Auditing Course Material

Part 4 of 61 (Chapters 301-400)

10. Contract of Insurance

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

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10. Contract of Insurance

Following are the essential elements of a valid Insurance Contract:

1. Offer or Proposal

The offer or proposal and its acceptance may be verbal or in writing but in Insurance contracts these are in writing. Where the insurance company cannot accept the risk, the proposal is declined. Where the insurance company conveys its decision to accept the risk quoting a premium, a proposal is made.

2. Acceptance

When a person to whom the proposal is made (or the 'promisee'), signifies his assent thereto, the proposal is said to be accepted. A proposal, when accepted, becomes a promise.

3. Consideration

In Insurance contracts, premium payment is the consideration on part of the insured and the promise to Indemnify is the consideration on part of the Insurer.

4. Competency to Contract

With respect to the insurer, if the company is formed as per laws of the country & empowered to solicit insurance, then the insurer is capable of entering into an agreement. With respect to the insured, the person should be of legal age i.e., 18 years, is of sound mind and not disqualified under any law. However, the life assured could suffer from the above infirmities.

5. Consensus ad idem

Two or more persons are said to consent when they agree upon the same thing in the same sense. Both the insurance company and the Policyholder must agree on the same thing in the same sense. The Policy document issued to the Policyholder clearly defines the obligations of the insurer and the terms and conditions upon which the Insurance contract is issued.

6. Free Consent

Consent is said to be free when it is not caused by (a) Coercion, or (b) Undue influence or (c) Fraud, or (d) Misrepresentation, or (e) Mistake. When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is a contract voidable at the option of the party whose consent was so caused.

7. Lawful object

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

10. Contract of Insurance

Though all contracts share fundamental concepts and basic elements, insurance contracts typically possess a number of characteristics not widely found in other types of contractual agreements.

The most common of these features are given below:

1. Aleatory

An insurance contract is aleatory rather than commutative. Aleatory contracts have a chance element and an uneven exchange. Under an aleatory contract, the performance of at least one of the parties is dependent on chance. An aleatory contract also involves an uneven exchange: one of the parties promises to do much more than the other party. Depending on chance, one party may receive a value out of proportion to the value that is given.

In contrast, other commercial contracts are commutative. A commutative contract is one in which the values exchanged by both parties are theoretically even. For example, the purchaser of a real estate normally pays a price that is viewed to be equal to the value of the property.

2. Adhesion

In a contract of adhesion, one party draws up the contract in its entirety and presents it to the other party on a 'take it or leave it' basis; the receiving party does not have the option of negotiating, revising, or deleting any part or provision of the document. Insurance contracts are of this type, because the insurer writes the contract and the insured either 'adheres' to it or is denied coverage.

3. Utmost good faith

In a contract of utmost good faith, each party has a duty to reveal all material information (that is, information that would likely influence a party's decision to either enter into or decline the contract), and if any such data is not disclosed, the other party will usually have the right to void the agreement.

4. Executory

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

5. Unilateral

A contract may either be bilateral or unilateral. In a bilateral contract, each party exchanges a promise for a promise. However, in a unilateral contract, the promise of one party is exchanged for a specific act of the other party. Insurance contracts are unilateral in nature; only the Insurer makes a promise to do something, the insured on the other hand after payment of premium does not make any promises, though he must comply with the conditions if he wants the insurer to perform. He does not promise to meet the conditions, therefore, Insurance contracts are said to be unilateral as in contrast to bilateral contracts in which both parties make enforceable promises and either party can force the other to perform or pay damages for not performing.

6. Conditional

Insurance contracts are also conditional. Even when a loss is suffered, certain conditions must be met before the contract can be legally enforced. For example, the insured individual or beneficiary must satisfy the condition of submitting to the insurance company sufficient proof of loss or prove that he or she has an insurable interest in the person insured.

There are 3 basic types of conditions: conditions precedent, conditions subsequent and Conditions precedent to liability. The express and implied conditions can be categorized as follows:

1. **Conditions precedent**, e.g., disclosure of all material facts before the conclusion of the contract. A breach of the condition can enable the insurer to avoid his liability under the policy from its very beginning.
2. **Conditions subsequent**, e.g., notification of any change in the risk during the currency of the policy. A breach of these conditions entitles the insurer to avoid the liability under the policy after it has come into force.
3. **Conditions precedent to liability**, e.g., notice of loss within the prescribed time limits. The breach of this condition can prevent the insured from claim benefits.

7. Personal contracts

Insurance contracts are usually personal agreements between the insurance company and the insured individual and are not transferable to another person without the insurer's consent. That is why when a car is sold, the Insurance does not automatically pass on to the new owner. It may be assigned but only with the consent of the Insurer.

8. Warranties and Representations

A warranty is a statement that is considered guaranteed to be true and, once declared, becomes an actual part of the contract. Typically, a breach of warranty provides sufficient grounds for the contract to be voided. Conversely, a representation is a statement that is believed to be true to the best of the other party's knowledge. In order to void a contract based on a misrepresentation, a party must prove that the information misrepresented is indeed material to the agreement.

9. Misrepresentations and Concealments

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

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

10. Fraud

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

11. Impersonation (false pretences)

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

12. Insurance and Gambling

While it is true that both Insurance and gambling involve money changing hands on the basis of chance events, it is important to understand the difference between the two as discussed:

- Gambling creates the risk whereas Insurance transfers an existing risk from one party to another.
- In Insurance, Insurable Interest is a pre-requisite whereas in gambling, the interest is limited to the amount to be won or lost.
- The Insured is immune from loss and his identity is known before the event whereas in gambling, the loser cannot be identified before the event.
- Full disclosure (Utmost Good Faith) is required from both parties to an assurance contract whereas this is not necessary in a gambling contract.
- Insurance contract is enforceable at law whereas there is no legal recourse for any of the two parties in a gambling contract.

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11. Policy Structure

The policy document is typically divided into the following key elements:

1. Heading

This contains the name of the insurer and other particulars regarding the issuing office; the name of the policy etc.

2. Preamble or Recital Clause

This contains relevant information regarding the subject matter of insurance, the locations, identity, value, and period of insurance required etc.

3. Attestation or Signature Clause

This clause provides for the signature on the policy. The policy is signed by the authorized official of the insurer.

4. Operative or Insuring clause

This clause states the peril(s) which are to be insured against.

5. Exclusions

This clause states the various conditions under which the policy will not pay.

6. Implied/express conditions

Generally **express conditions** are those that require the insured to do something, for example, in cargo insurance transit by road during monsoon. There are 2 types of express conditions:

1. Conditions, which are applicable to all policies of that class and are therefore, printed on the policy document.
2. Special conditions, which are applicable only to that specific policy. The special conditions are thus handwritten or typed or rubber-stamped on the policy. (e.g., type of packing, compulsory excess, unloading survey, etc.).

Implied conditions are those, which are so basic and material that their existence forms the very basis of the policy and cannot be ignored. In the absence of express conditions, the insurance contract is subject to implied conditions, which relate to:

- Good faith
- Insurable interest
- Subject matter of insurance
- Identification of the subject matter.

Implied conditions can be expressed in a policy explicitly or can be modified or excluded by the express conditions.

Note that, all conditions whether expressed or implied are the operative clauses of a policy. They are recited as conditions to be fulfilled by the insured for assuming the right to recover under the policy.

7. Average Clause

A fire insurance policy has an average clause mentioned in it which takes care of the cases of under-insurance. If the assets in the fire insurance policy are insured for less than their full value, the insured requires to bear a proportion of the loss according to the average clause mentioned in the policy document.

8. Sum Insured

The sum insured is always fixed by the proposer. Some important points in this regard are as follows:

- It is the limit of Insurer's liability under a policy.
- It is the amount on which the rate is applied to determine the premium payable for the insurance.
- The sum insured should represent the actual value of the property to be insured. Insuring for higher value than the actual value gives no advantage to the insured as payment of claim, if, any, is subject to the 'principle of indemnity', which means payment is only for actual loss.
- Insuring for value lesser than the actual value makes the insured self-insurer for the difference and claim, if any, is subjected to 'average clause', whereby he is penalized for under-insurance.
- In case of joint ownership of any property, the insured can get the claim only in respect of his share. He could, however, insure full value of the property on behalf of other co-owners as well which case the claim, if any, is paid to each co-owner to the

extent of their insurable interest.

9. Market Value

This is determined by the amount at which property of the same age and condition can be bought and sold. This value takes into account both depreciation due to age and appreciation due to inflation.

10. Reinstatement Value

In fire insurance, the principle of indemnity can be modified in the case of building, machinery and other fixed assets where, subject to the sum insured representing the value of similar new property, it can be insured under 'Reinstatement Value' clause.

In case of reinstatement value policy, the basis of loss settlement is the value of new property without taking any depreciation into account. In other words, it means it is replacement of old with new. This type of insurance enables the owner to replace his property without any financial strain on his own resources and is quite commonly taken by industrialists and building owners.

11. Duty of Assured Clause

All policies have a duty of assured clause, which spells out that the duty of the assured is, to behave as if he was not insured. Hence, in the event of a peril operating, he or his agent have to take all necessary steps to avert losses/ mitigate the damages caused due to peril.

12. Duration of Cover Clause

Particularly in transit insurance, where insured requires that warehouse to warehouse cover be issued - the duration of cover is defined as from the time the goods leave the place of storage, and continue through transhipment till the goods reach final destination, or on the expiry of a certain period of time after the goods are discharged – 60/15/7 days depending on whether transit is by sea/air or road.

13. Deductibles

A deductible is that portion of the amount of an insured loss, which the insured agrees to pay. It is common in almost all types of insurance policies to stipulate a definite amount of money, which is to be borne by the insured. The insurer becomes liable for any amount beyond the deductible amount stated in the contract.

Deductibles are not used in life insurance because the death of an insured is always a total loss. It is also not used in personal liability insurance because even for a small claim, the insurer must provide a legal defence.

14. Coinsurance

Where the amount of insurance on large industrial complexes is substantial, it is advisable for the insured to seek cover from different insurers in the risk for varying proportions of acceptance, so that the total is covered. The practice is for each insurer to issue a policy with a specification or schedule giving a description of the property insured, with the "co-insurance clause" included therein.

Survey of the risk, rating, collection of premium and preparation of the specification is carried out by the "leading office", that is the office carrying the largest share in the business.

15. Underinsurance

A situation wherein the owner of a property or the person suffering a health condition does not have enough insurance to cover the value of the item or the health care costs may be termed as underinsurance. An underinsured individual finds out about his lack of insurance coverage only after he files a claim.

In case of underinsurance, the insurance pay-out is less than what it should be, and it may not be enough to cover replacement and repair costs for the asset damaged. In underinsurance, the policyholder is considered to be the self-insurer to the extent of underinsurance and needs to bear the proportion of the loss accordingly.

Underinsurance may be caused by many factors depending upon the nature and type of insurance. It ranges from a failure to update a policy in a timely manner to an underestimate of reconstruction or replacement value. Failure to report new construction or additions to the property or a decision not to purchase sufficient insurance due to cost could also lead to underinsurance problems. Relying on the health insurance problem by the employer may also be a reason of underinsurance. Even in many cases, cost cutting measure is also a reason of underinsurance.

12. Insurance Documents

Proper documentation is a must for any insurance policy because any wrong information may lead to repudiation of the claim. Some of the important documents which are required from the time of taking the insurance to the settlement of the claim are discussed below.

1. Prospectus

Every insurance company issues the prospectus wherein the profile of the company and the features of the products are explained. After going through the company profile and the product feature, the person may decide whether to buy the product of a particular company or not.

2. Policy Schedule

It is the document which together with various clauses, warranties and conditions forms the contract.

3. Certificates of Insurance

These are usually given in marine transit insurance under open policies and also for motor insurance. In motor insurance, they are mandatory as it confirms that there is insurance cover existing for the vehicle plying on public roads. They are less detailed than a policy and not stamped, but essentially give the same information regarding insurance.

4. Cover Note

A cover note is a temporary document issued as confirmation of the insurance contract in advance of the policy as it may take some time for the policy to be issued. Till the policy is ready the cover note is the proof that the insurance cover is in force. The cover note contains brief details of the Insurance cover and is valid for 15 days extendable to a maximum of 60 days. Once the policy is issued, the validity of the cover note ceases.

5. Endorsements

There may be instances, when during the currency of the policy, certain changes may be advised by the customer, for example, change in location, correction of name or other details of subject matter insured. There may be instances of increase in the value to be insured, inclusion of extra covers or deletion of covers etc. In such cases, the insurer would, on being so solicited by the insured customer, issue an endorsement which would reflect the changes or amendments and would thereafter form part of the policy document.

Generally, endorsements are issued for such alterations as:

- Change in insurable interest,
- Cancellation of insurance,
- Change in the value at risk,
- Change in the location or situation of risk,
- Reduction or addition to the risk,
- Change of the insured as when a transfer of interest or assignment of interest is made.

Sometimes an endorsement is also issued to correct a typographical error in the policy already issued.

6. Renewal Notice

While it is not obligatory to issue renewal notices reminding insured that the policy is due for renewal, yet, out of courtesy and as a part of good business practice, insurers send a renewal notice one month in advance of the date of expiry advising the insured to renew the policy.

7. Warranties

Warranties are an extension of the terms and conditions contained in the clauses which attach to the policy schedule. Warranty is a statement by which the insured undertakes to do/not do a particular thing or fulfil a condition, or whereby he affirms or negates the existence of a particular state of facts which affect the incidence of a claim.

8. Claim Form

Claim forms are issued to the insured when he notifies a loss under a policy. Claim forms vary according to different classes of insurance but are generally designed to elicit complete information regarding the loss, i.e., circumstance of loss, date and time of loss, cause of loss and extent of loss etc.

9. Survey Report

This report is submitted by duly licensed surveyors who are appointed by the insurers to investigate the loss when notice of loss and claim form is received. The report provides independent evidence of the cause and extent of loss and other information to the insurers for processing and settling of claims.

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13. Claim Settlement

The general procedure for seeking claim settlement is same in most forms of General Insurance and is as follows.

- Step 1 – Intimation of Claim by the Insurer
- Step 2 – Registration of Claim after checking if claim is payable If not payable repudiate the claim, as per approved process.
- Step 3 – Appointment of surveyor, loss assessor, investigator etc., to assess loss, if insurer is liable to pay under the policy.
- Step 4 – Final settlement – payment of the claim, full and final discharge of the liability.
- Step 5 – Institute recovery proceedings, as applicable.

Claim in Life Insurance policies and insurance claim recovery is discussed next.

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13. Claim Settlement

There may be 3 types of claims in life insurance policies:

1. Survival Benefit Claim

Survival benefit is not payable under all types of plans. It is payable in endowment or money back plans after a lapse of a fixed period say 4 or 5 years, provided firstly the policy is in force and secondly the policyholder is alive.

2. Maturity Benefit Claim

It is a final payment under the policy as per the terms of the contract. In other words, the claim for which a policyholder/life insured can apply for after surviving the complete policy term is called maturity claim.

3. Death Benefit Claim

If the life assured dies during the term of the policy, the death claim arises. If the death has taken place within the first 2 to 3 years of the commencement of the policy, it is called an early death claim and if the death has taken after 2 to 3 years, it is called a non-early death claim.

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13. Claim Settlement

Insurance Claims Recovery, also known as "subrogation" or subrogated claims recovery, is a legal term meaning that the insurance company assumes the right of its insured to pursue a claim against a wrongdoer. The insured, who under the duty of the assured clause, is required to protect right of recovery against persons responsible for the loss, surrenders the same on being compensated according to the principle of indemnity which restricts him from benefiting and making a profit, by recovering from the third party as well.

Pay and recover is used, generally in motor accident compensation cases, where award is pronounced by the Motor Accident Claims Tribunal (MACT). After payment of the claim to the injured party or his legal heirs etc., the insurer can initiate action against the erring party, e.g., the owner of the insured vehicle.

Modes of Recovery

The modes of recovery are as follows:

- **Excess/deductible** – That portion of the claim which is to be borne by the insured is called an excess or deductible.
- **Subrogation** – Rights and remedies preferred against the third party.
- **Contribution** – This occurs when the insured property is insured by more than one insurer - in such cases recovery would be made by the lead insurer from the co insurer.
- **Reinsurance** – Reinsurance is the most common method of risk transfer – where the risk is re-insured with reinsurers and after the claim the same is recovered from them after payment to insured.
- **Salvage** – Salvage is also a form of recovery in any claim. In most property claims, including transit insurance claims, damaged property can be disposed off for either lower or scrap value, this is done to reduce the financial impact of claims.

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13. Claim Settlement

Nomination is the right of the Policyholder to designate a beneficiary who will receive the Sum assured and other benefits under the Life insurance policy from the Insurance Company in the event of his unfortunate death during the term of the Insurance Policy.

The role of Nominee is restricted to receiving benefits only upon death of the life assured. However, where the Life assured survives the date of maturity of the Policy but dies before the maturity proceeds could be paid to him, the Maturity proceeds shall be paid to the Nominees.

Nomination is required only if a person takes own life policy. Where the Policyholder and Life assured are different, upon death of the Life assured, the death benefits are payable only to the Policyholder.

The Insurance Act, 1938 recognizes 2 types of Nominees:

1. a Beneficial Nominee (spouse, children and parents), and
2. a Collector Nominee (where the Nominee is any other person not covered under the above 3 relationships, he is called a Collector Nominee who merely acts as a Trustee for other Legal heirs).

Where Minor is appointed as Nominee, an **Appointee** (Guardian) has to be appointed in the Proposal form. Such Appointees are entitled to receive Policy benefits during the minority of the Nominee as Trustees for the Minors.

Nomination is made in proposal or can be made (or changed) subsequently.

If the Nominee(s) pre-decease the Life assured and no fresh nomination made thereafter, the benefits payable upon subsequent death of the life assured shall accrue to the legal heirs of the deceased life assured.

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13. Claim Settlement

In the absence of a nomination, the insurance company discharges the claim amount to the Class I legal heir, that is, to son, daughter, spouse and mother. If there is a will, the proceeds will be distributed according to the wishes of a person stated in his will. This is according to the Indian Succession Act, 1925.

Alternatively, the insurance company asks for a succession certificate by the court of law, which will clearly state to whom the amount should be paid.

In case there is more than one legal heir, the insurer will call for a joint discharge statement, waiver of legal evidence and an indemnity bond. These documents safeguard the insurer's interest in case of any dispute on settlement of the claim.

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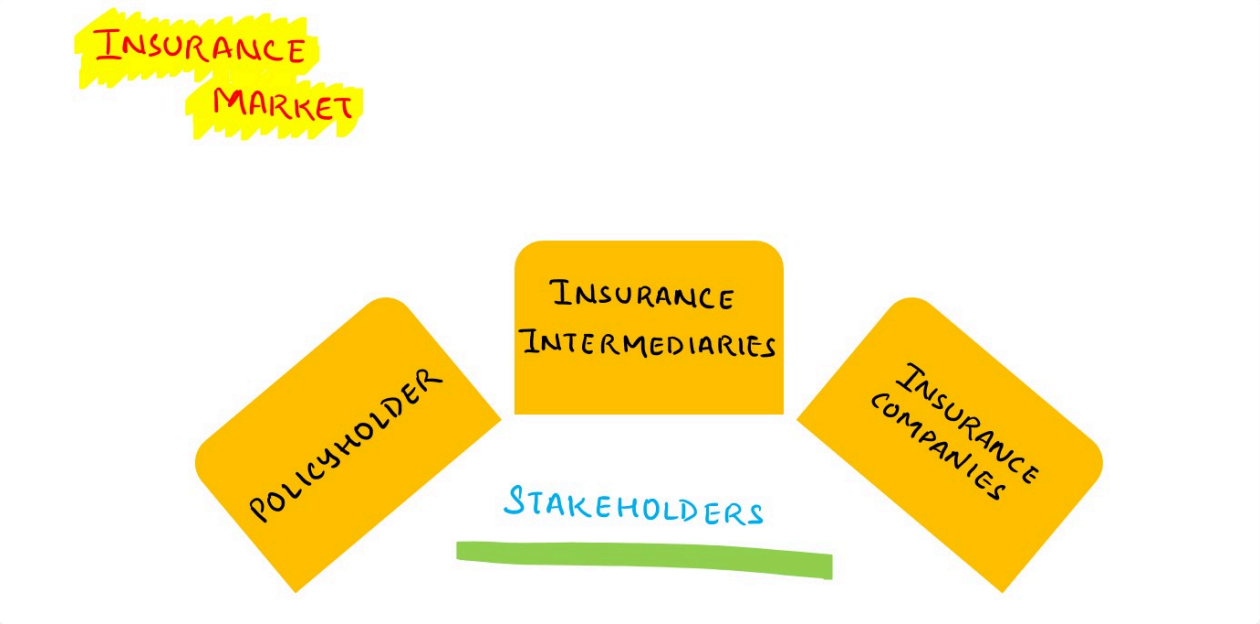
14. Insurance Market



The insurance industry of India has insurance companies comprising of life insurance business and non-life insurers as well. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company, however, there are public sector insurers in the non-life insurance segment as well. In addition to these, there is a sole national re-insurer, namely General Insurance Corporation of India (GIC Re). Other stakeholders in the Indian Insurance market include agents (individual and corporate), brokers, surveyors and third-party administrators servicing health insurance claims.

Stakeholders

An Insurance Market typically comprises of the following 3 stakeholders - Policy holder; Insurance Agent, Intermediary or Insurance Intermediary; Insurance Company/ Insurer.

1. A **Policyholder** is a customer to whom the Policy is issued. The Policyholder can be an Individual Policyholder or a Corporate Policyholder. Individual Policyholders are also called the Retail segment and constitutes the biggest chunk of Customers. Corporate Policyholders comprise of Business entities that purchase insurance cover for various business needs. In the Life insurance segment, it can be Group Term Life Insurance policies, Group Superannuation Policies, Group Credit Life Policies.
2. **Insurance intermediaries** serve as the critical link between insurance companies seeking to place insurance policies and consumers seeking to procure insurance coverage.
3. **Insurance companies** (or Insurers) provide the service of insurance coverage to the Policyholders. They accept the premiums from the Policyholders who take Insurance Policies through the registered intermediaries and provide the Insurance cover by issuing Insurance Policy documents.

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15. Insurance Distributors

Before, privatization, Individual Agents used to be the only distributors. However, after formation of IRDAI, many new forms of distributors like Corporate Agents, Insurance Brokers, Web Aggregators, and Insurance Marketing Firms were recognised and registered by the Regulatory Authority.

IRDAI have framed Regulations/Guidelines and provided a framework for the following Distributors to operate in the insurance market.

These are discussed next one by one.

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15. Insurance Distributors

As per Insurance Act, 1938, an insurer may appoint any person to act as insurance agent for the purpose of soliciting and procuring insurance business.

No person shall act as an insurance agent for more than one life insurer, one general insurer, one health insurer at a time.

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15. Insurance Distributors

In the case of a Corporate Agency, a Partnership firm or a Company may apply for doing insurance agency, as against individuals. However, unlike Individual agent who can work for only 1 insurer in a line of business (Life/Non-Life/Standalone health), a Corporate agent is allowed to work for up to 3 insurers in each line of business. Therefore, a corporate agent can work up to a maximum of 9 insurers, with a cap of 3 insurers in each line of business.

There are 2 types of Corporate agencies: Exclusive & Non-Exclusive Corporate agencies. An **exclusive corporate agent** is one who does only insurance solicitation and a **Non-Exclusive corporate agent** is one whose primary business is something different and insurance solicitation is a secondary line of business. For example, Banks are Non-Exclusive Corporate agents whose primary business is banking and secondary business is insurance solicitation.

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15. Insurance Distributors

An Insurance Broker represents a 'client' and not insurer and is therefore independent of the insurer. Unlike a Corporate Agent who can represent up to 3 insurers, Brokers can sell the products of any number of insurance companies. Sales practices of Broker do not bind the insurer, even though the insurer is liable on the contract issued to the customer. However, Consumer Courts & Ombudsmen hold insurers responsible for misrepresentation of Brokers.

There are 3 categories of Insurance Brokers - Direct, Reinsurance and Composite.

1. **Direct brokers** are licensed by the IRDAI and familiarise themselves with the insurance business of the various clients so as to explain and arrange the same with an insurer. A direct broker provides advisory services with regard to the most appropriate policy and its related terms and conditions.
2. **Reinsurance** is insurance for insurance companies. A reinsurance broker arranges reinsurance contracts between direct insurers and reinsurers. Since he/she works on behalf of both parties, he is contractually obligated to both.
3. **Composite brokers** are a combination of direct brokers and reinsurance brokers and therefore have a double role.

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15. Insurance Distributors

Tele marketing is a non-face-to-face method of selling insurance and includes telephonic mode of sale, through internet, emails, SMS and other forms of non-personal sales methods by insurers or brokers.

There are 3 models through Distance marketing:

1. Only lead generation (generating interest in buying insurance, no selling insurance).
2. Only solicitation (selling insurance).
3. Lead generation and solicitation (both generating interest and selling insurance).

A Broker by his nature, cannot push or promote products of only one or few insurers as this could be serve counter-productive to customer's interests.

No Variable Insurance Product can be sold under Distance marketing.

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15. Insurance Distributors

A Web Aggregator is an online seller of insurance products – allowed to sell insurance products of multiple insurance companies, for example, Policy Bazaar. They are permitted to do only online sales, though telephonic solicitation is also allowed. Since the Web Aggregator aggregates the insurance products of multiple insurance companies through internet (Web), they are called Web Aggregators.

The concept of web aggregator is used for online enquiry/shopping, wherein end consumers could get information and quotes on diverse financial products across service providers at one point. Web aggregators are essentially insurance portals that help you compare products and enable purchase by directing you to the insurer or the insurer to you. Web Aggregator is a company registered under the Companies Act and approved by IRDAI which maintains or owns a website and provides information on insurance products of different insurers.

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15. Insurance Distributors

A Micro Insurance Agent is recognised to sell insurance products predominantly in rural areas and to the under privileged sections of the Society.

Micro-Insurance Agent as defined in IRDA (Micro Insurance) Regulations, 2005, which means- (i) a Non-Government Organisation (NGO); or (ii) a Self-Help Group (SHG); or (iii) a Micro-Finance Institution (MFI), who is appointed by an insurer to act as a micro-insurance agent for distribution of micro-insurance products, where:

1. **Non-Government Organisation (NGO)** means a non-profit organisation registered as a society under any law and has been working at least for 3 years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency, and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people.
2. **Self-Help Group (SHG)** means any informal group consisting of 10 to 20 or more persons and has been working at least for 3 years with marginalised groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people.
3. **Micro-Finance Institution (MFI)** means any institution or entity or association registered under any law for the registration of societies or co-operative societies, as the case may be, inter alia, for sanctioning loan/finance to its members.

Micro insurance agent can work with 1 life, 1 non-life, 1 health and Agriculture Insurance Company.

Following can become a Micro Insurance Agent:

- Non-Governmental Organisations or Self-Help Groups or Micro Finance Institutions or Reserve Bank of India regulated Non-Banking Finance Companies-Micro Finance Institutions,
- District and Urban Cooperative Banks,
- Primary Credit Cooperative Societies,
- District Co-operative Banks, Regional Rural Banks and Urban Cooperative Banks,
- Primary Agricultural & other Co-operative Societies and
- Banking Correspondents.

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15. Insurance Distributors

An Insurance Marketing Firm is allowed to sell Insurance Products as well as other financial products under one entity. Apart from Insurance Products, they are also allowed to sell other financial products such as Mutual funds, small savings etc.

IMF can be a Company or LLP or Cooperative Society; or any other entity as may be specified in the regulations.

IMFs are free to sell insurance products from multiple indemnifiers while retaining an honest and upfront responsibility toward their clients.

IMFs are required to market products of 2 life, 2 general and 2 health insurance companies. However, with regard to general insurance, IMFs can market only retail (individual) lines of products.

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15. Insurance Distributors

The License to CSC e-Governance Services India Limited has been granted on 12th Sept 2013 by IRDA to work as an Authorized Intermediary to market specifically approved insurance products through the Rural Authorised Persons (Village Level Entrepreneur's) under the CSC Scheme of National e-Governance Plan under the IRDA Guidelines on Common Service Centres, 2013.

A CSC is a low-cost setup and distribution center for government institutions to deliver e-governance services to the rural population. The CSC-SPV (special purpose vehicle) has been established by the Indian government under the National e-Governance Plan. To monitor and supervise the progression of CSC-SPVs, a State Designated Agency (SDA) acts as a nodal agency, and the Service Centre Agency (SCA) becomes the implementing agency which provides the required investment budget and the functional specification of the CSC as identified by the SDA.

The License permits both Life and Non-Life Insurers in India to Market Retail Insurance Policies and Services through Common Service Centres Network.

A **Village Level Entrepreneur (VLE)** is licensed to solicit or negotiate an insurance policy of 'all the insurance companies' with which CSC-SPV has an agreement.

VLEs in order to solicit insurance sales and service as Rural Authorised Person (RAP) of Insurance will have to comply with all the applicable provisions of the Insurance Act 1938, the IRDA Act 1999, and the rules, regulations, circulars or guidelines, as applicable, issued from time to time.

Under this model, VLEs who offer certain services to the Villagers like payment of utility bills, booking of train tickets, selling of manures and fertilizers etc., are also permitted to sell insurance products. Under this model, the VLE network is used to sell insurance in rural areas. This measure is intended to increase the insurance penetration in the country.

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15. Insurance Distributors

A Point of Sales Persons (POSP) Model is a recent innovation and is intended to sell simplified products in any area – Urban or Rural.

Insurance company/Insurance Broker are responsible for the acts of the POSP and liable for penal provisions under the Insurance Act in case of misconduct of POSP appointed by the Insurance company/Insurance Broker.

POS Products can be sold by POS Persons, Individual Agents, Intermediaries and Insurers.

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15. Insurance Distributors

A Motor Insurance Service Provider (MISP) is any automobile dealer (authorised dealer or sub-dealer) of automobile manufacturer, for selling new or used automotive vehicles. He is authorised to sell only Motor Insurance Policies, including add-ons.

Either an Insurer or an Intermediary can sponsor a MISP. MISP can work for any number of insurers of Intermediaries.

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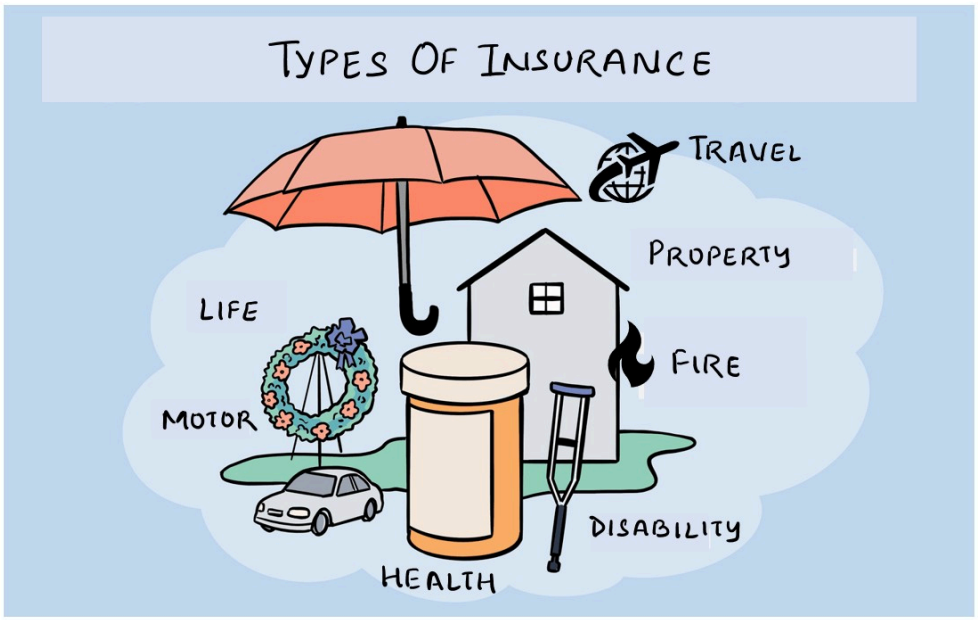
16. Types of Insurance



Insurance is a financial mechanism that provides protection against various risks and uncertainties. It involves the transfer of risk from an individual or entity to an insurance company in exchange for a premium. The primary goal of insurance is to offer financial security and support in the event of unforeseen circumstances.

There are several types of insurance, each designed to address specific needs and risks. These are discussed next.

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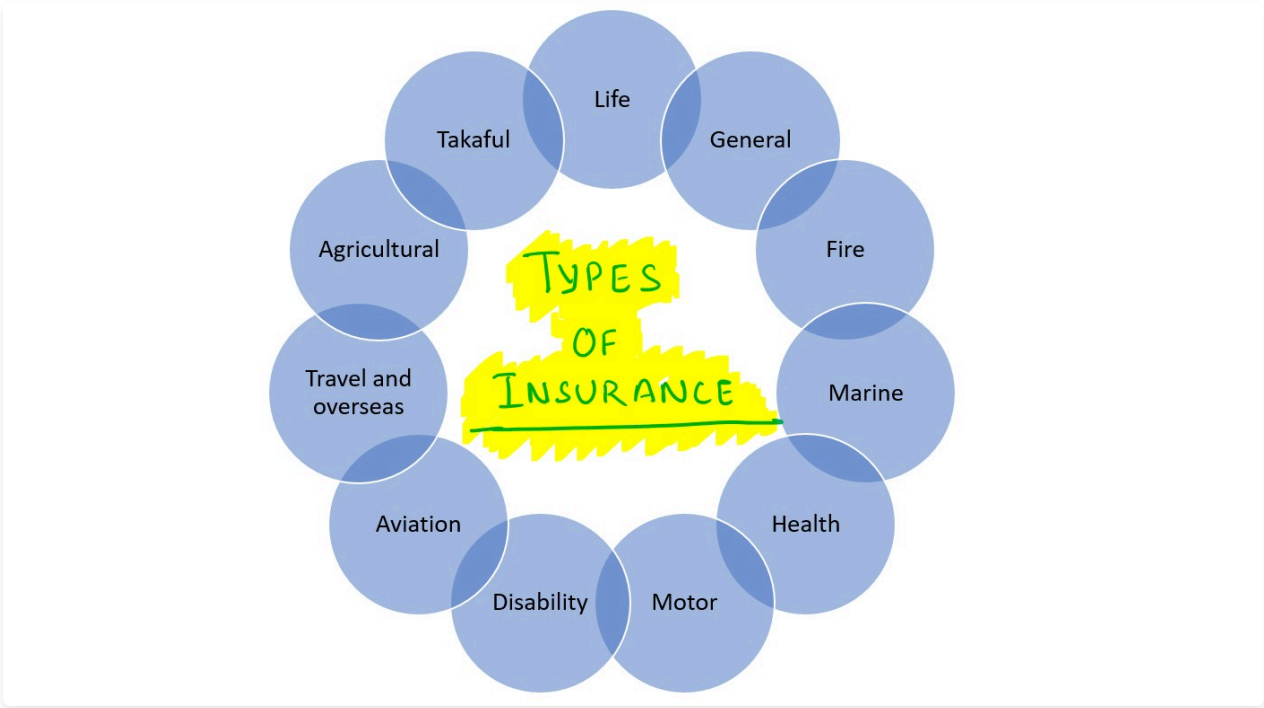
17. Life Insurance



Since life itself is uncertain, all individuals try to assure themselves of a certain sum of money in the future to take care of unforeseen events or happenings. Individuals in the course of their life are always exposed to some kind of risks.

This insurance provides protection to the family at the time of premature death or gives adequate amount at old age when earning capacities are reduced.

The insurance is not only a protection but is a sort of investment because a certain sum is returnable to the insured at the time of death or at the expiry of a certain period.

Life insurance also encourages savings as the amount of premium has to be paid regularly. It thus, provides a sense of security to the insured and his dependents.

Elements

The main elements of a life insurance contract are as follows.

- The life insurance contract must have all the essentials of a valid contract.
- The contract of life insurance is a contract of utmost good faith.
- In life insurance, the insured must have insurable interest in the life assured. Without insurable interest the contract of insurance is void.
- In case of life insurance, insurable interest must be present at the time when the insurance is affected. It is not necessary that the assured should have insurable interest at the time of maturity also.
- Life insurance contract is not a contract of indemnity. The life of a human being cannot be compensated and only a specified sum of money is paid. That is why, the amount payable in life insurance on the happening of the event is fixed in advance. The sum of money payable is fixed, at the time of entering into the contract.

The types of Life Insurance Products are discussed next.

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17. Life Insurance

These are pure life insurance products where the benefit (lump sum) is payable only on the happening of death during the term of the life insurance policy. These policies cover the risk of dying early and provide a lump sum to the Nominee (usually a Family member) to take care of their future needs.

In case the Life assured survives the Term of the Policy, nothing is payable. However, there are options available for return of premiums paid in case the Life assured survives the term of the Policy. These Policies are taken for a fixed term.

Premiums under Term insurance products are relatively the lowest as they do not have any savings component. This is the cheapest of all the Life insurance policies. Premium depends upon the age of the life insured. Higher the age, higher the premium, as the risk taken by the life insurance company increases with age.

Since Term insurance products do not provide any benefit during survival of the Life assured (except for Return of premiums upon survival till the end of the term of the Policy), these products are still unpopular.

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17. Life Insurance

Whole Life Insurance Products cover the risk of dying early till the person's death, as compared to a Term where the risk coverage is available only till the expiry of the term mentioned in the Policy, say 5 years, 10 years, 15 years etc., as chosen by the Policyholder.

Essentially, Whole Life insurance products are extensions of Term insurance products and also provide benefits (usually lump sum) payable only on the death of the life assured. But the coverage is available throughout the life.

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17. Life Insurance

Under Endowment Products, the benefits (Sum assured) are payable either upon death during the term of the Policy or if the Life assured survives the maturity of the Policy, upon maturity of the policy, whichever is earlier. Therefore, at the end of the Policy term, in case the Life assured survives, the Policyholder gets a lump sum benefit.

Typically, the premium for an Endowment plan is higher compared to a Whole Life plan for the same age. This is because Endowment plans usually provide a higher level of insurance coverage and also have a savings component.

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17. Life Insurance

These are extensions of Endowment Products where under, the Policyholder is entitled to periodic pay-outs, if he survives specified terms during the tenure of the Policy.

For example, if the Life assured survives 10 years from the date of taking the Policy, 25% of the Sum Assured shall be paid, 50% at the end of 15 years and the balance on Maturity. Under these products, the Sum Assured, instead of being paid only upon survival on maturity, is accelerated and paid in instalments. However, in the event of death anytime during the term of the Policy, full Sum Assured is paid, irrespective of the instalments that may have been paid already.

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17. Life Insurance

Annuities are periodic (usually monthly) pay-outs made in consideration of a lump sum amount deposited in the beginning of the Policy. Annuity products come in handy for Pension Policies which are used to plan post-retirement income.

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17. Life Insurance

These are Life Insurance Products which are a combination of Term insurance plus Investments. A linked insurance plan is a type of insurance plan that is linked to the stock market. The returns you get under these plans depend on the performance of the market. A Unit Linked Insurance Plan (ULIP) is the most common example of a linked insurance policy.

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17. Life Insurance

These are also called Universal Life Products, which provide a guaranteed interest credits (like a Bank account) in addition to Life insurance cover. These are in the nature of Deposit-linked-life insurance products. However, these products are not popular in India.

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18. General Insurance

A popular or generally accepted idea is that all insurance other than life is non-life or general insurance.

General Insurance comprises of insurance of property against fire, burglary and natural calamities like floods and earthquakes etc., personal insurance such as Accident and Health Insurance, and liability insurance which covers legal liabilities. There are also other covers such as Errors and Omissions insurance for professionals, credit insurance, agricultural insurance, etc.

The non-life insurers offer policies covering machinery against breakdown, there are policies that cover the hull of ships and so on. A marine cargo policy covers goods in transit including by sea, air and road. Further, insurance of motor vehicles against damages and theft forms a major chunk of non-life insurance business. In respect of insurance of property, it is important that the cover is taken for the actual value of the property to avoid being imposed a penalty should there be a claim.

Personal insurance covers include policies for Accident, Health etc. Products offering Personal Accident cover are benefit policies. Health insurance covers offered by non-life insurers are mainly hospitalization covers either on reimbursement or cashless basis. The cashless service is offered through **Third Party Administrators** who have arrangements with various service providers, i.e., hospitals. The Third-Party Administrators also provide service for reimbursement claims. Sometimes the insurers themselves process reimbursement claims.

Accident and health insurance policies are available for individuals as well as groups. A group could be a group of employees of an organization or holders of credit cards or deposit holders in a bank etc. Normally when a group is covered, insurers offer group discounts.

Liability insurance covers such as Motor Third Party Liability Insurance, Workmen's Compensation Policy, etc., offer cover against legal liabilities that may arise under the respective statutes— Motor Vehicles Act, the Workmen's Compensation Act, etc.

The transactions of general insurance business in India are governed by 2 main statues, namely:

1. The Insurance Act, 1938
2. General Insurance Business (Nationalisation) Act, 1972.

The different forms of General Insurance Business are discussed next.

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18. General Insurance

Fire insurance is a contract whereby the insurer, in consideration of the premium paid, undertakes to make good any loss or damage caused by fire during a specified period up to the amount specified in the policy. Normally, the fire insurance policy is for a **period of 1 year** after which it is to be renewed from time to time. The premium may be paid either in lump sum or instalments.

A claim for loss by fire must satisfy the 2 following conditions:

1. There must be actual loss; and
2. Fire must be accidental and non-intentional.

The risk covered by a fire insurance contract is the loss resulting from fire or some other cause, and which is the proximate cause of the loss.

The policy has standard excess clause, the amount which is deducted from each and every loss. The amount is dependent on the Sum Insured under the policy.

The underwriting in fire insurance relates to understanding and rating the assets for arriving at the premium to be charged to cover the same against the Fire and allied perils. This exercise involves C.O.P.E. (CONSTRUCTION, OCCUPATION, PROTECTION AND EXPOSURES) analysis of the assets.

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18. General Insurance

This is the oldest branch of Insurance which provides protection against loss by marine perils or perils of the sea. Marine perils are collision of ship with the rock, or ship attacked by the enemies, fire and capture by pirates and actions of the captains and crew of the ship. These perils cause damage, destruction or disappearance of the ship and cargo and non-payment of freight. So, marine insurance insures ship hull, cargo and freight. Thus, it is a device wherein the insurer undertakes to compensate the owner of a ship or cargo for complete or partial loss at sea. The insurer guarantees to make good the losses due to damage to the ship or cargo arising out of the risks incidental to sea voyages.

The insurer in this case is known as the underwriter and a certain sum of money is paid by the insured in consideration for the guarantee/protection he gets. There are 3 things involved i.e., ship or hull, cargo or goods, and freight.

1. **Ship or hull Insurance:** Since the ship is exposed to many dangers at sea, the insurance policy is for indemnifying the insured for losses caused by damage to the ship.
2. **Cargo Insurance:** The cargo while being transported by ship is subject to many risks. These may be at port i.e., risk of theft, lost goods or on voyage etc. Thus, an insurance policy can be issued to cover against such risks to cargo.
3. **Freight Insurance:** If the cargo does not reach the destination due to damage or loss in transit, the shipping company is not paid freight charges. Freight insurance is for reimbursing the loss of freight to the shipping company i.e., the insured.

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18. General Insurance

A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g., annually, monthly) or lifelong in the case of private insurance, or be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national health policy for public insurance.

Health Insurance is a type of insurance that covers medical expenses that arise due to an illness. These expenses could be related to hospitalisation costs, cost of medicines or doctor consultation fees.

The Insurance Act, 1938 defines **Health insurance business** to include Policies providing the following benefits:

- Sickness benefits, medical benefits, hospital benefits, surgical benefits (both in-patient as well as out-patient benefits),
- Travel insurance,
- Personal accident cover.

Health Insurance encompasses 2 types:

1. **Indemnity Plans** - The Indemnity Plans are traditional health covers that cover hospitalization costs from the sum assured.
2. **Definite Benefit Plans** - Definite benefit plans offer lump-sum payments on the detection of illness.

Health Insurance Plans

Health insurance plans in India today can be broadly classified into these categories:

1. **Hospitalization (Mediclaim Plans):** Hospitalization plans are indemnity plans that pay cost of hospitalization and medical costs of the insured subject to the sum insured. The sum insured can be applied on a per member basis in case of individual health policies or on a floater basis in case of family floater policies.

2. **Family Floater Health Insurance:** Family health insurance plan covers entire family in one health insurance plan. It works under assumption that not all member of a family will suffer from illness in one time. It covers hospital expense which can be pre and post.

3. **Pre-Existing Disease Cover Plans:** It offers covers against disease that policyholder had before buying health policy such as diabetes, kidney failure etc.

4. **Senior Citizen Health Insurance:** These kinds of health insurance plans are for older people in the family. It provides covers and protection from health issues during old age. According to IRDA guidelines, each insurer should provide cover up to the age of 65 years.

5. **Maternity Health Insurance:** It ensures coverage for maternity and other additional expenses. It takes care of both pre and post natal care, baby delivery (either normal or caesarean).

6. **Hospital Daily Cash Benefit Plans:** Daily cash benefits are a defined benefit policy that pays a defined sum of money for every day of hospitalization.

7. **Critical illness Plans:** These are benefit-based policies which pay a lump-sum (fixed) benefit amount on diagnosis of covered critical illness and medical procedures. These illnesses are generally specific and high severity and low frequency in nature that cost high when compared to day to day medical / treatment need, for example, heart attack, cancer, stroke etc.

8. **Pro Active Plans:** These are designed keeping in mind the Indian market and provide assistance based on medical, behavioural and lifestyle factors associated with chronic conditions. These services aim to help customers understand and manage their health better.

9. **Disease Specific Special Plans:** Some companies offer specially designed disease specific plans like Dengue Care. These plans aim to help customers manage their unexpected health expenses better and at a very minimal cost.

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18. General Insurance

In Insurance, offering of any rebates or discounts or concessions or any form of inducement to a Customer for taking out an insurance policy or for continuing an insurance policy is strictly prohibited under Insurance Act, 1938, unless offering of a discount or rebates or concessions are part of the product specifications as approved by IRDAI under "File and use" for an insurance product. No discount on any other third-party service or merchandise is allowed.

Insurers are allowed to offer reward to customers on early entry or continued renewals of health insurance policies or favourable claims experience or preventive or wellness habits, provided such benefits are approved by IRDAI and such benefits are disclosed in the Prospectus and Policy documents issued by the Insurer.

The following wellness benefits, in the form of discounts by tie-ups with Network Providers, viz., Hospitals or Diagnostic Centres empanelled by the Insurer, can be offered under Health insurance products:

- Outpatient consultations or treatments
- Pharmaceuticals
- Preventive health check-ups.

The above benefits in the form of discounts on cost of medicines, diagnosis or consultation offered by a Network Provider is also allowed if such offers are approved by IRDAI. Network Provider means the hospital or health care provider with whom insurer and/or Third Party Administrator (TPA) has a tie-up for providing health services either on cash basis or cashless basis.

A **Third Party Administrator (TPA)** is an intermediary registered with IRDAI, who facilitates claims settlement under health insurance policies for an insurer (with whom TPA has tied up) both under cashless basis as well cash basis, as per terms and conditions of the Health insurance policy issued by the insurer. However, a TPA cannot decide any claim – only an insurer can decide to accept or part-accept or reject any health insurance claim. Such TPAs also handle Personal Accident and Travel insurance claims. Further, TPAs are also allowed to conduct medical examination of Customers who take insurance policies.

Cash basis means that Customers first pays for the insured event covered under the Policy and then seeks reimbursement from the insurer.

Cashless basis means the Customer does not pay from his pocket first to the extent of the claim covered under the Policy and instead the Insurer, through the TPA arranges for direct payment of the claim amount to the Hospital or Diagnostic Centre to the extent of allowable amount within the Sum assured and as per terms and conditions of the Policy document. Any balance amount which is uncovered only is paid by the Customer.

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18. General Insurance

In Motor Insurance, First party is the owner of property (Motor Vehicle), Second party is the Insurer and the Third party is everyone else, say person on street. Normally, in insurance, loss or damage to the property of insured is covered. If your car gets damaged, its repair and replacement is covered. This is commonly called First party insurance or own damage section of Insurance policy.

Third-party insurance is compulsory for all vehicle-owners as per the Motor Vehicles Act. It covers only your legal liability for the damage you may cause to a third party-bodily injury, death and damage to third party property - while using your vehicle on public spaces.

According to Section 24 of Motor Vehicles Act, "No person shall use or allow any other person to use a motor vehicle in a public place, unless the vehicle is covered by a policy of Insurance." Here the term insurance is to be referred as "Third Party Insurance."

Third-Party Insurance is essentially a form of liability insurance purchased by an insured (first-party) from an insurer (second party) for protection against the claims of another (third party). The first party is responsible for their damages or losses, regardless of the cause of those damages. One of the most common types is third-party insurance is automobile insurance.

Usage-Based Insurance (UBI)

Usage-Based Insurance (UBI) also known as Pay As You Drive (PAYD) and Pay How You Drive (PHYD) and mile-based auto insurance is a type of vehicle insurance whereby the costs are dependent upon type of vehicle used, measured against time, distance, behaviour and place.

This differs from traditional insurance, which attempts to differentiate and reward "safe" drivers, giving them lower premiums and/or a no-claims bonus.

The general concept of pay as you drive includes any scheme where the insurance costs may depend not just on how much you drive but how, where, and when one drives.

Pay As You Drive (PAYD) means that the insurance premium is calculated dynamically, typically according to the amount driven.

Motor Vehicle Act 1988

The Motor Vehicles Act, 1988 regulates all aspects of road transport vehicles. The Act came into force from 01st July 1989. It replaced the Motor Vehicles Act, 1938 which earlier replaced the first such enactment Motor Vehicles Act, 1914.

The Act provides in detail the legislative provisions regarding licensing of drivers and conductors, registration of motor vehicles, control of motor vehicles through permits, special provisions relating to state transport undertakings, traffic regulations, insurance, liability, offences and penalties etc.

Section 140 of Motor Vehicles Act, 1988 deals with the liability without fault. The claimant involved in a motor vehicle accident is not required to prove wrongful act, neglect, or default on the part of the owner of the vehicle or by any other person.

The object behind no-fault principle is to give minimum statutory relief expeditiously to the victim of the road accident or his legal representative. To that extent, these provisions constitute a measure of social justice.

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18. General Insurance

This is a policy which covers insurance need of a person going abroad on a holiday, business tour or for education. The basic coverage is accidental and medical risk apart from other features. The other coverages available include Medical cover, Daily allowance in case of hospitalisation, Dental treatment, Repatriation of remains, Checked baggage loss, checked baggage delay, Personal accident, Personal liability, Financial emergency assistance, Hijack Distress Allowance, Trip cancellation and interruption, Missed connecting flights, Trip delays etc.

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18. General Insurance

Individual disability insurance pays the benefits if an individual cannot work because of sickness or injury. Individual policies specify how much will be paid, how soon the disability benefits will begin and when benefits will end. The length of time for which an individual may receive benefits can depend on whether the accident or illness caused the disability. Monthly benefits are payable for a fixed period set forth in the Policy document.

Personal Accident & Disability Insurance

Personal accident and disability insurance replaces income an individual loses if he has a long-term illness or injury and cannot work. It compensates individual against death, loss of limbs, loss of eyesight and permanent total disablement, permanent partial disablement and temporary total disablement. This is an important type of coverage for working-age people to consider. Disability insurance does not cover the cost of rehabilitation if one is injured. The coverage is usually offered on a world-wide basis.

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18. General Insurance

Aviation insurance is the insurance that covers the risks involved in the Civil Aviation. It is sometimes also called as **Aerospace Insurance**. Micro-satellites and commercial space launchers are all governed under this policy.

Aviation insurance offers protection against a wide array of perils, dangers, risks and damages to policyholders. Given that aircrafts are extremely prone to technical failures, accidents, terrorist activities, and such like, aviation insurance is extremely crucial.

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19. Agriculture Insurance

Agricultural Insurance is an effective mechanism for reducing the losses farmers suffer due to natural calamities such as floods, droughts, and outbreaks of pests and diseases. There are a number of schemes initiated by the Government to promote and protect interests of the agricultural sector; on of them is Pradhan Mantri Fasal Bima Yojana scheme which is discussed next.

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19. Agriculture Insurance

Pradhan Mantri Fasal Bima Yojana (PMFBY) was launched from kharif 2016 season. The objective is to provide insurance coverage and financial support to the farmers in the event of failure of any of the notified crop as a result of natural calamities, pests & diseases. The scheme is implemented by the Department of Agriculture, Cooperation & Farmers Welfare (DAC&FW), under the Ministry of Agriculture & Farmers Welfare (MoA&FW). For the purpose of this, the DAC&FW has empanelled Agriculture Insurance Company of India (AIC) and some private insurance companies. States have also been allowed to set up their own insurance companies for implementing the scheme. The difference between premium and the rate of Insurance charges payable by farmers shall be borne by the Government. It is applicable for:

1. Food crops (Cereals, Millets and Pulses),
2. Oilseeds,
3. Annual Commercial / Annual Horticultural crops.

Premium to be paid by the farmers:

- Kharif (All foodgrain and Oilseeds crops): 2%
- Rabi (All foodgrain and Oilseeds crops): 1.5%
- Kharif and Rabi (Annual Commercial / Annual Horticultural crops): 5%

Note that, since 2022, the DAC&FW has migrated from administered premium and claim-support insurance schemes to an upfront subsidy for actuarial premium-based system.

Also note that, earlier for crop insurance, MoA&FW implemented National Crop Insurance Programme (NCIP) having 3 components viz. National Agricultural Insurance Scheme (NAIS) / Modified NAIS, Weather Based Crop Insurance Scheme (WBCIS) and Coconut Palm Insurance Scheme (CPIS).

PMFBY replaced the NAIS/ Modified NAIS. WBCIS has been rationalized and made at par with PMFBY and is now known as RWBCIS. CPIS component is being continued as before.

Restructured Weather Based Crop Insurance Scheme (RWBCIS)

The Restructured Weather Based Crop Insurance Scheme (RWBCIS) was launched in 2016. It aims to mitigate the hardship of the insured farmers against the likelihood of financial loss on account of anticipated crop loss resulting from adverse weather conditions relating to rainfall, temperature, wind, humidity etc. WBCIS uses weather parameters as “proxy” for crop yields in compensating the cultivators for deemed crop losses. This scheme is also implemented by the Department of Agriculture, Cooperation & Farmers Welfare (DAC&FW).

Coconut Palm Insurance Scheme (CPIS)

Coconut Palm Insurance Scheme (CPIS) was implemented on pilot basis from the year 2009-10 in the coconut growing areas of Andhra Pradesh, Goa, Karnataka, Kerala, Maharashtra, Orissa, Tamil Nadu and West Bengal. The Insurance Company i.e., Agriculture Insurance Company of India (AIC) is implementing the scheme and responsible for making payment of all claims. The CPIS is administered by the Coconut Development Board (CDB). The Scheme is being implemented as component of NCIP w.e.f. Rabi 2013-14.

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20. Social Insurance

Social Insurance is one of the devices to prevent individual from falling to the death of poverty, misery and to help him in times of emergencies. It is a co-operative device which aims at granting adequate benefits to the insured on the compulsory basis in time of unemployment, sickness and other emergencies.

Social Insurance is any government-sponsored program with the following 4 characteristics:

1. The benefits, eligibility requirements and other aspects of the program are defined by statute;
2. Explicit provision is made to account for the income and expenses (often through a trust fund);
3. It is funded by taxes or premiums paid by (or on behalf of) participants (although additional sources of funding may be provided as well); and
4. The program serves a defined population, and participation is either compulsory or the program is subsidized heavily enough that most eligible individuals choose to participate.

Socially-Oriented Insurnace Scheme

Government Sponsored Socially Oriented Insurance Schemes in India are as follows.

- Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY)
- Pradhan Mantri Suraksha Bima Yojana (PMSBY)
- Life Cover under Pradhan Mantri Jan Dhan Yojana (PMJDY)
- Varishtha Pension Bima Yojana
- Pradhan Mantri Fasal Bima Yojana (PMFBY)
- Pradhan Mantri Vaya Vandana Yojana (PMVVY)
- Restructured Weather Based Crop Insurance Scheme (RWBCIS)

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20. Social Insurance

There are considerable similarities and differences among Social Insurance vis-à-vis Private Insurance which are given below.

Similarities

Typical similarities between social insurance programs and private insurance programs include:

1. **Wide pooling of risks:** Both social insurance programs and private insurance programs aim to pool risks among a large number of individuals. This allows the costs of providing insurance coverage to be spread out over a large number of people, reducing the individual costs for each participant.

2. **Specific definitions of the benefits provided:** Both types of insurance programs clearly define the benefits that will be provided to participants. This helps to ensure that individuals understand what they are covered for and what they can expect to receive in the event of a covered loss or incident.

3. **Specific definitions of eligibility rules and the amount of coverage provided:** Both social insurance and private insurance programs have specific eligibility rules that determine who is eligible to participate in the program and receive benefits. Additionally, both types of programs specify the amount of coverage that will be provided to eligible individuals.

4. **Specific premium, contribution or tax rates:** Both social insurance programs and private insurance programs require participants to pay a specific premium, contribution, or tax rate to help fund the program and meet the expected costs of providing insurance coverage. The amount of the premium, contribution, or tax will depend on factors such as the age, health status, and income of the individual, as well as the type and amount of coverage being provided.

Differences

Typical differences between private insurance programs and social insurance programs include:

1. **Equity versus Adequacy:** Private insurance programs are generally designed with greater emphasis on equity between individual purchasers of coverage, while social insurance programs generally place a greater emphasis on the social adequacy of benefits for all participants.

2. **Voluntary versus Mandatory Participation:** Participation in private insurance programs is often voluntary, and where the purchase of insurance is mandatory, individuals usually have a choice of insurers. Participation in social insurance programs is generally mandatory, and where participation is voluntary, the cost is heavily enough subsidized to ensure essentially universal participation.

3. **Contractual versus Statutory Rights:** The right to benefits in a private insurance program is contractual, based on an insurance contract. The insurer generally does not have a unilateral right to change or terminate coverage before the end of the contract period (except in such cases as non-payment of premiums). Social insurance programs are not generally based on a contract, but rather on a statute, and the right to benefits is thus statutory rather than contractual. The provisions of the program can be changed, if the statute is modified.

4. **Funding:** Individually purchased private insurance generally must be fully funded. Full funding is a desirable goal for private pension plans as well but is often not achieved. Social insurance programs are often not fully funded, and some argue that full funding is not economically desirable. Most international systems of social insurance are funded on an ongoing basis without reference to future liabilities. This is seen as a matter of solidarity between generations and between the sick and the healthy as a part of the social contract. In essence, this means that the current generation of healthy working people pay something now to meet the health care and living costs of those who are currently temporarily incapacitated through sickness or who have ceased work through old age or disability.

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21. Business Insurance Policies

Most businesses need to purchase the following types of insurance.

Property Insurance

Property insurance compensates a business, if the property used in the business is lost or damaged as the result of various types of common perils, such as fire or theft. Property insurance covers not just a building or structure but also the contents, including office furnishings, inventory, raw materials, machinery, computers and other items vital to a business's operations. Depending on the type of policy, property insurance may include coverage for equipment breakdown, removal of debris after a fire or other destructive event, some types of water damage and other losses.

Liability Insurance

Any enterprise can be sued. Customers may claim that the business caused them harm as the result of, for example, a defective product, or an error in a service or disregard for another person's property. Or a claimant may allege that the business created a hazardous environment. Liability insurance pays damages for which the business is found liable, up to the policy limits, as well as attorneys' fees and other legal defense expenses. It also pays the medical bills of any people injured by, or on the premises of, the business. This type of insurance also includes product liability insurance which protects you from claims that arise from the products you sell.

Commercial Vehicle Insurance

A commercial auto policy provides coverage for vehicles that are used primarily in connection with commercial establishments or business activities. The insurance pays any costs to third parties resulting from bodily injury or property damage for which the business is legally liable up to the policy limits.

Workers' Compensation Insurance

To protect employers from lawsuits resulting from workplace accidents and to provide medical care and compensation for lost income to employees hurt in workplace accidents, businesses are required to buy workers' compensation insurance. Workers compensation insurance covers workers injured on the job, whether they are hurt on the workplace premises or elsewhere, or in auto accidents while on business. It also covers work-related illnesses. Workers' compensation provides payments to injured workers, without regard to who was at fault in the accident, for time lost from work and for medical and rehabilitation services. It also provides death benefits to surviving spouses and dependents.

Fidelity Guarantee Insurance

Fidelity Guarantee Insurance policy provides cover against the financial loss suffered by the Insured as a result of fraud/dishonesty of employees of the insured up to the maximum limit selected for insurance per employee.

Cyber liability Insurance

Cyber liability insurance protects from the cost of damages or injuries that occur as a result of a data breach. If a business is hacked and customer data is stolen, this insurance will cover the cost of defence and any damages awarded. It also covers the cost of any public relations (PR) needed to repair reputation of the business, as well as credit monitoring for affected customers.

22. Takaful Insurance

Takaful insurance is specific to Islamic community. **Takaful** is a type of Islamic insurance, where members contribute money into a pool system in order to guarantee each other against loss or damage. Takaful-branded insurance is based on sharia, Islamic religious law, and explains how it is the responsibility of individuals to cooperate and protect each other.

The Takaful-compliant model does not allow the following 3 things in insurance/ investment activities:

1. Uncertainty and speculation (**Gharar**);
2. Gambling (**Maysir**);
3. In the case of investment or fund management, interest or usury (**Riba**).

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1. Introduction

All business activities are subject to uncertain events or happenings and may suffer loss or damage. Timely precaution can be taken to avoid some of the losses. But certain losses and damages have either to be borne by the businessman himself, or if possible, shared with others.

The possibility of loss or damage can be divided into 2 broad categories: uncertainties and risks. **Uncertainties** are the events, which cannot be foreseen. **Risk** is defined as the possibility of occurrence of loss. Greater the uncertainty, greater is the risk.

In other words, Risk has been defined as the possibility of occurrence of an unfavourable deviation from the expected, i.e., what you want to happen does not happen or vice versa what you do not want to happen, happens.
The knowledge of risk and its potential to cause loss creates uncertainty and gives rise to a feeling of insecurity which leads to worry amongst people. Risk with its resultant's uncertainty, insecurity and worry, definitely has an economic and a psychological cost.

Organizations face a very wide range of risks that can impact the outcome of their operations. The desired overall aim may be stated as a mission or a set of corporate objectives. The events that can impact an organization may inhibit what it is seeking to achieve (**hazard risks**), enhance that aim (**opportunity risks**), or create uncertainty about the outcomes (**control risks**). Risk management needs to offer an integrated approach to the evaluation, control and monitoring of these three types of risk.

PACED

In order to be successful, the risk management initiative should be Proportionate, Aligned, Comprehensive, Embedded and Dynamic (PACED).

Proportionate means that the effort put into risk management should be appropriate to the level of risk that the organization faces. Risk management activities should be aligned with other activities within the organization. Activities will also need to be comprehensive, so that any risk management initiative covers all the aspects of the organization and all the risks that it faces. Embedded risk management is where the right techniques are applied where appropriate, in the right strength, and in a way that generates evidence of operation and effectiveness. Finally, risk management activities should be dynamic and responsive to the changing business environment faced by the organization.

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2. Sources of Risks

Risk is all about losses. In the absence of possibility of loss there would be no risk, thus it is important to know about the factors, which cause or contribute towards the occurrence of loss or extent of loss. There are 2 such factors and these are “Perils” and “Hazards”.

These are discussed next.

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2. Sources of Risks

Perils cause the deviation in events from those that we expect. They are the immediate cause of loss. Their very existence ensures that we are surrounded by risk, for example, flood, death, sickness, theft, terrorism etc. Their types are discussed next.

Natural Perils

There are unexpected natural phenomena, which year in and year out cause untold misery, loss of life and property. Volcanic eruptions, fire due to lightning, landslides, cyclones, hurricanes, storms, floods, the vagaries of weather, unseasonal rainfall and prolonged dry spells, hailstorms are some other examples of natural risks that can cause losses. These perils are also called Act of God perils, and there is little that mankind can do to stop them, he can only learn to live with them and devise means to lessen the negative impact.

Man Made Perils

There are the manmade perils which cause loss; these are an outcome of our society and are the violent actions and unethical practices of people, which result in deviation from the expected.

Economic Perils

The third category of Perils or cause of Risk is economic in nature and the examples of this type of Risk are Depression, Inflation, Local fluctuations and the instability of Industrial firms.

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2. Sources of Risks

While perils are the direct cause of loss, hazards are the underlying factors, which increase the probability of occurrence of loss. There are conditions, which are more hazardous than others e.g., working as an electrician is a more hazardous occupation than that of a banker as it is more susceptible to accidents. There are 3 kinds of hazards:.

1. Physical hazards

These are related to the physical aspects of the property, which may influence the chances that the property may be damaged, or which may increase or decrease the losses incurred due to a particular risk. For example, the location of a building affects its vulnerability to losses due to fire, floods, earthquakes etc. A residential building close to a unit manufacturing crackers will be more susceptible to losses than a building located in a purely residential area.

2. Moral hazards

These also affect the probability of loss occurring and the risk is increased. A dishonest person may set his own house or property on fire to avail the Insurance benefit. An unscrupulous trader may arrange for a robbery in his own store to get the benefits.

3. Morale hazards

Morale hazard is an attitude of lack of concern about the outcome of one's actions. For example, carelessly stubbing out cigarettes and throwing them around, which may cause fire. Bad house-keeping is another example of a morale hazard as this also increases the chances of loss occurring.

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3. Types of Risks

The major types of Risks are discussed next.

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3. Types of Risks

With regards insurability, there are basically two categories of risks; (a) Speculative or dynamic risk; and (b) Pure or static risk.

Speculative (dynamic) risk

Speculative (dynamic) risk is a situation in which either profit OR loss is possible. Examples of speculative risks are betting on a horse race, investing in stocks/bonds and real estate. In the business level, in the daily conduct of its affairs, every business establishment faces decisions that entail an element of risk. The decision to venture into a new market, purchase new equipment, diversify on the existing product line, expand or contract areas of operations, commit more to advertising, borrow additional capital, etc., carry risks inherent to the business. The outcome of such speculative risk is either beneficial (profitable) or loss. Speculative risk is uninsurable.

Pure or Static Risk

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

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3. Types of Risks

Risk which involves exposure to uncertainty due to changes in rate or market price of an invested asset (e.g., interest rates, equity values) is called Market Risk.

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3. Types of Risks

The risk of loss from everything other than credit, market, and interest rate risks is called Operational Risk. It is the risk of human, process, system, or technological failure as well as risks from external events (i.e., event risk).

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3. Types of Risks

Credit Risk is due to the possibility that either one of the parties to a contract will not be able to satisfy its financial obligation under that contract. The classic example is that of one commercial enterprise extending credit to another enterprise or individual.

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3. Types of Risks

The risk of loss associated with fortuitous occurrences (e.g., fires, hurricanes, tortuous conduct) is known as Event Risk. Event risk, which is synonymous with pure risk, hazard risk, or insurance risk, presents no chance of gain, only of loss.

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3. Types of Risks

Interest rate risk is the exposure of a bank's current or future earnings and capital to adverse changes in market rates. This risk is a normal part of banking and can be an important source of profitability and shareholder value; however, excessive interest rate risk can threaten banks' earnings, capital, liquidity, and solvency. Therefore, it is important to effectively identify, measure, monitor, and control interest rate risk exposure through effective policies and risk management processes.

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3. Types of Risks

Financial risk refers to the danger in which the outcome of the event is measurable in terms of the money, i.e., any loss that could occur due to the risk which can be measured by the concerned person in monetary value. An example of financial risk includes a loss to the goods in the warehouse of the company due to the fire. These risks are insurable and are generally the main subjects of the insurance.

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3. Types of Risks

Non-financial risk refers to the risk in which the outcome of the event is not measurable in terms of the money, i.e., any loss that could occur due to the risk which cannot be measured by the concerned person in the monetary value. An example of the non-financial risk includes the risk of poor selection of the brand while purchasing mobile phones. These risks are uninsurable since they cannot be measured.

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3. Types of Risks

Static risk refers to the risk which remains constant over the period and is generally not affected by the business environment. These risks arise from human mistakes or actions of nature. An example of static risk includes the embezzlement of funds in a company by its employees. They are generally easily insurable as they are easy to measure.

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3. Types of Risks

Dynamic risk refers to the risk which arises when there are any changes in the economy. These risks are generally not easy to predict. These changes might bring financial losses to the members of the economy. An example of the dynamic risk includes the changes in the income of the persons in an economy, their tastes, preferences, etc. They are generally not easily insurable.

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3. Types of Risks

Fundamental risks affect the entire economy or large numbers of people or groups within the economy. Examples of fundamental risks are high inflation, unemployment, war, and natural disasters such as earthquakes, hurricanes, tornadoes, and floods. Particular risks are risks that affect only individuals and not the entire community. Examples of particular risks are burglary, theft, auto accident, dwelling fires. With particular risks, only individuals experience losses, and the rest of the community are left unaffected.

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3. Types of Risks

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

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3. Types of Risks

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

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3. Types of Risks

A financial risk is one where the outcome can be measured in monetary terms. There are other situations where this kind of measurement is not possible. Take the case of the choice of a new car, or the selection of an item from a restaurant menu. These could be construed as risky situations, not because the outcome will cause financial loss, but because the outcome could be uncomfortable or disliked in some other way.

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

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4. Risk Management Process

Risk Management Comprises of mainly following steps:

- Risk Analysis
- Risk Identification
- Risk Assessment
- Risk Planning
- Risk Controlling

The Risk Analysis is the process of identifying, analyzing and communicating the major risks. Once risks have been identified, they must then be assessed as to their potential severity of impact (generally a negative impact, such as damage or loss) and to the probability of occurrence.

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

There are 5 major methods of handling and controlling risk. These are discussed next.

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4. Risk Management Process

Risk Avoidance is one method of handling risk. For example, you can avoid the risk of being pick pocketed in Delhi Metro by not travelling in Metro. Similarly, you can avoid the risk of divorce by not marrying.

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4. Risk Management Process

Risk Retention is a second method of handling risk. An individual or a business firm may retain all or part of a given risk. Risk retention can be either active or passive. Active risk retention means that an individual is consciously aware of the risk and deliberately plans to retain all or part of it. For example, a motorist may wish to retain the risk of a small collision loss by purchasing an own damage insurance policy with a Rs 2,000 voluntary excess. A homeowner may retain a small part of the risk of damage to the house by purchasing a Householders policy with substantial voluntary excess.

Risk can also be retained passively. Certain risks may be unknowingly retained because of ignorance, indifference, or laziness. This is often dangerous if a risk that is retained has the potential for destroying a person financially. For example, many persons with earned incomes are not insured against the risk of long-term disability under either an individual or group disability income plan.

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4. Risk Management Process

Risks can be transferred by several methods, among which are the following:

- **Transfer of risk by contracts** - Unwanted risks can be transferred by contracts. For example, the risk of a defective television or stereo set can be transferred to the retailer by purchasing a service contract, which makes the retailer responsible for all repairs after the warranty expires.
- **Hedging price risks** - Hedging price risks is another example of risk transfer. Hedging is a technique for transferring the risk of unfavorable price fluctuations to a speculator by purchasing and selling futures contracts on an organized exchange, such as NSE.

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4. Risk Management Process

Loss control is another important method for handling risk. Loss control consists of certain activities undertaken to reduce both the frequency and severity of losses. Thus, loss control has 2 major objectives:

1. **Loss prevention:** Loss prevention aims at reducing the probability of loss so that the frequency of losses is reduced. Several examples of personal loss prevention can be given. Automobile accidents can be reduced, if motorists pass a safe driving course and drive defensively. Dropping out of college can be prevented by intensive study on a regular basis. The number of heart attacks can be reduced, if individuals watch their weight, give up smoking, and follow good health habits.
2. **Loss reduction:** Although stringent loss prevention efforts can reduce the frequency of losses, some losses will inevitably occur. Thus, the second objective of loss control is to reduce the severity of a loss after it occurs. For example, a warehouse can install a sprinkler system so that a fire is promptly extinguished, thereby reducing the loss.

Ideal Method for Handling Risk – Loss Control

From the viewpoint of society, loss control is the ideal method for handling risk. This is true for 2 reasons.

1. The indirect costs of losses may be large, and in some instances, they can easily exceed the direct costs. For example, a worker may be injured on the job. In addition to being responsible for the worker's medical expenses and a certain percentage of earnings (direct costs), the firm may also incur sizeable indirect costs: a machine may be damaged and must be repaired; the assembly line may have to be shut down; costs are incurred in training a new worker to replace the injured worker; and a contract may be cancelled because goods are not shipped on time. By preventing the loss from occurring, both indirect costs and direct costs are reduced.
2. The social costs of losses must also be considered. For example, assume that the worker in the preceding example dies from the accident. Substantial social costs are incurred because of the death. Society is deprived forever of the goods and services that the deceased worker could have produced. The worker's family loses its share of the worker's earnings and may experience considerable grief and financial insecurity. And the worker may personally experience great pain and suffering before he or she finally dies. In short, these social costs can be reduced through an effective loss control programme.

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4. Risk Management Process

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

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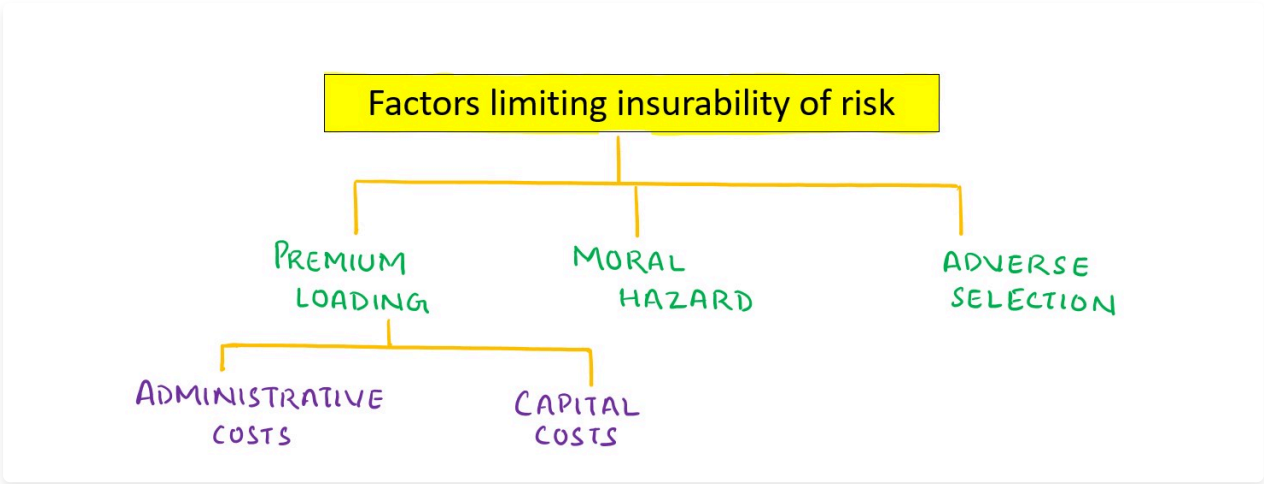
5. Factors limiting the insurability of risk

There are 3 major factors that increase costs and thereby limit the insurability of risk in private insurance markets, as explained next.



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5. Factors limiting the insurability of risk

Premium loading reflects insurer administrative and capital costs. If an insurance contract's premium equals the present value of expected claim costs, a risk-averse person will likely demand full insurance coverage for monetary losses that otherwise would be paid by the person. Because premiums almost always have a positive loading, however, risk-averse people will demand less than full coverage. As the loading increases, the quantity of coverage demanded is likely to decrease. Thus, any factor that increases administrative or capital cost (and thus the loading on a policy) will limit the amount of private market insurance coverage. Simply stated, higher premium loading generally imply less coverage. In addition, insurance coverage for some risk exposures is likely to be extremely limited or even nonexistent because of administrative and capital costs.

An insurance business anticipates a certain amount that might be claimed through insurance for a certain period. Like for example, till a person is healthy, he proved to be at a lower risk of claiming his insurance. When diagnosed with certain health complexities that could reoccur (like a heart-attack), he is at a greater risk to the company. So, to cover itself of losses that could occur from uncertainties of a customer's health, the insurance company charges a higher premium than it would before. The loading is based on one's medical history, nature of the job (whether or not dangerous) or hazardous habits.

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5. Factors limiting the insurability of risk

Moral Hazard refers to the effect of insurance on the insured's incentives to reduce expected losses. Since losses are incurred, a portion of the benefits accrues to the insurer in the form of lower expected claim costs. The two conditions are required for moral hazard to arise. First, expected losses must depend on the insured's behavior after having obtained insurance. Second, it must be costly for the insurer to observe precautions by policy holders and measure their impact on expected claim costs.

For example: You have not insured your house from any future damages. It implies that a loss will be completely borne by you at the time of a mishappening like fire or burglary. Hence you will show extra care and attentiveness. You will install high tech burglar alarms and hire watchmen to avoid any unforeseen event. But if your house is insured for its full value, then if anything happens you do not really lose anything. Therefore, you have less incentive to protect against any mishappening. In this case, the insurance firm bears the losses and the problem of moral hazard arises.

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5. Factors limiting the insurability of risk

Another factor that limits the insurability of risk is adverse selection. It refers to situations in which consumers have different expected losses (for example, book worms versus skateboarders), but the insurer is unable to distinguish between the two types of consumers and charge them different premiums. If an insurer offers insurance at the same price to heterogeneous consumers and consumers know their expected losses, then the higher expected loss consumers (skateboarders) will tend to purchase more insurance coverage relative to the case where insureds are charged premium based on their expected losses. Conversely, the lower expected loss consumers (bookworms) will tend to purchase less insurance coverage. When this scenario occurs, adverse selection takes place.

Thus, adverse selection arises because it is too costly to classify insureds perfectly. Indeed, if each consumer's expected claim costs could be observed costless, then insurance premiums (barring government restrictions) would vary exactly with expected claim costs and there would be no adverse selection.

A good example of adverse selection is in the health insurance market. People most likely to purchase health insurance are those who are most likely to use it, i.e. smokers/drinkers/those with underlying health issues. The insurance company knows this and so raises the average price of insurance cover. This risks pricing healthy consumers out of the market, meaning that only high risk individuals gain insurance – this is clearly a market failure. One interpretation of adverse selection is that "we tend to trust the people we shouldn't!"

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6. Re-insurance

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

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

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

1. Introduction

Financial Inclusion (FI) is the endeavor to ensure that vulnerable groups, including weaker sections and low-income populations, have access to affordable and suitable financial products and services. This access is facilitated by Banks and Financial Institutions in a fair and transparent manner. The concept of FI is multifaceted and encompasses various dimensions:

Banking Inclusion
This involves providing access to bank accounts and ensuring that individuals can effectively utilize these accounts for their financial needs.

Savings Inclusion
FI extends to enabling access to savings products and ensuring active participation in savings initiatives.

Credit Inclusion
It involves providing access to mainstream credit and ensuring that individuals can effectively utilize credit facilities.

Financial Service Inclusion
This dimension encompasses providing access to a range of financial services, including appropriate credit, savings, insurance, and pension products.

Information Inclusion
FI includes facilitating access to timely and relevant information, empowering individuals to make informed decisions about their financial matters.

Overall, Financial Inclusion aims to create an environment where individuals from vulnerable groups can access a variety of financial tools and services at an affordable cost. This inclusive approach is essential for promoting economic stability and ensuring that all segments of society have the opportunity to participate in and benefit from the formal financial system.

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2. FI Journey in India

Earlier, in India, the financial services have been used by a very limited group of people. To increase the penetration of usage in terms of area and service sector, certain policy measures have been taken by the Regulator (RBI), Central & State Governments. The historical journey of FI in India, is described below.

Before 1990, several initiatives were undertaken for enhancing the usage of the banking services for sustainable and equitable growth. These included:

- Nationalization of banks (1969–1980)
- Priority sector lending requirements
- Lead bank scheme (1969)
- Establishment of regional rural banks (1975–1976)
- Service area approach (1989)
- Self-Help Group - bank linkage program (1989–1990)

The **Lead Bank Scheme**, introduced towards the end of 1969, envisages assignment of lead roles to individual banks (both in public sector and private sector) for the districts allotted to them. A bank having a relatively large network of branches in the rural areas of a given district and endowed with adequate financial and manpower resources has generally been entrusted with the lead responsibility for that district. The lead bank acts as a leader for coordinating the efforts of all credit institutions in the allotted districts to increase the flow of credit to agriculture, small-scale industries and other economic activities.

Under **Self-Help Group – bank linkage program**, banks were allowed to open savings accounts for Self-Help Groups (SHGs). SHGs are registered/unregistered entities which usually has a membership of 15 to 20 members from very low income families, usually women. They mobilize savings from members and uses the pooled funds to give loans to the needy members. Under this program, banks provide loans to the SHGs against group guarantee and the quantum of loan could be several times the deposits placed by such SHGs with the banks. Banks should consider entire credit requirements of SHG members, namely, (a) income generation activities, (b) social needs like housing, education, marriage, etc. and (c) debt swapping. The programme was started at the initiative of NABARD in 1992 to link the unorganized sector with the formal banking sector.

The **Service Area Approach (SAA)** was a scheme launched by the RBI in 1989 for an orderly development of the rural areas of the country. Under the SAA, all rural and semi-urban branches of banks were allocated specific villages, generally in geographical difficult areas, the overall development and the credit needs of which were to be taken care of by the respective branches. The concerned bank should meet the banking needs of the service area by creating link between bank credit-production and productivity and income expansion.

The **State Level Bankers Committee (SLBC)** were constituted in 1970s, as an apex inter-institutional forum to create adequate coordination machinery for Financial Inclusion and other developmental issues. It comprises representatives of Commercial Bank, RRBs, State Co-operative Banks, RBI, NABARD, heads of Government Departments, representatives of Financial Institutions etc. operating in a State. There is one sponsor bank for each SLBC. Similarly, there are District Level Committees with district level **Lead District Manager, LDM.**

The Reserve bank of India setup a commission (**Khan Commissio**n) in 2004 to look into Financial Inclusion and the recommendations of the commission were incorporated into the Midterm review of the policy (2005-06).

Some of the steps taken by RBI include the directive to banks to offer No-frills account, easier KYC norms, offering GCC cards to the poor, better customer services, promoting the use of IT and intermediaries and asking SLBCs and UTLBCs to start a campaign to promote FI on a pilot basis.

No-Frill Account is a basic saving fund account having all the features of a normal saving fund account which it differs in the following aspects. (i) The holder is not required to maintain any minimum balance requirement and also nothing is charged for opening this type of account, (ii) KYC norms have been simplified so that everyone can have this account, (iii) Transactions are limited to 5-10 free transactions per month, (iv) ATM facility is provided free of cost (v) There is no account maintenance cost.

Banks were advised to give credit in the form of **overdraft on saving bank account** to its customers, so that in case of small credit need like medical bill, any accidental charges etc. can be met in.

The '**Know Your Customer**' (KYC) norms were relaxed in 2008 for No-Frill Accounts, in order to make it easy for people to avail financial services. In 2010-11, KYC norms were further relaxed by including (a) job cards issued by/under Mahatma Gandhi

National Rural Employment Guarantee Act (MNREGA) and (b) Aadhaar letters in the list of Proof of Identity (PoI) documents, required for opening bank account.

In 2005, the RBI advised all scheduled commercial banks including RRBs, to introduce a General Credit Card (GCC) Scheme for issuing GCC to their constituents in rural and semi-urban areas based on the assessment of income and cash flow of the household similar to that prevailing under a normal credit card.

Eligible farmers were provided a **Kisan Credit Card** and a Passbook or a Card-cum-Passbook. Revolving cash credit facility allowing any number of withdrawals and repayments within the limit.

The **Kisan Credit Card** (KCC) Scheme was introduced in 1998 for issue of KCC to farmers so that farmers may use them to readily purchase agriculture inputs such as seeds, fertilizers, pesticides etc. and draw cash for their production needs. It was launched by the Reserve Bank of India and the National Bank for Agriculture and Rural Development (NABARD to provide a much-needed relief to debt-ridden farmers.

The KCC scheme has since been simplified and provides for issue of ATM enabled RuPay Debit Card.

In 2006, the Government of India constituted the **Committee on Financial Inclusion** under the chairmanship of Dr. Rangarajan to prepare a strategy of FI.

In January 2006, the RBI permitted banks to utilise the services of non-Government Organisations (NGOs/SHGs), Micro Finance Institutions (other than Non-Banking Financial Companies), and other civil society organisations (CSOs), as intermediaries in providing financial and banking services through the use of **Business Facilitators (BFs)** and **Business Correspondents (BCs) model**. BC model allows banks to provide door-step delivery of services especially to do 'cash in-cash out' transactions, thus addressing the 'last mile' problem.

During 2010-11, in order to harness the large and widespread retail network of corporate for providing financial and banking services, **'for profit' companies** were also allowed to be engaged as intermediaries to work as BCs for banks in addition to entities permitted earlier.

The BCs carry **hand-held devices** which are essentially smart card readers (now a days, Aadhaar based biometric authentication devices). The information captured is transmitted to a central server where the accounts are maintained. These devices are used for making payments to rural customers and receiving cash from them at their doorsteps. Mobile phones have also been developed to serve as card readers. Account holders are issued smart cards which have their photographs and finger impressions.

In the budget speech in 2007 (February), the Finance Minister announced setting up of 2 funds of Rs. 50 Crores each, viz: **Financial Inclusion Fund (FIF)** and **Financial Inclusion Technology Fund (FITF)**. The objective of the FIF was, to support 'developmental and promotional activities', with a view of securing greater FI, particularly among weaker sections, low income groups and in under-developed regions and hitherto unbanked areas. The objectives of FITF were to enhance investment in Information and Communications Technology (ICT), aimed at stimulating research and technology innovation in the area of FI, increase the adoption of technology among financial services providers.

The Working Group to Examine the Procedures and Processes of Agricultural Loans (Chairman: Shri C.P. Swarnakar), appointed by Reserve Bank of India, had recommended in its report (April 2007) that banks should actively consider opening of counselling centres, either individually or with pooled resources, for credit and technological counselling. Accordingly, a Model Scheme for "**Financial Literacy and Credit Counseling Centres (FLCC)**" was launched by RBI in 2009.

In year 2012, Lead banks were advised by RBI to set up Financial Literacy Centres (FLCs) in each of the Lead District Manager (LDM) Offices in a time bound manner.

Financial Literacy Centres are basic units that initiate the financial literacy activities at the ground level as it enables consumers to understand benefits of formal products and to make choices that fit their needs and represent good value for money.

During Phase-I (2010-13), all unbanked villages with population more than 2,000 were identified and allotted to various banks (public sector banks, private sector banks and regional rural banks) through State Level Bankers' Committees (SLBCs) for coverage through various modes – Branch or BC or other modes such as ATMs, mobile vans, etc. It was named **Swabhiman Scheme.**

After the completion of the first phase of the roadmap, the second phase (2013-16) to provide banking services in unbanked villages with populations less than 2000 was rolled out.

All domestic Scheduled Commercial Banks (SCBs) – both in the public sector and private sector – were advised to draw up board-approved **Financial Inclusion Plans (FIPs)** as an integral part of their business strategy based on their competitive advantage. FIPs are submitted to the RBI and are implemented over blocks of 3 years.

In April 2011, domestic SCBs were mandated to open at least 25% of the total branches opened during a year, in unbanked rural (Tier-5 and Tier-6) centres.

Basic Saving Bank Deposit (BSBD) accounts were provisioned in 2012. These accounts had minimum common facilities such as no minimum balance, deposit and withdrawal of cash at bank branch and ATMs, receipt/ credit of money through electronic payment channels, facility of providing ATM card.

Direct Benefit Transfer or DBT was launched by the Government of India in 2013. This was done by transferring subsidies directly to the people through their bank accounts. The objective was that, crediting subsidies into bank accounts will reduce leakages, delays, etc.

In September 2013, banks were allowed to provide **e-KYC services** based on Aadhaar thus paving the way for bank accounts to be opened by all and facilitating easy access to banking services.

The **Direct Benefit Transfer of LPG** (DBTL) or **PAHAL** (Pratyaksh Hanstantrit Labh) scheme was launched in 2013 for transfer of subsidy directly into bank account of beneficiary for LPG cylinder.

A **Committee on Comprehensive Financial Services** for Small Businesses and Low Income Household was set up by the RBI in September 2013 under the chairmanship of Nachiket Mor, an RBI board member.

In 2015, the Reserve Bank of India (RBI) constituted a committee to work out a 5-year (medium-term) action plan for financial inclusion under the RBI executive director **Deepak Mohanty**.

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3. Recent Initiatives

Next, we will discuss key government-led schemes and initiatives pertaining to Financial Inclusion.

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3. Recent Initiatives

PMJDY is National Mission for Financial Inclusion to ensure access to financial services, namely, a basic savings & deposit accounts, remittance, credit, insurance, pension in an affordable manner. Under the scheme, a Basic Savings Bank Deposit (BSBD) account can be opened in any bank branch or Business Correspondent (Bank Mitra) outlet, by persons not having any other account. It was launched in 2014.

Key Features are given below:

- One basic savings bank account is opened for unbanked person.
- There is no requirement to maintain any minimum balance (however required if wishes to get a cheque book).
- Interest is earned on the deposit in PMJDY accounts.
- RuPay Debit card is provided to PMJDY account holder.
- There is also inbuilt Rs. 2 lakh (revised from 1 lakh in 2018) accident insurance cover and a Life Insurance cover of Rs 30,000.
- An OverDraft (OD) facility up to Rs 10,000 after 6 months (no conditions on overdraft up to Rs 2000), for age limit of 18-65 years.
- PMJDY accounts are eligible for Direct Benefit Transfer (DBT), Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Atal Pension Yojana (APY), Micro Units Development & Refinance Agency Bank (MUDRA) scheme.
- The slogan of the scheme is 'Mera Khata, Bhagya Vidhata'.
- There is a provision of bio-metric account opening, which help even illiterate people to be a part of the banking net.
- Any individual above 10 years can open a bank account.

In 2018, second phase of PMJDY was launched with target for financial inclusion of every adult individual (earlier it was every household).

Jan Dhan Darshak, a Geographic Information System (GIS) mobile application, has also been launched to provide a citizen centric platform for locating financial service touch points across all providers such as banks, post office, ATMs, CSC, etc.

The JAM (short for **Jan Dhan-Aadhaar-Mobile**) trinity is the initiative by Government of India to link Jan Dhan accounts, Mobile numbers and Aadhar cards of Indians to directly transfer subsidies to intended beneficiaries and eliminate intermediaries and leakages. The JAM trinity was first proposed in the Economic Survey 2014-15.

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3. Recent Initiatives

Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY) were launched in 2015.

Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY)

PMJJBY was launched in 2015 for the growth of the low-income section of society. It offers a renewable 1 year term life cover of Rs 2 Lakh to all subscribing bank account holders in the age group of 18 to 50 years (life cover up to 55 years), covering death due to any reason, for a premium of Rs. 330 per annum per subscriber, to be auto debited from subscriber's bank account.

Pradhan Mantri Suraksha Bima Yojana (PMSBY)

Similarly, PMSBY was also launched in 2015. It offers a renewable 1 year accidental death cum disability cover to all subscribing bank account holders in the age group of 18 to 70 years (life cover up to 70 years) for a premium of Rs. 12 per annum per subscriber to be auto debited from subscriber's bank account. The scheme provides a cover of Rs. 2 Lakh for accidental death or total permanent disability and Rs 1 Lakh in case of permanent partial disability. NRIs are also eligible but claim would be paid only in Indian currency.

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3. Recent Initiatives

The Stand Up India scheme was launched in 2016 on the 125th birth anniversary of Dr. Bhimrao Ambedkar (14th April 1891). The Scheme facilitates bank loans between Rs 10 lakh and Rs 1 Crore to at least 1 Scheduled Caste (SC) or Scheduled Tribe (ST) borrower and at least 1 woman borrower per bank branch for setting up a greenfield enterprise (loans available for greenfield project only). This enterprise may be in manufacturing, services or the trading sector. In case of non-individual enterprises at least 51% of the shareholding and controlling stake should be held by either an SC/ST or woman entrepreneur.

The broad features of the scheme are as under:

- Composite loan between Rs. 10 lakh and upto Rs. 1 crore, inclusive of working capital component for setting up any new enterprise.
- The loan is repayable in 7 years, with a maximum moratorium period of 18 months.
- Debit Card (RuPay) for withdrawal of working capital.
- Credit history of borrower to be developed.
- Refinance window through Small Industries Development Bank of India (SIDBI) with an initial amount of Rs.10,000 crore.
- Creation of a corpus of Rs. 5,000 crores for credit guarantee through National Credit Guarantee Trustee Company Ltd. (NCGTC).
- Handholding support for borrowers with comprehensive support for pre loan training needs, facilitating loan, factoring, marketing etc.
- Web Portal for online registration and support services.

The overall intent of the proposal is to leverage the institutional credit structure to reach out to these underserved sectors of the population by facilitating bank loans in the non-farm sector set up by such SC, ST and Women borrowers.

The process would be led by SIDBI with involvement of **Dalit Indian Chamber of Commerce and Industry (DICCI)** and various sector – specific institutions all over the country. The offices of SIDBI and National Bank for Agriculture and Rural Development (NABARD) shall be designated Stand Up Connect Centres (SUCC).

The Government has set up the **Credit Guarantee Fund for Stand Up India (CGFSI)**. A Credit Guarantee corpus fund of Rs. 5000 crore for Stand Up India scheme, operated by National Credit Guarantee Trustee Company Ltd. (NCGTC) has been approved.

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3. Recent Initiatives

Atal Pension Yojna was launched in 2015 is open to all bank account holders in the age group of 18 to 40 years and they can choose different contributions based on the pension amount. Under this scheme monthly pension is guaranteed to the subscriber and after him to his spouse and after their death, pension corpus as accumulated till the age of 60 years is returned to the nominee of subscriber. Central Government also contributes 50% of the contribution subject to a maximum of Rs 1000 per annum.

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3. Recent Initiatives

In 2018, the Government of India launched the Financial Inclusion Index to compare performance of states in Financial Inclusion. The Department of Financial Services (DFS), Ministry of Finance will release an Annual Financial Inclusion Index (FII) which will be a measure of access and usage of a basket of formal financial products and services that includes savings, remittances, credit, insurance and pension products.

The index have 3 measurement dimensions:

1. Access to financial services
2. Usage of financial services and
3. Quality.

FII enables fulfilment of G20 Financial Inclusion Indicators requirements.

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3. Recent Initiatives

In August 2021, the Government launched e-RUPI. It is a cashless and contactless digital payment medium (electronic voucher), which will be delivered to mobile phones of beneficiaries in form of an SMS-string or a QR code. This will essentially be like a prepaid gift-voucher that will be redeemable at specific accepting centres without any credit or debit card, a mobile app or internet banking. e-RUPI will connect the sponsors of the services with the beneficiaries and service providers in a digital manner without any physical interface. Note that, e-RUPI is not a platform. It has been developed by the NPCI on its UPI platform, in collaboration with the Department of Financial Services, Ministry of Health & Family Welfare and National Health Authority. Corporates can issue these vouchers for their employees. Voucher redemption can be tracked by the issuer.

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4. National Strategy for Financial Inclusion 2019-2024

The Reserve Bank of India (RBI) released the National Strategy for Financial Inclusion 2019-2024 on January 10, 2020. It sets forth the vision and objectives of financial inclusion policies in India.

The RBI has identified certain critical gaps in financial inclusion, such as:

- inadequate infrastructure (in parts of rural hinterland, far flung areas in Himalayan and North-Eastern region),
- poor tele and internet connectivity in rural hinterland,
- socio-cultural barriers, and
- lack of market players in payment product space.

The RBI identified 6 strategic objectives of a national strategy for financial inclusion:

1. universal access to financial services,
2. providing basic bouquet of financial services,
3. access to livelihood and skill development,
4. financial literacy and education,
5. customer protection and grievance redressal, and
6. effective coordination.

To achieve this vision, it identified following milestones:

- providing banking access to every village (or hamlet of 500 households in hilly areas) within a 5 km radius by March 2020.
- strengthening digital financial services to create infrastructure to move towards a cash less society by March 2022, and
- ensuring that every adult has access to a financial service provider through a mobile device by March 2024.

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1. Introduction

The Digital payments provide an unprecedented opportunity to the people, especially those living in rural and far flung areas of the state to get connected to the main stream economy. It promises access to formal financial services and benefits from e-commerce, especially for those who continue to be excluded. In addition to accelerating financial inclusion, opening new business models and markets digital payments can improve the State's ability to curb tax leakages, funding of criminal activities and reduce cash related costs.

The phenomenal global growth in digital payments may be attributed to 4 factors:

1. Digital and technology revolution,
2. Entry of several non-banking PSPs (Payment Service Providers) into payments space,
3. Customers becoming more demanding and expecting instantaneous and one-touch payment solutions
4. Progressive changes in the regulatory framework.

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2. Government Support

Payment and settlement systems in India are for financial transactions. They are covered by the **Payment and Settlement Systems Act, 2007 (PSS Act)**, and regulated by the RBI and the Board for Regulation and Supervision of Payment and Settlement Systems.

The **National Payments Corporation of India (NPCI)**, an umbrella organisation for operating retail payments and settlement systems in India, is an initiative of Reserve Bank of India (RBI) and Indian Banks' Association (IBA) under the provisions of the Payment and Settlement Systems Act, 2007, for creating a robust Payment & Settlement Infrastructure in India.

The Government, in 2017, announced several activities for the promotion of digital transactions including the target of 2,500 Crore digital transactions in FY 2017-18 to be achieved via 5 modes of payment viz. UPI, USSD, Aadhaar Pay, IMPS and Debit Cards. The target for 2018-19 was 3,000 Crore transactions. **For 2020-21, the Government had target of 4500 Crore transactions.**

Recent Initiatives

Some of recent initiatives on Digital Payments are:

- Levy a surcharge of 2% on cash withdrawal of above Rs 1 crore in a year (announced in July 2019).
- Abolition of MDR (Merchant Discount Rate) charge for low cost digital payment options, for firms with annual turnover of more than Rs 50 crore. (announced in July 2019). The MDR will instead be borne by supporting Banks and the Reserve Bank of India. **The MDR is the fees that Merchant pays to the Bank, as fees for digital payment.** Low cost digital payment modes will include options such as BHIM UPI, UPI QR Code, Aadhaar Pay, Debit Cards, NEFT, RTGS, among others.
- The MDR for transactions up to Rs 2000 was already abolished in Jan 2018, for a period of 2 years.

In June 2020, the RBI announced creation of a Payments Infrastructure Development Fund (PIDF). The 500 crores PIDF seeks to encourage acquirers to deploy Points of Sale (PoS) infrastructure for both physical and digital modes. RBI will make an initial contribution of Rs 250 crore to the PIDF, covering half of the fund. The remaining contribution will be from card-issuing banks and card networks operating in the country. The PIDF will be governed through an Advisory Council and managed and administered by RBI. The setting up of this fund is in line with the recommendations of the report of the committee on deepening of digital payments, **chaired by Nandan Nilekani.**

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3. Digital Payment

Various Government initiatives related to digital payment are discussed next.

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3. Digital Payment

The Credit cards are issued by banks and some other entities authorized by RBI. These cards give you the ability to withdraw or use extra money. Credit cards are used for domestic as well as international payments. The Debit cards are issued by the bank where you have your account. You can use these cards for the money in your account.

On usage of Debit cards, the Merchants are required to pay upto 0.9% of Merchant Discount Rate (MDR) charges to their acquiring Bank. From 01 Jan 2020, Government of India has waived MDR on RuPay debit card and UPI.

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3. Digital Payment

The Prepaid Instruments, PPIs, are instruments that facilitate purchase of goods and services, including financial services, remittance facilities, etc., against the value stored on such instruments.

The PPIs that can be issued in the country are classified under 3 types:

1. **Closed System PPIs:** These PPIs are issued by an entity for facilitating the purchase of goods and services from that entity only and do not permit cash withdrawal.
2. **Semi-closed System PPIs:** These PPIs are issued by banks (approved by RBI) and non-banks (authorized by RBI) for purchase of goods and services, including financial services, remittance facilities, etc., at a group of clearly identified merchant locations / establishments which have a specific contract with the issuer (or contract through a payment aggregator / payment gateway) to accept the PPIs as payment instruments. These instruments do not permit cash withdrawal, irrespective of whether they are issued by banks or non-banks.
3. **Open System PPIs:** These PPIs are issued only by banks (approved by RBI) and are used at any merchant for purchase of goods and services, including financial services, remittance facilities, etc. Cash withdrawal at ATMs / Points of Sale (PoS) terminals / Business Correspondents (BCs) are also allowed through such PPIs.

The PPIs may be issued as cards, wallets, and any such form / instrument which can be used to access the PPI and to use the amount therein. PPIs in the form of paper vouchers are no longer be issued.

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3. Digital Payment

The National Common Mobility Card (NCMC) was launched with the tagline of 'One Nation One Card' in March 2019. The High level Committee on Deepening of Digital Payments (CDDP) under chairmanship of Shri Nandan Nilekani recommended that NCMC cards be usable at all transit locations. The NCMC card has 2 instruments on it – a regular debit card which can be used at an ATM, and a local wallet (stored value account), which can be used for contactless payments, without the need to go back to the server or additional authentication. It is envisioned that a single card will be usable for all local travel needs across the country.

Initially conceptualized by the Ministry of Housing and Urban Affairs (MoHUA), the National Common Mobility Card is an open loop card, which can be used for all local travel needs in the country. This is aimed at low value payments for various segments e.g. Transit, Smart cities, Toll, Parking and other low value merchant payments, in addition to the normal day to day retail payments. The vision behind the introduction of this card is to have interoperability, based on open standards.

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3. Digital Payment

For transferring funds real time and 24\(\times \)7\(\times \)365 interbank was a major challenge faced in banking industry. The NEFT & RTGS were available to user for fund transfer during only banking hours. With the above context in mind, NPCI launched Immediate Payment Service (IMPS) in 2010.

IMPS provides robust & real time fund transfer which offers an instant, 24\(\times \)7, interbank electronic fund transfer service that could be accessed on multiple channels like Mobile, Internet, ATM, SMS, Branch and USSD (using *99#). This facility is provided by NPCI through its existing NFS switch. The eligible criteria for the Banks who can participate in IMPS is that the entity should have valid banking or prepaid payment instrument license from Reserve Bank of India to participate in IMPS.

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3. Digital Payment

UPI or Unified Payment Interface is a payment mode which is used to make fund transfers through the mobile app. You can transfer funds between two bank accounts using UPI apps. You will have to register for mobile banking to use UPI apps. UPI is built over IMPS infrastructure. This mode permits Non banking institutions to participate as **Third Party App (TPA)** with Integration with Acquiring Banks. Many of leading apps such as Google Pay and PhonePe have participated using UPI in Indian Payments ecosystem.

You need to download a UPI app and create a VPA (Virtual Payment Address) or UPI ID. Some of UPI apps available in market are, Paytm, BHIM (owned by NPCI), PhonePe, Google Pay (Tez), SBI UPI app, HDFC UPI app, ICICI UPI app etc. It is not mandatory to use the UPI app from your bank to enjoy UPI service. You can download and use any UPI app, irrespective of your bank account. UPI apps are a faster solution to send money using VPA or even IFSC and Account number.

The **BHIM is an acronym of Bharat Interface For Money Application**. It is a mobile app launched by Govt. of India for instant money transfer through a mobile. The mobile app is based on the Unified Payment Interface (UPI). The BHIM App has been developed by National Payments Corporation of India (NPCI) and is available on Android, iOS and Windows operating system for mobiles.

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3. Digital Payment

AEPS is an **Aadhaar based digital payment mode**. The term AEPS stands for Aadhaar Enabled Payment Service. Customer needs only his or her Aadhaar number to pay to any merchant. AEPS allows bank to bank transactions. It means the money you pay will be deducted from your account and credited to the payee's account directly.

You need to link your Aadhaar number with your bank account to use AEPS. You can use AEPS with the help of PoS (Point of sale) machines. You can withdraw or deposit cash, send money to another Aadhar linked account with it. The good thing about AEPS is that it doesn't need your signature, bank account details or any password. It uses your fingerprint as biometric authentication.

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3. Digital Payment

USSD banking or *99# Banking is a mobile banking based digital payment mode. You do not need to have a smartphone or internet connection to use USSD banking. You can easily use it with any normal feature phone. The *99# code works as a bridge between your telecom operator's server and your bank's server. It uses your registered mobile number to connect with your bank account.

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3. Digital Payment

The NPCI has developed the National Electronic Toll Collection (NETC) program for automatic toll collection on roads. The FASTag is a device that employs Radio Frequency Identification (RFID) technology for making toll payments directly while the vehicle is in motion. FASTag (RFID Tag) is affixed on the windscreen of the vehicle and enables a customer to make the toll payments directly from the account which is linked to FASTag. As reported in Dec 2019, the Government has planned to make FASTag mandatory. FASTags are issued by 22 NPCI authorized banks only.

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3. Digital Payment

Bharat QR, developed by NPCI, Mastercard, and Visa, is an integrated payment system. The system, which was launched in September 2016, facilitates users to transfer their money from one source to another. The money transferred through Bharat QR is received directly in the user's linked bank account. It provides a common interface for American Express, Visa, Mastercard, and RuPay cards. As opposed to other such systems, used by private companies and banks, BharatQR is interoperable with all the banks.

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3. Digital Payment

National Payments Corporation of India (NPCI) has implemented **National Automated Clearing House (NACH)** for Banks, Financial Institutions, Corporates and Government a web-based solution to facilitate interbank, high volume, electronic transactions which are repetitive and periodic in nature. NACH System can be used for making bulk transactions towards distribution of subsidies, dividends, interest, salary, pension etc. and also for bulk transactions towards collection of payments pertaining to telephone, electricity, water, loans, investments in mutual funds, insurance premium etc.

NACH's **Aadhaar Payment Bridge (APB) System**, developed by NPCI has been helping the Government and Government Agencies in making the Direct Benefit Transfer scheme a success. APB System has been successfully channelizing the Government subsidies and benefits to the intended beneficiaries using the Aadhaar numbers. The APB System links the Government Departments and their sponsor banks on one side and beneficiary banks and beneficiary on the other hand.

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3. Digital Payment

RuPay is an Indian card scheme conceived and launched by the National Payments Corporation of India (NPCI) on 26 March 2012. It was created to fulfil the Reserve Bank of India's (RBI) desire to have a domestic and multilateral system of payments in India. In India, 90% of credit card transactions and almost all debit card transactions are domestic; however, the cost of transactions was high due to the dominance of foreign card schemes like Visa and Mastercard. RuPay facilitates electronic payment at all Indian banks and financial institutions.
