II of that Schedule;
2. A Profit and Loss A/c in accordance with the Regulations contained in Part I of the Second Schedule and in the forms set forth in Part II of that Schedule; and
3. A Revenue Account in accordance with the Regulations and in the forms set forth in the Third Schedule in respect each class of insurance business.

There is a basic distinction between accounting for insurance companies and non-insurance companies:

In insurance, premium received is the income whereas consideration realised on sale is the income in a non insurance company.

All expenses and revenues relating to the period are considered for arriving at the profit, in a non-insurance company. If the accounting is on 'cash' basis, all expenses and revenues irrespective of the period are considered for arriving at the profit of the company.

In the case of life insurance business, the excess of premium income over expenditure is credited to a life fund. In life insurance, a valuation balance sheet is prepared at fixed intervals to find out the profit or loss. The difference between the fund and net liability on actuarial basis as on the valuation date is taken as profit/loss. Excess of life fund over net liability is profit and if net liability is in excess over life fund it is loss. The profit or loss of the business is ascertained by a periodical actuarial valuation for determination of liabilities under existing policy contracts.

In the case of general business, a certain percentage of the premium income at the end of each year is carried forward as provision for unexpired liability and the balance is credited to the Profit and Loss Account. The provision of the earlier year is brought to the credit of the Revenue Account. All expenses and claims for the year are charged against the premium income of the year and the provisions of the earlier years are brought forward. The resultant balance in the Revenue Account is either profit or loss for the year.

Copies of the final accounts prepared in accordance with the regulations made by the authority duly audited and certified by the insurer have to be submitted to the authority every year (Sec. 12).

17.7. ACTUARIAL ABSTRACTS

The insurer carrying on life insurance business should cause, every year, an investigation into the life insurance business conducted by him, including a valuation by an actuary and submit the abstracts to the authority. If it appears to the authority that the valuation report furnished does not properly indicate the conditions of the insurer, the authority may, after giving notice, cause a fresh investigation and valuation.

17.8. INTRODUCTION OF NEW PRODUCTS—FILE AND USE PROCEDURE

Insurance Regulatory and Development Authority notifications mention that whenever a **new product** is designed and desired to be introduced in the market, an application has to be made to the Authority giving details of the brand name of the product, its terms and conditions, features, options, evaluations, limitations, provisions, etc., and also inform about the targeted market and treatment of different segments in underwriting the risks.

The Actuary should certify that the premium rates for the products are **'fair'** and the advantages, terms and conditions related to the plan are workable and reasonable.

Under this 'File and use of Product' procedure, the IRDA can seek any additional information within 30 days of receipt of the application. If no such information is sought, the insurer can commence selling of the product in the market.

When the insurer wishes to make **changes** to the existing provisions in the product, they shall submit an application to the Authority setting out the detail of the changes in the terms and conditions and giving reasons for the proposed changes.

Similarly, even when the insurer wishes to **withdraw** an existing product, the Authority has to be informed giving the details of the product to be withdrawn and the reasons for withdrawal.

The insurer must also ensure that the brochure introducing the product is written in simple, unambiguous and easily comprehensible language and there is no statement which may lead to misunderstanding. All illustrations to express the features and benefits of the product should be prepared in consultation with the appointed actuary and they should be clear and fair to enable a proposer to make an informed decision.

The Life Insurance Council will set the rates of return to be used in the illustrations and they should be uniformly followed by all the insurers (IRDA Cir. 2/2004).

17.9. PROTECTION OF INTERESTS OF INDIVIDUAL POLICY-HOLDERS

Insurance Act 1938 has various provisions to safeguard the interests of the policyholders. They have been discussed in detail in earlier chapters. Some of those important provisions are:

- Policy to become **'indisputable'** after two years from the date it was effected (Sec. 45).
- Rights of **Nomination** (Sec. 39) Right to **assign** (Sec. 38) Written acknowledgement to be given.
- Notice of option to be made available in the event of default of premium, unless they are stated in the policy itself (Sec. 50).
- Automatic non-forfeiture regulations-**Guaranteed surrender value** (Sec. 113).
- Every insurer is required to maintain a **register or record** of policies containing the details regarding every policy issued by the insurer. Similarly a **register of claims** containing the details of the claims made or rejected has to be maintained (Sec. 14).

IRDA in exercise of the powers conferred by Sec. 114A of the Indian Insurance Act 1938 and in consultation with the Insurance Advisory Council has made the IRDA (Protection of Policyholders' Interests) Regulations 2002 establishing certain benchmarks in the quality of sales as well as service in life insurance. They include:

- Duty of the insurer to communicate decision on the proposal within 15 days.
- Right of the insured to review and if not satisfied with the policy to **return the policy within 15 days.**
- Decision to **admit or repudiate** the claim should be made **within 30 days** of receipt of paper.
- If investigation is felt necessary it has to be completed **within 6 months.**
- If the settlement of claims is **delayed,** the Insurer has to pay **interest at 2 per cent over the bank rate.**
- All queries of the policy holders have to be responded **within 7 days** of receipt.

The insurer while issuing the policy should enclose a **Policy Information Statement** which contains information about the person in the office to be contacted for any service or information and also the availability of grievance redressal mechanism (IRDA Cir, 2/2004).

Policyholders have the right to expect insurance companies to keep the promises they make. When there is an error of omission or commission not consistent with expected or defined service levels; there is deficiency, in service which results in giving scope for grievance. The **IRDA Grievance Call Centre (IGCC)** receives and registers complaints through toll free number. The IGCC interfaces with the **Integrated Grievance Management System (IGMS)**, the online system for grievance management that not only offers a gateway for complaints to register and track grievances but is also a tool for the Authority to monitor disposal of grievances by insurance companies.

Further, the requirement of insurance companies to have Board approved grievance redressal policies; compliance requirements relating to IRDA guidelines for grievance redressal and the requirement under the **Corporate Governance Guidelines** to have a Policyholder protection committee, disclosure norms and observing ethics in conduct of affairs have gone a long way in protecting the interests of Policyholders.

17.10. BUSINESS IN RURAL AREAS AND SOCIAL OBLIGATIONS

The Malhotra Committee, while recommending for liberalisation of the industry felt 'There is a view that new entrants to the insurance field would, on profit considerations, concentrate on more lucrative areas and neglect the small man and the rural sector. It is, therefore, necessary that new entrants into the life insurance field should write a specified proportion of their business in rural areas. It should be ensured that such insurers do not avoid writing small business.'

When the Bill for IRDA was presented in Parliament, the Standing Committee suggested four amendments which included provisions to ensure statutory obligations on the part of the insurers to undertake certain amount of business in rural areas and also to cover weaker sections in the society. Accordingly the Act was passed and amendments in the Insurance Act 1938 were carried out under sections 32B and 32C. Powers were given to IRDA to frame regulations in this regard.

IRDA Regulations on Rural and Social Sectors have directions on minimum business to be done in rural and extension of insurance cover to the economically vulnerable and backward classes.

In **rural** areas, the insurers have to write certain minimum percentage of policies every year. The minimum percentage is on their total business **as number of policies**. It should be 7 per cent in the first year, 9 per cent in the second year, 12 per cent in the third year, 14 per cent in the fourth year and 16 per cent from the fifth year onwards, out of their total business in the financial year.

In the **social sector** the obligations are that the insurer must cover at least 5000 lives in the first financial year, 7500 lives in the second year, 10,000 lives in the third year, 15,000 lives in the fourth year, 20,000 lives from the fifth year onwards. The social sector is defined as including the unorganised sector, the informal sector, the economically vulnerable or backward classes and other categories of persons, both in rural and urban areas. IRDA has clarified that in social sector the minimum criteria is on the **number of lives** insured for the first time and not on the number of policies.

Micro Insurance

The clientele in rural areas and in social sector are distinctly different from the market familiar to the insurers. They need special type of products and they can be contacted only through the people closer to them. Marketing strategies based on the concept of 'micro insurance' are thought of to bring these segments under the umbrella of insurance.

IRDA has issued a detailed instructions and guide lines on micro insurance in 2005. Accordingly the life insurer and general insurer can join to have a tie-up and develop integrated policy for micro insurance beneficiaries.

The micro insurance products should be in simple terms and easy to understand. IRDA has outlined a framework for such packages of insurance. The sum assured should have a limited range and within the reach of the people in this sector. (₹ 5000 to 50000 depending on the product.)

The range of products may cover dwelling house, household articles, tools and implements, crop insurance, health insurance, accident insurance, term insurance, endowment insurance, etc.

They can be distributed by specially appointed distributed channels. IRDA, for this purpose has approved appointing Non-Government Organisations, Self-Groups and Micro-Finance Institutions as agents who can sell exclusively micro insurance products. The training, documents, and other communications, as far as possible can be in local language.

The business done in micro insurance may be reckoned for the statutory obligations under rural and social sectors.

17.11. CODE OF CONDUCT—FOR AGENTS

IRDA's regulations with regard to competence building for agents have been discussed in the chapter on Distribution Channel.

IRDA has also framed **Code of Conduct** for Agents. They require them to identify them before canvassing insurance, make need based selling, disclose the commission when asked for, facilitate revealing the material facts in proposal and render necessary after sale service. They should not interfere with the business introduced by other agents or advise for lapsing of the policies taken through other agents and always act courteously towards customers. Any violation of this code of conduct will lead to termination of agency.

17.12. CODE OF CONDUCT—FOR ADVERTISEMENT

IRDA's Regulation on advertisements govern the rules of the game to be followed while promoting the products. In a way it is a code of conduct for the insurers. The regulations are applicable to intermediaries also. *Inter alia,* the regulations state that information and illustrations on the products:

- Should identify the product clearly
- Benefits should match policy provisions
- Should not be beyond the ability of the policy to be delivered
- Should not mislead, hide or minimise the unfavorable factors
- Should not make unfair comparison. Limitations, condition, etc., have to be disclosed sufficiently.

Every insurer should follow the professional conduct as prescribed by the Advertisement Standards Council of India. A copy of the advertisement has to be filed with the IRDA and a compliance officer appointed by the insurer shall be responsible to oversee the advertisement programme.

The regulations made by IRDA stipulate that every proposal for an insurance product shall carry the statutory warning as prescribed under Sec. 41 of the Insurance Act 1938 regarding **prohibition of rebates** as an inducement to take out or renew an insurance. Such rebates, either directly or indirectly, shall not be allowed or accepted. If any person fails to comply with this provision he shall be liable to payment of a fine.

17.13. SUPERVISION OVER ADMINISTRATION

Investigation—Intervention by IRDA

'Where IRDA is satisfied that in the public interest or in the interest of the policy holders or in the interest of insurance business as a whole or in order to secure the proper management of the insurer it is necessary to do so', they can investigate, intervene and take action. The Authority has been vested with wide powers by the Act a well as Regulations.

IRDA may appoint an Investigating Authority to **investigate** the affairs of the insurer and to report to the Authority. Wherever necessary, the Investigating Authority can employ an auditor or actuary to assist him in investigation. On receipt of the report, IRDA, after giving such opportunity to the insurer, can require the insurer to take necessary action. The authority arising out of the report can even cancel the registration of the insurer or direct to apply to the court to wind up the organisation. (Sec. 33)

IRDA may appoint such staff and at such places as they may consider necessary, for the scrutiny of the returns, statements and information furnished by insurer under the Act and generally to ensure the efficient performance of the insurer. (Sec. 33A)

In the public interest or in the interests of the policy holders, IRDA may issue directions to insurers generally or to any insurer in particular, from time to time and the insurers or the insurer shall be bound to comply with them (Sec. 34). Under this important section, IRDA has issued a number of circulars to regulate and provide new direction to the industry.

The appointment of managing or whole-time director or chief executive officer shall have effect only after the approval of the IRDA. Where the Authority is satisfied, by order, a director or the chief executive officer may be removed and the Authority may appoint a suitable person for the post to hold office during the pleasure of the Authority. If it is found necessary the Authority may appoint additional directors also (Sec. 34A, 34B, 34C).

IRDA is given powers to require the insurer, wherever necessary, to call for the board meeting or any committee to discuss the matters arising out of the affairs of the insurer and also appoint observers to watch the proceedings. It may require the insurer to make such changes in the management, as they may find necessary, within a time frame (Sec. 34E).

If the insurer fails to produce the records asked for or there is any likelihood of falsifying or tampering with the records, IRDA can authorise an officer to search and seize the documents, books, reports, etc., and IRDA can take safe custody of such records for their further investigation (Sec. 34H).

Transfer of life insurance business to any other insurer or amalgamation of life insurance business with any other insurer is possible only with the approval of IRDA and in accordance with the rules given in Sec. 35, 36 and 37. If it is satisfied, IRDA itself may prepare scheme of amalgamation (Sec. 37A).

17.14. SUPERVISION OVER MARKET CONDUCT

Guidelines relating to distance marketing have been issued by IRDA which address challenges relating to mis-selling using **distance marketing** mode, a fallout of the advancement in technology. While the benefits of having new and faster channels need to be reaped, the loopholes created by them need plugging and this is precisely what the guidelines are aimed at.

IRDA also examines the complaints from a regulatory prespective and takes steps as deemed fit. Apart from providing a tool for monitoring disposal of grievanaces by insurance companies, the **Integrated Grievance Management System (IGMS)**, enables IRDA to monitor market conduct issues and take necessary steps to ensure better understanding of the products by the public and keeping their policies in force.

Further to ensure that clear information regarding products is given to prospect/policyholder in a way he/ she can understand, the Authority is considering the proposal for introduction of Key Features Documents in a simple language. A Key Features Document would ensure disclosure by insurers of important information such as premium details, payment modes, various charges, risks involved, what happens in the event of discontinuance, etc.

17.15. CONSUMER EDUCATION

The IRDA has a responsibility in imparting consumer education in insurance. It has developed a consumer education website (www.policyholder.gov.in) which covers various areas of insurance relating to consumer education. It has published series of Policyholder Handbooks. The education material is being distributed to various schools and other agencies to spread the message of insurance.

Life Insurance Council

Life Insurance Council is a body set up under section 64C of the Insurance Act, 1938. All registered life insurers are members of the council and are represented to it by Chief Executive Officers. There are two nominees from IRDA on the Council, one of whom is the Chairman of the Council. The Secretary General functions as the chief executive of the Council. The Council has formed several standing Sub-committees. In addition, as and when needed, specific areas of work are taken up at meeting of 'working groups' constituted to discuss emerging issues from time to time.

General Insurance Council

General Insurance Council is a body set up under Section 64C of the Insurance Act, 1938. All registered non-life insurers are members of the council and are represented to it by Chief Executive Officers. There are two nominees from IRDA on the Council, one of whom is the Chairman of the Council. The Secretary General functions as the chief executive of the Council. In addition the council provides various forums where the Senior Executives of the member Companies exchange their views, experiences and common concerns affecting the industry in various spheres.

Insurance Rules

Under Sec. 114 of the Insurance Act 1938 Central Government has been empowered to frame rules to carry out the purposes of the Act by notification in the Gazette. The Insurance Rules 1939 cover the form of accounts returns, etc.

Insurance Rule 17D specifically provides the cap on the expenses for life insurance business. In the first four years of its formation the insurer is permitted to incur expenses up to 20 per cent of the renewal premium. It is gradually reduced and from the tenth year onwards it should not exceed 15 per cent of the renewal premium. Similarly for general insurance, the maximum percentage of expenses has been provided for over total gross premium, in a graded manner.

IRDA has been given powers under Sec. 114A to make regulations to carry out the purposes of the Act. Thus the provisions of the Act, Insurance Rules and Regulations provide a multi point control in the regulatory system preferred in our country.

17.16. ALARM SIGNALS AND IRDA INTERVENTION

As observed by the Malhotra Committee 'regulatory arrangement try to create systems whereby alarm signals are triggered in good time so that timely correctives are applied'. In the past, when the corporate agency was found less serious about selection of lives, procedures were tightened to make it more authentic and responsible. Training for agents was further streamlined to see that the desired inputs are given in a phased manner, guidelines were given for Group Schemes. When the unit linked plans were found to be sold in a variety of ways instructions were issued to bring the insurers under some kind of discipline. The insurers were advised to observe the spirit behind plans like Key Man Insurance and Partnership Insurance and issue appropriate policies. Identity of the proposer, and proof for his address are now insisted upon to avoid the threat of money laundering in insurance. To cover the rural masses, Micro Insurance has been introduced with suitable distribution strategies. Similarly in the sphere of general insurance, IRDA could intervene and apply correctives. The object is to facilitate development of a healthy insurance market and to protect the genuine interests of the customers.

SUMMARY

- Regulation of insurance started in the year 1912 when Life Assurance Companies Act, 1912 was promulgated. Life insurance was nationalised in 1956 and in 1973 general insurance came under State control. In 2000, when insurance business was liberalised a regulatory body called IRDA was created with wide powers with the twin objectives of protecting the interests of the policy holders and promoting the industry on proper lines.
- This statutory functionary has powers to register, advise, caution, investigate, inspect, authorise, search, seize, fine, amalgamate and liquidate insurance companies.
- The emphasis is on fair premium rates and policy conditions, spread of business, control on investments, efficiency and economy in administration, solvency, equitable distribution of profits, prompt settlement of claims and fulfilling policy holders' reasonable expectations.

REVIEW QUESTIONS

1. There is a strong need for regulation in insurance. Why?
2. What is the main objective of IRDA? How it is constituted?
3. Discuss how an insurance company, in India, can be promoted?

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4. State with reasons whether the following statements are TRUE or FALSE.
   (*i*) There is no limit for the foreign participation in the capital of an insurance company.
   (*ii*) Solvency margin implies the ability of the insurer in meeting the demands.
   (*iii*) An insurance product can be introduced or withdrawn without any information to IRDA.
5. Investment is an important function in insurance. Explain.
6. What is the special type of insurance products introduced in the rural market? How it is distributed?
7. What are the Advertising norms stipulated by IRDA?
8. State the initiatives taken by IRDA to protect the interests of policyholders.
9. Consumer education Discuss the role of IRDA.
10. Insurance Rules specify the cap on expenses of an insurance company. Elaborate.

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UNIT

18

INSURANCE LAWS AND REGULATIONS

STRUCTURE

18.1. INSURANCE ACT AND RELEVANT LEGISLATIONS

General insurance companies operating in India are governed by the Insurance Act 1938 and the Insurance Regulatory and Development Authority Act 1999. Those who deal with insurance should be conversant with these two pieces of legislation. In addition there are several other acts, knowledge of which is important and relevant in the insurance business, more particularly non-life business. Brief details of those acts are furnished below.

Insurance Act 1938 is the basic act on insurance, covering registration, activities, insurance, business and a wide range of matters connected with insurance.

Insurance Regulatory and Development Authority Act 1999 covers all the regulatory aspects based on the Insurance Act.

THE INSURANCE ACT 1938*

Sections

Provisions Applicable to Insurers

* A short description of the contents are given here and for full details please refer to the insurance Act 1938.

3. Registration
3A. Renewal of registration
3B. Certification of soundness of terms of life insurance business
4. Minimum limits for annuities and other benefits secured by policies of life insurance
5. Restriction on name of insurer
6. Requirement as to capital
6A. Requirements as to capital structure and voting rights and maintenance of registers of beneficial owners of shares
6AA. Manner of divesting excess shareholding by promoter in certain cases
6B. Provision for securing compliance with requirements relating to capital structure
6C. Conversion of company limited by shares into company limited by guarantee
7. Deposits
8. Reservation of deposits
9. Refund of deposit
10. Separation of accounts and funds
11. Accounts and balance sheet
12. Audit
13. Actuarial report and abstract
14. Register of policies and register of claims
15. Submission of returns
16. Returns by insurers established outside India
17. Exemption from certain provisions of the Indian Companies Act 1913
17A. This Act not to apply to preparation of accounts, etc., for periods prior to this Act coming into force
18. Furnishing reports
19. Abstract of proceedings of general meetings
20. Custody and inspection of documents and supply of copies
21. Powers of Authority regarding returns
22. Powers of Authority to order revaluation
23. Evidence of documents
24. [Repealed]
25. Returns to be published in statutory forms
26. Alternations in the particulars furnished with application for registration to be reported

Investment, Loans and Management

27. Investment of assets
27A. Further provisions regarding investments
27B. Further provisions regarding investments
27C. Prohibition for investment of funds outside India
27D. Manner and conditions of investment
28. Statement of investment of assets
28A. Return of investments relating to controlled fund and changes therein
28B. Returns of investments relating to the assets and changes therein
29. Prohibition of loans

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SOLVENCY MARGIN, ADVANCE PAYMENT OF PREMIUM AND RESTRICTIONS ON THE OPENING OF A NEW PLACE OF BUSINESS

PROVIDENT SOCIETIES

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Rules

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PRELIMINARY

ACTUARIES

DEPOSITS WITH THE BANK

SECURITIES AND INVESTMENTS

PROSPECTUSES, TABLES AND PROPOSAL FORMS

COMMITTEE OF THE INSURANCE COUNCILS

ELECTION OF DIRECTORS BY POLICY HOLDERS

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LICENCES AND CERTIFICATES

16. Licence fee for insurance agents and collection thereof
16A. Issue of licences to insurance agents
16B. Bona fide insurance agents for the purposes of Section 41
16C. Fee for principal, chief and special agents
16D. Issue of certificates to principal, chief and special agents
16E. Issue of duplicate licenses and certificates
16F. Description of stamps
16G. Allowance for unused stamps
16H. Cancellation of licences or certificates

SHARES, OWNERSHIP AND DISPOSAL

17. Declaration as to the nature of ownership of shares
17A. Declaration as to beneficial interest in shares
17AA. Form for declaration
17B. Disposal of shares by Administrator-General

LIMITATION OF EXPENSES OF MANAGEMENT

17C. Statement of the bases of premiums
17D. Limitation of expenses of management in life-insurance business
17E. Limitation of expenses of management in general insurance business
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Life Insurance Business in India was nationalized with effect from January 19, 1956. On the date, the Indian business of 16 non-Indian insurers operating in India and 75 Provident Societies were taken over by Government of India. Life Insurance Corporation of India, Act was passed by the Parliament on June 18, 1956 and came into effect from July 1, 1956. Life Insurance Corporation of India commenced its functioning as a corporate body from September 1, 1956. Its working is governed by the LIC Act. The LIC is a corporate having perpetual succession and a common seal with a power to acquire hold and dispose of property and can by its name sue and be sued.

THE LIFE INSURANCE CORPORATION ACT, 1956*

ARRANGEMENT OF SECTIONS

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2. Definitions.

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4. Constitution of the Corporation.
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* A Short description of the contents are given here and for full details please refer to the life insurance corporation Act 1956.

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INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY ACT 1999

An Act

To provide for the establishment of an Authority to protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto and further to amend the Insurance Act, 1938, the Life Insurance Corporation Act, 1956 and the General Insurance Business (Nationalisation) Act, 1972.

BE it enacted by Parliament in Fiftieth Year of Republic of India as follows:

CHAPTER I
PRELIMINARY

1. Short Title, Extent and Commencement

1. This Act may be called the Insurance Regulatory and Development Authority Act, 1999.
2. It extends to the whole of India.
3. It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint:

Provided that different dates may be appointed for different provisions of this Act and any reference in any such provision to the commencement of this Act shall be construed as a reference to the coming into force of that provision.

2. Definitions

1. In this Act, unless the context otherwise requires:
   (*a*) "appointed day" means the date on which the Authority is established under sub-Section (1) of Section 3;
   (*b*) "Authority" means the Insurance Regulatory and Development Authority established under sub-Section (1) of Section 3;
   (*c*) "Chairperson" means the Chairperson of the Authority;
   (*d*) "Fund" means the Insurance Regulatory and Development Authority Fund constituted under sub-Section (1) of Section 16;
   (*e*) "Interim Insurance Regulatory Authority" means the Insurance Regulatory Authority set up by the Central Government through Resolution No.17(2)/94-Ins-V, dated the 23rd January, 1996;
   (*f*) "intermediary or insurance intermediary" includes insurance brokers, reinsurance brokers, insurance consultants, surveyors and loss assessors;
   (*g*) "member" means a whole time or a part time member of the Authority and includes the Chairperson;
   (*h*) "notification" means a notification published in the Official Gazette;
   (*i*) "prescribed" means prescribed by rules made under this Act;
   (*j*) "regulations" means the regulations made by the Authority.
2. Words and expressions used and not defined in this Act but defined in the Insurance Act, 1938 (4 of 1938) or the Life Insurance Corporation Act, 1956 (31 of 1956) or the General Insurance Business (Nationalisation) Act, 1972 (57 of 1972) shall have the meanings respectively assigned to them in those Acts.

CHAPTER II
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

3. Establishment and Incorporation of Authority

1. With effect from such date as the Central Government may, by notification, appoint, there shall be established, for the purposes of this Act, an Authority to be called "the Insurance Regulatory and Development Authority."
2. The Authority shall be a body corporate by the name aforesaid having perpetual succession and a common seal with power, subject to the provisions of this Act, to acquire, hold and dispose of property, both movable and immovable, and to contract and shall, by the said name, sue or be sued.
3. The head office of the Authority shall be at such place as the Central Government may decide from time to time.
4. The Authority may establish offices at other places in India.

4. Composition of Authority: The Authority shall consist of the following members, namely:

(*a*) a Chairperson;

(*b*) not more than five whole-time members;

(*c*) not more than four part-time members,

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:

Provided that the Central Government shall, while appointing the Chairperson and the whole-time members, ensure that at least one person each is a person

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having knowledge or experience in life insurance, general insurance or actuarial science, respectively.

5. **Tenure of Office of Chairperson and Other Members**
   1. The Chairperson and every other whole-time member shall hold office for a term of five years from the date on which he enters upon his office and shall be eligible for reappointment:

      Provided that no person shall hold office as a Chairperson after he has attained the age of sixty-five years:

      Provided further that no person shall hold office as a whole-time member after he has attained the age of sixty-two years.
   2. A part-time member shall hold office for a term not exceeding five years from the date on which he enters upon his office.
   3. Notwithstanding anything contained in sub-Section (1) or sub-section (2), a member may:
      (*a*) relinquish his office by giving in writing to the Central Government notice of not less than three months; or
      (*b*) be removed from his office in accordance with the provisions of section.
6. **Removal from Office**
   1. The Central Government may remove from office any member who:
      (*a*) is, or at any time has been, adjudged as an insolvent; or
      (*b*) has become physically or mentally incapable of acting as a member: or
      (*c*) has been convicted of any offence which, in the opinion of the Central Government, involves moral turpitude; or
      (*d*) has acquired such financial or other interest as is likely to affect prejudicially his functions as a member; or
      (*e*) has so abused his position as to render his continuation in office detrimental to the public interest.
   2. No such member shall be removed under clause (*d*) or clause (*e*) of sub-section (1) unless he has been given a reasonable opportunity of being heard in the matter.
7. **Salary and Allowances of Chairperson and Members**
   1. The salary and allowances payable to, and other terms and conditions of service of, the members other than part-time members shall be such as may be prescribed.
   2. The part-time members shall receive such allowances as may be prescribed.
   3. The salary, allowances and other conditions of service of a member shall not be varied to his disadvantage after appointment.
8. **Bar on Future Employment of Members:** The Chairperson and the whole-time members shall not, for a period of two years from the date on which they cease to hold office as such, except with the previous approval of the Central Government, accept
   (*a*) any employment either under the Central Government or under any State Government; or
   (*b*) any appointment in any company in the insurance sector.
9. **Administrative Powers of Chairperson:** The Chairperson shall have the powers of general superintendence and direction in respect of all administrative matters of the Authority.
10. **Meetings of Authority**
    1. The Authority shall meet at such times and places and shall observe such rules and procedures in regard to transaction of business at its meetings (including

quorum at such meetings) as may be determined by the regulations.

2. The Chairperson, or if for any reason he is unable to attend a meeting of the Authority, any other member chosen by the members present from amongst themselves at the meeting shall preside at the meeting.
3. All questions which come up before any meeting of the Authority shall be decided by a majority of votes by the members present and voting, and in the event of an equality of votes, the Chairperson, or in his absence, the person presiding shall have a second or casting vote.
4. The Authority may make regulations for the transaction of business at its meetings.

11. Vacancies, etc., not to Invalidate Proceedings of Authority: No act or proceeding of the Authority shall be invalid merely by reason of:

(*a*) any vacancy in, or any defect in the constitution of, the Authority; or

(*b*) any defect in the appointment of a person acting as a member of the Authority; or

(*c*) any irregularity in the procedure of the Authority not affecting the merits of the case.

12. Officers and Employees of Authority

1. The Authority may appoint officers and such other employees as it considered necessary for the efficient discharge of its function under this Act.
2. The terms and other conditions of service of officers and other employees of the Authority appointed under sub-Section(1) shall be governed by regulations made under this Act.

CHAPTER III
TRANSFER OF ASSETS, LIABILITIES, ETC., OF INTERIM INSURANCE REGULATORY AUTHORITY

13. Transfer of Assets, Liabilities, etc., of Interim Insurance Regulatory Authority: On the appointed day:

(*a*) all the assets and liabilities of the Interim Insurance Regulatory Authority shall stand transferred to, and vested in, the Authority.

Explanation: The assets of the Interim Insurance Regulatory Authority shall be deemed to include all rights and powers, and all properties, whether movable or immovable, including, in particular, cash balances, deposits and all other interests and rights in, or arising out of, such properties as may be in the possession of the Interim Insurance Regulatory Authority and all books of account and other documents relating to the same; and liabilities shall be deemed to include all debts, liabilities and obligations of whatever kind;

(*b*) without prejudice to the previous of clause (*a*), all debts, obligations and liabilities incurred, all contracts entered into and all matters and things engaged to be done by, with or for the Interim Insurance Regulatory Authority immediately before that day, for or in connection with the purpose of the said Regulatory Authority, shall be deemed to have been incurred, entered into or engaged to be done by, with or for, the Authority;

(*c*) all sums of money due to the Interim Insurance Regulatory Authority immediately before that day shall be deemed to be due to the Authority; and

(*d*) all suits and other legal proceedings instituted or which could have been instituted by or against the Interim Insurance Regulatory Authority immediately before that day may be continued or may be instituted by or against the Authority.

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CHAPTER IV
DUTIES, POWERS AND FUNCTIONS OF AUTHORITY

14. Duties, Powers and Functions of Authority

1. Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business.
2. Without prejudice to the generality of the provisions contained in sub-section (1), the powers and functions of the Authority shall include:
   (*a*) issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;
   (*b*) protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;
   (*c*) specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
   (*d*) specifying the code of conduct for surveyors and loss assessors;
   (*e*) promoting efficiency in the conduct of insurance business;
   (*f*) promoting and regulating professional organisations connected with the insurance and re-insurance business;
   (*g*) levying fees and other charges for carrying out the purposes of this Act;
   (*h*) calling for information from, undertaking inspection of, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermedi- aries and other organisations connected with the insurance business;
   (*i*) control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business not so controlled and regulated by the Tariff Advisory Committee under Section 64U of the Insurance Act, 1938 (4 of 1938);
   (*j*) specifying the form and manner in which books of account shall be maintained and statement of accounts shall be rendered by insurers and other insurance intermediaries;
   (*k*) regulating investment of funds by insurance companies;
   (*l*) regulating maintenance of margin of solvency;
   (*m*) adjudication of disputes between insurers and intermediaries or insurance intermediaries;
   (*n*) supervising the functioning of the Tariff Advisory Committee;
   (*o*) specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organisations referred to in clause (*f*);
   (*p*) specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector; and
   (*q*) exercising such other powers as may be prescribed.

CHAPTER V
FINANCE, ACCOUNTS AND AUDIT

15. Grants by Central Government: The Central Government may, after due appropriation made by Parliament by law in this behalf, make to the Authority grants of such sums of money as the Government may think fit for being utilised for the purposes of this Act.

16. Constitution of Funds

1. There shall be constituted a fund to be called "the Insurance Regulatory and Development Authority Fund" and there shall be credited thereto:
   (*a*) all Government grants, fees and charges received by the Authority;
   (*b*) all sums received by the Authority from such other source as may be decided upon by the Central Government;
   (*c*) the percentage of prescribed premium income received from the insurer.
2. The Fund shall be applied for meeting:
   (*a*) the salaries, allowances and other remuneration of the members, officers and other employees of the Authority;
   (*b*) the other expenses of the Authority in connection with the discharge of its functions and for the purposes of this Act.

17. Accounts and Audit

1. The Authority shall maintain proper accounts and other relevant records and prepare an annual statement of accounts in such form as may be prescribed by the Central Government in consultation with the Comptroller and Auditor-General of India.
2. The accounts of the Authority shall be audited by the Comptroller and Auditor-General of India at such intervals as may be specified by him and any expenditure incurred in connection with such audit shall be payable by the Authority to the Comptroller and Auditor-General.
3. The Comptroller and Auditor-General of India and any other person appointed by him in connection with the audit of the accounts of the Authority shall have the same rights, privileges and authority in connection with such audit as the Comptroller and Auditor-General generally has in connection with the audit of the Government accounts and, in particular, shall have the right to demand the production of books of account, connected vouchers and other documents and papers and to inspect any of the offices of the Authority.
4. The accounts of the Authority as certified by the Comptroller and Auditor-General of India or any other person appointed by him in this behalf together with the audit-report thereon shall be forwarded annually to the Central Government and that Government shall cause the same to be laid before each House of Parliament.

CHAPTER VI
MISCELLANEOUS

18. Power of Central Government to Issue Directions

1. Without prejudice to the foregoing provisions of this Act, the Authority shall, in exercise of its powers or the performance of its functions under this Act, be bound by such directions on questions of policy, other than those relating to technical and administrative matters, as the Central Government may give in writing to it from time to time.

   Provided that the Authority shall, as far as practicable, be given an opportunity to express its views before any direction is given under this sub-section.
2. The decision of the Central Government, whether a question is one of policy or not, shall be final.

19. Power of Central Government to Supersede Authority

1. If at any time the Central Government is of the opinion:
   (*a*) that, on account of circumstances beyond the control of the Authority, it is unable to discharge the functions or perform the duties imposed on it by or under the provisions of this Act, or

(b) that the Authority has persistently defaulted in complying with any direction given by the Central Government under this Act or in the discharge of the functions or performance of the duties imposed on it by or under the provisions of this Act and as a result of such default the financial position of the Authority or the administration of the Authority has suffered; or

(c) that circumstances exist which render it necessary in the public interest so to do,

the Central Government may, by notification and for reasons to be specified therein, supersede the Authority for such period, not exceeding six months, as may be specified in the notification and appoint a person to be the Controller of Insurance under section 2B of the Insurance Act, 1938 (4 of 1938), if not already done:

Provided that before issuing any such notification, the Central Government shall give a reasonable opportunity to the Authority to make representations, if any, of the Authority.

2. Upon the publication of a notification under sub-Section(l) superseding the Authority:

(a) the Chairperson and other members shall, as from the date of supersession, vacate their offices as such;

(b) all the powers, functions and duties which may, by or under the provisions of this Act, be exercised or discharged by or on behalf of the Authority shall, until the Authority is reconstituted under sub-section (3), be exercised and discharged by the Controller of Insurance; and

(c) all properties owned or controlled by the Authority shall, until the Authority is reconstituted under sub-section (3), vest in the Central Government.

3. On or before the expiration of the period of supersession specified in the notification issued under sub-Section (1), the Central Government shall reconstitute the Authority by a fresh appointment of its Chairperson and other members and in such case any person who had vacated his office under clause(a) of sub-Section (2) shall not be deemed to be disqualified for reappointment.

4. The Central Government shall cause a copy of the notification issued under sub-section (1) and a full report to any action to be laid before each House of Parliament at the earliest.

20. Furnishing of Returns, etc., to Central Government

1. The Authority shall furnish to the Central Government at such time and in such form and manner as may be prescribed, or as the Central Government may direct to furnish such returns, statements and other particulars in regard to any proposed or existing programme for the promotion and development of the insurance industry as the Central Government may, from time to time, require.

2. Without prejudice to the provisions of sub-Section (1), the Authority shall, within nine months after the close of each financial year, submit to the Central Government a report giving a true and full account of its activities including the activities for promotion and development of the insurance business during the previous financial year.

3. Copies of the reports received under sub-Section (2) shall be laid, as soon as may be after they are received, before each House of Parliament.

21. Chairperson, Members, Officers and other Employees of Authority to be Public Servants: The Chairperson, members, officers and other employees of Authority shall be deemed, when acting or purporting to act in pursuance of any

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of the provisions of this Act, to be public servants within the meaning of Section 21 of the Indian Penal Code (45 of 1860).

22. Protection of Action Taken in Good Faith: No suit, prosecution or other legal proceedings shall lie against the Central Government or any officer of the Central Government or any member, officer or other employee of the Authority for anything which is in good faith done or intended to be done under this Act or the rules or regulations made thereunder:

Provided that nothing in this Act shall exempt any person from any suit or other proceedings which might, apart from this Act, be brought against him.

23. Delegation of Powers

1. The Authority may, by general or special order in writing, delegate to the Chairperson or any other member or office of the Authority subject to such conditions, if any, as may be specified in the order such of its powers and functions under this Act as it may deem necessary.
2. The Authority may, by a general or special order in writing, also form committees of the members and delegate to them the powers and functions of the Authority as may be specified by the regulations.

24. Power to Make Rules

1. The Central Government may, by notification, make rules for carrying out the provisions of this Act.
2. In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely :
   (*a*) the salary and allowances payable to, and other terms and conditions of service of, the members other than part-time members under sub-section (1) of Section 7;
   (*b*) the allowances to be paid to the part-time members under sub-section (2) of Section 7;
   (*c*) such other powers that may be exercised by the Authority under clause (*q*) of sub-Section (2) of Section 14;
   (*d*) the form of annual statement of accounts to be maintained by the Authority under sub-Section (1) of Section 17;
   (*e*) the form and the manner in which and the time within which returns and statements and particulars are to be furnished to the Central Government under sub-Section (1) of Section 20;
   (*f*) the matters under sub-Section (5) of Section 25 on which the Insurance Advisory Committee shall advise the Authority;
   (*g*) any other matter which is required to be, or may be, prescribed, or in respect of which provision is to be or may be made by rules.

25. Establishment of Insurance Advisory Committee

1. The Authority may, by notification, establish with effect from such date as it may specify in such notification, a Committee to be known as the Insurance Advisory Committee.
2. The Insurance Advisory Committee shall consist of not more than twenty-five members excluding ex-officio members to represent the interests of commerce, industry, transport, agriculture, consumer fora, surveyors, agents, intermediaries, organisations engaged in safety and loss prevention, research bodies and employees' association in the insurance sector.
3. The Chairperson and the members of the Authority shall be the ex-officio Chairperson and ex-officio members of the Insurance Advisory Committee.
4. The object of the Insurance Advisory Committee shall be to advise the Authority on matters relating to the making of the regulations under Section 26.

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5. Without prejudice to the provisions of sub-Section (4), the Insurance Advisory Committee may advise the Authority on such other matters as may be prescribed.

26. Power to Make Regulations

1. The Authority may, in consultation with the Insurance Advisory Committee, by notification, make regulations consistent with this Act and the rules made thereunder to carry out the purposes of this Act.
2. In particular, and without prejudice to the generality of the foregoing power. such regulations may provide for all or any of the following matters, namely :

   (*a*) the time and places of meetings of the Authority and the procedure to be followed at such meetings including the quorum necessary for the transaction of business under sub-section (1) of Section 10;

   (*b*) the transactions of business at its meetings under sub-section (4) of Section 10;

   (*c*) the terms and other conditions of service of officers and other employees of the Authority under sub-Section (2) of Section 12;

   (*d*) the powers and functions which may be delegated to Committees of the members under sub-Section (2) of Section 23; and

   (*e*) any other matter which is required to be, or may be, specified by regulations or in respect of which provision is to be or may be made by regulations.

27. Rules and Regulations to be Laid before Parliament: Every rule and every regulation made under this Act shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive session aforesaid, both Houses agree in making any modification in the rule or regulation or both Houses agree that the rule or regulation should not be made, the rule or regulation shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule or regulation.

28. Application of Other Laws not Barred: The provisions of this Act shall be in addition to, and not in derogation of, the provisions of any other law for the time being in force.

29. Power to Remove Difficulties:

1. If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order published in the Official Gazette, make such provisions not inconsistent with the provisions of this Act as may appear to be necessary for removing the difficulty:

   Provided that no order shall be made under this section after the expiry of two years from the appointed day.

2. Every order made under this section shall be laid, as soon as may be, after it is made, before each House of Parliament.

30. Amendment of Act 4 of 1938: The Life Insurance Act, 1938 shall be amended in the manner specified in the First Schedule to this Act.

31. Amendment of Act 31 of 1956: The Life Insurance Corporation Act, 1956 shall be amended in the manner specified in the Second Schedule to this Act.

32. Amendment of Act 57 of 1972: The General Insurance Business (Nationalisation) Act, 1972 shall be amended in the manner specified in the Third Schedule to this Act.

THE INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY ACT, 1999

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Section 1 and 2 – Title and Definition

Section 3 – Establishment of the Insurance Regulatory and Development Authority by the Central Government as a body corporate.

Section 4 – The Authority shall consist of a Chairperson, not more than five whole-time members and not more than four part time members, to be appointed by the Central Government.

Section 5 – Provides that the Chairperson and members shall hold office for five years.

Section 6 – The Central Government may remove from office the Chairperson and members of the Authority in certain circumstances.

Section 7 – Salary, allowances and other terms and conditions of service of the Chairperson, whole time members and part time members.

Section 8 – Provides that the Chairperson and members shall be ineligible for appointment in central or state governments or any private company in the insurance sector for a period of two years from the date on which they cease to hold office.

Section 9 – Chairperson's powers, in administrative matters of the Authority.

Section 10 – Conduct of the meetings of the Authority

Section 11 – Matters that will not invalidate the proceedings of the Authority

Section 12 – Powers to appoint officers and other employees

Section 13 – transfer of assets, library, etc., of the Regulatory Authority.

Section 14 – The Authority shall regulate promote and insure orderly growth of insurance business and prescribe its powers and functions.

Section 15 – Grants to the Authority by the central government.

Section 16 – Provides for the constitution of IRDA Fund.

Section 17 – The Authority shall maintain its accounts in the form prescribed by the Central Government and that the Accounts will be audited by the Comptroller and Auditor General of India

Section 18 – The decision of the central government on policy shall be final.

Section 19 – The Central Government may by notification and for reasons specified therein supersede the Authority.

Section 20 – Returns, etc., to be filed by the Authority to the central government.

Section 21 – the Chairpersons, members, officers and employees of the Authority shall be public servants

Section 22 – Protection of action take in good faith.

Section 23 – Delegation of powers of the Authority.

Section 24 – Central government has the power to make rules for carrying out the provision of the Bill.

Section 25 – Formation of insurance advisory committee which will consist of not more than 25 members excluding the chairperson and other members.

Section 26 – Authority to make regulations consistent with the provision of the bill.

Section 27 – Rules and Regulations shall be laid before each house of parliament.

Section 28 – The provision of these act shall be in addition to and not in derogation of the provisions of any other law.

Section 29 – Empower the central government to remove difficulties in implementation.

Section 30 – Amendment to certain provisions of the insurance Act, 1938 in the manner as set out in the first schedule of the bill.

Section 31 – Seeks to amend the Life Insurance Corporation Act, 1956. The exclusive privilege of the Life Insurance Corporation shall cease so as to enable other Indian insurance companies to do life insurance business.

Section 32 – Seeks to amend the General Insurance Business (Nationalisation) Act, 1972.

The exclusive privilege of the General Insurance Corporation and the four subsidiary companies shall cease so as to enable other Indian insurance companies to do non-life insurance business.

THE OTHER ACTS RELEVANT TO INSURANCE BUSINESS

Marine Insurance Act 1903
Motor Vehicles Act, 1988
Contract Act
Consumer Protection Act, 1986
Exchange Control Regulations/Foreign Exchange Management Act (FEMA)
The Indian Stamp Act, 1899.
The Workmen's Compensation Act, 1923
Public Liability Insurance Act, 1991
The Carriage of Goods by Sea Act, 1925
The Merchant Shipping Act, 1958
The Bill of Lading Act, 1985
The Indian Ports (Major Ports) Act, 1963
The Carriers Act, 1865
Indian Railways Act, 1989
The Indian Post Office Act, 1898
The Carriage by Air Act, 1972
Multi-modal Transportation Act, 1993
The Inland Steam Vessels (Amendment) Act, 1977
Sale of Goods Act

18.2. INSURANCE AND TAX BENEFITS

INDIVIDUALS

Traditionally individuals who buy insurance get a tax break on the premium paid in respect of life insurance. The periodical payment of premium of life policies is allowed as deduction in the taxable income and consequently the individual's tax burden is lessened. Again at the time of receiving the maturity value of life policies the extra income derived over aggregate amount of premium paid, which is usually called as bonus or guaranteed addition is also exempt from income tax, while on the other hand a similar income by way of interest rent etc on other investments are taxable. Thus there is two way tax benefit as far life insurance is concerned. Similarly premium paid on health insurance policies for self and family members is also eligible for tax benefits. The benefits are at a higher rate if unfortunately, the dependent children are handicapped, physically or mentally. The quantum of benefit or tax concession, changes from time to time. The rates are announced at the time of Union Budget. Apart from risk cover, when the return on the investment in insurance is considered, the tax benefits should also be take into account.

In case of commercial enterprises premium paid on all insurances purchased by them is an allowed expenditure for tax purposes.

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18.3. CONSUMER PROTECTION ACT 1986

Every year, 15 March is observed as 'World Consumer Rights Day' for it was on this day in 1962 that John F Kennedy, the then US President declared four rights of the consumer in his special message to the American Congress—**Right to Safety, Right to be Informed, Right to Choose and Right to be Heard**. These rights also found a place in the socio-economic agenda of India.

In order to serve the cause of consumers at large, the Consumer Protection Act 1986, (COPRA) a Central legislation came into force on April 15, 1987. It is a major legislative step to protect the consumer's interest and to provide **simple, speedy and inexpensive** redressal to consumers' grievances. For that purpose, a set of special redressal forums were established with quasi judicial powers:

1. **District Consumer** Redressal Forum headed by a District Judge with a financial jurisdiction of ₹ **20 lakh**.
2. **State Commission** headed by a Judge of the High Court with financial limit of **one crore.**
3. **National Commission** headed by a Judge of the Supreme Court to hear disputes above One crore.

State and National Commissions have appellate powers also. Over this three tier system, the **Supreme Court** serves as the ultimate judicial authority. These forums grant relief of specific nature and award compensation to consumers.

The Act defines a consumer as a person who buys goods or services for a consideration **for his use**. Life Insurance is primarily a service rendered to the insuring public. There is a consumer relationship between the insured and the insurer and therefore **insurance company comes under the purview of the act.** So if there is a **defect or deficiency in service** rendered by the insurance company the insured (policy holder) has the right to seek redressal from these forums. Defect or deficiency means any fault, imperfection, shortcoming, or inadequacy in the quality, nature and manner of performance in relation to the service.

Over the years, a number of cases have been referred to these forums and decided on issues like delay in settlement of claims, repudiation of claims, wrong adjustment of premium, delay in services like granting of loan, transfer of policy, etc.

There is a recent trend among the forums to proceed against the agents also for deficiency in service. It is true that there is a direct consumer relationship between the insured and the insurance company. But the role of the agent through whom the policy was purchased also comes into focus in some cases. The agent explains the benefits and canvasses the proposal. He helps the proposer in filling up the proper forms. While doing so the policy holder is hiring the services of the agent and he is acting as the agent of the proposer. If the forum finds the agent responsible for giving wrong advice and inducing the policy holder to suppress any material information, it is considered as a defect and deficiency in service and he is liable for punishment.

Under this Act, there are about 600 District Forums, over 30 State Commissions and the National Commission functioning in the country, with the objective of resolving consumer grievances. The majority of disputes insurance disputes referred to them are for reasons of delay or repudiation of claims. The policy holders in general have immensely benefited by their services for the past two decades.

Evaluating Customer Service

Customer service, in life insurance, can be evaluated at different levels. The insurer can establish benchmarks or standards for various service transactions and compare the actual performance with them. Such standards would be helpful in evaluating the **'timeliness'** of the service rendered. Wherever there are significant deviations, the insurer can investigate and improve the performance by conscious steps to cut the delays or by rationalising the procedures.

The percentage of claims outstanding at the end of a period to the claims payable during the period will reveal the **speed** with which the claims are settled by the office. Such ratios can be worked out for Maturity and Death claims separately. For service transactions like settlement of loans, etc., the maximum time to complete the service can be established and actual time lag in each case compared.

Quality of service can be evaluated through **customer surveys** and by inviting customers to **customer meets** and enabling them to express their **expectations** and their **experiences** with the company.

The **lapse ratio** when compiled properly can reveal the first year and subsequent year lapses indicating customer retention. A poor ratio may indicate miss-selling or inadequate follow up for premium payments. Similarly **ratio of early claims or claims repudiated** may reveal deficiency in underwriting or indiscriminate selling.

It is now usual for an insurer to have a representative of policy holders in the **Board.** Insurers also have consultative committees where the policy holders are represented. Appointment of **Grievance Redressal** officers, provision of **toll free interactive telephones,** establishing **customer portals** where the customer can register the complaint and track its status and facilitating downloading of certain forms through a website are certain measures taken by the insurer to ensure speedy disposal of complaints to the satisfaction of the policy holders.

SUMMARY

- General insurance companies operating in India are governed by the Insurance Act 1938 and the Insurance Regulatory and Development Authority Act 1999. Those who deal with insurance should be conversant with these two pieces of legislation.

REVIEW QUESTIONS

1. Write a short note on the Insurance Act 1938.
2. What is Insurance Regulatory and Development Authorty Act 1999? Explain breifly.
3. Write down duties, Powers and functions of authorty of IRDA.
4. How the Consumer Protection Act aims to protect the four rights recognized under the Act? How life insurance comes under the purview of the Act?

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