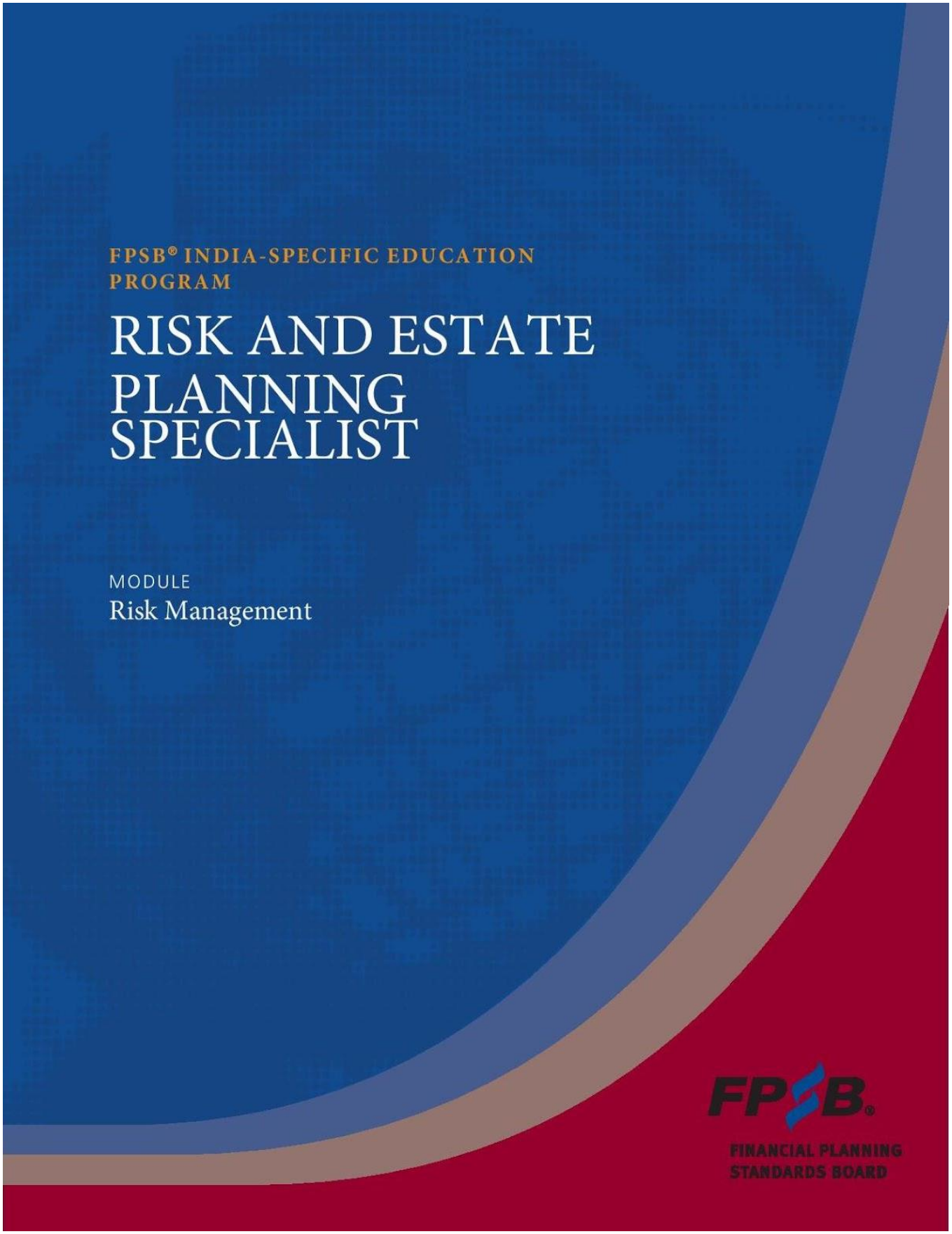

India-Specific Risk Management

Table of Contents

Chapter 1: Overview of the Insurance Sector in India

Learning Objectives

Upon completion of this section, students should be able to:
1-1 Explain the insurance sector in India
1-2 Describe the laws governing the insurance business in India

Topics

1.1 Economic, Commercial and Social Aspect of Insurance

Insurance is a protection and risk management mechanism. A well-built insurance sector enhances risk-taking for the Government in the economy, as it provides some safety from unanticipated, loss-causing events. Since the funds are available for the long term, investment in the long term projects becomes easier leading to rapid infrastructural development. On an individual basis, insurance money provides support to the family in the event of loss due to death, immobility, work restraints, illness etc. Thus, the insurance industry is of prime significance for any country's economic development.

The insurance sector in India has gone through a full circle - from being unregulated to completely regulated and then being partly deregulated by allowing private companies to solicit insurance and also allowing Foreign Direct Investment (FDI) of up to 49% (as of 2019) to strengthen the insurance market even further.

For the society as a whole, insurance works as a protection mechanism by mitigating the effects of untoward and uncontrollable events such as illness, accident, death, natural disasters. It is thus a precondition for the development of the economy. It manages, diversifies and absorbs the risks of individuals, and companies, thereby allowing them to recover from sudden misfortune. Once the external risks are managed through insurance, productive activities such as buying a home and starting or expanding a business are spurred. In turn, these activities fuel the demand chain, facilitate supply and also support trade. The aggregate impact of all this is level consumption patterns and a wider contribution to financial and social stability.

India is one of the fastest growing economies and as such the insurance market in India is poised for strong growth. The insurance industry itself is getting bigger with the country's economy and the insurance companies are increasing their operations in the country.

The insurance regulator in India (IRDAI) is actively working on diverse areas such as retention ratio, claim settlement ratio, protection of interests of policy holders, policyholder grievance redressal, consumer financial education and insurance literacy, prevention of unfair business practices, spurious calls amongst many others for ensuring orderly growth of insurance industry in India.

1.2 Scope of Insurance Business

1.2.1 Life Insurance – History and Growth

The history of insurance sector in India has been aptly time-lined by the insurance regulator (IRDAI) (Reference www.irdai.gov.in). The same is edited and placed below so as to cover the developments over the entire 200 year period correctly.

The year 1818 saw the advent of life insurance business in India with the establishment of the Oriental Life Insurance Company in Calcutta. Further down, the year 1870 saw the enactment of the British Insurance Act and in the last three decades of the nineteenth century, the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) were started in the Bombay Residency. The Indian Life Assurance Companies Act, 1912 was the first statutory measure to regulate life business. In 1928, the Indian Insurance Companies Act was enacted to enable the Government to collect information about both life and non-life business transacted in India by Indian and foreign insurers. In 1938, with a view to protecting the interest of the insurance public, the earlier legislation was consolidated and amended by the Insurance Act, 1938.

The Insurance Amendment Act of 1950 got rid of Principal Agencies. However, there were a large number of insurers and the competition level was high. Unfair trade practices were also

prevailing. The Government of India, hence, decided to nationalize insurance business. An Ordinance was issued on 19th January, 1956 nationalizing the Life Insurance sector and Life Insurance Corporation (LIC) came into existence in the same year. Life Insurance Corporation absorbed 154 Indian, 16 non-Indian insurers and 75 provident societies.

The process of re-opening of the insurance sector began in the early 1990s and in 1993 the Government set up a committee, under the chairmanship of R.N.Malhotra, to propose recommendations for reforms in the insurance sector. The committee suggested that the private sector be allowed to enter the insurance industry. Following the recommendations of the Malhotra Committee report, the Insurance Regulatory and Development Authority (IRDA) was constituted as an autonomous body in 1999, and as a statutory body in 2000, to regulate and develop the insurance industry. In August 2000, IRDA opened up the market and Foreign companies were allowed ownership of up to 26%.

At the end of March 2019 there are 70 insurers operating in India of which 24 are life insurers, 27 are general insurers, 7 are stand-alone health insurers and 12 are re-insurers which includes foreign reinsurers' branches and Lloyd's India. Of the 70 insurers presently in operation, eight are in the public sector and sixty-two are in the private sector.
(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in).

Other stakeholders in the insurance market include the agents (individual and corporate), brokers, surveyors and third party administrators (TPAs) servicing the health insurance claims.

India is ranked 10th among the 88 countries, in life insurance business, for which data is published by Swiss Re. During 2018, India's share in the global life insurance market was 2.61% and in this year the life insurance premium in India increased by 7.70% (inflation adjusted) while global life insurance premium increased by 0.20% (inflation adjusted). In terms of premium collected, it was US $ 73.74 billion for India while it was US $ 2820.18 billion for the world. During 2018-19, the life insurance industry in India recorded a premium of Rs. 508,000 crore (a growth of 10.75% from 2017-18) while 286.48 lakh new individual policies were issued (a growth of 5.61% from 2017-18).
(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in).

Insurance penetration is measured as the percentage of insurance premium to GDP while insurance density is the ratio of premium to population. For 2018, in India, the insurance penetration stood at US$ 2.74 for life and US$ 0.97 for non-life; while the insurance density was US$ 55.00 for life and US$ 19.00 for non-life. *(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in).*

1.2.2 General Insurance – Historical Perspective and Potential

General Insurance in India started with the Triton Insurance Company Ltd. in 1850 in Calcutta by the British. In 1907, the Indian Mercantile Insurance Ltd, was set up as the first company to transact all classes of general insurance business. The year 1957 saw the formation of the General Insurance Council, which framed a code of conduct for ensuring fair conduct and sound business practices.

In 1972, the general insurance business was nationalized with the passing of the General Insurance Business (Nationalization) Act. A total of 107 insurers were amalgamated and grouped into four companies, namely National Insurance Company Ltd., the New India Assurance Company Ltd., the Oriental Insurance Company Ltd and the United India Insurance Company Ltd. In 1971, the General Insurance Corporation of India was incorporated as a company.

In December, 2000, General Insurance Corporation of India's (GIC) subsidiaries were restructured as independent companies and simultaneously GIC was converted into a national re-insurer. In July, 2002, the Parliament passed a bill de-linking the four subsidiaries from GIC. (edited and reproduced from www.irdai.gov.in)

1.2.2.1 Non – life Insurance

General insurance, or non-life insurance, companies offer various types of insurance products in areas of health, motor, personal accident, home, travel insurance products etc. With increasing income levels in India , there is an increased demand for vehicles. Also, increasing health awareness combined with a growing economy is giving a major boost to this sector.

In the year 2018, the general insurance industry in India underwrote a total direct premium of Rs. 1.69 lakh crore (a growth of 12.47% from 2017). However, the share of Indian non-life insurance premium in global non-life insurance premium was at 1.1% and India ranked 15th in global non-life insurance markets.

The Motor business is the largest non-life insurance segment with a share of 38% and a premium collection of Rs. 64,522 crore in 2018-19. The fire and marine are the other important areas of the non-life insurance sector. *(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in).*

1.2.2.2 Health Insurance

Health insurance is one of the emerging sectors in India. The Indian health system is one of the largest in the world on account of the sheer size of India's population. Rising cost of healthcare and increasing longevity has created awareness among the citizens concerning the importance of health insurance. As a result, the health industry in India has rapidly become one of the foremost necessary sectors in terms of income and job creation.

In business terms, the standalone health insurers registered a growth rate of 36.56% in the year 2018-19 and the health insurance premium continues to grow over 20% year-on-year during the last 4 years. Health insurance in India is classified into Government sponsored health insurance, group health insurance and individual health insurance. In the year 2018-19, the general and health insurance companies have issued around 2.07 crore policies covering a total of 47.20 crore lives.
(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in).

1.2.2.3 Re-Insurance

After its de-nationalization in the year 2000, the General Insurance Corporation of India (GIC Re) has become the only Indian reinsurer. Foreign reinsurers were in operation as only servicing offices in India, liaising with Indian marketplace for their parent offices. Doors were opened for foreign reinsurers in the year 2016, once the Insurance Act was amended.

At present, GIC Re is the national reinsurer, providing reinsurance to the direct general insurance companies in India. The total net premium written by GIC Re during 2018-19 increased by 3.62% to Rs. 38,996 crore as compared to 2017-18.

Along with ITI Reinsurance Limited (ITI Re) the reinsurance program was designed to meet the objective of optimizing the retention of reinsurance within the country, ensuring adequate coverage for exposure, developing adequate capacities within the domestic market and providing reinsurance support to direct insurance companies in

India and foreign insurers/reinsurers. Meanwhile, ITI Re did not commence business operations and surrendered their certificate of registration for cancellation.

Section 101A of the Insurance Act, 1938 stipulates that every insurer shall reinsure with the Indian reinsurer such percentage of the sum insured on each general insurance policy as may be specified by the Authority. With a view to make India a Reinsurance hub, the Insurance Law (Amendment) Act, 2015 has allowed foreign reinsurers and the Society of Lloyd's to open their branches in India to transact reinsurance business. *(Reference - IRDAI Annual Report 2018-19, www.irdai.gov.in)*.

1.3 Laws governing insurance business in India

1.3.1 The Insurance Act, 1938

Insurance industry, like any other industry, is governed by a number of Acts. The Insurance Act of 1938 was the primary legislation governing all types of insurance to furnish strict state jurisdiction over insurance business. This Act has been amended by Insurance (Amendment) Act, 2002. It is applicable to all the states of India.

Part I of this Act lays down the definitions such as 'the insurance company', 'insurer', 'insurance agent', 'actuary', 'intermediaries' and others related to all aspects of the Insurance industry. Part II is the main section of this Act which deals with the provisions applicable to the insurers. It spells out the various mandatory requirements for an Insurance Company including registration of policies and claims, furnishing reports, provisions regarding investments by the insurance company, assignment and transfer of policies, registration of intermediaries including agents, insurance business in rural or social sector and various other provisions of law for protection of the insured.

Part V of this Act lays down the penalty for default in complying with this Act. It also gives power to the Authority (IRDA) to make regulations. *(Reference The Insurance Act, 1938 at www.irdai.gov.in)*.

1.3.2 The Insurance Laws (Amendment) Act, 2015

This Act amended three previous Acts related to the insurance sector in India - The Insurance Act, 1938, The General Insurance Business (Nationalization) Act, 1972 and The Insurance Regulatory and Development Authority Act, 1999. In order to make the insurance sector more practical, the insurance regulator in India (Insurance Regulatory and Development Authority of India - IRDAI) has been given further authority to formulate Rules.

Under the new Act:

- Various Sections have been amended, omitted or substituted, while some new Sections have been inserted,
- Provisions related to investments by insurance companies and prohibition for investment of funds outside India have been strengthened,
- The power of investigation and inspection by the Authority has been further increased,
- Provisions related to assignment and transfer of insurance policies, nomination of policy holder, prohibition of payment by way of commission have all been strengthened,
- Revised limitation of management expenses in insurance business have been set,
- New provisions have been inserted related to the appointment and record of insurance agents.

As per Section 7A, the cap on Foreign Direct Investment (FDI) in Indian insurance companies has been raised to 49% providing additional capital flow in the insurance sector. Another important amendment was related to mis-statement wherein no policy of life insurance shall

now be called in question by the insurer on any ground whatsoever after the expiry of three years from the policy date. The Act has also allowed foreign reinsurers to do business in Indian territory. In order to set up an efficient grievance redressal system, the Securities Appellate Tribunal (SAT) has been made the appellate authority to IRDAI's order.

1.3.3 Law relating to Agency under the Indian Contract Act, 1872

Agency connotes a relationship between two persons/parties wherein one person (the Agent) has the power to act on behalf of another (the Principal) to create a legal relationship between the two parties. It is important for a financial advisor to understand the laws regarding Agency because nearly all business transactions worldwide are meted out through this relationship between the Agent and the Principal.

Chapter X of the Indian Contract Act, 1872 deals with laws regarding Agency. Section 182 of the Act defines an "agent" as a person employed to do any act for another, or to represent another in dealings with third persons. The person for whom such an act is done, or who is so represented, is known as the "principal". It also deals with appointment and authority of agents/sub-agents, Agent's duty to Principal and Principal's duty to Agent amongst other important subject matters.

In business law, Agency contracts are quite common. An Agency is created when one person delegates his authority to some different person, or appoints him to do some specific tasks in their specified areas of work. As such, establishing a Principal-Agent relationship bestows the rights and duties upon both the parties. Some examples of such a relationship are insurance agency, advertising agency, travel agency, brokers, etc.
(Reference The Indian Contract Act, 1872 at http://uputd.gov.in/site/writereaddata/siteContent/indian-contract-act-1872.pdf)

1.3.4 The Consumer Protection Act, 2019

The Consumer Protection Act, 2019 is enacted to protect the interests of the consumers in India. It makes provision for the establishment of authorities for timely and effective administration and settlement of consumers' disputes. It applies to all goods and services. The 2019 Act repeals the 1986 Act whereby it has substantially enhanced the scope of protection afforded to consumers by bringing within its purview advertising claims, endorsements and product liability. While it continues to have Dispute Redressal Commissions at the District, State and National levels, the monetary value of complaints that can be entertained at each of these commissions has been increased substantially.

The jurisdiction of the Consumer Commissions has been expanded to allow complaints to be made at the place where the complainant resides or works as opposed to the 1986 Act where complaints had to be instituted where the other party resides or conducted business, or where the action cause arose. The 2019 Act also introduces the power of judicial review, which will allow Consumer Commissions to review their orders.

In contrast to the 1986 Act, appeals from the State Commission to the National Commission may now only be made where they involve a major question of law. Similarly, appeals from the National Commission to the Supreme Court can only be made against complaints which originated in the National Commission. Also, the period prescribed for preferring appeals has now been made more stringent.

The Consumer Protection Act, 2019 is a positive step towards further reformation and development of consumer laws in India.
(Reference http://egazette.nic.in/WriteReadData/2019/210422.pdf, and https://consumeraffairs.nic.in/acts-and-rules/consumer-protection).

1.3.5 Doctrines of Waiver and Equitable Estoppel

The legal doctrines of Waiver and Estoppels are directly related to the responsibilities of insurance agents. They are important to individuals because they can work to their advantage when dealing with an insurance company. Application of these doctrines to the specific situation can make the difference between the insurance policy being cancelled or remaining in force, or, between claims being denied or being paid.

Let us understand these two specific terms – Waiver and Estoppel.

Waiver is the conscious and discretionary giving up of a known legal right. It is a unilateral act of one person which results in his surrender of a legal right. The legal right could be constitutional, statutory, or a written agreement. The key issue is whether or not the person voluntarily gave up his right.

A waiver can be express or implied. Express waiver could be oral or written. In either case, it is a clear statement that a right is being given up. For example, if an insurance company notifies a policy holder that it has not lapsed the insured's policy for non-payment of premiums, even though it had the right to do so, it has explicitly waived that right.

Implied waivers are created through the conduct of the waiving party that clearly indicates that a right will not be enforced. For example, if the insurance company accepts the premium from a policyholder after the expiration of the grace period, the company has impliedly waived its right to claim that the policy had lapsed.

Estoppel: Cambridge dictionary defines Estoppel as “a legal rule that prevents someone from changing their mind about something they have previously said is true in court”. As per Investopedia, “estoppel prevents someone from arguing something contrary to a claim made or act performed by that person previously.” Often described as a rule of fair play, equitable estoppel prevents a person from going back on his words.
From the insurance point of view, an insurer may waive a right, and after the policy holder has relied upon the waiver and acted upon it, the insurer will be stopped from claiming the right. Assume an individual fails to disclose some information in the insurance proposal form and the insurer does not request that information and issues the insurance policy (a waiver). Now, in future when a claim arises, the insurer cannot question the contract on the basis of non-disclosure. This is estoppel.

Chapter 2: Regulatory Infrastructure around Insurance

Learning Objectives

2-1 Understand the regulatory infrastructure around insurance
2-2 Explain the authorities which control- various insurance functions

2.1 Insurance Regulatory and Development Authority of India (IRDAI) Act, 1999

The Insurance Regulatory and Development Authority of India (IRDAI) was incorporated as an autonomous and statutory body in April 2000, following the recommendations of the Malhotra Committee, with a purpose to regulate and develop the insurance industry. It had been established by the Insurance Regulatory and Development Authority Act, 1999.

IRDAI is a 10-member body including the Chairman, five full-time and four part-time Members, all appointed by the Government of India. The Insurance Act, 1938, which is the principal Act governing the insurance sector in India, provides the powers to IRDAI to frame Regulations for supervision of the insurance sector.

IRDAI states its mission as “To Protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto."

2.1.1 Duties, Powers and Functions

Section 14 of the IRDAI Act, 1999 mentions the duties, powers and functions of IRDAI - which includes the following:

- Registering and regulating insurance companies
- Protecting policyholders’ interests
- Licensing and establishing norms for intermediaries of insurance
- Promoting professional organizations in insurance
- Regulating and supervision of premium rates and terms of general insurance covers
- Specifying financial reporting norms of insurance companies
- Regulating investment of policyholders’ funds by insurance companies
- Ensuring the protection of solvency margin by insurers
- Safeguarding insurance coverage in rural and weaker areas of society

2.1.2 Licensing and Governance of Insurance Companies and Intermediaries

One aspect of the Regulator is to ensure that the insurers have in place good governance practices with an emphasis on overall risk management and also to ensure financial stability. In the year 2009 IRDAI had outlined comprehensive guidelines on Corporate Governance practices of the management of insurance functions. On account of the changes brought in by the Companies Act, 2013, those guidelines were further revised with effect from 2016 after due consultation with the industry representatives and other stakeholders and professionals.

Termed as Corporate Governance Guidelines for Insurers in India - 2016, the objective of these guidelines is to ensure that the Board and the management of the insurance company recognize the expectations of all stakeholders and those of the Regulator. The company should also have the ability to quickly address issues of non-compliance.

These Guidelines address various requirements covering the following elements of Corporate Governance in insurance companies:

- Governance structure
- Board of Directors
- Key management functions
- Role of appointed actuaries
- External audit - appointment of statutory auditors
- Disclosures
- Relationships with stakeholders
- Whistle-blower policy

2.1.3 Apex Insurance Regulator and Industry Watch-Dog

IRDAI is the apex body overseeing the insurance business in India. Every insurance company is registered under IRDAI and it sets all rules and regulations on the insurance industry.

IRDAI draws its power from the IRDAI Act, 1999 and the Insurance Act, 1938. As defined in Section 14 of the IRDAI Act, the functions, roles and responsibilities of IRDAI are far-reaching. The regulator serves as an industry watch-dog for regulating and promoting the insurance and reinsurance industries in India.

The role of IRDAI is to protect the interest of the policy holders, to oversee the growth of the insurance industry and to help in bringing economic growth. All the insurance companies and related associates such as agents, TPAs, brokers, surveyors, repositories etc are expected to perform and function under the aegis of the rules framed by IRDAI. There are stiff reporting guidelines for the companies and the agents which need to be adhered to.

2.1.4 Supervision of Tariff Advisory Committee (TAC)

Tariff Advisory Committee is a statutory body established by the Insurance (Amendment) Act, 1968 "to control and regulate the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business."

The management of the TAC is as per the Insurance Act, 1938 (as amended from time to time), the Insurance Regulatory and Development Act, 1999 and the regulations passed by IRDAI. The IRDAI Chairman is the TAC Chairman, while a senior officer of IRDAI is nominated as Vice- Chairman. There are ten elected members from the Indian market. Under Section 14(2) of the IRDAI Act, 1999, the duties, powers and functions of TAC are as follows:

- Drawing up and Updating Tariffs
- Clarifying Queries of Insurers
- Ensuring Implementation of the Tariffs
- Collection of Data and Analysis
- Publishing Tariffs and Other Regulations
- Inspection of Risks

The Tariff Advisory Committee's role as a Regulator of products and prices are left unchanged by the IRDAI Act, though IRDAI supervises the functioning of TAC. Thus, there are complementary but mutually exclusive work areas for both organisations. Decisions taken by the TAC within its jurisdiction, subject to observance of prescribed procedures, are final and binding on all non-life insurers as well as the insured in India.

2.1.5 Power to Issue Guidelines and Directions

Section 14 of Chapter IV of the IRDAI Act, 1999, gives authority and power to IRDAI to act in the best interest of the policy holder. Accordingly, IRDAI shall have the duty to regulate, promote and ensure orderly growth of the insurance business and reinsurance business. Various Sections of the Act give powers to IRDAI such as the Power to Delegate to the Chairperson, or any other member, any of its powers and functions. IRDAI may, by a general or special order, also form committees of the members and delegate to them the powers and functions of the Authority.

IRDAI may also establish a Committee, to be known as the Insurance Advisory Committee, and in consultation with the Committee make regulations consistent with the Act and the rules made thereunder to bring out the purposes of the Act. However, every rule and every regulation made under the Act shall be laid before each House of Parliament while it is in session.

2.2 Insurance Councils and General Insurance Council

2.2.1 Constitution and Powers

Life Insurance Council is a forum that provides linkage among all the stakeholders of the industry. It evolves and coordinates all discussions and analysis between the government, regulatory body and the public. It functions through many sub-committees and includes all life insurance companies in India.

The General Insurance Council is again a very important link between IRDAI and the non-life insurance industry. The Council not only plays the role envisaged for it by the Insurance Act, but it also facilitates the overall growth of the industry for the best interest of all the stakeholders.

The Life Insurance Council and the General Insurance Council have been constituted under section 64C of the Insurance Act, 1938 in the year 2001. The Insurance Council functions through several sub-committees and includes all insurance companies in India.

The mission of Insurance Council is to:

- Function as an effective forum to assist, advise and assist insurers in maintaining high standards of conduct and provide services to policyholders
- Interact with the government and various bodies on policy matters
- Actively participate in disseminating insurance awareness in India
- Take steps to develop education and analysis in insurance

(Reference: www.lifeinscouncil.org)

2.2.2 Self- Regulatory Mechanism

The Insurance Councils have been conferred various powers under the Insurance Act, 1938 and the IRDAI Act, 1999. They interact with the government and other statutory bodies on various policy issues and work as an active link between the Indian life insurance industry and the global markets.

The Insurance Councils work as a self-regulatory organization. They develop codes of conduct for the member companies, compliance programs to observe rules and regulations etc. They represent the collective interest of the insurance companies and provide help and guidance to members. They are responsible for building a positive image of the insurance industry among people. The Councils aid, advise and assist insurers for rendering efficient service to the policy holders. They also interact with other organizations of the financial service sector.

The General Insurance Council also has a Code of good Insurance Practices which lists down general provisions, application of the law, regulations and guidelines, claims handling and grievance redressal amongst other provisions.

(Reference: www.gicouncil.in/regulations/self-regulation)

2.3 Insurance Information Bureau of India (IIB)

Insurance industry is data-driven. It depends on data for all activities including pricing of the insurance products. With the growth of the insurance industry, and also opening up of the sector to private players, the Insurance Regulatory and Development Authority of India (IRDAI) required strong and credible information support. However, there was no dedicated agency to collect data and consolidate the same into an industry-level pool/repository.

In the year 2009, IRDAI constituted the Insurance Information Bureau of India (IIB) supported by an advisory body under the Chairmanship of IRDAI. The Bureau was later registered as an independent society in November 2012.

The Bureau works through its insurance verticals of Life, Health, Motor, Property, Fire, Engineering with exclusive support from IT and analytics. The main functional areas of IIB includes:

- Act as sole point for the whole insurance industry data
- Ensure data is accessible to numerous market players, researchers, policyholders and general public for real time decision making
- Provide benchmark rates for the industry
- Publish reports to help IRDAI in regulatory functions and insurers in decision making
- Publish reports for the advantage of the entire industry
- Provide the mandated inputs for policy analysis and insurance industry development activities
- Take initiative for detection of fraud, identification of vehicles not insured, etc.

All the insurance companies submit transaction level data on policies and claims at predetermined frequencies. This data covers demographic, policy and product attributes which is then used by IIB to generate annual reports, thematic reports and customized reports, besides undertaking various research studies. It also provides data to IRDAI for setting the premium rates for third party motor insurance.

The Bureau provides a bundle of services associated with motor insurance to various stakeholders like public, police, transport departments and insurers through its service package titled V-Seva. The services are call centre, SMS and web-based and supply data relating to insurance status of the vehicle, stolen vehicles, possession of recovered vehicles, accident record etc.

IIB also handles the Central Index Server that acts as a nodal point between any two insurance repositories and helps in de-duplication of demat accounts. The Bureau has also built a repository of insurance salespersons. Through this, based on key identifiers, the de-duplication is expedited to confirm that the applicant is not engaged with any other insurance company or insurer intermediary.
(Reference: www.iib.gov.in)

2.4 Insurance Ombudsman

2.4.1 Establishment and Objectives

The Insurance Ombudsman was created by a Government of India Notification in the year 1998. The purpose was quick disposal of the grievances of the policy holders in an efficient, economical and impartial manner. For a policyholder, the insurance company is the first point of contact for any complaint. In case of a non-satisfactory reply or no reply, one can approach the Ombudsman.

The Executive Council of Insurers, earlier known as Governing Body of Insurance Council (GBIC), has been started under the Insurance Ombudsman Rules, 2017, to set-up and facilitate the insurance ombudsman institution in India. It comprises members of the Life Insurance Council and General Insurance Council formed under Section 40C of the Insurance Act, 1938.

They are empowered to entertain complaints on all aspects of insurances including:

- repudiation of claims by the insurer
- delay in settlement of claims
- dispute in regard to premium paid or payable
- dispute on the legal construction of the policies
- non-issuance of insurance documents to policyholders after receipt of premium

Presently there are 17 insurance Ombudsman in different cities *(Reference www.ecoi.co.in)* and any person who has a grievance against an insurer can make a complaint in writing to the Ombudsman within jurisdiction over the location of the insurance company office. The institution of Ombudsman is of great importance for the protection of interests of policyholders for building their confidence in the system.

2.4.2 Appointment, Tenure and Jurisdiction

The Executive Council of Insurers issues orders of appointment of the insurance Ombudsman on the recommendations of the committee comprising of Chairman of IRDA, Chairman of LIC, Chairman of GIC and a representative of the Central Government.

Eligibility: The incumbents for the position of an Ombudsman are drawn from Insurance Industry, Civil Services, Administrative Services and Judicial Services within India.

Tenure: An insurance Ombudsman is appointed for a term of three years or till the age of seventy, whichever is earlier, and is eligible for re-appointment.

Jurisdiction: The Executive Council of Insurers has appointed seventeen (17) Ombudsman across the country allotting them different geographical areas. The Ombudsman can hold sitting at different places within their area of jurisdiction in order to expedite clearance of complaints.

2.4.3 Rights and Powers

Vide Notification dated 25 April 2017, published in Gazette, the Insurance Ombudsman Rules, 2016 were further revised, and now referred to as the Insurance Ombudsman Rules, 2017. Accordingly, various rights and powers have been provided to the Insurance Ombudsman, as listed below:

1. The Ombudsman receives and take into account complaints or disputes relating to:
   (a) delay in settlement of claim, beyond the time period stated in the regulations;
   (b) any repudiation of claims either wholly or part by the insurer;
   (c) disputes regarding to paid premiums or payable in case of insurance policy;
   (d) misrepresentation of policy terms and conditions at any time within the policy document or policy contract;
   (e) legal construction of insurance policies;
   (f) policy servicing related grievances against insurance companies and their agents and intermediaries;
   (g) issuance of insurance policy, which is not in conformity with the proposal form submitted by the proposer;
   (h) non-issuance of insurance policy after the receipt of premium; and
   (i) any other matter arising from the violation of provisions of the Insurance Act, 1938 or the rules, circulars, guidelines issued by the IRDAI from time to time.
2. The Ombudsman shall act as counsellor and mediator relating to matters provided there is written consent of the parties to the dispute.
3. The Ombudsman shall be prohibited from handling any matter if he is an interested party or having conflict of interest.

For policyholders, the insurance ombudsman offices provide hope and the institution has helped to generate faith and confidence amongst the consumers.

2.5 Insurance Institute of India (III)

The Insurance Institute of India (III), earlier known as Federation of Insurance Institutes, was formed in 1955 in Mumbai, for the purpose of promoting insurance education and training to people working or intending to work in the insurance sector. It is a professional institute

devoted mainly for insurance-related education.

The institute awards Certificates and Diplomas to successful candidates. These are recognized by the Indian Government, the IRDAI and various insurance companies in India and abroad. Such Certificates and Diplomas are also recognized by similar institutes in various countries like UK, Canada and the United States, for grant of exemption from some of their papers.

In its role as an apex education and training provider III is associated with all the sectors of the insurance industry.

2.5.1 Authority and Functions

The management and control of the Institute, its affairs and business shall be carried on by and vested in the Council subject to the provisions of the Memorandum and Regulations of the Institute. The Council consists of Members from LIC and GIC and elects amongst themselves a President, Deputy President and other executive positions. The President holds office for a period of 2 years and the Deputy President and other office bearers shall hold office for 1 year.

It shall be the duty of the Council to coordinate and direct the work of the Institute and to present a report on the position of the Institute on the affairs and proceedings during the past year. The Council has power to make Provisions for carrying out the objects of the Institute and for conducting its affairs, make Rules or Bye-laws.

The main functions of Insurance Institute of India are:

- To run college and conduct examinations within the insurance field and related subjects for awarding certificates, diplomas and degrees to those interested in insurance.
- To prepare and provide reading materials and similar alternative education methods for encouraging and helping the study of any subject bearing on any branch of insurance.
- To form and maintain a library.
- To provide scholarships, grants and prizes for research or any other educational work pertaining to insurance.
- To ascertain the law and practice relating to all matters connected with insurance and to disseminate such knowledge among those interested in insurance.
- Assist people in the insurance industry to acquire the skills and expertise.

2.5.2 Education and Training

The IRDAI has recognized the Institute as the examining body to conduct pre-recruitment examinations for Insurance Agents, Corporate Agents, Web Aggregators, Insurance Marketing Firm and Renewal of Insurance Broker exams as well as pre-licensing test for Insurance Surveyors and Loss Assessors.

The Directorate of Postal Life Insurance, New Delhi has licensed the Insurance Institute of India to develop the course material for Postal Life Insurance Agents and also recognized them as the exam conducting body to organize licensing examination of Postal Life Insurance Agents.
(Reference www.insuranceinstituteofindia.com)

Chapter 3 Insurance Intermediation in India

Learning Objectives

3-1 Describe the categories of intermediaries
3-2 Compare other specialists in insurance

3.1 Categories of intermediaries, their respective Domains, Functions and Code of Conduct
- 3.1.1 Individual Agents
- 3.1.2 Corporate Agents, Bancassurance
- 3.1.3 Insurance Brokers
- 3.1.4 Web Aggregators
- 3.1.5 Insurance Marketing Firms
- 3.1.6 Point of Sales Persons

3.2 Other Specialists in Insurance (other than procurement)
- 3.2.1 Insurance Surveyor or Loss Assessor
- 3.2.2 Medical Examiners
- 3.2.3 Third Party Administrators
- 3.2.4 Insurance Repositories (electronic issue of insurance policies)

3.1 Categories of Intermediaries, their respective Domains, Functions and Code of Conduct

3.1.1 Individual Agents

In the insurance industry, an individual agent is one who has undergone the required training, passed an examination and then duly licensed by IRDAI to sell insurance policies and provide after-sales service, including claim assistance.

The Insurance Act, 1938 defines an insurance agent as "one who is licensed under Section 42 of that Act and is paid by way of commission or otherwise, in consideration of his soliciting or acquiring business of insurance, including business concerning continuance, renewal or revival of policies of insurance."

The license can be issued for life insurance, general insurance or both. In addition, an agent can also represent one standalone health insurance company, Agriculture Insurance Company of India for selling crop insurance and Export Credit Guarantee Corporation of India for credit insurance.

Agents serve as representatives of the insurance companies and sell policies on behalf of the insurers. The insurer enters into a contractual agreement with the agent that specifies the types of products the agent may sell and the commission the insurer will pay for each. While some agents are salaried, most agents rely on commissions for income. Some insurers try to encourage agents to sell new policies by paying a higher base commission for new policies than for renewals. In addition to base commissions, many insurers pay trail commissions.

The role of an agent begins at the stage of sale and continues through the duration of the contract. Every agent has to adhere to the code of conduct specified by IRDAI. Some of these are:

- Disseminate the requisite information in respect of insurance products offered by his insurer;
- Disclose the commission scales, if asked by the prospect;
- Denote the premium to be charged;
- Explain to the prospect the type of information required in the proposal form, and also the importance of disclosure of material information;
- Bring to the notification of the insurance company any adverse habits or income inconsistency of the prospect, within the form of a report (called “Insurance Agent’s Confidential Report”), and any material proven fact that could adversely have an effect on the underwriting decision;
- Inform the prospect concerning the acceptance or rejection of the proposal by the insurer;
- Obtain the necessary documents while filing the proposal form and other documents afterwards asked for.

3.1.2 Corporate Agents, Bancassurance

Every corporate entity (firm/company) may represent an insurance company and sell its policies. While involved in a specific business, companies can sell insurance policies to their already existing clients. For instance, a travel agent might recommend a travel insurance policy or a car dealer might recommend a motor insurance policy. Corporate agent thus represents a company or a registered firm for solicitation and procurement of insurance business and the insurer allots the agency code to the company/firm.

During the validity of a certificate of registration, a corporate agent can have agreements with a maximum of three life insurance companies or three general insurance companies or three

health insurance companies to solicit and service their insurance products. In addition, they can represent Export Credit Guarantee Corporation and Agriculture Insurance Corporation of India. The license validity is for three years from its issuance date, and can be renewed for a period of three years.

The corporate agents are regulated as per the IRDAI (Registration of Corporate Agents) Regulations, 2015. Every corporate agent shall abide by the Code of Conduct as specified in Schedule lll of these Regulations, and:

- be answerable for all the acts of omission and commission of its principal officer and each specified person;
- ensure that the principal officer and all specified persons are properly trained, skilled and knowledgeable in the insurance products they market;
- ensure that the principal officer and therefore the specified person do not make any misrepresentation on policy benefits to the prospect;
- ensure that prospect does not purchase an insurance under any compulsion;
- extend all probable help and assistance to an insured in completing all formalities and documentation in the event of a claim.

While doing so, every corporate agent will:

- conduct its transactions with clients with utmost good faith and integrity at all times;
- act with carefulness and persistence;
- treat all data given by the potential clients as totally confidential.

Bancassurance

Banks and insurance companies collaborate to make a partnership within which the bank sells the insurance firm's product to its clients. This arrangement of selling an insurance product by the insurance company through a bank is known as Bancassurance.

The Bancassurance channel helps to:

- improve the channels through which insurance policies are sold/marketed so as to make them reach to the common man
- widen the area of working of the banking sector
- increase in competition and better servicing, better pricing for the customer

This arrangement works well for both the bank and the insurance company, because the bank earns a commission amount from the insurance company whereas the insurance company widens its market share and customer base.

Being the mixture of the banking and also the insurance sector, bancassurance comes beneath the scope of both RBI and IRDAI. As per RBI, any scheduled commercial bank is allowed to undertake insurance business as an agent of the insurance company without any risk participation. Banks cannot become brokers, as RBI does not allow banks to promote separate insurance broking business. As per IRDAI (Licensing of Banks as Insurance Brokers) Regulations, 2013 banks can act as corporate agents for solely one life and one non-life insurance firm for a commission and no alternative pay except commission.

The current architecture of one-bank-one-insurer helps banks sell the product of their own insurer and might lead to conflict of interest in some cases. IRDAI has recently drafted guidelines to promote open architecture in bancassurance. In the new model, the banks will have to have multiple tie-ups and sell products of multiple insurers.

3.1.3 Insurance Brokers

The concept of Insurance Broker was introduced by IRDAI through IRDAI (Insurance Brokers) Regulations, 2002, which were amended in 2013 and 2018. The objective of these Regulations is to supervise and monitor the insurance broker as an insurance intermediary.

Insurance brokers provide insurance from all the companies under one roof. Unlike an agent who is tied with one company, a broker is not bound by any one company. Brokers can find a good deal on insurance for their client because they have a complete understanding of the insurance market and they can negotiate premiums with the insurer.

Application to act as an insurance broker can be made for any one of the following categories:
(i) direct broker (general) (ii) direct broker (life) (iii) direct broker (life and general both) (iv) composite broker (v) reinsurance broker

The Insurance Brokers Regulations define the distinction between them. While a direct broker can solicit only insurance business for its client, the reinsurance broker can solicit reinsurance business and a composite broker can solicit both insurance and reinsurance business for its clients with insurers and/or reinsurers located in India and/or abroad.

The brokers have to invest minimum capital as prescribed by IRDAI and have to comply with other requirements like infrastructure, Professional Indemnity cover, payment of license fee etc.

The functions of an insurance broker, as prescribed by the Regulations, include the following:

- Rendering advice on appropriate insurance cover,
- Maintaining detailed information of available insurance markets,
- Submitting quotation received from insurer/s to the client,
- Providing underwriting information of the client to the insurer,
- Assisting clients in paying premium, negotiation of the claims, maintaining proper records of claims.

The Regulations also prescribe a code of conduct in matters related to sales practices wherein every insurance broker shall:

- confirm that he is a member of the Insurance Brokers Association of India (IBAI) or any other body of insurance brokers;
- confirm that he does not employ agents to bring in business by canvassing, call centers;
- ensure that the client understands the type of service he can offer;
- ensure that the policy proposed is suitable to the needs of the client;
- give guidance only on those matters in which it is conversant
- recommend other specialist for guidance when required;
- not make inaccurate or unfair criticisms of any insurer;
- explain why a policy is proposed and provide comparisons;
- explain when and how the premium is payable.

3.1.4 Web Aggregators

Insurance Web Aggregators compile and supply information regarding insurance policies of different companies on a website. Web aggregators are licensed to supply data relating to insurance products, comparison of comparable products offered by different insurance companies and have linkages to websites of various insurers from where customers will choose and get policies on-line. They are governed under IRDAI (Insurance Web Aggregators) Regulations, 2017.

The Insurance Web Aggregator has to:

- Exhibit information in their designated website describing the insurer's products
- Ensure that the data systems, together with the aggregation website(s)/portals, Lead Management System and the Data Centers hosting the website(s)/Portal(s)/Lead Management System are in compliance with the data security standards and procedures
- Ensure that the leads and other information is transmitted to the insurers and others using secured layer data encryption technologies
- Use solely RBI registered payment gateways for assortment and transfer of premium to insurers
- Ensure to get the information systems (both hardware and software) audited by CERT-In empanelled Information Security Auditing organizations
- Submit a certificate from the statutory auditor every year

For conduct in matters relating to client relationship every web aggregator shall:

- handle all its transactions with clients with utmost good faith and honesty
- act with care and diligence
- ensure that the customer understands his relationship with the Web Aggregator and on whose behalf the Web Aggregator is acting
- consider all the information supplied by the prospective customers as totally confidential
- avoid conflict of interest

Every web aggregator is also expected to follow guidelines in relation to complaint handling wherein he shall have a system of recording and monitoring complaints, ensure that the website contains details of complaints handling procedure and ensure that the grievance is resolved to the fullest satisfaction of the customer in a reasonable time bound manner.

3.1.5 Insurance Marketing Firms

Insurance Marketing Firms are a distribution channel meant to solicit insurance products and to distribute other financial products by employing individuals licensed to market, distribute and service such financial products. They are regulated under the Insurance Act, 1938, the IRDAI Act, 1999, the IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015 and various Regulations, Circulars, Guidelines and instructions issued thereunder.

The registration which is issued under these Regulations is valid for three years. The Insurance Marketing Firms can undertake the insurance servicing activities of only those insurers with whom they have an agreement.

Such firms engage Insurance Sales Person (ISP) for the purpose of soliciting and procuring insurance products of a maximum of two Life insurance companies, two General and Health insurance companies at any point of time, along with Export Credit Guarantee Corporation Ltd. (ECGC) and Agriculture Insurance Company of India Ltd (AIC). They may engage the same person for sale of other financial products also, if that person fulfills the criteria of qualification and certification requirements as mentioned in the Regulations.

The other financial products include mutual funds regulated by SEBI, pension products regulated by PFRDA, financial products of banks/ banking / NBFC regulated by RBI, non-insurance products offered by Department of Posts, Government of India.

IMFs are allowed to solicit or procure:

- all kind of products sold on individual and retail basis, including crop insurance

- group personal accident, group health, property, GSLI and term insurance policies for Micro, Small and Medium Enterprises (MSME)

Insurance Marketing Firms shall:

- ensure that ISPs are competent, qualified, and have undergone the required training and passed the examination as specified by IRDAI
- not divulge any confidential information about its client except where such disclosures are required to be made in compliance with any law
- act in the public interest and in fiduciary capacity be accountable for the omissions and commissions of their own employees/persons engaged by them
- maintain at all times a professional indemnity insurance cover throughout the validity of the period of the registration

3.1.6 Point of Sales Persons (PoSP)

To increase insurance penetration in the country and to facilitate growth in the non-life and health insurance business, IRDAI introduced a new distribution model called “Point of Sales Person” (PoSP) in the year 2015. Every PoSP can represent an insurance company or an insurance intermediary.

PoSP have a lower qualification compared to other insurance distributors such as agents, brokers and corporate agents. Accordingly, IRDAI has directed these individuals to sell only basic insurance products viz. motor insurance, travel insurance and personal accident insurance which do not require a lot of underwriting. These products also do not require much discussion with the customer at the time of sale and their benefits are simple to explain. Based on the information provided by the customer, the insurance policy is automatically generated by the system.

The “Point of Sales Person” is authorized to sell only the following pre-underwritten products:

- Motor Comprehensive Insurance Policy for Two-wheeler, commercial vehicles and private cars.
- Third party liability Policy for Two-wheelers, commercial vehicles and private cars.
- Personal Accident Policy
- Travel Insurance Policy
- Home Insurance Policy

3.2 Other Specialists in Insurance (other than procurement)

3.2.1 Insurance Surveyor or Loss Assessor

Regulation 12 of the IRDAI (Insurance Surveyors and Loss Assessors) Regulations, 2015 mandates appointment of Surveyors and Loss Assessors either by Insured or Insurer to assess the loss under an insurance policy in respect of (a) motor insurance (b) other than motor insurance. The regulations define the “Surveyor and Loss Assessor” as a person who is licensed by the Authority to act as a Surveyor and Loss Assessor. The definition of intermediary and insurance intermediary includes insurance surveyors and loss assessors.

Indian Institute of Insurance Surveyors and Loss Assessors (IIISLA) is promoted by IRDAI. Every person who is a student of IIISLA, and intending to act as a Surveyor and Loss Assessor in respect of general insurance business, can apply to IRDAI for grant of a License. The validity of the license is for three years.

As per the Regulations, following are some of the duties and responsibilities of a Surveyor and Loss Assessor:

- Maintaining confidentiality without exposing the insurer’s liability and insured’s claim;
- Conducting inspection/survey of the property on behalf of insurer or insured;

- Investigating and checking reasons of the loss including extent of loss, type of ownership and insurable interest;
- Conducting surveys and remark about excess/under insurance;
- Guiding the insurer and the insured on loss minimization, loss control, safety and security measures;
- Evaluating liability under the insurance contract;
- Replying to the queries of the insured/insurer in regard to the claim/loss;
- Commenting on salvage and its disposal wherever necessary.

Every Surveyor and Loss Assessor have to follow a code of conduct wherein they shall:

- behave ethically and with integrity,
- strive for objectivity in professional judgment,
- act impartially,
- conduct with courtesy and consideration to all people
- not accept or conduct survey works in areas for which he does not hold a license,
- not accept or perform task which he is not competent to accept,
- carry out his professional task with due diligence,
- keep himself informed about all developments pertinent to his professional practice,
- maintain a proper record for the work done by him and comply with all relevant laws.

3.2.2 Medical Examiners

Underwriting is a very important aspect for the insurers at the time of sale of a policy. Any misstatement or wilful concealment of material information leads to disputes at the time of claim settlement. Health is one of the important parameters for the insurer to decide the premium rates. It is utmost important for the insurer to know the factual health condition of the person proposing to buy the policy, especially in case of health insurance and life insurance (term) plans.

Insurers engage the facilities of reputed doctors and hospitals for carrying out health check-ups of the applicant. A medical test is done which includes a detailed health check-up of the applicant. It usually includes two parts:

- A questionnaire where the doctor asks a series of questions. It could be verbal or written down.
- Basic sample collections of urine and blood to determine vital medical parameters.

These tests indicate whether any medical conditions and illnesses exist which the insurer should be aware of, at the time of sale of the insurance policy; and then provide the most suitable cover. However, in India, most times the insurers ask for such medical tests only for applicants over a specific age or a high sum assured.

3.2.3 Third Party Administrators (TPAs)

A third-party administrator is a company/agency/organisation, holding a license from IRDAI, which provides various operational services as an outsourcing entity of an insurance company. Processing of claims is a recurring and standardized activity. Insurance companies, therefore, outsource some of their administrative burden to third parties and use the services of TPAs. The stakeholders involved are the insurance companies, health care providers and the policyholder.

Introduced by the IRDA in 2001, TPAs function as an intermediary between the insurer and the insured. The job of a TPA is to maintain databases of all the policyholders, issue them identity cards and handle all the post policy issues including claim settlements. As such they need a deep knowledge of the rules and regulations of the insurance services.

The TPAs run round the clock toll-free number. TPAs also perform some of the pertinent aspects of insurance such as providing ambulance services, medicines and supplies, guidance for specialized consultation to policyholders, and providing information about health facilities, bed availability, organizing well-being programs. They bring about greater efficiency/quality in delivery of services, greater penetration of health insurance, improved standardization in procedures and due diligence while minimizing costs/expenditure.

3.2.4 Insurance Repositories

Insurance Repository is a company which is formed and registered under the Companies Act, 2013 and has been granted a registration certificate by IRDAI for maintaining insurance policies data in electronic form on behalf of the insurance companies. This enables policy holders to buy and keep insurance policies in an electronic form, rather than paper form. Such policies are known as “electronic policies” or “e-Policies”.

A policyholder needs to open an e-Insurance Account (e-IA) with the Insurance Repository to buy and keep policies in electronic mode. Once an e IA is opened, the account holder can ask for the conversion of all his policies, issued by different insurers, into electronic mode to this single account. A person can have just one e-IA with any of the Insurance Repositories.

There are 4 such Insurance repositories as of June 30, 2019:

- NSDL Database Management Limited
- Central Insurance Repository Limited
- Karvy Insurance Repository Limited
- CAMS Repository Services Limited

There are many benefits of holding insurance policies in electronic form including:

- The policies are in safe custody and can be easily accessed when needed.
- All insurance policies (life, pension, health or general) can be electronically held under a single e-IA.
- Premium can be paid online for all the policies.
- There is no requirement to visit the offices of individual insurance companies for service.
- No need to go through KYC verification again at the time of purchase of new policy.
- All services are available free of charge.

Chapter 4 Life Insurance

Learning Objectives

4-1 Illustrate the structure and organization of life insurance companies in India
4-2 Understand the insurer's fixing of premium and distribution of benefits
4-3 Illustrate various group insurance schemes
4-4 Understand the features of Insurance Contract and Policy Document
4-5 Distinguish policy revival schemes and claims

4.1 Structure and Organization of Life Insurance Companies in India
4.2 Mandate and Responsibilities
4.3 Income Sources and Rate-fixing
    4.3.1 Premium and Types
    4.3.2 Factors in Fixation of premium, Rate Making
        4.3.2.1 Mortality Tables and Actuarial Valuation
        4.3.2.2 Age, Medical Condition and Sum Assured
        4.3.3.3 Rate of Guaranteed Benefits
        4.3.3.4 Right Premium and Adverse Selection
4.4. Distribution of Benefits
    4.4.1 Bonus – With Profit or Participating Plans
    4.4.2 Simple and compound Reversionary Bonus, Guaranteed Addition
    4.4.3 Terminal Bonus, Survival Bonus, Loyalty Addition
    4.4.4 Interim Bonus
4.5 Taxation Aspect of Various Life Insurance Policies for Individuals
4.6 Loans Eligibility Against Life Insurance Policies – With Profit, Endowment and investment Plans
4.7 Group Insurance Schemes
    4.7.1 Group Term Insurance Schemes
    4.7.2 Employees' Deposit Linked Insurance (EDLI) Scheme
    4.7.3 Group Gratuity Schemes
        4.7.3.1 Actuarial Valuation; data of retirement, resignation, death, disability
        4.7.3.2 Methods to Manage – Create internal resources, Set up a Gratuity Fund
4.8 Investment Linked Insurance – Unit Linked Insurance Plan (ULIP)
    4.8.1 Protection, Investment and Income Tax Benefits (subject to Lock-in Period)
    4.8.2 Choice of Plans – Equity, Debt, Hybrid, Money Market Fund and Switch options
    4.8.3 Net Asset Value based redemption, maturity and claim settlement
4.9 Contingency Planning
    4.9.1 Disability insurance with premium waiver option
    4.9.2 Child Plans with premium waiver
4.10 Insurance Policy Document and Legal Implications
    4.10.1 Preamble
    4.10.2 Operative Clause
    4.10.3 Proviso
    4.10.4 Schedule
    4.10.5 Attestation
    4.10.6 Conditions and Privileges

4.11 Policy Revival Schemes
- 4.11.1 Ordinary and Special Revival
- 4.11.2 Instalment Revival
- 4.11.3 Loan-cum-Revival
- 4.11.4 Foreclosure of Policy and Reinstatement provisions
- 4.11.5 Surrender of Policy
- 4.11.6 Assignment of Policy

4.12 Claims
- 4.12.1 Claims by Maturity
  - 4.12.1.1 Claims at Periodic Intervals (Money-Back Plans)
  - 4.12.1.2 Claims at Maturity (on surviving the Policy term)
- 4.12.2 Claims by Death
  - 4.12.2.1 Claimant (Nominee/Assignee) or Legal Representative (Proof of Title)
  - 4.12.2.2 Documents Required – Letter of Intimation, Death Certificate (Proof of Death)
  - 4.12.2.3 Non-Early Death Claim (Beyond three years) – Presumed to be Dead for missing persons, applicability of Indian Evidence Act,1872

4.1 Structure and Organization of Life Insurance Companies in India

Insurance sector is divided into two distinct categories – Life Insurance and Non-Life Insurance (also termed as General Insurance). In India, both Life Insurance and General Insurance businesses are governed by the Insurance Regulatory and Development Authority of India (IRDAI) which is the primary regulator for insurance in India. It was established in 1999 under the government legislation called the Insurance Regulatory and Development Authority (IRDAI) Act, 1999.

Presently, there are 24 life insurance companies which are operative in India. Life Insurance Corporation (LIC) of India is the only public sector company while there are 23 private sector life insurance companies. Many of the insurance companies are joint ventures either between public or private sector banks and national/international insurance financial corporates. This collaboration with the foreign markets has made the insurance sector grow tremendously in India.

The life insurance companies in India have traditionally kept an investment perspective to insurance, with an idea of providing insurance along with a growth in savings. They have also introduced emerging trends like product innovation, multi-distribution and better claims management in the Indian market.

The postal department also transacts life insurance business through Postal Life Insurance, which is exempt from the purview of the regulator. The government is also striving hard to provide insurance to individuals below the poverty line by introducing schemes such as:

- Pradhan Mantri Suraksha Bima Yojana (PMSBY),
- Rashtriya Swasthya Bima Yojana (RSBY) and
- Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY).

Insertion of these schemes have assisted in increasing the insurance reach to the masses.

All these efforts have led to massive growth within the life insurance sector in the past few years. Today in India, life insurance forms a formidable part of the capital market and is second only to the banking sector for mobilizing savings. As per the provisional figures published by the Life Insurance Council as of 31st December, 2019, the life insurance sector controls:

- More than Rs. 37,455 crore of deployed capital
- Over Rs. 39,62,775 crore of managed assets
- Investments in infrastructure exceeding Rs. 4,15,049 crore

comprising:

- Over 11,295 branches
- More than 22.60 lakh agents
- 2.92 lakh direct employees and growing significantly
- 32.69 crore in-force policies

Other demographic factors like the growing awareness of the need for insurance, growing middle class and young insurable crowd will substantially increase the growth of the Insurance sector in India.

4.2 Mandate and Responsibilities

The Insurance Act, 1938 is the main Act governing the insurance sector in India. It provides the powers to the Insurance Regulatory and Development Authority of India (IRDAI) to frame regulations for supervision of the insurance industry. IRDAI is a statutory body formed under an Act of Parliament. The preamble to the IRDAI Act, 1999, is *"to protect the interests of*

holders of insurance policies, to regulate, promote and ensure orderly growth of the Insurance industry" for overall supervision and growth of the Insurance sector in India.

IRDAI sets the mandate for the insurance sector to:

- Encourage systematic growth of the insurance industry.
- Protect the interest of the policyholders.
- Promote high standards of integrity within the market.
- Speed up claim settlement.
- Set standards and conduct vigilance.

Section 25 of IRDAI Act, 1999 also lays down the establishment of the Insurance Advisory Committee which advises on matters relating to making of regulations for the insurance industry. The draft regulations are first placed in the meeting of the Insurance Advisory Committee and after incorporating the recommendations they are approved by the IRDAI. Every Regulation approved is then notified in the Gazette of India.
(Reference www.financialservices.gov.in)

The key **responsibility** of insurers is to assist policyholders in managing risk in an efficient way through their **insurance** products, and to pay the claims covered by such **insurance** products. Insurers, being large institutional investors, help in funding the economic activity of the country. They also play an important role in the operation of the economy by encouraging people and businesses to make high-value investments.

Some other key responsibilities of the insurance companies are:

- To mobilize savings of the people.
- To extend the sphere of insurance, thereby including the socially and economically backward classes.
- To act as trustees of the insured public.
- To safeguard economic use of resources collected from policyholders.
- To manage business in a fiduciary capacity.

4.3 Income Sources and Rate-fixing

Insurance companies mostly generate revenue in three ways:
(a) By charging premiums to the customers for insurance cover, which is their underwriting income, (b) Reinvesting such income in low-risk investments, and (c) Unpaid claims on lapsed policies. Let us see how.

Underwriting income: Insurance companies fix the premium by calculating the risk on each policy. During the year, the company collects huge premiums and may not have to pay claims on those policies for many years ahead. The difference between such premiums collected by the insurer and the money paid out by way of claims is the underwriting income for the insurer. In certain years such income is large on account of few claims paid, while, in other years the income could be less due to high claim amount on account of natural calamities etc.

Reinvesting: Insurance companies invest a portion of the collected premiums in low-risk investments such as stocks, bonds, and other interest-bearing accounts hopefully earning a sizable return.

Lapsed coverage: A policy lapses when people no longer pay the premium and abandon their policy. Also, many times the insured survives the policy term (i.e. outlives the term). In all such cases while the company has collected all the premiums over the years it has not made any pay out thereby generating income for the company.

Since an insurance company is into business, the rate charged should cover expenses and losses, and earn some profit. Rate fixing (also called insurance pricing) is the determination of what rates, or premiums, to be charged for insurance. It is also the process of establishing rates for reinsurance or other risk transfer mechanisms. The rate reflects three major elements: the loss cost per unit of risk exposure, the administrative expenses and the profit.

A rate provides for all costs associated with the transfer of risk so that equity among all the insured is maintained. Such rates fulfill these four criteria which are usually used by actuaries:

- Rates should be reasonable,
- Rates should not be disproportionate,
- Rates should be adequate, and
- Rates should not be unfairly biased.

4.3.1 Premium and Types

Each insurance policy is a contract between the individual (the insured) and the insurance company (the insurer). If the insured suffers a loss, then, based upon the contract terms, the insurer is bound to cover that loss. However, the insured must pay a fee to the insurer, known as premium, to enable them to take the risk of such a loss.

Since premiums are used by the insurer to pay for claims of the insured, the insurer must charge an adequate premium, which will cover for losses, administrative costs of running the company and eventually result in profit for the company. At the same time, there should not be excessive charging of premium by the insurer and they should be justifiable. Also, same rates should be charged from all members of an underwriting class with a similar risk profile.

Premiums can be classified as Pure premium and Gross premium.

The pure premium, determined by actuarial studies, consists of that part of the premium which is necessary to pay for losses and loss related expenses. 'Load' is in addition to the premium which is necessary to cover other expenses, particularly sales expenses, and to allow for a profit.

The gross rate is then the sum of pure premium and the loading per exposure unit.
Gross Rate = Pure Premium + Load

Thus, gross premium is the premium which is charged from the insurance applicant and is calculated as the gross rate (as above) multiplied by the quantity of exposure units to be insured.
Gross Premium = Gross Rate x Quantity of Exposure Units

4.3.2 Factors in Fixation of premium, Rate-making

The process of premium fixation involves various considerations including selling goals, competition, legal restrictions and also estimating future costs related to the transfer of risk. Such costs include the amount of claims and expenses of their settlement, operational and administrative expenses, and the cost of capital.

Insurers face a problem in setting fair and adequate premiums. Since the premium pays for insurance coverage in the immediate future, actual losses and expenses are not known when the premium is collected. Only after the premium period has elapsed, will the insurer come to know what its true costs are. Larger insurance firms maintain their own databases to estimate frequency and also the amount of losses for each and every underwriting category, however smaller firms rely on rating bureaus for loss data.

Rate-making (also called rate-fixing, insurance pricing, premium fixation) for life insurance is simpler, since there are mortality tables that tabulate the number of deaths for each age, which includes a population of many people. Rate-making in life insurance is based on mortality rate, interest and expense. Some of the important factors in Rate-Making are:

- Rates should be fair
- Rates should produce a premium adequate to meet total losses but should not bring unreasonably large profits.
- Rates should be revised often enough to reflect current costs

Rates charged for life insurance increase with age as people are more likely to die as they get older.

4.3.2.1 Mortality Tables and Actuarial Valuation

A mortality table (life table or actuarial table) shows the rate of deaths likely to occur in a defined population during a selected time interval. It shows the probability of a person's death before his next birthday, based on his current age. Thus, a mortality table gives a probability of the number of people who are expected to die per 1,000 living in any given year. They typically cover from birth of a person through his age 100, in one-year increments. A most basic mortality table would look like as the one given below.

Period Life Table, 2016

Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
0	0.006364	100,000	76.04	0.005331	100,000	80.99
1	0.000432	99,364	75.52	0.000359	99,467	80.43
2	0.000284	99,321	74.55	0.000247	99,431	79.46
3	0.000234	99,292	73.58	0.000169	99,407	78.48
4	0.000170	99,269	72.59	0.000155	99,390	77.49
5	0.000157	99,252	71.60	0.000135	99,375	76.50
6	0.000147	99,237	70.62	0.000120	99,361	75.51
7	0.000136	99,222	69.63	0.000109	99,349	74.52
8	0.000120	99,209	68.64	0.000100	99,338	73.53
9	0.000101	99,197	67.64	0.000094	99,328	72.54
10	0.000088	99,187	66.65	0.000093	99,319	71.54
11	0.000093	99,178	65.66	0.000098	99,310	70.55

Essentially, mortality tables are long-term mathematical tabulations to measure a population's longevity and are usually constructed separately for men and women. Since people with different characteristics die at different rates, characteristics such as smoking status, occupation, income levels and socio-economic class are also included in mortality tables to distinguish different risks.

Mortality tables are a very crucial part of actuarial work. After analysing the data from the mortality tables, actuaries perform risk assessments and try to predict the probability of claim. Through separate mortality and sickness tables they also try to predict the probable losses due to sickness. In mathematical terms, they have to figure out the amount of death benefit payable in each future year, and its present value, and the probability that the insured person will die in each of those years. From there, the premium can be determined. If the probability of a claim is high, the premium amount is high for the associated risk.

4.3.2.2 Age, Medical Condition and Sum Assured

Besides relying on mortality tables, there are several factors that insurance companies consider at the stage of underwriting and subsequently price the premium of their life insurance policies.

Age: Age is one of the most essential underwriting factors. The possibility of a young individual contracting a life threatening disease or dying young is very unlikely. Also, a young person will pay more number of premiums compared to someone older. Therefore, the premium amount is lower for people buying a life insurance policy at a younger age.

Gender: Premium rates are higher for men than for women as statistically men have a shorter life expectancy than women and thereby they pose a higher risk of claim. Hence, premiums for males is higher than compared to females falling within the same criteria.

Smoking and drinking: For a policyholder, smoking and drinking are injurious to health and increase his risk of contracting life threatening diseases. As such, insurance companies charge a higher premium for off-setting higher risk from people who smoke or drink alcohol.

Current health status: Insurers have the applicant undergo a few medical tests such as sugar level, blood pressure, etc to determine the current health state of the individual applying for the life insurance policy. If any critical illness or condition is revealed in such tests, it will result in higher premiums, or even in rejection of his application. On the other side, healthier individuals get the benefit of lowered premiums.

Medical History of the family: If a policyholder has a history of serious illnesses from a hereditary perspective, it increases his probability of getting it transmitted. Hence, the individual's premium goes up. On the contrary, someone who has had a relatively smooth medical history, he stands a greater chance of availing lower premiums for his policy.

Death benefit and Policy Term: The larger the amount of death benefit, the higher is the premium charged by the insurance company to the policyholder. Likewise, longer the policy term, higher will be the premium. This is because the risk of death of the policyholder is higher for a policy which covers him for 30 years than a policy which covers the same risk for 10 years.

Occupation: People engaged in occupations like shipping, mining, fishing, industrial production etc are considered doing a more dangerous job than people working in an office where the work environment is relatively safer. As such, premiums charged by life insurance companies from policyholders in such occupations are much higher than from people engaged in relatively safer jobs or desk jobs.

Every insurance policy is based on each individual person and premiums are computed based on the insurer's rules of rating. How these factors affect the premium is dependent on the insurer and the way they treat a combination of these and other similar factors.

4.3.2.3 Rates of Guaranteed Benefits

Insurance providers offer a “guaranteed benefit” option with the traditional insurance plans. In such plans, in lieu of a bonus which varies depending on the profits generated, the insurers declare a 'guaranteed addition' (GA) or a 'guaranteed return'. A guaranteed benefit on the investment means that the investment amount in the policy will grow at the rate of return which is guaranteed. The insured is assured to receive such benefits as stated in the benefit illustration of the policy plan.

Guaranteed benefit plans are designed to cater to the risk-averse investors and offer them the benefit of life insurance along with guaranteed payouts at different stages of the policy, in addition to the maturity amount. However, the structure of the guaranteed plans may vary across insurers. Some offer a guaranteed return based on the premium paid, while others on the sum assured of the policy. The amount may also vary based on the policy term or the premium paying term. In some plans, the guaranteed returns get added to the policy from the second year onwards, while in some, they start at a later date.

The plans that come with these options usually charge a higher premium than the non-guaranteed plans. Therefore, the returns, after adjusting for the costs on account of the guarantee, are low in such plans. Since these plans come at a higher cost and low return they should be chosen by the customers only if they suit their requirements.

4.3.2.4 Right Premium and Adverse Selection

Insurance is a contract between the insurer and the life assured. Premium is the consideration which makes the contract valid. Insurers use premiums to cover liabilities associated with the policies they underwrite and to keep the revenue model viable. As such, it is utmost important for the insurers to charge the right premium amount from the policyholders.

Normal insurance premiums are calculated on the basis of policyholders being in average good health and a safe work environment. ‘Adverse selection’ in insurance refers to insurance firm's acceptance of applicants who are at a greater than normal risk, but have concealed information about their actual condition. In such situations, the applicant has deliberately hidden material information, which is of critical nature for ascertaining his risk profile. The insurer, with less information, is at a disadvantage to the applicant in determining the correct premium. As the risk is not factored at the time of sale of the policy, this adverse selection leads to faulty determination of premiums and loss to the insurance company.

Truth is, the insurance company cannot possibly know the individual factors that determine every potential buyers health profile. Therefore, before the sale, the company asks all individuals to fill out questionnaires to spell out the material information - followed by a very detailed underwriting process. Say, an individual, who is a habitual smoker and does not exercise, knowing well that answering truthfully means higher insurance premiums, lies and does not declare about his smoking and exercise habits. This leads to adverse selection where the insurer is at a disadvantage and will charge the normal premium to such an individual of higher risk.

Implications of Adverse Selection

Insurance will not be commercially viable for the company when prospective buyers have better information about their risk than the company itself. In such cases of adverse selection, people who know that they have a higher risk than the average of the group will buy the insurance plan. However, those who have a below-average risk

may find that the policy is too costly than their perceived value of risk and so may not buy.

In such cases, premiums set by the insurer, basis the average risk ascertained by the underwriters and the data outlined in the mortality tables, will not be sufficient for the insurer to cover the claims that eventually arise. The reason is that there will be more wilful buyers of the policy who have above-average risk than those who have below-average risk.

4.4 Distribution of Benefits

All the premiums collected from the policyholders get accumulated in the corpus of the insurance company. A large part of this is invested by the company in government secured debt instruments and a small part is invested in equities. On the basis of earnings from these investments, valuation of the assets and liabilities of the insurance company, and the claims paid, the insurance company distributes the profits to 'with-profits' policyholders. This is termed a bonus.

Bonuses are declared on an annual basis during the term of the policy. However, the bonus may or may not be declared each year as it is dependent on the company's profitability. The amount of bonus also differs each year depending on the profits generated by the company.

The insurance companies come up with multiple types of bonuses, which are clearly spelt out in the policy brochure. Along with other parameters, at the time of purchase of a policy it is also advisable to check the type of bonus which the policy offers.

4.4.1 Bonus - 'With-Profit' or Participating Plans

Life insurance companies declare bonus (profit share) on their plans from time to time. Insurance plans where the profit is shared with the policyholders is called a 'with-profit' plan. The customers who take with-profit policies pay a comparatively higher premium which entitles them, but not necessarily guarantee, to the share in the profit of the company. The percentage of bonus in such plans might vary from one policyholder to another depending on the type of the policy, the term and the premium of the policy.

4.4.2 Simple and Compound Reversionary Bonus, Guaranteed Addition

The bonuses, declared regularly and paid at the time of maturity or at the time of policy surrender during the policy term or on the death of the life assured, are called reversionary bonuses. Once declared, they are included as a part of the guaranteed benefits. The amount of bonus is a percentage of the sum assured. They are normally declared annually at the end of each financial year.

In a simple reversionary bonus, the bonus which has been accrued in the previous years, does not earn cumulative interest and only the principal amount is considered in the interest calculation each year. Meanwhile, in a compound reversionary bonus the bonus is computed as a percentage on the sum assured and on all preceding accumulated bonuses. Different companies follow different approaches to bonus - some might follow the simple approach while others may follow the compounding approach.

Similar to bonus, Guaranteed Additions (GAs) are also a form of pay outs. They are calculated at a rate per every thousand of the sum assured. They are allowed for each year for which premiums are paid under the policy. The GAs are disclosed to the policy holder upfront at the time of purchase of the policy. At the time of admittance of a claim, they are added to the basic sum assured for making the payment.

4.4.3 Terminal Bonus, Survival Bonus, Loyalty Addition

After declaring the payouts through reversionary bonuses if some residual profits still remain available in the policy, they are paid as terminal bonus. It is paid to the policyholder at the time of maturity of the policy. It can be said to be a loyalty bonus given to the policyholder for continuing the policy till maturity. Since this is not a guaranteed amount, its value is disclosed only at the time of maturity of the policy and is totally a discretionary payment from the insurance company. Survival bonus is paid at the time of policy maturity wherein the policy holder survives the policy term.

Meanwhile, loyalty additions are given to the policy holder to continue paying the premium and keep the policy alive. Loyalty additions are given as a percentage of annual premium and vary from company to company and policy to policy. They are currently offered on most of the ULIP plans and the endowment plans. While some companies pay loyalty addition only at the time of policy maturity, others pay them at every 3 or 5 year intervals. The value of loyalty additions depends on the premium amount, policy term, premium payment term etc.

4.4.4 Interim Bonus

Insurance companies pay bonus in all cases where a policy matures, or results in a death claim, between the two bonus declaration dates. This is often referred to as the interim bonus.

There may be a short period in between the bonus declaration date and the maturity/claim date for which the policy has not received bonus, although it has accrued all the declared bonuses till the end of the last financial year. In such cases, a bonus is added on a pro-rata basis using the interim bonus rates declared by the company. In this way, the insurance company ensures that policyholders who happen to claim benefits in the middle of the year, on account of death or policy maturity, receive benefit, on a pro-rata basis, for that interim period of the year for which the policy was in force.

4.5 Taxation aspects of various Life Insurance Policies

Life insurance is one of the fundamental aspects of a safe and sound financial life not only for the individual but also for his or her entire family. No wonders then, by giving ample tax benefits the government also encourages people to cover their risks.

There are various provisions on insurance as contained under the prevalent income tax laws (Income Tax Act, 1961, as amended each year), wherein tax benefits are allowed on the premiums paid and money received from the insurance claims.

Tax treatment for premiums paid: Section 80C of the IT Act provides a widely used benefit by way of deduction of taxable income, up to a maximum of Rs. 1.50 lakh, for life insurance premiums paid. This deduction is available for life insurance policies, on the life of self, spouse or child, though the child could be a major or a minor, married or unmarried, earning or non-earning as well. Financial dependence of the child on the parent is not mandatory for the parent to claim tax benefits. Also, there is no restriction on the number of children in respect of whom the premiums are paid by the parents to claim this deduction.

One can avail this maximum benefit of Rs. 1.50 lakh on the premium paid towards a pension plan also. On maturity, one-third of the maturity amount, withdrawn in the form of cash, is tax-free while monthly pension receipts are treated as income in the hands of the assessee and taxed accordingly.

However, the premium paid should be a maximum of 10% of the sum assured for each individual year for which the policy continues. For this purpose, sum assured means the minimum amount which the insurance company has agreed to pay in the event of death and does NOT include any bonus.

In case of a single premium policy, the policy holder is required to keep the life insurance policy alive for a minimum of 2 years from the date of commencement. For Unit Linked Insurance Plans (ULIPs), premiums have to be paid for 5 years. If these stipulations are violated in any year then in such a case the benefit of deduction already taken in the preceding years would be deemed as the income of the taxpayer in the year in which the policy is terminated.

Tax Treatment of money received: If the policy holder fulfils the criteria of payment of premiums, the maturity proceeds from the life insurance policies are tax free under section 10(10)D. Money received by the family member or the nominee on the death of the policy holder, including the bonus, in respect of the life insurance policy is exempt from income tax, except that issued as a Keyman insurance policy.

For events other than death, proceeds received from an insurance company in lieu of a life insurance policy, issued up to March 31, 2003, will be exempt from income tax. However, for policies issued between April 1, 2003 to March 31, 2012 money received from an insurance company, other than on death, shall be taxable if the premium exceeds 20% of the sum assured in any of the years. For policies issued after April 1, 2012 the same will become taxable if the premium exceeded 10% of the sum assured in any year.

According to Section 194DA of the IT Act, TDS is to be deducted on maturity payouts if the policy is not exempt under section 10(10) D or if the maturity amount exceeds Rs. 1 lakh in a given financial year. The applicable rate of TDS is 1% for all cases where PAN number is available and 20% where PAN is not available. The union budget 2019 has proposed to amend TDS on insurance policy proceeds to 5%.

4.6 Loans Eligibility Against Life Insurance Policies – With Profit, Endowment and investment Plans

A policy holder can take a loan from the insurance company against his life insurance policy. Once the premiums have been paid for a few years (usually 2-3 years), the cash value gets built up and the policyholder may withdraw a portion of this cash surrender value under the policy as a loan. Since the loan is secured there is limited scrutiny by the lender (insurance company) - while in other cases, lenders usually evaluate the credit scores. So, the loan application process is faster and easier. However, it may take a few years for a life insurance policy to accumulate a significant cash value/surrender value. So, the loan amount is limited if the loan is taken in the initial years of the policy.

Insurance companies place conditions for disbursing the loan, some of which are:

- A loan cannot be taken against a term plan. It can be availed only against traditional life insurance policies viz. endowment plans, money-back plans, whole life etc. where there is a guaranteed return and the policy itself is used as a collateral for the loan.
- A three-year waiting period before the insurer allows a loan under the policy. This is to check whether the policyholder has been regular in paying premiums or not.
- The loan amount varies between 80% to 90% of the policy surrender value for the traditional plans. For ULIPs, the loan amount depends on the corpus value at the time of loan application.
- The interest rates are generally lower than those charged on personal loans and are specified in the policy document.
- The policy holder has to continue paying the premiums even after availing the loan.
- The policy, against which the loan is taken, is assigned to the insurance company as a security till the loan is repaid.

Repayment: The loan amount and the interest needs to be repaid during the term of the policy. If only interest is paid, then at the time of settlement, the due principal amount will be deducted from the claim amount. If the policy holder dies during the loan term, the pending amount will be deducted from the claim amount and disbursed to the nominee.

It is important to pay back the loan on time. Otherwise, the interest will keep adding to the loan amount, and may at some point exceed the policy's cash/surrender value. The policy in such a case will lapse, and the policyholder will lose the insurance cover.

Taking a loan against an insurance policy could be advantageous as the policyholder gets a chance to unlock the cash value of the policy and use the funds for his financial needs, while maintaining his risk cover and without surrendering his policy. Further, since the loan amount is not considered as an income, it is not taxable.

4.7 Group Insurance Scheme

Group insurance schemes are used by the Government for social welfare. They offer both life and non-life insurance protection under group policies to different groups such as employers-employees, professionals, co-operatives, weaker sections of society, etc. They also provide insurance coverage for people in certain approved occupations at the lowest possible premium cost.

In group insurance a large number of individuals are covered under a single policy called the 'master policy'. The insurance contract is entered into between (a) the body/organization which represents the individuals, the employer or the association, and (b) the insurance company. The individuals are the beneficiaries of the scheme. The main advantage of such a scheme is its low premium and simple insurability conditions. The benefits apply uniformly to all the individuals and there is no individual choice of the member.

The sum assured, premium and other terms of insurance cover are negotiated between the policyholder and the insurance company and not by the individual beneficiaries. The group insurance policy does not have a fixed term; and, the terms and the coverage can be negotiated at the time of renewal.

The premium cost for an individual is not risk-based. Rather, it is uniform for all the insured people in the group. The premiums are based on age combination of members, their occupation and working conditions of the group.

The premium is paid to the insurer by the policyholder, who may or may not collect the same from the employees/individuals concerned. Some companies absorb the entire cost of the policy as a benefit to its employees. If the premium is collected by the employer it can be by way of a deduction from the salary where the contribution may either be the full premium or partial premium. Generally, personal statements and medical examination are not necessary up to a predetermined sum assured.

A person normally remains covered as long as he continues to work for a certain employer, unlike in an individual insurance policy where the insurer often has the right to reject the policyholder's policy renewal, depending on the risk profile.

4.7.1 Group Term Insurance Schemes

Group term insurance plan is a specified life insurance policy that is specially aimed to provide coverage to a large group of people under a single policy. Here, the owner of the policy is the employer or the organization and the policy provides coverage to all the members of the organization or employers.

A group term insurance plan provides some financial security to the dependent families in the absence of the employee. Although the employees may have their own individual insurance plans, yet a group term insurance policy is beneficial on the whole. Several group insurance schemes additionally offer covers for outstanding loans to borrowers, while others offer benefits with critical illness and disability. Such a policy does not entitle the employee to any proceeds (sum assured) upon surviving the term but provides the payout of lump sum proceeds in the event of demise.

4.7.2 Employees' Deposit Linked Insurance (EDLI) Scheme

Employee Provident Fund & Miscellaneous Provisions (EPF & MP) Act, 1952 provides long-term savings for the salaried workers in the private sector. In 1976, the government introduced the Employees Deposit Linked Insurance Scheme (EDLI) to extend the benefits of life insurance to the members of EPFO, which later became a part of the EPF Act. Organizations having more than 20 employees need to register for EPF. Thus, all employees having an EPF account automatically become eligible for the EDLI scheme. This scheme works in conjunction with EPF and EPS.

EDLI applies to all organizations registered under the (EPF & MP) Act, 1952. All such organizations have to compulsory subscribe to this scheme and offer benefits of life insurance to its employees. An employer can opt for another group insurance scheme, but the benefits offered by such a scheme must be equal to or more than those offered under EDLI.

The main objective behind this scheme is to ensure that the family members get some financial assistance in the case of death of the member during the period of his service. Family members under the EDLI scheme are defined as the spouse, unmarried daughter or a male child up to 25 years of age.

In case of death of the active member, during his service period, his nominee or legal heir gets a lump sum payment of up to Rs. 6 lakh. The extent of the benefit is decided on the salary drawn by the employee in the last 12 months of employment before his death.

The pay-out under EDLI is calculated as under:
{Average Monthly Salary of the Employee for the last 12 months (capped at Rs. 15,000 p.m.) x 30} + Bonus Amount (Rs. 1,50,000). Therefore, the maximum payout under EDLI to the beneficiary works out to be Rs. 6,00,000.

In order to claim the insurance benefit, Form 5 IF has to be filled by the nominee after the death of the member. The claim form has to be signed and certified by the employer before submission.

Salient features of the scheme are:

- There is no prerequisite of separate enrolment by the employee for EDLI, as all members of PF are automatically covered under the scheme after becoming a member of EPF scheme.
- There is no exclusion for any member from this scheme.
- There is no minimum service required to avail the benefit.
- Individual factors such as age, education, gender etc. of the employee does not affect the eligibility criteria for covering under EDLI scheme.
- The members are covered by the EDLI scheme as long as they are an active member of the EPF.
- The employer has to make the contribution for EDLI (0.50% of monthly salary upto a maximum of Rs. 75 per month) and no fee is deducted from the employee's salary.

- Effective 15th February 2018, the assured benefit shall not be less than Rs. 2,50,000 and not more than Rs. 6,00,000.
- The maximum average monthly salary of an employee is capped at Rs. 15,000. If the basic salary of a member goes above Rs. 15,000 per month, the maximum benefit is capped at Rs. 6,00,000.
- Average monthly salary is calculated as the Basic Salary + Dearness Allowance.
- There are no exclusions to the insurance coverage provided by EDLI. It protects the insured person irrespective whether the person is in India or abroad.
- Benefits under EDLI are transferable with any job change, due to which the new employer continues to make payment in the existing account.
- The insurance benefits can be availed by the nominees, family members or the legal heirs of the member.

4.7.3 Group Gratuity Schemes

Gratuity is a statutory benefit to be paid by the employer to employees as per terms under the 'Payment of Gratuity Act, 1972' in recognition of his services either as a gratuitous payment or acknowledgment of the employer satisfaction towards his employee who is leaving after rendering long service on his:

- Retirement, or
- Permanent Total Disablement during service, or
- Death during service, or
- Resignation after five continuous years of service.

Every organization, having ten employees during the last financial year, becomes liable to pay gratuity to employees who have completed continuous service of five years, which is payable at the time of leaving their service. Gratuity is a defined benefit plan calculated by taking into account the last drawn salary and the number of years of service of the employee. The employer can also structure a gratuity benefit for his employees which is higher than stipulated in the Act.

Group Gratuity schemes ensure that the employer has sufficient funds to take care of their employees' future liability of gratuity. The employer can choose to invest a certain amount of money in Group Gratuity Plans offered by insurance companies in order to meet this future liability. The amount is invested in different equity and debt funds to provide market linked returns over a long term. The corpus, thus created, is used by the employer to make claim payments for gratuity when employees retire or leave.

The group gratuity schemes come with taxation benefits for the employers. The money invested by the employer towards premium in such schemes is considered as a business expense. This enables the employer to reduce its taxable business income. Also, the funds invested lead to generation of profits and interest income as they multiply.

At the end of each financial year most insurers review the employee data for changes in salaries, exits and new appointments. By this, they revalue the liability based on such changes.

Group gratuity schemes mandate that the gratuity amount is deposited by the employer in such schemes for each respective year; otherwise, accounts of a company are not considered true and fair as per Indian Accounting Standards (AS-15), which might lead to future disputes for the employer.

4.7.3.1 Actuarial Valuation; data of retirement, resignation, death, disability

The purpose of an actuarial valuation is to calculate the 'present value' of payments that would be done by the enterprise to its employees in future as part of an employee

benefit plan. Actuaries start by making the following assumptions about future salary increment rates, attrition and mortality rates:

- **Discount rate** – this is used to convert the future payments of the company into a present value. This amount is shown as the liability of the company in their financial statements.
- **Salary escalation and attrition rates** – these are the company's best estimates of future salary increments and attrition.
- **Other assumptions** include retirement age, disability, mortality, leave balance, resignation etc. are important factors for calculation purposes.

The assumptions are then used to project the benefit payments that will be made by the company to its employees, as per the rules of the benefit plan.

Chapter IX of the Companies' Act, 2013, requires that companies get an actuarial valuation conducted to estimate the liability and also make other disclosures as required by the accounting standard issued by ICAI. One of the accounting standards, AS 15, requires an actuarial valuation to be conducted externally by a certified actuary at least once a year for employee benefits schemes, including gratuity benefits. Auditors or company officials are not able to do these calculations by themselves.

Companies who have been accumulating their liability corpus with an insurer can get AS 15 valuation certificates from their insurer, signed by a qualified actuary.

4.7.3.2 Methods to Manage – Create internal resources, Set up a Gratuity Fund

Gratuity is not a part of the salary package but a legal obligation to be borne by the company at the time of exit of the employee. In order to manage the present and future liabilities of gratuity, companies can follow any of the following two options:

'Pay as you go' option where the company makes a provision for gratuity in their balance sheet on the accrual basis taking an actuarial report. As and when an employee leaves, the company pays gratuity from its resources.

- 'Funding' option where the company sets up an approved Gratuity Trust and contributes to this Trust. The company can then choose to either self-manage the funds of the Trust or else have them managed by an insurance firm. In this case, when an employee leaves the services of the company, gratuity will be paid from the Gratuity Trust.

Accounting provisions made by the company for gratuity in the Financial Statements/Balance Sheet are not allowed as deductions under Section 40A(7) of the Income Tax Act, 1961. However, if the company sets up an irrevocable trust, which is approved as per Part C of the Fourth schedule to the Income Tax Act, 1961, the contributions made by the company in such a trust are allowed as a business expense under section 36(1)(v) of the Income Tax Act, 1961.

Further, there are three types of tax benefits for the company:

- Annually, an amount equal to 8.33% of basic salaries paid into a gratuity fund can be claimed as a tax-deductible expense.
- Contribution equal to 8.33% for each year of past service of an employee paid into a gratuity fund is eligible as a tax-deductible expense, when the gratuity liabilities are funded for the first time.
- Interest or investment income earned within the gratuity fund is tax-free.

However, companies need to consider several other factors before deciding whether they should fund gratuity liabilities using internal resources or they should set up a trust. Some of these are:

- **Opportunity cost**: For funding gratuity liabilities, companies need to source cash from within the business and invest in a gratuity trust thereby denying alternative ways that cash could be put to use and the return it would generate.
- **Liquidity management**: If companies pay off the gratuities to employees as and when they leave, the amount paid would vary from year to year depending on the number of people leaving, thereby creating a burden on their annual cash flows. However, if the gratuity scheme is actuarially funded, the fund will build up during the years when no major payouts are paid and then money from this fund could be used when large payoffs are required to be paid.
- **Cash flow stability**: Gratuity payouts increase exponentially as the employees age and work longer. If the liabilities are funded, companies can replace the increasing gratuity payouts with a stable stream of contributions into the fund.

Finally, the decision of funding the gratuity liability shall depend on how significant the above factors are for the organization for meeting their overall business objectives. Small and new companies gain from better liquidity and stability while larger companies benefit from the tax benefits.

4.8 Investment Linked Insurance – Unit Linked Insurance Plan (ULIP)

Investment-linked insurance plans, often referred to as unit-linked insurance plans (ULIPs), are life insurance plans which combine protection with investment. A part of the premium paid by the policy buyer is utilized to provide him life insurance cover while the remaining part of the premium is invested in financial funds, wherein the investor is allotted units. Investment-linked plans are exposed to investment risk, like other types of investments, which is borne entirely by the policy buyer.

Such plans charge different types of fees and charges towards insurance coverage, fund management, policy administration, surrender, fund switching etc. All such fees and charges are typically deducted through the sale of the units while the rest of the units remain invested in the policy.

4.8.1 Protection, Investment and Income Tax Benefits (subject to Lock-in Period)

Based on the financial situation and requirement, ULIPs provide multiple options to the investor to choose the amount of life cover and the investment by varying the amount of premium. Such plans also provide flexibility to choose the type of funds based on the risk profile of the investor.

While the premium of such plans remains constant throughout the life of the policy, the cost of insurance cover increases year by year as one gets older. This implies that more units have to be sold to pay for the insurance charges, leaving less units for investment under the policy. In contrast to other participating policies such as a whole life plan or an endowment plan, ULIPs do not guarantee cash values. Instead, the fund value of the policy depends on the market price of the units held under the policy at the time of redemption/maturity.

Another feature of ULIP is that as the financial needs of the investor change over time he can vary his insurance coverage and the investment mix. He may also top-up his investments, make withdrawals and switch funds.

ULIPs offer tax benefits both at the time of investment and on maturity of the policy. Premiums paid for ULIPs are eligible for tax deduction under Section 80C of the Income Tax Act, 1961 up to a maximum of Rs. 1,50,000. However, such plans must be kept in force for a period of 5 years to claim deduction, and the premiums must be paid regularly to avail tax benefits.

Further, under section 10(10D) of the Income Tax Act, if the premium paid on the policy is up to 10% of the sum assured during the entire term of the policy, the amount received on maturity is exempt from tax.

4.8.2 Choice of Plans – Equity, Debt, Hybrid, Money Market Fund and Switch options

Unit linked insurance plans give an opportunity to the policy holder to earn market-linked returns. In such plans, part of the premiums is invested in market instruments, including equity and debt, in varying proportions to suit the financial requirement and risk appetite of the individual. The investments are subject to the risks associated with the capital markets and the NAVs of the units may go up or down based on the factors influencing the capital market. This investment risk in ULIPs is borne by the policyholder. Some of the asset classes in which the funds are invested are:

Equity: A portion of premium is invested in equity funds and stocks of companies. As the equity markets are volatile, such investments are considered to be risky; but they tend to offer higher reward in terms of growth in money over a period of time. As such, choosing equity is a suitable option for those investors who have a higher risk appetite.

Debt: Here a significant portion of the available money is invested in fixed-interest generating securities like corporate bonds, government securities, treasury bills, commercial paper and other money market instruments. Investing money in such avenues lowers the risk factor for the investors. The prime reason for investing in debt instruments is to earn interest income.

Hybrid: Also known as balanced funds, such investments fall in the medium-risk category. They vary the amount of investment in fixed components like corporate bonds and varied components like stock markets. Such funds are one of the more stable and prudent investments.

Money Market: Money market funds are also known as cash funds through which the policy holder receives a set amount of returns upon maturity. These funds fall in the lowest-risk category.

An investor of a ULIP plan can choose the type of fund he would like to invest in, based on his risk appetite and investment goals. Investors seeking lower risk opt for debt funds while those seeking higher returns can opt for equity investments. Moreover, ULIP plans allow flexibility to switch between funds based on circumstantial changes.

Switch Option: To safeguard a policyholder's return from market volatility, ULIPs offer switching the investment plan. Policyholders can move units partially or completely between different asset classes like equity, debt and balanced as per their risk appetite and financial goals. Some insurance companies allow unlimited switch options, while others have a limit of 5 to 10 switches in a policy year. However, to generate good returns on investments from the switch, the policyholder needs to constantly review and monitor his investments as the market conditions change frequently.

4.8.3 Net Asset Value based redemption, maturity and claim settlement

Net Asset Value, or NAV, is the market value of the investments held by the fund after deducting liabilities such as management fees, marketing expenses, operating expenses and

other charges. Thus, NAV of a ULIP plan is the total value of the units' holdings minus the value of its liabilities.

The value of the ULIP plan held by a policyholder is, therefore, the number of units in the policy held at any point of time multiplied by the NAV of the fund on that day. This value will increase or decrease along with the price of various assets in which the money is invested. The updated NAV is posted on the website of the insurer on a daily basis.

Because of this inherent feature of the ULIP plans, the payout value of such plans is not fixed but varies on a daily basis. There are three situations under which pay-outs can be received from a ULIP plan.

- Upon Policy Surrender: ULIPs have a lock-in period of 5 years. In case the policyholder surrenders the policy during the lock-in period, the insurer pays the surrender value after deducting all the applicable charges from the fund value. If the policyholder surrenders the policy after completion of the lock-in period, but before the maturity of the policy, the insurer pays the fund value as calculated by multiplying the NAV (on the particular date) by the number of units held.
- Upon Maturity: When the policy period gets over, fund value as derived by multiplying the NAV (on the maturity date) by the number of units held is paid to the policyholder.
- Upon Policyholder's death: If the policyholder of a ULIP plan dies during the policy term, the nominee gets the higher of the Sum Assured or the Fund Value as a death benefit. So, if the fund value is lower than the sum-assured, then the sum assured will be paid. But when the fund's value is more than the sum assured, the death benefit paid is the accumulated amount in the fund.

4.9 Contingency Planning

A contingency fund, if in place, can be accessed to manage unexpected outcomes which could otherwise lead to temporary financial losses. Such a contingency reserve helps one tide over life's unexpected circumstances that may otherwise drain the available financial resources and investments. For example, a sudden job loss can leave one struggling to meet every day financial obligations. Having a contingency fund will ensure that he or she does not have to worry as funds have already been kept aside anticipating any adverse situation. Thus, it becomes important to plan beforehand for unforeseen contingencies.

Every family's financial strategy needs to provide for these risks. An emergency fund should be the first goal towards which a household should save against the possibility of loss or reduction of income. It should be held in liquid assets to enable easy access as and when required. If the emergency fund is used up to meet any adverse requirements, then efforts must be made to replenish it as soon as possible. The adequacy of the emergency fund should also be reviewed periodically.

4.9.1 Disability insurance with premium waiver option

Disability means that one is unable to perform all the material duties in a job. It may be temporary (i.e. short term) or permanent.

Opting for disability insurance is one way of contingency planning. It insures one's earned income from the risk of a disability, due to sickness or injury, which might prevent him from doing his job. It also covers paid sick leave, short-term and long-term disability benefits. People working in organizations where employers do not provide disability insurance benefits, or those who are self-employed must purchase such policies towards contingency planning.

The premiums and available benefits under such policies may vary between company to company depending on occupation, age, etc. Generally, the premiums are higher for policies which provide additional monthly benefits, or offer benefits for longer periods of time, and start

payments of benefits more quickly following a disability claim. Premiums are also higher for policies that state disability in broader terms, meaning thereby the policy would pay benefits in a wider range of circumstances.

Some important aspects that must be considered before choosing disability insurance include:

a) waiting period before income starts,
b) the policy covers short and long term disabilities, and
c) whether the policy covers disabilities arising due to accidents or illnesses

Waiver of premium for disability is a provision in the policy that states the insurer will not require the insured to pay the premium if they are seriously injured. Insurance companies can vary in their definition of a disability, and policies can vary on when and for how long they will waive a premium in the event of a disability. Also, insurance companies may charge a higher premium to incorporate this waiver within the policy.

4.9.2 Child Plans with premium waiver

Child Insurance Plans are the best way for investing in a child's future. They are a mix of investment and insurance to aid in 'financial planning for a child's' future needs and requirements.

From a very early age of the child, the parent can invest fixed amounts every year which can also be timed to mature when the child attains a certain age, say 18 years. Major events in the child's life, like marriage or higher studies, can be planned and financed by Child Insurance Policies by taking adequate plans at the right time. Such plans can also be purchased as soon as the child is born.

They can be market-linked also wherein the fund value is determined by the NAV. Also, the premiums paid are exempt from income tax under section 80(C) of the Income Tax Act, 1961. The plan benefits are also tax-free in nature under Section 10 (10D) of the said Act.

Key features:

- The premiums payable can be on a lump sum basis i.e. single premium, or paid frequently for a selected period of time or on a regular basis. The amount payable will depend on the chosen sum assured and the insurer.
- The policy tenure can be for 10 years and above whereby dependent children from just born to a maximum of age of 25, with certain exceptions, are covered.
- The maturity amount of a policy can be chosen based on personal requirements.
- Money-back child life insurance plans offer a segmented payout method, which can both be in a lump sum or in yearly instalments.
- In ULIPs, the policyholder can withdraw partial amounts to cover financial difficulties.

Waiver of premium: It is an inherent benefit rider of a child education plan. This feature is applicable if the policyholder i.e. the parent, dies within a stipulated period of time. In such a case, the insurance company waives off all the future premiums until the maturity of the policy. This rider enables the policy to continue without any breaks and passes the financial burden of the premium to the insurer. This ensures that the maturity benefit which was set for a certain age remains intact as planned, in addition to the death benefit paid.

4.9.3 Married Women's Property Act and Insurance Planning

The proceeds from a life insurance policy may be recovered by one's creditors if some money is due to them. Their rights supersede that of beneficial nominees. To avoid such a situation, one can buy the life insurance policy under Section 6 of the MWP Act. It gives special

protection to the policy holder's wife and children, and prevents creditors from attaching a life insurance policy taken under the MWP Act.
Section 6 of the MWP Act provides that a policy of insurance effected by any married man on his own life and expressed to be for the benefit of his wife, or wife and children, or any of them, shall ensure and be deemed to be a trust for their benefit and shall not, so long as any object of the trust remains, be subject to the control of the husband, or to his creditors, or form part of his estate.

Simply put, once the policy is bought under the MWP Act, as long the beneficiaries named in the policy is alive, no one else will have any right to the benefits, not even the husband's parents, husband's creditors and the husband himself will also have no rights over the survival benefits of the policy, if any.

Key points

- The term policy bought under MWP Act is considered as a Trust.
- The beneficiaries (wife and/or children) once mentioned in the policy remain unchanged throughout the term.
- Only trustees have control on the policy and the receipt of the benefit amount.
- In case of a death claim, the policy proceeds are received by the Trust and can be claimed only by trustees.
- The Trust holds the claim proceeds for the benefit of the wife and/or children. The policy holder cannot take a loan against the policies endorsed under MWP Act.
- In case a cash-value policy is surrendered, the proceeds will go to the beneficiaries.
- If the husband survives the policy term, the maturity proceeds would still be paid to his beneficiaries.

4.10 Insurance Policy Document and Legal Implications

Any insurance policy is an integrated contract in the form of an Agreement between the insured and the insurer. It is a policy of assurance subject to conditions and privileges of the policy document.

A policy document is a standard, formal document which contains all the details of the insurance contract, under different sections. It lists the details of the insured (name, date of birth, address, contact details etc), the policy schedule, key covers under the policy, including the extensions and exclusions. It clearly mentions the free-look period, the benefits under the policy plan, rights of the insured, details of the policy cover and suicide exclusion clause amongst other general provisions. It also spells out the name of the product, its UIN (unique identification number) as listed under IRDAI. If the policy has been sold through the agency channel or an insurance agent their details are also mentioned in the policy document.

The insurance contract is legally enforceable and both the parties to the contract are bound by the terms and conditions listed in the policy document during the entire term of the policy. The policy document is issued by the insurer once the first premium has been paid by the insured. Policy document is, in fact, a bible for the insured and the insurer.

4.10.1 Preamble

Preamble in an insurance policy is the declaration by the insurer. It is an introductory paragraph in a contract that identifies the type of agreement, the date on which the agreement is signed, parties to the agreement, their status (whether they are individuals or entities), and their addresses. It can be said to be a preliminary statement at the beginning of a statute, stating its purpose and explaining the reason for its enactment.

In other words, the preamble simply says that the insurers will, in return for the premium, pay the losses or claims made under the policy. Most policies have a distinct preamble although some policies may not. Given below is one such Preamble for reference and understanding.

"WHEREAS the insured _____ , named in the Schedule hereto by a proposal and declaration, which shall be the basis of this contract and is deemed to be incorporated herein, has applied to the _____ Insurance Company Limited (hereinafter called the Company) for the insurance hereinafter contained and has paid the premium as consideration for such Insurance in respect of accident or damage occurring during the period of Insurance stated in the Schedule or during any subsequent period for which the Insured pays and the Company may accept the premium for the renewal of this Policy."

4.10.2 Operative Clause

Operative Clause: The operative clause of the policy is a promissory clause. It is a promise that the insurer undertakes to pay the benefits of the policy to the insured if the reason(s) for which the policy was incepted happens while the policy is still in force. It is the single most important clause because it defines what is covered by the policy. The operative clause is framed as widely as possible. However, by way of an extension the insurer may offer covers that are wider than those mentioned in the operative clause. A typical Operative Clause in a general insurance policy would read like:

"OPERATIVE CLAUSE: The Company hereby agrees subject to the terms, conditions and exclusions herein contained or endorsed or otherwise expressed hereon, to indemnify the Insured to the extent of the intrinsic value of the property of the Insured or member(s) of his family, so lost, destroyed or damaged, by Fire, Riot and Strike, Theft or Accident, from any fortuitous cause, any time during the period of this insurance and within the limits stated in the Schedule hereto, provided that the liability of the Company shall in no case exceed in respect of each item the sum expressed in the Schedule hereto to be insured thereon or in the whole the total sum insured hereby."

4.10.3 Proviso

Proviso denotes a condition, provision, specification included in an agreement deed, mortgage, lease or contract, the implementation or non-implementation of which affects the instrument's validity. It usually begins with the word ".....provided always that... .".

Simply put, it is a clause in a statute or contract upon whose compliance the application or validity of a legal document depends. For example, health insurance companies may impose provisos for additional insurance if they consider an applicant's health to be an unfavourable risk.

4.10.4 Schedule

A schedule of insurance is that part of an insurance contract which sets out the details specific to the policy. It is issued by the insurer as part of the policy. It specifies details of the insured's policy containing complete description of properties covered which are in force, the time period of cover against the properties explained, the coverage amount, the exclusions, the deductibles, and the mode of payment and schedule.

Policy schedule is also known as a schedule of insurance. The purpose of a schedule of insurance is to clarify for the insurance company and the insured person precisely what is covered. A schedule is not a stand-alone document from the policy wording itself and should always be read in conjunction with the policy wording.

A typical schedule in an insurance policy would look like:

BASE POLICY – (Policy Name)TYPE OF POLICY – Non-Linked and Non-Participating Single Premium Group Term Insurance Plan OFFICE –POLICY NO: PROPOSAL NO:DATE OF PROPOSAL:DATE OF COMMENCEMENT OF RISK (Effective Date of Coverage):MASTER POLICYHOLDER: IDENTIFICATION SOURCE & I.D NO.:Details of Insured as at the Effective Date of Coverage: As per Register of Members provided by Master Policyholder
ADDRESS (For all communication purposes): TEL. NO.:MOBILE NO.:EMAIL: Maturity Date: Date on which Survival Benefit is payable:
NAME OF THE INSURANCE AGENT/ INSURANCE Intermediary: INSURANCE AGENT/ INSURANCE Intermediary LICENSE NO.: INSURANCE AGENT/ INSURANCE Intermediary CODE: ADDRESS: TEL. NO.:MOBILE NO.:EMAIL:Details of Sales Personnel (for direct sales only):

4.10.5 Attestation

Attestation is the act of witnessing the signing of official document and then also signing it to verify that it was properly signed by those bound by its contents. Many a times, an attestation clause is a provision given in a legal document, normally located after the original signature. By signing the attestation clause, the signatories declare and confirm that everything within the clause is true and the document's legal requirements have been met.

Mostly, an attestation is a third-party identification of a documented validity of the agreement. Attestations are usually related with agreements of great personal and monetary significance, especially legal documents.

Insurance companies mandate attestation as a legal acknowledgement of the authenticity of a document and a verification that proper processes were followed in order for the document to be effective.

4.10.6 Conditions and Privileges

All policy documents list down, under different sections, the terms and conditions of the policy to be followed by the policyholder. It also lists their rights and privileges as a customer of the policy. The motive is to educate the policy holder on all aspects of the product purchased by him.

By doing this, the insurer expects the policy holder to maintain his policy for the entire term in a rightful way so that there are no claim denials or the policy does not lapse for lack of information. Given below are some of the important sections covered in the life insurance policy document:

- Definitions of words and phrases used in the policy document
- Benefits covered under the plan
- Claim process
- Premium payment
- Provisions including suicide exclusion, free look period, fraud and misrepresentation
- Assignment and nomination
- Termination of policy
- Dispute redressal process
- Communication and notices
- Governing laws and jurisdiction
- Details of Ombudsman

4.11 Policy Revival Schemes

Life insurance policies lapse if the premiums are not paid, even within the allowable grace period. Insurers allow automatic revival of a lapsed policy if the outstanding premiums are paid along with interest, generally within six months of the first unpaid premium.

Other conditions of revival of a life insurance policy are determined by the insurer on the basis of factors such as sum assured, period of lapse, period already run by the policy, age, health and occupation of the life assured. So, in cases other than automatic revival on payment of arrears of premium and the interest, insurers insist for evidence of continued good health of the life assured, which can be accomplished through a self-declaration of good health and/or medical report from an authorized medical examiner.

Let us see some variants of revival of lapsed life insurance policies.

4.11.1 Ordinary and Special Revival

Under **ordinary revival**, the policyholder can easily revive his/her lapsed policy by approaching the nearby branch office of the insurer and paying all unpaid premiums along with interest. This must be done within 6 months from the lapsation date of the policy. Along with the self-declaration of good health, depending on the age of the policy holder, insurers also require medical reports.

A policy holder can take advantage of the **special revival** scheme when he/she is not able to repay the outstanding premium. Under this scheme, the initiation date of the policyholder can be changed and he/she shall pay a single premium according to the age at the time of revival. The insurer can also ask for a declaration of good health and a few medical reports. After January 1, 2014 policyholders can revive their non-linked policies within 5 years and unit linked policies within 3 years of first unpaid premium.

4.11.2 Instalment Revival

When a policyholder is not able to pay arrears of unpaid premiums in a single amount he can choose to pay the outstanding amount in instalments. Depending on the payment mode i.e. quarterly or half yearly, the life assured might be needed to pay one half yearly or two quarterly premiums. The balance of arrears would then be spread so as to be paid with future premiums. The arrears of premiums are calculated in the usual manner as under ordinary schemes. Some insurers stipulate that there should not be any loan outstanding under the policy at the time of availing such a benefit.

4.11.3 Loan-cum-Revival

This is useful when the insured is not able to pay a lump sum revival amount from his pocket at that time. The insured person can revive the policy by taking a policy loan. The loan amount is adjusted in premiums. Until the revival date, the amount of loan is calculated as if the policy is within a forced condition. The insured will have to pay the additional amount in case there is any deficit in the revival amount. If the loan amount is more than the revival amount then the extra amount will be paid to the insured.

4.11.4 Foreclosure of Policy and Reinstatement provisions

Foreclosure is an action of closing the policy by the insurer due to default in payment of outstanding loan and/or loan interest on the due date. Reinstatement is the process by which the insurer puts back into force a policy that has either been terminated because of non-payment of premiums or has been continued under one of the non-forfeiture provisions.

For reinstatement, the insured will have to submit proof of continued insurability, and will have to pay all the due premiums along with the revival charges prescribed at the time of payment.

If the insurance company deems fit, the insured might have to undergo a medical examination as well. After the successful completion of these conditions, the insurance policy shall come into force with all its original benefits.

4.11.5 Surrender of Policy

Every policyholder has the option to exit from his life insurance policy before its maturity, referred to as 'surrender of policy'. A regular premium policy can be surrendered after the premiums have been paid for 3 years continuously. The policy holder gets an amount technically called a 'Surrender Value' which is some part of the total accumulated bonus and the premiums paid. However, this value differs from one insurance company to another.

Guaranteed surrender value: At the time of purchase, the policyholder is guaranteed a fixed percentage of paid premiums depending on the number of years the policy was continued; the more the years for which the premiums were paid, the higher will be the surrender value. The Guaranteed Surrender Value is the total premiums paid excluding any Extra Premium and Rider Premium, multiplied by the applicable Guaranteed Surrender Value factor less any survival benefits already paid under the policy.

Special surrender value: In this case, in addition to the paid premiums, the surrender value is also a factor of the sum assured, bonuses and policy term. The Special Surrender Value factors applicable to the policy may alter from time to time with prior approval of IRDAI. Also, no surrender value is available on Rider premiums, if any.

4.11.6 Assignment of Policy

Assignment means transfer of the right, title and interest of the life insurance policy from one person to another. The person who transfers his rights is called the assignor and the person to whom the policy is transferred is called the assignee.

In India assignment is governed by Section 38 of the Insurance Laws (Amendment) Act, 2015 as amended from time to time. On execution of the assignment the assignee gets all rights title and interest in respect of policy assigned and becomes the owner of the policy.

Assignment can be made either on the policy document by an endorsement, or through a separate deed of assignment signed by the assignor stating the fact of assignment and duly attested. The first assignment can be made only by the policyholder, which becomes operative as soon as it is executed. An assignment can neither be cancelled nor can the policy be reverted back to the assignor unless the assignee reassigns the policy. A notice of assignment is necessary to be submitted with the insurer in writing. The assignee is not entitled to increase the death benefit. However, an assignment can be made in favor of more than one person.

Assignments can either be absolute or conditional. In absolute assignment, the assignor passes on the full benefits of the policy to the assignee. Once the assignment has been made, the policy remains with the assignee and in case of death of the assignee, benefits are passed on to his/her legal heirs. The assignor (policyholder) loses his right of benefit under the policy. Absolute assignment is commonly seen in commercial situations where the policy is typically mortgaged against a debt assumed by the policyholder, like a housing loan.

In conditional assignment, the policy may revert to the assignor on the happening of a certain event or events or performance of a promised duty by the assignor. If assignee dies before the life assured, the policy would revert to the assignor. The assignor can ensure that he gets the benefits of the policy if he survives its tenure, even if the policy has been assigned.

4.12 Claims

A claim is a demand raised by the insured which the insurer should settle as per the promise specified in the insurance contract (policy document). A claim gets triggered by the occurrence of one or more events covered under the insurance contract.

Insurers have an obligation to settle the claim promptly as it is one of the most important services that they can provide to their customers. At the time of settlement of claim, the insurer generally checks:

- Whether the insured event has taken place?
- Whether the policy holder has performed his part of obligations with regard to payment of premiums, age proof etc.?
- Who are the persons entitled to claim the amount payable under the policy?

The most common types of claims are Maturity Claim and Death Claim as discussed herein.

4.12.1 Claims by Maturity

The amount which is payable on completion of the policy term is called Maturity Claim. It is paid only if the policy has completed its due course of time and the policy has been continued properly, i.e. all due premiums have been paid on time. To avail this benefit, the insured has to furnish the original policy document and duly filled maturity claim form, also called the policy discharge form. Money received from maturity claims is tax free as per the income tax laws.

4.12.1.1 Claims at Periodic Intervals (Money-Back Plans)

For money-back policies the insurance company makes specific payments to the policy holder periodically as specified in the terms of the policy. Such payments are known as survival benefits. For maturity claims, the insurer pays the sum assured less such survival benefits paid during the term of the policy.

4.12.1.2 Claims at Maturity (on surviving the Policy term)

Endowment plans and whole life plans pay the insured a specific amount at the end of the policy term, if the insured survives the entire term and has met other criteria of the policy. The amount payable is the sum insured plus any accumulated bonuses, less any outstanding premiums and interest thereon.

4.12.2 Claims by Death

Life insurance is a contract between an insured (policyholder) and the insurer, whereby the insurer promises to pay the designated beneficiary a sum of money upon the death of the insured. Such a claim is called a death claim. Depending on the policy terms, other events such as terminal illness or critical illness may also trigger payments.

The death claim amount is payable in case of policies where premiums are paid up-to-date or the death occurs within the grace period. Payment from the policy can be either taken as a lump sum or as an annuity, which can be paid in regular installments for either a stated time period or for the lifetime of the beneficiary.

4.12.2.1 Claimant (Nominee/Assignee) or Legal Representative (Proof of Title)

A life insurance cover allows the policy holder to specify a nominee to get the benefit in case he passes away during the policy term. When a policyholder gets a life insurance plan, the beneficiary is an essential part which is named in the policy. Nominees are generally legal heirs as most people get life insurance for their family members. In case, the nominee is not available or also dies in the process, the legal heir becomes the beneficiary.

Thus, a claimant, in the context of insurance, is a policyholder, or the beneficiary, who files a formal request to his insurer for payment to cover a specific loss. Claim intimation can also be made by relatives of the insured, even if they are not a nominee or assignee. The insured's nominee has to carry out the required procedure to receive the insurance claim.

Life insurance claimants or beneficiaries can be many. A business, charitable institution or a group of people can also be legal heirs for a particular life insurance policy. Often, the nominee for the life insurance policy is awarded to a minor. In case, the parent dies during the policy term, the minor does not get the money. The money is given to the appointee or legal guardian of the minor child. Benefits for critical illness riders or accident and disability riders go to the life insured if he is still alive.

When no nomination has been made in the policy, the claimant is required to attach proof that he is legally entitled to make the claim. The insurance company will verify the claim and may ask for additional documents for proof of title to stake a claim.

4.12.2.2 Documents Required – Letter of Intimation, Death Certificate

In order to process the claim expeditiously, insurance companies require documentary evidence of the covered event - for example death of the insured. Given below are some of documents required to be submitted by the beneficiary to the insurer to facilitate processing of the claim:

- Letter from beneficiary intimating about the death
- Claim form by the nominee
- Certificate of burial or cremation
- Certificate from the doctor/physician
- Certificate from the hospital
- Employer's certificate
- Certified court copies of police report like First Information Report (FIR), Inquest Report, Post-Mortem Report, Final Report which are required in case of death by accident.
- Death certificate issued by municipal authorities etc.

However, insurers may seek additional documents, if required, to process the claim in a conclusive manner. SEP

4.12.2.3 Non-Early Death Claim (Beyond three years) – Presumed to be Dead for missing persons, applicability of Indian Evidence Act, 1872

Proof of death is necessary for settling a claim. However, sometimes a person is reported missing without any information about his or her whereabouts.

Sections 107 and 108 of the Indian Evidence Act, 1872 deals with presumption of death. Under this Act, if an individual has not been heard for seven years, he or she is presumed to be dead. If the nominee, or heirs, claim that the life insured has been missing and should be assumed to be dead, insurers require a decree from a competent court.

However, the insurer may also act on its own, without a decree of the court, if reasonably strong circumstantial evidence exists to show that the life insured could not have survived a fatal accident or hazard. It is necessary that the premiums should be paid until the court decrees presumption of death; although insurers may, as a concession, waive the premiums during the seven years' period. This is at the option of the individual insurer.

Chapter 5 General Insurance

Learning Objectives

5-1 Explain the Indian general insurance market
5-2 Evaluate the various insurance classifications
5-3 Understand public liability, product liability, professional and employer liabilities
5-4 Distinguish the nuances of Motor Vehicles Act with respect to public liability
5-5 Determine the non-life insurance contract, policy document and legal implications

Introduction

Insurance in India refers to the market for insurance which covers both the public and the private sector organizations. It is listed in the Indian Constitution in the Seventh Schedule as a Union List subject, implying it can only be enacted by the Central Government.

Section 7(A), Part I of The Insurance Act, 1938 defines “Indian insurance company”:

Any insurer being a company -

- which is formed and registered as per the Companies Act, 1956 (1 of 1956);
- in which the total holdings of equity shares of a foreign company, either by itself or through its subsidiary companies or its nominees, shall not exceed twenty-six percent paid-up equity capital of such Indian insurance company;
- whose only purpose is to conduct general insurance business or life insurance business or reinsurance business.

5.1 Structure of Indian General Insurance Market (non-life Insurance)

As per The Insurance Act, 1938, "general insurance business" means fire, marine or miscellaneous insurance business, whether carried on singly or in combination with one or more of them.

General insurance (*also called non-life insurance)* offers cover for day-to-day living such as travel, health, car and bikes, home insurance, accident and marine. It also provides cover for industrial equipment, crop insurance, gadget insurance for mobiles, pet insurance etc. There are also covers such as Errors and Omissions insurance for professionals, individual and business liabilities, credit insurance etc.

In the year 2001, the sector was opened up to the private players and ever since many new companies have established their presence in the market. At present, in India, there are public sector undertakings which come under the Government and private companies in the general insurance market.

As in life insurance, the general insurance industry is also regulated by IRDAI. There are many Regulations, Acts and Rules, as amended from time to time, which govern the general insurance industry in India. Some of them are:

- Insurance Act, 1938 and Insurance Laws (Amendment) Act, 2015
- Insurance Regulatory and Development Authority Act, 1999; IRDAI (Protection of Policyholders’ Interests) Regulations, 2017; IRDAI (Insurance Brokers) Regulations, 2018 and IRDAI (Registration of Insurance Marketing Firm) (First Amendment) Regulations, 2016
- Marine Insurance Act, 1963; Motor Vehicles Act, 1988; Public Liability Insurance Act, 1991; Consumer Protection Act, 1986, etc.
- General Insurance Business (Nationalization) Act, 1972

Other stakeholders in the general insurance market include the insurance agents, corporate agents, brokers, web-aggregators, surveyors and Third Party Administrators (TPAs) servicing the health insurance claims. There has been a move in the channel mix from the previously agency-focused model to further diversified distribution mix.

The general insurance industry has witnessed several changes (regulatory and structural) ever since it was opened to the private sector in 2001. The industry has been witnessing trends such as increased digital presence and many innovations around customer education and service. Insurance companies are involving e-commerce websites, online travel portals and online payment companies to make a package and cross-sell insurance. Since November

2017, IRDAI guidelines have allowed motor vehicle dealers to act as registered insurance distributors.

The general insurance industry is being driven by the rising demand in related sectors like the automobile industry and the healthcare industry. There is also an increase in the purchasing power of the middle-class population, coupled with a growing young and working population.

The Government of India has also taken a number of initiatives to boost the industry such as:

- National Health Protection Scheme as 'Ayushman Bharat' to provide coverage of up to Rs. 5 lakhs to over 100 million families,
- Pradhan Mantri Fasal Bima Yojana (PMFBY) to benefit marginal farmers

All of this has led to increased penetration, higher coverage, multiple channels and better reach and competitiveness in the market. For your clients, this may be an area of increasing interest for advice.

5.2 Government and Private Insurance Companies

As per insurance regulator IRDAI (www.irdai.gov.in) the evolution of general insurance dates back to the Industrial Revolution in the west and the consequential growth of sea-faring trade and business in the 17th century. It came into the country as a legacy of British occupation. General Insurance in India has its origin in 1850 in Calcutta by the British in the formation of Triton Insurance Company Ltd. In 1907, Indian Mercantile Insurance Ltd. was established, being the first company to transact all types of general insurance business. After that, in 1957 the General Insurance Council was formed which is a division of the Insurance Association of India. The General Insurance Council framed the code of conduct for safeguarding fair conduct and rigorous business practices. In the year 1968, the Insurance Act, 1938 was revised for regulating investments and setting minimum solvency margins.

Subsequently in 1972, the general insurance industry was nationalized and 107 insurance companies were merged into four companies namely The New India Assurance Co. Ltd., The National Insurance Co. Ltd., The Oriental Insurance Co. Ltd. and The United India Insurance Co. Ltd. The General Insurance Company (GIC) was incorporated in 1972 itself and the other four companies became its subsidiaries. In the year 2000, GIC became the Indian Reinsurer and its regulatory role over its subsidiaries came to an end. Since 2003, GIC's role as a holding company of its subsidiaries also ended and the ownership of the subsidiaries was assigned to the Government of India.
(Refer www.financialservices.gov.in)

Till 1999, in India private insurance companies were not there. The government then introduced the Insurance Regulatory and Development Authority (IRDA) Act in the year 1999, thereby de-regulating the insurance sector and allowing private companies by setting a limit on Foreign Direct Investment (FDI) to 26%, which was later on increased in 2014 to 49% with the safeguard of Indian ownership and control.

At present, there are four general insurance companies in the public sector, two specialized insurers namely Agriculture Insurance Company Ltd. catering crop insurance and Export Credit Guarantee Corporation of India which caters to credit insurance, five private sector insurance companies to underwrite policies entirely in Personal Accident, Health and Travel insurance sectors and another 27 general insurance companies in the private sector. GIC Re now functions as the sole reinsurance company in India.

In the insurance industry, there has been operational and technological changes which have led to the growth of various distribution channels. Insurance companies are developing other channels to drive growth at lower costs, due to rising commissions in traditional channels like

agents and banks. This has led to the emergence of additional channels such as call centres, mobile, web aggregators and digital direct-to-customer channels.

5.3 Agents and Brokers

Insurance agents and brokers, both, are vital to the business interest of the insurers as they play a key role in distribution and administration of the insurance products.

The agents serve as an intermediary between the insurer and the insured. An insurance agent's responsibility is purely administrative in nature. They are only liable for timely and precise processing of forms, paperwork and premiums, say for example in motor insurance. They have no duty to conduct a thorough examination of an individual's business or to ensure that appropriate health insurance cover has been provided. Rather, it is the policyholder's duty to ensure that he has purchased the required insurance cover.

On the other hand, brokers function as a super-independent agent. They have a higher duty towards the policyholders as they offer a host of insurance products and services to them. They analyze a business, interpret the data from various databases and secure correct and adequate cover for the insurance business. Brokers normally charge an administrative fee on premium payments as they are expected to have additional technical and professional expertise as compared to an insurance agent.

The differences between the two can be summed up as below:

S. No.	Agent	Broker
1.	Insurer's representative	Insured's representative
2.	Governed by IRDA regulation on Agent	Governed by IRDA regulation on Brokers
3.	Can deal only in products of insurance company of which they are agents	Can deal with any insurance company
4.	Commission is the remuneration	Brokerage is the remuneration
5.	Professional indemnity is not mandatory	Professional indemnity is mandatory

5.4 Loss assessors

A loss assessor is an expert contracted by the individual documenting the claim to ensure that it gets processed successfully by the insurer. For ensuring this, the loss assessor takes care of all the regulations and processes that are necessary for a guaranteed settlement. A good loss assessor works with the customer to document the claim and cater to all the queries and requests not only from the side of the customer but also from the side of the insurer, from the paperwork to the more practical aspects.

Loss assessors also meet the insurer's staff members and their selected loss adjusters, for discussing the best possible claim settlement for the client. They are excellent negotiators and experts on policy terms and conditions. At the same time, they know how to properly quantify claims to ensure that the claim is filed for an accurate and realistic amount. They have a thorough understanding of how the insurer's claim department works. A loss assessor could be approached for help where the insurer has declined the claim, or where claim settlements have been delayed.

It is vital that the claimant enlists the services of a loss assessor as early as possible – ideally as soon as one knows that he has to file an insurance claim. This will not only increase the chances of making a successful claim, but also free the individual from dealing with their

insurers. The more the delay, the harder it is for the loss assessors to prepare and present a successful claim.

Working of a loss assessor: He would typically start by evaluating the property and checking the damage done to it. For example, if a house has been damaged due to fire, the loss assessor would evaluate the house, check its monetary value, evaluate the damages done, and decide if they are claimable. Once he has collected the evidence and all related information, he makes a report of the case and sends it to the insurance company on behalf of the claimant. At times, he also negotiates on behalf of the claimant and makes sure that the case is properly settled by the insurer.

5.5 Classification

Any type of insurance which is not considered to be life-insurance is known as General Insurance. In different countries, general insurance is named differently - yet it covers all forms of non-life insurance.

General insurance is categorized as insurance for valuables other than our life – for example: house, land, office, cargo, travel, motor, marine etc. which might bring financial loss against damage, loss and theft. General insurance covers almost everything related to property, vehicle, cash, household goods and also one's liability towards others.

The broad categories that cover all types of General Insurance are:

- Non-life (Home and Contents, Travel)
- Health,
- Agriculture,
- Credit,
- Reinsurance,
- Liability,
- Motor Vehicle, and

A general insurance policy typically has a period of one year, renewable every year. The premium and the cover of such policies depend upon the type and extent of insurance.

5.5.1 Non-Life Insurance

Non-life insurance refers to the insurance of physical goods and properties. It is a means to provide financial protection of a building, machinery, equipment, furniture, vehicle etc. against the risk of fire, earthquake, accident or theft. Examples of non-life insurance policies include home-owners policies, damage cover from fire, marine accidents, travel, theft, automobile policies etc.

Our valuable possessions such as home, business, vehicle etc. are exposed to various hazards. Traveling also involves risks like risk of accident, risk associated with loss of baggage / passport and medical expenses. Since the probability of occurrence of these risks is very difficult to ascertain, it becomes difficult to measure the amount of damage such risks would do on their incidence.

Fire insurance: Fire insurance is taken for getting financial compensation against any loss caused to property and assets by fire. The insurer promises to pay a defined sum of money to the insured in case of loss to property caused by fire, within the policy period. The insured can claim the actual value of goods lost by fire or the amount insured, whichever is less I.e. insured cannot claim more than the value of the goods lost.

Marine insurance: It is taken to claim compensation against losses due to perils in the sea. It is a contract taken to indemnify against damage of goods in sea voyage. The subject matter in marine insurance is a ship, cargo or freight.

Motor insurance: It is taken to claim financial compensation for the loss of motor vehicle caused by theft, accident etc. We will study about this in detail further ahead.

Difference between life- and non-life insurance

Base of difference	Life insurance	Non-life insurance
Subject matter	Life of a human being	Goods or properties
Period of contract	Long term contract – 10 years, 20 years and so on	Short term contract taken normally for one year and is renewed periodically
Indemnity	Not a contract of indemnity since value of human life cannot be quantified in terms of money	Contract of indemnity where loss of goods and properties is indemnified in terms of money
Compensation	Insurer pays predetermined sum of money to the insured on the maturity of policy or to the nominee in case of death of the insured	Insurer pays predetermined sum of money to the owner of goods or properties in case of loss of such goods or properties on account of risk defined
Nature of expenses	Premium paid is personal expense	Premium paid is normally considered business expense

5.5.2 Health Insurance

Health insurance plans reimburse the insured for their medical expenses, which includes treatments, surgeries, hospitalization and likewise expenses which arise from injuries or illnesses. Such policy also provides coverage for any future medical expenses of the insured.

Like any other insurance policy, a health insurance policy is also a contract between the insurance company (the insurer) and the customer (an employer or an organization). Usually, the health insurance policy is renewed every year but at times it can also be for lifetime.

In India, health insurance usually reimburses for only hospitalization and for treatment at hospitals when the insured is hospitalized for at least 24 hours. The expenses for nursing, hospital bed, fees of surgeon or doctor's consultation fees, operation theatre charges are covered in most of the cases. Certain diseases that are specified under the policy's terms and conditions may be excluded from coverage or may be covered only after certain years of the policy issue date. Aesthetic treatments or any other treatment that does not require to stay in hospital, are also excluded from the policy.

In India, the Mediclaim policies were the first health policies. With the coming of private insurers, Indian insurance market saw the introduction of many innovative products like family floater plans, top-up plans, critical illness plans, hospital cash and top-up policies.

Classification of Health Insurance Plans

Hospitalization: Hospitalization plans are reimbursement plans that pay hospitalization and medical costs to the policy holder subject to the sum insured. In case of individual health policies, the sum insured is generally applied on a per member basis and in case of family

floater policies, sum insured is on a floater basis that can be utilized by any member who is insured under the plan. Generally, these policies do not pay any cash benefit.

There is another variant of hospitalization policy called a top-up policy. Top-up policies have a feature of high deductible which is typically set for a level of existing cover. This policy aims to cater to those people who have some base amount of insurance from their employer. People can add-on their insurance cover with this top-up policy, when the cover is not enough.

Family Floater: These plans cover the entire family under one health insurance plan. It works under the assumption that all family members will not suffer from illness at the same time. It covers hospital and other expenses.

Pre-Existing Disease Plans: It offers cover against diseases the policy holder had before buying his health policy e.g. diabetes, kidney ailment, coronary disease and others.

Senior Citizen Health Insurance: This health insurance plan is specially designed for the old age people. They provide cover from health issues during old age.

Maternity Health Insurance: Maternity health insurance ensures cover for maternity and other additional expenses. It takes care of both pre- and post-natal care, baby delivery (either normal or caesarean), ambulance charges, etc. These services are supervised by the Maternity Benefit Act, 1961 as amended in the year 2017.
Critical Illness Plans: These are benefit based policies which pay a lump sum (fixed) benefit amount on diagnosis of a covered critical illness and medical procedures. These illnesses are generally explicit and of high severity with low frequency in nature but involve high cost in comparison to the day to day medical treatment, e.g. heart attack, cancer etc. Some insurance companies also provide an option of staggered payment in combination with upfront lump sum payment.

Hospital Daily Cash Benefit Plans: This is usually a predefined benefit policy where the insurer pays a fixed sum of money for every day of hospitalization for a fixed number of days in the policy year, subject to certain deductions of a few days.

Long term and disability: There are also policies which meet a specific need, such as paying for long term care. Disability insurance, which substitutes loss of income due to illness or accident, is also considered as a health insurance policy, even though it is not precisely for medical expenses. The policy covers hospitalization because of accidental injury and sickness, subject to some exclusions and waiting periods, which are clearly being stated in the policy wordings.

How can one claim health insurance?

Cashless: In case of a cashless settlement, also called direct payment, the insurance company directly settles the admissible claim amount with the concerned hospital; and the insured person pays to the hospital those expenses which are not covered under his health insurance policy. Under the cashless scheme, the policyholder, and all those who are mentioned in the policy, can undertake treatment from the hospitals approved by the insurer.

Reimbursement: In case the policyholder is admitted in a hospital which is not under the network of his insurance company, he will have to make all the payments on his own to the hospital, and after staying for the duration of his treatment he has to submit these original bills/papers, along with the claim form, to the insurance company for reimbursement of his expenses, within the policy limits.

In the light of rising healthcare costs, coupled with increasing demand for quality healthcare services and lack of easy access to such services to people from low income groups, health insurance is evolving as an alternative method for financing healthcare.

5.5.2.1 Taxation Aspect of Health Insurance Policies – Individuals, Family and dependent Senior Citizens

Every individual can claim a tax deduction under Section 80D of the Income Tax Act, 1961, for his health insurance which is paid from his total income in any given year. One can also take the benefit of tax deduction by purchasing the health insurance policy to insure their spouse, dependent children and parents. These policies can be individual plans or a family floater. The children must be dependent on the parents for their insurance premium to be eligible for deduction. Health insurance premiums paid by parents for children who are not dependent on them are not allowed as a deduction for the parent.

Section 80D: The quantum of tax benefit depends on the age of the individual who is insured. Explained below is the limit available under section 80D as applicable across various age groups.

No one over 60: In case no one in the family i.e. self, spouse and children, is over the age of 60, then deduction is available up to Rs. 25,000 only. For health insurance premium paid for the parents below the age of 60, the deduction is available up to Rs. 25,000. Hence total deduction which one can claim in income tax is up to Rs. 50,000.

Either parent over 60: In case either one of the parents or both the parents is/are over the age of 60, deduction of up to Rs. 50,000 paid towards health insurance premiums for the parents is allowed. Also, premium paid for the family i.e. self, spouse and children, continues to be deductible up to Rs. 25,000, thereby making the total deduction available up to Rs. 75,000 in a year.

Eldest family member over 60: Where either self or spouse is over the age of 60, one can claim up to Rs. 50,000 in tax benefit on health insurance. Additionally, for parents over the age of 60, health insurance is also allowed up to Rs. 50,000 in deduction. So, total deduction in this case can be up to Rs. 1 lakh a year.

Super-senior citizens (80 years or above): Such citizens who do not have any health insurance policy can claim a deduction up to Rs. 50,000 every financial year towards medical check-ups and treatments.

Preventive Health Check-up

Any payment made towards preventive health check-ups entitles the taxpayer to a deduction of up to Rs. 5,000, within the overall limit of Rs. 25,000 / Rs. 50,000 as the case may be. This deduction can be claimed by either individual for himself, spouse, children who are dependent or parents. One can claim a health check-up deduction up to Rs. 5,000 inclusive of all the dependents in his or her family. However, this facility is not available independently for every individual family member.

HUF

Just like individual taxpayers, an HUF can also claim a deduction under section 80D for a health insurance taken for any of the members of the HUF. This deduction will be Rs. 25,000 for the insured member whose age is less than 60 years, and will be Rs. 50,000 for the insured of 60 years of age or more.

The above deductions can be summarized as below:

Section 80DD - Medical Treatment of Disabled Dependent
Deduction under this section is available to a resident individual or a HUF on:
(a) Expenditure spent on medical treatment (which includes nursing), training and rehabilitation of a handicapped dependent relative
(b) Deposit or payment to stated scheme for care of handicapped dependent relative:
(i) Where disability is between 40% and less than 80% (non-severe disability) – fixed deduction Rs. 75,000.
(ii) Where disability is 80% or more (severe disability) – fixed deduction Rs. 1,25,000.

Disability certificate shall be required from an approved medical authority for claiming deduction under this section.

Section 80DDB - Deduction for Medical Expenditure either on Self or Dependent for Specified Deceases

a. For individuals and HUFs whose age is below 60 years: A deduction up to the extent of Rs. 40,000 can be availed by a resident individual or a HUF. The deduction can be availed for the expenses incurred for the treatment of specified medical diseases or illnesses for himself or his dependents. In case of an HUF, such a deduction is available for medical expenses incurred for these prescribed ailments for any HUF members.

b. For senior citizens and super senior citizens: In case the individual on behalf of whom such expenses are incurred is a senior citizen, including super senior citizens, the deduction up to Rs. 1 lakh can be claimed by HUF or individual taxpayer.

However, one needs to get a prescription for such medical treatment from the concerned doctor / specialist in order to claim such a deduction.

The deductions can only be claimed if one pays the premium for his or her dependent children and not for independent children. Also, the premiums paid for health insurance availed by brothers/sisters do not qualify for tax deductions. Whereas the deduction can be claimed even when the parents and spouse are not dependent.

Single Premium Health Insurance Policies
Under Section 80D, where the taxpayer has made a premium payment in lump sum in a year for a policy which is valid for more than one year, he can claim a deduction of the proportionate amount. The appropriate fraction is arrived by dividing the lump sum premium paid, by the number of years of the policy. However, this is subject to the limits of Rs. 25,000 or Rs. 50,000 as the case may be.

Key Points
- Contribution towards health insurance plan has to be made to a scheme as specified by the Central Govt. /IRDAI.
- All premium payment modes are accepted by the insurer, except cash. Also, third party premium payments are not acceptable.
- Senior citizen is defined as an individual resident of India whose age is 60 years or more during the related financial year.
- The deduction cannot be claimed if the premium is paid for grandparents, brother, sister, aunts, uncles or any other relative.
- Premium paid for working children is not eligible for claiming deduction under this section.
- In the case of part payment by the insured and a parent, both can claim a deduction to the extent paid by each.

- The deduction has to be taken for the premium without showing the GST from the premium amount.
- For claiming deduction, premium payment receipt and policy copy which confirms the family member's name and age and their relation should be preserved.

5.5.2.2 Taxation Aspect of Group Health Insurance Policies for Corporates

A group or corporate health insurance policy is purchased by an employer for eligible employees of a company as one of the key employee benefit packages. In certain instances, health insurance policy is part of an employer's statutory obligations. Group health insurance plans may also provide cover to family members of employees.

These plans are designed to include and exclude members as they join and leave the company. These policies are generally low in premiums due to the reduced risks involved. These plans allow lenience in covering pre-existing illnesses amongst other things.

Tax benefit: Employers get taxation benefits on a group health insurance, as the policy can help in decreasing their tax liability. The employee should be in active employment for being eligible for taking policy benefits under group health. The tax deduction can be availed for the premium being paid by the employer. The company lists this amount as an expense for employee benefit in their financial statements.

However, Group Health Insurance premium provided by the company is not eligible for deduction by the employee.

5.5.3 Agriculture Insurance

Agriculture insurance (also called crop or farm insurance) is an important part of agriculture in India on account of two reasons. Firstly, agriculture is a risky business because of unpredictable and uncontrollable unrelated perils. Secondly, most farmers are small and have less ability to survive the agricultural risks. As such, agriculture insurance plays an important role in safeguarding their financial losses.

Agriculture insurance provides cover to the loss in crop production which might be caused due to natural disasters. It also covers the loss of revenue due to the fall in price of agricultural commodities. This policy is usually bought by farmers or planters.

In India agriculture insurance was started in 1985. Before that, the Comprehensive Crop Insurance Scheme (CCIS) was used to cover the major crop productions. Although plans extending insurance cover for crops in India have been in process since then, they have not been able to include the majority of the agricultural sector.

The Government has introduced many agricultural schemes in the country to protect farmers from natural disasters. These are:
National Agricultural Insurance Scheme (NAIS),
Pilot Weather Based Crop Insurance Scheme (WBCIS),
Pilot Modified National Agricultural Insurance Scheme (MNAIS), and
Pilot Coconut Palm Insurance Scheme (CPIS).

In 2003, the private players entered the market.

In 1999-2000, Rashtriya Krishi Bima Yojana or National Agricultural Insurance Scheme (NAIS) was brought in by the Government. The scheme offers insurance cover for loss of food crops (pulses, oilseeds, cereals), and other horticultural, commercial crops. For food crops

the premium rates vary from 1.5% to 3.5% of the sum insured. In the case of commercial crops and horticulture, the actuarial rates are charged.

Small farmers can avail subsidy of 50% on the premiums from the government. The subsidy is distributed over a 5 years period, distributed uniformly between the Centre and the State Government.

NAIS operates either:
(a) On the basis of a premise approach where every mentioned crop has a set geographical area such as circle, mandal, block, tehsil, gram panchayat etc., or
(b) On an individual basis - for area specific calamities such as hailstorms, cyclones, landslides and floods.

Agriculture Insurance Company of India Ltd. (AIC) has been supervising and implementing agriculture insurance schemes in India since 1st April 2003, earlier done by General Insurance Corporation of India. Meanwhile, AIC also handles various kinds of insurance businesses which are linked to agriculture and related activities.

Benefits of Agriculture Insurance

- It benefits farmers to maintain agricultural credit flow
- Rationalizes loss assessment procedures
- Helps to build up precise statistical data of crop production
- Encourage farmers to implement progressive farming practices and better technology in agriculture

Depending on the policy opted by the farmer, his personal and property needs can be covered under the agriculture insurance policy. Some of the events covered under such policies are:

- Loss of the farmer's property or damage caused due to fire or natural disaster (which includes storm, flood, tornado, earthquake, cyclone etc.)
- Cover for personal accident for the insured farmer and his family.
- Cover for loss of pump set
- Cover for damage/loss of tractor
- Cover for damage/loss caused by power failure

Farmers lack required documents and land records. This is one of the major reasons for their not availing the facility of agriculture insurance. Also, the compensation is often delayed and inadequate. Because of all these reasons the farmers face fund shortage and are not able to start their next cycle of crop cultivation.

Claim process

To begin with, the farmers must first register themselves with the insurance provider company. The insurance company will then offer the appropriate cover scheme to the farmer which will include market price from the past or a minimum support price guarantee. The premium for any type of price insurance has to be paid by the farmers. The government helps in the premium payment during the initial stage.

During the harvest period, in the notified market price goes less than the guaranteed price, then the farmer will be compensated by the insurer. In case of damage to the crops, first the yield data need to be received from the State Govt. according to the prescribed cut-off dates. Then the claims will be run down and settled by the investigating agency. Individual nodal banks will then receive the cheques related to the claim filed and the claim particulars. Individual banks then credit the accounts of the individual farmers and particulars of the beneficiaries are displayed on the bank's notice board.

5.5.4 Credit Insurance

Credit insurance covers the payment risk resulting from the delivery of goods or services, e.g. an Indian manufacturer sells his goods on credit to some international client and seeks protection against payment delays and non-payment by its buyers. The credit insurer covers a group of buyers. It pays a percentage of receivables, which were unpaid as a result of insolvency, bankruptcy or protracted default.

The buyer may be situated in the same country as the supplier or situated in another country. The credit insurance covers non-payment as a result of insolvency of the buyer or non-payment after an agreed number of months after the due date. Credit insurance also insures risk of non-payment because of an event which was outside the control of the buyer or seller (political risk cover).

Credit insurance is designed to protect manufacturers from the risks due to default in payment. It enables them to expand their business without fear or loss. Some of the losses covered under this policy are on account of:

- Insolvency - protects business against the risk of non-payment if a buyer becomes insolvent.
- Protracted Default – protects when a buyer fails to pay the receivable within a predefined period calculated from the due date of payment of the receivable.
- Political Risks - These risks cover non-payment due to Moratorium, Transfer Restriction / Inconvertibility, War, Import/Export Restriction, Natural Disaster, License Cancellation etc.

5.5.4.1 Export Credit Guarantee Corporation of India Limited (ECGC)

ECGC Ltd. (Formerly known as Export Credit Guarantee Corporation of India Ltd.) wholly owned by Government of India, was set up in 1957 with the objective of promoting exports from the country by providing credit risk insurance and related services for exports. Over the years it has designed different export credit risk insurance products to suit the requirements of Indian exporters. ECGC is essentially an export promotion organization, seeking to improve the competitiveness of the Indian exports by providing them with credit insurance covers.

The Corporation has introduced various export credit insurance schemes to meet the requirements of commercial banks extending export credit. The insurance covers enable the banks to extend timely and adequate export credit facilities to the exporters. ECGC keeps its premium rates at the optimal level.

ECGC provides:
(i) a range of insurance covers to Indian exporters against the risk of non – realization of export proceeds due to commercial or political risks
(ii) different types of credit insurance covers to banks and other financial institutions to enable them to extend credit facilities to exporters, and
(iii) Export Factoring facility for Micro, Small and Medium Enterprises (MSME) sector which is a package of financial products consisting of working capital financing, credit risk protection, maintenance of sales ledger and collection of export receivables from the buyer located in overseas country.
(Source: www.commerce.gov.in)

5.5.4.2 Role of ECGC in facilitating International Trade

The role of the ECGC is wide and also within the scope of management of credit risk. Its primary role is to provide risk insurance products which cover losses and bad debts from exports. The ECGC also provides credit insurance to financial institutions so they can provide trade-risk cover to the exporters. In addition, ECGC also offers

overseas investment insurance to the Indian companies that are entering into international joint ventures, in the form of equity or loans.

ECGC provides guidance to exporters on export related activities, including credit-rating based information for different countries. The ECGC also helps exporters arrange for export finance from financial institutions. Finally, it assists exporters with debt recovery and checking the credit worthiness of overseas customers.

5.5.5 Reinsurance (General Insurance Corporation of India Limited – GIC Re)

Insurance companies purchase Reinsurance to share and mitigate their risk. So, reinsurance occurs when different insurance companies share the risk by purchasing insurance policy from other insurers to limit their own total loss. By sharing the risk, an insurance company takes on clients whose cover would be too big for a single insurance company to handle alone. The premium paid by the insured is shared by all the insurance companies purchasing the reinsurance.

The company that first issues the policy is known as the primary insurer and the company which accepts the future liability from the primary insurer is known as the reinsurer. Primary companies 'cede' business to a reinsurer. Reinsurance can either be treaty or facultative. Treaties are agreements that cover extensive groups of policies, for example covering primary insurer's all auto business. Facultative covers specific individual, high-value risks that would not be accepted under a treaty.

General Insurance Corporation of India (Global Reinsurance Solutions – GIC Re)
(Reference : www.gicofindia.com)

In India, general insurance business was nationalized by the General Insurance Business (Nationalization) Act, 1972 (GIBNA). The Government of India took over the shares of 55 Indian insurance companies and the undertakings of 52 insurers carrying on general insurance business. General Insurance Corporation of India (GIC) was formed in pursuance of Section 9(1) of GIBNA, incorporated in 1972 under the Companies Act, 1956 as a private company limited by shares. GIC was formed for the purpose of superintending, controlling and carrying on the business of general insurance. In November 2000, GIC was re-notified as the Indian Reinsurer.

GIC Re is the only reinsurer in the domestic market, which provides reinsurance directly to the general insurer in the Indian market. GIC Re receives statutory cession of 5% on every policy subject to certain limits. GIC has started running the reinsurance programs of various insurers in SAARC countries, South East Asia, Middle East and Africa.

GIC functions within the regulations of the following Acts:

- The Companies Act, 2013
- Insurance Act, 1938
- General Insurance Business (Nationalisation) Act, 1972
- General Insurance Business (Nationalisation) Amendment Act, 2002
- Insurance Regulatory and Development Authority Act, 1999

5.5.5.1 Mandatory Provisions

The IRDAI (Reinsurance) Regulations were notified in the year 2018. These Regulations consolidated the provisions governing reinsurance business in India into one set of applicable regulations. They also introduced new requirements for both life and general reinsurance business. Some of the changes introduced by the 2018 Regulations are summarized below.

Applicability: The 2018 Regulations apply to insurance companies in India, insurance cooperative societies, legislative bodies doing insurance business and foreign reinsurance branches in India**.**

Reinsurance programs: The 2018 Regulations retain the objectives of the reinsurance program set out under the earlier regulations.

Retention policies: Every Indian insurance company who is dealing in life insurance business must now have to maintain at least 25% of the sum at risk for pure protection life insurance business portfolios and 50% for other portfolios. Separately, both Indian reinsurers and foreign reinsurance branches must retain at least 50% of their Indian business.

Maintenance of records: Indian insurance companies should submit all reinsurance contracts and a list of reinsurers in soft copy, with their respective credit rating.

Cross-border reinsurers: The definition of 'cross-border reinsurer' has been modified to mean a foreign reinsurer only, and it excludes foreign insurers. It does include parent or group companies of foreign reinsurance branches.

The 2018 Regulations serve to consolidate the existing Regulations for life and general reinsurance business in India. Filing requirements and processes have also been streamlined. The 2018 Regulations also bring about an important reform in permitting foreign reinsurance branches to compete with other Indian reinsurers for reinsurance of general insurance risks.

5.5.5.2 Concept of Ceding

An insurance company should have enough capital for paying all the future claims which are related to the issued policies. While this requirement protects the consumers, it limits the amount of business which an insurer can do. So, if the insurer can reduce its future liability of claims by transferring a part of it to another insurer, it can lower the amount of capital required to stay in good financial health to pay the claims of its policyholders. Capital freed up in this manner shall be able to support more or larger insurance policies. It also helps insurance companies maintain lower premiums for their policyholders.

A ceding company (also referred to as primary insurer) is an insurance company that passes the part of its risks to a reinsurance firm (also referred to as accepting company). Passing off risk in this manner allows the ceding company to hedge against undesired exposure to loss and to reduce their overall risk exposure and liability. This allows them to remain solvent even if they have to pay out a big insurance claim. The reinsurance company receives a premium in exchange for taking on the risk and pays the claim as and when it arises. The agreement between the primary insurer and the reinsurer is called the reinsurance contract, and it covers all terms related to the ceded risk.

5.5.6 Liability Insurance – Legal Liability Policies

Liability insurance provides protection to an individual and/or business against the risks that they may be held legally liable. Liability insurance offers protection to the insured against claims resulting from malpractice, injury, negligence and damage to people or property. The insurance company compensates the costs for which the insured party would be responsible if found legally liable.

Put simply, it protects the insured against financial loss of his actions or negligence or if his property is found to cause injury or death to a person, or damage to a person's property or if a person suffers a loss while relying on the services or advice of the insured.

A liability insurance policy is most suitable to cover the business owners, professionals and self-employed people. It covers two main financial risks –
(a) the legal cost of defending a claim, and
(b) the compensation required to be paid.

There are three forms of liability insurance:

- Public liability
- Professional indemnity
- Product liability

5.5.6.1 Public Liability

Public liability insurance covers costs from legal action if any individual or entity is found liable for injury or death of another person, economic loss, or damage of property of another person resulting from any negligence on their part.

Though liability insurance is optional it is recommended for businesses as the likelihood of being sued for negligence is very high, and costly as well. So, purchasing this policy proves prudent. For example, in public events, liability insurance is compulsory and is also checked by the licensing authority.

Irrespective of whether it is mandatory or not, many companies procure liability insurance to avoid financial risk. Most times small industries do not purchase these policies as the premium amount could be high. Further, in all cases where risk is exceptionally high, insurers either refuse to insure these liabilities or charge an excessive premium.

Public liability insurance does not cover people or establishments involved in hazardous and criminal activities.

The Public Liability Insurance Act, 1991

Hazardous industries pose risks from accidents not only to the persons employed but also to the public living in the vicinity. While the employees are protected under various laws, members of the public have to go through a long legal process for any compensation. More often, such people are from economically weaker sections of the society.

To bring some relief to the sufferings of the public due to accidents in hazardous installations, Public Liability Insurance was made mandatory and Public Liability Insurance Bill was introduced in the Parliament.

The Public Liability Insurance Act, 1991, provides for mandatory Public Liability Insurance. Under Section 4 of the Act, every owner, before starting to handle any hazardous substance, has to take Public Liability Insurance policies covering liabilities. This is meant to provide immediate relief to any person suffering injury or death or damage to property and for other incidental and connected matters.

Some of the provisions under the Act are as below:

Application for Relief: An application for relief shall be made by the victim to the Collector within 5 years of the accident. He shall also give notice to the owner and the insurer, while giving them an opportunity of being heard. The Collector shall make the award determining the amount of relief payable. The victim can approach the Court for higher compensation.

Establishment of Relief Fund: The Central Government is empowered under Section 7A of the Act to establish an Environment Relief Fund by notification in the official Gazette. This fund is utilised for the payment of relief under the awards made by the collector.

Power to Call for Information, Entry and Inspection: The Act empowers the Central Government to call for information, entry, inspection, search and seizure of the premises of the hazardous installation wherein the owner is obligated to submit all such information to the inspecting agencies.

Offences and Penalties: The Act provides for the penalties of not taking a public liability insurance policy. Furthermore, failure to comply with the directions issued with regard to regulation of handling of hazardous substances etc. is punishable with imprisonment or fine or both depending on the circumstances.

Environmental Impairment Liability (EIL)

Environmental damage refers to the injurious presence of solid, liquid, gaseous, or thermal contaminants, irritants, or pollutants on land, atmosphere or water body. Sometimes, the damage caused by the pollution can be immediate, while other times it becomes evident years after the event.

Also called pollution legal liability plan, Environmental Impairment Liability (EIL) covers pollution and environmental damage. An EIL policy covers for injury, property damage, natural resource damage, clean-up costs and others resulting from pollution emanating from a site or location. As such companies at risk for losses associated with pollution purchase such policies.

Organizations buy EIL cover because they might hold environmental risk due to their operations. Some examples would be:

- chemical companies handle substances which can go underground and poison an entire drinking water supply.
- By-products from a manufacturing company's operations can find their way through agriculture fields and water bodies leading to damage of natural resources.
- Tanning industries might dispose their waste in open plots thereby leading to mass infection and spread of disease

The liability associated with these risks is high and so companies look to transfer such risks by purchasing EIL cover.

EIL policies are written on a claims-made basis. The claim must be first reported during the policy period, and the pollution condition in the claim must have occurred after the retroactive date of the policy.

5.5.6.2 Product Liability

In general terms, law requires that every product should meet the ordinary expectations of the consumer. When a product has a defect or danger, it cannot be said to have met the ordinary expectations of the consumer.

Product liability governs the liability of manufacturers, and sellers in the distribution chain, for injury to a person or property by the consumption or use of the product sold. Product liability law is to help protect consumers from dangerous or defective products, and hold the manufacturers and sellers responsible for placing such defective products in the hands of a consumer.

Product liability insurance, therefore, covers the risk faced by the manufacturers and others in the distribution chain for third party damage, injury or harm, illness, accidental death or to a business or property by their product or service. It also covers liabilities which may arise out of packaging defects, absence of warning labels/precautions etc. which might affect the performance or quality of the product. People might also take action against the manufacturer if they believe that they have been injured by a particular product.

Product liability insurance can be taken by the product manufacturers, and all partners in the seller chain. This policy also extends to cover vendors of the manufacturers or the sellers.

The laws relating to product liability, in India, have been constantly evolving for the protection of consumers. The Courts are adopting a pro-consumer approach by awarding compensation and damages which are more punitive than compensatory in nature.

5.5.6.3 Professional Indemnities

Professional indemnity policies are designed to protect various professionals such as doctors, engineers, architects, lawyers, financial consultants etc who provide advice or service to their clients. It is designed to protect such professionals from legal costs and claims which could arise from monetary loss or damage of property after following the advice or receiving service.

Along with the business, such policies should also cover any director, partner, employee or related entity when they act within the scope of their overall duties. Such policies cover all amounts which the insured professional becomes legally liable to pay as damages to the third party. Sometimes it also provides for the defence cost of the lawyer subject to the overall limit of the indemnity selected. In all such policies, only civil liability claims are covered while any liability arising out of any criminal act or act committed in violation of any law is not covered.

In professional liability, the claim amount is unknown. So, insurers set a limit to liability to which they will bear the loss and the balance has to be borne by the person taking such a cover. The basic rate of premium for a professional indemnity policy ranges from 0.30% to 1% of the amount insured. To a large extent the premium depends on factors such as profession, experience, income limits, jurisdiction and claim experience.

5.5.6.4 Employer's Liability Insurance

Employers are responsible for the health and safety of their employees while they are at work and may be held liable for an accident arising out of the general course of

employment. For example, a worker may get injured due to the chemicals in his factory, or an employee might get food infection from the canteen food.

Employers' liability insurance enables the employers to compensate the cost of injuries, illness or fatality of their employees' on account of workplace conditions or practices, whether they are caused on site or off site. Through Employers' liability insurance, the employers not only indemnify themselves against any such unfortunate events but also save themselves from the financial losses and legal cases.

Public liability insurance is different. It covers claims made by members of the public or other businesses, but not the claims made by the employees.

Employer's Liability Act, 1938

Employer's Liability Act, 1938 was enacted for the protection of workmen at their workplaces and to safeguard their related interests. Employers' Liability Act, 1938 clearly defines the employer with respect to the workers deputed either by the contractors or by the manpower supply agencies. So, the Act comes handy when doubts are raised by the employers with regard to their liability towards the workmen, especially when they are engaged through contractors or when they are outsourced.

The Act restricts the events and the extent to which employers shall be liable to their employees occurring in the course of their employment. It abolishes the common rule that the employer is not liable if the injury is caused by the fault or negligence of a fellow employee.

The Workmen's Compensation Act, 1923

The Workmen's Compensation Act, 1923 was formed primarily to give compensations to workmen, and their dependants, in case of injury and accident (including certain occupational diseases) in the course of employment resulting in disablement or death. The Act aims to ensure that workmen have a meaningful life post-accident while performing their duty.

The Act is recognized all over India. It applies to all workmen, including casual workers, in factories, construction work, mines, circuses, plantations, transport, railways, ships and any other potentially dangerous occupations as specified in Schedule II of the Act. It is also applicable to workmen of Indian companies who are sent to work abroad. The Act is not applicable to defence personnel.

The Act offers relief to the workers who would otherwise go to court to seek compensation if they get injured during their employment. The compensation paid to a workman is in the form of a relief and social security measure provided by the Act. The Act also defines the amount to be paid depending on the intensity of the injury. For an employer to pay compensation, the injury or death suffered by the workman must be on account of an 'accident arising out of and in the course of his employment'.

The Employees State Insurance Act, 1948 (ESI)

The Employees State Insurance Act, 1948 is a beneficial and social legislation. Its aim is to provide financial backing and support to people working in factories and establishments in times of medical distress resulting in loss of wages or earning capacity. The medical situations could be sickness, maternity disorders, disability (temporary or permanent), death due to employment injury, occupational disease.

The Act is applicable to non-seasonal factories. It has since been extended to shops, hotels, restaurants, cinemas, road transport undertakings, newspaper establishments, private medical and educational institutions wherever 10, or more than 10, people are employed. However, in some states the threshold for coverage of establishments is 20 employees. With effect from January 1, 2017, the monthly wage should not exceed Rs. 21,000 for such employees.

As per provisions of the Act, the principal employers under this Act have to pay a sum of money to the Employees State Insurance Corporation (ESIC). This money is later payable by ESIC to the employees for their benefits. The contribution payable to ESIC shall comprise the employer's contribution and employee's contribution at a specified rate. At present the employee's contribution rate is 0.75% of the wages and that of the employer is 3.25% of the wages paid/payable. Employees who receive a daily average wage up to Rs.137 are exempted from paying their own contribution, but the employers will continue to contribute the employers' share for these employees.

Section 46 of the Act provides social security benefits such as medical benefit, sickness benefit, maternity benefit, disability benefit and dependents' benefit. In addition, the scheme also provides some other need based benefits to insured workers such as vocational rehabilitation, physical rehabilitation and old age medical care.

Role or Powers of Employees State Insurance Corporation (ESIC)

Under Section 2-A of the ESI Act it is mandatory for every organization meeting the requirement of the number of employees to register itself under the ESI scheme within 15 days of their registration. Once the organization gets covered under the ESI Act, it remains covered even if the number of employees reduces.

When any person joins an organization, it is compulsory for him to provide his, and his family details, to such an organization for online registration. Upon registration, a 17 digit identification number is generated by the organization using the ESIC portal. The organization has to print the identity certificate and affix a photograph provided by the employee and authenticate the certificate. The same identification number is to be used by the employee even in case of change of place or employment.

The organization has to maintain the employee's wage record, attendance sheet, books of accounts, inspection book and accident register. The organization is required to file its monthly contributions on the ESIC portal every month. Contributions are deducted and paid depending on the total wage earned by the employee. Overtime is not included when calculating the wages of an employee. If the wages of any employee exceed Rs. 21,000 per month, then he will be covered under the scheme benefit only till the end of the contribution period. Any employee who fails to pay his contribution in the given time period will have to pay an interest of 12% per annum for each day of delay on payment.

In case of an untimely death of the covered employee, due to an injury or disease contracted from the work environment, all his benefits will be paid to the nominee. In addition, funeral expenses of the deceased employee are reimbursed to the dependents/family members. The benefit shall be paid by

the bank after his case has been analyzed and approved within 21 days from the last contribution month.

A public grievances redressal system has also been set up by ESIC to help in queries or issues of the workers and employees under the ESI scheme.

The Employees Provident Funds and Miscellaneous Provisions Act, 1953

The Employees' Provident Funds & Miscellaneous Provisions Act, 1952 was brought by the government with an objective of making post-retirement provisions for the industrial workers, and their dependents in case of their death. It provides cover to workers against risks of old age, retirement, retrenchment or death. It is applicable to every establishment as specified in Schedule I of the Act and employing 20 or more persons.

The Act is administered by the Government through the Employees' Provident Fund Organization (EPFO) which works under the Ministry of Labour and Employment.

EPFO provides for the provident fund, family pension and deposit-linked insurance for the employees in factories and other establishments. Accordingly, the following three schemes are in operation under the Act:

- Employees' Provident Fund (EPF) Scheme, 1952
- Employees' Deposit Linked Insurance (EDLI) Scheme, 1976
- Employees' Pension Scheme (EPS), 1995

These schemes provide old age and survivorship benefits, long term protection and security to the employee and after his death to his family members, loans during sickness and for the purchase or construction of a dwelling during the period of his membership.

The employer and employee contribute 12% each of the employee's salary (basic + dearness allowance subject to a maximum of Rs. 15,000) to the EPF. The 12% employer's contribution is split into 3.67% for the EPF account and 8.33% for the EPS account. Apart from this, an additional 0.5% has to be paid by the employer towards EDLI.

EPFO sets a fixed interest on these contributions every year depending upon the rate which is pre-decided by the GOI along with the Central Board of Trustees. The trustees board consists of representatives from the government, the employers and the employees. The annual interest rate for the year 2019 - 2020 is 8.50 %. The interest earned is directly transferred to the EPF account of the employee account every year.

The accrued amount in the fund can be withdrawn by the nominee or legal heirs after employee's death or can be withdrawn by the employee himself upon resignation. The withdrawals are tax free subject to various provisions under the Income Tax Act.

The Maternity Benefit Act, 1961

The Maternity Benefit Act, 1961 is designed to protect the employment of a woman during the time of her maternity. It entitles her to a full-paid absence from work at the rate of her average daily wage in the three months preceding

her maternity leave. Every establishment having 10 or more employees needs to apply this Act in their workplace/establishment. The law mandates that employers must inform women in writing about the maternity benefits available under the Act, at the time of their joining the workforce.

In order to claim benefits under the Act, a woman must have been working as an employee in the establishment for at least 80 days within the last 12 months. Women having two surviving children are eligible for 26 weeks of paid leave and women having more than two children get 12 weeks of paid leave. Out of the 26 weeks, if desired, a woman can claim up to 8 weeks before the delivery. In case of a miscarriage, a woman can claim 6 weeks of paid leave with average pay from the date of miscarriage. If a woman adopts a child, then also she will get a 12-week long paid maternity leave.

The law allows women employees to work from home after the expiry of the 26 weeks' leave period if the nature of work allows and on terms that are mutually agreeable with the employer. As per the Act every establishment employing 50 or more employees also has to provide a mandatory crèche facility. As an additional protection, discharge or dismissal of the women employee by the establishment is not permissible while she is on maternity leave. In all cases of death of the pregnant employee, the maternity benefit shall be paid to the person nominated by such an employee or to her legal representative.

The Act imposes punishment/penalty if an employer does not pay maternity benefits as per the Act to an eligible woman.

The Payment of Gratuity Act, 1972

Gratuity is a voluntary payment made by the employer to the employee in recognition of his continuous, meritorious service. Gratuity comes under the Payment of Gratuity Act, 1972. The gratuity scheme is available to people working in factories, mines, oilfields, plantations, ports, railway companies and shops or establishments in which 10 or more persons are employed, or have been employed on any day of the last 12 months.

Gratuity is payable to an employee (or to a nominee in case of his death) who has rendered continuous service of 5 years or more at the time of his termination of employment, superannuation, retirement or resignation. However, completion of continuous service of 5 years is not necessary where the termination of employment is due to death or disablement due to accident or disease.

Gratuity amount depends on two factors – the last drawn salary and the number of years of service. The maximum gratuity amount that is at present tax exempt cannot exceed Rs. 20 lakhs in total from one or more employers.

The gratuity payable to an employee can be wholly forfeited if the employee has been terminated for his disorderly conduct, act of violence or moral turpitude in the course of his employment.

5.6 Motor Insurance

All vehicles running on the road have to compulsorily take motor insurance. It offers protection against bodily injuries, death, physical damage and third party liabilities arising out of accidents involving motor vehicles. Motor Insurance policies are subject to the basic principles applicable to property and liability insurance in general. The owner of the vehicle bears a legal

relationship to the vehicle whereby he stands to benefit by the safety of the vehicle, and stands to lose by any loss, damage, injury or creation of liability.

Motor insurance can be broadly classified into three heads.

Car Insurance provides coverage against accidental loss or damages to own car or to a third party. The premium amount depends on the make, the value of the car and year of manufacturing. Two-wheeler insurance provides protection for users of all kinds of two-wheelers. The two-wheeler policy has similar features as that of a car insurance. Commercial Vehicle Insurance provides protection to commercial vehicles that are used for other than personal purposes, such as for carrying goods.

5.6.1 The Motor Vehicles Act, 1988

The Motor Vehicles Act, 1988 is laid by an Act of Parliament. It regulates all aspects of the road transport vehicles. As per the Act, no motor vehicle can be used in public places unless it carries an insurance policy issued by an authorized insurer. The cover ensures the insured's liability in respect of death or bodily injury to third parties and also damage to property of third parties.

Some of the reasons for formulation of the Act are listed below:

- Concern for road safety standards, and pollution-control measures, standards for transportation of hazardous and explosive materials.
- Need for effective ways of tracking down traffic offenders.
- Stricter procedures relating to grant of driving licences and the period of validity thereof.
- Provision for issuing fitness certificates of vehicles also by the authorized testing stations.
- Provision for higher compensation in all cases of hit and run motor accidents and also in “no-fault liability”.
- Provision for compensation from the insurer to the victims of motor accidents amounting to actual liability for all classes of vehicles.
- Maintenance of State registers for driving licences and vehicle registration.
- Constitution of Road Safety Councils.
- Providing adequate compensation to victims of road accidents without going into long drawn procedure.Protecting consumers’ interest in the transport sector.
- Concern for road safety standards, transport of hazardous chemicals and pollution control.
- Delegation of greater powers to State Transport Authorities and rationalizing the role of public authorities in certain matters.

5.6.2 The Motor Vehicles (Amendment) Bill, 2019

The Motor Vehicles (Amendment) Bill, 2019, was brought about to amend the Motor Vehicles Act, 1988, and address issues related to road safety, third party insurance, vehicle’s fitness and compensation for victims of road accidents.
Main features of the Bill are:

- Increased penalties for traffic violations and stricter provisions for offences such as drunken driving, juvenile driving, driving without license, over-speeding, dangerous driving and overloading.
- Mandatory fitness testing for vehicles, removing unfit vehicles, setting standards for vehicle testing.
- Penalty for those who deliberately violate safety and environmental regulations.
- Recall of defective motor vehicles if there is a likelihood that the defect may cause a threat to the environment.

- Setting up of a National Road Safety Board to advise the government on all aspects of road safety, registration and licensing of vehicles.
- Incorporate 'Good Samaritan' guidelines for those who come forward to help road accident victims.
- Compensation for road accident victims, scheme for cashless treatment of road accident victims through prompt medical care.
- Constitution of Motor Vehicle Accident Fund by the Central government to provide compulsory insurance cover to all road users in India.

5.6.3 Motor Accident Claims Tribunal

Motor Accident Claims Tribunal was set up under the provisions of the Motor Vehicles Act, 1988. Its purpose is to provide a speedier remedy to the victims of motor vehicle related accidents. The Tribunals take away jurisdiction of the Civil Courts in all such matters which concerns the motor accidents.

The Tribunal can adjudicate upon claims for compensation when the accident, arising out of the use of a motor vehicle, involves death or bodily injury to the person, or damage to the property of the third party.

According to the Motor Vehicles Act, 1988, compensation can be claimed by the person who has sustained injury in an accident involving motor accident, or by the owner of the damaged vehicle or property, or by a nominee/heir/legal representatives of the deceased who died in the accident, or by the duly authorized agent of the injured person. There is no time limit for filing the accident claim. But, in cases of an unusual delay in filing the claims, the Tribunal might seek explanations.

Claim petition can be filed by the concerned person in that Claims Tribunal which has a jurisdiction over the area in which either the accident occurred, or where the claimant resides/carries on business, or where the defendant resides. Appeals from the Claims Tribunal lie with the High Courts. It has to be filed by the concerned person within 90 days from the date of award of the Tribunal.

5.6.4 Types of Losses

Motor insurance broadly provides two types of cover:
(A) Comprehensive cover which provides for loss or damage to the insured (own) vehicle and also provides for third party liability for (a) bodily injury and/or death, and (b) property damage.
(B) Liability cover which provides only for the third party liability for (a) bodily injury and/or death, and (b) property damage. Personal accident cover for owner/driver is also included in this cover.

5.6.4.1 Loss or damage to the Vehicle (Own Damage)

This policy provides for covers against loss or damage to the insured vehicle and/or its accessories due to:

- Fire, explosion, self-ignition, lightening
- Burglary, housebreaking, theft
- Riot, strike
- Earthquake, Flood, typhoon, hurricane, cyclone and other similar disasters
- Accidental external means
- Malicious act
- Terrorist activity
- Vehicles in transit by road, rail, waterway, lift, air or any other mode

The policy can also be extended later on to cover additional risks on payment of extra premium:

- Any damage or loss caused to the accessories fitted inside the motor vehicle
- Personal accident cover under private car policies for passengers and paid drivers
- Legal liability to employees
- Legal liability to passengers in commercial vehicles

However, some of the **policy exclusions** in this cover are:

- Wear and tear, mechanical/electrical breakdown, failures or breakages
- Damage of tyres unless the motor vehicle is itself damaged at the same time
- Any accidental loss or damage suffered under the influence of liquor or drugs

In case of an accidental damage to the motor vehicle, the policy holder should immediately inform the nearest office of the insurer. Thereafter, he is required to submit the claim form along with a copy of the Registration Certificate of the vehicle, driving license of the driver of the vehicle at the time of accident, estimate of the repairs required and other documents as mandated by the insurer. Once the initial documentation is complete, the vehicle will be surveyed by the company appointed surveyor, who shall submit his report to the company. At times, insurance companies also require that the salvage amount of the damaged parts are deposited with them after approval of the claim.

In case of a theft of the vehicle, the owner must immediately lodge a First Information Report (F.I.R) with the police and submit the Final Police Report to the insurance company as soon as it is received. Once the claim is approved by the company, the Registration Certificate of the vehicle is to be transferred in the name of the company, keys of the vehicle have to be handed over to the company, and a letter of Subrogation and Indemnity, on a stamp paper duly notarized, is also to be submitted for settling the claim.

5.6.4.2 Third Party Liability – Compulsory Insurance

Third Party Liability cover only provides indemnity to the insured, in the event of an accident caused by the use of the motor vehicle. In such a cover, the insured is liable to pay for:

- Death or injury to any person, including the occupants of the motor vehicle
- Damage of property which does not belong to the insured

In case of a third party liability, the policyholder must immediately inform the insurance company of the incidence likely to give rise to liability claim. A claim form, duly filled in, along with copies of Registration Certificate, Diving License, FIR are to be submitted to the insurance company at the earliest. If any summons is received from Court, the same should also be sent to the insurance company immediately.

5.7 Policy Document and Legal Implications

Any insurance policy is an integrated contract in the form of an Agreement between the insured and the insurer. It is a policy of assurance subject to conditions and privileges of the policy document.

A policy document is a standard, formal document which contains all the details of the insurance contract, under different sections. It lists the details of the insured (name, date of birth, address, contact details etc.), the policy schedule, key covers under the policy, including the extensions and exclusions. It clearly mentions the free-look period, the benefits under the policy plan, rights of the insured, details of the policy cover and suicide exclusion clause amongst other general provisions. It also spells out the name of the product, its UIN (unique

identification number) as listed under IRDAI. If the policy has been sold through the agency channel or an insurance agent their details are also mentioned in the policy document.

The insurance contract is legally enforceable and both the parties to the contract are bound by the terms and conditions listed in the policy document during the entire term of the policy. The policy document is issued by the insurer once the first premium has been paid by the insured. Policy document is, in fact, a bible for the insured and the insurer.

5.7.1 Proposal Form

A proposal form is the most basic document, required to be completed by the proposer at the time of applying for an insurance policy. It is a legal document which helps the insurance company evaluate all the potential risks in relation to the insurance policy being offered. The form is designed to seek all the relevant information from the proposer which then helps the insurance company in underwriting and deciding the premium amount. Insurance company, therefore, offers a policy on the basis of the proposal form.

A proposal form seeks fundamental information of the proposer and also on the subject matter of insurance. This includes the name, age, address, occupation details of the proposer. Some other important elements of information gathered through the proposal form are:

- Medical history of the life to be assured and the health status of his or her family members in case of health insurance.
- Claim history and details of previous related losses, whether insured or not.
- Other past or present related insurances for assessing the moral hazard of the proposer.
- Whether any insurance of the proposer was previously declined by any other insurers.
- Nominee details.
- Some high-value risk policies require income details of the proposer to satisfy the insurer about the proposer's ability to pay for the insurance and the need for his insurance.
- Amount of insurance cover required - it must represent the actual value of the property or the subject matter of insurance.
- A declaration stating that responses given in the proposal form are true and nothing has been concealed or misrepresented.

Every proposal form is to be signed by the proposer or by the authorized person when the proposer is not an individual. The signature has to be dated as well on the proposal form.

5.7.2 Policy Component

Once the proposer buys the insurance policy, the insurer sends him a printed copy of his policy document, along with the receipt of payment. Every policy document contains standard sections, also called components, which list out the terms and conditions, facts, statements, the do's and don'ts. The insurance regulator IRDAI and the Insurance Act, 1938 mandate provisions which need to be featured in the policy component.

All the important aspects of the insurance contract, framed in a policy, are listed in the policy document under various components. For a general insurance policy, the three crucial *components* of insurance *policies* are the premium, the *policy* limit, and the deductibles.

5.7.2.1 Heading

The heading of an insurance policy states the name of the policy, such as 'Private Car Package Policy' or 'Standard Fire and Special Perils Policy' or 'Burglary Insurance Policy' etc. The heading might vary occasionally between insurer to insurer, but mostly

standard wordings are maintained throughout the industry for the benefit and easy understanding of the policy holder. Below the heading, the UIN number of the product, as provided by IRDAI, is also mentioned compulsorily to avoid any anomaly about the product and its features.

5.7.2.2 Preamble

Preamble in an insurance policy is the declaration by the insurer. It is an introductory paragraph in a contract that identifies the type of agreement, the date on which the agreement is signed, parties to the agreement, their status (whether they are individuals or entities), and their addresses. It can be said to be a preliminary statement at the beginning of a statute, stating its purpose and explaining the reason for its enactment.

In other words, the preamble simply says that the insurers will, in return for the premium, pay the losses or claims made under the policy. Most policies have a distinct preamble, although some policies may not.

5.7.2.3 Operative Clause

The operative clause in a policy is a promissory clause. It is a promise that the insurer undertakes to pay the benefits of the policy to the insured if the reason(s) for which the policy was incepted happens while the policy is still in force. It is the single most important clause because it defines what is covered by the policy. The operative clause is framed as widely as possible. However, by way of an extension the insurer may offer covers that are wider than those mentioned in the operative clause.

5.7.2.4 Policy Schedule

A schedule of insurance is that part of an insurance contract which sets out the details specific to the policy. It is issued by the insurer as part of the policy. It provides details of the insured's policy including full description of properties covered which are in force, the period of cover against the properties described, the amount of coverage, the exclusions, the deductibles, and the payment mode and schedule.

Policy schedule is also called schedule of insurance. The purpose of a schedule of insurance is to provide clarification to the insurer and the insured about what all is covered in the policy. A schedule is not a stand-alone document from the policy wording itself and should always be read in conjunction with the policy wording.

5.7.2.5 Signatures

Every insurance policy is a legally enforceable contract. As such, a duly constituted attorney or signatory of the insurance company has to affix his signature on each page of the insurance policy document, for and on behalf of the company. The insurance company also puts its seal thereby legalizing the document. If there are any annexures or addendums to the policy document, the same have to be signed and stamped as above.

5.7.2.6 Exceptions

Exceptions are those situations, circumstances or conditions which are not covered by the insurance company in the contract. So, at the time of buying a policy, the proposer should read in detail the exclusions mentioned in the policy brochure. Exceptions are applicable to all sections of the policy. The insurer clearly states that under the policy the company shall not be liable to the Exceptions mentioned therein.

The IRDAI Act, 1999 and the Insurance Act, 1938 mandate that the prospectus of every insurance product shall clearly state the Exceptions where the company can deny claim and call the policy void.

General exceptions in a Private Car Package Policy read as:

'The Company shall not be liable under this policy in respect of
1. any accidental loss or damage and/or liability caused sustained or incurred outside the geographical area;
2. any claim arising out of any contractual liability;
3. any accidental loss or damage and/or liability directly or indirectly caused by or contributed to by or arising from contamination by radioactivity;
3. any accidental loss or damage and/or liability directly or indirectly arising out of war, invasion, hostilities etc.'

5.7.2.7 Conditions

All policy documents list down, under different sections, the terms and conditions of the policy to be followed by the policyholder. It also lists their rights and privileges as a customer of the policy. The motive is to educate the policy holder on all aspects of the product purchased by him.

By doing this, the insurer expects the policy holder to maintain his policy for the entire term in a rightful way so that there are no claim denials or the policy does not lapse for lack of information. Given below are some of the important sections covered in the insurance policy document:

- Definitions of words and phrases used in the policy document
- Benefits covered under the plan
- Claim process
- Premium payment
- Assignment and nomination
- Termination of policy
- Dispute redressal process
- Communication and notices
- Governing laws and jurisdiction
- Details of Ombudsman

Chapter 6: Various Provisions and Perspectives for Policyholders

Learning Objectives

Upon completion of this section, students should be able to:
6-1 Evaluate benefits and limitations of holding multiple policies with different insurers
6-2 Describe group insurance policies by employers and their sufficiency
6-3 Determine merits/demerits of surrendering insurance policy
6-4 Explain benefits and limitations of Keyman insurance from personal and organizational perspectives
6-5 Distinguish between Offline and Online Insurance Policies
6-6 Discuss global coverage of different life and general insurance policies

Topics

6.1 Provisions in insurance when the insurance is taken from multiple companies

Life Insurance Policies

As you experience major life changes such as buying a house, getting married, having a child, starting a business etc. that significantly impacts your financial liabilities, it makes sense to commensurately increase the life insurance cover. It involves buying additional life insurance policy or increasing the cover limit on the current policy.

If you have multiple life goals, life insurance companies offer plans for each of your goals, be it children's education, other endowment policies and deferred annuities. With a term life policy, you can buy new coverage with a term length tailored to your life event, like a policy that lasts for the length of a business loan or home loan for the number of years you plan to financially support your family and their life goals. A good way is to buy reducing term insurance which is linked to your loan balance, also called the ladder strategy. It involves buying multiple term life insurance policies with different term lengths that expire as you pay down your debts. This allows you to pay lower premiums over the lifetime of multiple policies than if you paid a single premium for the life of one higher-coverage policy.

One benefit of having policies from different and multiple insurers is to have a risk management in place apart from having competitive premium rates. If guarding against this risk is important for you, holding policies with multiple companies allows you to spread this risk across more than one insurer. However, one should avoid applying to multiple insurers at the same time to prevent complications later. It is a known fact that the purpose of insurance is not benefiting from it, but to financially restore the earlier state in case of unfortunate event of loss.

Life is irreplaceable, but everybody has a human life value. Usually a person's current income, earning capacity and other potentialities like assets would determine how much coverage one should have. A life insurance company to which an insurance is proposed will ask the details (extent of life cover and the type of policies) of all previous life insurance policies in order to determine whether the insured life has an uncovered value which can be additionally insured. A person may have liabilities the extent of which is unlimited to have a strong basis for insurance. The total coverage across all life insurance policies of an individual cannot be more than the future income to be earned by that individual. Another factor to be kept in mind by an insurer is the premium paying capacity keeping in the purview an individual current gross income, disposable income and potentiality for increase in that income.

Such restrictions of human life value however do not apply strictly to endowment plans. The current and future earning potential are dominant parameters here to assess the insured's premium bearing capacity. The life cover in with-profit policies is usually a small portion relative to premium when compared with the same metric in term life policies.

Non-life Insurance Policies

Under non-life insurance the losses incurred from a specific financial event are compensated to the insured. The physical assets (property, valuables, durables, vehicles, etc.) and the legal liabilities are usually covered under a non-life insurance policy. The amount specified in the policy is the sum insured which, during the policy period, is the insurer's maximum liability for claims. Also, the policy period of a non-life insurance plan is usually short, i.e., one year. The claim is not fully borne by the insurance company. The policyholder needs to pay a small share called deductible. If no claims are made under a general insurance policy, then the policyholder is awarded a discount called no-claim bonus.

While buying general insurance, you are required to fill proposal forms wherein the insurer asks for disclosure of any existing policy. If the policies are from two different insurers, then each of the companies need to be informed about the other policy. Insurance companies need this information as most policies come with a contribution clause which means that if the same insured person has more than one policy, all the policies will contribute in equal proportion to the sum insured in case of a claim.

If you have two indemnity policies, you have the right to choose the policy under which you want to make the claim first. If the claim amount is higher than the sum insured under the policy on which you first made the claim, you can claim the balance bill amount on the second policy. One should always remember to check the older policy first, as the waiting period and pre-existing exclusions are likely to have been completed in the older policy.

For individuals, the insured assets are usually not so large in value that one may need multiple insurers. However, if certain perils are not covered by one insurer, one may approach an insurer to cover the same. It may however be advisable to seek coverage from more than one health insurer to have better network of health facilities (hospitals) apart from the top-up provision.

For the corporate that insure manufacturing facilities, plants and machinery, warehouses, finished goods, inventory, fleet of business utilities (aircrafts, ships, road-lines and other carriers), shipments of plant and machinery and other goods, office premises with gadgets, etc. it is advisable that multiple policies be obtained with contribution limits and with specific perils covered including umbrella policy to have a proper risk management plan in place. Even insurance companies may like to participate in combination as the risk covered is large in value. The insurance companies may also seek reinsurance facility in case they take up the coverage singly.

6.2 Provisions related to employer provided and group policies – benefits/limitations

Group Life Insurance

Many a times organized employment features group insurance from the employer as part of employee benefit. There is no individual underwriting of each employee and the policy comes with an optimum premium. It is also be extended by certain employers such as factories and small manufacturers to their workers under group savings linked insurance scheme. It is necessary for such employers to provide this group insurance.

Some advantages of a group life insurance provided by the employer are:
1. **Convenience:** Getting insurance cover through work is relatively easy. The paperwork is often part of employee data available with the employer or gathered during recruitment process by the HR department.
2. **Price:** Basic cover through employment is usually free for the employee, thereby getting a small amount of cover at no cost.
3. **Acceptance:** Most basic life insurance plans through work are underwritten at a general level, so even people with medical conditions are provided cover.

Some disadvantages of group life insurance through the employer generally emanate from the insufficiency of such covers. The basic premise of group insurance is that a large number of homogeneous individuals should be covered so that a small amount of life insurance benefit can be extended in case of unfortunate death of any one or more from such group. This is the reason that the premium per individual is also small which is affordable by the employer. Some other limitations of group life insurance are:

1. **Cover is tied to employment:** If the employee leaves the job, he/she is not able to take the policy along to next employer. And if the next job does not offer group life insurance, he or she will have to buy an individual policy from the open market which would be much costlier in comparison to the group plan.
2. **Low cover amounts:** Cover amounts can be low in a group plan. It may be just a token amount when compared with the extent of liabilities left over by an employee in case of unfortunate death. Hence, it should not be solely relied upon as a sufficient coverage.

Group Health Insurance

A group or corporate health insurance policy is purchased by an employer for eligible employees of the corporate where the premium amount is borne by the employer. These plans are designed to include and exclude members as they join and leave the company. The cover may be extended to the dependents of the employee as well. The corporate may be covering its employees to protect the health of employees and toward meeting the overall risk management of the corporate. The corporate gets tax benefits as well while making the employment attractive and morally binding on employees. It is important that the details of employees and his/her dependent are provided to insurer. The insurer may additionally opt to get some employees in higher risk categories go through a medical test with the primary objective to make the business viable by loading premium, if any. However, once extended by the insurer, the benefits accrue alike at the level of each covered employee irrespective of the health status.

Group health insurance benefits the employees by way of instant query redressal, and a faster claim settlement. If not taken any health cover, such group plans cover an employee's immediate family members credibly well. Another significant advantage is that the cover begins from the first day of the policy unlike the case of individual health policies.

However, group health plans provide coverage to the employees only as long as they work in that organization. Also, the cover amount in such plans is limited and normally the employee does not have a say in increasing his coverage. In case of pre-morbidities at the level of employee, separate health plans may be obtained to cover the concerned family members at risk.

Property Insurance by Building Society

Insurance for the entire building property taken by a housing cooperative society is not a sufficient property cover for individual members of that society. A society may take property insurance to restore the skeletal structure of the building in case of permanent damage. Only a partial cover may be eligible for limited damage to the building. However, to an occupying member the damage may be comprehensive in which case the cover eligible to the building would not be of help. Further, if the cause of damage emanates from a member's premises and the damage is significant internally, the property cover to building may not be evoked at all. Also, the damage may extend to other movable property like furniture, gadgets, and other furnishing apart from the internal structure of the house which would not be covered even if the insurance to society property could be invoked.

Hence, it is in the interest of a flat owner to get sufficient homeowner's insurance that covers value to restore goods and furnishing to their original state in case of any damage to the property. Moreover, such comprehensive insurance covers also provide for rent for a significant period until the restoration/reconstruction of the premises which is not there in property cover taken by the building management.

6-3 Provision of life insurance policy surrender – merits/demerits

Surrender of insurance policy means encashing a life insurance policy before benefits are due to be paid, that is prior to the policy's due maturity. A policy acquires surrender value only when premiums for full three years have been paid to the insurer. In the case of ULIP, one can stop paying the premium and collect the surrender value after five years from the start of the policy.

Also, not all policies will acquire surrender value. Only ULIP or endowment plans which have a savings component embedded will partially return the amount invested. Pure term insurance policies do not have savings element and they do not return anything if not renewed on timely basis. Surrendering a policy may be a last resort, only when an alternative sufficient life cover has been contracted or when the premium seems too high for the benefits entailed in the policy. The surrender value comes at a steep discount. Some endowment plans also have the provision of loans in case of need of money. In case the premium is unaffordable and the required period has been completed in a policy, it can be made paid-up as well to continue life cover besides a terminal value on surviving the term.

Let us see some merits and demerits of surrendering insurance policy before its maturity.

Merits:

- Life policies are taken for long term periods say 20, 30 years and it is always advisable to discontinue those policies which come with high premiums and fancy promises either in terms of bonuses or money backs at periodic intervals. Remember it is your money given by way of premium which is returned by the insurer as a bonus or money-back.

- There is also not much sense in continuing with multiple policies having small sum assured each taken from different insurers. If you miss paying the premiums, the policy

goes into the lapsed mode and the insurer charges penalty and requires medical tests for revival.

Demerits:

- **Loss of life cover:** Surrendering a life insurance policy exposes you to the risks related to the uncertainties related to death and disablement. Continuing your policy till maturity provides continued life cover and help loved ones address financial needs at various stages of life in case of any unfortunate event.

- **Tax benefits and regular bonuses stop:** Mostly, the premiums paid towards life insurance policy is exempt from Income Tax under section 80C of the Income Tax Act. Some life insurance policies pay loyalty bonuses in the form of regular pay-outs or lump sum when the policy matures. Surrendering policies mid-way takes away the entitlement of a policyholder to these benefits.

- **Beware of Surrender Charges:** The insurer levies charges on the paid-up value of the policy at the time of its surrender, thereby reducing the total surrender value. Many a times these charges are significant and have a good impact on the surrender value.

6-4 Comparative evaluation of various life insurance policies

There are four broad categories of life insurance policies in India – term plan, endowment plan, money-back plans, and the Unit Linked Insurance Plans. In most of the term plans there is no money value on survival, while the endowment plans and the money-back plans have an embedded cash value depending on multiple factors. ULIPs are market-linked and the insured has the opportunity to encash the policy benefits after a minimum period of five years. Let us have a look at these four types of life insurance policies.

Term insurance comes at a nominal premium per lakh of sum assured depending on age and other factors of the insured. When seen from the point of view of covering large scale liabilities like a home loan, or financial goals like higher education and life-long living expenses of survivors, term insurance offers the required scalability for an affordable premium. As is in the case of liabilities, term plans are also scalable to cover the future income in case of unfortunate demise of the earner. The concept is human life value. They can be bought for long tenures of say 10, 20 or 30 years.

Other with-profit insurance policies come with a nominal life insurance cover. It is not that they do not offer the kind of large covers like term plans. The per lakh sum assured charges a premium which is almost 10-times the premium of a term plan. These policies pay the mortality charges out of the premium paid and the remaining amount after deduction of administrative charges goes into safe investments such as bonds and government securities which yield a return in the end which just nudges inflation for the period of the policy. ULIP offers an opportunity for market linked investments and can potentially return in line with the market movement within the policy term.

Endowment life insurance policies provide the combined benefit of life insurance and savings. The savings may look attractive on the back of tax benefits, if the annual premium stays within the defined range as compared to the sum assured. Such policies should be looked up to meet cash flows coinciding with specific financial goals like children's higher education, marriage or retirement. However, as these goals come with a sufficient long tenure, the idea

of investing in these policies is belied singularly from return point of view. And they do not cover life sufficiently. The fact that a sum assured may look attractive when starting an endowment plan but on maturity the effect of inflation may take all the sheen away even after counting accrued bonuses and other loyalty additions.

Money-back plans can be had to provide cashflows at regular interval of 4-5 years. They also come with high premiums. ULIP has a low-cost structure as compared with endowment and money-back policies. It has liquidity and returns aspect built into apart from tax benefits. But for a significant life cover, ULIPs can be an option to meet long term goals like retirement. They also have the flexibility of options from equity heavy to debt heavy near the goals to protect the value.

6-5 Benefits and limitations in different types of non-life insurance policies

Three broad categories under which non-life insurance policies are issued in India are – health insurance, motor insurance and property insurance. Let us have a look at the benefits and limitations individually.

Health insurance cover is taken to mitigate the financial impact of a person due to hospitalization in recovering against an ailment connected with specified morbidities, usually non-existent at the time of initial coverage, or an injury due to accident. The coverage can be widened to cover critical illnesses and accidental disability. Some key advantages of health insurance are:

- It offers financial coverage against hospitalization and medical procedures.
- One can avail cashless claim benefit ensuring that medical bills are directly settled between the insurer and the hospital.
- Health insurance premiums enjoy income tax benefits under various sections of the Income-tax Act, 1961.

Most health insurance plans also have a waiting period of up to 2-3 years for pre-existing diseases. If the person is already suffering from a health condition such as blood pressure, diabetes, thyroid, etc. at the time of purchasing a policy, any medical costs arising from these conditions will not be covered until the waiting period is over. Also, as chances of suffering from a health condition increase considerably with age, insurers make up for the increased risk by charging a higher premium.

Motor insurance policy helps in safeguarding the financial risks from driving or owning a motor vehicle in case of an accident, theft or a vehicle breakdown. They help meet third-party liability in case an injury is caused to a person or a damage is inflicted on somebody's property due to owning and operating the vehicle. Considerable sums may be involved in reinstating the vehicle condition in case of an accident. Motor insurance helps meet such expenses. It also helps you reclaim a portion of the car/bike's on-road price if your vehicle is stolen, or salvage value if the vehicle is damaged beyond repair due to accidents.

Not having a third-party motor insurance cover is a criminal offence for the owners of the vehicle. If you are caught driving without a valid third-party insurance cover, heavy fine may be imposed as per the applicable provisions under the Indian Motor Vehicle Act.

Property insurance plans insure buildings, residence or commercial, toward financials in restoring to their original state in case of damage due to specified perils. Many such plans also financially safeguard the content inside the immovable property, such as erected plant and machinery in manufacturing facilities, expensive gadgets and air-conditioning systems in commercial establishments, and furniture, fixtures, durables and valuables in house property. The covers are against the risk of fire, burglary, flood and natural calamities such as earthquakes, cyclones, etc. The property insurance policies are the best option to cover the financial costs arising due to such risks. However, you may need to buy optional additional coverage or exclusive coverage for some high-value items, or face the risk of being underinsured.

6-6 Features of health insurance and critical illness insurance - crucial difference

A health insurance plan covers hospitalization expenses, including bed/ICU charges, room rent, doctor's fee, ambulance charges and medications administered during hospitalization. The reimbursed amount is only to the extent of the expenses incurred, subject to limits, subject further to the financial coverage afforded in the policy.

On the other hand, a critical illness policy covers serious life-threatening ailments such as cancer, open heart coronary artery bypass grafting, open heart replacement/repair of valves, kidney failure, etc. which may require certain expensive surgical procedures to treat. The specific set of illnesses covered is listed in the respective health insurance policy. A good part in such plans is that one need not be hospitalized to make a claim. Once a person is diagnosed, and the situation conforms to the policy's terms and conditions, a lump sum is paid to the insured.

The following chart compares the features of these two types of health plans:

	Health insurance	**Critical illness cover**
How it works?	Reimburses the actual costs/expenses incurred due to hospitalization, subject to limits.	Pays a lump sum when diagnosed with a critical illness – as defined in the policy.
What does it cover?	Actual medical expenses incurred and billed by the hospital for treatment during hospitalization.	Provides the benefit as specified in the policy, does not impose limits of actual cost incurred or the hospitalization as condition.
Coverage Provided?	Several illnesses are taken into consideration and the coverage is widespread.	It covers only critical illnesses as listed in the policy.

6-7 Basic Health Insurance policy, top-up/super top-up, and floater policy

Generally, the basic health insurance plan covers hospitalization expenses including pre- and post-hospitalization stages, costs of medicines, doctor's fees, diagnostic tests, etc.

Regular health insurance plans come in two basic variants: Individual plans and family floaters.

Individual plans cover one individual only up to the limit of insurance purchased. They are useful if a certain member in the family is at high health risk (viz. family history or some pre-existing ailment or general health) which may require larger financial cover. Also, if more than one member is at similar high health risk, separate health insurance policies are recommended with individual sufficient sum assured. Such individual plans may become very expensive cumulatively on the family budget.

A family floater health insurance policy aims at optimizing premium costs for a family. Such a policy is especially recommended if the family is relatively young and is in good state of health. It allows a household to avail health insurance for the entire family without needing to buy separate plans for each member. Generally, husband, wife, dependent children (up to a certain age, say 25 years) and dependent parents are allowed health cover under such floater plans. The premium is optimized as a lump sum assured health cover costs are eligible during a policy year to any one or more members, presuming that not all members would need medical attention requiring hospitalization at the same time (in a policy year). However, the family floaters are recommended as good first health insurance cover especially for a young family.

If you have a health insurance policy, including a family floater, with a comparatively low sum assured, you can consider buying a top-up insurance plan. A top-up plan increases the insurance coverage over and above the existing base policy at a substantially lower cost compared with the base policy. It is highly recommended to go for a top-up plan with the same insurance company or a different insurer than increasing the sum assured in the base policy, which may involve a scalable premium. Such top-up plans naturally have a deductible limit up to which the costs are borne by the base policy. For instance, a top-up health insurance policy of Rs 20 lakh may come in force for hospitalization in excess of Rs 10 lakh which may be covered in a base policy, and only costs exceeding Rs 10 lakh are eligible to be paid from a top-up plan.

There are two types of top-up plans. Simple Top-up policy which allows the insured to make a claim that exceeds the deductible value or basic threshold limit (the sum assured of the base policy) during a single hospitalization. All claims are treated individually in this cover and multiple claims under the same policy period are not aggregated. The deductible is the limit set in the policy schedule.

There is one drawback in the top-up policy. It pays costs toward an ailment only once during the policy year. What if a recovered person develops complications again during the same policy year requiring further hospitalization and treatment? And what if another such disease strikes during the same policy year? A super top-up has answer to this problem. It pays claims for cumulative medical expenses of multiple hospitalizations within the same policy year of one or more members (in case the plan is family super top-up). Such a plan can be availed from any insurer and is not limited to the base policy insurer. In the long run, a super top-up plan is a cost-saver and offers cover for wide range of illnesses. It is especially beneficial for senior citizens who have frequent medical expenses that can be covered due to cumulative coverage.

6-8 Provisions of Keyman insurance - personal and organizational perspectives

As the name suggests, Keyman insurance is a life insurance cover taken by the employer on the life of its key employee/s. The employer is the policyholder, and pays the premiums, while the employee is the life insured. If such an employee dies during the term of the policy, the employer receives the sum assured which compensates the employer for the financial loss suffered due to the death of its key employee. Only term insurance plan can be bought under a Keyman insurance. The term of the policy is matched with the outstanding period to the retirement of the key employee.

A Keyman insurance policy is considered beneficial for the business as:

- The policy helps businesses face the financial loss incurred in case their key employee dies during the term of the policy.
- The premium paid for a Keyman insurance policy is considered a deductible business expense for tax purposes.
- If the business has availed loans on the key employee's guarantee, the death of such an employee would result in substantial liability in the hands of the business. The policy proceeds of a Keyman insurance policy can help the business meet such liabilities and restore the confidence of creditors in the business.

For the keyman covered by the business, there are no direct benefits. However, the following can be considered as positive ramifications of such an arrangement being in place:

- In addition to the life insurance, key person insurance is also available as disability coverage in case the individual is incapacitated and either not available to work for a period or no longer able to work. There are good chances that during the period of disability, employee's remuneration stays intact.
- The net proceeds of the keyman insurance policy may be utilized in compensating the family by the business owner.
- The keyman insurance policy can be assigned by a business to the retiring keyman and in such a case it will be considered as transfer, akin to a compensation to the employee and hence may be taxed in employee's hands. It depends on the provision of the policy and the jurisdiction.

There are no downsides of keyman insurance except that the premium is very high which is the combination of the sum sought to be assured (usually very high) and the medical profile and age of the keyman employee.

6-9 Provisions of Overseas Travel Insurance

Overseas medical insurance policy covers the medical expenses while the beneficiary is located or based outside India. Such policies provide indemnity for expenses incurred for medical treatment for illness, disease contracted or injury sustained during overseas travel.

Such policies cover medical expenses both as inpatient as well as outpatient for the eneficiary while in a foreign country. Some of the plans under the Overseas Mediclaim Policy are:

- Business and Holiday Travel cover for individuals
- Study Policy for students undertaking studies abroad
- Corporate Frequent Policy for the corporate sending their executives abroad

While one can travel overseas without a medical plan, it is not advisable to take risk as one could find mounting expenses if in case anything goes wrong. Also, there are countries such as Germany, Japan, Netherland, USA, etc which have mandatory overseas travel insurance for visitors, even for short visits. The perils covered in an overseas travel insurance policy are medical expenses due to illness or accident, disability or accidental death, apart from such usual and frequently occurring irritants as lost or stolen luggage, financial loss due to flight delays, flight cancellations/reschedules. Some policies include limited liability coverage as well. One important point to remember is that the domestic health insurance will not cover for medical expenses incurred when travelling abroad.

6-10 Offline versus Online Insurance Policies

We live in a digital age today and a number of insurance policy seekers look online for purchasing insurance. Some of the reasons behind the online trend are:

- Companies are able to provide online insurance policies at reduced prices since there is no agent or broker involved.
- At the time of buying policy online, people read the policy documents thoroughly, which in turn keeps them well informed of what they are about to invest in.
- Online insurance helps in comparing prices of insurance through aggregators. This makes online insurance selection process easier.
- Buying insurance online is flexible as person is able to do so from anywhere and at any time.
- Purchasing an online insurance plan allows to interact with the insurer directly through live customer assistance to regular updates on policy premiums and renewal.
- Buying an insurance policy online eliminates the chances of a fraud, because you directly get it from the company.
- Buying insurance online makes the whole process paperless and all policy details are available online.
- In the case of online insurance policies, you have access to varied customer reviews about different policies.

6-11 Global coverage of insurance policies

Life insurance policies

Life Insurance policies, while being comprehensive and detailed, have a worldwide coverage. This means that the insurer will honour the provisions of the policy irrespective of whether the insured is based within India or abroad at the time of the eventuality. Effectively, the life insurance policy remains in force when one travels. So, if a policyholder dies while travelling abroad, the nominee becomes eligible to get the benefits under the policy.

Mostly, the insurers ask for a travel questionnaire to be filled by an insurance applicant. This is to understand their risk profile. For example, insurers may decline proposals if the person is frequently travelling to high-risk zone countries. They might demand high premium if a person is travelling abroad to engage in high-risk or adventure sports. However, once the policy is issued, it is for a worldwide cover.

This also means that the existing life insurance policy in India continues when one moves abroad as long as he or she keeps up the payments and provides accurate information about

past, current or future residency/travel plans when applying for the cover. However, there may be certain exclusions that apply as per policy provisions.

When deciding whether or not to continue covering you even when abroad, your insurer will take into account a few factors, such as:

- For how long will you be abroad? This is usually not an issue if you are only going for a short period of time.
- where are you traveling? Some insurers will only cover you in certain countries and other high-risk countries are excluded.
- What will you be doing while you are abroad? If you are planning to carry out any dangerous activities, such as sky-diving, para-gliding, hot-air ballooning, water skiing, ice-skating, car racing, or other adventure sports involving a high risk to life, the insurers may refuse to cover you during your stay abroad.

Some insurers insist that you pay the premiums from an Indian bank account, and this will mean retaining your account in India. In certain cases, some insurers may also want you to have proof of India address which is still valid.

For raising the claim, all the documentation, including claim form, death certificate, and other certificates from authorities, will have to be submitted with the insurer in India. The policy sum is also payable only in India.

Remittance of bonus, maturity proceeds, surrender value or claims proceeds in respect of Rupee policies, issued to foreign nationals who are not permanent residents in India, may be paid in Indian Rupees or may be remitted abroad, if the claimant so desires. For example, the NRI plans of a certain life insurer provide:

- Remittance of bonus, maturity proceeds, surrender value or claims proceeds to be made in Indian Rupees.
- If the premium is paid in foreign currency, the remittance will be permitted only in proportion to the premium paid in the foreign currency.

General and other non-life insurance policies

Health and Travel Insurance

To have a safe and worry-free travel, holiday or extended stay in a foreign country, it is important that the traveller be adequately insured with a visitor insurance policy plan which includes accident and sickness coverage with international travel insurance protection from a health insurance provider.

Visitors insurance plan offers the tourist with medical coverage protection during travel abroad i.e. outside the home country of residence. In general, such a policy covers the following:

- Medical expenses for injury or sickness
- Emergency medical and health expenses
- Inpatient/outpatient surgery charges
- Prescription drugs and medication costs
- Emergency medical evacuation/ reunion
- Flight accident or Common carrier accidental coverage
- Trip Cancellation and travel interruption benefits

Marine Cargo Insurance

Marine Cargo business involves international transit and the shipment is exposed to various risks from origin to the destination. The domestic movement or importing and exporting of goods can expose the seller/consignor or the buyer/consignee to huge financial losses in case shipment is damaged or lost in transit. It is crucial that the shipment is protected from various possible perils like fire, lightening, collision between two carriers, overturning of the carrier, etc. This type of insurance policy can be taken by sellers, buyers, import/export merchants, contractors, banks or anyone who has an insurable interest in it. Generally, it is the responsibility of the sellers to purchase such insurance.

It may be legal requirement as well as the export/import marine insurance fulfils the obligation under letter of credit required by a bank. The insurance may be demanded at the port by some countries during import operations in order to complete import procedures. International cargo insurance takes the responsibility to expedite the release of cargo following the general average which is an internationally accepted principle.

Reinsurance - the backbone of insurance

Reinsurance helps spread the risk of loss more widely across companies and borders. It helps the insurance businesses who pass on the excess risk to reinsurers at affordable costs. This in turn helps the insured as well in the form of reduced premium.

Reinsurance is a global business. It helps increasing the risk capacity of insurers and hence the businesses across the world. It primarily enables the insurance companies to restrict the loss to their balance sheets and thus helps them to stay solvent. In doing so, insurance companies are able to honour all the claims related to a particular risk.

Reinsurance fulfils to primary insurance the same function as primary insurance does to its customers. It provides an essential service to insurance companies in spreading risk, reducing uncertainty and smoothing costs. Reinsurance is an integral part of worldwide insurance business. The largest risks that of catastrophic events cannot be adequately covered by the insurance industry within one national jurisdiction or even within one continent. For example, large conventions such as international sporting events like Olympics and various World Cup events have tens of billions of dollars at stake. They take place in a certain jurisdiction. Although the insurer of that jurisdiction may be capable of bearing the risk out of such an event, the local economy does not gain upon the contingent event taking place. It is imminent that such risks should be reinsured at a global level.