FOURESS INSURANCE BROKING SERVICES (P) LTD.
IRDA LICENCE DB No.169 (Life & General) (Valid till 29/5/2021)
CIN/1A Ref No: U93000TG2000PTC034406
Regd. & Head Office: 28A, Journalist Colony, Jubilee Hills, Hyderabad-500033
Phones : 9550194849, E-mail :yadavallins@fouress.com

Index

Module 1

Concept of Insurance

Asset

An ASSET is something of value. It may be physical [like a car or a home] or it may be non-physical [like reputation and goodwill] or it may be personal [like body parts like a hand, eyes or legs]

Risk

Risk is the chance that there could be damage or loss to Asset by which it will lose its financial value. It is doubt that outcome of a situation could be not favorable.

Peril

Peril is cause of loss e.g. fire, hail or theft. A specific event which might cause a loss.

Examples of Perils

Natural Perils- Fire, wind, hail, flood.

Human Perils-Theft, riot, vandalism, negligence.

Economic Perils - Stock market declines, inflation, technological advances.

Hazard

A hazard, on the other hand, is a condition that either increases the chance that a peril will happen or may cause its effect to be worse if it does.

For e.g. If lung cancer is a peril then smoking can be a hazard that may increase the chance that the peril (lung cancer) will occur.

Examples of Hazards

Physical hazards - Example: a family history of heart disease, high blood pressure etc. is a physical hazard.

Moral hazards - Refer to the habits and activities of the individual that increase risks. They may also arise from a state of mind, i.e. the attitude and behaviour of the individual. Example: consumption of alcohol, smoking etc.

Case Study

* On 26 January 2001 one of the worst earthquakes in India's history hit Gujarat. Thousands of people lost their lives in this tragic event. Lakhs of people were injured, and property worth thousands of crores of rupees was destroyed. The epicentre of the earthquake was located northeast of Bhuj Town in Western Gujarat.

* In this case the earthquake was the peril and the poorly constructed houses and schools which were not earthquake resistant and easily collapsed were a hazard.

* Similarly in the event of a tsunami (such as the one that happened on 26 December 2004) leading to widespread loss of life and property, the tsunami will be the peril and flimsy houses and buildings constructed near the seashore which are washed away causing their occupants to drown will be a hazard.

* Remember that while insurance cannot prevent the peril from happening, the resulting loss from the occurrence of the peril can be insured against.

Asset	**Peril**	**Hazard**
Life	Cancer	Excessive Smoking
Factory	Fire	Explosive material left Unattended
Car	Car Accident	Careless driving by driver
Cargo	Storm	Water seeping in cargo and spoiling; Cargo not packaged in waterproof containers

What is important about here?

* Firstly, events causing loss must be *unpredictable*; if we can anticipate and predict an event, we can prepare for it.

* A vehicle carrying explosives can yield far greater loss from fire than tanker carrying water.

* Similarly, the probability of a person having a respiratory problem is high in a polluted city or the individual engaged in horse racing has a higher risk of accidental injury than one who sits in a shop

* Secondly, such unpredictable and untoward events are often a cause of financial loss and grief.

What about natural wear and tear?

* It is true that nothing lasts forever. Every asset has a finite lifetime during which it is functional, and yields benefits.

* At some future date its value becomes nil. This is a natural process and we discard or change our mobiles, our washing machines and our clothes when they are worn out. Therefore, losses arising out of normal wear and tear are not covered in insurance.

Types of Risks

Dynamic risk - It arises from changes in economy like changes in prices, consumer tastes, income and technology. May benefit society in long run.

Static risk – It will arise without any change in economy like dishonesty.

Pure risks - There is no probability of gain, only the possibilities of loss or no loss. Example – fire. If it happens there is loss.

Speculative risks – It offers the possibility of gain or of loss. These are not insurable. gambling on horses or stock market speculation.

Fundamental risks – It affect large populations. Their impact is widespread and tends. to be catastrophic. Examples of fundamental or systemic risks are wars, droughts, floods and earthquakes and terrorist attacks.

Particular risks – It is felt by individual rather than entire group. Most insurable risks are particular risks, like robbery or burning of house.

Financial Risks – It involves financial loss. In insurance we are concerned with risks involving financial loss.

Methods of Handling Risks

* Avoiding Risk- Avoiding risk altogether. e.g. avoid the risk of financial loss in the stock market by not investing in it.

* Controlling Risk- Take steps to prevent or reduce losses. e.g. a cloth merchant can reduce likelihood of a fire in his godown by banning smoking in the godown.

* Accepting Risk - To accept or retain, risk and assume all financial responsibility for loss arising due to that risk.

* Transferring Risk: Transfer risk to another party, shifting the financial responsibility for that risk to the other party, generally in exchange for a fee. e.g insurance.

Objectives of Risk Management

The objective of risk management is to loss prevention or to reduce the extent of loss. This requires taking steps before any event has occurred like wearing helmet or seat belt to prevent injury in case of an accident. What does risk management leads to -

a) For industry and economy – a organisation facing risk seeks to prepare for possible happening in financial terms so that it continues on projected growth path even after loss.
b) Reduction in Anxiety – Risk management reduce fear created because of uncertainty and costs.
c) For meeting externally imposed obligations - Risk management satisfies responsibilities imposed by others like bankers where there is requirement of insured property as collateral.
d) Social Responsibility - Measures taken prior to loss contributes prevention and reduction of fear of loss.

What is Insurance?

Insurance is nothing but a risk transfer mechanism wherein the person taking out insurance transfers their risk to the insurance company in return for a payment.

Insurance relates to the protection of the economic value of assets. An asset is valuable to its owner because they expect some benefits from it. The benefit can be in the form of income generated from the asset (giving a car on rent) or convenience (using the car for their own travel).

Insurance cannot prevent the event insured for from happening. It can only provide compensation for the loss that comes as a result of the happening of insured event.

Insurance companies collect premiums from people from all those who are exposed to the same risks – and put the money into a risk pool.

Not everyone will experience the happening of an insured event at the same time, but those who do are compensated from this risk pool.

Law of large numbers - Larger the pool, more predictable the amount of losses in a given period. Since not all members of the pool are the same age or in the same health condition, we can assume

not all of them will be making a claim at the same time. For e.g. out of the 1,000 individuals insured by an insurance company, if the probability of death is 1% then the company will have to pay claims for 10 people.

For example

There are 10,000 people in the group. The everyone in the group has Life Insurance of Rs. 50,000/- each. It is assumed that out of these, 10 persons will die in a year. Since everyone in the group has sum insured of Rs 50,000, the total amount of Rs 5,00,000 will have to be paid to survivors of these persons. If each person in the group contributes Rs.100/-, the common fund would be Rs.10,00,000/-. This would be enough to pay Rs.50,000 to each of the 10 suffered lives. Thus 10,000 persons share the risk of 10 lives.

Purpose and need for Insurance

Insurance reduces burdens

Burden of risk refers to the costs, losses and disabilities one has to bear as a result of being exposed to a given loss situation/event.

There are two types of risk burdens that one carries – primary and secondary.

a) Primary burden of risk

The primary burden of risk consists of losses that are suffered by households (and business units), as a result of pure risk events. These losses are often direct and measurable and can be easily compensated for by insurance.

For example, when a factory gets destroyed by fire, the actual value of goods damaged or destroyed can be estimated and the compensation can be paid to the one who suffers such loss. If an individual undergoes a heart surgery, the medical cost of the same is known and compensated.

In addition, there may be some indirect losses. For example, a fire may interrupt business operations and lead to loss of profits which also can be estimated, and the compensation can be paid to the one who suffers such a loss.

b) Secondary burden of risk

Suppose no such event occurs and there is no loss. Does it mean that those who are exposed to the peril carry no burden? The answer is that apart from the primary burden, one also carries a secondary burden of risk.

The secondary burden of risk consists of costs and strains that one has to bear merely from the fact that one is exposed to a loss event. Even if the said event does not occur, these burdens have still to be borne.

Let us understand some of these burdens:

i. Firstly there is physical and mental strain caused by fear and anxiety. The anxiety may vary from person to person, but it is present and can cause stress and affect a person's wellbeing.
ii. Secondly when one is uncertain about whether a loss would occur or not, the prudent thing to do would be to set aside a reserve fund to meet such an eventuality. There is a cost involved in keeping such a fund. For instance, such funds may be held in a liquid form and yield low returns.

By transferring the risk to an insurer, it becomes possible to enjoy peace of mind, invest funds that would otherwise have been set aside as a reserve, and plan one's business more effectively. It is precisely for these reasons that insurance is needed.

Risk Management Techniques

Another question one may ask is whether insurance is the right solution to all kinds of risk situations. The answer is, 'No'.

Insurance is only one of the methods by which individuals may seek to manage their risks. Here they transfer the risks they face to an insurance company. However, there are some other methods of dealing with risks, which are explained below:

1. Risk avoidance

Controlling risk by avoiding a loss situation is known as risk avoidance. Thus, one may try to avoid any property, person or activity with which an exposure may be associated.

For example

i. One may refuse to bear certain manufacturing risks by not getting into manufacturing activity and contracting out the manufacturing to someone else.
ii. One may not venture outside the house for fear of meeting with an accident or may not travel at all for fear of falling ill when abroad.

2. Risk retention

One tries to manage the impact of risk and decides to bear the risk and its effects by oneself. This is known as self-insurance.

For example, a business house may decide, based on experience about its capacity to bear small losses up to a certain limit, to retain the risk with itself.

3. Risk reduction and control

This is a more practical and relevant approach than risk avoidance. It means taking steps to lower the chance of occurrence of a loss and/or to reduce severity of its impact if such loss should occur.

Important

The measures to reduce chance of occurrence are known as, 'Loss Prevention". The measures to reduce degree of loss are called, Loss Reduction".

Risk reduction involves reducing the frequency and/or sizes of losses through one or more of:

a) Education and training, such as holding regular "fire drills" for employees, or ensuring adequate training of drivers, forklift operators, wearing of helmets and seat belts and so on. One example of this can be educating school going children to avoid junk food, so that they do not fall sick.

b) Making Environmental changes, such as improving "physical" conditions, e.g. better locks on doors, bars or shutters on windows, installing burglar or fire alarms or extinguishers. The State can take measures to curb pollution and noise levels to improve the health status of its people. Regular spraying of Malaria medicine helps in prevention of outbreak of the disease.

c) Changes made in dangerous or hazardous operations, while using machinery and equipment or in the performance of other tasks. For example, leading a healthy lifestyle and eating properly at the right time helps in reducing the incidence of falling ill.

d) Separation, spreading out various items of property into varied locations rather than concentrating them at one location, is a method to control risks. The idea is, if a mishap were to occur in one location, its impact could be reduced by not keeping everything at that one place. For instance, one could reduce the loss of inventory by storing it in different warehouses. Even if one of these were to be destroyed, the impact would be reduced considerably.

4. Risk financing

This refers to the provision of funds to meet losses that may occur

a) Risk retention through self-financing involves self-payment for any losses as they occur. In this process the firm assumes and finances its own risk, either through its own or borrowed funds, this is known as self-insurance. The firm may also engage in various risk reduction methods to make the loss impact small enough to be retained by the firm.
b) Risk transfer is an alternative to risk retention. Risk transfer involves transferring the responsibility for losses to another party. Here the losses that may arise as a result of a fortuitous event (or peril) are transferred to another entity.
c) Insurance is one of the major forms of risk transfer, and it permits uncertainty to be replaced by certainty through insurance indemnity.

Considerations before opting for Insurance

When deciding whether to insure or not, one needs to weigh the cost of transferring the risk against the cost of bearing the loss, that may arise, oneself. The cost of transferring the risk is the insurance premium. The best situations for insurance would be where the probability is very low, but the loss impact could be very high. In such instances, the cost of transferring the risk through its insurance (the premium) would be much lower while the cost of bearing it on oneself would be very high.

a) Don 't risk a lot for a little: A reasonable relationship must be there between the cost of transferring the risk and the value derived.

b) Don't risk more than you can afford to lose: If the loss that can arise as a result of an event is so large that it can lead to a situation that is near bankruptcy, retention of the risk would not appear to be realistic and appropriate.

For example, what would happen if a large oil refinery were to be destroyed or damaged? Could a company afford to bear the loss?

Role of insurance in society

Insurance companies play an important role in a country's economic development. They are contributing in a significant sense to ensuring that the wealth of the country is protected and preserved. Some of their contributions are given below.

a) Their investments benefit the society at large. An insurance company's strength lies in the fact that huge amounts are collected and pooled together in the form of premiums.

b) These funds are collected and held for the benefit of the policyholders. Insurance companies are required to keep this aspect in mind and make all their decisions in dealing with these funds in ways that benefit the community. This applies also to its investments. That is why successful insurance companies would not be found investing in speculative ventures i.e. stocks and shares.

c) The system of insurance provides numerous direct and indirect benefits to the individual, his family, to industry and commerce and to the community and the nation as a whole. The insured - both individuals and enterprises - are directly benefitted because they are protected from the consequences of the loss that may be caused by an accident or fortuitous event. Insurance, thus, in a sense protects the capital in industry and releases the capital for further expansion and development of business and industry.

d) Insurance removes the fear, worry and anxiety associated with one's future and thus encourages free investment of capital in business enterprises and promotes efficient use of existing resources. Thus, insurance encourages commercial and industrial development along with generation of employment opportunities, thereby contributing to a healthy economy and increased national productivity.

e) A bank or financial institution may not advance loans on property unless it is insured against loss or damage by insurable perils. Most of them insist on assigning the policy as collateral security.

f) Before acceptance of a risk, insurers arrange survey and inspection of the property to be insured, by qualified engineers and other experts. They not only assess the risk for rating purposes but also suggest and recommend to the insured, various improvements in the risk, which will attract lower rates of premium.

g) Insurance ranks with export trade, shipping and banking services as an earner of foreign exchange to the country. Indian insurers operate in more than 30 countries. These operations earn foreign exchange and represent invisible exports.

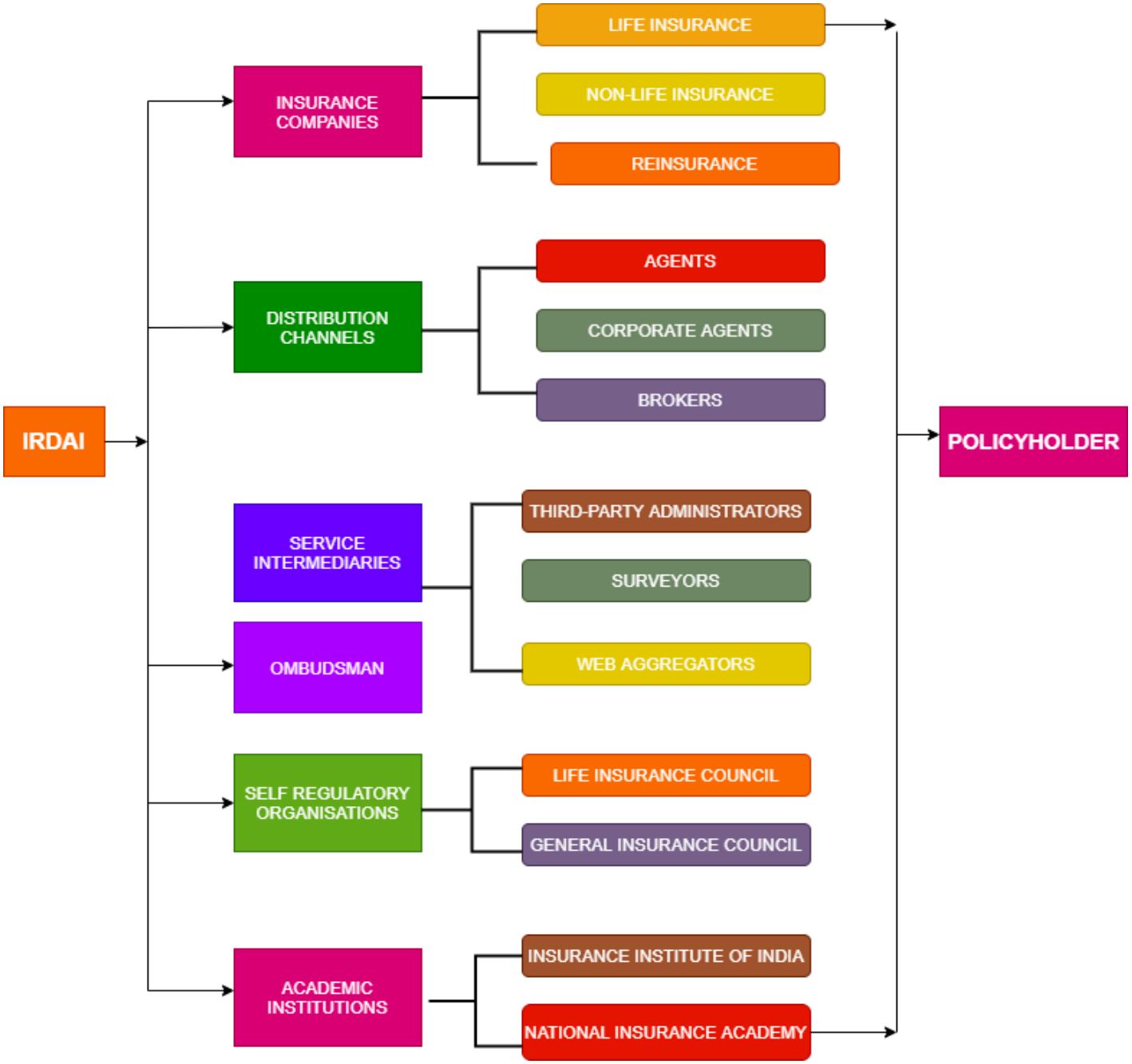
h) Insurers are closely associated with several agencies and institutions engaged in fire loss prevention, cargo loss prevention, industrial safety and road safety.

Module -2
INDIAN INSURANCE MARKET

History of Insurance in India

1818–1829	First insurance company: in 1818 the Oriental Life Insurance Company in Kolkata (then Calcutta) was the fi rst company to start a life insurance business in India. However, the company failed in 1834
1870	Following the enactment of the British Insurance Act 1870, the last three decades of the nineteenth century saw the creation of the Bombay Mutual (1871), Oriental (1874) and Empire of India (1897) in the Bombay Residency
1912	The Indian Life Assurance Companies Act 1912 was the fi rst statutory measure to regulate life business.
1938	To protect the interest of the insuring public, the earlier legislation was consolidated and amended by the Insurance Act 1938 which gave the Government effective control over the activities of insurers
1972	The General Insurance Business (Nationalization) Act 1972 (GIBNA) was passed.
1993	Malhotra committee recommended, among other things, that the private sector and foreign companies (but only through a joint venture with an Indian partner) be permitted to enter the insurance industry. 1999
1999	Formation of the IRDA

Indian Insurance Market



- Post-liberalisation, the insurance industry in India has recorded significant growth. The Indian insurance industry is expected to grow to Rs 19,56,920 crore in Financial Year 2020, This is backed by the solid economic growth and higher personal disposable incomes in the country.

- Overall insurance penetration in India reached 3.69 per cent in 2017 from 2.71 per cent in 2001. Gross premiums written in India reached Rs 5,78,000 crore in Financial Year 2018-19, with Rs 4,08,000 crore from life insurance and Rs 1,69,000 crore from non-life insurance.

- The market share of private sector companies in the non-life insurance market rose from 13.12 per cent in Financial Year 2003 to 55.7 per cent in Financial Year 2019-20 (up to April 2019). In life insurance segment, private players had a market share of 25.29 per cent in new business in FY19.

- Government has increased Foreign Direct Investment (FDI) limit in Insurance sector from 26 per cent to 49 per cent. This is targeted to attract investments in the sector. As per Union Budget 2019-20, 100 per cent foreign direct investment (FDI) has been permitted for insurance intermediaries.

- The insurance industry of India consists of 53 insurance companies of which 24 are in life insurance business and 29 are non-life insurers. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company.

- Out of 29 non-life insurance companies, there are six public sector insurers, which include two specialised insurers namely Agriculture Insurance Company Ltd for Crop Insurance and Export Credit Guarantee Corporation of India for Credit Insurance.

- Moreover, there are 5 private sector insurers are registered to underwrite policies exclusively in Health, Personal Accident and Travel insurance segments. They are Star Health and Allied Insurance Company Ltd, Apollo Munich Health Insurance Company Ltd, Max Bupa Health Insurance Company Ltd, Religare Health Insurance Company Ltd and Cigna TTK Health Insurance Company Ltd.

- The reinsurance programmes of Indian direct insurance companies transacting direct insurance business are supported by Indian Reinsurer/s, Foreign Reinsurer Branches(FRBs), Llyod's India(including its syndicates and service companies) and the Cross Border Reinsurers.

- Other stakeholders in Indian Insurance market include approved insurance agents, licensed Corporate Agents, POSPs, Common Service Centres, Web-Aggregators, Surveyors and Third-Party Administrators Servicing Health Insurance claims.

- In 2017, insurance sector in India saw 10 merger and acquisition (M&A) deals worth US$ 903 million. Enrolments under the Pradhan Mantri Suraksha Bimas Yojana (PMSBY) reached 130.41 million in 2017-18. National Health Protection Scheme was announced under Budget 2018-19 as a part of Ayushman Bharat. The scheme will provide insurance cover of up to Rs 500,000 (US$ 7,723) to more than 100 million vulnerable families in India.

- Going forward, increasing life expectancy, favourable savings and greater employment in the private sector is expected to fuel demand for pension plans. Likewise, strong growth in the automotive industry over the next decade would be a key driver for the motor insurance market.

Insurance Regulatory and Development Authority of India

The Insurance Regulatory and Development Authority of India (IRDAI) is an autonomous, statutory body tasked with regulating and promoting the insurance and re-insurance industries in India. It was constituted by the Insurance Regulatory and Development Authority Act, 1999, an Act of Parliament passed by the Government of India. The agency's headquarters are in Hyderabad, Telangana, where it moved from Delhi in 2001.

IRDAI is a 10-member body including the chairman, five full-time and four part-time members appointed by the government of India.

Functions of IRDAI

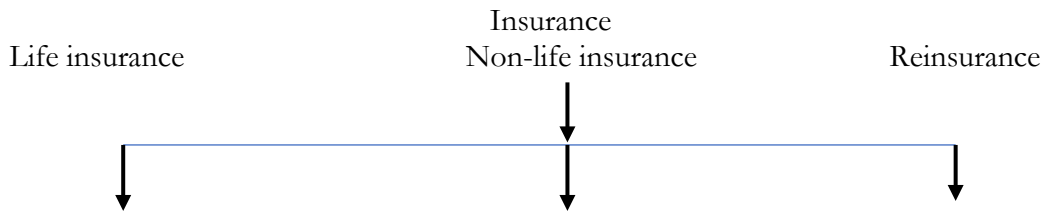
The functions of the IRDAI are defined in Section 14 of the IRDAI Act, 1999, and include:

- Issuing, renewing, modifying, withdrawing, suspending or cancelling registrations
- Protecting policyholder interests
- Specifying qualifications, the code of conduct and training for intermediaries and agents
- Specifying the code of conduct for surveyors and loss assessors
- Promoting efficiency in the conduct of insurance businesses
- Promoting and regulating professional organisations connected with the insurance and re-insurance industry
- Levying fees and other charges
- Inspecting and investigating insurers, intermediaries and other relevant organisations
- Regulating rates, advantages, terms and conditions which may be offered by insurers not covered by the Tariff Advisory Committee under section 64U of the Insurance Act, 1938 (4of 1938)
- Specifying how books should be kept
- Regulating company investment of funds
- Regulating a margin of solvency
- Adjudicating disputes between insurers and intermediaries or insurance intermediaries
- Supervising the Tariff Advisory Committee
- Specifying the percentage of premium income to finance schemes for promoting and regulating professional organisations
- Specifying the percentage of life- and general-insurance business undertaken in the rural or social sector
- Specifying the form and the manner in which books of accounts shall be maintained, and statement of accounts shall be rendered by insurers and other insurer intermediaries

Insurer

A company who, through a contractual agreement, undertakes to compensate specified losses, liability, or damages incurred by another individual. An **insurer** is frequently an **insurance** company and is also **known as** an underwriter.

Types of Insurance Organisations



Life Insurance

Life insurance companies cover risks that relate to human lives. They offer different benefits under different types of products and cover the risk of early death, as well as the risk of living into old age. Under traditional plans, like term insurance plans, insurance companies provide death cover.

Non-Life insurance companies

Non-life insurance companies generally cover risks other than those relating to human lives. The exceptions to this are personal accident and health insurance, which are provided by non-life insurance companies. All assets are exposed to various risks: they can be damaged or destroyed by fire, earthquake, riot, theft, flooding, cyclones etc. If the asset is damaged by any of these risks, the owner will be at a disadvantage and they will lose the income or the convenience the asset provided. Non-life insurance companies offer products that cover these risks and compensate the owner should the asset be damaged by one of them. For example, Home Insurance policy, Private Car Policy, Health Insurance Policy, Fire and allied Peril policy etc.

Reinsurance companies

Insurance companies can only take on so much risk. Once that limit is reached, the insurer itself is exposed to the risk of loss. When this happens, insurers look to transfer some of their risks to someone else to shield themselves from overexposure. This is where reinsurance companies come into use. A reinsurance company is an insurer for the insurance company.

Insurance Intermediaries

Insurance Intermediary is an entity or a person, other than Insurer and Insured, and takes active participation in the process of sale of insurance and/or post sales-servicing. Insurance Intermediaries, play an important role in fulfilment of the insurance and also provides required support to the Insurers in key areas.

Individual agents -These are engaged by insurance companies and given the required training.

Brokers – The Brokers are representative of clients. It is there job to select best insurance product available for client. For this they have to understand risk philosophy of the client and research into all products available from insurers and to provide comparison to the client. The Brokers can engage all insurance companies.

Insurance POSPs - These can sell the products of a number of life insurance companies. They have the advantage of being able to compare the insurance products of various insurance companies and then offer a plan that best suits the requirements of the customer. The POSP represents the client: they keep in mind the customer's requirements rather than favouring any specific products of any specific insurance company.

Web- aggregator /ISNP websites -These use the internet to collect together and provide quotes from various life insurance companies. An individual can input their details and compare quotes from different companies. They can then choose the one that best suits their needs.

Underwriters- These decide whether to accept or reject the insurance proposal. If the proposal is to be accepted, then the underwriter decides at what price it should be accepted.

Actuaries - These calculate the standard price of products. They take into account statistical data and the past claims experience of the company. Apart from pricing individual products, they also do an overall financial assessment of the insurance company from time to time to make sure that the company has sufficient reserves to pay for future liabilities.

Third party Administrators (TPAs) - These do the work of building hospital networks. They also help with approvals at the time of cashless admission to a hospital and with settling the bill with the insurer on discharge.

Loss adjusters/surveyors - These do the work of assessing and certifying a loss when a claim is made on the insurance company. They have a major role to play in non-life insurance business.

Training institutes -These have the responsibility of supplying trained manpower to meet the ever-growing need for skilled labour in the insurance industry. The Insurance Institute of India (III), Insurance Institute of Risk Management (IIRM) and the National Insurance Academy (NIA) are premier training institutes in the field of insurance

Insurance Ombudsman – In case of grievance against any insurer the institution of Insurance Ombudsman set up under the Redressal of Public Grievance Rules, 1998. Subject matter of complaints that can be taken up before Insurance Ombudsmen are partial or complete repudiation of claims and delay in settlement, non-issuance of policy, dispute relating to premium and interpretation of clauses in relation to claim. If not satisfied, the policyholder or claimant may ignore the award and go to the court, consumer forum etc., and if the customer consents, the insurer is has to implement the award unless it chooses to approach Court.

Self-Regulatory institutions - Self-regulation in insurance is through the Life insurance council and the General insurance council. These Councils include all registered life and general insurance companies as their members respectively and are statutory bodies constituted under the Insurance Act, 1938.

Agents

Agents are engaged by insurance companies and they act as the main link between the insurance company and the insured. After passing the prescribed examination and getting their licence, these agents seek and gain insurance business for the insurer. Agents are not on the payroll of the insurance company but are paid commission based on the sales they make.

Their role is to recommend to clients the right products that address the clients' needs. At the same

time, they must act in the interests of the insurance company by using their unique position of knowing their clients well enough to protect the insurance company from any undue adverse product selection.

Agents facilitate the smooth sale of insurance products by assisting their clients with completing the paperwork involved, and after the policy is sold the agent should ensure it is serviced properly until maturity or in the event of a claim. At the time of a claim, the agent should also assist the client to complete the required formalities to ensure quick settlement.

Every licensed agent must adhere to the Code of Conduct specified by the IRDA in the Insurance Regulatory and Development Authority (Licensing of Insurance Agents) Regulations 2000 as per Regulation 8. In the Code of Conduct the IRDA gives details as to what an agent shall and shall not do.

For instance, the agent should disclose all information relating to the insurance company that they represent and the products they are recommending. They should act in the best interests of the client while at the same time making sure that there is no adverse election against the insurance company.

Point of Sales Person (POSP)

To increase insurance penetration in the country, the industry needs more distributors to travel the last mile. To achieve that goal, what's needed is a simple certification process for these distributors. So, to get such distributors on board quickly, the Insurance Regulatory and Development Authority of India (IRDAI), in 2015, allowed for a new type of distributor, called the point of sale (POSP) person. Given that these individuals have a lower qualification and training threshold, compared to other insurance distributors such as agents, POSPs and corporate agents, IRDAI has allowed these individuals to sell only basic insurance products, which don't require a lot of underwriting.

As per the regulator, certain class of motor, travel, health and life insurance policies which require very little underwriting as they are based on information provided by the prospect, can be solicited by a POSP.

Therefore, the intervention required for such products is minimal and the training and exams for such persons could be of a lesser degree than those for a full-fledged distributor.

Further, to ensure faster certification of point of sale persons, the IRDAI has relaxed the certification programme by allowing the insurers or intermediaries hiring POSP to train and examine these individuals in-house based on the recommended model syllabus.

A person seeking to become a POSP, must:

- be 18 years of age
- have passed 10th class examination
- have PAN card

- have Aadhar Card
- not be engaged with any other insurance company in any capacity

Accordingly, IRDAI has allowed:

- in-house training by the insurer or intermediary engaging the POSPP
- to conduct an in-house training of 15 hours followed by an in-house examination
- the POSPP will then issue a certificate and maintain the records for at least 5 years.
- No fees to be paid by POSP for training and examination
- POSP to enter an written agreement with POSP which specifies terms and conditions

Each POSP must follow a Code of Conduct devised by the IRDAI under POSPP regulations, to ensure that the interest of the policyholders and prospective policyholders is safeguarded againstany malpractices.

A POSP can sell following insurance policies

1. Motor Comprehensive Insurance Policy for 2-wheelers, private cars and commercial vehicles
2. Third Party cover for 2-wheelers, private cars and commercial vehicles
3. Personal Accident policy
4. Home Insurance policy
5. Travel Insurance policy
6. Health Insurance Policy

MODULE-3

LEGAL PRINCIPLES OF AN INSURANCE CONTRACT

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

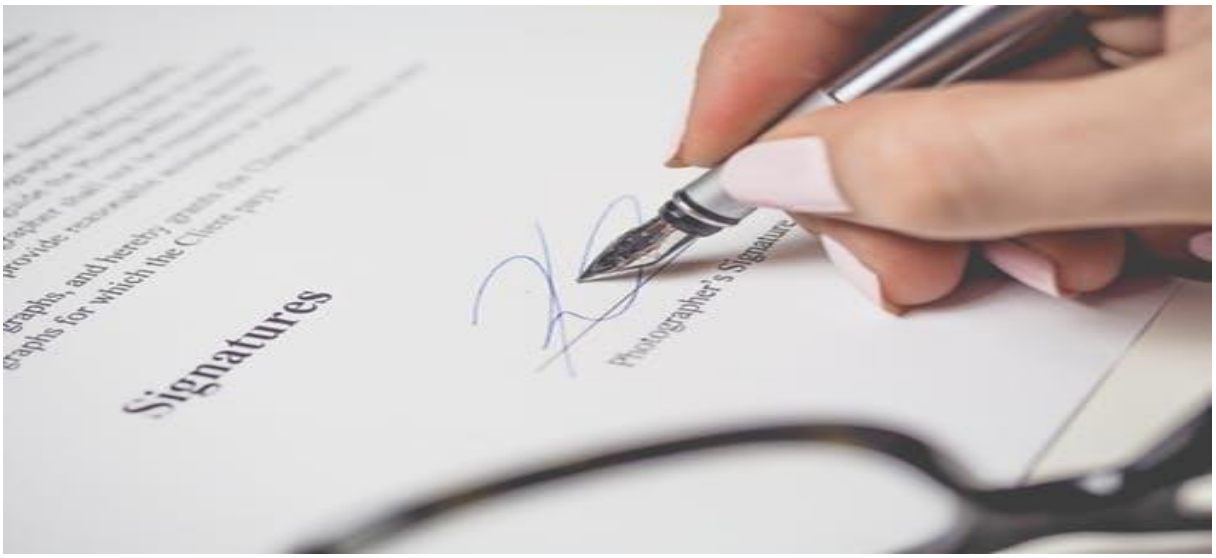
Legal aspects of an insurance contract

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

The insurance contracts

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

An insurance policy is a contract entered into between two parties, viz., the company, called the insurer, and the policy holder, called the insured and fulfils the requirements enshrined in the Indian Contract Act, 1872.



Elements of a valid contract

The elements of a valid contract are:

i. **Offer and acceptance**

ii. When one person signifies to another his willingness to do or to abstain from doing anything with a view to obtaining the assent of the other to such act, he is said to make an offer or proposal. Usually, the offer is made by the proposer, and acceptance made by the insurer.

When a person to whom the offer is made signifies his assent thereto, this is deemed to be an acceptance. Hence, when a proposal is accepted, it becomes a promise.

The acceptance needs to be communicated to the proposer which results in the formation of a contract.

Offer is the initial step where the Proposer submits the Proposal form to the insurer along with the answers to the predefined questions.

When a proposer accepts the terms of the insurance plan and signifies his assent by paying the deposit amount, which, on acceptance of the proposal, gets converted to the first premium, the proposal becomes a policy. If any condition is put, it becomes a counteroffer. The policy bond becomes the evidence of the contract.

The Acceptance by the insurer of the details contained in the Proposal form, is a limited acceptance and is only based on disclosed facts. Any misrepresentations gives the insurer an option to cancel the contract or dishonor claims of insured. Thereby, acceptance is a conditional and limited acceptance only. Issuance of insurance policy by the insurer to the insured is a testament of acceptance by the insurer.

iii. Consideration

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

iv. Agreement between the parties

Both the parties should agree to the same thing in the same sense. In other words, there should be "consensus ad-idem" between both parties. Both the insurance company and the policyholder must agree on the same thing in the same sense.

v. Free consent

There should be free consent while entering into a contract.

Consent is not said to be free when it is caused by

- Coercion
- Undue influence
- Fraud
- Misrepresentation
- Mistake

When consent to an agreement is caused by coercion, fraud or misrepresentation, the agreement is voidable, i.e. the agreement is valid unless declared invalid by any party to contract.

i. **Coercion -** Involves pressure applied through criminal means.
ii. **Undue influence** - When a person who is able to dominate the will of another, uses her position to obtain an undue advantage over the other.
iii. **Fraud** - When a person induces another to act on a false belief that is caused by a representation, he or she does not believe to be true. It can arise either from deliberate concealment of facts or through misrepresenting them.
iv. **Mistake** - Error in one‟ s knowledge or belief or interpretation of a thing or event. This can lead to an error in understanding and agreement about the subject matter of contract.
v. **Capacity of the parties**
Both the parties to the contract must be legally competent to enter into the contract. The policyholder must have attained the age of majority at the time of signing the proposal and should be of sound mind and not disqualified under law. For example, minors cannot enter into insurance contracts.
vi. **Legality**

The object of the contract must be legal, for example, no insurance can be had for illegal acts. Every agreement of which the object or consideration is unlawful is void. The object of an insurance contract is a lawful object.

Principles of Insurance

a) Uberrima Fides or Utmost Good Faith

This is one of the fundamental principles of an insurance contract. Also called uberrima fides, it means that every party to the contract must disclose all material facts relating to the subject matter of insurance.

A distinction may be made between Good Faith and Utmost Good Faith. All commercial contracts in general require that good faith shall be observed in their transaction and there shall be no fraud or deceit when giving information. Apart from this legal duty to observe good faith, the seller is not bound to disclose any information about the subject matter of the contract to the buyer.
Insurance contracts stand on a different footing. Firstly, the subject matter of the contract is intangible and cannot be easily known through direct observation or experience by the insurer. Again, there are many facts, which by their very nature, may be known only to the proposer. The insurer has to often rely entirely on the latter for information.

Hence the proposer has a legal duty to disclose all material information about the subject matter of insurance to the insurers who do not have this information.

Rajesh made a proposal for an insurance policy. At the time of applying for the policy, David was suffering from and under treatment for Diabetes. But Rajesh did not disclose this fact to the insurance company. Rajesh was in his thirties, so the insurance company issued the policy without asking David to undergo a medical test. Few years down the line, Rajesh "s health deteriorated, and he had to be hospitalized. Rajesh could not recover and died in the next few days. A claim was raised on the insurance company

To the surprise of Rajesh "s nominee, the insurance company rejected the claim. In its investigation, the insurance company found out that Rajesh was already suffering from diabetes at the time of applying for the policy and this fact was deliberately hidden by Rajesh. Hence the insurance contract was declared null and void and the claim was rejected.

Following are some examples of material information that the proposer should disclose while making a proposal:

i. **Life Insurance:** own medical history, family history of hereditary illnesses, habits like smoking and drinking, absence from work, age, hobbies, financial information like income details of proposer, pre-existing life insurance policies, occupation etc.

ii. **Fire Insurance:** construction and usage of building, age of the building, nature of goods in premises etc.

iii. **Marine Insurance:** description of goods, method of packing etc.

iv. **Motor Insurance:** description of vehicle, date of purchase, details of driver etc.

If utmost good faith is not observed by either party, the contract may be avoided by the other. This essentially means that no one should be allowed to take advantage of his own wrong especially while entering into a contract of insurance.

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

Section 45 of Insurance Act – within 2 years of policy Insurer can cancel the policy if it is of opinion material facts were not disclosed by insured

i. Misleading of facts by the insured

An executive is suffering from Hypertension and has had a mild heart attack recently, following which he decides to take a medical policy but does not reveal his true condition. The insurer is thus duped into accepting the proposal due to misrepresentation of facts by insured.

ii. Misleading of facts by the insurer

An individual has a congenital hole in the heart and reveals the same in the proposal form. The same is accepted by the insurer and proposer is not informed that pre-existing diseases are not covered for at least 4 years.

a) Insurable Interest

Insurable interest is said to exist when an individual stands to gain or benefi t from the continued existence or well-being of another individual(s) or property, and at the same time the individual would suffer a financial loss or inconvenience if there is damage to the other individual(s) or property

Three essential elements of insurable interest:

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

Example

- Owner of property can insure.
- Banks/Financiers/Mortgagee and Mortgagor have insurable interest in vehicle or property for which they have given loan.
- Buyers, Sellers, Shipper all have insurable interest in cargo.
- Everyone has insurable interest in Self, wife & children.
- Owner of the vehicle has insurable interest in, third party, and occupants of car as well as in the vehicle.
- Executors and Trustees have insurable interest in the property under their charge.

Insurance contracts are not gambling transaction and insurable interest must be there. Subject matter of insurance contract is related to financial interest one has in the property to be insured.

WHEN INSURABLE INTEREST SHOULD BE PRESENT

- In case of **Fire & Miscellaneous Insurance**: At all the time i.e. at the time of effecting insurance as well as at the time of Loss/Claim.
- In case of **Marine Insurance**: The insurable interests need not to exist at the time of effecting insurance, but it must exist at the time of loss. Exporter, Importer, Shipper and Carrier can affect insurance.

- In case of **Life insurance**: The insurable interest is required to exist at the time of entering a contract.
- Lawful possession of property will normally support insurable interest if possession also includes responsibilities i.e. future challans, any accident future liabilities while vehicle in use or not.

b) Indemnity

Insurance contract gives financial compensation sufficient to place the insured in same financial position after the loss as he enjoyed immediately before it occurred.

Suresh has taken out an individual health insurance policy with a sum insured of Rs. 2,00,000. Suresh falls ill and had to be hospitalised, resulting in a hospital bill of Rs. 40,000. So, in this case the insurance company will compensate (indemnify) Suresh with Rs. 40,000

The insured cannot gain by over-insuring his property. But he will lose by under-insurance. One would then be entitled to indemnity for loss only in the same proportion as one's insurance.

Example, the house, worth Rs. 10 lakhs has only been insured for a sum of Rs. 5 lakhs. If the loss on account of fire is Rs. 60,000, one cannot claim this entire amount. It is deemed that the house owner has insured only to the tune of half its value and he is thus entitled to claim just 50% [Rs. 30,000] of the amount of loss. This is also known as underinsurance.

In most types of non-life insurance policies, which deal with insurance of property and liability, the insured is compensated to the extent of actual amount of loss i.e. the amount of money needed to replace lost or damaged property at current market prices less depreciation.

Indemnity might take one or more of the following modes of settlement:

- Cash payment
- Repair of a damaged item
- Replacement of the lost or damaged item
- Restoration, (Reinstatement) for example, rebuilding a house destroyed by fire

c) Subrogation

It is the process an insurance company uses to recover claim amounts paid to a policy holder from a negligent third party.

Subrogation can also be defined as surrender of rights by the insured to an insurance company that has paid a claim against the third party.
Mr. Kishore's household goods were being carried in Happy Transport service. They got damaged due to driver's negligence, to the extent of Rs 45,000 and the insurer paid an amount of Rs 30,000 to Mr. Kishore. The insurer stands subrogated to the extent of only Rs 30,000 and can collect that amount from Happy Transport

How subrogation Arises?

- Tort: Where insured has sustained some damages, lost rights or incurred liability due to tortuous acts of some other person then the insurer, having indemnified for the loss is entitled to take action to recover the outlay from the wrongdoer.
- Contract: Subrogation relates to the rights, which arise out of certain contracts. This may arise where there is a custom of the trade to which the contract applies. The other situation where subrogation may arise from contract is where a person has a contractual right to compensation regardless to fault. Insurer will assume the benefits of these rights
- Statute: In U.K. the insurance company has the right to recover from police for loss to the property for which claim has been paid for the damage sustained due to riot.
- Subject Matter of Insurance: After payment of claim of lost property the insurance company procures the right of taking over the property if recovered.

When Subrogation right arises: The right of common law arises when insurance company has admitted the claim and paid it.

Modification of subrogation: The Company can exercise the right before payment or even may not exercise the right under Knock for Knock agreement. The right may also be waived in case the injury or damage to employee is due to negligence of other employee.

d) Proximate Cause

How did the loss occur? Under this rule, insurer looks for the main cause which sets into motion the chain of events producing the loss, which may not necessarily be the last event that immediately preceded the loss i.e. it is an event which is closest to, or immediately responsible for causing the loss.

Unfortunately, when a loss occurs there will often be a series of events leading up to the incident and so it is sometimes difficult to determine the nearest or proximate cause. For example, a fire might cause a water pipe to burst. Despite the resultant loss being water damage, the fire would still be considered the proximate cause of the incident.

Example 1 - Ajay has car insurance policy which covers damage to car but does not cover theft. Ajay's car was stolen. Two days later, the police found the car in a damaged condition. Investigation revealed that the thief had banged the car into a tree. Ajay filed a claim with insurance company for the damages to the car.

Example 2 - Mr. Pinto, while riding a horse, fell on the ground and had his leg broken, he was lying on the wet ground for a long time before he was taken to hospital. Because of lying on the wet ground, he had fever that developed into pneumonia, finally dying of this cause. Mr Pinto has a Personal Accident policy but no life or health insurance.

In example 1 the claim is not admissible as the incident of damage to car was as result of theft which was not covered.

In example 2 the claim is admissible as the death was result of accident which was covered.

Contribution

The principle of "Contribution" implies that if the same property is insured with more than one insurance company, the compensation paid by all the insurers together cannot exceed the actual loss suffered.

If insured were to collect the amount of the loss from each insurer fully, insured would make a profit from the loss. This would violate the principle of indemnity. Essentials of Contribution-

- Two or more policies must exist
- Policies must have common interest
- Policies must cover a common peril which gives rise to loss
- Policies must have common subject matter
- Each policy must be liable for loss
- Each insurer pay in proportion to the sums insured on the policies.

For example, a stock is insured for Rs 6,00,000 with 3 insurance companies in following order

Policy A sum Insured	Rs. 100,000
Policy B sum Insured	Rs. 200,000
Policy C sum Insured	Rs. 300,000
Total	**Rs. 600,000**

In case of the loss of Rs 60,000 which works out to 10% of the total sum insured, the share of loss for the three insurers will be Rs.10,000 for insurer A, Rs.20,000 for insurer B and Rs.30,000 for insurer C.

Proposal Form

Proposal Form is the basis of each insurance contract. It contains disclosure of material facts

relating to proposer, upon which the insurer performs underwriting and the premium amount is quoted.
As per law:

"Proposal form" means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk.

The principle of utmost good faith and the duty of disclosure of material information begin with the proposal form for insurance.

Salient Features of Proposal Form

- Proposal form is a set of pre-defined questions or a questionnaire, seeking responses from the proposer.
- Proposal form may vary from insurer to insurer and from subject matter to subject matter.
- Proposal forms are signed by the proposer, signifying the authenticity of the information provided therein.
- Proposal forms are retained by the insurer, as it serves as the basic document of the issued insurance policy.
- No policy can be issued without the proposer submitting a proposal form, filled with disclosures relating to the subject-matter.
- Depending upon the mode of purchase, proposal form can be digital and in paper form.

Declaration - Insurance companies usually add a declaration at the end of the proposal form to be signed by the insurer. This ensures that the insured has filled up the form accurately and understood the facts given therein, so that at the time of a claim there is no scope for disagreements, on account of misrepresentation of facts. This serves the main principle of utmost good faith on the part of the insured.

Sales Literature

Sales literature contains information relating to an insurance policy, which are aimed at:

- Explaining/Portraying the features of the insurance policy; and
- Solicitation of the policy

Depending upon the volume of the information provided in the sale literature and the medium of publishing, sale literature can be brief like Pamphlets, fliers or can be detailed like Prospectus.

Prospectus is the main document of a sales literature as it is the complete set of information that is associated with an insurance policy. Prospectus contains all the information about the respective insurance product

Prospectus is the main document and all sales literature is developed by adopting extracts from the prospectus. Since sales literature is used to promote the product, it is to be ensured that the literature is completed correct and is not confusing to the prospects

Payment of Premium

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

Section 64 VB of Insurance Act, 1938

a) Section 64 VB of the Insurance Act-1938 provides that no insurer shall assume any risk unless and until the premium is received in advance or is guaranteed to be paid or a deposit is made in advance in the prescribed manner
b) Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with or dispatch by post to the insurer the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.
c) It is also provided that the risk may be assumed only from the date on which the premium has been paid in cash or by cheque.
d) Where the premium is tendered by postal or money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked, or the cheque is posted as the case may be.
e) Any refund of premium which may become due to an insured on account of the cancellation of policy or alteration in its terms and conditions or otherwise, shall be paid by the insurer directly to the insured by a crossed or order cheque or by postal / money order and a proper receipt shall be obtained by the insurer from the insured, and such refund shall in no case be

credited to the account of the agent.

In brief:

1) All the insurance policies can be only issued once the premium is received by the Insurer. Even if the premium is received by the Agent, then also the policy cannot be issued.
2) All the refunds, in any case, shall be paid by either directly crediting the account of the applicant/insured or by a cheque in the name of the applicant/insured.
3) All the monies collected by the Agents for the policy, shall be forwarded to the insurer without any deduction.
4) However, the insurer may choose to accept certain payment methods only.

Premium Receipts

1) All the payments made to the insurer by the prospects or insured have to be substantiated with a premium receipt.
2) A premium receipt is an acknowledgement drawn in the name of the person paying the money by the insurer.
3) For all practical purposes, the premium receipt is an evidence of payment of premium to the insurer by the prospect/insured.

Insurance Policy or Insurance Certificate is issued once the premium is realized by the insurer. It is the conclusive document that signifies that the insurance policy has been issued and the risk has been transferred.

Insurance Policy documents, basically consists of details like:

- Name of the insured
- Address of the insured
- Subject matter
- Date of premium receipt
- Policy tenure
- When the renewal is due
- Terms and conditions related to the policy
- Address of the Insurer
- Ombudsman details, etc.

Endorsement

Endorsement refers to change in the terms and conditions of the insurance policy. Depending upon the type of policy, few changes are allowed that does not result in change of the subject matter or the risk associated thereto.

It is attached to the policy and forms part of it. The policy and the endorsement together constitute the evidence of the contract. Endorsements may also be issued during the currency of the policy to record changes / amendments.

Endorsements normally required under a policy related to:

a) Variations /changes in sum insured
b) Change of insurable interest by way of sale, mortgage, etc.
c) Extension of insurance to cover additional perils / extension of policy period
d) Change in risk, e.g. change of construction, or occupancy of the building in fire insurance
e) Transfer of property to another location
f) Cancellation of insurance
g) Change in name or address etc.

Warranties

In literal sense, Warranty is an assurance given by one party to the other party, to induce the other party to enter into a transaction.

A warranty in an insurance policy is a promise by the insured party that statements affecting the validity of the contract are true. Most insurance contracts require the insured to make certain warranties. For example, to obtain a health insurance policy, an insured party may have to warrant that he does not suffer from a terminal disease. If a warranty made by an insured party turns out to be untrue, the insurer may cancel the policy and refuse to cover claims.

In insurance contracts, the insured must declare that:

1) All the declarations related to the subject matter has been disclosed/provided; and
2) All the declarations made are true to the complete knowledge of the insured and nothing is concealed.

It is in the best interest of the insured to give all and true disclosures, related to the subject-matter. It allows the insurer to ascertain the actual risk associated with the subject-matter are allows the insurer to arrive at a correct premium quote or if the insurer is willing to accept the risk at all.

In the event of complications associated with the authenticity and completeness of the disclosures. Warranties made by the insured in the proposal form can be used against the insured to decline his claim and if the insurer wants, to cancel the policy on grounds of moral turpitude.

Rebate

Rebate are the incentives provided by either the insurer or the agents to the prospective insured to affect their purchase decision and induce them to purchase insurance policy. Since inducing the prospects with rebates, harms the fair competition in the market the

provision of providing rebates is strictly prohibited by the issued regulations.

In the Section 41 of The Insurance Act, 1938, it is stated that:

"Prohibition of Rebates

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to [take out or renew or continue] an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing [or continuing] a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: [Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shallnot be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.]

Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to 3[five hundred rupees]."

Therefore, no insurer or any agent of the insurer is allowed to offer or promise to offer any rebates to the prospects for solicitation, retention or brand building purpose.

Claim

The most important function of an insurance company is to settle claims of policyholders on the happening of a loss event. Insurer fulfils this promise by providing prompt, fair and equitable service in either paying the policyholder or paying claims made against the insured by a third party

Intimation of Claim

1) Policy conditions provide that the loss be intimated to the insurer immediately. The purpose of an immediate notice is to allow the insurer to investigate a loss at its early stages. Delays may result in loss of valuable information relating to the loss. It would also enable the insurer to suggest measures to minimize the loss and to take steps to protect salvage. The notice of loss is to be given as soon as reasonably possible.
2) After this initial check/scrutiny, the claim is allotted a number and entered in the claims register, with details like policy number, name of insured, estimate of amount of loss, date of loss, the claim is now ready to be processed.
3) On receipt of the claim form, from the insured, the insurers decide about investigation and assessment of the loss. If the claim amount is small, the investigation to determine the cause and extent of loss is done, by an officer of the insurers. Otherwise it is conducted by a professional, licensed Surveyor.

Surveyors

Surveyors are professionals licensed by IRDAI. They are experts in inspecting and evaluating losses in specific areas. Surveyors and loss assessors are hired by general insurance companies normally, at the time of a claim. They inspect the property in question, examine and verify the causes and circumstances of the loss. They also estimate the quantum of the loss and submit reports to the insurance company.

Claims made outside the country in case of 'Travel Policy' or 'Marine Open Cover' for exports, are assessed by the claims settling agents abroad named in the policy.

These agents may assess the loss and make payment, which is reimbursed by the insurers along with their settling fees. Alternatively, all the claims papers are collected by the insurance claim settling agents and submitted to the insurers, along with their assessment.

Loss Assessment and Claim settlement

Claims assessment is the process of determining whether the loss suffered by the insured is caused by the insured peril and there is no breach of warranty.

Settlement of claims has to be based on considerations of fairness and equity. For a non-life Insurance company, expeditious settlement of claim is the benchmark of efficiency for its services. Each company has internal guidelines about time taken in claims processing, which its employees follow.

This is generally known by the term "Turnaround time" (TAT). Some insurers have also put in place, facility for the insured to check claim status online from time to time. Some non-life insurance companies have also set up claims hub for speedy processing of claims.

Important aspects in an insurance claim

i. The first aspect to be decided is whether the loss is within the scope of the policy. The legal doctrine of proximate cause provides guidelines to decide whether the loss is caused by an insured peril or an excluded peril. The burden of proof that the loss is within the scope of the policy is upon the insured. However, if the loss is caused by an excluded peril the onus of proof is on the insurer.

ii. The second aspect to be decided is whether the insured has complied with policy conditions, especially conditions which are precedent to "liability".
iii. The third aspect is in respect of compliance with warranties. The survey report would indicate whether or not warranties have been complied with.
iv. The fourth aspect relates to the observance of utmost good faith by the proposer, during the currency of the policy.
v. On the occurrence of a loss, the insured is expected to act as if he is uninsured. In other words, he has a duty to take measures to minimise the loss.
vi. The sixth aspect concerns the determination of the amount payable. The amount of loss payable is subject to the sum insured. However, the amount payable will also depend upon the following:

- The extent of the insured" s insurable interest in the property affected
- The value of salvage
- Application of underinsurance
- Application of contribution and subrogation conditions

The claims which are dealt with in insurance policies fall into the following categories:

i. Standard claims

These are claims which are clearly within the terms and conditions of the policy. The assessment of claim is done keeping in view scope and the sum insured opted for and other methods of indemnity laid down for various classes of insurance.

The claim amount payable by the insurer takes into account various factors like valuation at time of loss, insurable interest, salvage prospects, loss of earnings, loss of use, depreciation, replacement value depending on the policy taken.

ii. Non-Standard claims

These are claims where the insured may have committed a breach of condition or warranty. The settlement of these claims is considered subject to rules and regulations framed by the non-life insurance companies.

iii. Condition of average or average clause

This is a condition in some policies which penalizes the insured for insuring his property at a sum insured less than its actual value known as underinsurance. In the event of a claim the insured gets an amount that is proportionately reduced from his actual loss in accordance to the amount underinsured.

iv. Act of God perils - Catastrophic losses

Natural perils like storm, cyclone, flood, inundation, and earthquake are termed as "Act of God" perils. These perils may result in losses to many policies of insurer in the affected region.

In such major and catastrophic losses, the surveyor is asked to proceed to the loss site immediately for an early assessment and loss minimization efforts. Simultaneously, insurers‟ officials also visit the scene of loss particularly when the amount involved is large. The purpose of the visit is to obtain an immediate, on the spot idea of the nature and extent of loss.

Preliminary reports are also submitted if the surveyors face some problems regarding the assessment and may desire guidance and instructions from insurers who are thus given an opportunity to discuss the issues with the insured, if necessary.

In such major and catastrophic losses, the surveyor is asked to proceed to the loss site immediately for an early assessment and loss minimization efforts. Simultaneously, insurers' officials also visit the scene of loss particularly when the amount involved is large. The purpose of the visit is to obtain an immediate, on the spot idea of the nature and extent of loss.

Preliminary reports are also submitted if the surveyors face some problems in regard to the assessment and may desire guidance and instructions from insurers who are thus given an opportunity to discuss the issues with the insured, if necessary.

v. On account payment

Apart from preliminary reports, interim reports are submitted from time to time where repairs and/or replacements are made over a long period. Interim reports also give the insurer an idea of the development of assessment of loss. It also helps in recommendation of "On account payment" of the claim if desired by the insured. This usually happens if the loss is large and the completion of assessment may take some time.

If the claim is found to be in order, payment is made to the claimant and entries made in the company records. Appropriate recoveries are made from the co-insurers and reinsurers, if any. In some cases, the insured may not be the person to whom the money is to be paid.

Motor Claim

Motor third party claims involving death and personal injuries are assessed based on doctor‟s report. These claims are dealt by Motor Accident Claims Tribunal and the amount to be paid is decided by factors like the age and income of the claimant.

Claims involving third party property damage are assessed based on a survey report.

- Motor own damage claim is assessed on the basis of surveyor's report.
- It may require police report if third party damage is involved.

Health Claims

Health insurance claims are assessed either in house or by third party administrators (TPA"s) on behalf of the non-life insurance companies. The assessment is based on the medical reports and expert opinion.

Discharge vouchers

Settlement of the claim is made only after obtaining a discharge under the policy. A sample of discharge receipt for claims (under personal accident insurance) for injuries is worded along the following lines: (may vary from company to company)

Name of the Insured

Claim No. Policy No.

Received from the Company Ltd.

The sum of Rs._____in full and final settlement of compensation due to me/us on account of injuries sustained by me/us due to accident which occurred on or about the_____I/we give this discharge receipt to the Company in full and final settlement of all my/our claim present or future arising directly or indirectly in respect of the said claim.

Date (Signature)

Salvage

Salvage generally refers to damaged property. On payment of loss, the salvage belongs to insurers.

MODULE-4
INSURANCE PRODUCTS

General Insurance Products

The POSP can sell only products, which are:

i. Pre-underwritten.
ii. Simple to understand.
iii. Have standard benefits.
iv. Notified by authority.
v. Filed by insurer under F&U for POSP.

- The insurance company shall file the product with the Authority under the file use guidelines for information.
- Every proposal form, in paper or in paperless form, insurance policy and other related documents shall carry provision to record the Aadhaar card number of the PAN card number in order to tag the policy to the POSP who is selling the said policy.
- The insurance company will record the Aadhaar card number or the PAN card number of the POSP in the proposal form and insurance policy.

Eligible Products for POSP

As notified by IRDA, only the following type of products can be solicited by the POSP in General Insurance including Stand-Alone Health Insurance category:

i. Motor Comprehensive insurance package policy for two-wheeler, private car and commercial vehicles
ii. Third party liability (Act only) policy for two-wheeler, private car and commercial vehicle
iii. Personal accident policy
iv. Travel insurance policy
v. Home insurance policy
vi. Fire & allied peril dwelling insurance
vii. Hospital cash policy where a fixed benefit in the form of cash for every day of hospitalization with a limit of Rs. 1 lakh per individual.
viii. Critical illness policy which covers 8-9 critical illness with the maximum sum insured limit of Rs 3 lakhs per individual.
ix. The indemnity-based health insurance products may be offered to only individual policyholders excluding groups and government scheme. Upto Rs.5 lacs per life/individual will be the maximum sum insured.

Motor Insurance

Motor Insurance is a vehicle policy to protect from financial losses arising from unforeseen risks. such as accidents, thefts or Third-Party Liabilities such as accidents, thefts or Third-Party Liabilities

As per the Motor Vehicles Act, 1988, Motor Car Insurance is mandatory in India.

Motor Vehicle act 1939 stipulates that no vehicle can run on road without liability only policy.

There can only be two types of losses which could arise on the above-mentioned vehicles i.e.

1) Own Damage Cover
2) Third Party Liability Cover
3) Comprehensive cover

For proper understanding, let it be known that insured is 1st party, insurance company is 2nd party and every-body else falls under 3rd party including the passengers of private or commercial vehicles.

Own Damage Cover

Following damages are covered

i. Accidental Loss
ii. Fire / Explosion
iii. Theft
iv. Natural Disasters
v. Man Made Calamities
vi. Owner Driver

Exclusions under Insurance

1. Wear & Tear
2. Breakdown
3. Depreciation
4. Intentional / Illegal Driving
5. Out of Geographical Limits
6. Pre-Existing Damage
7. Un-Authorized use Of Vehicle

The validity of a Motor Insurance Policy is one year which means that it must be renewed it annually before expiry.

The premium depends on several factors such as make, model, year manufactured, engine capacity, Insured Declared Value (IDV), location and driver's age/gender/marital status/occupation, among a few others. These days, one can even buy an Online Car Insurance policy without needing to visit the insurance company office in person.

As per the guidelines of IRDAI, it is a mandatory cover that needs to be taken for any vehicle plying on the road. This policy covers damages to any third party and the premium is very low.

Coverages

A. Third Party Cover

i. Third party property cover up to 7.5 lac.
ii. Third party injury or death Amount will be decided by court based on victim's family background, no. of dependent and earning source.
iii. Owner Driver cover up to 15 lacs. (Optional)

Premium Of third-party insurance depends upon the CC of vehicle

As per IRDAI guidelines, in case of brand-new vehicle purchase, it is mandatory to purchase third party liability policy in advance for 1, 3 years or 5 years, in case of car and bike respectively.

B. Comprehensive Cover

Comprehensive Cover includes Own Damage Cover and Third-Party Cover.

This policy can be voluntarily availed by the policyholder for a more inclusive coverage on his vehicle which provides an all-round protection. The coverage includes damage to the vehicle through every factor such as theft and fire other than the third-party damage cover. While the Third-Party Policy is compulsory, this policy depends on the choice of the policyholder.

- Tyres, Tube, Batteries
- Airbags, Denting & painting, Covered up to 50%
- Plastic, Nylon, Rubber
- Glass cover up to - 100%
- Fiber Glass cover up to - 70%
- Rest metal, wooden and Fiber part cover by as per the age of vehicle.

Insured Declared Value (IDV)

IDV is the sum Insured of vehicle. The amount which is reimbursed to the customer in case his vehicle gets stolen or faces total damage. There is no restriction on regular repair claims within this limit. IT has nothing to do with resale value of Car. It is derived from ex-showroom price of the vehicle. Every Insurance company has their Master for IDV.

Premium calculation is based on MMV - Make, Model, Variant, IDV, Year of Registration, RTO Location, Discounts (If Applicable)

AGE	**IDV**
NEW (0 to 6 Months)	95% of Ex-showroom
6 Months to 1 Year	85%
1 Year to 2 Years	80%
2 Years to 3 Years	70%
3 Years to 4 Years	60%
4 Years to 5 Years	50%
5 Years and above	Flexible

Calculation of Insured Declared Value

No Claim Bonus (NCB)

No Claim Bonus is the insurer's reward to the policyholder for not making a claim in the preceding years. As per the guidelines of IRDA a policy holder or a customer can avail maximum discount of 50% by maintaining a claim-free record.

- If claim was not taken in previous year policy .....20% of OD Premium.
- No claim taken in 2 consecutive years .....25% of OD Premium.
- No claim taken in 3 consecutive years .....35% of OD Premium.
- No claim taken in 4 consecutive years .....45% of OD Premium.
- No claim taken in 5 consecutive years .....50% of OD Premium

Customer Will Not be Eligible to Avail the Benefits, If:

- Claim taken during policy year.
- Ownership transfer of vehicle (No change in ownership in last 12 months).
- Policy break case: In such cases where policy was already expired, after 90 days, customer will not be eligible to avail the benefits of NCB.
- Policy Switch: In such cases where previous year policy was a third-party insurance, and for next year customer want to proceed with comprehensive plan.

Other Discounts:

- ARAI (Automobile Research Association of India) - approved Anti-theft devices gives 2.5% or maximum Rs 500.
  - oGear Lock
  - oSteering Lock
- Member of Automobile Association of India –5% or maximum of Rs 200 on OD premium.
- Voluntary Excess

This is the limit chosen by the amount depends on the policyholder who chooses the limit factoring in his affordability and risk. Choosing a higher amount of Voluntary Deductible causes a lowering in premium policyholder to meet a part of the claim from his own pocket before raising it to the insurer.

- 2500 ..... 750 or 20% of OD premium whichever is less
- 5000 .....1500 or 25% of OD premium whichever is less
- 7500 .....2000 or 30% of OD premium whichever is less
- 15000…..... 2500 or 35% of OD premium whichever is less

Zero Depreciation

Also known as Nil Depreciation, Depreciation waiver, Bumper to Bumper cover

It covers the depreciation amount of the claim.

- All parts will be covered by 100% except tyres, tubes & battery up to 50%.
- All Insurer have limit of 2 claims after that depreciation will be applicable.
- Most selling Add-on
- Should be suggested to those who have new car, new driver, regular usage.
- Even one claim can break the add on cost
- Price increases with age
- Not available after 5 years age of car
- Cost of Consumables
- AC Gas, Nut Bolts, Engine Oil, Coolant, Greece will be covered up to 100%

Cost of Consumables

AC Gas, Nut Bolts, Engine Oil, Coolant, Greece will be covered up to 100%

Engine Gear Box Cover

This covers the consequential damage to the internal child parts of vehicle's engine, due to water ingression / leakage of lubricating oil or damage to gear box.

- Engine damage because of coolant, oil leakage
- Engine damage due to Water logging
- Must buy for High End Car
- Not available after 5 years age of car

Invoice Cover / Return to Invoice

- Covers the Invoice price (Ex-showroom + Registration Charges + Road Tax) in case of theft or total damage
- Should be suggested to those who have theft issues around their locality or regularly ply on highways
- Not available after 3 years age of car
- Price increases with age

NCB Protection

- Retains the NCB even if the claim is made.
- Valid up to 2 claims (Depends upon the insurer).
- Should be suggested to those who have high NCB.

Accessories Cover

For any extra fitted accessories over the car manufactured by the company, additional charges are to be paid

Type of Accessories

- Non-electrical like roof rack, roof rail, bumper guard etc.
- Electrical accessories like fog lamps, rear camera, Stereo
- Premium - 4% of accessories value.

Bi Fuel Kit: CNG/LPG

Note: Though it is not mandatory to mention the electronic/non-electronic accessories, but if CNG/LPG kit is fitted in the car then it has to be declared otherwise claim irrespective of damage to Kit can rejected

.

Premium

- In Case of Company Fitted CNG/LPG: 5% Of OD Premium + 60 For Third Party Liability
- In Case of Externally Fitted CNG/LPG: 4% Of Kit Value + 60 For Third Party Liability

Passenger Cover

It covers the personal accident of passengers.

It covers only in case of death, semi or permanent disability.

Premium for Passenger Cover

Rs 5 = Rs 10000 Per Passenger

Rs 25 = Rs 50000 Per Passenger

Rs 50 = Rs 100000 Per Passenger

Rs 100 = Rs 200000 Per Passenger

Nature of injury	Scale of compensation
Death	100%
Loss of two limbs or sight of two eyes or one limb and sight of one eye	100%
Loss of one limb or sight of one eye	50%
Permanent total disablement from injuries other than named above	100%

Paid Driver Cover

Legal liability cover for paid driver: fix Rs. 50
Claim will be settled by court based on Workmen Compensation Act.

Claim Procedure

- Own Damage - Losses to the vehicle may be either partial or total loss.
- Partial loss - The insured will submit a detailed estimate of repairs from the workshop of his choice along with claim form. The insurance company appoints an independent surveyor or an in-house surveyor (if the loss is less than INR. 20,000), who would assess the loss and submit his report. The company will process the report, settle the loss and make payments on completion of formalities.
- Total loss - Losses could be due to accident, fire or theft. In case of accidents (including fire) where the vehicle is beyond the scope of economical repairs or where the liability exceeds 75% of the IDV, the claims are settled on total loss basis. The liability under such cases is the IDV of the vehicle. The insurance company would take the possession of the damaged vehicle for sale through auction (after getting it transferred in its name from the RTO concerned) and settle the claim, after completion of usual formalities.
- For theft cases - there are certain additional formalities than that of accidental cases. The insured must lodge an F.I.R. and must obtain untraced report from the police. Insured also needs to write to RTO and police station that having taken the claim from the insurance company, the vehicle should not be transferred without their permission and insurance company may be informed if the vehicle is traced out later.
- The new tariff has provided compulsory excess on all vehicles. This excess must be deducted
- before making the payment.

Third party claims

- These claims are being dealt by advocates in the Motor Accident Claim Tribunal (MACT). The tribunal awards the compensation based on the facts of the case and the insurance company deposits the award in the court. If the liability is not in dispute, these cases could be compromised in conciliation or Lok-Adalat.
- Civil court has no jurisdiction in motor third party claims and there is no time limit to file case under the MACT.
- However, Sec.140 of the MV Act provides compensation to the victim under No-Fault Liability, which is Rs.50,000/- for death & Rs.25, 000/- for if injury caused results into Permanent Total Disablement. M.A.C.T however has to pass an order for compensation. This award under no fault liability cannot be recovered but would be adjusted against the final award.
- Hit and Run Sec. 163 of MV Act provides if some vehicle hit some person resulting death then Rs. 25000/- & in case of grievous injury Rs. 12500/- are payable under Solatium Fund.

Health Insurance

Policy provides for reimbursement of hospitalization/domiciliary hospitalization expenses for illness/ disease suffered or accidental injury sustained during policy period.

In the event of any admissible claim, the amount of such expenses as would fall under different heads mentioned below, reasonably and necessarily incurred thereof.

a) Room, Boarding Expenses for hospital/nursing home
b) Nursing Expenses
c) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees
d) Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses.

Liability in respect of all claims admitted during the period of insurance will up to Sum Insured.

Mediclaim insurance scheme also provides for:

a) Family discount in premium
b) Cumulative Bonus
c) Cost of Health Check-up

(Note: Renewal of insurance without break is essential)

A regular hospitalization indemnity policy covers expenses only if the duration of stay in hospital is for 24 hours or more. Except in case of certain procedures which are called daycare procedures, do not require 24 hours hospitalization. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under daycare surgeries and the list is ever growing.

Pre and post hospitalization expenses

i. Pre- hospitalization expenses
ii. Hospitalization could be either emergency hospitalization or planned. If a patient goes in for a planned surgery, there would be expenses incurred by him prior to the hospitalization
iii. Pre- hospitalization expenses could be in the form of tests, medicines, doctors" fees etc. Such expenses relevant and pertaining to the hospitalization are covered under the health policies.

iv. Post hospitalization expenses
After stay in the hospital, in most cases there would be expenses related to recovery and follow-up.

Post hospitalization expenses could be in the form of medicines, drugs, review by doctors etc. after discharge from hospital. Such expenses have to be related to the treatment taken in hospital and are covered under the health policies.

Though the duration of cover for pre and post hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for thirty days pre and sixty days post hospitalization.

Domiciliary Hospitalization

If the condition is that the illness requires attention at a hospital, but the condition of the patient is such that he cannot be moved to a hospital or there is lack of accommodation in hospitals. This treatment is also covered.

This cover usually carries an excess clause of three to five days meaning that treatment costs for the first three to five days must be borne by the insured. The cover also excludes domiciliary treatments for certain chronic or common ailments such as Asthma, Bronchitis etc.

Exclusions

The exclusion is any pre-existing condition(s) as defined in the policy, till first 48 months of continuation of policy.

Waiting periods

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

COVERAGE OPTIONS AVAILABLE

i. Individual coverage

An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc. In such covers, each person insured under the policy can claim upto the maximum amount of his sum insured during the currency of the policy. Premium will be charged for each individual insured according to his age and sum insured chosen and any other rating factor.

Add on covers

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

- Maternity cover- Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.
- Critical illness cover - Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.
- Reinstatement of sum insured - After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.
- Coverage for AYUSH – Ayurvedic – Yoga - Unani – Siddha – Homeopath - Few policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

Value added covers

- Outpatient cover: As we know health insurance products in India mostly cover only in-patient hospitalization expenses. Few companies now offer limited cover for out-patient expenses under some of the high-end plans.
- Hospital cash: This provides for fixed lump sum payment for each day of hospitalization for a specified period. Normally the period is granted for 7 days excluding the policies deductible of 2/3 days. Thus, the benefit would trigger only if hospitalization period is beyond the deductible period. This is in addition to the hospitalization claim but within the overall sum insured of the policy or may be with a separate sub-limit.
- Recovery benefit: Lump sum benefit is paid if the total period of stay in hospital due to sickness and/or accident is not less than 10 days.
- Donor's expenses: The policy provides for reimbursement of expenses towards donor in case of major organ transplant as per the terms and condition defined in the policy.
- Reimbursement of ambulance: Expenses incurred towards ambulance by Insured/insured person are reimbursed up to a certain limit specified in the schedule of the policy.
- Expenses for accompanying person: This is intended to cover the expenses incurred by accompanying person towards food, transportation whilst attending to insured patient during the period of hospitalization. Lump sum payment or reimbursement payment as per the policy terms is paid, up to the limit specified in the schedule of the policy

Claim

Cashless hospitalization

This is a planned hospitalization wherein the insured is aware of the hospitalization in advance. This duration period may vary from case to case. The insured's major treatment cost is paid directly to the hospital by TPA (Third Party Administrator).

Medical Reimbursement

Under this procedure, the insured has to bear the entire expenses incurred during hospitalization. After getting discharged from hospital, the insured/policy holder can claim medical reimbursement.
The insured has to approach the concerned TPA under which he/she is covered, fill the requisite form and satisfy all the requirements as mentioned the claim is paid.

Householder's Insurance

This policy provides coverage against certain special perils and fire outbreak specific to residential homes. This coverage can be bought by house owners (for their own house) and by tenants residing in a rented house. The sum insured, for this policy, is calculated as Building - Cost of reconstruction (exclusive of land value). A Standard Fire and Special Perils policy covers the insured home against loss and damages caused due to following causes –

- Natural calamities like lightning, fire, volcanic eruptions, bush fire, forest fire, earthquakes, storms, floods.
- Damages caused due to explosion/implosion, man-made anti-social activities like strikes, riots, damage caused with malicious intent
- Damage caused by direct contact of rail/road, vehicle. Damage caused due to the insured house, with your own vehicle, is not included in this cover.
- Damage caused due to bursting or/and overflowing of water tanks, pipes and apparatus
- Subsidence including rockslide and landslide
- Missile testing operations
- Damage caused due to leakage from automatic sprinkler installations

In addition to this, the policy also protects any permanent fixtures within the house. This includes your kitchen and bathroom fittings, and the ceiling/roof of the insured house. Some houses have

garages, an outdoor room/house or sheds. This type of insurance usually extends to these structures as well.

Public Liability Coverage

If any guests or third-party suffers an injury or damage to them or their property inside the insured's home, then this type of home insurance policy provides coverage against the same.

Personal Accident

This type of home insurance covers you and your family. A compensation is given in case of permanent disablement or death of the insured person due to accidental or physical injury, even if it has happened anywhere is the world.

Burglary & Theft

In case of an occurrence of burglary or theft in the insured house, if any valuable contents are stolen or damaged, the policy covers for it.

Contents Insurance

It is not just the house, but also the contents inside the house on which one would have spent a lot of time and money deserve equal protection. This type of home insurance policy protects the goods inside house from damages and loss owing to theft, fire, flood and other such mishaps. Documents, portable equipment, jewelry, TV, refrigerator, etc. are covered. It does help when one has to replace the interiors of house if house is flooded or has been burnt to ashes by fire.

Tenants' Insurance

As a tenant who has rented a house or flat, the need is not to cover building but to focus entirely on protecting contents. This type of insurance is a must have for every tenant to protect his contents.

Landlords' insurance

The maintenance and upkeep of the building/apartment/structure of the house (that is rented out) are clearly responsibility of Landlord. There is also cover for things like loss of rent and public liability.

What is not covered?

- Destruction of property willfully.
- Damages to property due to wear and tear.
- Loss to property due to war
- Loss to property unoccupied for more than a certain specified period.
- Money in the form of cash, antiques and collectibles.

Travel Insurance

Travel insurance is an insurance product for covering unforeseen losses incurred while travelling, either internationally or domestically. Basic policies generally only cover emergency medical expenses while overseas, while comprehensive policies typically include coverage for trip cancellation, lost luggage, flight delays, public liability, accidents, illness, missed flights, canceled tours, lost baggage, theft, terrorism, travel-company bankruptcies, emergency evacuation and other expenses.

Most travel insurance policies must be purchased prior to departure from home, or from the first departure point (e.g. an airport), depending on the product. Most policies require one to state start and finish journey in the country of residence.

Medical

In the event of minor injury or illness overseas, medical benefits offer coverage for visits to general practitioners, medicine, ambulance fees, and limited dentistry benefits. In the event of hospitalization, most travel insurance policies include emergency assistance services, which can offer guarantees of payment to hospitals for treatment, liaise treating doctors, and organize transfers between hospitals or medical evacuations back to the insured person's country of origin. More comprehensive policies include an emergency companion cover, so that a family member can remain with the insured person while in hospital.

In the event of death overseas, medical benefit sections typically include cover for repatriation of remains to insured person's the country of origin, or a funeral overseas.

Cancellation

Comprehensive travel insurance policies include cover for any cancellation fees or lost deposits relating to cancellation of the insured's person's trip for a range of unforeseen and unexpected circumstances. These include illness or injury, natural disasters and bad weather, strikes and riots, hijacking, and family emergencies. Depending on the policy, it may also include cancellation due to jury service, being made redundant from full-time employment, having annual leave revoked if one is in the armed forces or emergency services, and prohibition of or advisory against travel by a government to a particular destination.

Alternative transport and travel expenses

Many policies include benefits for alternative transport, accommodation, and meal expenses if your transport provider is delayed by a certain period, provided any layover times met the criteria in the policy. Policies may also include a benefit to purchase essential items like clothing and toiletries in the event baggage is delayed by an airline.

Luggage

Luggage benefits cover for loss, damage or theft of personal effects during your journey, including passports and other travel documents. It may also include limited benefits for theft of cash.

Public liability

This covers legal liability as a result of a claim made against you for bodily injuries or damage to property of other persons.

The insurance menu includes five main courses: trip cancellation and interruption, medical, evacuation, baggage, and flight insurance. Supplemental policies can be added to cover specific concerns, such as identity theft or political evacuation. The various types are generally sold in some combination — rather than buying only baggage, medical, or cancellation insurance, you'll usually purchase a package that includes most or all of them.

Personal Accidental Insurance Coverage

Personal accident insurance is an agreement between the insurance company and the person insured where the former will provide financial compensation to the latter or his/her family in case of permanent disability/death caused directly and only due to any accident.

In case there is an injury due to an accident that requires immediate treatment, the policy will ensure coverage for the costs in this case. These reimbursement amounts are very useful in such situations. Several policies have risk coverage against accidental death of the person insured. There is coverage for disability caused by an accident. These plans are often available as add-ons with home or car insurance policies.

Coverages

Following coverage benefits with a personal accident insurance policy –

1. Accidental Death Cover

An accident can be both emotionally and financially devastating for the dependent family members. In case of fatal injuries, the entire sum assured is paid to the nominee as mentioned in the policy document.

2. Permanent/Total Disability Cover

In case an accident results in permanent disabilities or lifelong total impairment such as loss of both the limbs, then a specified sum insured amount is paid to the policyholder.

3. Permanent Partial Disability Cover

If bodily injuries, resulting in permanent partial disabilities, then a certain percentage (up to 100%) of the benefit is paid to the insured.

4. Temporary Total Disability

In case the insured meets with temporary total disabilities and is bedridden, then the insurer will provide a weekly allowance to recompense the loss of income. The insured can also utilize this claim amount to pay the EMIs, in case there is a loss of earnings.

Major Inclusions and Exclusions of Personal Accident Insurance Plan

Inclusions

- Accidental death
- Permanent total/ partial disability
- Accidental dismemberment
- Medical expenses/ hospitalization charges
- Child education support
- Life support benefit
- Burns, broken bones and Ambulance
- Daily allowance
- Accidental dismemberment

Exclusions

- Natural death
- Pre-existing disability or injury
- Childbirth or pregnancy
- Suicide or self-injuries
- Non-allopathic treatments
- Influence of intoxicants
- Committing a criminal act or being involved in war activities, suffering from a mental disorder
- Participating in the naval, military, air force, adventurous or sports activities
- Childbirth or pregnancy

MODULE-5
MISCELLANOUS

1. Grievance Redressal Mechanism

As per the prevailing regulation of IRDAI, every insurer and intermediary involved in the insurance market, has to ensure that a proper and effective mechanism to resolve complaints and grievances of policyholders, claimants is in place. Further, the said mechanism should provide for efficient and with swift resolutions of the complaints.
The same lines, the company has put in place, a mechanism for allowing resolution of grievances, which provides for below:

A. Grievance/Complaint' - A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/deficiency of service of an insurance company and/or any intermediary or asks for remedial action.
B. 'Company' shall mean Girnar Insurance Brokers Private Limited
C. 'Policyholder' shall mean any customer or prospective customers (including legal heirs, assigns or legal representatives) who reports a Grievance to the Company

Grievance Redressal

Girnar Insurance Brokers Private Limited (hereinafter referred as "The Company/GIBPL") believes that excellence in customer service is the most important tool for sustained business growth. Therefore, the company follows a philosophy of providing resolution of the customers' complaint/grievance in a manner that effectively resolves the complaint to customer's satisfaction.

OBJECTIVE

The objective of this policy is to provide for efficient & effective grievance redressal mechanism to policyholders, nominees and other persons claiming under policies and has been formulated taking into account the following:

a) Complaints raised by customers are dealt with courtesy and on time.

b) Customers are always treated fairly .

c) Complete transparency is maintained with the customers.

d) All complaints are dealt with efficiently and fairly.

e) Customers are fully informed of avenues to escalate their complaints / grievances within the organization.

f) Customers are informed of their rights to alternative remedy if they are not fully satisfied with the response of the Company to their complaints.

g) Recognize that our quality and business goals go hand in hand and have a Continual improvement of the customer complaint handling process through the use of various tools and information technology available for business process improvement.

SCOPE

The policy shall cover all the complaints/grievances received from the policy holder/ its nominee/beneficiary/authorized person (with the written consent of the policy owner). The company will not accept any complaint from third party, agencies on behalf of the customer unless we have written consent from the policy holder.

Grievances received from consumer forums, ombudsman office or court will be dealt separately
by the legal team.

Inquiry or Request are not covered under this policy.

DEFINATIONS

"Complainant" means a policyholder or prospect or any beneficiary of an insurance policy who
has filed a complaint or grievance against the insurer or the company

"Complaints" or "Grievance" means written expression (includes a communication in the form of electronic mail or other electronic scripts), if dissatisfaction by a complainant with insurer, company or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, company or other regulated entities

Explanation – An inquiry or request would not fall within the definition of the complaint or grievance.

An Inquiry and Request would mean the following:
An "Inquiry" is defined as any communication from a customer for the primary purpose of requesting information about a company and/or its services.

A "Request" is defined as any communication from a customer soliciting a service such as a change or modification in the policy

COMPLAINT REDRESSAL PROCESS

FOURESS INSURANCE BROKING SERVICES (P) LTD.
IRDA LICENCE DB No.169 (Life & General) (Valid till 29/5/2021)
CIN/1A Ref No: U93000TG2000PTC034406
Regd. & Head Office: 28A, Journalist Colony, Jubilee Hills, Hyderabad-500033
Phones : 9550194849, E-mail :yadavallins@fouress.com

If you have a grievance that you wish to redress, you may contact us with the details of your grievance through any:

Step 1 : Channel for communication

- Email : yadavallins@fouress.com or
  28A, Journalist Colony, Jubilee Hills, Hyderabad-500033

Procedure to deal with Complaints:

- All grievances will be given acknowledgment receipt within 24 working hours of the receipt of complaint.
- All couriers will be answered within 14 days from the date of receipt.
- All grievance from walk in customer will be acknowledged immediately and log shall be maintained in this regard.
- Based on type of grievance the company shall exercise all efforts to resolve the same within 14 working days from the date of receipt of complaint.
- Once the complaint is resolver a closure mail shall be sent to the customer with the request of rating the same.

Resolution of Grievances

GIBPL endeavors to resolve all grievances to the satisfaction of the customers. In order to ensure fair resolution for the customer, the Regulator has set conditions for treating the grievances as closed.

- As per IRDAI regulations, a grievance shall be considered as disposed off and resolved:
- When GIBPL has acceded to the request of the complainant fully. or
- Where the complainant has indicated in writing, acceptance of the response of the company. or
- Where the complainant has not responded to the Company within 8 weeks of the Company's written response.

Escalation Matrix

If a client is not satisfied with the resolution provided through various channels, the client has the option to escalate the issues to a higher level, as per the escalation matrix given underneath

- In case the customer is not satisfied with the decision or not have received any response withing 14 working days, he/she may escalate the matter to our Grievance Officer at info@fouress.com or write a letter at 28A, Journalist Colony, Jubilee Hills, Hyderabad-500033
- If the customer is still dissatisfied with the decision/resolution to the complaint provided by the Grievance officer, The Customer may approach our Principal Officer at
- 28A, Journalist Colony, Jubilee Hills, Hyderabad-500033

Protection of Policyholders' Interests Regulations

Protection of the interest of Policyholders, has always been the priority of IRDAI. Numerous steps have been taken by the regulator in such regards and promulgation of IRDA (Protection of Policyholders' Interests Regulations) 2017 (hereinafter as Regulation) is a major piece of legislation issued in this regard.

The said Regulations apply to all insurers, distribution channels, intermediaries, insurance intermediaries, other regulated entities and policyholders.
The major features of IRDA (Protection of Policyholders' Interests) Regulations, 2017 are as following

1. All products Prospectus will clearly define the scope of benefits, the extent of insurance cover, warranties, exclusions/exceptions and conditions of the insurance cover along with explanations.
    a. Eligibility of the insurance product to concerned persons
    b. The perils and contingencies to be covered by insurance
2. Were the client is depending on advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect with unbiased
3. The contents of the proposal forms must be explained to client.
4. Canvassing shall not involve compulsion, inconvenience or nuisance of any kind to the client
5. Information on Free Look Period to be given to client.
6. Nomination facility to be explained to client.
7.

Know Your Customer Norms

KYC or "Know Your Customer" norms were enforced by Government of India, in order to verify address, identity and photograph of the individual using various services like gas, banks etc. In insurance sector, importance of KYC norms increases during times of insurance claims, as in recent past, many fraudulent insurance claims cases have surfaced in various parts of India.
Cases of purchasing insurance policies with fictitious address or identity were caught, therefore, KYC have helped insurers to do physical verification of their customers.

Key components of KYC

In order to keep check on possible attempts of money laundering or financing of terrorism every insurer in India are required to have an AML/CFT (Anti Money Laundering/Counter financing of terrorism) in place. There are few basic functions assigned to these AML/CFT units, that they must disperse, which are,

- Must have an internal setup of policies, procedures and controls for KYC.
- Must appoint a chief compliance officer, who will be responsible for enactment of KYC norms. Recruitment and training of required number of employees/agents under KYC norms.
- Carrying out control/audit of all accounts of the KYC norms. Right time for doing KYC

When should KYC be done?

- In case of General insurance products KYC norms must be done at the time of claims, whenever the claim amount is 1 lac or more.
- AML/CFT checks are compulsory for cases where threat of money laundering or terrorist financing is suspected. Whenever, there is no direct relationship between insured and the third party, verification of KYC becomes more important.
- Suspicious transactions covered under KYC -There are various financial activities that must be approved under KYC norms in order to fortify any vulnerability, if present,
    - Where customer is reluctant to provide information or providing fictitious details for identification.
    - Cash based transactions, where payments are 5 lacs or above. It must consider multiple DDs in denomination of 50,000 or less.
    - Repeated policy surrender cases in look up period by a specific individual. Policies assigned to parties without any valid relationship with them.
    - Policy from places, where person don't have any relationship in terms of residence or place of employment.
    - Frequent change in address requests.
    - Where claims by policyholder are fraudulent or with overestimated pricing.
    - Intentional overpayment of premium and subsequent requests for refunds of overpaid premium. Returning policies and asking for refund on cancelled policy through insurer's cheque.

Anti-Money Laundering Procedures

"Money laundering" is an act of disguising illegal sources of money so that it looks as if it has originated from a legal source. There are 3 stages which are as follows: Placement: Generation of illegally acquired cash (e.g. through criminal acts like kidnapping, drug trafficking etc.) and placing in the financial system Layering: Passing such illegal money through a series of complex financial

transactions with an intent to disguise the true origin and ownership of the proceeds Integration: Using the illegal money to purchase genuine assets - at this stage, it becomes impossible for investigative agencies to detect the source and origin of such illegal funds

Financial Action Task Force (FATF) is an inter-governmental body that sets broad standards policies to combat money laundering and terrorist financing. India became a member country of FATF in June 2010 It has released 40 initial and 9 special recommendations- an important recommendation is establishment of AML program In India, the Prevention of Money Laundering Act (PMLA) was enacted in 2002 but brought into force with effect from July 1, 2005 For General Insurance companies, IRDA has issued Guidelines on AML from time to time

Further, IRDAI has also prescribed Anti-Money Laundering Counterfeit Measures Guidelines 2013, to modulate the conduct of the entities engaged in the insurance market. Each entity and its employee have to discharge their responsibilities towards taking befitting measures to counter money laundering and terrorism. Primarily, as a POSP:

1) performing thorough investigation of the identity of the prospect applying for insurance.
2) ensuring that all the requisite documents to evidence.
3) establishing the identity of the prospect are provided to the insurance company; and
4) explaining to the prospect about the necessity of furnishing the required documents, shall amount to full discharge of the obligations of the POSP.

Further, a POSP shall always be vigilant and must ensure any suspicious individuals encountered by them during the solicitation process and who are trying to submit irregular documents, must be reported to the insurer.

When does the detailed KYC requirements arise, at the time of:

1) applying for insurance, wherein the premium amount is more than INR Rs 50,000.
2) claim settlement, wherein the claim amount is more than INR 1 Lakh, and
3) assignment of insurance policy.

Some other instances, wherein POSP has to discharge extended responsibility by reporting such cases to the POSP:

1) If the prospect, insist of paying the premium in cash entirely and amount is more than INR 50,000/-.
2) If the prospect is hesitant in furnishing the identity proofs.
3) If the prospect in the initial only asks POSP the feasibility of assignment of the insurance policy to another person.
4) If the prospect is willing to pay premium for another person with whom he does not have any insurable interest.

Further, each POSP should utilize their best judgement in identifying the cases which should be reported to the insurer.

Do's and Don'ts for a POSP

This document, herein after referred to as "Code of Conduct" or "COC", is developed by Girnar Insurance Private Limited (hereinafter as the "Company"), to act as a ready reference for all the Point of Sales Persons (hereinafter as the "POSP"), engaged with the Company, to provide clear directions for ethical conduct and to further modulate the conduct to induce ethical inclination. The Code of Conduct developed by the Company shall supersede all the understanding that the POSP may have and shall warrant utmost compliance with the content contained therein. By acceptance to letter of engagement to render professional services for the company, it shall be deemed that the POSP has read and agreed to the terms contained therein.
The POSP shall ensure that all the terms are profusely understood and in case of any concern or ambiguity, POSP shall immediately have it resolved with the concerned management. Any contravention of the terms, would allow the company to take punitive actions against the POSP, extending to termination of the engagement contract.

CODE OF CONDUCT – POSP

1. Every insurance POSP shall follow recognised standards of professional conduct and discharge their functions in the interest of the clients or policyholders.

2. **Conduct in matters relating to client's relationship**— Every insurance POSP shall:

a) conduct its dealings with clients with utmost good faith and integrity at all times.
b) act with care and diligence.
c) ensure that the client understands their relationship with the insurance POSP and on whose behalf the insurance POSP is acting.
d) treat all information supplied by the prospective clients as completely confidential to themselves and to the insurer(s) to which the business is being offered.
e) take appropriate steps to maintain the security of confidential documents in their possession.
f) hold specific authority of client to develop terms.
g) understand the type of client it is dealing with and the extent of the client 's awareness of risk and insurance.
h) obtain written mandate from client to represent the client to the insurer and communicate the grant of a cover to the client after effecting insurance. Unless it is specifically mentioned otherwise, the written mandate obtained from the client shall be valid for a period of one year if the mandate has no validity period mentioned. However, in the case of pre-underwritten policies or retail/individual policies there is no requirement of obtaining mandate from the client.
i) avoid conflict of interest.
j) Obtain necessary documents required under KYC norms and share with insurance company.
k) Assist the client in opening e-insurance account.

3. **Conduct in matters relating to Sales practices**— Every insurance POSP shall:

a) identify itself and explain as soon as possible the degree of choice in the products that are on offer.

b) ensure that the client understands the type of service it can offer.
c) ensure that the policy proposed is suitable to the needs of the prospective client.
d) give advice only on those matters in which it is knowledgeable and seek or recommend other specialist for advice when necessary.
e) explain why a policy or policies are proposed and provide comparisons in terms of price, cover or service where there is a choice of products.
f) state the period of cover for which the quotation remains valid if the proposed cover is not affected immediately.
g) explain when and how the premium is payable and how such premium is to be collected, where another party is financing all or part of the premium, full details shall be given to the client including any obligations that the client may owe to that party;
h) explain the procedures to be followed in the event of a loss.
i) not indulge in any sort of money laundering activities.

4. **Conduct in relation to furnishing of information** — Every insurance POSP shall:
a) ensure that the consequences of non-disclosure and inaccuracies are pointed out to the prospective client.
b) avoid influencing the prospective client and make it clear that all the answers or statements given are the latter's own responsibility.
c) ensure that the information provided by the client on the basis of which the risk is accepted by the insurer is made part of the proposal form and shared with the client and the insurer. Any wrongful submission of information may be dealt as per the terms and conditions of the insurance contract.
d) ask the client to carefully check details of information given in the documents and request the client to make true, fair and complete disclosure where it believes that the client has not done so and in case further disclosure is not forthcoming it should consider declining to act further;
e) explain to the client the importance of disclosing all subsequent changes that might affect the insurance throughout the duration of the policy; and
f) disclose on behalf of its client all material facts within its knowledge and give a fair presentation of the risk.

5. **Conduct in relation to explanation of insurance contract** — Every insurance POSP shall:
a) provide the list of insurer(s) participating under the insurance contract and advise any subsequent changes thereafter;
b) explain all the essential provisions of the cover afforded by the policy recommended by him so that, as far as possible, the prospective client understands what is being purchased.
c) quote terms exactly as provided by insurer.
d) draw attention to any warranty imposed under the policy, major or unusual restrictions, exclusions under the policy and explain how the contract may be cancelled.
e) provide the client with prompt written confirmation that insurance has been affected. If the final policy wording is not included with this confirmation, the same shall be forwarded as soon as possible.
f) notify changes to the terms and conditions of any insurance contract and give reasonable notice before any changes take effect.

g) advise its clients of any insurance proposed on their behalf which will be affected with an insurer outside India, where permitted, and, if appropriate, of the possible risks involved;and
h) not to favour any particular insurer while arranging insurance contracts to the clients.

6) Conduct in relation to renewal of policies — Every insurance POSP shall:
a) ensure that its client is aware of the expiry date of the insurance even if it chooses not to offer further cover to the client.
b) ensure that renewal notices contain a warning about the duty of disclosure including the necessity to advise changes affecting the policy, which have occurred since the policy inception or the last renewal date.

7) Conduct in relation to claim by client— Every insurance POSP shall: -
a) explain to its clients their obligation to notify claims promptly and to disclose all material facts and advise subsequent developments as soon as possible.
b) request the client to make true, fair and complete disclosure where it believes that the client has not done so. If further disclosure is not forthcoming it shall consider declining to act further for the client.
c) give prompt advice to the client of any requirements concerning the claim.
d) forward any information received from the client regarding a claim or an incident that may give rise to a claim without delay, and in any event within three working days.
e) advise the client without delay of the insurer's decision or otherwise of a claim; and give all reasonable assistance to the client in pursuing his claim.

8) Conduct in relation to documentation — Every POSP shall: —
a) ensure that any documents issued comply with all statutory or regulatory requirements from time to time in force.
b) send policy documentation without avoidable delay,
c) make available, with policy documentation, advice that the documentation shall be read carefully and retained by the client.
d) not withhold documentation from its clients without their consent, unless adequate and justifiable reasons are disclosed in writing and without delay to the client. Where documentation is withheld, the client must still receive full details of the insurance contract.
e) ensure that the reply is sent promptly or use its best endeavours to obtain a prompt reply to all correspondence.
f) ensure that all written terms and conditions are fair in substance and set out, clearly and in plain language, client's rights and responsibilities.
g) subject to the payment of any monies owed to it, make available to any new insurance broker instructed by the client all documentation to which the client is entitled and which is necessary for the new insurance broker to act on behalf of the client; and
h) Assist the client in obtaining / receiving electronic insurance policies.

9) Conduct in relation to receipt of complaints — Every insurance POSP shall: —
a) accept complaints either by phone or in writing, including through electronic mode.
b) act on complaint promptly.

c) ensure that response letters are sent and inform the complainant of what he may do if he is unhappy with the response.

10) Conduct in relation to matter Client relationship— Every insurance POSP shall:

a) draw the attention of the client to Section 41 of the Act, which prohibits rebating and sharing of commission or remuneration or reward.

For any questions, please connect with your respective Relationship Manager.