HEALTH INSURANCE

INTRODUCTION TO HEALTH INSURANCE

What is Healthcare

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

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

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

Evolution of Health Insurance in India

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

a) Employees' State Insurance Scheme

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

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

All workers earning wages up to Rs. 15,000 are covered under the contributory scheme wherein employee and employer contribute 1.75% and
4.75% of pay roll respectively; state governments contribute 12.5% of the medical expenses.

The benefits covered include:

a) Free comprehensive healthcare at ESIS facilities
b) Maternity benefit
c) Disability benefit
d) Cash compensation for loss of wages due to sickness and survivorship and
a) Funeral expenses in case of death of worker

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

b) Central Government Health Scheme

The ESIS was soon followed by the Central Government Health Scheme (CGHS), which was introduced in 1954 for the central government employees including pensioners and their family members working in civilian jobs. It aims to provide comprehensive medical care to employees and their families and is partly funded by the employees and largely by the employer (central government).

The services are provided through CGHS's own dispensaries, polyclinics and empanelled private hospitals.
It covers all systems of medicine, emergency services in allopathic system, free drugs, pathology and radiology, domiciliary visits to seriously ill patients, specialist consultations etc.
The contribution from employees is quite nominal though progressively linked to salary scale - Rs.15 per month to Rs.150 per month.
In 2010, CGHS had a membership base of over 800,000 families representing over 3 million beneficiaries.

a) Commercial health insurance

Commercial health insurance was offered by some of the non-life insurers before as well as after nationalisation of insurance industry. But, as it was mostly loss making for the insurers, in the beginning, it was largely available for corporate clients only and that too for a limited extent.
In 1986, the first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies (these were then the subsidiaries of the General Insurance Corporation of India). This product, **Mediclaim** was introduced to provide coverage for the hospitalisation expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc. It underwent several rounds of revisions as the market evolved, the last being in 2012.

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

A. INFRASTRUCTURE:

1. Public health sector

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

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

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

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

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

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

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

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

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

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

2. Private sector providers

India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary. These range from voluntary, not-for-profit organisations and individuals to for-profit corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks). In India nearly 77% of the allopathic (MBBS and above) doctors are

practicing in the private sector. Private health expenditure accounts for more than 75% of all health spending in India. The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level.

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

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

INSURANCE PROVIDERS:

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

INTERMEDIARIES:

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

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

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

3. **Third Party Administrators** are a new type of service providers who came into business since 2001. They are not authorized to sell insurance but provide administrative services to insurance companies. Once a health insurance policy is sold, the details of the insured persons are shared with a appointed TPA who then prepares the data base and issues health cards to the insured persons. Such health cards enable the insured person to avail cashless medical facilities (treatment without having to pay cash immediately) at hospitals and clinics. Even if the insured person does not use cashless facility, he can pay the bills and seek reimbursement from the appointed TPA. TPAs are funded by the insurance companies for their respective claims and are remunerated by them by way of fees which are a percentage of the premium.

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

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

OTHERS IMPORTANT ORGANIZATIONS

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

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

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

3. **Insurance Information Bureau of India** was promoted in year 2009 by IRDA and is a registered society with a governing council of 20 members mostly from the insurance sector. It collects analyses and creates various sector-level reports for the insurance sector to enable data-based and scientific decision making including pricing and framing of business strategies. It also provides key inputs to the Regulator and the Government to assist them in policymaking. The Bureau has generated many reports, both periodic and one-time, for the benefit of the industry.IIB handles the Central Index Server which acts as a nodal point between different Insurance Repositories and helps in de-duplication of demat accounts at the stage of creation of a new account. The Central Index Server also acts as an exchange for transmission/routing of information pertaining to transactions on each policy between an insurer and the insurance repository.

4. **Educational institutions** such as Insurance Institute of India and National Insurance Academy which provide a wide variety of insurance and management related training and a host of private training institutes which provide training to would-be agents
5. **Medical Practitioners** also assist insurance companies and TPAs in assessing health insurance risks of prospective clients during acceptance of risks and also advise insurance companies in case of difficult claims.

6. **Legal entities** such as the Insurance Ombudsman, Consumer courts as well as civil courts also play a role in the health insurance market when it comes to redressal of consumer grievances.

INSURANCE DOCUMENTATION

In the insurance industry, we deal with a large number of forms, documents etc. This chapter takes us through the various documents and their importance in an insurance contract. It also gives an insight to the exact nature of each form, how to fill it and the reasons for calling specific information.

1. Proposal forms
2. Acceptance of the proposal (underwriting)
3. Prospectus
4. Premium receipt
5. Policy Document
6. Conditions and Warranties
7. Endorsements
8. Interpretation of policies
9. Renewal notice
10. Anti-Money Laundering and 'Know Your Customer Guidelines

Medical Questionnaire

In case of adverse medical history in the proposal form, the insured person has to complete a detailed questionnaire relating to diseases such as Diabetes, Hypertension, Chest pain or Coronary Insufficiency or Myocardial Infarction.

These have to be supported by a form completed by a consulting physician. This form is scrutinised by company's panel doctor, based on whose opinion, acceptance, exclusion, etc. are decided.

IRDAI has stipulated that a copy of the proposal form and the annexures thereof, have to be attached to the policy document and the same should be sent to the insured for his records.

2. Role of intermediary

The intermediary has a responsibility towards both parties i.e. insured and insurer

An agent or a broker, who acts as the intermediary between the insurance company and the insured has the responsibility to ensure all material information about the risk is provided by the insured to insurer. IRDAI regulation provides that intermediary has responsibility towards the client.

Duty of an intermediary towards prospect (client)

IRDAI regulation states that "An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest

Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect in a fair manner.

Where, for any reason, the proposal and other connected papers are not filled by the customer, a certificate may be incorporated at the end of proposal form from the customer that the contents of the form and documents have been fully explained to him and that he has fully understood the importance of the proposed contract.

Underwriting and processing of proposals

As per IRDAI guidelines, the insurer has to process the proposal within 15 days' time. The agent is expected to keep track of these timelines, follow up internally and communicate with the prospect / insured as and when required by way of customer service. This entire process of scrutinizing the proposal and deciding about acceptance is known as underwriting.

Premium receipt

When the premium is paid by the customer to the insurer towards premium, the insurer is bound to issue a receipt. A receipt is also to be issued in case any premium is paid in advance.

Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance.

1. **Payment of Premium in Advance (Section 64 VB of Insurance Act, 1938)**
   As per Insurance Act, **premium is to be paid in advance, before the start of the insurance cover.** This is an important provision, which ensures that only when the premium is received by the insurance company, a valid insurance contract can be completed and the risk can be assumed by the insurance company. This section is a special feature of non-life insurance industry in India.

a) Section 64 VB of the Insurance Act-1938 provides that no insurer shall assume any risk unless and until the premium is received in advance or is guaranteed to be paid or a deposit is made in advance in the prescribed manner

b) Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with or dispatch by post to the insurer the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.

c) It is also provided that the risk may be assumed only from the date on which the premium has been paid in cash or by cheque.

d) Where the premium is tendered by postal or money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked or the cheque is as the case may be.

e) Any refund of premium which may become due to an insured on account of the cancellation of policy or alteration in its terms and conditions or otherwise, shall be paid by the insurer directly to the insured by a crossed or order cheque or by postal / money order and a proper receipt shall be obtained by the insurer from the insured. It is the practice now a days to credit the amount directly to the Insured's bank account. Such refund shall in no case be credited to the account of the agent.

2. Method of payment of premium

The premium to be paid by any person proposing to take an insurance policy or by the policyholder to an insurer may be made in any one or more of the following methods:

a) Cash
b) Any recognised banking negotiable instrument such as cheques, demand drafts, pay order, banker's cheques drawn on any schedule bank in India;
c) Postal money order;
d) Credit or debit cards;
e) Bank guarantee or cash deposit;
f) Internet;
g) E-transfer
h) Direct credits via standing instruction of proposer or the policyholder or the life insured through bank transfers;
i) Any other method or payment as may be approved by the Authority from time to time;

As per IRDAI Regulations, in case the proposer / policyholder opts for premium payment through net banking or credit / debit card, the payment must be made only through net banking account or credit / debit card issued in the name of such proposer / policyholder.

Policy Document

The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899.
IRDAI Regulations for protecting policy holder's interest specified what A health insurance policy should contain:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter
b) Full description of the persons or interest insured
c) The sum insured under the policy person and/or peril wise
d) Period of insurance
e) Perils covered and exclusions
f) Any excess / deductible applicable
g) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium
h) Policy terms, conditions and warranties
i) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy
j) The obligations of the insured in relation to the subject-matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances
k) Any special conditions
l) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured
m) The address of the insurer to which all communications in respect of the policy should be sent
n) The details of the riders, if any
o) Details of grievance redressal mechanism and address of ombudsman

Interpretation of policies

Contracts of insurance are expressed in writing and the insurance policy wordings are drafted by insurers. These policies have to be interpreted according to certain well-defined rules of construction or interpretation which have been established by various courts. **The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself.** If the policy is issued in an ambiguous manner, it will be interpreted by the courts in favour of the insured and against the insurer on the general principle that the policy was drafted by the insurer.

Policy wordings are understood and interpreted as per the following rules:

a) An express or written condition overrides an implied condition except where there is inconsistency in doing so.

b) In the event of a contradiction in terms between the standard printed policy form and the typed or handwritten parts, the typed or handwritten part is deemed to express the intention of the parties in the particular contract, and their meaning will overrule those of the original printed words.

c) If an endorsement contradicts other parts of the contract the meaning of the endorsement will prevail as it is the later document.

d) Clauses in italics over-ride the ordinary printed wording where they are inconsistent.

e) Clauses printed or typed in the margin of the policy are to be given more importance than the wording within the body of the policy.

f) Clauses attached or pasted to the policy override both marginal clauses and the clauses in the body of the policy.

g) Printed wording is over-ridden by typewritten wording or wording impressed by an inked rubber stamp.

h) Handwriting takes precedence over typed or stamped wording.

i) Finally, the ordinary rules of grammar and punctuation are applied if there is any ambiguity or lack of clarity.

Renewal Notice

Most of the non-life insurance policies are issued on annual basis.

There is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date. However, as a matter of courtesy and healthy business practice, insurers issue a renewal notice in advance of the date of expiry, inviting renewal of the policy. The notice shows all the relevant particulars of the policy such as sum insured, the annual premium, etc. It is also the practice to include a note advising the insured that he should intimate any material alterations in the risk.

The insured's attention is also to be invited to the statutory provision that no risk can be assumed unless the premium is paid in advance.

Anti-Money Laundering and Know Your Customer Guidelines

Criminals obtain funds through their illegal activities but seek to pass it on as legal money by a process called money laundering.

Money Laundering is the process by which criminals transfer funds to conceal the true origin and ownership of the proceeds of criminal activities. By this process, money can lose its criminal identity and appear valid.

Criminals attempt to use financial services, including banks and insurance, to launder their money. They make transactions by using false identities, for example, by purchasing some form of insurance and then managing to withdraw that money and then disappearing once their purpose is served.

Steps to prevent such attempts at money laundering have been receiving efforts at government levels world-wide, including India.

The legislation of Prevention of Money Laundering Act was enacted by the government in 2002. The Anti-Money Laundering guidelines issued by IRDAI soon after have indicated suitable measures to determine the true identity of customers requesting for insurance services, reporting of suspicious transactions and proper record keeping of cases involving or suspected of involving money laundering.

According to the Know Your Customer guidelines, every customer needs to be properly identified by collection of the following documents:

1. Address verification
2. Recent photograph
3. Financial status
4. Purpose of insurance contract

The agent is therefore required to collect documents at the time of bringing in business to establish the identity of customers:

1. In case of Individuals - Collect full name, address, contact numbers of insured with ID and address proof, PAN number and full bank details for NEFT purposes
2. In case of corporates - collect Certificate of Incorporation, Memorandum and Articles of Association, Power of Attorney to transact the business, copy of PAN card
3. In case of Partnership firms - Collect Registration certificate (if registered), Partnership deed, Power of Attorney granted to a partner or an employee of the firm to transact business on its behalf, Proof of identity of such person
4. In case of Trusts and foundations - similar to that of partnership

HEALTH INSURANCE PRODUCTS

Introduction to health insurance products

The Health Insurance Regulations of IRDA define health cover as follows
"Health insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

Health insurance products available in the Indian market are mostly in the nature of **hospitalization products.** These products cover the expenses incurred by an individual during hospitalization. Again, these types of expenses are very high and mostly beyond the reach of the common man due to increasing cost of healthcare, surgical procedures, new and more expensive technology coming in the market and cost of newer generation of medicines. In fact, it is becoming very difficult for an individual even if he is financially sound to bear such high expenses without any health insurance.

Therefore, health insurance is important mainly for two reasons:

- **Providing financial assistance to pay for medical facilities** in case of any illness.
- **Preserving the savings of an individual** which may otherwise be wiped out due to illness.

The first retail health insurance product covering hospitalization costs Mediclaim - was introduced by the 4 public sector insurers in 1986. These companies also introduced a couple of other covers like Bhavishya Arogya Policy covering proposers at a young age for their post-retirement medical costs, the Overseas Mediclaim policy offering travel insurance and Jana Arogya Bima policy for the poorer people.

Broad classification of health insurance products

Whatever be the product design, health insurance products can be broadly classified into 3 categories:

a) Indemnity covers

These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.

b) Fixed benefit covers

Also called as 'hospital cash', these products pay for a fixed sum per day for the period of hospitalization. Some products also have a fixed graded surgery benefit incorporated in the product.

c) Critical illness covers

This is a fixed benefit plan for payout on occurrence of a pre-defined critical illness like heart attack, stroke, cancer etc.

The world over health and disability insurance go together but in India, **ersonal accident cover** has traditionally been sold independent of health insurance.
Also health insurance usually does not include expenses incurred whilst outside India. For this purpose, another product - **overseas health insurance or travel insurance** - needs to be purchased. Only in recent times, a few high end health insurance products of private insurers include overseas insurance cover as part of regular health insurance cover, subject to certain terms and conditions.

A regular hospitalization indemnity policy covers expenses only if the duration of stay in hospital is for 24 hours or more. However with advancements in medical technologies, treatment procedures for many surgeries do not require hospitalization. Now as daycare procedures, they can be conducted at specialized daycare centers or hospitals as the case may be. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under daycare surgeries and the list is ever growing. These are also covered under the policy.

Coverage of outpatient expenses is still very limited in India, with very few such products offering OPD covers. However there are some plans that cover treatment as outpatient and also related health care expenses associated with doctor visits, regular medical tests, dental and pharmacy costs.

DOMICILIARY HOSPITALIZATION
Although this benefit is not commonly used by policyholders, an individual health policy also has a provision to take care of expenses incurred for medical treatment taken at home without being admitted to a hospital. However, the condition is that though the illness requires attention at a hospital, the condition of the patient is such that he cannot be moved to a hospital or there is lack of accommodation in hospitals.

COMMON EXCLUSIONS
1. Pre-existing diseases

   This is almost always excluded under individual health plans since otherwise it would mean covering a certainty and poses a high risk to the insurer. One of the important disclosures required at the time of taking a health policy is regarding previous history of ailments / injuries of each insured person covered. This will enable the insurer to decide on accepting the proposal for insurance.
   The exclusion is: Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his / her first policy with the company.
2. Weight control programs/ supplies/ services
3. Cost of spectacles/ contact lenses/ hearing aids etc.
4. Dental treatment expenses that do not require hospitalisation
5. Hormone replacement
6. Home visit charges
7. Infertility/ subfertility/ assisted conception procedure
8. Obesity (including morbid obesity) treatment
9. Psychiatric & psychosomatic disorders
10. Corrective surgery for refractive error
11. Treatment of sexually transmitted diseases
12. Donor screening charges
13. Admission/registration charges

14. Hospitalisation for evaluation/ diagnostic purpose
15. Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed
16. Any expenses when the patient is diagnosed with retro virus and/or suffering from HIV/ AIDS etc. is detected directly or indirectly
17. Stem cell implantation/ surgery and storage
18. War and nuclear related causes
19. All non-medical items such as registration charges, admission fees, telephone, television charges, toiletries, etc.
20. A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident

Waiting periods: This is applicable for diseases for which typically treatment can be delayed and planned. Depending on the product, waiting periods of one / two / four years apply for diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout and Rheumatism, Calculus Diseases, gout and rheumatism, age related osteoarthritis, osteoporosis

COVERAGE OPTIONS AVAILABLE

i. **Individual coverage**
An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc.

ii. **Family floater**
In the variant known as a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Sub limits and Disease specific capping

Some of the products have disease specific capping e.g. cataract. A few also have sub limits on room rent linked to sum insured e.g. per day room rent restricted to 1% of sum insured and ICU charges to 2% of sum insured. As expenses under other heads such as ICU charges, OT charges and even surgeon's fees are linked to the type of room opted for, room rent capping helps in restricting expenses under other heads also and hence the overall hospitalization expenses.

Co-payment (popularly called Co-pay)

A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Deductible

Deductible is a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and

for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Coverage of pre-existing diseases
In view of regulatory requirement, pre-existing diseases which were excluded earlier are specifically mentioned with a waiting period of four years. Few high end products by some insurance companies have reduced the period to 2 and 3 years

Renewability
Lifelong renewability was introduced by few insurers. Now, this has been made compulsory by IRDAI for all policies.

Zone wise premium

Normally, the premium would depend on the age of the insured person and the sum insured selected. Premium differential has been introduced in certain zones with higher claims cost e.g. Delhi and Mumbai form part of highest premium zone for certain products by some insurers.

Coverage for Day care procedure

Advancement of medical science has seen inclusion of large number of procedures under day care category. Earlier only seven procedures were specifically mentioned under daycare - Cataract, D and C, Dialysis, Chemotherapy, Radiotherapy, Lithotripsy and Tonsillectomy. Now, more than 150 procedures are covered and the list keeps growing.

Cost of pre policy check up

Cost of medical examination was earlier borne by prospective clients. Now insurer reimburses the cost, provided the proposal is accepted for underwriting, the reimbursement varying from 50% to 100%. Now this has also been mandated by IRDAI that insurer would bear at least 50% of health checkup expenses.

Duration of pre and post hospital cover
Duration of pre and post hospital coverage is extended to 60 days and 90 days by most insurers especially in their high end product. Few insurers have also capped these expenses linked to certain percentage of claim amount, subject to a maximum limit.

Add on covers

Various new additional covers called Add-on covers have been introduced by some of the insurers. Some of them are:

- **Maternity cover:** Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.

- **Critical illness cover:** Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.
- **Reinstatement of sum insured:** After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.
- **Coverage for AYUSH - Ayurvedic - Yoga - Unani - Siddha - Homeopath:** Few policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

Top-up covers or high deductible insurance plans

A top-up cover is also known as a high deductible policy. Most people in the international markets buy top-up covers in addition to high co-pay policies or uncovered diseases or treatment. However in India, the key reason for introduction of top-up cover initially seems to be lack of high sum insured products, though the same is no longer the case. The maximum amount of cover under a health policy remained at Rs 5,00,000 for a very long time. Anyone wanting a higher cover was forced to buy two policies paying double the premium. This led to the development of the Top-Up policies by insurers, which offers cover for high sums insured over and above a specified amount (called threshold).

Package policies

Package or umbrella covers give, under a single document, a combination of covers.

For instance in other classes of business, there are covers such as Householder's Policy, Shopkeeper's Policy, Office Package Policy etc. that, under one policy, seek to cover various physical assets including buildings, contents etc. Such policies may also include certain personal lines or liability covers.
Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

Personal Accident and disability cover

Personal Accident (PA) Cover provides compensation due to death and disability in the event of unforeseen accident. Often these policies provide some form of medical cover along with the accident benefit.
In a PA policy, while the death benefit is payment of 100% of the sum insured, in the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability to weekly compensation for temporary disablement.

Types of disability covered

Types of disability which are normally covered under the policy are:

i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,
ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.

iii. Temporary total disability (TTD): means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

The client has choice to select only death cover or death plus permanent disablement of Or Death plus permanent disablement and also temporary total disablement

2. **Sum insured**

Sums insured for PA policies are usually decided on the basis of gross monthly income. Typically, it is 60 times of the gross monthly income. However, some insurers also offer on fixed plan basis without considering the income level. In such policies sum insured for each section of cover varies as per the plan opted.

3. **Benefit plan**

Being a benefit plan, PA policies do not attract contribution. Thus, if a person has more than one policy with different insurers, in the event of accidental death, PTD or PPD, claims would be paid under all the policies.

4. **Scope of cover**

These policies are often extended to cover medical expenses, which reimburses the hospitalization and other medical costs incurred following the accident. Today we have health policies which are issued to cover medical/ hospitalization expenses incurred consequent to an accident. Such policies do not cover diseases and their treatment and instead cover only accident related medical costs.

Overseas travel insurance

1. Need for the policy

An Indian citizen travelling outside India for business, holidays or studies is exposed to the risk of accident, injury and sickness during his stay overseas. The cost of medical care, especially in countries such as USA and Canada, is very high and could cause major financial problems if a person travelling to these countries were to meet with an unfortunate accident/ illness. To protect against such unfortunate events, travel policies or overseas health and accident policies are available.

2. Scope of coverage

Such policies are primarily meant for accident and sickness benefits, but most products available in the market package a range of covers within one product. The covers offered are:

i. Accidental death / disability
ii. Medical expenses due to illness / accident
iii. iii. Loss of checked in baggage
iv. Delay in arrival of checked in baggage
v. Loss of passport and documents
vi. Third party liability for property / personal damages
vii. vii. Cancellation of trips
viii. Hijack cover

3. Types of plans

The popular policies are the Business and Holiday Plans, the Study Plans and the Employment Plans.

4. Who can provide this insurance

Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.

5. Who can take the policy

An Indian citizen travelling abroad on business, holiday or for studies can avail this policy. Employees of Indian employers sent on contracts abroad can also be covered.

6. Sum insured and premiums

The cover is granted in US Dollars and generally varies from USD 100,000 to USD 500,000. For the section covering medical expenses evacuation, repariation, which is the main section. For other sections the S.I. is lower, expect for the liability cover. Premiums can be paid in Indian rupees except in the case of the employment plan where premium has to be paid in dollars. The plans are usually of two types:

- ✓ World-wide excluding USA / Canada
- ✓ World-wide including USA / Canada

Some products provide for cover in Asian countries only, Schengen countries only etc.

HEALTH INSURANCE CLAIMS

Claims management in insurance

It is very well understood that insurance is a **'promise'** and the policy is a **'witness'** to that promise. The occurrence of an insured event leading to a claim under the policy is the true test of that promise. How well an insurer performs is evaluated by how well it keeps its claims promises. One of the key rating factors in insurance is the claims paying ability of the insurance company.

Role of claims management in insurance company

As per industry data- "the health insurance loss ratio of various insurers ranges from 65% to above 120%, with major part of the market operating at above 100% loss ratio". Most companies are making losses in health insurance business.

This means that there is a great need to adopt sound underwriting practices and efficient management of claims to bring better results to the company and the policyholders

Management of health insurance claims

Challenges in health insurance

It is important to understand the peculiar features of the health insurance portfolio in depth so that health claims can be effectively managed. These are:

a) Majority of the policies are for hospitalization indemnity where the subject matter covered is a human being. This brings forth emotional issues that are not normally faced in other classes of insurance.

b) India presents very peculiar patterns of illnesses, approach to treatment and follow up. These result in some people being excessively cautious with some others being unworried about their illness and treatment.

c) Health insurance can be purchased by an individual, a group such as a corporate organization or through a retail selling channel like a bank. This results in the product the customer at the other.

d) Health insurance depends on the act of being hospitalized, to trigger a claim under the policy. However, there is great difference in the availability, specialization, treatment methods, billing patterns and charges of all health service providers whether doctors, surgeons or hospitals which make it very difficult to assess claims.

e) The discipline of healthcare is the fastest developing one. New diseases and conditions keep occurring resulting in development of new treatment methods. Examples of this are key-hole surgeries, laser treatments, etc. This makes health insurance more technical and the skills to handle the insurance claims for such procedure needs constant improvement.

b) More than all these factors, the fact that a human body cannot be standardized adds a completely new dimension. Two people could respond differently to the same treatment for the same illness or require different treatments or varying periods of hospitalization.

Claim process in health insurance

A claim may be serviced either by the insurance company itself or through the services of a Third Party Administrator (TPA) authorized by the insurance company.

From the time a claim is made known to the insurer / TPA to the time the payment is made as per the policy terms, the health claim passes through a set of well-defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form the major part of health insurance business.

The general process and supporting documents for a claim under fixed benefit product or critical illness or daily cash product etc. would be quite similar, except for the fact that such products may not come with cashless facility.

The claim under an indemnity policy could be a

a) Cashless claim

The customer does not pay the expenses at the time of admission or treatment. The network hospital provides the services based on a pre-approval from the insurer/TPA and later submits the documents to the insurer/TPA for settlement of the claim.

b) Reimbursement claim

The customer pays the hospital from his own resources and then files his claim with Insurer/TPA for payment of the admissible claim.

In both cases, the basic steps remain the same.

1) Intimation
2) Registration
3) Verification of documents
4) Capturing the billing information
5) Coding of claims
6) Processing of claim
- **i) The member hospitalized must be covered under the insurance policy**
- **ii) Admission of the patient within the period of insurance**
- **iii) Hospital definition**
- **iv) hospitalization**
- **v) Day-care treatments**
- **vi) OPD**
- **vii) Treatment procedure/line of treatment**
- **viii) Pre-existing illnesses**
- **ix) Initial waiting period**
- **x) Exclusions**
- **xi) Compliance with conditions with respect to the claims**

7) Arriving at the final claim payable
- **i) Sum insured available for the member under the policy**
- **ii) Balance sum insured available under the policy for the member after taking into account any claim made already**
- **iii) Sub-Limits**
- **iv) Check for any limits specific to illness**
- **v) Check whether entitled or not to cumulative bonus**
- **vi) Other expenses covered with limitation**
- **vii) Co-payment**

8) Payment of claim
- i) **Management of deficiency of documents / additional information required**

9) Denial claims
10) Suspect claims for more detailed investigation
- **i) Impersonation**
- **ii) Fabrication of documents**
- **iii) Inflation of expenses**
- **iv) Outpatient treatment converted to in-patient / hospitalization**

11) **Cashless settlement process by TPA**

Documentation in health insurance claims

Health insurance claims require a range of documents for processing, as explained earlier. Each document is expected to assist in answering the two key questions - admissibility (Is it payable?) and extent of claim (how much?).
This section explains the need for and content of each of the documents required to be submitted by the customers:

- **Discharge summary**
- **Investigation reports**
- **Consolidated and detailed bills:**
- **Receipt for payment**
- **Claim form**
- **Identity proof**
- **Documents contingent to specific claims**

Claims reserving

This refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims. While this looks very simple, the process of reserving requires enormous care - any mistake in reserving affects the insurer's profits and solvency margin calculation.

GENERAL SECTION

Elements of insurance

We have seen that the process of insurance has four elements

- Asset
- Risk
- Risk pooling
- Insurance contract

Let us now look at the various elements of the insurance process in some detail.

1. **Asset**

An asset may be defined as 'anything that confers some benefit and has an economic value to its owner'

Economic value

Serving needs

2 Risk

The second element in the process of insurance is the concept of risk. We shall define risk as the **chance of a loss**. Risk thus refers to the likely loss or damage that can arise on account of happening of an event. We do not usually expect our house to burn down or our car to have an accident. Yet it can happen.

Examples of risks are the possibility of economic loss arising from the burning of a house or a burglary or an accident which results in the loss of a limb.

This has two implications.

i. **Firstly,** it means that that the loss may or may not happen. The chance or likelihood of loss can be expressed mathematically. Risk always implies a probability. Its value always lies between 0 and 1, where 0 represents certainty that a loss will not happen while 1 represents certainty that it will happen
ii. **Secondly,** the event, whose occurrence actually leads to the loss, is known as a **peril**. It is the cause of the loss

3. **Risk pooling**

The third element in insurance is a mathematical principle that makes insurance possible. It is known as the principle of risk pooling.

4. The insurance contract

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

Legal aspects of an insurance contract

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

We have already seen that one of the elements of insurance is that it involves a contract between insurer and insured.

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

2. **Elements of a valid contract**

The elements of a valid contract are:

a) **Offer and acceptance**:

Usually, the offer is made by the proposer, and acceptance is made by the insurer.

b) **Consideration**

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

c) **Agreement between the parties**

Both the parties should agree to the same thing in the same sense.

d) **Capacity of the parties**

Both the parties to the contract must be legally competent to enter into the contract. For example, minors cannot enter into insurance contracts.

e) **Legality**

The object of the contract must be legal, for example, no insurance can be had for smuggled goods.

The following cannot be an element of Insurance contract

i. **Coercion**

Involves pressure applied through criminal means.

ii. **Undue influence**

When a person, who is able to dominate another, uses her position, influence or power to obtain undue advantage.

iii. **Fraud**

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

iv. **Mistake**
Error in judgement or interpretation of an event. This can lead to an error in understanding and agreement about the subject matter of contract

Insurance contract - special features

Let us look at the special features of an insurance contract.

1. Indemnity

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

g Subrogation

Subrogation follows from the principle of indemnity.

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

c) Contribution

This principle is applicable to only non-life Insurance. Contribution follows from the principle of indemnity, which implies that one cannot gain more from insurance than one has lost through the peril

Uberrima Fides or Utmost Good Faith

There is a difference between **good faith** and **utmost good faith.**

a) Good faith

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

The rule observed here is that of **"Caveat Emptor"** which means **buyer beware**.

The parties to the contract are expected to examine the subject matter of the contract and so long as one party does not mislead the other and the answers are given truthfully, there is no question of the other party avoiding the contract.

b) **Utmost good faith**

Insurance contracts stand on a different footing. The proposer has a legal duty to disclose all material information about the subject matter of insurance to the insurers who do not have this information.
Material information is that information which enables the insurers to decide:

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

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

What is meant by complete disclosure?
The law imposes an obligation to disclose all material facts.

c) **Material fact**

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

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

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

i. Facts indicating that the particular risk represents a greater exposure than normal. Examples are hazardous nature of cargo being carried at sea; past history of illness

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

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

Duty of disclosure in non-life insurance
In non-life insurance, the contract will stipulate whether changes are required to be intimated or not. When an alteration is made to the original contract affecting the risk, the duty of disclosure will arise. The duty of disclosing material facts ceases when the contract is concluded by issue of a cover note or a policy. The duty arises again at the time of renewal of the policy, if during the period of the policy; there is any change in the risk.

d) **Breach of utmost good faith**

Let us now consider situations which would involve a breach of utmost good faith. Such breach can arise either through **non-disclosure or misrepresentation**.

i. **Non-Disclosure**

- Insured is silent in general about material facts because the insurer has not raised any specific enquiry
- Through evasive answers to questions asked by the insurer
- May be inadvertent [occurs without one's information or intention] or because the proposer thought that a fact was not material. In such case it is innocent.] When a fact is intentionally not disclosed it is treated as concealment. In this case there is intent to deceive.

ii. **Misrepresentation**

A statement made during negotiation of a contract of insurance is called representation. This may be a definite statement of fact or a statement of belief, intention or expectation.

When it is a fact, it is expected to be substantially correct.

When it concerns matters of belief or expectation, it must be made in good faith.

Misrepresentation is of two kinds:

- **Innocent Misrepresentation** relates to inaccurate statements, which are made without any fraudulent intention e.g. an individual who occasionally smokes and is not a habitual smoker may not reveal the same in the proposal form as he does not think it has any bearing on the risk.
- **Fraudulent Misrepresentation** are false statements made with deliberate intent to deceive the insurer or are made recklessly without due regard for truth. E.g. a chain smoker may deliberately not reveal the fact that he smokes.

3. Insurable interest

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

a) Gambling and insurance

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

Three essential elements of insurable interest:

1. There must be property, right, interest, life or potential liability capable of being insured.

2. Such property, right, interest, life or potential liability must be the subject matter of insurance.
3. The insured must bear a legal relationship to the subject matter such that he stands to benefit by the safety of the property, right, interest, life or freedom of liability. By the same token, he must stand to lose financially by any loss, damage, injury or creation of liability

b) Time when insurable interest should be present

In case of fire and accident insurance, insurable interest should be present both at the time of taking the policy and at the time of loss.

In case of health and personal accident insurance apart from self, family can also be insured by the proposer since he / she stands to incur financial losses if the family meets with an accident or undergoes hospitalisation. However, in marine cargo insurance, insurable interest is required only at the time of loss.

4. Proximate cause

The last of the legal principles, which applies only to non-life insurance, is the principle of proximate cause.

Non-life Insurance contracts provide indemnity only if losses that occur are caused by insured perils, which are covered the policy. Determining the actual cause of loss or damage is a fundamental step in the consideration of any claim.

Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is indeed as a result of an insured peril.

Motor Insurance

Think of a situation where you have bought a new car using all your savings and taken it for a drive. Out of nowhere, a dog comes in your way and to avoid hitting it, you swerve sharply, go over the divider and hit another car and injure the other person. So the outcome of a single incident has resulted in damage to own car, public property and another car as also injury to another person.

In this scenario, if you do not have a car insurance, you may end up paying far more than what it costs to purchase your car.

- Do you have that much money to pay?
- Should the other party's insurance pay for your actions?
- What if they don't have insurance?

That is why the laws of the land make it mandatory to have car insurance. While motor insurance doesn't prevent these things from happening, it provides a financial security blanket for you.

Apart from an accident, the car can also be stolen, damaged by an accident or destroyed by fire and you would suffer financially.
Motor insurance must be taken by a vehicle owner whose vehicle is registered in her / his name with the Regional Transport Authority in India.

Mandatory Third Party Insurance

As per the Motor Vehicles Act, 1988, it is mandatory for every owner of a vehicle plying on public roads, to take an insurance policy, to cover the amount, which the owner becomes legally liable to pay as damages to third parties as a result of accidental death, bodily injury or damage to property. A Certificate of Insurance must be carried in the vehicle as a proof of such insurance.

Motor insurance coverage

The country has a large vehicle population. A number of new vehicles keep coming on to the road every day. Many of them are very costly as well. People say that in India, vehicles do not get junked, but only keep changing hands. This means that old vehicles continue to be on the road and new vehicles get added. The area of the roads (the space for driving) is not growing correspondingly with the number of vehicles. The number of people walking on the road is also increasing. Police and hospital statistics say that the number of road accidents in the country is increasing. The amount of compensations awarded to accident victims by Courts of Law are increasing. Even vehicle repair costs are going up.
All these show the importance of motor insurance in the country

Motor Insurance covers all types of vehicles plying on public roads such as:

- Scooters and motorcycles
- Private cars

- All types of commercial vehicles: Goods carrying and passenger carrying

- Miscellaneous type of vehicles e.g. cranes,
- Motor Trade (Vehicles in Showrooms and Garages)

'Third-Party Insurance'

An insurance policy purchased for protection against the legal actions of another party. Third-party insurance is purchased by the insured (first party) from an insurance company (second party) for protection against another party's claims (third party) for liability arising out of the action of the insured

Third party insurance is called 'Liability Insurance' as well.

Two important types of covers that are popular in the market are discussed below:

a) Act [Liability] Only Policy: As per Motor Vehicles Act it is mandatory for any vehicle plying in public place to insure liabilities towards third parties.

The policy only covers the vehicle owner's legal liability to pay compensation for:
- Third party bodily injury or death ·
- Third party property damage

Liability is covered for an unlimited amount in respect of death or injury and damage.

The claims for compensation to third party victims in case of death or injury caused by a motor accident are to be filed by the complainant in Motor Accident Claim Tribunal (MACT).

b) Package Policy / Comprehensive Policy: (Own damage + Third party liability)

In addition to the above, the loss or damage to the vehicle insured by specified perils (known as own damage to motor vehicles) is also covered subject to the value declared (called IDV - already discussed in chapter 5) and other terms and conditions in the policy. Some of these perils are fire, theft, riot and strike, earthquake, flood, accident etc.

Some insurers may also pay for towing charges from the place of accident to the workshop. A restricted cover is also available covering the risk of fire and / or theft only, in addition to the compulsory cover granted under Act (Liability) Only Policy.

The policy can also cover loss or damage to accessories fitted in the vehicle, personal accident cover under private car policies for passengers, paid driver; legal liability to employees and non-fare paying passengers in commercial vehicles. Insurers also provide free emergency services or use of alternative car in case of breakdown.

Sum Insured and Premium

The sum insured of a vehicle in a Motor Policy is referred to as Insured's Declared Value (I.D.V.).

In case of theft of vehicle or total damage beyond repairs in an accident, the claim amount will be determined on the basis of the IDV. The IDV of the vehicle is fixed on the basis of the manufacturer's / dealer's listed selling price of the brand and model of the vehicle proposed for insurance at the commencement of insurance / renewal and adjusted for depreciation as per schedule.

IDV of vehicle which is beyond 5 years of age and of obsolete models of the vehicles (i.e. models which the manufacturers have discontinued to manufacture) is determined on the basis of an understanding between insurers and insured.

Rating / premium calculation depends on factors like the Insured's Declared Value, cubic capacity, geographical zone, age of the vehicle etc.

COMMERCIAL INSURANCE

Property / Fire Insurance

Commercial enterprises are broadly divided into two types:

- Small and Medium Enterprises [SMEs] and
- Large Business Enterprises

Historically, general insurance sector has largely developed by catering to the needs of these customers.

Selling general insurance products to commercial enterprises calls for a careful matching of insurance products with their needs. Agents must have a proper understanding of the products available. Let us briefly consider some of these general insurance products.

Property / Fire Insurance

Fire insurance policy is suitable for commercial establishments as well as for the owner of property, one who holds property in trust or in commission and for, individuals / financial institutions who have financial interest in the property.

All immovable and movable property located at a particular premises such as buildings, plant and machinery, furniture, fixtures, fittings and other contents, stocks and stock in process, including stocks at suppliers / customer's premises, machinery temporarily removed from the premises for repairs can be insured. Monetary relief is essential to rebuild and renew the property damaged to bring back the business to its normal course. It is here that fire insurance plays its role.

Business Interruption Insurance

This type of insurance is also known as Consequential Loss Insurance or Loss of Profit Insurance

Fire insurance provides indemnity against material or property damage or loss suffered to building, plant, machinery fixtures, fittings, merchandise goods, etc. by insured perils. **This may result in total or partial interruption of the insured's business**, resulting in various economic losses, during the period of interruption.

1. Coverage under Business Interruption Policy

Consequential Loss (CL) Policy [Business Interruption (BI)] provides indemnity for loss of what is termed as gross profit - which includes Net Profit plus Standing Charges along with the increased cost of working incurred by the insured to get the business back to normalcy, as soon as possible to reduce the final loss. The perils covered and conditions are the same as those covered under the fire policy.

This policy can be taken only in conjunction with standard fire and special perils policy as claims under this policy are admissible only if there is a claim under standard fire and special perils policy.

Burglary Insurance

The policy is meant for business premises like factories, shops, offices, warehouses and godowns which may contain stocks, goods, furniture fixtures and cash in a locked safe which can be stolen. The scope of cover is clearly expressed in the policy.

1. Risks covered under burglary insurance

a) Loss of property following actual forcible and violent entry into the premises or loss followed by actual, forcible and violent exit from the premises or hold up.

b) Damage to insured property or premises by burglars. Property insured is covered only when it is lost from the insured premises and not from any other premises.

2. A) Cash cover

An important part of burglary cover is cash cover. It operates only when the cash is secured in a safe, which is burglar proof and is of an approved make and design. The common conditions applicable for granting cash cover are given below:

a) Cash lost from the safe following the use of the original key to open it is covered only where such key has been obtained by violence or threats of violence or through means of force. This is generally known as **"key clause"**.

b) A complete list of the amounts of cash in safe is kept secure in some place other than the safe. The liability of the insurer is limited to the amount actually shown by such records.

B) First Loss Insurance

In the cases, which are of low value in high bulk, (such as cotton in bales, grain, sugar etc.) the risk of losing the entire stock on a single occasion is considered remote. The value that can be burgled is ascertained as probable maximum loss and the premium is charged for this maximum probable loss while covering the entire stock at risk. It is assumed that a second burglary may not follow immediately or the insured may take additional security measures from its recurrence.

C) Declaration cover and floater cover is also possible in respect of stocks, similar to fire insurance.

3. Exclusions

The policy does not cover theft by employees, family members or other persons who are lawfully on the premises, nor does it cover larceny or ordinary theft. It also excludes losses that are covered by a fire or plate glass policy.

4. Extensions

The policy can be extended to cover riot, strikes and terrorism risks at extra premium.

5. Premium

Rates of premium for burglary policy depend upon the nature of insured property, the moral hazard of the insured himself, construction and location of premises, safety measures (*e.g. watchmen, burglar alarm)*, previous claims experience etc.

In addition to details given in the proposal form, a pre-acceptance inspection is done by insurers where high values are involved.

Money Insurance

Handling of cash is an integral part of any business. Its intended to protect banks and industrial business establishments against loss of money. Money is at risk in the premises as well as outside. It can be unlawfully taken away while withdrawing, depositing, making payments or collections.

1. Coverage of Money Insurance

Money insurance policy is designed to cover the losses that may occur while cash, cheques / postal orders / postal stamps are being handled. The policy normally provides cover under two sections

a) Transit section

It covers loss of cash as a result of robbery or theft or similar actions whilst it is carried outside by the insured or her authorised employees.

The transit section specifies two amounts:

i. **Limit per carrying**: This is the maximum amount that insurers may be required to pay in respect of each loss.

ii. **Estimated amount in transit during the policy period:** It represents the amount to which the rate of premium is to be applied to arrive at the amount of premium.

Policies can be issued on **"declaration basis"**, similar to the practice in fire insurance. Insurers thus charge a provisional premium on the estimated amount in transit and adjust this premium at the time of expiry of the policy, based on actual amount in transit during the policy period, as declared by the insured.

b) Premises section

This section covers loss of cash from one's premises / locked safe due to burglary, housebreaking, hold up etc. Other features of the policy are normally the same as of burglary insurance (of business premises) that we have discussed under Learning Outcome C above.

Fidelity Guarantee Insurance

Companies suffer financial loss due to what are termed as white collar crimes like fraud or dishonesty of their employees. Fidelity guarantee insurance indemnifies employers against

the financial loss suffered by them due to fraud or dishonesty of their employees by forgery, embezzlement, larceny, misappropriation and default.

1. Coverage under Fidelity Guarantee Insurance

Cover is granted against a direct pecuniary loss and does not include consequential losses.

a) The loss should be in respect of moneys, securities or goods
b) The act should be committed in the course of the duties specified;
c) The loss has be discovered within 12 months of expiry of the policy or death retirement resignation or dismissal of the employee, whichever is earlier
d) No cover is provided in respect of a dishonest employee who has been re-employed

2. Types of Fidelity Guarantee Policy

There are various types of fidelity guarantee policies, as discussed below:

a) Individual policy

This type of policy is used where only one individual is to be guaranteed. Name, designation of the employee and amount of guarantee has to be specified.

b) Collective policy

This policy comprises a schedule listing out the names of those employees to whom the guarantee applies, along with a note on the duties of each employee and separate individual sums insured.

c) Floating policy or floater

In this policy, the names and duties of the individuals to be covered are inserted in a schedule, but instead of individual amounts of guarantee, a specified amount of guarantee is “floated” over the whole group. A claim in respect of any one employee will, therefore, reduce the floated guarantee, unless the original sum is reinstated by payment of an extra premium.

d) Positions policy

This is similar to a collective policy with the difference that only the schedule lists out "positions’ that are to be guaranteed for a specified amount and the name are not mentioned.

e) Blanket policy

This policy covers the entire staff without showing names or positions. No enquiries about the employees are made by the insurers. Such policies are only suitable for an employer with a large staff and the organization makes adequate enquiries into the antecedents of employees. The references that the employer obtains must be available to the insurers in the event of a claim. The policy is granted only to large firms of repute

Engineering Insurance

Engineering insurance is a branch of general insurance that developed parallel with the growth of fire insurance. Its origins can be traced to the development of industrialization, which highlighted the need for a separate cover for plant and machinery. Concept of **All Risks** cover was also developed with regard to engineering projects - covering damage due to any cause except those specifically excluded. The products covered various stages - from construction to testing till the plant became operational. The customers for this insurance are both large and small industrial units. This also includes units having electronic equipment and contractors doing big projects.

Types of engineering insurance policies

Let us briefly consider the major policies that fall under this type of insurance

1. Contractors All Risks (C.A.R.) Policy

This is designed to protect the interests of contractors and principals engaged in civil engineering projects from small buildings to massive dams, buildings, bridges, tunnels, etc. The policy provides an "All Risk" cover - thus providing indemnity against any sudden and unforeseen loss or damage that occurs to property insured at the construction site. This can be extended to cover third party liability and other exposures. Premium chargeable depends on the nature of the project, the project cost, the project period, geographic location and the period of testing.

2. Contractors Plant & Machinery (CPM) Policy

Suitable for contractors involved in construction business for covering all kinds of machinery like cranes, excavators, from unforeseen and sudden physical loss or damage from any cause including:

a) Burglary, theft, R.S.M.D.T.
b) Fire and lightning, external explosion, earthquake and other Acts of God perils
c) Accidental damage while at work due to faulty manhandling, dropping or falling, collapse, collision and impact; can be extended for third party damage.

Premium depends on the type of equipment and the location at which it operates.

The cover is operative whilst the equipment is at work or at rest or being dismantled for cleaning or overhauling or re-assembling thereafter. The cover also applies while the same are lying at contractors own premises.

3. Erection All Risks (EAR) Policy

This policy is also known as Storage-cum-Erection (SCE) policy. It is suitable for the principal or contractors of a project whereas plant and machinery is being erected as it is exposed to various external risks. This is a comprehensive insurance policy that covers any sort of contingency right from the moment the materials are unloaded at the project site and continues during the entire project period until the project is tested, commissioned and handed over.

Premium chargeable depends on the nature of the project, the cost, the project period, geographic location, and the period of testing.

If required an marine cover can be issued along with the erection policy for providing coverage to the equipment and materials during the transit phase till delivered at the project site.

4. Machinery Breakdown Policy (MB)

This policy is suitable for every industry which operates on machines and for whom breakdown of plant and machinery is of serious consequence. This policy covers machines like generators, transformer and other electrical, mechanical and lifting equipment.

The policy covers unforeseen and sudden physical damage by mechanical or electrical breakdown by any cause (subject to excepted risks) to the insured property:

a) While it is at work or at rest.
b) While being dismantled for cleaning or overhauling
c) During cleaning or overhauling operations and during reassembly thereafter.
d) When being shifted within the premise.

Premium is charged on the reinstatement / replacement value of individual machinery. The machine as a whole should be insured. Rates depend on the type of machine; the industry in which it is used and its value. Discounts are offered based on factors such as stand-by facilities, spares available and claims experience.

5. **Boiler and Pressure Plant Policy**

This covers boilers and pressure vessels, against:

a) Damage, other than by fire, to the boilers and / or other pressure plant and to surrounding property of the insured; and
b) Legal liability of the insured on account of bodily injury to the person, or damage to the property, of third parties, caused by explosion or collapse due to internal pressures of such boiler and / or pressure plant.

Industrial All Risks Insurance

The Industrial All Risks Policy was designed to cover, industrial properties - both manufacturing and storage facilities, anywhere in India under one policy. It provides indemnification against material damage and business interruption. Usually, the policy provides cover for the following:

i. Fire and specified perils as per fire insurance practice,
ii. Burglary (except larceny)
iii. Machinery breakdown / boiler explosion / electronic equipment
iv. Business interruption following operation of perils mentioned above

(Note: Business interruption following perils under (c) above is usually not included in the package cover but available as optional cover)

The policy offers widest range of cover compared to that provided by individual operational policies.

Premium rates for the policy depend on the cover opted, claims experience, and deductibles opted, risk assessment report for MLOP etc.

Marine Insurance

Marine insurance is classified into two types: marine cargo and marine hull

1. Marine Cargo Insurance

Though the term 'marine' may indicate only losses due to sea (marine) mis-adventures, **marine cargo insurance** covers much more. It provides indemnity in respect of loss of or damage to goods during transit by rail, road, sea, air or registered post, within the country as well as abroad. Type of goods may range from diamonds to household goods, bulk items like cement, grains, over dimensional cargoes for projects etc.

Cargo insurance plays an important role in domestic trade as well as in international trade. Most contracts of sale require that the goods must be covered, either by the seller or the buyer, against loss or damage.

Who effects the insurance: The seller or the buyer of the goods [consignment] may insure the cargo depending upon the contract of sale.

Marine insurance contract needs to have provisions that apply internationally. This is because it covers goods that are in transit beyond any country's borders. The covers are accordingly governed by international conventions and certain clauses attached to the policy.

Different types of marine policies

i. Specific Policy

This policy covers a single shipment. It is valid for the particular voyage or transit. Merchants who are engaged in regular import and export trade or who are sending consignments regularly by inland transit would find it convenient to arrange insurances under special arrangements like the open policy.

ii. Open Policy

The carriage of goods within the country can be covered under an open policy. The policy is valid for one year and all consignments during this period have to be declared by the insured to the insurer as agreed between them on a fortnightly, monthly or quarterly basis.

Iii Open Cover

For large exporters and importers who have continuous trade, an open cover is issued. It sets out the terms of cover and rates of premium for one-year transaction of marine dispatches. The open cover is not a policy and it is not stamped. A certificate of insurance is issued for each declaration duly stamped for appropriate value.

Iv Duty and increased value insurance

These policies provide extra insurance if the value of the cargo is increased due to payment of customs duty or increase in the market value of the goods at the destination on the date of the landing.

v. Delay in Start Up

Many insured are opting for this cover. In case of new project any loss or damage to the equipment during transit may involve ordering of fresh equipment which leads to delay in completion of the project, and thereby loss of profits. The financial institutions who are interested in timely completion of the project for their debt servicing, would like this risk
covered by an insurance contract and the marine (cargo) insurance policy can be extended against consequential loss due to marine delays' or simply -delay start up.