

HEALTH INSURANCE

ACKNOWLEDGEMENT

This course has been prepared with the assistance of

A.G.Krishnan

A.N.Kaikini



भारतीय बीमा संस्थान

INSURANCE INSTITUTE OF INDIA

G - Block, Plot No. C-46,

Bandra Kurla Complex, Bandra (E), Mumbai - 400 051.

HEALTH INSURANCE

IC-32

Year of Edition: 2015

ALL RIGHTS RESERVED

This course is the copyright of the Insurance Institute of India, Mumbai. In no circumstances may any part of the course be reproduced.

The course is purely meant for the purpose of study of the subject by students appearing for the examinations of Insurance Institute of India and is based on prevailing best industry practices. It is not intended to give interpretations or solutions in case of disputes or matters involving legal arguments.

Published by: P. Venugopal, Secretary-General, Insurance Institute of India, G- Block, Plot C-46, Bandra Kurla Complex, Bandra (E) Mumbai - 400 051 and Printed at

PREFACE

Health Insurance has occupied the position of one of the fastest growing segment in the insurance industry for last few years, Coinciding with high growth in health insurance and its significance for insurance practitioner and managers.

Insurance Institute of India has developed this Health Insurance basic knowledge of insurance that enables agents to understand and appreciate their professional career in the right perspective, Needless to say, insurance business operates in a dynamic environment the agents will have to keep abreast of changes Health insurance agents will be based on the contents of this study course and questions will be framed and answers evaluated accordingly.

We thank IRDA for entrusting this work to III. We acknowledge the efforts made by the course writer in finalizing the syllabus and reviewing the course content.

The Institute wishes all those who study this course and pass the examination, very bright careers as insurance agents.

CONTENTS

CHAPTER NO.	TITLE	PAGE NO.
1	Introduction to insurance	1
2	Introduction to health insurance	16
3	Principles of insurance	37
4	Insurance documentation	52
5	Health insurance products	78
6	Health insurance underwriting	139
7	Health insurance claims	176
8	Health insurance selling process	227
9	Customer service and protection of customers' interests	251
10	Legal and regulatory aspects of insurance agency	286
11	Health insurance career prospects	317

CHAPTER 1

INTRODUCTION TO INSURANCE

Chapter Introduction

This chapter aims to introduce the basics of insurance and risk management and the role of insurance in economic development. You will also learn how insurance helps individuals and organizations in times of unexpected events and how insurance plays a vital role in ensuring social security.

Learning Outcomes

- A. What is insurance?
- B. Risk and Pooling
- C. Different ways of Managing Risk
- D. Cost of risk - When to Insure
- E. Role of Insurance in Economic Development
- F. Insurance and Social Security

After studying this chapter, you should be able to:

1. Understand how insurance works.
2. Explain the concept of risk.
3. Appreciate ways of managing risk.
4. Discuss the role of insurance in economic development.
5. Know the role of insurance in social security.

A. What is insurance?

Everything in this world is uncertain, except perhaps death. Here also, when the death will occur is uncertain. We open any newspaper and see news of fires in houses and factories, train accidents, floods or earthquakes destroying entire communities bringing both personal and economic losses to people. We hear about people dying suddenly due to accidents and diseases, some of them very young.

Why do these events make us anxious and afraid?

The reasons are simple.

- ✓ Firstly they are unpredictable; if we can expect and predict an event, we can prepare for it.
- ✓ Secondly, such unpredictable and unfortunate events are often the cause of economic loss and grief.
- ✓ Thirdly, we do not know who would be affected by such losses. .
- ✓ Fourthly, we do not know how severe such losses would be.

A community can come to the aid of individuals who are affected by such events, by having a system of sharing and mutual support.

How can we have a system of sharing and mutual support?

Suppose there are 100 families in a village. Over a period of 10 years, it is observed that, on an average, 5 families have had someone being hospitalized in any particular year.

Next year which 5 families will be affected? No one knows. Could more than 5 families be affected? No one knows. This is unpredictability.

However, they can use the concept of mutuality to help each other. This concept of mutuality and pooling of resources (called Insurance) can help them.

One villager could collect money from many persons in the village who are afraid they may suffer loss due to hospitalization.

The villager thus creates a fund from which those who *actually* suffer losses are compensated.

Any surplus or deficit, after accounting for expenses, is retained by the villager who provides the facility.

The surplus is partly taken as profit and partly treated as a reserve for abnormal claim years as there is no guarantee that in other years more than 5 families will not be affected.

However, it is not as easy as it looks as we have to consider some things.

- a) Would people agree to part with their hard earned money to create such a common fund?
- b) How could they be sure that their contributions are actually used for the desired purpose?
- c) How would they know if they are paying too much or too little?

Obviously someone trustworthy and competent has to start and organise the process and bring members of the community together for this purpose. That 'someone' is known as an Insurer who decides the contribution that each individual must make to the pool and arranges to pay to those who suffer the loss. The insurer must also win the trust of the individuals and the community. Such insurers also need to be watched over by some authority to take care of the last two questions and a few more.

Definition

Insurance may thus be defined as sharing of the losses of a few who are unfortunate to suffer such losses, amongst those exposed to similar uncertain events/ situations.

Explanatory Notes: Modern commerce was founded on the principle of ownership of property. When an asset loses value due to a certain event such as by loss or destruction, the owner of the asset suffers an economic loss.

However if a common fund is created from small contributions from many such owners of similar assets, this amount could be used to compensate the loss suffered by the unfortunate few.

In simple words, the risk or chance of suffering a certain economic loss and its consequence could be transferred from one individual to many through the mechanism of insurance.

B. Risk and Pooling

Let us understand certain basic concepts like asset, peril, risk, pooling and risk management which are frequently used in insurance business. .

- a) An **ASSET** may be physical (like a car or a building) or it may be non-physical (like name and goodwill) or it may be personal (like one's eyes, limbs and other aspect of one's body, including health).
- b) The asset may lose its value on the happening of a certain event. This chance of loss is referred to as **RISK**.
- c) The event which may cause this risk (like a fire, flood, earthquake or an accident or illness) is known as **PERIL**.
- d) And, finally, there is the principle of **POOLING**. This consists of collecting numerous individual contributions (known as premiums) from various persons. These persons have more or less similar assets which are exposed to similar risks.
- e) This pool of funds is used to **compensate** the few who might suffer the losses caused by a PERIL.
- f) This process of pooling funds and compensating the unlucky few is carried out through an institution known as the **INSURER**.
- g) The Insurer enters into an insurance **CONTRACT** with each person who seeks to participate in the scheme. Each participant is known as the **INSURED**

Insurance and Burden of Risk

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**
- ✓ **Secondary**

a) Primary burden of risk

The **primary burden of risk** is losses that are actually suffered by individuals, households or business units, as a result of pure risk events. These losses are often direct and measurable and can be easily compensated for by insurance.

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.

Similarly, if an individual has a sudden heart attack and undergoes a heart surgery, the medical cost of the same is known and can be compensated.

In addition there may be some indirect losses. For example the 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.

Similarly, if someone loses his ability to go to work and earn his daily wages due to his heart attack, it is an indirect loss.

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.

b) Secondary burden of risk

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

Example

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.

Secondly when one is uncertain about whether a loss would occur or not, he can create a fund to meet such a possible event. Practically, people may not be able to set aside such amounts and manage such funds.

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

C. Different ways of managing Risk

Another question one may ask is whether insurance is the only solution to all kinds of risk situations.

The answer is ‘No’.

Insurance is only one of the methods dealing with the risk by individuals. Some of the other methods of dealing with risks 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 activity which may expose him to a loss.

Example

One may simply avoid a risk by not stepping outside the house for the fear of meeting with an accident or may not travel at all for the fear of falling ill while abroad or refuse to bear certain manufacturing risks by contracting out the manufacturing to someone else.

But risk avoidance is a negative way to handle risk. Individual and social advancements cannot come unless people perform activities that require for some risks to be taken. By avoiding such activities, individuals and society would lose the benefits that such risk taking activities can provide.

2. Risk retention

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

Example

A person may decide, based on experience, that he has the capacity to bear medical expenses up to certain limit and decide to retain the risk with itself.

Thus, a man may take it for granted that he and his family will suffer colds and coughs or similar minor ailments requiring medical attention but he may decide not to insure it as he can bear these minor medical expenses.

3. Risk reduction and control

It 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.

The measures to *reduce chance of occurrence* are known as '**Loss Prevention**' measures while the measures to *reduce degree of loss* are known as '**Loss Reduction**' measures.

Risk reduction which involves reducing the frequency and/or size of losses is done through one or more of the following ways:-

- a) **Education and training**, such training school going children in road safety so that they may not suffer accidents or in maintaining proper hygiene to avoid getting sick and even educating them to avoid junk food so that they remain healthier.
- b) **Environmental changes**, such as improving "physical" conditions, e.g. the state taking measures to curb the pollution and noise levels to improve the health status of its people. Regular spraying of anti-mosquito pesticide helps in prevention of outbreak of the diseases such as malaria and dengue caused by mosquitoes.
- c) **Introducing precautionary measures** like not smoking, leading a healthy lifestyle and eating properly and at the right time which helps in reducing the incidence of falling ill.
- d) **Separation** or spreading out of risks which include measures by a company to separate hazardous operations from non-hazardous ones so that all employees do not get affected or a management policy not to send all its senior management on the same flight for a meeting.

4. Risk financing

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

- a) **Risk retention through self-financing** involves paying 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 an uncertain event or peril are transferred to another entity.

- ✓ Insurance is one of the major forms of risk transfer, and it permits uncertainty to be replaced by certainty through insurance indemnity.
- ✓ When a firm is part of a group, the risk may be transferred to the parent group which would then finance the losses.
- ✓ Risk relating to a dangerous process may be transferred by outsourcing the said work.

Thus, insurance is only one of the methods of risk transfer.

D. Cost of risk - When to Insure

1. Concept

Note that when we speak about a risk, we are not referring to a loss that has actually been suffered but a loss that is likely to occur. It is thus an expected loss. The cost of this expected loss (which is the same as the cost of the risk) is the product of two factors

- ✓ The **probability** that the peril being insured against may happen, leading to the loss. Probability always lies between 0 and 1, where 0 means impossibility of loss occurring and 1 means certainty of it happening.
- ✓ The **impact** or **severity** which is the amount of loss that may be suffered as a result of a loss. A mild earthquake may cause little or no loss whereas a major earthquake may result in widespread losses and hence more severe.

The cost of risk would increase in direct proportion with both probability and amount of loss.

When deciding whether to insure or not, one needs to weigh the cost of transferring the risk against the cost of oneself bearing the loss that may arise. The cost of transferring the risk is the insurance premium - driven by the two factors mentioned in the previous paragraphs.

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 oneself would be very high.

2. Cost of risk - The Considerations

a) Don't risk a lot for a little:

A reasonable relationship must exist between the cost of transferring the risk and the value derived.

Example

It would make no sense to insure against expenses for treating a headache.

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 close to bankruptcy, retention of the risk would not be realistic and appropriate and it is better to insure this risk.

Example

What would happen if someone in the family is affected by a terminal disease like Cancer? Could a middle class person afford to bear the expenses for the treatment? Such a peril has to be insured.

c) Consider the likely outcomes of the risk carefully

It is best to insure those assets for which the probability of occurrence (frequency) of a loss is low but the possible severity (impact), is high.

Example

For instance, it is important to insure against any personal accident, especially in the case of an earning member, since a road accident leading to loss of his life or even a limb may lead to loss of earning capacity and so would severely impact the finances of the family as a whole.

At the same time, when the probability of occurrence (frequency) is high, but the severity of the loss is low, if the total amount of loss due to all occurrences is more than what you can bear, this risk should be insured.

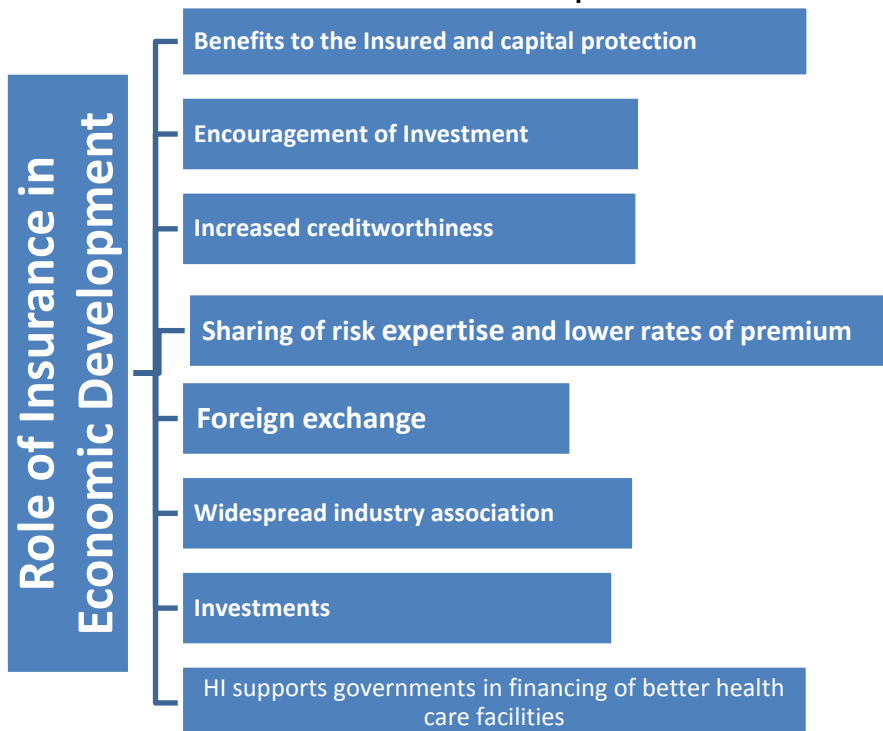
Example

An employer paying for the medical bills of his 10,000 employees would do well to insure his employees against illness rather than bearing the cost himself.

E. Role of insurance in economic development

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:

Diagram 1: Role of Insurance in Economic Development



1. Benefits to the Insured and capital protection

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 corporate, are directly benefitted because they are protected from effects of the loss that may be caused by an accident or uncertain event. Insurance, thus, in a sense protects the capital in industry and releases the capital for further expansion and development of business and industry.

2. Encouragement of Investment

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 and thereby contributes to a healthy economy and increased national productivity.

3. Increased creditworthiness

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 adding their name in the policy as co insured so that total loss claims are paid to them if there is balance loan to be paid back.

4. Sharing of risk expertise and lower rates of premium

Before acceptance of a large or complex 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 reduce the chance and severity of losses and also result in lower rates of premium.

5. Foreign exchange

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

Foreign exchange is also earned through acceptance of Reinsurance from abroad.

6. Widespread industry association

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

7. Investments

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. These funds are collected and held for the benefit of the policyholders.

Insurance companies need to keep this aspect in mind and make all 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, but they play a major role in the capital market investing in Government and debt securities as well as in stocks and shares to the extent permitted by the insurance regulator.

8. Social Security

The share of healthcare expenditure in India's GDP was very low at 4% for 2014. It is low when compared to other developing countries such as China 5.6%, Brazil 9.7% and South Africa 8.9%. Most of the government funds for health care is spent on manpower and other human resources leaving less funds for infrastructure.

As per World Bank, out of pocket health care expenditure in India was 86% leaving individuals to bear a large proportion of health care expenditures. As health care is very expensive, it leaves an individual, especially the poor population, vulnerable in case of any sickness. Health insurance provided by both commercial insurers and various governments helps individuals to tide over their medical emergencies and prevents families from falling into poverty.

Health insurance enables an individual to avail best quality health care whenever an individual requires. Cashless facility provided by insurers enables an individual to take quick medical aid without having to mobilize huge amount of money at a short notice.

As such, individuals are prevented from becoming bankrupt due to high medical costs at the time of emergencies due to existence of health insurance cover. Health insurance cover also provides for benefit payments when the individual is sick and he/she cannot engage in productive employment activities.

F. Insurance and Social Security

It is now recognised that provision of social security is an obligation of the State. Various laws, passed by the State for this purpose involve use of insurance, compulsory or voluntary, as a tool for social security. The Employees State Insurance Act, 1948 provides for Employees State Insurance Corporation to pay for the expenses of sickness, disablement, maternity and death for the benefit of industrial employees and their families, who are insured persons. The scheme operates in certain industrial areas as notified by the Government.

Insurers play an important role in social security schemes sponsored by the Government. The crop insurance scheme Rashtriya Krishi Bima Yojana (RKBY) is a measure with considerable social significance. The scheme benefits not only the insured farmers but also the community directly and indirectly.

All rural insurance schemes, operated on a commercial basis, are designed ultimately to provide social security to the rural families. The Government is also providing health insurance on a massive scale to population below the poverty line such as Universal Health Insurance Scheme and Rashtriya Swasthya Bima Yojana (RSBY) which is provided by general Insurance companies.

Apart from this support to Government schemes, the insurance industry itself offers on a commercial basis, insurance covers which have the ultimate objective of social security. Examples include Janata Personal Accident Policy, Jan Arogya Bima Policy etc.

Various government funded health insurance schemes provide health insurance coverage to large masses of population at affordable premium rates. Group insurance schemes run by government agencies and private corporates provide health care to all needy individuals irrespective of their current health conditions.

Health policies such as Personal Accident policies provide an individual accident cover, cost of hospitalisation and for loss of income.

Summary

- a) Insurance is “risk transfer through risk pooling”.
 - b) When persons having similar assets exposed to similar risks contribute into a common pool of fund it is known as pooling.
 - c) Risk retention, risk avoidance, risk reduction and control, risk financing are ways to manage risk.
 - d) The thumb rules of insurance state that one should risk not more than he can afford to lose, ensure that the reward is worth the risk and study all possible outcomes of a risk carefully.
 - e) Insurance plays an important role in the economic development of a country.
 - f) Insurance is also one of the means for providing social security.
-

Key terms

- a) Risk
- b) Pooling
- c) Asset
- d) Burden of risk
- e) Risk avoidance
- f) Risk control
- g) Risk retention
- h) Risk financing
- i) Risk transfer

CHAPTER 2

INTRODUCTION TO HEALTH INSURANCE

Chapter Introduction

This chapter will tell you about how insurance evolved over time. It will also explain what healthcare is, levels of healthcare and types of healthcare. You will also learn about the healthcare system in India and factors affecting it. Finally, it will explain how health insurance evolved in India and also the various players in the health insurance market in India.

Learning Outcomes

- A. History of Insurance and Evolution of Insurance in India
- B. What is Healthcare
- C. Levels of Healthcare
- D. Types of Healthcare
- E. Factors affecting health systems in India
- F. Evolution of Health Insurance in India
- G. Health Insurance Market

After studying this chapter, you should be able to:

1. Understand how insurance evolved.
2. Explain the concept of healthcare and the types and levels of healthcare.
3. Appreciate the factors affecting healthcare in India and the progress made since independence.
4. Discuss the evolution of health insurance in India.
5. Know the health insurance market in India.

A. History of Insurance and Evolution of Insurance in India

Insurance, in some form or the other, is known to have existed thousands of years ago. Various civilisations, over the years, have practised the concept of pooling and dividing among themselves, all the losses suffered by some members of the community. Yet, the business of insurance, as we know it today, began only two or three centuries ago.

1. Modern commercial insurance

The earliest kind of risks to be handled through the concept of insurance was losses due to misadventure at sea - what we call marine risk. Marine insurance was thus the first of many kinds of insurance.

However, the earliest type of modern insurance was in the form of protection by business guilds or societies in Europe especially in Italy in the 14th century. These guilds operated on a subscription basis funding losses by members due to shipping losses, fire, death of members, or loss of livestock. A form of fire insurance as we know it today appears to have been in existence in Hamburg in 1591.

As for England, the Great Fire of London in 1666, in which most of the city and more than 13,000 houses were destroyed, gave a boost to insurance and the first fire insurance company, called the Fire Office, was started in 1680.

Lloyds: The origins of insurance business as practiced today, is traced to the Lloyd's Coffee House in London. Traders, who used to gather there, would agree to share the losses to their goods being carried by ships, due to perils of the sea. Such losses used to occur because of perils of the sea, such as pirates who robbed on the high seas or bad sea weather spoiling the goods or sinking of the ship due to any reason.

2. History of Modern Commercial Insurance in India

Modern insurance in India began in early 1800 or thereabouts, with agencies of foreign insurers starting marine insurance business. The first life insurance company to be set up was an English company, the Oriental Life insurance Co. Ltd. in 1818 and the first non-life insurer to be established in India was the Triton Insurance Co. Ltd. in 1850 both established in Calcutta.

The first wholly Indian insurance company was the Bombay Mutual Assurance Society Ltd., formed in 1870 in Mumbai. Many other Indian companies were set up subsequently as a result of the Swadeshi movement at the turn of century.

In 1912, the Life Insurance Companies Act and the Provident Fund Act were passed to regulate the insurance business. The Life Insurance Companies Act, 1912 made it compulsory that premium-rate tables and periodical valuation of companies be

certified by an actuary. However, the discrimination between Indian and foreign companies continued.

The oldest insurance company in India which still exists today is National Insurance Company Ltd., which was founded in 1906.

Depending on the need of the situation, the Indian insurance industry has been monitored by the Government, nationalized and then de-nationalized and this is how it happened:

a) Nationalisation of life insurance

Life insurance business was nationalised on 1st September 1956 and the Life Insurance Corporation of India (LIC) was formed. There were 170 companies and 75 provident fund societies doing life insurance business in India at that time. From 1956 to 1999, the LIC held the sole right to do life insurance business in India.

b) Nationalisation of non-life insurance

With the passing of General Insurance Business Nationalisation Act (GIBNA) in 1972, the non-life insurance business was also nationalised and the General Insurance Corporation of India (GIC) and its four subsidiaries were set up. At that point of time, 106 insurers in India doing non-life insurance business were merged with the formation four subsidiaries of the GIC of India.

c) Malhotra Committee and IRDA

In 1993 the Malhotra Committee was setup to explore and recommend changes for development of the industry including the reintroduction of an element of competition in the form of entry of private players. The Committee submitted its report in 1994. In 1997 the Insurance Regulatory Authority (IRA) was established.

d) The passing of the Insurance Regulatory & Development Act 1999 led to the formation of Insurance Regulatory and Development Authority (IRDA) in April 2000 as a statutory regulatory body “to protect the interests of policy holders and regulate promote and ensure orderly growth of the insurance industry”.

e) Restructuring of GIC

The GIC was converted into a national re-insurer and its four subsidiaries were restructured as independent companies. In December, 2000 the Parliament passed a bill de-linking the four subsidiaries from GIC in July, 2002. These are

- ✓ National Insurance Co. Ltd.
- ✓ The Oriental Insurance Co. Ltd.
- ✓ The New India Assurance Co. Ltd

- ✓ United India Insurance Co. Ltd.

f) Life insurance industry today

There are 24 insurance companies registered as “Life Insurance” companies. The list is given below.

g) Non-Life insurance industry today

There are 28 insurance companies registered as “General Insurance” companies.

- i. Agriculture Insurance Company of India Limited is a specialised insurer for risk related to crop insurance/rural insurance.
- ii. Export Credit and Guarantee Corporation of India, is a specialised insurer for risks related to export credit.
- iii. There are 5 standalone Health Insurance companies.
- iv. Rest of the companies handle all types of general insurance business.

List of life insurance companies:

1. Aegon Religare Life Insurance	13. IDBI Federal Life Insurance
2. Aviva Life Insurance	14. India First Life Insurance
3. Bajaj Allianz Life Insurance	15. Kotak Mahindra Old Mutual Life Insurance
4. Bharti AXA Life Insurance	16. Life Insurance Corporation
5. Birla Sun Life Insurance	17. Max Life Insurance
6. Canara HSBC OBC Life Insurance	18. PNB Metlife
7. DHFL Pramerica Life Insurance	19. Reliance Life Insurance
8. Edelweiss Life Insurance	20. Sahara India Life Insurance
9. Exide Life Insurance	21. SBI Life Insurance
10. Future Generali Life Insurance	22. Sriram Life Insurance
11. HDFC Standard Life Insurance	23. Star Union Dai-ichi Life Insurance
12. ICICI Prudential Life Insurance	24. Tata AIA Life Insurance

List of standalone health insurance companies

1. Apollo Munich Health Insurance
2. Cigna TTK Health Insurance
3. Max Bupa Health Insurance
4. Religare Health Insurance
5. Star Health Insurance

List of general insurance companies:

1. Agriculture Insurance Company	12. Magma HDI General Insurance
2. Bajaj Allianz General Insurance	13. National Insurance
3. Bharti AXA General Insurance	14. New India Assurance
4. Cholamandalam MS General Insurance	15. Oriental Insurance
5. Export Credit Guarantee Corporation	16. Raheja QBE General Insurance
6. Future Generali General Insurance	17. Reliance General Insurance
7. HDFC ERGO General Insurance	18. Royal Sundaram General Insurance
8. ICICI Lombard General Insurance	19. SBI General Insurance
9. IFFCO Tokio General Insurance	20. Shriram General Insurance
10. L&T General Insurance	21. Tata AIG General Insurance
11. Liberty Videocon General Insurance	22. United India Insurance
	23. Universal Sompo General Insurance

B. What is Healthcare

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

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

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

Over a period of time, modern medicine has evolved into a complex science and the goal of modern medicine is no longer mere treatment of sickness but includes prevention of disease and promotion of quality of life. A widely accepted definition of health is the one given by World Health Organisation in 1948; it states that “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease”. It is to be noted that Indian system of medicine like Ayurveda incorporated such a complete view of health from times immemorial.

Definition

World Health Organisation (WHO): Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.

Determinants of health

It is generally believed that the following factors determine the health of any individual:

a) Lifestyle factors

Lifestyle factors are those which are mostly in the control of the individual concerned e.g. exercising and eating within limits, avoiding worry and the like leading to good health; and bad lifestyles and habits such as smoking, drug abuse, unprotected sex and sedentary life style (with no exercise) etc. leading to diseases such as cancer, aids, hypertension and diabetes, to name a few.

Though the Government plays a critical role in controlling / influencing such behaviour (e.g. punishing people with non-bailable imprisonment who abuse drugs, imposing high taxes on tobacco products etc.), the personal responsibility of an individual plays a deciding role in controlling diseases due to life style factors.

b) Environmental factors

Safe drinking water, sanitation and nutrition are crucial to health, lack of which leads to serious health issues as seen all over the world, especially in developing countries. Communicable diseases like Influenza and Chickenpox etc. are spread due to bad hygiene, diseases like Malaria and Dengue are spread due to bad environmental sanitation, while certain diseases are also caused due to environmental factors e.g. people working in certain manufacturing industries are prone to diseases related to occupational hazards such as Asbestos in workers in asbestos manufacture and also diseases of the lungs in coal miners.

c) Genetic factors

Diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends amongst the population spread across the globe based on race, geographical location and even communities.

It is quite obvious that a country's social and economic progress depends on the health of its people. A healthy population not only provides productive workforce for economic activity but also frees precious resources which is all the more crucial for a developing country like India. At an individual level, ill health can cause loss of livelihood, inability to perform daily essential activities and push people to poverty and even commit suicide.

Thus the world over, governments take measures to provide for health and wellbeing of their people and ensuring access and affordability of healthcare for all citizens. Thus 'spend' on healthcare usually forms a significant part of every country's GDP.

This poses a question as to whether different types of healthcare are required for different situations.

C. Levels of healthcare

Healthcare is nothing but a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. Health care to be effective must be:

- Appropriate to the needs of the people
- Comprehensive
- Adequate
- Easily available
- Affordable

Health status of a person varies from person to person. It is neither feasible nor necessary to make the infrastructure available at same level for all types of health problems. The health care facilities should be based upon the probability of the incidence of disease for the population. For example, a person may get fever, cold, cough, skin allergies etc. many times a year, but the probability of him/her suffering from Hepatitis B is less as compared to cold and cough.

Similarly, the probability of the same person suffering from a critical illness such as heart disease or Cancer is less as compared to Hepatitis B. Hence, the need to set up the healthcare facilities in any area whether a village or a district or a state will be based upon the various health care factors called indicators of that area such as:

- ✓ Size of population
- ✓ Death rate
- ✓ Sickness rate
- ✓ Disability rate
- ✓ Social and mental health of the people
- ✓ General nutritional status of the people
- ✓ Environmental factors such as if it is a mining area or an industrial area
- ✓ The possible health care provider system e.g. heart doctors may not be readily available in a village but may be in a district town
- ✓ How much of the health care system is likely to be used
- ✓ Socio-economic factors such as affordability

Based on the above factors, the government decides upon setting up of centres for primary, secondary and tertiary health care and takes other measures to make appropriate healthcare affordable and accessible to the population.

D. Types of Healthcare

Healthcare is broadly categorized as follows:

1. Primary healthcare

Primary health care refers to the services offered by the doctors, nurses and other small clinics which are contacted first by the patient for any sickness, that is to say that primary healthcare provider is the first point of contact for all patients within a health system.

In developed countries, more attention is paid to primary health care so as to deal with health issues before the same become widespread, complicated and chronic or severe. Primary health care establishments also focus on preventive health care, vaccinations, awareness, medical counselling etc. and refer the patient to the next level of specialists when required.

For example, if a person visits a doctor for fever and the first diagnosis is indicative of Dengue fever, the primary health care provider will prescribe some medicines but also direct the patient to get admitted in a hospital for specialized treatment. For most of the primary care cases, the doctor acts like a 'Family Doctor' where all the members of the family visit the doctor for any minor sickness.

This method also helps the medical practitioner in prescribing for symptoms based on genetic factors and give medical advice appropriately. For example, the doctor will advise a patient with parental diabetic history to be watchful of the lifestyle from young age to avoid diabetes to the extent possible.

At a country level, Primary Health care centres are set up both by Government and private players. Government primary health care centres are established depending upon the population size and are present right up to the village level in some form or the other.

2. Secondary healthcare

Secondary health care refers to the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patient. It includes acute care requiring treatment for a short period for a serious illness, often (but not necessarily) as an in-patient, including Intensive Care services, ambulance facilities, pathology, diagnostic and other relevant medical services.

Most of the times, the patients are referred to the secondary care by primary health care providers / primary physician. In some instances, the secondary care providers

also run an 'In-house' Primary healthcare facility in order to provide integrated services.

Mostly, the secondary health care providers are present at the Taluk / Block level depending upon the population size.

3. Tertiary healthcare

Tertiary Health care is specialized consultative healthcare, usually for inpatients and on referral from primary/secondary care providers. The tertiary care providers are present mostly in the state capitals and a few at the district headquarters.

Examples of Tertiary Health care providers are those who have advanced medical facilities and medical professionals, beyond the scope of secondary health care providers e.g. Oncology (cancer treatment), Organ Transplant facilities, High risk pregnancy specialists etc.

It is to be noted that as the level of care increases, the expenses associated with the care also increase. While people may find it relatively easy to pay for the primary care, it becomes difficult for them to spend when it comes to secondary care and much more difficult when it comes to tertiary care. The infrastructure for different levels of care also varies from country to country, rural-urban areas, while socio-economic factors also influence the same.

E. Factors affecting the health systems in India

The Indian health system has had and continues to face many problems and challenges. These, in turn, affect the nature and extent of the healthcare system and the requirement at the individual level and healthcare organization at the structural level. These are discussed below:

1. Demographic or Population related trends

- a) India is second largest populated country in the world.
- b) This exposes us to the problems associated with population growth.
- c) The level of poverty has also had its effect on the people's ability to pay for medical care.

2. Social trends

- a) Increase in urbanization or people moving from rural to urban areas has posed challenges in providing healthcare.
- b) Health issues in rural areas also remain, mainly due to lack of availability and accessibility to medical facilities as well as affordability.
- c) The move to a more sedentary lifestyle with reduced need to exercise oneself has led to newer types of diseases like diabetes and high blood pressure.

3. Life expectancy

- a) Life expectancy refers to the expected number of years that a child born today will survive.
- b) Life expectancy has increased from 30 years at the time of independence to over 60 years today but does not address the issues related to quality of that longer lifespan.
- c) This leads to a new concept of 'healthy life expectancy'.
- d) This also requires the creation of infrastructure for 'Geriatric' (old age related) diseases.

F. Evolution of Health Insurance in India

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

a) Employees' State Insurance Scheme

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

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

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

The benefits covered include:

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

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

b) Central Government Health Scheme

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

comprehensive medical care to employees and their families and is partly funded by the employees and largely by the employer (central government).

The services are provided through CGHS's own dispensaries, polyclinics and empanelled private hospitals.

It covers all systems of medicine, emergency services in allopathic system, free drugs, pathology and radiology, domiciliary visits to seriously ill patients, specialist consultations etc.

The contribution from employees is quite nominal though progressively linked to salary scale - Rs.15 per month to Rs.150 per month.

In 2010, CGHS had a membership base of over 800,000 families representing over 3 million beneficiaries.

c) Commercial health insurance

Commercial health insurance was offered by some of the non-life insurers before as well as after nationalisation of insurance industry. But, as it was mostly loss making for the insurers, in the beginning, it was largely available for corporate clients only and that too for a limited extent.

In 1986, the first standardised health insurance product for individuals and their families was launched in the Indian market by all the four nationalized non-life insurance companies (these were then the subsidiaries of the General Insurance Corporation of India). This product, **Mediclaim** was introduced to provide coverage for the hospitalisation expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc. It underwent several rounds of revisions as the market evolved, the last being in 2012.

However, even after undergoing several revisions, the hospitalization indemnity-based annual contract continues to be the most popular form of private health insurance in India today, led by the current versions of Mediclaim. So popular is this product that private health insurance products are often termed by many people as 'Mediclaim covers' considering it as a product category rather than a specific product offered by the insurers.

With private players coming into the insurance sector in 2001, health insurance has grown tremendously but there is a large untapped market even today. Considerable variations in covers, exclusions and newer add-on covers have been introduced which will be discussed in later chapters.

Today, more than 300 health insurance products are available in the Indian market.

G. Health Insurance Market

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

A. INFRASTRUCTURE:

1. Public health sector

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

- a) The **Anganwadi workers** (1 for every 1,000 population) who are enrolled under the nutrition supplementation programme and the Integrated Child Development Service scheme (ICDS) of Ministry of Human Resource Development.
- b) The **Trained Birth Attendants (TBA)** and the **Village Health guides** (an earlier scheme of health departments in states).
- c) **ASHA** (Accredited Social Health Activist) volunteers, selected by the community under the NRHM (National Rural Health Mission) programme, who are new, village-level, voluntary health workers trained to serve as health sector's links in the rural areas.

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

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

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

physician, a gynaecologist and a paediatrician supported by 21 para-medical and other staff.

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

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

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

2. Private sector providers

India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary. These range from voluntary, not-for-profit organisations and individuals to for-profit corporate, trusts, solo practitioners, stand-alone specialist services, diagnostic laboratories, pharmacy shops, and also the unqualified providers (quacks). In India nearly 77% of the allopathic (MBBS and above) doctors are practicing in the private sector. Private health expenditure accounts for more than 75% of all health spending in India. The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level¹.

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

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

It is estimated that more than 7,000 voluntary agencies are involved in health-related activities. A large number of secondary and tertiary hospitals are also registered as non-profit societies or trusts, and contribute significantly to provision of inpatient services to insured persons.

3. Pharmaceutical industry

Coming to provider of medicines and health related products, India has a large pharmaceutical industry, which has grown from a Rs 10 crore industry in 1950 to a Rs

55,000 crore business today (including exports). It employs about 5 million people, with manufacturing taking place in over 6000 units.

The central level price regulator for the industry is the **National Pharmaceuticals Pricing Authority (NPPA)**, while the pharma sector is under the Ministry of Chemicals. Only a small number of drugs (76 out of the 500 or so bulk drugs) are under price control, while the remaining drugs and manufacture are under the free-pricing regime, carefully watched by the price regulator. The Drug Controllers of the States manage the field force which oversees quality and pricing of drugs and formulations in their respective areas.

B. INSURANCE PROVIDERS:

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

C. INTERMEDIARIES:

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

1. **Insurance Brokers** who may be individuals or corporates and work independently of insurance companies. They represent the people who want insurance and connect them to insurance companies obtaining best possible insurance covers at best possible premium rates. They also assist the insuring people during times of loss and making insurance claims. Brokers may place insurance business with any insurance company handling such business. They are remunerated by insurance companies by way of insurance commission.
2. **Insurance Agents** are usually individuals but some can be corporate agents too. Unlike brokers, agents cannot place insurance with any insurance company but only with the company for which they have been granted an agency. As per current regulations, an agent can act only on behalf of one general insurance company and one life insurance company one health insurer and one of each of the mono line insurers. at the most. They too are remunerated by insurance companies by way of insurance commission.
3. **Third Party Administrators** are a new type of service providers who came into business since 2001. They are not authorized to sell insurance but provide administrative services to insurance companies. Once a health insurance policy is sold, the details of the insured persons are shared with a appointed TPA who then prepares the data base and issues health cards to the insured persons. Such health

cards enable the insured person to avail cashless medical facilities (treatment without having to pay cash immediately) at hospitals and clinics. Even if the insured person does not use cashless facility, he can pay the bills and seek reimbursement from the appointed TPA. TPAs are funded by the insurance companies for their respective claims and are remunerated by them by way of fees which are a percentage of the premium.

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

Insurance Selling Activities: To sell by engaging Insurance Sales Persons (ISP) insurance products of two Life, two General and two Health Insurance companies at any point of time, under intimation to the Authority. In respect of general insurance, the IMF is allowed to solicit or procure only retail lines of insurance products as given in the file & use guidelines namely motor, health, personal accident, householders, shopkeepers and such other insurance products approved by the Authority from time to time. Any change in the engagement with the insurance companies can be done only with the prior approval of the Authority and with suitable arrangements for servicing existing policyholders.

Insurance Servicing Activities: These servicing activities shall be only for those insurance companies with whom they have an agreement for soliciting or procuring insurance products and are enumerated below:

- a. undertaking back office activities of insurers as allowed in the Guidelines on Outsourcing Activities by Insurance Companies issued by the Authority;
- b. becoming approved person of Insurance Repositories;
- c. undertaking survey and loss assessment work by employing on their rolls licensed surveyor & loss assessors;
- d. any other insurance related activity permitted by the Authority from time to time.

Financial Products Distribution: To distribute by engaging Financial Service Executives (FSE) who are individuals licensed to market, distribute and service such other financial products namely:

- a. mutual funds of mutual fund companies regulated by SEBI;
- b. pension products regulated by PFRDA;
- c. other financial products distributed by SEBI licensed Investment Advisors;
- d. banking/ financial products of banks/ NBFC regulated by RBI;
- e. non-insurance products offered by Department of Posts, Government of India;
- f. any other financial product or activity permitted by the Authority from time to time.

D. OTHERS IMPORTANT ORGANIZATIONS

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

1. **Insurance Regulatory and Development Authority of India (IRDAI)** which is the Insurance regulator formed by an Act of Parliament which regulates all business and players in the insurance market. It came into being in 2000 and is entrusted with the task of not only regulating but also developing insurance business.
2. **General Insurance and Life Insurance Councils**, who also make recommendations to IRDAI for governing their respective life or general insurance business.
3. **Insurance Information Bureau of India** was promoted in year 2009 by IRDA and is a registered society with a governing council of 20 members mostly from the insurance sector. It collects analyses and creates various sector-level reports for the insurance sector to enable data-based and scientific decision making including pricing and framing of business strategies. It also provides key inputs to the Regulator and the Government to assist them in policymaking. The Bureau has generated many reports, both periodic and one-time, for the benefit of the industry.

IIB handles the Central Index Server which acts as a nodal point between different Insurance Repositories and helps in de-duplication of demat accounts at the stage of creation of a new account. The Central Index Server also acts as an exchange for transmission/routing of information pertaining to transactions on each policy between an insurer and the insurance repository.

IIB has already launched its hospital unique ID master programme by enlisting the hospitals in 'the preferred provider network' serving the health insurance sector.

The latest initiative of IIB would be maintaining a health insurance grid connecting TPAs, insurers and hospitals. The aim of the initiative is to help the health

insurance sector to come out with a system of insurance claims management with transparency in treatment costs and efficient pricing of health insurance products.

4. **Educational institutions** such as Insurance Institute of India and National Insurance Academy which provide a wide variety of insurance and management related training and a host of private training institutes which provide training to would-be agents
5. **Medical Practitioners** also assist insurance companies and TPAs in assessing health insurance risks of prospective clients during acceptance of risks and also advise insurance companies in case of difficult claims.
6. **Legal entities** such as the Insurance Ombudsman, Consumer courts as well as civil courts also play a role in the health insurance market when it comes to redressal of consumer grievances.

Summary

- a) Insurance in some form or other existed many centuries ago but its modern form is only a few centuries old. Insurance in India has passed through many stages with government regulation.
- b) Health of its citizens being very important, governments play a major role in creating a suitable healthcare system.
- c) Level of healthcare provided depends on many factors relating to a country's population.
- d) The three type of healthcare are primary, secondary and tertiary depending on the level of medical attention required. Cost of healthcare rises with each level with tertiary care being the costliest.
- e) India has its own peculiar challenges such as population growth and urbanization which require proper healthcare.
- f) The government was also the first to come up with schemes for health insurance followed later by commercial insurance by private insurance companies.
- g) The health insurance market is made up of many players some providing the infrastructure, with others providing insurance services, intermediaries such as brokers, agents and third party administrators servicing health insurance business and also other regulatory, educational as well as legal entities playing their role.

Key terms

- a) Healthcare
- b) Commercial insurance
- c) Nationalization
- d) Primary, Secondary and Tertiary Healthcare
- e) Mediclaim
- f) Broker
- g) Agent
- h) Third Party Administrator
- i) IRDAI
- j) Ombudsman

CHAPTER 3

PRINCIPLES OF INSURANCE

Chapter Introduction

In this chapter, we shall learn about the basic principles that govern the working of insurance. The chapter is divided into two sections. The first section deals with the general legal aspects of an insurance contract and the second section deals with the special features of an insurance contract.

Learning Outcomes

- A. Insurance contract - legal aspects
- B. Insurance contract - special features

After studying this chapter, you should be able to:

1. Define the features of an insurance contract
2. Identify the special features of an insurance contract

A. Insurance contract - legal aspects

The insurance contract

In Chapter 1, we discussed how insurance works through the concept of pooling and mutual support. We discussed how a fund is created by the insurer for paying losses to persons affected by perils. When a person pays money to the insurer, he needs something to tell him what has been agreed. The insurer therefore provides him with a document called a policy which, in legal terms, is called a contract.

The terms of insurance are set forth in the form of a contract called the Insurance policy.

An Insurance policy can therefore be described as a CONTRACT under which

- one party (called the insurer) agrees
- for consideration or payment of money (called premium)
- to indemnify or compensate the other party (called the insured)
- for the financial loss which the latter may suffer due to loss by certain causes (called perils)
- during a specified period of time (policy period) and
- Up to an agreed amount (sum insured).

1. Legal aspects of an insurance contract

We will now look at some general features of an insurance contract and then consider the special features that govern 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.

2. Elements of a valid contract

To be legally enforceable and binding on all the parties, certain features or elements have to exist otherwise the contract is not valid. The elements of a valid contract are summarized below:

a. Offer and acceptance:

There has to be an offer made by one party and such offer must be accepted by the other party. In insurance, the offer is made by the proposer for which he is expected to fill up a proposal form, and acceptance is made by the insurer.

b. Consideration

This means that the contract must involve some mutual benefit to the parties. The premium is the consideration from the insured, and the promise to indemnify or compensate for the loss, is the consideration from the insurer. If there is no consideration, there is no contract. In view of section 64VB of the Insurance Act, 1938, premium must be paid by the insured before the insurer can be put on risk.

c. Agreement between the parties

Both the parties should agree to the same thing in the same sense. For example, if the insured wants to cover his sister called Madhuri under a family health policy and the insurer believes that she is his wife and agrees to grant cover to Madhuri, there is no agreement to the same thing in the same sense and the contract is not valid.

d. Capacity of the parties

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

e. Legality

The object of the contract must be legal, for example, no insurance can be taken for smuggled goods since smuggling is an illegal activity

f. Coercion

Coercion means the action or practice of persuading someone to do something by using force or threats. In other words, it means applying pressure on someone through criminal means. Thus, no contract is valid if it is made by any party threatening to commit suicide or threatening to use a gun on the other unless they sign a contract.

g. Undue influence

When a person, who is able to dominate the will of another, uses her position, influence or power to obtain undue advantage, it is undue influence. Undue influence usually arises when the two persons are in some relationship such as husband and wife, parent and child, doctor and patient, lawyer and client etc. If undue influence is used to persuade another to enter into a contract, such a contract is invalid.

h. Fraud

During negotiations, each party makes certain statements about matters relating to the contract. When a person makes another act on a false belief that is caused by such statements, which he or she does not believe to be true, it is a case of fraud. It can arise either from deliberate hiding of facts or through misrepresenting them.

i. Mistake

Mistake is an error in judgement or understanding of an event. This can lead to an error in the understanding and agreement about an essential part of the subject matter of contract. If both parties are mistaken, the contract is invalid but if only one party is mistaken, the validity of the contract will depend on the circumstances. It is to be noted that mistake of fact can be excused but mistake of law cannot be excused.

Test Yourself 1

Which among the following cannot be an element in a valid insurance contract?

- I. Offer and acceptance
 - II. Coercion
 - III. Consideration
 - IV. Legality
-

B. Insurance contract - special features

Insurance contracts, while being governed by the law of Contracts, are also subject to certain special features. Let us now look at the special features of an insurance contract.

1. Indemnity

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

The philosophy is that one should not make a profit by insuring one's assets and recovering more than the loss. The insurer would assess the economic value of the loss suffered and compensate accordingly.

It is also to be noted that human life is considered priceless and hence it can never be indemnified. Therefore, in case of insurance covering death, the sum insured for which the policy is taken is considered for payment. However, insurers, before accepting any value as sum insured, usually see whether the amount is reasonable taking into account the earning capacity of the person.

2. Subrogation

Subrogation follows from the principle of indemnity.

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

It means that if the insured has suffered from loss of property caused due to negligence of a third party and has been compensated by the insurer for that loss, the right to collect damages from the negligent party would lie with the insurer. Note that the amount of damage that can be collected is only to the extent of amount paid by the insurance company.

Subrogation prevents the insured from collecting twice for the loss - once from the insurance company and then again from the third party. Subrogation arises only in case of contracts of indemnity.

3. Contribution

This principle is applicable only to non-life Insurance. Contribution follows from

the principle of indemnity, which implies that one cannot gain more from insurance than one has lost through the peril.

Definition

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

If the insured were to collect insurance money for the full value from all the insurers, insured would make a profit from the loss. This would violate the principle of indemnity. Not only that, it would encourage people to use insurance as a tool for making speculative gains.

IRDAI Health /insurance Regulations have clearly spelt out the operation of this principle in relation to health policies as under:

The contribution clause shall not be applicable where the cover/benefit offered is fixed in nature and does not have any relation to the treatment costs. Therefore, in case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

If the claim relates to indemnification of treatment costs, the insurer shall not apply the contribution clause, but the policyholder shall have the right to require a settlement of his claim in terms of any of his policies. The insurer who has issued the chosen policy shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the chosen policy.

However, If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policy holder shall have the right to choose the insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

It may also be noted that the principle of contribution does not apply to life insurance or Personal Accident Insurance contracts. This is so because the value of human life is deemed to be priceless. Thus the legal heirs of a person can collect full amounts (Sum Insured) from each insurer for death claim against policies issued by such insurers.

4. Uberrima Fides or Utmost Good Faith

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

a) Good faith

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

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

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

Example

Mr. Chandrasekhar goes to a TV showroom and falls in love with a fanciful brand of TV with many features. The sales person knows from experience that the particular brand is not very reliable and has, in the past, given rise to problems for other customers. He does not reveal this for fear that it might endanger the sale.

In this case the salesman cannot be held guilty of deceit since the “Buyer Beware” principle would operate. However, the situation would have been different if the sales man had been asked about the reliability of the brand and had replied that it was very reliable.

b) Utmost good faith

Insurance contracts stand on a different footing. The proposer has a legal duty to disclose all material information about the subject matter of insurance to the insurers who do not have this information. This legal duty of utmost good faith arises under common law.

Material information is that information which enables the insurers to decide:

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

Insurance contracts are subject to a higher obligation than ordinary contracts. When it comes to insurance, good faith contracts become utmost good faith contracts. The concept of “Uberrima fides” is defined as involving “a positive duty to voluntarily disclose, accurately and fully all facts material to the risk being proposed, whether requested or not.”

What is meant by complete disclosure?

The law imposes an obligation to disclose all material facts. The duty applies not only to material facts which the proposer knows, but also extends to material facts which he ought to know.

Example

It must be noted that the principle of utmost good faith applies to the insured as well as the insurer.

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 but the proposer is not informed that pre-existing diseases are not covered for at least 4 years.

c) Material fact

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

Whether an undisclosed fact was material or not would depend on the circumstances of the individual case. In case of disputes, this would have to be decided ultimately only in a court of law.

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

- i. Facts indicating that the particular risk represents a greater exposure than normal such as proposer having past history of illness in case of health policies or taking part in motor sports in the case of personal accident policies.

- ii. Existence of past policies taken from all other insurers and their present status or whether any such proposal was declined or accepted with certain unusual conditions.
- iii. All questions in the proposal form, which is the application for insurance, are considered to be material, as these relate to various aspects of the subject matter of insurance and its exposure to risk. They need to be answered truthfully and fully in all respects

The following are some examples of material facts:

Example

i. Personal Accident Insurance

- ✓ The exact nature of occupation
- ✓ Age
- ✓ Height and weight
- ✓ If suffering from any physical disabilities etc.
- ✓ If engaged in any dangerous activities like motor sports, mountaineering etc.

ii. Health Insurance

- ✓ Any operations undergone in the past
- ✓ If suffering from Diabetes or Hypertension or any terminal disease
- ✓ Whether smoker, alcoholic or mentally depressed etc.

iii. General questions-applicable to all types of proposals.

- ✓ The fact that previous insurers had rejected the proposal or charged extra premium, or cancelled, or refused to renew the policy
- ✓ Previous losses suffered by the proposer

d) Duty of disclosure in non-life insurance

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

e) Breach of utmost good faith

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

i. Non-Disclosure

This arises in the following situations:

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

ii. Misrepresentation

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

When it is a fact, it is expected to be substantially correct. When it concerns matters of belief or expectation, it must be made in good faith.

Misrepresentation is of two kinds:

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

An insurance contract generally becomes void when there is concealment with intent to deceive, or when there is fraudulent non-disclosure or misrepresentation. In case of other breaches of utmost good faith, the contract may be rendered voidable, i.e. the affected party is free to decide whether or not to treat the contract as invalid.

5. Insurable interest

The existence of 'insurable interest' is an essential part of every insurance contract. A person can take insurance only on something in which he has some financial stake. Let us see how insurance differs from a gambling or wager agreement.

a) Gambling and insurance

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

Now consider a person's health and the event of his falling sick and requiring hospitalization. The individual who insures his health has a legal relationship with the subject matter of insurance - his health. He owns it and is likely to suffer financially, if it is destroyed or impaired. This relationship of ownership exists independent of whether the illness happens or does not happen, and it is this relationship that is important. Also note that the event (hospitalization) will lead to a loss regardless of whether one takes insurance or not.

Unlike a card game, where one could win or lose (called speculative risk), a hospitalization can have only one consequence - loss to the person (called pure risk).

The owner takes insurance to ensure that the loss suffered is compensated for in some way.

The interest that the insured has in his health or his money is termed as **insurable interest**. The presence of insurable interest makes an insurance contract valid and enforceable under the law.

In case of health and personal accident insurance, apart from self, family can also be insured by the proposer since he / she stands to incur financial losses if any member of the family meets with an accident or undergoes hospitalisation.

An employer has insurable interest in his employees and so, he can take health policies on behalf of his employees since their wellbeing is his concern also.

Important

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 from liability. By the same token, he must stand to lose financially by any loss, damage, injury or creation of liability.
-

Example

Mr Srinivasan has a family consisting of spouse, two kids and old parents.

Does he have an insurable interest in their well-being? Answer: Yes

Does he stand to financially lose if any of them is hospitalised? Answer: Yes

What about his neighbour's kids? Would he have an insurable interest in them? Answer: No

It would be relevant here to make a distinction between the subject matter of insurance and the subject matter of an insurance contract.

Subject matter of insurance relates to property or asset (including health) being insured against, which has a value of its own.

Subject matter of an insurance contract on the other hand is the insured's financial interest in that property. It is only when the insured has such an interest in the property that he has the legal right to insure. The insurance policy in the strictest sense covers not the property per se, but the insured's financial interest in the property.

b) Time when insurable interest should be present

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

6. Proximate cause

The last of the legal principles, is the principle of proximate cause.

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

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

Under this rule, insurer looks for the dominant (or most important) cause which sets into motion the chain of events producing the loss. Such a cause may not necessarily be the last event that immediately happened before 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.

Definition

Proximate cause is defined as the active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

To understand the principle of proximate cause, consider the following situation:

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 and caused his death. Though pneumonia might seem to be the immediate cause, in fact it was the accidental fall that emerged as the proximate cause and the claim was admitted under personal accident insurance.

Test Yourself 2

Mr. Pinto contracted pneumonia as a result of lying on wet ground after a horse riding accident. The pneumonia resulted in death of Mr. Pinto. What is the proximate cause of the death?

- I. Pneumonia
- II. Horse
- III. Horse riding accident
- IV. Bad luck

Test Yourself 3

What is the significance of the principle of contribution?

- I. It ensures that the insured also contributes a certain portion of the claim along with the insurer

- II. It ensures that all the insured who are a part of the pool, contribute to the claim made by a participant of the pool, in the proportion of the premium paid by them
- III. It ensures that multiple insures covering the same subject matter
- IV. It ensures that the premium is contributed by the insured in equal instalments over the year.

Summary

- a) Insurance is a contract and is governed by the law of Contracts
- b) The elements of a valid contract include offer and acceptance, consideration, legality, capacity of the parties and the agreement between parties.
- c) In addition to being governed by the law of Contracts, insurance is also governed by some special features.
- d) Indemnity ensures that the insured is compensated to the extent of his loss on the occurrence of an insured peril.
- e) Subrogation means the transfer of all rights and remedies, with respect to the subject matter of insurance, from the insured to the insurer, on settlement of a claim.
- f) 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.
- g) All insurance contracts are based on the principle of Uberrima Fides or Utmost good Faith.
- h) The existence of 'insurable interest' is an essential requirement of every insurance contract and is considered as the legal pre-requisite for insurance.
- i) Proximate cause is a key principle of insurance and is concerned with how the loss or damage actually occurred and whether it is indeed as a result of an insured peril.

Key terms

- a) Offer and acceptance
- b) Lawful consideration
- c) Uberrima fides
- d) Material facts
- e) Insurable interest
- f) Subrogation
- g) Contribution
- h) Proximate cause

CHAPTER 4

INSURANCE DOCUMENTATION

Chapter Introduction

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

Learning Outcomes

- A. Proposal forms
- B. Acceptance of the proposal (underwriting)
- C. Prospectus
- D. Premium receipt
- E. Policy Document
- F. Conditions and Warranties
- G. Endorsements
- H. Interpretation of policies
- I. Renewal notice
- J. Anti-Money Laundering and 'Know Your Customer Guidelines

After studying this chapter, you should be able to:

- a) Explain the contents of proposal form.
- b) Describe the importance of Prospectus
- c) Explain the premium receipt and Sec 64VB of Insurance Act, 1938
- d) Explain terms and wordings in insurance policy document.
- e) Discuss policy conditions, warranties and endorsement.
- f) Appreciate why endorsements are issued.
- g) Understand how policy wordings are seen in courts of law.
- h) Appreciate why renewal notices are issued.
- i) Know what Money Laundering is and what an agent needs to do regarding Know Your Customer guidelines.

A. Proposal forms

As stated earlier, insurance is a contract which is reduced in writing to a policy. Insurance documentation is not limited to issuance of policies. As there are many intermediaries like brokers and agents who operate between them, it is possible that an insured and his insurer may never meet.

The insurance company comes to know the customer and his/her insurance needs only from the documents that are submitted by the customer. Such documents also help the insurer to understand the risk better. Thus, documentation is required for the purpose of bringing understanding and clarity between insured and insurer. There are certain documents that are customarily used in the insurance business.

The insurance agent, being the person closest to the customer, has to face the customer and clarify all doubts about the documents involved and help him/her in filling them up. Agents should understand the purpose of each document involved and the importance and relevance of information contained in the documents used in insurance.

1. Proposal forms

The first stage of documentation is basically the proposal form through which the insured informs:

- ✓ who he/she is
- ✓ what kind of insurance he/she needs
- ✓ details of what he/she wants to insure and
- ✓ for what period of time

Details would mean the monetary value of the subject matter of insurance and all **material facts** connected with the proposed insurance.

a) Risk assessment by insurer

- i. **Proposal form is to be filled in by the proposer** for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide:
 - ✓ whether to accept or refuse to grant the insurance and
 - ✓ in the event of acceptance of the risk, to determine the rates, terms and conditions of the cover to be granted

Proposal form contains information which are useful for the insurance company to accept the risk offered for insurance. The principle of utmost good faith and the

duty of disclosure of material information begin with the proposal form for insurance.

The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the period of insurance and even after the conclusion of the contract.

Example

In the case of Personal Accident policy, If the insured has declared in the proposal form that he does not engage in motor sports or horse riding, he has to ensure that he does not engage himself in such pursuits throughout the policy period. This is a material fact for the insurer who will be accepting the proposal based on these facts and pricing the risk accordingly.

Proposal forms are printed by insurers usually with the insurance company's name, logo, address and the class / type of insurance / product that it is used for. It is customary for insurance companies to add a printed note in the proposal form, though there is no standard format or practice in this regard.

Examples

Some examples of such notes are:

'Non-disclosure of facts material to the assessment of the risk, providing misleading information, fraud or non-co-operation by the insured will nullify the cover under the policy issued',

'The company will not be on risk until the proposal has been accepted by the Company and full premium paid'.

Declaration in the proposal form: Insurance companies usually add a declaration at the end of the proposal form to be signed by the proposer. This ensures that the insured takes the pain to fill up the form accurately and has 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 also serves to stress the main principle of utmost good faith and disclosure of all material facts on the part of the insured.

The declaration converts the common law principle of utmost good faith to a contractual duty of utmost good faith.

Standard form of declaration

The IRDAI has specified the format of the standard declaration in the health insurance proposal as under:

1. I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority.

b) Nature of questions in a proposal form

The number and nature of questions in a proposal form vary according to the class of insurance concerned.

In personal lines like health, personal accident and travel insurance, proposal forms are designed to get information about the proposer's health, way of life and habits, pre-existing health conditions, medical history, hereditary traits, past insurance experience etc.

Elements of a proposal

i. Proposer's name in full

The proposer should be able to identify herself unambiguously. It is important for the insurer to know with whom the contract has been entered, so that the benefits under the policy would be received only by the insured. Establishing identity is important even in cases where someone else may have acquired an interest in the risk insured (like legal heirs in case of death) and have to make a claim.

ii. Proposer's address and contact details

The reasons stated above are applicable for collecting the proposer's address and contact details as well.

iii. Proposer's profession, occupation or business

In some cases like health and personal accident insurance, the proposer's profession, occupation or business are of importance as they could have a material bearing on the risk.

Example

A delivery man of a fast-food restaurant, who has to frequently travel on motor bikes at a high speed to deliver food to his customers, may be more exposed to accidents than the accountant of the same restaurant.

iv. Details and identity of the subject matter of insurance

The proposer is required to clearly state the subject matter that is proposed for insurance.

Example

The proposer is required to state if it is:

- i. An overseas travel (by whom, when, to which country, for what purpose) or
- ii. A person's health (with person's name, address and identification) etc. depending on the case

- v. **Sum insured** indicates limit of liability of the insurer under the policy and has to be indicated in all proposal forms.

Example

In case of health insurance, it could be the cost of hospital treatment, while for personal accident insurance this could be a fixed amount for loss of life, loss of a limb, or loss of sight due to an accident.

vi. Previous and present insurance

The proposer is required to inform the details about his previous insurances to the insurer. This is to understand his insurance history. In some markets there are systems by which insurers confidentially share data about the insured.

The proposer is also required to state whether any insurer had declined his proposal, imposed special conditions, required an increased premium at renewal or refused to renew or cancelled the policy.

Details of current insurance with any other insurer including the names of the insurers are also required to be disclosed. Especially in property insurance, there is a chance that insured may take policies from different insurers and when a loss happens, claim from more than one insurer. This information is required to ensure that the principle of contribution is applied so that the insured is indemnified and does not gain/profit due to multiple insurance policies for the same risk.

Further, in personal accident insurance an insurer would like to restrict the amount of coverage (sum insured) depending on the sum insured under other PA policies taken by the same insured.

vii. Loss experience

The proposer is asked to declare full details of all losses suffered by him / her, whether or not they were insured. This will give the insurer information about the subject matter of insurance and how the insured has managed the risk in the past. Underwriters can understand the risk better from such answers and decide on conducting medical examination or collecting further details.

viii. Declaration by insured

As the purpose of the proposal form is to provide all material information to the insurers, the form includes a declaration by the insured that the answers are true and accurate and he agrees that the form shall be the basis of the insurance contract. Any wrong answer will give the right to insurers to avoid the contract. Other sections common to all proposal forms relate to signature, date and in some cases, the agent's recommendation.

- ix. Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with, the proposer and incorporate the information in its policy. Where the insurer later claims that the proposer did not disclose any material information or provided misleading or false information on any matter material to the grant of a cover, the burden of proving it falls on the insurer.

It means the insurance company has a duty to record all the information received even orally, which the agent has to keep in mind by way of follow up.

Important

Given below are some of the details of proposal form for a health insurance policy:

1. The proposal form incorporates a prospectus which gives details of the cover, such as coverage, exclusions, provisions etc. The prospectus forms part of the proposal form and the proposer has to sign it as having noted its contents.
2. The proposal form collects information relating to the name, address, occupation, date of birth, sex, and relationship of each insured person with the proposer, average monthly income and income tax PAN No., name and address of the Medical Practitioner, his qualifications and registration number. Bank details of the insured are also now a days collected to make payment of claim money directly through bank transfer.
3. In addition, there are questions relating to the medical condition of the insured person. These detailed questions in the form are based on past claims experience and are to achieve proper underwriting of the risk.
4. The insured person is required to state full details if he has suffered from any of the specified diseases in the form.
5. Further, the details of any other illness or disease suffered or accident sustained are called for as follows:
 - a. Nature of illness / injury and treatment
 - b. Date of first treatment
 - c. Name and address of attending Doctor
 - d. Whether fully recovered
6. The insured person has to state any additional facts which should be disclosed to insurers and if he has any knowledge of any positive existence or presence of any illness or injury which may require medical attention.

7. The form also includes questions relating to past insurance and claims history and additional present insurance with any other insurer.
8. The special features of the declaration to be signed by the proposer must be noted.
9. The insured person agrees and authorises the insurer to seek medical information from any hospital / medical practitioner who has at any time attended or may attend concerning any illness which affects his physical or mental health.
10. The insured person confirms that he has read the prospectus forming part of the form and is willing to accept the terms and conditions.
11. The declaration includes the usual warranty regarding the truth of the statements and the proposal form as the basis of the contract.

Medical Questionnaire

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

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

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

2. Role of intermediary

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

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

IRDAI regulation provides that intermediary has responsibility towards the client.

Important

Duty of an intermediary towards prospect (client)

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

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

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

B. Acceptance of the proposal (underwriting)

We have seen that a completed proposal form broadly gives the following information:

- ✓ Details of the insured
- ✓ Details of the subject matter
- ✓ Type of cover required
- ✓ Details of the physical features both positive and negative
- ✓ Previous history of insurance and loss

In the case of a health insurance proposal, the insurer may also refer the prospective customer e.g. above 45 years of age to a doctor and/or for medical check-up. Based on the information available in the proposal and, where medical check-up has been advised, based on the medical report and the recommendation of the doctor, the insurer takes the decision. Sometimes, where the medical history is not satisfactory, an additional questionnaire to get more information is also required to be obtained from the prospective client. The insurer then decides about the rate to be applied to the risk factor and calculates the premium based on various factors, which is then conveyed to the insured.

Proposals are processed by the insurer with speed and efficiency and all decisions thereof are communicated by it in writing within a reasonable period.

Note on Underwriting and processing of proposals

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

Test Yourself 1

As per guidelines, an insurance company has to process an insurance proposal within _____.

- I. 7 days
- II. 15 days
- III. 30 days
- IV. 45 days

C. Prospectus

A Prospectus is a document issued by the insurer or on its behalf to the prospective buyers of insurance. It is usually in the form of a brochure or leaflet and serves the purpose of introducing a product to such prospective buyers. Issue of prospectus is governed by the Insurance Act, 1938 as well as by Protection of Policyholders' Interest Regulations 2002 and the Health Insurance Regulations 2013 of the IRDAI.

The prospectus of any insurance product should clearly state the scope of benefits, the extent of insurance cover and explain in a clear manner the warranties, exceptions and conditions of the insurance cover.

The allowable riders (also called Add-on covers) on the product should also be clearly stated with regard to their scope of benefits. Also, the premium related to all the riders put together should not exceed 30% of the premium of the main product.

Other important information which a Prospectus should also disclose includes:

1. Any differences in covers and premium for different age groups or for different entry ages
2. Renewal terms of the policy
3. Terms of cancellation of policy under certain circumstances
4. The details of any discounts or loading applicable under different circumstances
5. The possibility of any revision or modification of the terms of the policy including the premium
6. Any incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer
7. A declaration that all its Health insurance policies are portable which means that these policies can be renewed with any other insurer who offers similar cover with the same benefits he would have enjoyed had he continued with the existing insurer.

Insurers of Health policies usually publish Prospectuses about their Health insurance products. The proposal form in such cases would contain a declaration that the customer has read the Prospectus and agrees to it.

D. Premium receipt

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

Definition

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

1. Payment of Premium in Advance (Section 64 VB of Insurance Act, 1938)

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

Important

- 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. It is the practice now a days to credit the amount directly to the Insured's bank account. Such refund shall in no case be credited to the account of the agent.

There are exceptions to the above pre-condition payment of premium, provided in the Insurance Rules 58 and 59. One is for payment in instalments in case of policies which run for more than 12 months such as life insurance policies. Others include payment through a bank guarantee in specified cases where the exact premium cannot be ascertained in advance or by debit to a Cash Deposit account maintained by the client with the insurer.

2. Method of payment of premium

Important

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

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

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

Test Yourself 2

In case the premium payment is made by cheque, then which of the below statement will hold true?

- I. The risk may be assumed on the date on which the cheque is posted
 - II. The risk may be assumed on the date on which the cheque is deposited by the insurance company
 - III. The risk may be assumed on the date on which the cheque is received by the insurance company
 - IV. The risk may be assumed on the date on which the cheque is issued by the proposer
-

E. Policy Document

Policy Document

The policy is a formal document which provides an evidence of the contract of insurance. This document has to be stamped in accordance with the provisions of the Indian Stamp Act, 1899.

IRDAI Regulations for protecting policy holder's interest specified what

A health insurance policy should contain:

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

Every insurer has to inform and keep (the insured) informed periodically on the requirements to be fulfilled by the insured regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him to enable the insurer to settle a claim early.

F. Conditions and Warranties

Here, it is important to explain two important terms used in policy wordings. These are called Conditions and Warranties.

1. Conditions

A condition is a provision in an insurance contract which forms the basis of the agreement.

EXAMPLES:

- a. One of the standard conditions in most insurance policies states:
If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under the policy or if the loss or damage be occasioned by the wilful act, or with the connivance of the Insured, all benefits under this policy shall be forfeited.
- b. The Claim Intimation condition in a Health policy may state:
Claim must be filed within certain days from date of discharge from the Hospital. However, waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

A breach of condition makes the policy voidable at the option of the insurer.

2. Warranties

Warranties are used in an insurance contract to limit the liability of the insurer under certain circumstances. Insurers also include warranties in a policy to reduce the hazard. With a warranty, the insured, undertakes certain obligations that need to be complied within a certain period of time and also during the policy period and the liability of the insurer depends on the insured's compliance with these obligations. Warranties play an essential role in managing and improving the risk.

A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract. Warranty is not a separate document. It is part of the policy document. It is a condition precedent to (which operates prior to other terms of) the contract. It must be observed and complied with strictly and literally, whether it is material to the risk or not.

If a warranty is not fulfilled, the policy becomes voidable at the option of the insurers even when it is clearly established that the breach has not caused or contributed to a particular loss. However, in practice, if the breach of warranty is of a purely technical nature and does not, in any way, contribute to or aggravate the loss, insurers at their discretion may process the claims according to norms and guidelines as per company policy. In such case, losses can be treated as compromise claims and settled usual for a high percentage of the claim but not for 100 percent.

A personal accident policy may have the following warranty:

It is warranted that not more than five Insured Persons should travel together in the same air conveyance at one time. The warranty may go on to say how the claims would be dealt if there is a breach of this warranty.

Test Yourself 3

Which of the below statement is correct with regards to a warranty?

- I. A warranty is a condition which is implied without being stated in the policy
 - II. A warranty is a condition expressly stated in the policy
 - III. A warranty is a condition expressly stated in the policy and communicated to the insured separately and not as part of the policy document
 - IV. If a warranty is breached, the claim can still be paid if it is not material to the risk
-

G. Endorsements

It is the practice of insurers to issue policies in a standard form; covering certain perils and excluding certain others.

Definition

If certain terms and conditions of the policy need to be changed at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement.

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

Whenever material information changes, the insured has to advise the insurance company who will take note of this and incorporate the same as part of the insurance contract through the endorsement.

Endorsements normally required under a policy relate to:

- a) Variations / changes in sum insured
- b) Change of insurable interest by way of taking of a loan and mortgaging the policy to a bank.
- c) Extension of insurance to cover additional perils / extension of policy period
- d) Change in risk, e.g. change of destinations in the case of an overseas travel policy
- e) Transfer of property to another location
- f) Cancellation of insurance
- g) Change in name or address etc.

Specimen Endorsements

For the purpose of illustration, specimen wordings of some endorsements are reproduced below:

Cancellation of policy

At the request of the insured the insurance by this Policy is hereby declared to be cancelled as from <date>. The insurance having been in force for a period over nine months, no refund is due to the Insured.

Extension of cover to additional member in the Policy

At the request of the insured, it is hereby agreed to include Miss. Ratna Mistry, daughter of the insured and aged 5 years with a sum insured of Rs. 3 lakhs in the policy with effect from <date>.

In consideration, thereof an additional premium of Rs..... is hereby charged to the insured.

Test Yourself 4

If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments through _____.

- I. Warranty
 - II. Endorsement
 - III. Alteration
 - IV. Modifications are not possible
-

H. Interpretation of policies

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

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

- a) An express or written condition overrides an implied condition except where there is inconsistency in doing so.
- b) In the event of a contradiction in terms between the standard printed policy form and the typed or handwritten parts, the typed or handwritten part is deemed to express the intention of the parties in the particular contract, and their meaning will overrule those of the original printed words.
- c) If an endorsement contradicts other parts of the contract the meaning of the endorsement will prevail as it is the later document.
- d) Clauses in italics over-ride the ordinary printed wording where they are inconsistent.
- e) Clauses printed or typed in the margin of the policy are to be given more importance than the wording within the body of the policy.
- f) Clauses attached or pasted to the policy override both marginal clauses and the clauses in the body of the policy.
- g) Printed wording is over-ridden by typewritten wording or wording impressed by an inked rubber stamp.
- h) Handwriting takes precedence over typed or stamped wording.
- i) Finally, the ordinary rules of grammar and punctuation are applied if there is any ambiguity or lack of clarity.

Important

1. Construction of policies

An insurance policy is proof of a commercial contract and the general rules of construction and interpretation adopted by courts apply to insurance contracts as in the case of other contracts.

The principal rule of construction is that the intention of the parties of the contract is most important. That intention must be gathered from the policy document itself and the proposal form, clauses, endorsements, warranties etc. attached to it and forming a part of the contract.

2. Meaning of wordings

The words used are to be construed in their ordinary and popular sense. **The meaning to be used for words is the meaning that the ordinary man in the street would construe.**

On the other hand, **words which have a common business or trade meaning will be construed with that meaning unless the context of the sentence indicates otherwise.** Where words are defined by laws, the meaning of that definition will be used as per laws.

Many words used in insurance policies have been the subject of previous legal decisions which will be ordinarily applied. Again, the decisions of a higher court will be binding on a lower court decision. Technical terms must always be given their technical meaning, unless there is an indication to the contrary.

I. Renewal Notice

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

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

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

Test Yourself 5

Which of the below statement is correct with regards to renewal notice?

- I. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 30 days before the expiry of the policy
 - II. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 15 days before the expiry of the policy
 - III. As per regulations there is a legal obligation on insurers to send a renewal notice to insured, 7 days before the expiry of the policy
 - IV. As per regulations there is no legal obligation on insurers to send a renewal notice to insured before the expiry of the policy
-

J. Anti-Money Laundering and Know Your Customer Guidelines

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

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

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

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

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

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

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

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

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

4. In case of Trusts and foundations - similar to that of partnership

It is important to note here that such information also helps in cross-selling of products and is a helpful marketing tool.

Summary

- a) The first stage of documentation is the proposal form through which the insured informs about herself and what insurance she needs
- b) The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the policy period
- c) Insurance companies usually add a declaration at the end of the Proposal form to be signed by the proposer.
- d) Elements of a proposal form usually include:
 - i. Proposer's name in full
 - ii. Proposer's address and contact details
 - iii. Bank details in case of health policies
 - iv. Proposer's profession, occupation or business
 - v. Details and identity of the subject matter of insurance
 - vi. Sum insured
 - vii. Previous and present insurance
 - viii. Loss experience
 - ix. Declaration by the insured
- e) An agent, who acts as the intermediary, has the responsibility to ensure all material information about the risk is provided by the insured to insurer.
- f) The process of scrutinising the proposal and deciding about acceptance is known as underwriting.
- g) In health policies, a Prospectus is also provided to the insured and he has to declare in the proposal that he has read and understood it
- h) 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.
- i) Payment of premium can be made by cash, any recognised banking negotiable instrument, postal money order, credit or debit card, internet, e-transfer, direct credit or any other method approved by authority from time to time.
- j) A certificate of insurance provides proof of insurance in cases where it may be required
- k) The policy is a formal document which provides an evidence of the contract of insurance.

- l) A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract.
 - m) If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement.
 - n) The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself.
 - o) Money Laundering means converting money obtained through criminal means to legal money and laws to fight this have been introduced worldwide and in India
 - p) An agent has a responsibility to follow the Know Your Customer guidelines and obtain documents as required by these guidelines.
-

Key Terms

- a) Policy form
 - b) Advance payment of premium
 - c) Certificate of Insurance
 - d) Renewal notice
 - e) Warranty
 - f) Condition
 - g) Endorsement
 - h) Money Laundering
 - i) Know Your Customer
-

CHAPTER 5

HEALTH INSURANCE PRODUCTS

Chapter Introduction

This chapter will give you an overall insight into the various health insurance products offered by insurance companies in India. From just one product - Mediclaim to hundreds of products of different kinds, the customer has a wide range to choose appropriate cover. The chapter explains the features of various health products that can cover individuals, family and group.

Learning Outcomes

- A. Classification of health insurance products
- B. IRDA guidelines on Standardization in health insurance
- C. Hospitalization indemnity product
- D. Top-up covers or high deductible insurance plans
- E. Senior citizen policy
- F. Fixed benefit covers - Hospital cash, critical illness
- G. Long term care product
- H. Combi-products
- I. Package policies
- J. Micro insurance and health insurance for poorer sections
- K. Rashtriya Swasthya Bima Yojana
- L. Pradhan Mantri Suraksha Bima Yojana
- M. Pradhan Mantri Jan Dhan Yojana
- N. Personal accident and disability cover
- O. Overseas travel insurance
- P. Group health cover
- Q. Special products
- R. Key terms in health policies

After studying this chapter, you should be able to:

- a) Explain the various classes of health insurance
- b) Describe the IRDAI guidelines on standardization in health insurance
- c) Discuss the various types of health products available in the Indian market today
- d) Explain Personal Accident insurance

- e) Discuss overseas travel insurance
- f) Understand key terms and clauses in health policies

A. Classification of health insurance products

1. Introduction to health insurance products

The Health Insurance Regulations of IRDA define health cover as follows

Definition

“Health insurance business” or “health cover” means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

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

Therefore, health insurance is important mainly for two reasons:

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

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

Later insurance sector was opened up to the private sector players, which led to many more companies entering including the health insurance market. With that came greater spread of this business, a number of variations in these covers and also a few new covers too.

Today, the health insurance segment has developed to a large extent, with hundreds of products offered by almost all general Insurance companies stand along health insurers and life insurers. However, the basic benefit structure of the Mediclaim policy

i.e. cover against hospitalization expenses still remains the most popular form of insurance.

As per Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

1. Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.
2. Non-Life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium shall remain unchanged for the tenure.

2. Features of health policies

Health insurance basically deals with sickness and therefore expenses incurred due to sickness. Sometimes, the disease contracted by a person could be chronic or long lasting, lifelong or critical in terms of impact on day to day living activities. Expenses could also be incurred due to accidental injuries or due to disablement arising out of accident.

Various customers with different life styles, paying capacity and health status would have different requirements which need to be considered while designing suitable products to be offered to each customer segment. Customers also desire comprehensive cover while buying health insurance which would cover all their needs. At the same time, to achieve greater acceptability and bigger volume, health insurance products need to be kept affordable, they should also be easy to understand for the customer and also for the sales team to market them.

These are some of the desirable features of health insurance products which the insurance companies try to achieve in different forms for the customer.

3. Broad classification of health insurance products

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

a) Indemnity covers

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

b) Fixed benefit covers

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

c) **Critical illness covers**

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

The world over health and disability insurance go together but in India, **personal accident cover** has traditionally been sold independent of health insurance.

Also health insurance usually does not include expenses incurred whilst outside India. For this purpose, another product - **overseas health insurance or travel insurance** - needs to be purchased. Only in recent times, a few high end health insurance products of private insurers include overseas insurance cover as part of regular health insurance cover, subject to certain terms and conditions.

4. **Classification based on customer segment**

Products are also designed keeping in mind the target customer segment. The benefit structure, pricing, underwriting and marketing for each segment is quite distinct. Products classified based on customer segments are:

- a) **Individual cover** offered to retail customers and their family members
- b) **Group cover** offered to corporate clients, covering employees and groups, covering their members
- c) **Mass policies** for government schemes like RSBY covering very poor sections of the population.

B. IRDA Guidelines on Standardization in health insurance

With so many insurers providing numerous varied products and with different definitions of various terms and exclusions, confusion arose in the market. It became difficult for the customer to compare products and for third party administrators to pay claims against products of individual companies. Moreover, in critical illness policies, there was no clear understanding as to what was a critical illness and what was not. Maintaining electronic data for the health insurance industry was also becoming difficult.

To remove the confusion among insurers, service providers, TPAs and hospitals and the grievances of the insuring public, various organizations like IRDA, service providers, hospitals, Health Advisory Committee of the Federation of Chambers of Commerce and Industry got together to provide some kind of standardization in health insurance. Based on a common understanding, IRDA issued Guidelines on standardization in health insurance in 2013.

The guidelines now provide for standardization of:

1. definitions of commonly used insurance terms
2. definitions of critical illnesses
3. list of excluded items of expenses in hospitalization indemnity policies
4. claim forms and pre-authorization forms
5. billing formats
6. discharge summary of hospitals
7. standard contracts between TPAs, insurers and hospitals
8. standard File and Use format for getting IRDAI for new policies

This has been a big step to improve the quality of service of the health providers and the insurance industry and will also help in collection of meaningful health and health insurance data.

C. Hospitalization indemnity product

An indemnity based health insurance policy is the most common and highest sold health insurance product in India. The **Mediclaim policy** introduced in the eighties by the PSU insurers was the earliest standard health product and was the only product available in the market for a long time. Though this product, with a few changes, is marketed by different insurers under different brand names, Mediclaim continues to be the largest selling health insurance in the country.

Hospitalization indemnity products protect individuals from the expenditure they may need to incur in the event of hospitalisation. In most of the cases, they also cover a specific number of days before and after hospitalisation, but exclude any expenses not involving hospitalisation.

Such a cover is provided on an '**indemnity**' basis, that is, by making good part or all of the expenses incurred or amount spent during hospitalisation. This may be contrasted with the insurance coverage on '**benefit**' basis, where the amount that will be paid on the occurrence of a certain event (like hospitalisation, diagnosis of critical illness or each day of admission) is as stated in the insurance policy and is not related to the actual expenditure incurred.

Example

Raghu has a small family consisting of his wife and a 14 year old son. He has taken a Mediclaim policy, covering each member of his family, from a health insurance company, for an individual cover of Rs. 1 lakh each. Each of them could get recovery of medical expenses up to Rs. 1 lakh in case of hospitalisation.

Raghu was hospitalised due to heart attack and required surgery. The medical bill raised was Rs. 1.25 lakhs. The insurance company paid Rs 1 lakh according to the plan coverage and Raghu had to pay the remaining amount of Rs. 25,000 from his own pocket.

The main features of the indemnity based Mediclaim policy are detailed below, **though variations in limits of cover, additional exclusions or benefits or some additions may apply to products marketed by each insurer.** The student is advised that the following is only a broad idea about the product and he should acquaint himself with the product of the particular insurer he wishes to know more about. He also **needs to educate himself about some of the medical terms that may be used.**

1. Inpatient hospitalization expenses

An indemnity policy pays the insured the cost of hospitalization expenses incurred on account of illness / accident.

All expenses may not be payable and most products define the expenses covered which normally include:

- i. Room, boarding and nursing expenses as provided by the hospital / nursing home. This includes nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges and similar expenses
- ii. Intensive Care Unit (ICU) expenses
- iii. Surgeon, anesthetist, medical practitioner, consultants, specialists fees
- iv. Anesthetic, blood, oxygen, operation theatre charges, surgical appliances,
- v. Medicines and drugs,
- vi. Dialysis, chemotherapy, radiotherapy
- vii. Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents
- viii. Relevant laboratory / diagnostic tests and other medical expenses related to the treatment
- ix. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured

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

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

2. Pre and post hospitalization expenses

i. Pre hospitalization expenses

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.

Definition

IRDA Health Insurance Standardization guidelines define Pre-hospital expenses as:

Medical expenses incurred immediately before the insured person is hospitalized, provided that:

- a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
- b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

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.

ii. Post hospitalization expenses

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

Definition

Medical Expenses incurred immediately after the Insured Person is discharged from hospital, provided that:

- a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
- b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days after hospitalization and will be considered as part of claim.

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**.

Pre and post-hospitalization expenses form part of the overall sum insured for which cover is granted under the policy.

a) DOMICILIARY HOSPITALIZATION

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

This cover usually carries an **excess clause of three to five days** meaning that treatment costs for the first three to five days have to be borne by the insured. The cover also excludes domiciliary treatments for certain chronic or common ailments such as Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all type of Dysenteries including Gastroenteritis, Diabetes Mellitus Epilepsy, Hypertension, Influenza, Cough and Cold, fevers.

b) COMMON EXCLUSIONS

Some of the usual exclusions under hospitalization indemnity policies are given below. These are based on the suggested exclusions detailed in the Guidelines on Standardization in Health Insurance issued by IRDAI particularly Annexure IV. The student is advised to acquaint himself with the guidelines available on the IRDAI website.

It must be noted that if any of the exclusions are waived or any additional exclusions are imposed as per File and Use approved terms, these must be stated separately in the Customer Information Sheet and the policy.

1. Pre-existing diseases

This is almost always excluded under individual health plans since otherwise it would mean covering a certainty and poses a high risk to the insurer. One of the important disclosures required at the time of taking a health policy is regarding previous history of ailments / injuries of each insured person covered. This will enable the insurer to decide on accepting the proposal for insurance.

Definition

The IRDA guidelines on standardisation define Pre-existing as

“Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer.”

The exclusion is: Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his / her first policy with the company.

1. Weight control programs/ supplies/ services
2. Cost of spectacles/ contact lenses/ hearing aids etc.
3. Dental treatment expenses that do not require hospitalisation
4. Hormone replacement
5. Home visit charges
6. Infertility/ subfertility/ assisted conception procedure
7. Obesity (including morbid obesity) treatment
8. Psychiatric & psychosomatic disorders
9. Corrective surgery for refractive error
10. Treatment of sexually transmitted diseases
11. Donor screening charges
12. Admission/registration charges
13. Hospitalisation for evaluation/ diagnostic purpose
14. Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed
15. Any expenses when the patient is diagnosed with retro virus and/or suffering from HIV/ AIDS etc. is detected directly or indirectly
16. Stem cell implantation/ surgery and storage
17. War and nuclear related causes
18. All non-medical items such as registration charges, admission fees, telephone, television charges, toiletries, etc.
19. A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident.

Example

Mira had taken a health insurance policy for coverage of expenses in the event of hospitalisation. The policy had a clause for initial waiting period of 30 days.

Unfortunately, 20 days after she took the policy, Mira contracted malaria and was hospitalised for 5 days. She had to pay heavy hospital bills.

When she asked for reimbursement from the insurance company, they denied payment of the claim because the event of hospitalization occurred within the waiting period of 30 days from taking the policy.

- i. **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.

c) 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. Some insurers do not have a restriction on the dependents who can be covered. It is possible to cover each of such dependent insureds under a single policy with a separate sum insured chosen for each insured person. 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.

ii. Family floater

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

Example

If a floater policy of Rs. 5 lacs is taken for a family of four, it means that during the policy period, it will pay for claims related to more than one family member or multiple claims of a single member of the family. All these together cannot exceed the total coverage of Rs. 5 lacs. Premium will normally be charged based on the age of the oldest member of the family proposed for insurance.

The covers and exclusions under both these policies would be the same. Family floater policies are getting popular in the market as the entire family gets coverage for an overall sum insured which can be chosen at a higher level at a reasonable premium.

d) SPECIAL FEATURES

A number of changes to existing coverages and new value added features have been added to the basic indemnity cover offered under the earlier Mediclaim product. We shall discuss some of these changes. It is to be noted that not all products carry all the below mentioned features, and they may vary from insurer to insurer and product to product.

i. Sub limits and Disease specific capping

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

ii. Co-payment (popularly called Co-pay)

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

This ensures that the insured exercises caution in selecting his options and thus reduces his overall hospitalization expenses voluntarily.

iii. Deductible

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

cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Insurers are to define whether the deductible is applicable per year, per life or per event and the specific deductible to be applied.

iv. New exclusions have been introduced and later standardized by IRDAI:

- ✓ Genetic disorders and stem cell implantation / surgery.
- ✓ External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, slings, braces, stockings etc. of any kind, diabetic foot wear, glucometer / thermometer and similar related items etc. and also any medical equipment which is subsequently used at home etc.
- ✓ Any kind of Service charges, Surcharges, Admission fees / Registration charges etc. levied by the hospital
- ✓ Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period

v. Zone wise premium

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

vi. Coverage of pre-existing diseases

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

vii. Renewability

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

viii. Coverage for Day care procedure

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

ix. Cost of pre policy check up

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

x. Duration of pre and post hospital cover

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

xi. 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.

xii. Value added covers

Few indemnity products include value added covers as listed below. The benefits are payable up to the limit of sum insured specified against each cover in the schedule of the policy, not exceeding the overall sum insured.

- ✓ **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.
- ✓ **Family definition:** Definition of family has undergone changes in few health products. Earlier, primary insured, spouse, dependent children were granted cover. Now there are policies where parents and in-laws can also be granted cover under the same policy.

D. Top-up covers or high deductible insurance plans

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

This policy works along with a basic health cover having a low sum insured and comes at a comparatively reasonable premium. For example, Individuals covered by their employers can also opt for a top-up cover for additional protection (keeping the sum insured of the first policy as the threshold). This can be for self and family, which comes in handy in the unfortunate event of high cost treatment.

To be eligible to receive a claim under the top-up policy, the medical costs must be greater than the deductible (or threshold) level chosen under the plan and the reimbursement under the high deductible plan would be the amount of expense incurred i.e. greater than the deductible

Example

An individual is covered for a sum insured of Rs. 3 lacs by his employer. He could opt for a top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

If the cost of a single hospitalization is Rs. 5 lacs, the basic policy would cover up to Rs. three lacs only. With the top-up cover, the balance sum of Rs. two lacs would be paid out by the top-up policy.

Top-up policies come cheap and the cost of a single Rs. 10 lacs policy would be far higher than the top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

These covers are available on individual basis and family basis. Individual sum insured for each family member covered or a single sum insured floating over the family are offered in the market today.

In case the top-up plan requires the deductible amount to be crossed at every single event of hospitalization, the plan is known as a **Catastrophe based** high deductible plan. This means that to be payable, in the example given above, each and every claim must cross Rs. 3 lacs

However top-up plans that allow the deductible to be crossed post a series of hospitalizations during the policy period are known as **Aggregate based** high

deductible plans or **Super top-up** cover as known in the Indian market. This means that, in the example given above, each and every claim is added and when this crosses Rs. 3 lacs, the Top-up cover would start paying claims.

Most of the standard terms, conditions and exclusions of a hospital indemnity policy apply to these products. In some markets, where basic health cover is provided by the Government, insurers mostly deal only with granting the Top-Up covers.

E. Senior citizen policy

These plans are designed to offer cover to elderly people who often were denied coverage after certain age (e.g. people over 60 years of age). The structure of the coverage and exclusions are much like a hospitalization policy.

Special attention is paid to diseases of the elderly in setting coverage and waiting period. Entry age is mostly after 60 years and renewable lifelong. Sum insured range from Rs. 50,000 to Rs. 5,00,000. There is variation of waiting period applicable to certain ailments. Example: Cataract may have 1 year waiting for one insurer and 2 year waiting period for some other insurer.

Also certain ailments may not have waiting period for a particular insurer where as another may have. Example: Sinusitis does not fall in waiting period clause of some insurers but few others include it in their waiting period clause.

Pre-existing disease has either a waiting period or capping in some policies. Pre-post hospital expenses are either paid as a percentage of hospital claims or a sub limit whichever is higher. In some policies they follow the typical indemnity plans such as expenses falling within specified period of 30/60 days or 60/90 days.

IRDAI has mandated special provisions for insured persons who are Senior Citizens:

1. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront.
2. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
3. All health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

F. Fixed benefit covers - Hospital cash, critical illness

The greatest risk to an insurer in a health insurance policy is unnecessary and unreasonable use of the policy benefits. Knowing that the patient is covered under a health policy, doctors, surgeons and hospitals tend to over treat him. They prolong the length of stay in the hospital, carry out unnecessary diagnostic and laboratory tests and thus inflate the cost of treatment beyond the necessary amount. Another major impact on insurer's costs is the constant rise in medical costs, usually higher than the increase in premium rates.

The answer to this is the Fixed Benefit cover. While providing adequate protection to the insured persons, the fixed benefits cover also help the insurer to effectively price his policy for a reasonable duration. In this product, commonly occurring treatments are listed under each system such as ENT, Ophthalmology, Obstetrics and Gynaecology, etc. and the maximum pay out for each of these is spelt out in the policy.

The insured also gets a fixed sum as claim amount irrespective of the amount spent by him for the named treatment. The package charges payable for each of these treatments is generally based on a study of the reasonable cost that would be needed for treating the condition.

The package charges would include all components of the cost such as:

- a) Room rent,
- b) Professional fees,
- c) Diagnostics,
- d) Drugs,
- e) Pre and post hospitalization expenses etc.

The package charges could even include diet, transport, ambulance charges etc. depending on the product.

These policies are simple to administer as only proof of hospitalization and coverage of ailment under the policy are sufficient to process the claim.

Some products package a daily cash benefit along with the fixed benefit cover. The list of treatments covered could vary from around 75 to about 200 depending on the definitions of the treatments in the product.

A provision is made to pay a fixed sum for surgeries / treatment which do not find a place in the list named in the policy. Multiple claims for different treatments are possible during the policy period. However the claims are finally limited by the sum insured chosen under the policy.

Some of the fixed benefit insurance plans are:

- ✓ Hospital daily cash insurance plans
- ✓ Critical illness insurance plans

1. HOSPITAL DAILY CASH POLICY

a) Per day amount limit

Hospital cash coverage provides a fixed sum to the insured person for each day of hospitalization. Per day cash coverage could vary from (for example) Rs. 1,500 per day to Rs. 5,000 or even more per day. An upper limit is provided on the daily cash payout per illness as well as for the duration of the policy, which is usually an annual policy.

b) Number of payment days

In some of the variants of this policy, the number of days of daily cash allowed is linked to the disease for which treatment is being taken. A detailed list of treatments and duration of stay for each is stipulated which limits the daily cash benefit allowed for each type of procedure/ illness.

c) Standalone cover or add-on cover

The hospital daily cash policy is available as a standalone policy as offered by some insurers while, in other cases, it is an add-on cover to a regular indemnity policy. These policies help the insured to cover incidental expenses as the payout is a fixed sum and not related to the actual cost of treatment. This also allows the payout under the policy to be provided in addition to any cover received under an indemnity based health insurance plan.

d) Supplementary cover

These policies could supplement a regular hospital expenses policy as it is cost effective and provides compensation for incidental expenses and also expenses not payable under the indemnity policy such as exclusions, co-pay etc.

e) Other advantages of the cover

From the insurer's point of view, this plan has several advantages as it is easy to explain to a customer and hence can be sold more easily. It beats medical inflation as a fixed sum per day is paid for the duration of hospitalization whatever may be the actual expense. Also, acceptance of such insurance covers and claims settlements are really simplified.

2. CRITICAL ILLNESS POLICY

This product is also known as the **dreaded disease cover** or a **trauma care cover**.

With advancement in medical science, people are surviving some of the major diseases like cancer, strokes and heart attack etc. which in earlier times would have resulted in death. Again, life expectancy has increased considerably after surviving such major illnesses. However surviving a major illness entails huge expense for treatment as well as for living expenses post treatment. Thus onset of critical illness threatens financial security of a person

- a) Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.
- b) It is sold:
 - ✓ As a standalone policy or
 - ✓ As an add-on cover to a few health policies or
 - ✓ As an add-on cover in some life insurance policies

In India, critical illness benefits are most commonly sold by life insurers as riders to life policies and two forms of cover are offered by them - accelerated CI benefit plan and standalone CI benefit plan. Precise definition of the covered illnesses and good underwriting are extremely important when this benefit is sold. To avoid confusion, the definitions of 20 most common critical illnesses have been standardized under IRDA Health Insurance Standardization guidelines. (Please refer to the Annexure at the end).

However, the chance for adverse selection (whereby mostly those people most likely to be affected take this insurance) at issuance stage is quite high and it is important to determine health status of the proposers. Due to lack of sufficient data, currently pricing of critical illness plans is being supported through reinsurers' data.

- c) Critical illnesses are major illnesses that could not only lead to very high hospitalization costs, but could also cause disability, loss of limbs, loss of earning etc. and may require prolonged care post hospitalization.
- d) A critical illness policy is often recommended to be taken in addition to a hospital indemnity policy, so that the compensation under the policy could help in overcoming the financial burden of a family whose member is affected by such illness.
- e) The critical illnesses covered vary across insurers and products, but the common ones include:

- ✓ Cancers of specified severity
- ✓ Acute myocardial infarction
- ✓ Coronary artery surgery
- ✓ Heart valve replacement
- ✓ Coma of specified severity
- ✓ Renal failure
- ✓ Stroke resulting in permanent symptoms
- ✓ Major organ / bone marrow transplant
- ✓ Multiple sclerosis
- ✓ Motor Neuron disease
- ✓ Permanent paralysis of limbs
- ✓ Permanent disability due to major accidents

The list of critical illnesses is not static and keeps evolving. In a few international markets insurers classify conditions into 'core' and 'additional', even covering conditions like Alzheimer's disease. Sometimes 'terminal illness' is also included for coverage though premium would obviously be very high.

- f) While most critical illness policies provide for a lump sum payment on diagnosis of illness, there are a few policies which provide hospitalization expenses cover only in the form of reimbursement of expenses. Few products offer combination of both covers i.e. indemnity for in patient hospitalization expenses and lump sum payment upon diagnosis of major diseases named in the policy.
- g) Critical illness policies are usually available for persons in the age group of 21 years to 65 years.
- h) The sum insured offered under these policies is quite high as the primary reason of such a policy would be to provide for the financial burden of long term care associated with such diseases.
- i) Under these policies generally 100% of the sum insured is paid on diagnosis of a critical illness. In some cases compensation could vary from 25% to 100% of sum insured depending on the policy terms and conditions and severity of illness.
- j) A standard condition seen in all critical illness policies is the waiting period of 90 days from inception of policy for any benefit to become payable under the policy and the survival clause of 30 days after diagnosis of the illness. The survival clause has been included as this benefit must not be confused with a "death benefit" but more interpreted as a "survival (living) benefit" i.e. the benefit provided to overcome the hardships that may follow a critical illness.
- k) Rigorous medical examinations are to be undergone for persons especially over 45 years of age who wish to take the critical illness policy. Standard exclusions

are quite similar to those found in health insurance products, failure to seek or follow medical advice, or delaying medical treatment in order to dodge the waiting period is also specifically excluded.

- l) The insurer may compensate the insured only once for any one or more of the covered diseases of the policy or offer multiple payouts but up to a certain limited number. The policy terminates, once compensation is paid under the policy in respect of any of the insured person.
- m) The critical illness policy is also offered to groups especially corporates who take policies for their employees.

G. Long term care insurance

Today, with increasing life expectancy, the population of aged people in the world is going up. With an ageing population, the world over, long term care insurance is also gaining importance. Elderly people require long term care and also those people suffering from any kind of disability. Long term care means all forms of continuing personal or nursing care for people who are unable to look after themselves without a degree of support and whose health is not going to get better in future.

There are two types of plans for long term care:

- a) Pre-funded plans which are purchased by healthy insured to take care of their future medical expenses and
- b) Immediate need plans which are purchased by a lump sum premium when the insured is requiring long term care.

The severity of disability (and expected survival period) decides the quantum of benefit. Long term care products are yet to be developed in Indian market.

Bhavishya Arogya policy

The first pre-funded insurance plan was the Bhavishya Arogya policy marketed by the four public sector general insurance companies. Introduced in the year 1990, the policy is basically meant to take care of the healthcare needs of an insured person after his retirement, while he pays premium during his productive life. It is similar to taking a life insurance policy except that it covers future medical expenses rather than death.

a) Deferred Mediclaim

The policy is a sort of deferred or future Mediclaim policy and provides cover similar to the Mediclaim policy. The proposer can join the scheme any time between the age of 25 and 55 years.

b) Retirement age

He can choose a retirement age between 55 and 60 years with a condition that there should be a clear gap of 4 years between the date of joining and the retirement age chosen. The policy retirement age means the age selected by the insured at the time of signing the proposal and specified in the schedule for the purpose of start of benefit under the policy. This age cannot be advanced.

c) Pre-retirement period

The pre-retirement period means the period starting from the date of acceptance of the proposal and ending with the policy retirement age specified in the schedule. During this period the insured shall be paying installment/single premium amount as applicable. The insured has the option of paying either one lump-sum premium or in installments.

d) Withdrawal

In case, the insured dies or wishes to withdraw from the scheme either before the retirement age or after retirement age chosen, then appropriate refund of premium would be allowed subject to no claim having occurred under the policy. There is a provision of grace period of 7 days for payment of premium in the event of satisfactory reason for delay in renewal.

e) Assignment

The scheme provides for assignment.

f) Exclusions

The policy does not have exclusion of pre-existing diseases, 30 days waiting period and first year exclusion for specified diseases as in Mediclaim. Since it is a future Mediclaim policy, this is quite logical.

g) Group insurance variant

Policy can also be availed of on group basis in which case, facility of group discount is available.

H. Combi-products

Sometimes, products pertaining to life insurance are combined with health insurance products. This is a good way of promoting more products in a packaged way through two insurers coming together and entering into an understanding.

Health plus Life Combi Products therefore mean products which offer the combination of a life insurance cover of a life insurance company and a health insurance cover offered by non-life and/or standalone health insurance company.

The products are jointly designed by the two insurers and marketed through the distribution channels of both insurers. Obviously, this would entail a tie-up between two companies and as per current guidelines, such tie-up is permitted only between one life insurer and one non-life insurer at any time. A Memorandum of Understanding between such companies must be in place for the way marketing, policy servicing and sharing of common expenses will be carried out and also policy servicing parameters and transmission of premium. Approval of IRDAI for the tie-up may be sought by any one of the insurers. The agreement should be of a long term nature and withdrawal from the tie-up will not be permitted except under exceptional circumstances and to the satisfaction of the IRDAI.

One of the insurance companies may be mutually agreed to act as a lead insurer to play a critical role in facilitating the policy service as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy service. However, the claims and commission payouts are handled by the respective insurers depending on which section of the policy is affected.

'Combi Product' filing shall follow the File and Use guidelines issued from time to time and individually cleared. The premium components of both risks are to be separately identifiable and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, sales literature etc.

The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

Free Look option is available to the insured and is to be applied to the 'Combi Product' as a whole. However, the Health portion of the 'Combi Product' shall entitle its renewability at the option of policyholder from the respective Non-Life/standalone health Insurance Company.

Marketing of Combi Products can be done through Direct marketing channels, Brokers and Composite Individual and Corporate Agents common to both insurers but not through Bank referral arrangements. However, they cannot be intermediaries who are not authorized to market either of the products of either of the insurers.

Specific disclosures have to be made in the proposal and sales literature especially features like there are two insurers involved, that each risk is distinct from the other, who will settle claims, matters relating to renewability of both or only one of the covers at the option of the insured, servicing facilities etc.

The IT system to service this business must be robust and seamless as it means a lot of integration of data between the two insurers and data generation to IRDAI as required.

I. Package policies

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

For instance in other classes of business, there are covers such as Householder's Policy, Shopkeeper's Policy, Office Package Policy etc. that, under one policy, seek to cover various physical assets including buildings, contents etc. Such policies may also include certain personal lines or liability covers.

Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

In the case of travel insurance, the policy offered is also a package policy covering not only health insurance but also accidental death / disability benefits along with Medical expenses due to illness / accident, Loss of or delay in arrival of checked in baggage, Loss of passport and documents, Third party liability for property / personal damages, Cancellation of trips and even Hijack cover.

J. Micro insurance and health insurance for poorer sections

Micro-insurance products are specifically designed to aim for the protection of low income people from rural and informal sectors. The low income people form a sizable part of our population and usually don't have any health security cover. Therefore, this low value product, with an affordable premium and benefit package, is initiated to help these people to cope with and recover from common risks. Micro insurance is governed by the IRDA Micro Insurance Regulations, 2005.

These products come with a small premium and typically, the sum insured is below Rs.30,000, as required vide the IRDA micro-insurance regulations, 2005. Such covers are mostly taken on a group basis by various community organizations or non-governmental organizations (NGOs) for their members. The IRDA's rural and social sector obligations also require that insurers should sell a defined proportion of their policies as micro-insurance products, to enable wider reach of insurance.

Two policies particularly created by PSUs to cater to the poorer sections of society are described below:

1. Jan Arogya Bima Policy

Following are the features of Jan Arogya Bima Policy:

- a. This policy is designed to provide cheap medical insurance to poorer sections of the society.
- b. The coverage is along the lines of the individual Mediclaim policy. Cumulative bonus and medical check-up benefits are not included.
- c. The policy is available to individuals and family members.
- d. The age limit is five to 70 years.
- e. Children between the age of three months and five years can be covered provided one or both parents are covered concurrently.
- f. The sum insured per insured person is restricted to Rs.5,000 and the premium payable as per the following table.

Table 2.1

Age of the person insured	Up to 46 years	46-55	56-65	66-70
Head of the family	70	100	120	140
Spouse	70	100	120	140
Dependent child up to 25 years	50	50	50	50
For family of 2+1 dependent child	190	250	290	330
For family of 2+2 dependent children	240	300	340	380

- Premium qualifies for tax benefit under Section 80D of the Income Tax Act.
- Service tax is not applicable to the policy.

2. Universal Health Insurance Scheme (UHS)

This policy is available to groups of 100 or more families. In recent times even individual UHS Policies were made available to the public.

Benefits

Following is the list of benefits of universal health insurance scheme:

- **Medical reimbursement**

The policy provides reimbursement of hospitalization expenses up to Rs.30,000 to an individual / family subject to the following sub limits.

Table 2.2

Particulars	Limit
Room, boarding expenses	Up to Rs.150/- per day
If admitted in ICU	Up to Rs.300/- per day
Surgeon, Anaesthetist, Consultant, Specialists fees, Nursing expenses	Up to Rs.4,500/- per illness/ injury
Anaesthesia, Blood, Oxygen, OT charges, Medicines, Diagnostic material and X-Ray, Dialysis, Radiotherapy, Chemotherapy, Cost of pacemaker, Artificial limb, etc.	Up to Rs.4,500/- per illness/ injury
Total expenses incurred for any one illness	Up to Rs. 15,000/-

- **Personal accident cover**

Coverage for death of the earning head of the family (as named in the schedule) due to accident: Rs.25,000/-.

- **Disability cover**

If the earning head of the family is hospitalised due to an accident / illness compensation of Rs. 50/- per day will be paid per day of hospitalisation up to a maximum of 15 days after a waiting period of three days.

- **Premium**

Table 2.3

Entity	Premium
For an individual	Rs.365/- per annum
For a family up to five (including the first three children)	Rs.548/- per annum
For a family up to seven (including the first three children and dependent parents)	Rs.730/- per annum
Premium subsidy for BPL families	For families below the poverty line the Government will provide a premium subsidy.

K. Rashtriya Swasthya Bima Yojana

The government has also launched various health schemes, some of them applicable to particular states. To extend the reach of health benefits to the masses, it has implemented the Rashtriya Swasthya Bima Yojana in association with insurance companies. RSBY has been launched by the Ministry of Labour and Employment, Government of India, to provide health insurance coverage for the below poverty line (BPL) families.

Following are the features of Rashtriya Swasthya Bima Yojana:

- a. Total sum insured of Rs. 30,000 per BPL family on a family floater basis.
- b. Pre-existing diseases to be covered.
- c. Coverage of health services related to hospitalization and services of surgical nature which can be provided on a day-care basis.
- d. Cashless coverage of all eligible health services.
- e. Provision of smart card.
- f. Provision of pre and post hospitalization expenses.
- g. Transport allowance of Rs.100/- per visit.
- h. The Central and State Government pays the premium to the insurer.
- i. Insurers are selected by the State Government on the basis of a competitive bidding.
- j. Choice to the beneficiary between public and private hospitals.
- k. Premium to be borne by the Central and State governments in the proportion of 3:1. Central Government to contribute a maximum amount of Rs. 565/- per family.
- l. Contribution by the State Governments: 25 percent of the annual premium and any additional premium beyond Rs 750.
- m. Beneficiary to pay Rs. 30/- per annum as registration fee/ renewal fee.
- n. Administrative cost to be borne by the State Government.

- o. Cost of smart card additional amount of Rs. 60/- per beneficiary would be available for this purpose.
- p. The scheme shall commence operation from the first of the month after the next month from the date of issue of smart card. Thus, if the initial smart cards are issued anytime during the month of February in a particular district, the scheme will commence from 1st of April.
- q. The scheme will last for one year till 31st March of next year. This would be the terminal date of the scheme in that particular district. Thus, cards issued during the intervening period will also have the terminal date as 31st March of the following year.

Claim settlement to be done through TPA's mentioned in the schedule or by the insurance company. The settlement is to be made cashless as far as possible through listed hospitals.

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 60 days from the date of last consultation with the hospital.

L. Pradhan Mantri Suraksha Bima Yojana

The recently announced PMSBY covering personal accident death and disability cover insurance has attracted lot of interest and the scheme details are as under:

Scope of coverage: All savings bank account holders in the age 18 to 70 years in participating banks are entitled to join. Participating banks must tie up with any approved non-life insurer who will offer a Master Policy to such bank for the cover. Any person would be eligible to join the scheme through one savings bank account only and if he enrolls in more than one bank, he gets no extra benefit and the extra premium paid will stand forfeited. Aadhar would be the primary KYC for the bank account.

Enrollment Modality / Period: The cover shall be for the one year period from 1st June to 31st May for which option to join / pay by auto-debit from the designated savings bank account on the prescribed forms will be required to be given by 31st May of every year, extendable up to 31st August 2015 in the initial year. Initially on launch, the period for joining may be extended by Govt. of India for another three months, i.e. up to 30th of November, 2015.

Joining subsequently on payment of full annual premium may be possible on specified terms. Applicants may give an indefinite / longer option for enrolment / auto-debit, subject to continuation of the scheme with terms as may be revised on the basis of past experience. Individuals who exit the scheme at any point may re-join the scheme in future years through the above modality. New entrants into the eligible category from year to year or currently eligible individuals who did not join earlier shall be able to join in future years while the scheme is continuing.

Benefits under the insurance are as follows:

Table of Benefits	Sum Insured
Death	Rs. 2 Lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs. 2 Lakh
Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs. 1 Lakh

Joining and Nomination facility is available by sms, email or personal visit.

Premium: Rs.12/- per annum per member. The premium will be deducted from the account holder's savings bank account through 'auto debit' facility in one

instalment on or before 1st June of each annual coverage period. However, in cases where auto debit takes place after 1st June, the cover shall commence from the first day of the month following the auto debit. Participating banks will deduct the premium amount in the same month when the auto debit option is given, preferably in May of every year, and remit the amount due to the Insurance Company in that month itself.

The premium would be reviewed based on annual claims experience but efforts would be made to ensure that there is no upward revision of premium in the first three years.

Termination of cover: The accident cover for the member shall terminate:

1. On member attaining the age of 70 years (age nearest birth day) or
2. Closure of account with the Bank or insufficiency of balance to keep the insurance in force or
3. In case a member is covered through more than one account, insurance cover will be restricted to one only and the other cover will terminate while the premium shall be forfeited.

If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down. During this period, the risk cover will be suspended and reinstatement of risk cover will be at the sole discretion of Insurance Company.

M. Pradhan Mantri Jan Dhan Yojana

This financial inclusion campaign for Indian citizens in Banking Savings & Deposit Accounts, Remittance, Credit, Insurance and Pension in an affordable manner was launched by the Prime Minister of India, Narendra Modi on 28 August 2014 as announced on his first Independence Day speech on 15 August 2014. This scheme has set a world record in bank account opening during any one week. Aimed at including maximum number of people in the banking mainstream

An account can be opened in any bank branch or Business Correspondent (Bank Mitra) outlet. PMJDY accounts are being opened with Zero balance. However, if the account-holder wishes to get cheque book, he/she will have to fulfill minimum balance criteria.

Special Benefits under PMJDY Scheme

1. Interest on deposit.
2. Accidental insurance cover of Rs.1.00 lac
3. No minimum balance required.

4. Life insurance cover of Rs.30,000/-
5. Easy Transfer of money across India
6. Beneficiaries of Government Schemes will get Direct Benefit Transfer in these accounts.
7. After satisfactory operation of the account for 6 months, an overdraft facility will be permitted
8. Access to Pension, insurance products.
9. Accidental Insurance Cover
10. RuPay Debit Card which must be used at least once in 45 days.
11. Overdraft facility upto Rs.5000/- is available in only one account per household, preferably lady of the household.

As on 13th May 2015, a record 15.59 Crore accounts have been opened with a balance in account of Rs. 16,918.91 Crores. Of these, 8.50 Crore accounts have been opened with zero balance.

N. Personal Accident and disability cover

A **Personal Accident (PA) Cover** provides compensation due to death and disability in the event of unforeseen accident. Often these policies provide some form of medical cover along with the accident benefit.

In a PA policy, while the death benefit is payment of 100% of the sum insured, in the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability to weekly compensation for temporary disablement.

Weekly compensation means payment of a fixed sum per week of disablement subject to a maximum limit in terms of number of weeks for which the compensation would be payable.

1. Types of disability covered

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

- i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,
- ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.
- iii. **Temporary total disability (TTD):** means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

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

2. Sum insured

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

3. Benefit plan

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

4. Scope of cover

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

5. Value added benefits

Along with personal accident, many insurers also offer value added benefits like hospital cash on account of hospitalization due to accident, cost of transportation of mortal remains, education benefit for a fixed sum and ambulance charges on the basis of actual or fixed limit whichever is lower.

6. Exclusions

Common exclusions under personal accident cover are:

- i. Any existing disability prior to the inception of policy
- ii. Death or disability due to mental disorders or any sickness
- iii. Directly or indirectly caused by venereal disease, sexually transmitted diseases, AIDS or insanity.
- iv. Death or disability caused by radiation, infection, poisoning except where these arise from an accident.
- v. Any injury arising or resulting from the Insured or any of his family members committing any breach of law with criminal intent.
- vi. Death or disability or Injury due to accidental injury arising out of or directly or indirectly connected with or traceable to war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainments.

- vii. In the event the insured person is a victim of culpable homicide, i.e. murder. However, in most policies, in case of murder where the insured is not himself involved in criminal activity, it is treated as an accident and covered under the policy.
- viii. Death/Disablement/Hospitalization resulting, directly or indirectly, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.
- ix. While the Insured/Insured Person is participating or training for any sport as a professional, serving in any branch of the Military or Armed Forces of any country, whether in peace or war.
- x. Intentional self-injury, suicide or attempted suicide (whether sane or insane)
- xi. abuse of intoxicants or drugs and alcohol
- xii. whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or travelling in any aircraft or balloon other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world

Certain policies also exclude loss arising out of driving any vehicle without a valid driving license.

PA policies are offered to individuals, family and also to groups.

Family Package Cover

Family package cover may be granted on the following pattern:

- **Earning member (Persons Insured) and Spouse, if earning:** Independent capital sum insured for each, as desired, within usual limitations as in individual.
- **Spouse (if not earning member):** usually 50 percent of the capital sum insured of the earning member. This may be limited to a specified upper limit e.g. Rs.1,00,000 or Rs. 3,00,000.
- **Children (between the age of 5 years and 25 years):** usually 25 percent of the capital sum insured of the earning parent subject to a specified upper limit e.g. Rs. 50,000 per child.

Group Personal Accident Policies

Group Personal Accident Policies are usually annual policies only renewal being allowed on anniversary. However, non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

Following are different types of group policies:

- **Employer and Employee relationship**

These policies are granted to firms, association etc. to cover:

- Named employees
- Unnamed employees

- **Non Employer-Employee relationship**

These policies are granted to associations, societies, clubs, etc. to cover:

- Named members
- Members not identified by name

(Note: Employees may be covered separately)

Broken bone policy and compensation for loss of daily activities

This is a specialised PA policy. This policy is designed to provide cover against listed fractures.

- i. Fixed benefit or percentage of sum insured mentioned against each fracture is paid at the time of claim.
- ii. Quantum of benefit depends on the type of bone covered and nature of fracture sustained.
- iii. To illustrate further, compound fracture would have higher percentage of benefit than simple fracture. Again, percentage of benefit for femur bone (thigh bone) would have higher percentage over benefit of finger bone.
- iv. The policy also covers fixed benefit defined in the policy for loss of daily activities viz. eating, toileting, dressing, continence (ability to hold urine or stools) or immobility so that insured can take care of cost associated to maintain his/her life.

- v. It also covers hospital cash benefit and accidental death cover. Different plans are available with varying sums insured and benefit payout.

O. Overseas travel insurance

1. Need for the policy

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

2. Scope of coverage

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

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

3. Types of plans

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

4. Who can provide this insurance

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

5. Who can take the policy

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

6. Sum insured and premiums

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

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

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

1. Corporate frequent travellers plans

This is an annual policy whereby a corporate/employer takes individual policies for its executives who frequently make trips outside India. This cover can also be taken by individuals who fly overseas many times during a year. There are limits on the maximum duration of each trip and also the maximum number of trips that can be availed in a year.

An increasingly popular cover today is an annual declaration policy whereby an advance premium is paid based on the estimated man days of travel in a year by a company's employees.

Declarations are made weekly / fortnightly on the number of days of travel employee wise and premium is adjusted against the advance. Provision is also given for increase in the number of man days during the currency of the policy, as it gets exhausted on payment of additional advance premium.

The above policies are granted only for business and holiday travels.

Common exclusions under the OMP include pre-existing diseases. Persons with existing ailments cannot obtain cover for taking treatment abroad.

The health related claims under these policies are totally cashless wherein each insurer ties up with an international service provider with network in major countries who service the policies abroad.

P. Group health cover

1. GROUP POLICIES

As explained earlier in the chapter a group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals.

Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts.

Features of group policies- Hospitalisation benefit covers.

1. Scope of coverage

The most common form of group health insurance is the policy taken by employers covering employees and their families including dependent spouse, children and parents / parents in law.

2. Tailor-made cover

Group policies are often tailor-made covers to suit the requirements of the group. Thus, in group policies, one will find several standard exclusions of the individual policy being covered under the group policy.

3. Maternity cover

One of the most common extensions in a group policy is the maternity cover. This is now being offered by some insurers under individual policies, but with a waiting period of two to three years. In a group policy, it normally has a waiting period of nine months only and in some cases, even this is waived. Maternity cover would provide for the expenses incurred in hospitalization for delivery of child and includes C- section delivery. This cover is generally restricted to Rs. 25,000 to Rs. 50,000 within the overall sum insured of the family.

4. Child cover

Children are normally covered from the age of three months only in individual health policies. In group policies, coverage is given to babies from day one, sometimes restricted to the maternity cover limit and sometimes extended to include the full sum insured of the family.

5. Pre-existing diseases covered, waiting period waived off

Several exclusions such as the pre-existing disease exclusion, thirty days waiting period, two years waiting period, congenital diseases may be covered in a tailor-made group policy.

6. Premium calculation

The premium charged for a group policy is based on the age profile of the group members, the size of the group and most importantly the claims experience of the group. As the premium varies year on year based on experience, additional covers as mentioned above are freely given to the groups, as it is in the interest of the group policyholder to manage his claims within the premiums paid.

7. Non-employer employee groups

In India, regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking out a group insurance cover. When group policies are given to other than employers, it is important to determine the relation of the group owner to its members.

Example

A bank taking a policy for its saving bank account holders or credit card holders constitutes a homogenous group, whereby a large group is able to benefit by a tailor-made policy designed to suit their requirements.

Here the premium collected from each individual account holder may be quite low, but as a group the premium obtained by the insurer would be substantial and the bank offers a value add to its customers in the form of a superior policy and at better premium rates.

8. Pricing

In group policies, there is provision for discount on premium based on size of the group as also the claims experience of the group. Group insurance reduces the risk of adverse selection, as the entire group is covered in a policy and enables the group holder to bargain for better terms. However, in recent years, this segment has seen high loss ratios, primarily due to underpricing of premium due to competition. While, this has led to some review of premium and cover by insurers, it is still difficult to declare that the situation has since been corrected.

9. Premium payment

The premiums could be either totally paid by the employer or group owner, but it is usually on a contribution basis by the employees or group members. However it is a single contract with the insurer, with the employer/group owner collecting the premium and paying the premium covering all the members.

10. Add-on benefits

Tailor-made group policies offer covers such as dental care, vision care, and cost of health checkup and sometimes, critical illness cover too at additional premiums or as complimentary benefits.

Notes:

IRDAI has laid down conditions for granting of group accident and health covers. This protects individuals from being misled by fraudsters into joining invalid and money making group policy schemes.

Recently introduced government health insurance schemes and mass products can also be classified as group health covers since the policies are purchased for an entire segment of the population by the government.

Definition

Group definition could be summarized as below:

- a) A group should consist of persons with a commonality of purpose, and the group organizer should have the mandate from a majority of the members of the group to arrange insurance on their behalf.
- b) No group should be formed with the main purpose of availing insurance.
- c) The premium charged and benefits available should be clearly indicated in the group policy issued to individual members.
- d) Group discounts should be passed on to individual members and premium charged should not be more than that given to the insurance company.

2. CORPORATE BUFFER OR FLOATER COVER

In most group policies, each family is covered for a defined sum insured, varying from Rs. One lac to five lacs and sometimes more. There arise situations where the sum insured of the family is exhausted, especially in the case of major illness of a family member. In such situations, the buffer cover brings relief, whereby the excess expenses over and above the family sum insured are met from this buffer amount.

In short the buffer cover would have a sum insured varying from Rs. ten lacs to a crore or more. Amounts are drawn from the buffer, once a family's sum insured is exhausted. However this utilization is usually restricted to major illness / critical illness expenses where a single hospitalization exhausts the sum insured.

The amount that could be utilized by each member from this buffer is also capped, often up to the original sum insured. Such buffer covers should be given for medium sized policies and a prudent underwriter would not provide this cover for low sum insured policies.

Q. Special Products

1. Disease covers

In recent years, disease specific covers like cancer, diabetes have been introduced in the Indian market, mostly by life insurance companies. The cover is long term - 5 years to 20 years and a wellness benefit is also included - a regular health check-up paid for by the insurer. There is incentive for better control of factors like blood glucose, LDL, blood pressure etc. in the form of reduced premiums from second year of policy onwards. On the other hand, a higher premium would be chargeable for poor control.

2. Product designed to cover diabetic persons

This policy can be taken by persons between 26 and 65 years and is renewable up to 70 years. Sum Insured ranges from Rs. 50,000 to Rs. 5,00,000. Capping on Room rent is applicable. Product is aimed to cover hospitalization complications of diabetes like diabetic retinopathy (eye), kidney, diabetic foot, kidney transplant including donor expenses.

Test Yourself 6

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for _____ pre-hospitalization.

- I. Fifteen days
 - II. Thirty days
 - III. Forty Five days
 - IV. Sixty days
-

R. Key terms in health policies

1. Network Provider

Network provider refers to a hospital/nursing home/day care center which is under tie-up with an insurer/TPA for providing cashless treatment to insured patients. Insurers / TPAs normally negotiate favourable discounts on charges and fees from such providers who also guarantee a good level of service. Patients are free to go to out-of-network providers but there they are generally charged much higher fees.

2. Preferred provider network (PPN)

An insurer has the option to create a preferred network of hospitals to ensure quality treatment and at best rates. When this group is limited to only a select few by the insurer based on experience, utilization and cost of providing care, then we have what is known as the preferred provider network.

3. Cashless service

Experience has shown that one of the causes of debt is borrowing for treatment of illness. A cashless service enables the insured to avail of the treatment up to the limit of cover without any payment to the hospitals. All that the insured has to do is approach a network hospital and present his medical card as proof of insurance. The insurer facilitates a cashless access to the health service and directly makes payment to the network provider for the admissible amount. However, the insured has to make payment for amounts beyond the policy limits and for expenses not payable as per policy conditions.

4. Third party administrator (TPA)

A major development in the field of health insurance is the introduction of the third party administrator or TPA. Several insurers across the world utilize the services of independent organizations for managing health insurance claims. These agencies are known as the TPAs.

In India, a TPA is engaged by an insurer for provision of health services which includes among other things:

- i. Providing an identity card to the policyholder which is proof of his insurance policy and can be used for admission into a hospital
- ii. Providing a cashless service at network hospitals
- iii. Processing of claims

TPAs are independent entities who are appointed by insurers for processing and finalizing health claims. TPAs service health policyholders starting from issuance of

unique identity cards for hospital admissions up to settlement of claims either on cashless basis or reimbursement basis.

Third party administrators were introduced in the year 2001. They are licensed and regulated by IRDAI and mandated to provide health services. The minimum capital and other stipulations to qualify as a TPA are prescribed by IRDAI.

Thus health claims servicing are now outsourced by the insurers to the TPAs, at a remuneration of five-six percent of the premium collected.

Third party administrators enter into an MOU with hospitals or health service providers and ensure that any person who undergoes treatment in the network hospitals is given a cashless service. They are the intermediaries between the insurer(s) and the insured(s), who co-ordinate with the hospitals and finalize health claims.

5. Hospital

A hospital means any institution established for in-patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

- a) has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- b) has qualified nursing staff under its employment round the clock;
- c) has qualified medical practitioner(s) in charge round the clock;
- d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
- e) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

6. Medical practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. However, insurance companies are free to make a restriction that the registered practitioner should not be the insured or any close family member.

7. Qualified nurse

Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

8. Reasonable and necessary expenses

A health insurance policy always contains this clause as the policy provides for compensation of expenses that would be deemed to be reasonable for treatment of a particular ailment and in a particular geographical area.

A common meaning would be the charges incurred that are medically necessary to treat the condition, does not exceed the usual level of charges for similar treatment in the locality in which it is incurred and does not include charges that would not have been made if no insurance existed.

IRDAI defines Reasonable Charges as the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

This clause provides protection to the insurer against inflation of bills by the provider and also prevents insured from going in for high end hospitals for treatment of common ailments, which could be otherwise done at reasonably low costs.

9. Notice of claim

Every insurance policy provides for immediate intimation of claim and specified time limits for document submission. In health insurance policies, wherever cashless facility is desired by the customer, intimations are given well before the hospitalization. However in cases of reimbursement claims, the insured sometimes does not bother to intimate insurers of the claim and submits the documents after a lapse of several days / months. Delay in submission of bills could lead to inflation of bills, frauds by insured / hospital, etc. It also affects making proper provisions for claims by the insurance company. Hence insurance companies usually insist on immediate intimation of claims. The time limit for submission of claim documents is normally fixed at 15 days from the date of discharge. This enables quick and accurate reporting of claims, and also enables the insurer to carry out investigations wherever required.

IRDA guidelines stipulate that claim intimation/paper submission beyond stipulated time should be considered if there is a justifiable reason for the same.

10. Free health check

In individual health policies, a provision is generally available to give some form of incentive to a claim free policyholder. Many policies provide for reimbursement of the cost of health check-up at the end of four continuous, claim free policy periods. This is normally capped at 1% of the average sum insured of the preceding three years.

11. Cumulative bonus

Another form of encouraging a claim free policyholder is providing a cumulative bonus on the sum insured for every claim free year. This means that the sum insured gets increased on renewal by a fixed percentage say 5% annually and is allowed up to a maximum of 50% for ten claim-free renewals. The insured pays the premium for the original sum insured and enjoys a higher cover.

As per IRDAI guidelines, cumulative bonus can be provided only on indemnity based health insurance policies and not benefit policies (except PA policies). The operation of cumulative bonus should be stated explicitly in the prospectus and the policy document. Moreover, if a claim is made in any particular year, the cumulative bonus accrued can only be reduced at the same rate at which it is accrued.

Example

A person takes a policy for Rs. 3 lacs at a premium of Rs. 5,000. In the second year, in case of no claims in the first year, he gets a sum insured of Rs. 3.15 lacs (5% more than the previous year) at the same premium of Rs. 5,000. This could go up to Rs. 4.5 lacs over a ten year claim free renewal.

12. Malus/ Bonus

Just as there is an incentive to keep the health policy free of claims, the opposite is called a malus. Here, if the claims under a policy are very high, a malus or loading of premium is collected at renewal.

Keeping in view that health policy is a social benefit policy, so far malus is not charged on individual health policies.

However, in case of group policies, the malus is charged by way of loading the overall premium suitably to keep the claim ratio within reasonable limits. On the other hand if experience is good a discount in premium rate is allowed which is turned as Bonus.

13. No claim discount

Some products provide for a discount on premium for every claim free year instead of a bonus on sum insured.

14. Co-payment

Co-payment is the concept of the insured bearing a portion of each and every claim under a health policy. These could be compulsory or voluntary depending on the

product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations.

Some products in the market have co-payment clauses in respect of certain diseases only, such as major surgeries, or commonly occurring surgeries, or for persons above a certain age.

15. Deductible / Excess

Also called as excess, in health policies, it is the fixed amount of money the insured is required to pay initially before the claim is paid by insurer, for e.g. if the deductible in a policy is Rs. 10,000, the insured pays first Rs. 10,000 in each insured loss claimed for. To illustrate, if the claim is for Rs. 80,000, the insured bears the first Rs. 10,000 and the insurer pays Rs. 70,000.

Deductible may also be a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer.

16. Room rent restrictions

While several products are open ended with the sum insured being the maximum amount payable in the event of a claim, several products today place a restriction on the category of room that an insured chooses by linking it to the sum insured. Experience shows that all expenses of hospitalization follow the room rent, with higher room rent leading to proportionately higher charges under all heads of expenses. Hence a person with a sum insured of one lac would be entitled to a room of Rs 1,000 per day if the policy has a room rent restriction of 1% of sum insured per day. This clearly indicates that if one prefers luxury treatment at high end hospitals, then the policy too should be purchased for high sums insured at appropriate premium.

17. Renewability clause

The IRDA guidelines on renewability of health insurance policies makes lifetime guaranteed renewal of the health policies compulsory. An insurance company can deny renewal only on the grounds of fraud or misrepresentation or suppression by insured (or on his behalf) either in obtaining insurance or subsequently in relation thereto.

18. Cancellation clause

The cancellation clause is also standardized by regulatory provisions and an insurance company may at any time cancel the policy only on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured.

A minimum of fifteen days' notice in writing by registered A/D to the insured at his last known address is required. Where a policy is cancelled by the insurer, the company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance provided no claim has been paid under the policy.

In the event of cancellation by the insured, premium refund is on short period rates, meaning insured would receive refund of premium for a percentage less than the pro-rata. If a claim is made no refund would be made.

19. Free look in period

If a customer has bought a new insurance policy and received the policy document and then finds that the terms and conditions are not what he wanted, what are his options?

IRDAI has built into its regulations a consumer-friendly provision that takes care this problem. The customer can return it and get a refund subject to the following conditions:

1. This applies only to life insurance policies and to health insurance policies with tenure of at least one year.
2. The customer must exercise this right within 15 days of receiving the policy document
3. He has to communicate the same to the insurer in writing
4. The premium refund will be available only if no claim has been made on the policy and will be adjusted for
 - a) proportionate risk premium for the period on cover
 - b) expenses incurred by the insurer on medical examination and
 - c) stamp duty charges

20. Grace period for renewal

A significant feature of a health insurance policy is maintaining continuity of insurance. As benefits under a policy are maintained only if policies are renewed without break, timely renewal is of great importance.

As per IRDAI guidelines, a 30 days grace period is allowed for renewal of individual health policies.

All continuity benefits are maintained if the policy is renewed within 30 days from expiry of the earlier insurance. Claims, if any, during the break period will not be considered.

Insurers may consider granting a longer grace period for renewal, depending on individual products.

Most of above key clauses, definitions, exclusions have been standardized under Health Regulations and Health Insurance Standardization guidelines issued by IRDA. Students are advised to go through the same and also keep themselves updated on guidelines and circulars issued by IRDA from time to time.

Test Yourself 7

As per IRDA guidelines, a _____ grace period is allowed for renewal of individual health policies.

- I. Fifteen days
 - II. Thirty days
 - III. Forty Five days
 - IV. Sixty days
-

Summary

- a) A health insurance policy provides financial protection to the insured person in the event of an unforeseen and sudden accident / illness leading to hospitalization.
- b) Health insurance products can be classified on the basis of number of people covered under the policy: individual policy, family floater policy, group policy.
- c) A hospitalization expenses policy or Mediclaim reimburses the cost of hospitalization expenses incurred on account of illness / accident.
- d) Pre hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days (generally 30 days) prior to hospitalization and will be considered as part of claim.
- e) Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days (generally 60 days) after hospitalization and will be considered as part of claim.
- f) In a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.
- g) A hospital daily cash policy provides a fixed sum to the insured person for each day of hospitalization.
- h) Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.
- i) High Deductible or Top-up Covers offer cover for higher sum insured over and above a specified chosen amount (called threshold or deductible).
- j) The fixed benefits cover provides adequate cover to the insured person and also helps the insurer to effectively price his policy
- k) A Personal Accident (PA) Cover provides compensation in the form of death and disability benefits due to unforeseen accidents.
- l) Out-patient covers provide for medical expenses like dental treatments, vision care expenses, routine medical examinations and tests etc. that do not require hospitalization.

- m) A group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals.
- n) Corporate Floater or Buffer Cover amount helps meet excess expenses over and above the family sum insured.
- o) Overseas Mediclaim / Travel Policies provide cover to an individual against exposure to the risk of accident, injury and sickness during his stay overseas.
- p) Corporate Frequent Travelers' Plan is an annual policy whereby a corporate takes individual policies for its executives who frequently make trips outside India.
- q) Many terms used in health insurance have been standardized by IRDA by regulation to avoid confusion especially for the insureds.

Answers to Test Yourself

Answer 1

The correct option is II.

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

Answer 2

The correct option is I.

As per IRDA guidelines, a 30 days grace period is allowed for renewal of individual health policies.

Self-Examination Questions

Question 1

Which of the below statement is correct with regards to a hospitalization expenses policy?

- I. Only hospitalization expenses are covered
- II. Hospitalization as well as pre and post hospitalization expenses are covered
- III. Hospitalization as well as pre and post hospitalization expenses are covered and a lumpsum amount is paid to the family members in the event of insured's death
- IV. Hospitalization expenses are covered from the first year and pre and post hospitalization expenses are covered from the second year if the first year is claim free.

Question 2

Identify which of the below statement is correct?

- I. Health insurance deals with morbidity
- II. Health insurance deals with mortality
- III. Health insurance deals with morbidity as well as mortality
- IV. Health insurance neither deals with morbidity or mortality

Question 3

Which of the below statement is correct with regards to cashless service provided in health insurance?

- I. It is an environment friendly go-green initiative started by insurance companies to promote electronic payments so that circulation of physical cash notes can be reduced and trees can be saved.
- II. Service is provided free of cost to the insured and no cash is to be paid as the payment is made by the Government to the insurance company under a special scheme
- III. All payments made by insured have to be made only through internet banking or cards as cash is not accepted by the insurance company
- IV. The insured does not pay and the insurance company settles the bill directly with the hospital

Question 4

Identify the correct full form of PPN with regards to hospitals in health insurance.

- I. Public Preferred Network
- II. Preferred Provider Network
- III. Public Private Network
- IV. Provider Preferential Network

Question 5

Identify which of the below statement is incorrect?

- I. An employer can take a group policy for his employees
 - II. A bank can take a group policy for its customers
 - III. A shopkeeper can take a group policy for its customers
 - IV. A group policy taken by the employer for his employees can be extended to include the family members of the employees
-

Answers to Self-Examination Questions

Answer 1

The correct option is II.

In a hospitalization expenses policy, hospitalization as well as pre and post hospitalization expenses are covered.

Answer 2

The correct option is I.

Health insurance deals with morbidity (rate of incidence of disease).

Answer 3

The correct option is IV.

Under the cashless service, the insured does not pay and the insurance company settles the bill directly with the hospital.

Answer 4

The correct option is II.

PPN stands for Preferred Provider Network.

Answer 5

The correct option is III.

Statements I, II and IV are correct. Statement III is incorrect as a shopkeeper cannot take group insurance for its customers.

CHAPTER 6

HEALTH INSURANCE UNDERWRITING

Chapter Introduction

This chapter aims to provide you detailed knowledge about underwriting in health insurance. Underwriting is a very important aspect of any type of insurance and plays a vital role in issuance of an insurance policy. In this chapter, you will get an understanding about basic principles, tools, methods and process of underwriting. It will also provide you the knowledge about group health insurance underwriting.

Learning Outcomes

- A. What is underwriting?
- B. Underwriting - Basic concepts
- C. File and Use guidelines
- D. Other health insurance regulations of IRDAI
- E. Basic principles and tools for underwriting
- F. Underwriting process
- G. Group health insurance
- H. Underwriting of Overseas Travel Insurance
- I. Underwriting of Personal Accident Insurance

After studying this chapter, you should be able to:

- a) Explain what is meant by underwriting
- b) Describe the basic concepts of underwriting
- c) Explain the principles and the various tools followed by underwriters
- d) Appreciate the complete process of underwriting individual health policies
- e) Discuss how group health policies are underwritten

Look at this Scenario

Manish aged 48 years, working as a software engineer, decided to take a health insurance policy for himself. He went to an insurance company, where they gave him a proposal form in which he was required to answer a number of questions related to his physical build and health, mental health, pre-existing illnesses, his family health history, habits and so on.

On receipt of his proposal form, he was also required to submit many documents such as identity and age proof, proof of address and previous medical records. Then they told him to undergo a health check-up and some medical tests which frustrated him.

Manish, who considered himself a healthy person and with a good income level, started wondering why such a lengthy process was being followed by the insurance company in his case. Even after going through all this, the insurance company told him that high cholesterol and high BP had been diagnosed in his medical tests, which increased the chances of heart diseases later. Though they offered him a policy, the premium was much higher than what his friend had paid and so he refused to take the policy.

Here, the insurance company was following all these steps as part of their underwriting process. While providing risk coverage, an insurer needs to evaluate risks properly and also to make reasonable profit. If the risk is not assessed properly and there is a claim, it will result in a loss. Moreover, insurers collect premiums on behalf of all insuring persons and have to handle these moneys like a trust.

A. What is underwriting?

1. Underwriting

Insurance companies try to insure people who are expected to pay adequate premium in proportion to the risk they bring to the insurance pool. This process of collecting and analyzing information from a proposer for the risk selection is known as underwriting. On the basis of information collected through this process, they decide whether they want to insure a proposer. If they decide to do so, then at what premium, terms and conditions so as to make a reasonable profit from taking such risk.

Health insurance is based on the concept of morbidity. Here morbidity is defined as the likelihood and risk of a person becoming ill or sick thereby requiring treatment or hospitalization. To a large extent, morbidity is influenced by age (generally being higher in senior citizens than in young adults) and also increases due to various other adverse factors, such as being overweight or underweight, personal history of certain past and present diseases or ailments, personal habits like smoking, current health status and also occupation of the proposer if it is deemed to be hazardous. Conversely, morbidity also decreases due to certain favourable factors like lower age, a healthy lifestyle etc.

Definition

Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted. Thus, it is a process of risk selection and risk pricing.

2. Need for underwriting

Underwriting is the backbone of an insurance company as acceptance of the risk carelessly or for insufficient premiums will lead to insurer's insolvency. On the other hand, being too selective or careful will prevent the insurance company from creating a big pool so as to spread the risk uniformly. It is therefore critical to strike the correct balance between risk and business, thereby being competitive and yet profitable for the organization.

This process of balancing is done by the underwriter, in accordance with the philosophy, policies and risk hunger of the insurance company concerned. The job of the underwriter is to classify the risk and decide the terms of acceptance at a proper price. It is important to note that acceptance of risk is like giving a promise of future claim settlement to the insured.

3. Underwriting - risk assessment

Underwriting is a process of risk selection which is based upon the characteristics of a group or individual. Here based on the degree of the risk, the underwriter decides whether to accept the risk and at what price. Under any circumstances, the process of acceptance has to be done with fairness and on an equitable basis i.e. every similar risk should be classified equally without any prejudice. This classification is normally done through standard acceptance charts whereby every represented risk is quantified and premiums are calculated accordingly.

Although age affects the chance of sickness as well as death, it must be remembered that sickness usually comes much before death and could be frequent. Hence, it is quite logical that the underwriting norms and guidelines are much tighter for health coverage than death coverage.

Example

An individual who is diabetic has a far higher chance of developing a cardiac or kidney complication requiring hospitalization than of death, and also health episodes can happen multiple times during the course of insurance coverage. A life insurance underwriting guideline might rate this individual as an average risk. However, for medical underwriting, he would be rated as a higher risk.

In health insurance, there is a higher focus on medical or health findings than financial or income based underwriting. However, the latter cannot be ignored as there has to be an insurable interest and financial underwriting is important to rule out any adverse selection and ensure continuity in health insurance.

4. Factors which affect chance of illness

The factors which affect morbidity (risk of falling ill) should be considered carefully while assessing risk are as follows:

- a) **Age:** Premiums are charged corresponding with age and the degree of risk. For e.g. the morbidity premiums for infants and children are higher than young adults due to increased risk of infections and accidents. Similarly, for adults beyond the age of 45 years, the premiums are higher, as the probability of an individual suffering from a chronic ailment like diabetes, a sudden heart ailment or other such morbidity is much higher.
- b) **Gender:** Women are exposed to additional risk of morbidity during child bearing period. However, men are more likely to get affected by heart attacks than women or suffer job related accidents than women as they may be more involved in hazardous employment.

- c) **Habits:** Consumption of tobacco, alcohol or narcotics in any form has a direct bearing on the morbidity risk.
- d) **Occupation:** Extra risk to accidents is possible in certain occupations, e.g. driver, blaster, aviator etc. Likewise, certain occupations may have higher health risks, like an X-Ray machine operator, asbestos industry workers, miners etc.
- e) **Family history:** This has greater relevance, as genetic factors influence diseases like asthma, diabetes and certain cancers. This does impact the morbidity and should be taken into consideration while accepting risk.
- f) **Build:** Stout, thin or average build may also be linked to morbidity in certain groups.
- g) **Past illness or surgery:** It has to be ascertained whether the past illness has any possibility of causing increased physical weakness or even recur and accordingly the policy terms should be decided. For e.g. kidney stones are known to recur and similarly, cataract in one eye increases possibility of cataract in the other eye.
- h) **Current health status and other factors or complaints:** This is important to ascertain the degree of risk and insurability and can be established by proper disclosure and medical examination.
- i) **Environment and residence:** These also have a bearing on morbidity rates.

Test Yourself 1

Underwriting is the process of _____.

- I. Marketing insurance products
 - II. Collecting premiums from customers
 - III. Risk selection and risk pricing
 - IV. Selling various insurance products
-

B. Underwriting - Basic concepts

1. Underwriting purpose

We begin with examining the purpose of underwriting. There are two purposes

- i. To prevent anti-selection that is selection against the insurer
- ii. To classify risks and ensure equity among risks

Definition

The term **selection of risks** refers to the process of evaluating each proposal for health insurance in terms of the degree of risk it represents and then deciding whether or not to grant insurance and on what terms.

Anti-selection (or adverse selection) is the tendency of people, who suspect or know that their chance of experiencing a loss is high, to seek out insurance eagerly and to gain in the process.

Example

If insurers were not selective about whom and how they offered insurance, there is a chance that people with serious ailments like diabetes, high BP, heart problems or cancer, who knew that they would soon require hospitalization, would seek to buy health insurance, create losses for the insurer.

In other words, if an insurer did not exercise selection it would be selected against and suffer losses in the process.

2. Equity among risks

Let us now consider equity among risks. The term “Equity” means that applicants who are exposed to similar degrees of risk must be placed in the same premium class. Insurers would like to have some type of standardization to determine the premiums to be charged. Thus people posing average risks should pay similar premium while people who pose higher risks should pay higher premium. They would like standardization to apply to the vast majority of individuals who pose average risks while they could devote more time to decide upon and rate risks which are more risky.

a) Risk classification

To usher equity, the underwriter engages in a process known as **risk classification** i.e. individuals are categorized and assigned to different risk classes depending on the degree of risks they pose. There are four such risk classes.

i. Standard risks

These consist of those people whose anticipated morbidity (chance of falling ill) is average.

ii. Preferred risks

These are the ones whose anticipated morbidity is significantly lower than average and hence could be charged a lower premium.

iii. Substandard risks

These are the ones whose anticipated morbidity is higher than the average, but are still considered to be insurable. They may be accepted for insurance with higher (or extra) premiums or subjected to certain restrictions.

iv. Declined risks

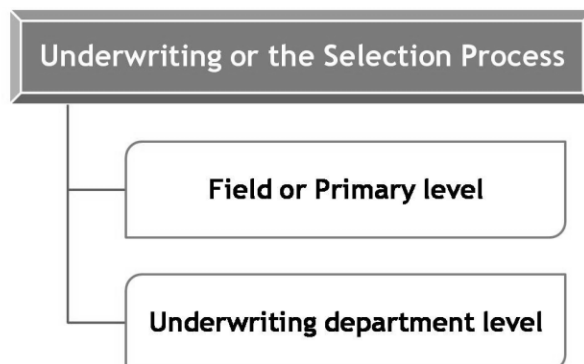
These are the ones whose impairments and anticipated extra morbidity are so great that they could not be provided insurance coverage at an affordable cost. Sometimes an individual's proposal may also be temporarily declined if he or she has been exposed to a recent medical event, like an operation.

3. Selection process

Underwriting or the selection process may be said to take place at two levels:

- ✓ At field level
- ✓ At underwriting department level

Diagram 1: Underwriting or the selection process



a) Field or Primary level

Field level underwriting may also be known as **primary underwriting**. It includes information gathering by an agent or company representative to decide whether an applicant is suitable for granting insurance coverage. The agent plays a critical role as primary underwriter. He is in the best position to know the prospective client to be insured.

A few insurance companies may require that agents complete a statement or a confidential report, asking for specific information, opinion and recommendations to be provided by the agent with respect to the proposer.

A similar kind of report, which has been called as **Moral Hazard report**, may also be sought from an official of the insurance company. These reports typically cover the occupation, income and financial standing and reputation of the proposed life.

What is Moral Hazard?

While factors like age, gender, habits etc. refer to the physical hazard of a health risk, there is something else that needs to be closely watched. This is the moral hazard of the client which can prove very costly to the insurance company.

An extreme example of bad moral hazard is that of an insured taking health insurance knowing that he will undergo a surgical operation within a short time but not disclosing this to the insurer. There is thus a deliberate intention of taking insurance just to collect a claim.

Indifference towards loss is another example. Because of the existence of insurance, the insured may be tempted to adopt a careless attitude towards his health knowing that any hospitalization would be paid by his insurer.

Another type of hazard called ‘morale hazard’ is also worthy of mention. Here the insured would not commit any fraud but, knowing that he has a large sum insured, he would prefer to take the most expensive treatment, staying in the most expensive hospital room etc. which he would not have done had he not been insured.

Fraud monitoring and role of agent as primary underwriter

Much of the decision with regard to selection of a risk depends on the facts that have been disclosed by the proposer in the proposal form. It may be difficult for an underwriter who is sitting in the underwriting department to know whether these facts are untrue and have been fraudulently misrepresented with deliberate intent to deceive.

The agent plays a significant role here. He or she is in the best position to ascertain that the facts that have been represented are true, since the agent has direct and personal contact with the proposer and can thus monitor if any willful non-disclosure or misrepresentation has been made with an intent to mislead.

b) Underwriting department level

The second level of underwriting is at the department or office level. It involves specialists and persons who are proficient in such work and who consider all the relevant data on the case to decide whether to accept a proposal for insurance and on what terms.

C. File and Use guidelines

It must be remembered that every insurer has to create its products before marketing them and this is also one of the functions of the underwriting department. The IRDAI has issued guidelines for this which are summarized below:

Every company designs its products keeping in mind the target customers' needs, wants and affordability, underwriting considerations, actuarial pricing, competitive conditions in the market etc. Thus we see high number of options for different categories of customers to choose from even though at the base level, hospitalization expense indemnity products dominate the Indian market.

Every new product needs approval of IRDA before introduction. The product needs to be filed with the Regulator under 'File and Use' provisions as mentioned below. Once introduced, product withdrawal also needs to follow guidelines. Students are advised to familiarize themselves with all provisions, forms, returns etc. related to File and Use guidelines.

File and use procedure for health insurance products as per IRDA guidelines:

- a) No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use Procedure.
- b) Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.
 - 1. Any revision or modification in a policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.
 - 2. The possibility of a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus.
- c) The File and Use application form has been standardized by IRDAI and has to be sent along with many annexures including the Database sheet and the Customer Information Sheet.

The Customer Information Sheet which is to be given to every insured along with the prospectus and the policy contains details of the cover, the exclusions, waiting period if any before claim becomes payable, whether the

payout will be on reimbursement basis or a fixed amount, renewal conditions and benefits, details of co-pay or deductible and cancellation conditions etc.

The File and Use application for the prior approval of the Authority shall be certified by the Appointed Actuary and the CEO of the insurance company and shall be in such formats and accompanied by such documentation as may be stipulated by the Authority from time to time.

d) Withdrawal of health insurance product

1. To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing -policyholders.
2. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.
3. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.
4. The withdrawn product shall not be offered to the prospective customers.

e) All particulars of any product shall after introduction be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under File and Use procedure.

f) Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

D. Other Health Insurance regulations of IRDAI

In addition to the File and Use guidelines, the Health Insurance regulations also require the following:

- a. All Insurance Company's shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The policy should among other matters prescribe the proposal form in which prospects may apply for purchasing a Health Policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Policy of the Company.
- b. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.
- c. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.
- d. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
- e. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document, clearly state the events which will require the submission of such information and the conditions applicable in such event.
- f. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use guidelines.

Guidelines regarding portability of health policies

IRDAI has brought out very clear guidelines regarding portability of life and health insurance policies. These are enumerated below:

1. Portability shall be allowed in the following cases:

- a. All individual health insurance policies issued by non-life insurance companies including family floater policies
 - b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right for portability at next renewal.
2. Portability can be opted by the policyholder only at renewal and not during currency of the policy.
3. A policyholder wanting to port his policy to another insurance company has to apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of the existing policy.
4. The new insurer may or may not offer portability if policyholder fails to make an application in the IRDAI-prescribed form at least 45 days before the premium renewal date.
5. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to the IRDAI guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.
6. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.
7. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.
8. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.
9. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it

shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.

10. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.
11. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.
12. Where the outcome of acceptance of portability is still awaited from the new insurer on the date of renewal
 - a. the existing policy shall be allowed to be extended, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and
 - b. the existing policy shall not be cancelled until such time a confirmed policy from new insurer is received or at the specific written request of the insured
 - c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.
 - d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.
13. In case the policyholder has opted short period extension as stated above and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.
14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.

15. No commission shall be payable to any intermediary on the acceptance of a ported policy.

16. For any health insurance policy, waiting period already elapsed under the existing policy with respect to pre-existing diseases and time bound exclusions shall be taken into account and reduced to that extent under the newly ported policy.

Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

Note 2: For group health insurance policies, the individual member's shall be given credit as stated above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

17. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of Rs. 2 lakhs and accrued bonus of Rs. 50,000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs. 2.50 lakhs by charging the premium applicable for Rs. 2.50 lakhs. If insurer B has no product for Rs. 2.50 lakhs, insurer B would offer the nearest higher slab say Rs. 3 lakhs to insured by charging premium applicable for Rs. 3 lakhs SI. However, portability would be available only up to Rs 2.50 lakhs.

18. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

a. all health insurance policies are portable;

b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

E. Basic principles of insurance and tools for underwriting

1. Basic principles relevant to underwriting

In any form of insurance, whether it is life insurance or general insurance, there are certain legal principles which operate along with acceptance of risks. Health insurance is equally governed by these principles and any violation of the principles results in the insurer deciding to avoid the liability, much to the dissatisfaction and frustration of the policyholders. These core principles are:

1. Utmost good faith (Uberrima fides) and the insurable interest

2. Tools for underwriting

These are the sources of information for the underwriter and the basis on which the risk classification is done and premiums finally decided. The following are the key tools for underwriting:

a) Proposal form

This document is the base of the contract where all the critical information pertaining to the health and personal details of the proposer (i.e. age, occupation, build, habits, health status, income, premium payment details etc.) are collected. This could range from a set of simple questions to a fully detailed questionnaire according to product and the needs/policy of the company, so as to ensure that all material facts are disclosed and the coverage is given accordingly. Any breach or concealment of information by the insured shall render the policy void.

b) Age proof

Premiums are determined on the basis of the age of the insured. Hence it is imperative that the age disclosed at the time of enrollment is verified through submission of an age proof.

Example

In India, there are many documents which can be considered as age proof but all of them are not legally acceptable. Mostly valid documents are divided into two broad categories. They are as follows:

- a) Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc.
- b) Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.

c) Financial documents

Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard. However, normally the financial documents are only asked for in cases of

- a) Personal accident covers or
- b) high sum assured coverage or
- c) when the stated income and occupation as compared to the coverage sought, show a mismatch.

d) Medical reports

Requirement of medical reports is based on the norms of the insurer, and usually depends upon the age of the insured and sometimes on the amount of cover opted. Some replies in the proposal form may also contain some information that leads to medical reports being asked for.

e) Reports of sales personnel

Sales personnel can also be seen as grassroots level underwriters for the company and the information given by them in their report could form an important consideration. However, as the sales personnel have an incentive to generate more business, there is a conflict of interest which has to be watched out for.

Test Yourself 2

The principle of utmost good faith in underwriting is required to be followed by _____.

- I. The insurer
 - II. The insured
 - III. Both the insurer and the insured
 - IV. The medical examiners
-

Test Yourself 3

Insurable interest refers to _____.

- I. Financial interest of the person in the asset to be insured
 - II. The asset which is already insured
 - III. Each insurer's share of loss when more than one company covers the same loss
 - IV. The amount of the loss that can be recovered from the insurer
-

F. Underwriting process

Once the required information is received, the underwriter decides the terms of the policy. The common forms used for underwriting health insurance business are as below:

1. Medical underwriting

Medical underwriting is a process in which medical reports are called for from the proposer to determine the health status of an individual applying for health insurance policy. The health information collected is then evaluated by the insurers to determine whether to offer coverage, up to what limit and on what conditions and exclusions. Thus medical underwriting can determine the acceptance or declining of a risk and also the terms of cover.

However, medical underwriting involves high costs in terms of receiving and examining medical reports. Also, when insurers use a high degree of medical underwriting, they are blamed for 'cream-skimming' (accepting only the best kind of risk and denying others). It also causes frustration among prospective clients and reduces the number of people willing to insure with those insurers as they do not want to provide the requisite information and detail and to undergo the required tests.

Health status and age are important underwriting considerations for individual health insurance. Also current health status, personal and family medical history enable an underwriter to determine presence of any pre-existing diseases or conditions and eventually the probability of future health problems that may require hospitalization or surgical intervention.

Further proposal forms are designed in a manner to elicit information about past treatments taken, hospitalizations and surgeries undergone. This helps an underwriter to evaluate the possibility of recurrence of an earlier ailment, its impact on current or future health status or future complications. Some diseases for which the proposer is taking medicines only may soon require hospitalization any time soon or recur.

Example

Medical conditions like hypertension, overweight/obesity and raised sugar levels have a high probability of future hospitalization for diseases of the heart, kidney and the nervous system. So, these conditions should be carefully considered while assessing the risk for medical underwriting.

Since adverse changes in health status generally occur post 40 years, mainly due to normal ageing process, insurers do not require any medical examination or tests of the proposer earlier than the age of 45 years (some insurers could raise this requirement

to 50 or 55 years too). Medical underwriting guidelines may also require a signed declaration of the proposer's health status by his/her family physician.

In the Indian health insurance market, the key medical underwriting factor for individual health insurance is the age of the person. Persons above the age of 45-50 years, enrolling for the first time are normally required to undergo specified pathological investigations to assess health risk profile and to obtain information on their current health status. Such investigations also provide an indication of prevalence of any pre-existing medical conditions or diseases.

Example

Drugs, alcohol and tobacco consumption may be difficult to detect and seldom declared by the proposer in the proposal form. Non-disclosure of these poses a major challenge in underwriting of health insurance. Obesity is another problem which threatens to become a major public health problem and underwriters need to develop underwriting tools to be able to adequately price the complications arising out of the same.

2. Non-medical underwriting

Most of the proposers which apply for health insurance do not need medical examination. If it could be known with a fair degree of accuracy that only one-tenth or less of such cases will bring the adverse results during medical examination, insurers could dispense with medical examination in majority of the cases.

Even, if the proposer were to disclose all material facts completely and truthfully and the same were checked by agent carefully, then also the need for medical examination could have been much less. In fact, a slight increase in the claims ratio can be accepted if there is savings in the costs of medical checkup and other expenses and also as it will reduce the inconvenience to the proposer.

Therefore, insurance companies are coming up with some medical policies where the proposer is not required to undergo any medical examination. In such cases, companies usually create a 'medical grid' to indicate at what age and stage should a medical underwriting be done, and therefore these non- medical limits are carefully designed so as to strike a proper balance between business and risk.

Example

If an individual has to take health insurance coverage quickly without going through a long process of medical examinations, waiting periods and processing delays, then he can opt for a non-medical underwriting policy. In a non-medical underwriting policy, premium rates and sum assured are usually decided on the basis of answers to a few

health questions mostly based on age, gender, smoking class, build etc. The process is speedy but the premiums may be relatively higher.

3. Numerical rating method

This is a process adopted in underwriting, wherein numerical or percentage assessments are made on each component of the risk.

Factors like age, sex, race, occupation, residence, environment, build, habits, family and personal history are examined and scored numerically based on pre-determined criteria.

4. Underwriting decisions

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories. Based on the above tools and his judgment, the underwriter classifies the risk into the following categories:

- a) Accept risk at standard rates
- b) Accept risk at an extra premium (loading), though it may not be practiced in all companies
- c) Postpone the cover for a stipulated period/term
- d) Decline the cover
- e) Counter offer (either restrict or deny part of the cover)
- f) Impose a higher deductible or Co-pay
- g) Levy permanent exclusion(s) under the policy

If any illness is permanently excluded, it is endorsed on the policy certificate. This becomes an additional exclusion apart from the standard policy exclusion and shall form the part of the contract.

Expert individual risk assessment by underwriters is vital to insurance companies as it keeps the insurance system in balance. Underwriting enables insurers to group together those with the same level of expected risk and to charge them the same premium for the protection they choose. The benefit for the policyholder is availability of insurance at a fair and competitive price whereas the benefit for an insurer is the ability to maintain the experience of its portfolio in line with the morbidity assumptions.

5. Use of general or standard exclusions

The majority of policies impose exclusions that apply to all their members. These are known as standard exclusions or sometimes referred to as general exclusions. Insurers limit their exposure by the implementation of standard exclusions.

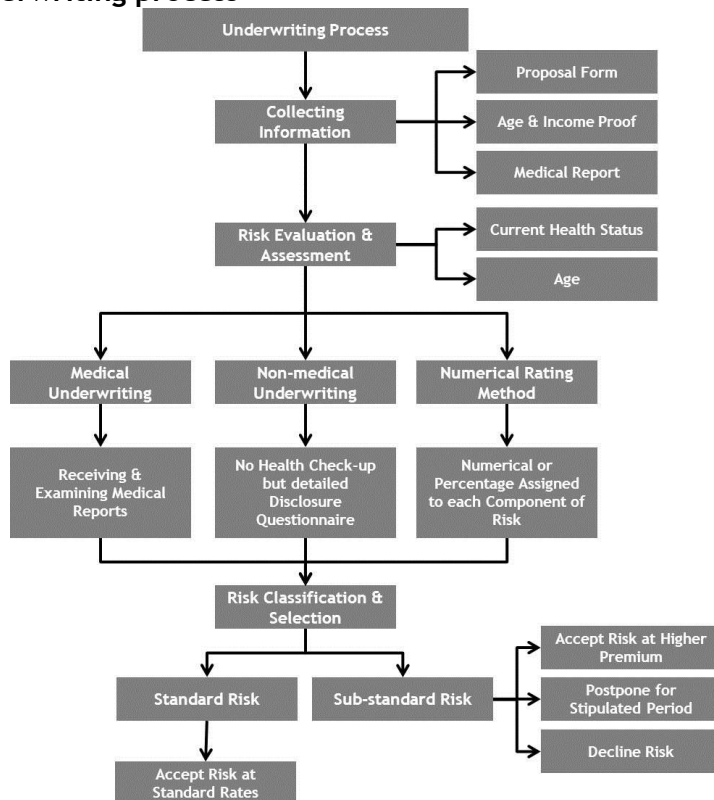
The same have been discussed in earlier chapter.

Test Yourself 4

Which of the following statements about medical underwriting is incorrect?

- I. It involves high cost in collecting and assessing medical reports.
- II. Current health status and age are the key factors in medical underwriting for health insurance.
- III. Proposers have to undergo medical and pathological investigations to assess their health risk profile.
- IV. Percentage assessment is made on each component of the risk.

Diagram 1: Underwriting process



G. Group health insurance

1. Group health insurance

Group insurance is underwritten mainly on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer. Thus, while accepting a group for health insurance, the insurers take into consideration the possibility of existence of a few members in the group who may have severe and frequent health problems.

Underwriting of group health insurance requires analyzing the characteristics of the group to evaluate whether it falls within the insurance company's underwriting guidelines as well as the guidelines laid down for group insurance by the insurance regulators.

Standard underwriting process for group health insurance requires evaluating the proposed group on the following factors:

- a) Type of group
- b) Group size
- c) Type of industry
- d) Eligible persons for coverage
- e) Whether entire group is being covered or there is an option for members to opt out
- f) Level of coverage - whether uniform for all or differently
- g) Composition of the group in terms of sex, age, single or multiple locations, income levels of group members, employee turnover rate, whether premium paid entirely by the group holder or members are required to participate in premium payment
- h) Difference in healthcare costs across regions in case of multiple locations spread in different geographical locations
- i) Preference of the group holder for administration of the group insurance by a third party administrator (of his choice or one selected by the insurer) or by the insurer itself
- j) Past claims experience of the proposed group

Example

A group of members working in mines or factories is at higher health risk than a group of members working in air-conditioned offices. Also the nature of diseases (thereby claims) are also likely to be quite different for both groups. Therefore, the insurer will price the group health insurance policy accordingly in both the cases.

Similarly to avoid adverse selection in case of groups with high turnover such as IT companies, insurers can introduce precautionary criteria requiring employees to serve their probationary period before becoming eligible for insurance.

Due to highly competitive nature of group health insurance business, insurers allow substantial flexibility and customization in benefits of the group insurance plans. In employer-employee group insurance plans, the benefits design is usually developed over time and used as an employee retention tool by the human resources department of the employer. Often, the flexibility is the result of competition among insurers to match or improve the benefits of the existing group insurance plan given by another insurer to capture and shift business.

2. Underwriting other than employer- employee groups

Employer-employee groups are traditionally the most common groups offered group health insurance. However, as health insurance gains acceptance as an effective vehicle of financing healthcare expenditure, different types of group formations have now developed. In such a scenario, it is important for group health insurance underwriters to take into consideration the character of the group composition while underwriting the group.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, multiple-employer groups, franchisee dealers, professional associations, clubs and other brotherhood organizations.

Governments in different countries have been buyers of group health insurance coverage for poorer sections of the society. In India, governments both at the central and state level have aggressively been sponsoring group health insurance schemes for the poor e.g. RSBY, Yeshaswini etc.

Though basic underwriting considerations for such diverse groups are similar to generally accepted group underwriting factors, additional aspects include:

- a) Size of the group (small group size may suffer from frequent changes)
- b) Different levels of healthcare cost in different geographical regions
- c) Risk of adverse selection in case all group constituents do not participate in the group health insurance plan

d) Continuation of members in the group in the policy

There has been a growth in irregular types of group formations just to take advantage of such group health insurance benefits at cheap prices, called 'groups of convenience'. The insurance regulator IRDA has therefore issued group insurance guidelines with a view to regulate the approach to be adopted by insurers in dealing with various groups. Such non-employer groups include:

- a) Employer welfare associations
- b) Holders of credit cards issued by a specific company
- c) Customers of a particular business where insurance is offered as an add-on benefit
- d) Borrowers of a bank and professional associations or societies

The rationale of the group insurance guidelines is to restrict formation of groups for the sole purpose of availing insurance with advantage of flexible design, coverage of benefits not available on individual policies and cost savings. It has been observed that such 'groups of convenience' have often led to adverse selection against the insurers and eventually high claim ratios. Group insurance guidelines by the regulatory authority, thus, help in responsible market conduct by the insurers. They instill discipline in underwriting by insurance companies and also in canvassing group insurance schemes by setting up administration standards for group schemes.

H. Underwriting of Overseas Travel Insurance

Since the main cover under Overseas Travel Insurance policies is the health cover, the underwriting would follow the pattern for health insurance in general.

The premium rating and acceptance would as per individual company guidelines but a few important considerations are given below:

1. Premium rate would depend on the age of the proposer and the duration of foreign travel.
2. As medical treatment is costly overseas, the premium rates are normally much higher compared to domestic health insurance policies.
3. Even among the foreign countries, USA and Canada premium is the highest.
4. Care should be taken to rule out the possibility of a proposer using the policy to take medical treatment abroad and hence the existence of any pre-existing disease must be carefully considered at the proposal stage.

I. Underwriting of Personal Accident Insurance

The underwriting considerations for personal accident policies are discussed below:

Rating

In personal accident insurance, the main factor considered is the occupation of the insured. Generally speaking exposure to personal accidents at home, on the street etc. is the same for all persons. But the risks associated with profession or occupation varies in accordance with the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is being constructed.

It is not practical, to fix a rate for each profession or occupation. Hence, occupations are classified into groups, each group reflecting, more or less, similar risk exposure. The following system of classification is simple and found to be feasible in practice. Individual companies may have their own basis of classification.

Classification of Risk

On the basis of occupation, the risks associated with the insured person may be classified into three groups:

- **Risk group I**
Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, persons engaged in administration functions, persons primarily engaged in occupations of similar hazards.
- **Risk group II**
Builders, Contractors and Engineers engaged in superintending functions only, Veterinary Doctors, paid drivers of motor cars and light motor vehicles and persons engaged in occupation of similar hazards.
All persons engaged in manual labour (except those falling under Group III), cash carrying employees, garage and motor Mechanics, Machine operators, Drivers of trucks or lorries and other heavy vehicles, professional athletes and sportsmen, woodworking Machinists and persons engaged in occupations of similar hazards.
- **Risk group III**
Persons working in underground mines, explosives magazines, workers involved in electrical installation with high tension supply, Jockeys, circus personnel, persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons engaged in occupations / activities of

similar hazard.

Risk groups are also known in the form of 'Normal', 'Medium' and 'High' respectively.

Age Limits

The minimum and maximum age for being covered and renewed varies from company to company. Generally a band of 5 years to 70 years is the norm. However, in case of persons who already have a cover, policies may be renewed after they complete 70 years but up to the age of 80 subject to a loading of the renewal premium.

No medical examination is usually required for renewal or fresh cover.

Medical Expenses

The medical expenses cover is as follows:

- A personal accident policy can be extended by endorsement, on payment of extra premium to cover medical expenses incurred by the insured in connection with the accidental bodily injury.
- These benefits are in addition to the other benefits under the policies.
- It is not necessary that person has to be hospitalised.

War and Allied Risks

War risk cover may be covered to Indian personnel / experts working in foreign countries on civilian duties with additional premium.

- P.A. policies issued during peace time or normal period would be at say 50 percent extra over the normal rate (i.e. 150 percent of the normal rate.)
- P.A. policies issued during abnormal/ apprehensive period (i.e. during the period when warlike conditions have already occurred or are imminent in foreign country/i.e. where the Indian personnel are working on civilian duties) at say 150 percent extra over the normal rate (i.e. 250 percent of the normal rate)

The Proposal Form

The form elicits information on the following:

- Personal details
- Physical condition
- Habits and pastimes
- Other or previous insurances
- Previous accidents or illness
- Selection of benefits and sum insured
- Declaration

The above required details can be explained as follows:

- Personal details relate to, inter alia, age, height and weight, full description of occupation and average monthly income.
- Age will show whether the proposer is within the limits of age for entrants for the policy desired. Weight and height should be compared with a table of average weight for sex, height and age and further investigation would be made if the proposer is say 15 percent or more over or under the average.
- Physical condition details relate to any physical infirmity or defect, chronic diseases etc.
- Proposers who have lost a limb or the sight of an eye may only be accepted on special terms in approved cases. They constitute abnormal risks because they are “less able to avoid certain types of accidents and in view of the fact that if the remaining arm or leg is injured or the sight or the remaining eye is affected, the degree and length of disablement is likely to be much greater than normal.
- Diabetes may retard recovery as the wound may not heal quickly and the disablement may be unduly prolonged. The medical history of the proposer must be examined in order to determine whether and to what extent injuries or illnesses may affect the future accident risks. There are many complaints of such an obviously serious nature as to make the risk uninsurable, e.g. valvular disease of the heart.
- Hazardous pastimes like mountaineering, polo, motor racing, acrobatics etc., require extra premium.

Sum Insured

The sum insured in a personal accident policy has to be fixed with caution, as they are benefit policies and not subject to strict indemnity. Care should be taken to consider income derived through ‘gainful employment’. In other words, income which will not be affected by accident to the proposer should not be considered while determining the sum insured.

As practices of fixing the S.I varies among insures/underwriters, the exact amount for which the cover could be granted depends on the underwriters. However the general practice that the cover granted should not exceed the equivalent of 72 months / 6 years' earning of the insured.

This restriction is not strictly applied if the policy is for capital benefits only. For temporary total disablement cover however it should not happen that in the event of compensation payable, the same is disproportionate to his earnings during the same period. If the cover is for weekly compensation for TTD, the sum insured usually does not exceed twice his/her annual income.

While giving cover to persons who are not gainfully employed e.g. housewives, students etc. the insurers make sure that they provide for capital benefits only and that no weekly compensation is provided for.

Family Package Cover

For children and non-earning spouse the cover is limited to death and permanent disablement (total or partial). However, based on individual company's norms the Table of Benefits may be considered. Some Companies allow TTD cover to non-earning spouse also up to a particular limit.

A discount of 5 percent is usually granted on the gross premium.

Group Policies

A group discount is allowed off the premium, if the number of insured person exceeds a certain number say 100. Group policy however may be issued when number is smaller, say 25 but without any discount.

Normally, policies on unnamed basis are issued only to very valued clients, where the identity of the member is clearly ascertainable beyond doubt.

Group discount criteria

Group policies should be issued only in respect of the named groups. For the purpose of availing of group discount and other benefits, the proposed "Group" should fall clearly under any one of the following categories:

- Employer - employee relationship including dependents of the employee

- Pre identified segments / groups where the premium is to be paid by the State / Central Governments
- Members of a registered co-operative society
- Members of registered service clubs
- Holders of credit card of banks / Diners / Master / Visa
- Holders of deposit certificates issued by banks / NBFC's
- Shareholders of banks / public limited companies

In case of proposals relating to any further category different from the above categories, they may be deliberated and decided upon by the technical department of the respective insurers.

No group discount can be offered on the 'anticipated' group size. Group discount is to be considered and worked out only on the actual number of members registered in the 'Group' at the time of taking out the policy. It can be reviewed at renewals.

Sum insured

The sum insured may be fixed for specific amounts separately for each insured person or it may be linked to emoluments payable to the insured persons.

The principle of 'All or None' applies in a group insurance. Additions and deletions are made thereto with pro rata additional premium or refund.

Premium

Varying rates of premium are applicable to named employees as per the classification of risks and the benefits selected. Thus rates will vary according to the occupation of persons covered.

Example

The same rate will apply to well defined groups of employee all of whom, broadly speaking follow the same type of occupation.

In respect of unnamed employees the employer is required to declare the number of employees in each classification based on authentic records maintained by him.

Premium rates for named member of an association, clubs etc. apply according to the classification of risk.

When the membership is of a general nature and not restricted to any particular occupation, underwriters use their discretion in applying the rates.

On-duty covers

The cover provided during the on-duty hours is as follows:

- If P.A cover is required only for the restricted hours of duty (and not for 24 hours a day), a reduced premium say 75 percent of the appropriate premium is charged.
- The cover applies to accident to the employees arising out of and in the course of employment only.

Off-duty covers

If cover is required only for the restricted hours, when the employee is not at work and/or not on official duty, the reduced premium of say 50 percent of the appropriate premium may be charged.

Exclusion of death cover

It is possible to issue group P.A. policies excluding the death benefit, subject to individual company guidelines.

Group discount and Bonus/Malus

Since a large number of persons are covered under one policy, there is less administrative work and expense. Besides, usually all members of the group will be insured and there will be no adverse selection against the insurers. Hence, a discount in premium is allowed, according to a scale.

Rating under renewal of group policies is determined with reference to the claims experience.

- Favourable experience is rewarded with a discount in the renewal premium (bonus)
- Adverse experience is penalised by loading of renewal premium (malus), according to a scale
- Normal rates will apply for renewal if the claims experience is, say, 70 percent

Proposal form

- It is customary to dispense the forms for completion by the members and to have one document only, completed by the insured.
- He is required to make a declaration that no member suffers from a physical infirmity or defect that would render his participation unacceptable.
- Sometimes even this precaution is waived, it being understood and/or made clear by endorsement that disability prior to the commencement of cover and also any cumulative effect as a result of such disability stand excluded.

However the practice may vary among the companies.

Test Yourself 5

- 1) In a group health insurance, any of the individual constituting the group could anti-select against the insurer.
 - 2) Group health insurance provides coverage only to employer-employee groups.
- I. Statement 1 is true and statement 2 is false
 - II. Statement 2 is true and statement 1 is false
 - III. Statement 1 and statement 2 are true
 - IV. Statement 1 and statement 2 are false
-

Information

As part of the risk management process, the underwriter uses two methods of transferring his risks especially in case of large group policies:

Coinurance: This refers to the acceptance of a risk by more than one insurer. Normally, this is done by way of allocating a percentage of the risk to each insurer. Thus the policy may be accepted by two insurers say, Insurer A with a 60% share and Insurer B with a 40% share. Normally, insurer A would be the lead insurer handling all matters relating to the policy, including issuance of the policy and settlement of claims. Insurer B would reimburse insurer A for 40% of the claims paid.

Reinsurance: The insurer accepts risks of various types and sizes. How can he protect his various risks? He does this by re-insuring his risks with other insurance companies and this is called reinsurance. Reinsurers therefore accept risks of insurers either by way of standing arrangements called treaties or on a case to case basis called facultative reinsurance. Reinsurance is done world-wide and hence it spreads risk far and wide.

Summary

- a) Health insurance is based on the concept of morbidity which is defined as the risk of a person falling ill or sick.
 - b) Underwriting is the process of risk selection and risk pricing.
 - c) Underwriting is required to strike a proper balance between risk and business thereby maintaining the competitiveness and yet profitability for the organisation.
 - d) Some of the factors which affect a person's morbidity are age, gender, habits, occupation, build, family history, past illness or surgery, current health status and place of residence.
 - e) The purpose of underwriting to prevent adverse selection against the insurer and also ensure proper classification and equity among risks.
 - f) The agent is the first level underwriter as he is in the best position to know the prospective client to be insured.
 - g) The core principles of insurance are: utmost good faith, insurable interest, indemnity, contribution, subrogation and proximate cause.
 - h) The key tools for underwriting are: proposal form, age proof, financial documents, medical reports and sales reports.
 - i) Medical underwriting is a process which is used by the insurance companies to determine the health status of an individual applying for health insurance policy.
 - j) Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.
 - k) Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.
 - l) The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.
 - m) Group insurance is mainly underwritten based on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.
-

Answers to Test Yourself

Answer 1

The correct option is III.

Underwriting is the process of risk selection and risk pricing.

Answer 2

The correct option is III.

The principle of utmost good faith in underwriting has to be followed by both the insurer and the insured.

Answer 3

The correct option is I.

Insurable interest refers to the pecuniary or the financial interest of a person in the asset he is going to get insured and can suffer financial loss in the event of any damage to such asset.

Answer 4

The correct option is IV.

Percentage and numerical assessment is made on each component of the risk in numerical rating method, and not medical underwriting method.

Answer 5

The correct option is IV.

In a group health insurance, when all members of a group are covered under a group health insurance policy, the individuals constituting the group cannot anti-select against the insurer.

In addition to employee-employer groups, insurers have provided group health insurance coverage to varied type of groups such as: labour unions, trusts and societies, professional associations, clubs and other fraternal organisations.

Self-Examination Questions

Question 1

Which of the following factor does not affect the morbidity of an individual?

- I. Gender
- II. Spouse job
- III. Habits
- IV. Residence location

Question 2

According to the principle of indemnity, the insured is paid for _____.

- I. The actual losses to the extent of the sum insured
- II. The sum insured irrespective of the amount actually spent
- III. A fixed amount agreed between both the parties
- IV. The actual losses irrespective of the sum assured

Question 3

The first and the primary source of information about an applicant, for the underwriter is his _____.

- I. Age proof documents
- II. Financial documents
- III. Previous medical records
- IV. Proposal form

Question 4

The underwriting process is completed when _____.

- I. All the critical information related to the health and personal details of the proposer are collected through the proposal form
- II. All the medical examinations and tests of the proposer are completed
- III. The received information is carefully assessed and classified into appropriate risk categories
- IV. The policy is issued to the proposer after risk selection and pricing.

Question 5

Which of the following statements about the numerical rating method is incorrect?

- I. Numerical rating method provides greater speed in the handling of a large business with the help of trained personnel.
 - II. Analysis of difficult or doubtful cases is not possible on the basis of numerical points without medical referees or experts.
 - III. This method can be used by persons without any specific knowledge of medical science.
 - IV. It ensures consistency between the decisions of different underwriters.
-

Answers to Self-Examination Questions

Answer 1

The correct option is II.

The morbidity of an individual is not affected by their spouse's job, though their own occupation is one of the important factors which can affect their morbidity.

Answer 2

The correct option is I.

According to the principle of indemnity, insured is compensated for the actual costs or losses, but to the extent of the sum insured.

Answer 3

The correct option is IV.

The primary source of information about an applicant, for the underwriter is his proposal form or application form, in which all the critical information related to the health and personal details of the proposer are collected.

Answer 4

The correct option is III.

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.

Answer 5

The correct answer is II.

A more careful analysis of difficult or doubtful cases is made possible by numerical rating method because past experience with reference to the doubtful points is expressed numerically in terms of a known standard and shadings.

CHAPTER 7

HEALTH INSURANCE CLAIMS

Chapter Introduction

In this chapter we will discuss about claim management process in health insurance, documentation required and the process of claim reserving. Apart from this we will also look into claims management under personal accident insurance and understand the role of TPAs.

Learning Outcomes

- A. Claims management in insurance
- B. Management of health insurance claims
- C. Documentation in health insurance claims
- D. Claims reserving
- E. Role of third party administrators (TPA)
- F. Claims management - personal accident
- G. Claims management- Overseas travel insurance

After studying this chapter, you should be able to:

- a) Explain the various stakeholders in insurance claims
- b) Describe how health insurance claims are managed
- c) Discuss the various documents required for settlement of health insurance claims
- d) Explain how reserves for claims are provided for by insurers
- e) Discuss personal accident claims
- f) Understand the concept and role of TPAs

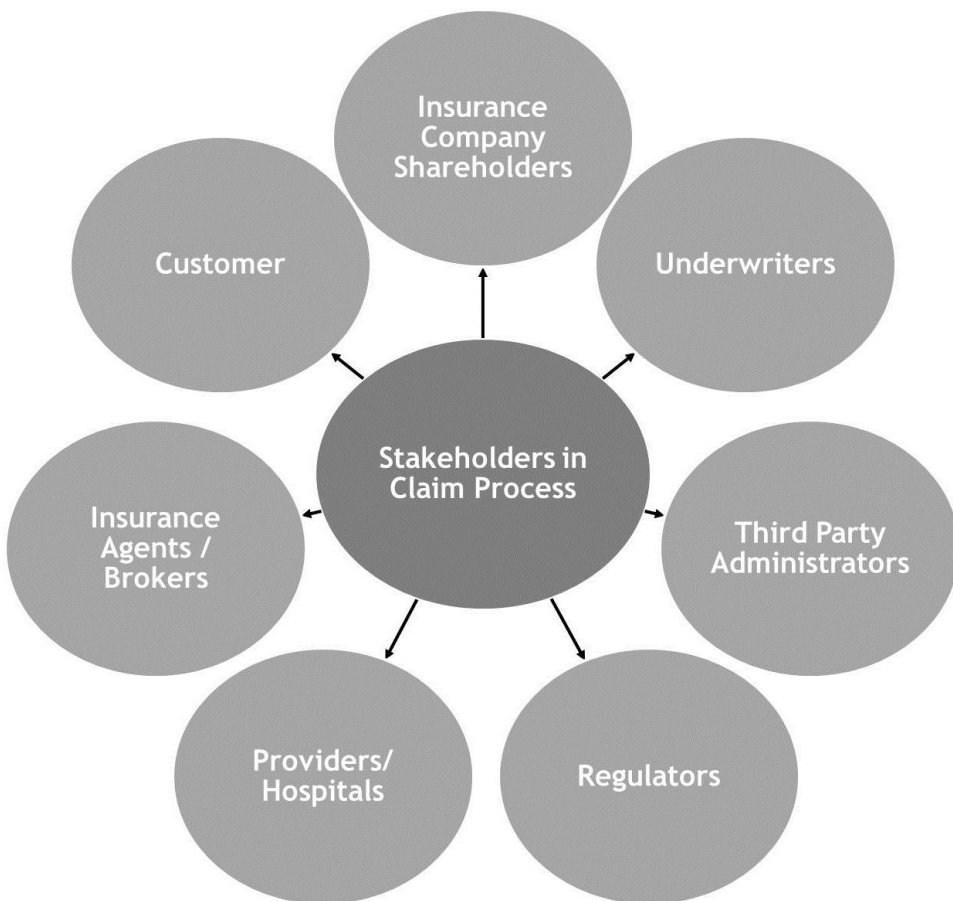
A. Claims management in insurance

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

1. Stakeholders in claim process

Before we look in detail at how claims are managed, we need to understand who are the interested parties in the claims process.

Diagram 1: Stakeholders in claim process



Customer	The person who buys insurance is the first stakeholder and ‘receiver of the claim’.
Owners	Owners of the insurance company have a big stake as the ‘payers of the claims’. Even if the claims are met from the policy holders’ funds, in most cases, it is they who are liable to keep the promise.
Underwriters	Underwriters within an insurance company and across all insurers have the responsibility to understand the claims and design the products, decide policy terms, conditions and pricing etc.
Regulator	The regulator (Insurance Regulatory and Development Authority of India) is a key stakeholder in its objective to: <ul style="list-style-type: none"> ✓ Maintain order in the insurance environment ✓ Protect policy holders’ interest ✓ Ensure long term financial health of insurers.
Third Party Administrators	Service intermediaries known as Third Party Administrators, who process health insurance claims.
Insurance agents / brokers	Insurance agents / brokers not only sell policies but are also expected to service the customers in the event of a claim.
Providers / Hospitals	They ensure that the customer gets a smooth claim experience, especially when the hospital is on the panel of the TPA the Insurer to provide cashless hospitalization.

Thus managing claims well means managing the objectives of the each of these stakeholders related to the claims. Of course, it may happen that some of these objectives can conflict with each other.

2. Role of claims management in insurance company

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

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

Test Yourself 1

Who among the following is not a stakeholder in insurance claim process?

- I. Insurance company shareholders
 - II. Human Resource Department
 - III. Regulator
 - IV. TPA
-

B. Management of health insurance claims

1. Challenges in health insurance

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

- a) Majority of the policies are for hospitalization indemnity where the subject matter covered is a human being. This brings forth emotional issues that are not normally faced in other classes of insurance.
- b) India presents very peculiar patterns of illnesses, approach to treatment and follow up. These result in some people being excessively cautious with some others being unworried about their illness and treatment.
- c) Health insurance can be purchased by an individual, a group such as a corporate organization or through a retail selling channel like a bank. This results in the product being sold as a standard commodity at one extreme while being tailored to satisfy needs of the customer at the other.
- d) Health insurance depends on the act of being hospitalized, to trigger a claim under the policy. However, there is great difference in the availability, specialization, treatment methods, billing patterns and charges of all health service providers whether doctors, surgeons or hospitals which make it very difficult to assess claims.
- e) The discipline of healthcare is the fastest developing one. New diseases and conditions keep occurring resulting in development of new treatment methods. Examples of this are key-hole surgeries, laser treatments, etc. This makes health insurance more technical and the skills to handle the insurance claims for such procedure needs constant improvement.
- f) More than all these factors, the fact that a human body cannot be standardized adds a completely new dimension. Two people could respond differently to the same treatment for the same illness or require different treatments or varying periods of hospitalization.

The portfolio of health insurance is growing rapidly. The challenge of such rapid growth is the huge number of products. There are hundreds of health insurance products in the market and even within a company one can find many different products. Each product and its variant has its peculiarity and therefore needs to be studied before a claim can be handled.

Growth of the health portfolio also brings about the challenge of numbers - a company selling 100,000 health policies to retail customers covering say, 300,000 members

under these policies, has to be prepared to service about 20,000 claims at least! With the expectation of cashless service and speedy settlement of claims, organizing health insurance claims department is a significant challenge.

Typically health insurance policies written in India cover hospitalization anywhere within the country. The team handling claims must understand the practices across the country to be able to appreciate the claim presented.

The health claims manager meets these challenges using expertise, experience and various tools available to him.

In the final analysis, health insurance offers the satisfaction of having assisted a person who is in need and is undergoing the physical and emotional stress of illness of himself or his family.

Efficient claims management ensures that right claim is paid to right person at the right time.

2. Claim process in health insurance

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

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

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

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

The claim under an indemnity policy could be a:

a) Cashless claim

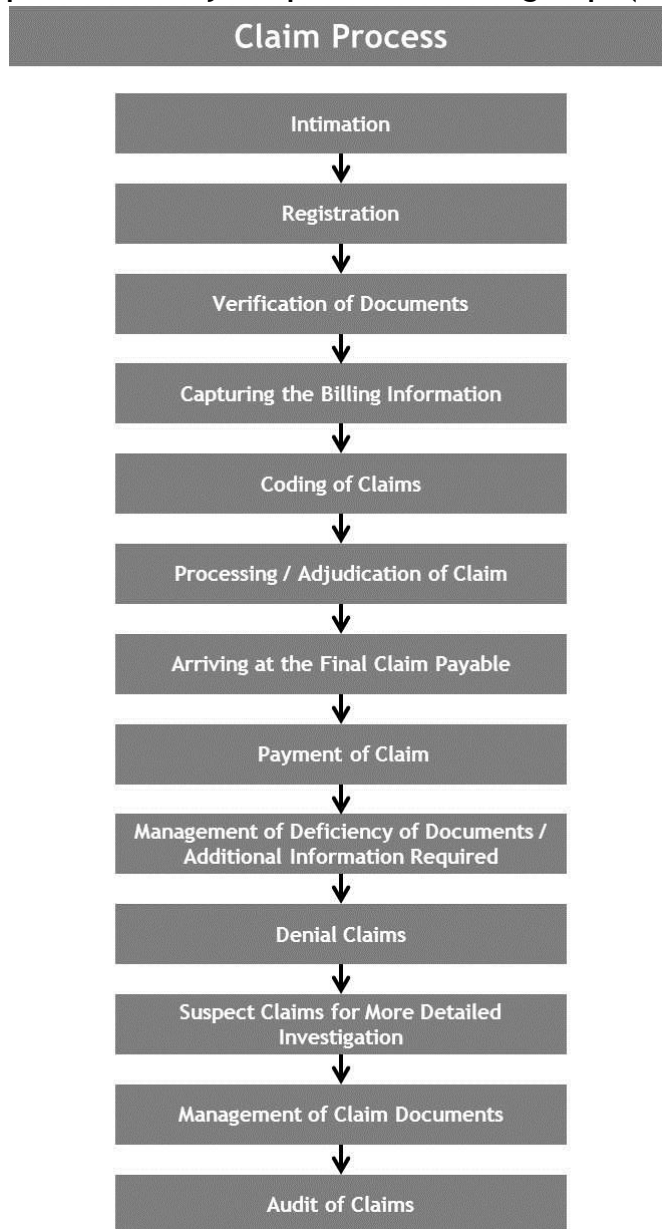
The customer does not pay the expenses at the time of admission or treatment. The network hospital provides the services based on a pre-approval from the insurer/TPA and later submits the documents to the insurer/TPA for settlement of the claim.

b) Reimbursement claim

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

In both cases, the basic steps remain the same.

Diagram 2: Claim process broadly comprises of following steps (not in exact order)



a) Intimation

Claim intimation is the first instance of contact between the customer and the claims team. The customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently, the act of intimation of a claim event was a formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable. Typically it is required before hospitalization in case of planned admission, and within 24 hours of hospitalization in case of an emergency.

The timely availability of information about hospitalization helps the Insurer/TPA to verify that the hospitalization of the customer is genuine and there is no impersonation or fraud and sometimes, to negotiate the charges.

Intimation earlier meant 'a letter written, submitted and acknowledged' or by fax. With development in communication and technology, intimation is now possible through call centres run by insurers/TPAs open 24 hours as well as through the internet and e-mail.

b) Registration

Registration of a claim is the process of entering the claim in the system and creating a reference number using which the claim can be traced any time. This number is called Claim number, Claim reference number or Claim control number. The claim number could be numeric or alpha-numeric based on the system and processes used by the processing organization

Registration and generation of a reference no. is usually done once the claim intimation is received and the correct policy number and insured person's particulars are matched.

Once a claim is registered in the system, a reserve for the same would be created simultaneously in the accounts of the insurer. At the time of intimation/registration, the exact claim amount or estimate may not be known. The initial reserve amount is therefore a standard reserve (mostly based on historical average claim size). Once the estimate or expected amount of liability is known, the reserve is revised upward/downward to reflect the same.

c) Verification of documents

Once a claim is registered, the next step is to check for the receipt of all the required documents for processing.

It must be appreciated that for a claim to be processed following are the most important requirements:

1. The documentary evidence of the illness
2. Treatment provided
3. In-patient duration
4. Investigation Reports
5. Payment made to the hospital
6. Further advice for treatment
7. Payment proofs for implants etc.

Verification of documents follows a checklist which the claim processor checks out. Most of the companies ensure that such checklists are part of the processing documentation.

The missing documentation is noted at this stage - while some processes involve requesting for the documents not submitted by the customer / hospital at this point, most of the companies first complete the scrutiny of all the documents submitted before requesting for additional information so that the customer is not inconvenienced.

d) Capturing the billing information

Billing is an important part of the claim processing cycle. Typical health insurance policies provide for indemnifying expenses incurred in the treatment with specific limits under various heads. The standard practice is to classify the treatment charges into:

- ✓ Room, board and nursing expenses including registration and service charges.
- ✓ Charges for ICU and any intensive care operations.
- ✓ Operation theatre charges, anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and any medical expenses incurred which is integral part of the operation.
- ✓ Surgeon, anaesthetist, medical practitioner, consultant's, specialists fees.
- ✓ Ambulance charges.
- ✓ Investigation charges covering blood test, X-ray, scans, etc.
- ✓ Medicines and drugs.

Documents submitted by the customer are examined to capture information under these heads so that the settlement of claims can be done with accuracy.

Though there are efforts being made to standardize the billing pattern of hospitals, it is common for each hospital to use a different method for billing and the challenges faced in this are:

- ✓ Room charges can include some non-payables such as service charges or diet.
- ✓ Single bill can include different headings or a lump-sum bill for all investigations or all medicines.
- ✓ Non-standard names being used - e.g. nursing charges being called service charges.
- ✓ Use of words like “similar charges”, “etc.”, “allied expenses” in the bill.

Where the billing is not clear, the processor seeks the break up or additional information, so that the doubts on the classification and admissibility are resolved.

To address this issue, IRDAI issued Health Insurance Standardization Guidelines which have standardized the format of such bills and the list of non-payable items.

Package rates

Many hospitals have agreed package rates for treatment of certain diseases. This is based on the ability of the hospital to standardize the treatment procedure and use of resources. In recent times, for treatment at Preferred Provider Network and also in case of RSBY, package cost of many procedures has been pre-fixed.

Example

- a) Cardiac packages: Angiogram, Angioplasty, CABG or Open heart surgery, etc.
- b) Gynaecological packages: Normal delivery, Caesarean delivery, hysterectomy, etc.
- c) Orthopaedic packages
- d) Ophthalmological packages

Additional costs due to complications after surgery are charged separately on actual basis if incurred over and above these.

Packages have the advantages of certainty of the cost involved and standardization of the procedures and so such claims are easier to handle.

e) Coding of claims

The most important code set used is the World Health Organization (WHO) developed **International Classification of Diseases (ICD) codes**.

While ICD is used to capture the disease in a standardized format, procedure codes such as **Current Procedure Terminology (CPT) codes** capture the procedures performed to treat the illness.

Insurers are relying on the coding increasingly and Insurance Information Bureau (IIB), which is part of Insurance Regulatory and Development Authority (IRDAI), has started an information bank where such information that can be analyzed.

f) Processing of claim

A reading of the health insurance policy shows that while it is a commercial contract, it involves medical terms that define when a claim is payable and to what extent. The heart of claims processing in any insurance policy, is in answering two key questions:

- ✓ Is the claim payable under the policy?
- ✓ If yes, what is the net payable amount?

Each of these questions requires understanding of a number of terms and conditions of the policy issued as well as the rates agreed with the hospital in case treatment has taken place at a network hospital.

Admissibility of a claim

For a health claim to be admissible the following conditions must be satisfied.

i. The member hospitalized must be covered under the insurance policy

While this looks simple, we come across situations where the names (and in more cases, the age) of the person covered and person hospitalized do not match. This could be because of:

It is important to ensure that the person covered under the policy and the person hospitalized is the same. This kind of fraud is very common in health insurance.

ii. Admission of the patient within the period of insurance

iii. Hospital definition

The hospital where the person was admitted should be as per the definition of “hospital or nursing home” under the policy otherwise the claim is not payable.

iv. Domiciliary hospitalization

Some policies cover domiciliary hospitalization i.e. treatment taken at home in India for a period exceeding 3 days for an ailment which normally requires treatment at hospital/nursing home.

Domiciliary hospitalization, if covered in a policy, is payable only if:

- ✓ The condition of the patient is such that he/she cannot be removed to the Hospital/Nursing Home or
- ✓ The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

v. Duration of hospitalization

Health insurance policies normally cover hospitalization exceeding 24 hours as an in-patient. Therefore the date and time of admission as well as discharge becomes important to note if this condition is satisfied.

Day-care treatments

Technological developments in the healthcare industry have led to simplification of many procedures that earlier required complex and prolonged hospitalization. There are a number of procedures carried out on day care basis without need for hospitalization exceeding 24 hours.

Most of the day care procedures are on pre-agreed package rate basis, resulting in certainty in costs.

vi. OPD

Some policies cover treatment/consultations taken as an out-patient also, subject to a specific sum insured which is usually less than the hospitalization sum insured.

The coverage under OPD varies from policy to policy. For such reimbursements, the clause for 24 hours hospitalization is not applicable.

vii. Treatment procedure/line of treatment

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

- ✓ Unani
- ✓ Siddha

- ✓ Homeopathy
- ✓ Ayurveda
- ✓ Naturopathy etc.

Most policies exclude these treatments while some policies cover one or more of these treatments with sub-limits.

viii. Pre-existing illnesses

Definition

Pre-existing illnesses refer to “Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to his/her health policy with the company whether explicitly known to him or not.”

The reason for excluding pre-existing illnesses is due to the fundamental principles of insurance that a certainty cannot be covered under insurance.

However, application of this principle is quite difficult and involves a systematic check of the symptoms and treatment to find out whether the person had the condition at the time of insuring. As medical professionals can differ in the opinions of duration of the illness, the opinion of when the disease first showed up is carefully taken before applying this condition to deny any claim.

In the evolution of health insurance, we come across two modifications to this exclusion.

- ✓ The first is in the case of group insurance where the entire group of people is insured, with no selection against the insurer. Group policies covering, say all government employees, all families below poverty line, all families of employees of a major corporate group, etc. are treated favorably as compared to a single family opting to cover for the first time. These policies often deleted the exception, with exception adequate price built in.
- ✓ The second modification is that pre-existing illnesses are covered after the a certain period of continuous coverage. This follows the principle that even a condition is present in a person, if it does not show up for a certain period of time, it cannot be treated as a certainty.

ix. Initial waiting period

A typical health insurance policy covers illnesses only after an initial 30 days (except accident related hospitalization).

Similarly, there are lists of illnesses such as:

<ul style="list-style-type: none"> ✓ Cataract, ✓ Benign Prostatic Hypertrophy, ✓ Hysterectomy, ✓ Fistula, ✓ Piles, 	<ul style="list-style-type: none"> ✓ Hernia, ✓ Hydrocele, ✓ Sinusitis, ✓ Knee / Hip Joint replacement etc.
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------

These are not covered for an initial period that could be one year or two years or more depending on specific insurance company's product.

The claim processor identifies if the illness is one of these and how long the person has been covered to check if it falls within this admissibility condition.

x. Exclusions

The policy lists out a set of exclusions which in general can be classified as:

- ✓ Benefits such as maternity (though this is covered in some policies).
- ✓ Outpatient and Dental treatments.
- ✓ Illnesses which are not intended to be covered such as HIV, Hormone therapy, obesity treatment, fertility treatment, cosmetic surgeries, etc.
- ✓ Diseases caused by alcohol/drug abuse.
- ✓ Medical treatment outside India.
- ✓ High hazard activities, suicide attempt, radioactive contamination.
- ✓ Admission for tests/investigation purpose only.

In such a case it is extremely important for the claims handler to specifically explain the circumstances so that the specialist opinion is exactly to the point and will stand the scrutiny in a court of law, if challenged.

xi. Compliance with conditions with respect to the claims.

The insurance policy also defines certain actions to be taken by the Insured in case of a claim, some of which are important for admissibility of the claim.

In general, these relate to:

- ✓ Intimation of claim within certain period - we have seen the importance of intimation earlier. The policy could stipulate a time within which such intimation must reach the company.
- ✓ Submission of claim documents within a certain period.
- ✓ Not being involved in misrepresentation, misdescription or non-disclosure of material facts.

g) Arriving at the final claim payable

Once the claim is admissible, the next step is to decide the the amount of claim payable. To compute this we need to understand the factors that decide the claim amount payable. These factors are:

i. Sum insured available for the member under the policy

There are policies issued with individual sum insured, some issued on floater basis where the sum insured is available across the family or policies which are on floater basis but with a limit per member.

ii. Balance sum insured available under the policy for the member after taking into account any claim made already:

While calculating the balance of sum insured available after deducting claims already paid, any later cashless authorization provided to the hospitals will also have to be noted.

iii. Sub-Limits

Most policies specify room rent limitation, nursing charges etc. either as a percentage of sum insured or as a limit per day. Similar limitation could be in force for consultant fee, or ambulance charges, etc.

iv. Check for any limits specific to illness

The policy could specify a certain amount or capping for maternity cover or for other diseases say, cardiac illness.

v. Check whether entitled or not to cumulative bonus

Verify whether the insured is entitled to any no-claim bonus (in case the insured has not claimed from his policy in the previous year/s). No-claim bonus often comes in the form of additional sum insured, which in fact increases the sum insured of the patient/insured. Sometimes, the cumulative bonus may also be wrongly stated as claims intimated towards the end of the previous year may not have been taken into account.

vi. Other expenses covered with limitation:

There could be other limits e.g. if treatment is undertaken under Ayurvedic system of medicine, usually the same has a much lower limit. Health check-up costs are only up to a certain limit after four years of the policy. Hospital cash payment also has a per day limit.

vii. Co-payment

This is normally a flat percentage of the assessed claim before payment. The co-pay could also be applicable only in select circumstances - only for parent claims, only for maternity claims, only from second claim onwards or even only on claims exceeding a certain amount.

Before the payable amount is adjusted to these limits, the claim amount payable is computed net of deductions for non-payable items.

Non-payable items in a health claim

The expenses incurred in treating an illness can be classified into:

- ✓ Expenses for cure and
- ✓ Expenses for care.

Expenses for curing an illness comprise of all the medical costs and the normal related facilities. In addition, there could be costs incurred to make the stay in a hospital more comfortable or even luxurious.

A typical health insurance policy attends to the expenses for curing an illness and unless stated specifically, the extra expenses for luxury are not payable.

These expenses can be classified into non-treatment charges such as registration charge, documentation charges, etc. and to items that can be considered if directly relating to the cure (e.g. protein supplement during the inpatient period specifically prescribed).

Earlier every TPA/insurer had its own list of non-payable items, now the same has been standardized under IRDAI Health Insurance Standardization Guidelines.

The order of arriving at the final claim payable is as follows:

Table 2.1

Step I	List all the bills and receipts under the various heads of room rent, consultant fee, etc.
Step II	Deduct the non-payable items from the amount claimed under each head
Step III	Apply any limits applicable for each head of expense
Step IV	Arrive at the total payable amount and check if it is within sum insured overall

Step V	Deduct any co-pay if applicable to arrive at the net claim payable
---------------	--------------------------------------------------------------------

h) Payment of claim

Once the payable claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The approved claim amount is advised to the Finance / Accounts function and the payment may be made either by cheque or by transferring the claim money to the customer's bank account.

When the payment is made to the hospital, necessary tax deduction, if any is made from the payment.

Where the payment is handled by the Third Party Administrator, the payment process may vary from insurer to insurer. A more detailed insight into working of TPAs is provided later on.

Payment updates in the system are crucial for handling customer inquiries. Typically these details will be shared through the system with the call centre / customer service team.

Once payment is made, the claim is treated as settled. Reports have to be periodically sent to the company's management, intermediaries, customers and IRDAI for number and amount of settled claims. The typical analysis of settled claims includes the % settled, amount of non-payables as a proportion, average time taken to settle claims, etc.

i) Management of deficiency of documents / additional information required

Processing of a claim requires the scrutiny of a list of key documents. These are:

- ✓ Discharge summary with admission notes,
- ✓ Supporting investigation reports,
- ✓ Final consolidated bill with break up into various parts,
- ✓ Prescriptions and pharmacy bills,
- ✓ Payment receipts,
- ✓ Claim form and
- ✓ Customer identification.

Experience shows that one out of four claims submitted has a suffer from being incomplete in terms of the basic documents. It is therefore required that the customer is advised of the documents not submitted and is given a time limit within which he can attach them to his claim.

Similarly, it may happen that while a claim is being processed, additional information may be required because:

- i. The discharge summary provided is not in the correct format as prescribed by IRDAI or does not capture some details of the diagnosis or the history of the illness.
- ii. Treatment given has not been described in enough detail or requires clarification.
- iii. The treatment is not in line with the diagnosis as per discharge summary or medicines prescribed are not related to the illness for which treatment was provided.
- iv. The bills provided do not have the required break up.
- v. Mismatch of age of the person between two of the documents.
- vi. Mismatch in date of admission / date of discharge between discharge summary and the bill.
- vii. The claim requires a more detailed scrutiny of the hospitalization and for this, the hospital's indoor case papers are required.

In both the cases, the customer is informed in writing or through email detailing the requirement of additional information. In most cases, the customer will be able to provide the information required. However, there are circumstances where the information required is too important to be overlooked but the customer does not respond. In such cases, the customer is sent reminders that the information is needed to process the claim and after three such reminders, a claim closure notice is sent.

In all correspondence relating to a claim when it is in process, you will see that the words "Without Prejudice" are mentioned on top of the letter. This is a legal requirement to ensure that the right of the insurer to reject a claim after these correspondences remains intact.

Example

The insurer may ask for indoor case papers to study the case in detail and may come to a conclusion that the procedure / treatment does not fall within the policy conditions. The act of asking for more information should not be treated as an act that implies that the insurer has accepted the claim.

Managing shortfalls in documentation and explanation and additional information required is a key challenge in claims management. While the claim cannot be processed without all the required information, the customer cannot be put to inconvenience by frequent requests for more and more information.

Good practice requires that such request is raised once with a consolidated list of all information that may be needed and no new requirement is raised thereafter.

j) Denial claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall within the terms of the policy. This could be because of a variety of reasons some of which are:

- i. Date of admission is not within the period of insurance.
- ii. The Member for whom the claim is made is not covered.
- iii. Due to Pre-existing illness (where the policy excludes such condition).
- iv. Undue delay in submission without valid reason.
- v. No active treatment; admission is only for investigation purpose.
- vi. Illness treated is excluded under the policy.
- vii. The cause of illness is abuse of alcohol or drugs
- viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing. Usually, such denial letter clearly states the reason for denial, narrating the policy term / condition on which the claim was denied.

Most insurers have a process by which a denial is authorized by a manager senior to the one authorized to approve the claim. This is to ensure that any denial is fully justified and will be explained in case the insured seeks any legal remedy.

Apart from the representation to the insurer, the customer has the option, to approach the following in case of denial of claim:

- ✓ Insurance Ombudsman or
- ✓ The consumer forums or
- ✓ IRDAI or
- ✓ Law courts.

In case of each denial the file is checked to assess if the denial will stand the legal scrutiny in the normal course and the documents are stored in a safe location, should a need to defend the decision arise.

k) Suspect claims for more detailed investigation

Insurers have been trying to handle the problem of fraud in all lines of business. In terms of sheer number of fraud claims handled, health insurance presents a great challenge to the insurers.

Few examples of frauds committed in health insurance are:

- i. **Impersonation**, the person insured is different from person treated.
- ii. **Fabrication of documents** to make a claim where there is no hospitalization.
- iii. **Inflation of expenses**, either with the help of the hospital or by addition of external bills fraudulently created.
- iv. **Outpatient treatment converted to in-patient / hospitalization** to cover cost of diagnosis, which could be high in some conditions.

With newer methods of frauds emerging on a daily basis, the insurers and TPAs have to continuously monitor the situation on the ground and come up with measures to find and control such frauds.

Claims are chosen for investigation based on two methods:

- ✓ Routine claims and
- ✓ Triggered claims

A TPA or an insurer may set an internal standard that a specific percentage of the claims be physically verified; this percentage could be different for cashless and reimbursement claims.

Under this method, claims are chosen using random sampling method. Some insurers stipulate that all claims above a certain value be investigated and a sampled set of claims which are below that limit are taken up for verification.

In the second method, each claim goes through a set of checkpoints which if not in line, trigger investigation such as

- i. a high portion of the claim relating to medical tests or medicines
- ii. customer too eager to settle
- iii. bills with over-writing, etc.

If the claim is suspected to be not genuine, the claim is investigated, however small it is.

n. Cashless settlement process by TPA

How does the cashless facility work? At the heart of this is an agreement that the TPA insurer enters into, with the hospital. There are agreements possible with other medical service providers as well. We shall look at the process used for providing cashless facility in this section:

Table 3.1

Step 1	<p>A customer covered under health insurance suffers from an illness or sustains an injury and so is advised admission into a hospital. He/she (or someone on his/her behalf) approaches the hospital's insurance desk with the insurance details such as:</p> <ol style="list-style-type: none"> i. TPA name, ii. His membership number, iii. Insurer name, etc.
Step 2	<p>The hospital compiles the necessary information such as:</p> <ol style="list-style-type: none"> i. Illness diagnosis ii. Treatment, iii. Name of treating doctor, iv. Number of days of proposed hospitalization and v. The estimated cost <p>This is presented in a format, called the cashless authorization form.</p>

<p>Step 3</p>	<p>The TPA studies the information provided in the <i>cashless authorization form</i>. It checks the information with the policy terms and the agreed tariff with the hospital, if any, and arrives at the decision on whether the cashless authorization could be provided and if so, for how much amount it should be authorized.</p> <p>The TPA could ask for more information to arrive at the decision. Once the decision is made, it is communicated to the hospital without delay.</p> <p>Both forms have now been standardized under IRDAI Health Insurance Standardization Guidelines; refer to Annexure at the end).</p>
<p>Step 4</p>	<p>The patient is treated by the hospital, keeping the amount authorized by the TPA as credit in the patient's account. The member may be called on to make a deposit payment to cover the non-treatment expenses and any co-pay required under the policy.</p>
<p>Step 5</p>	<p>When the patient is ready for discharge, the hospital checks the amount of credit in the account of the patient approved by the TPA against the actual treatment charges covered by insurance.</p> <p>If the credit is less, the hospital requests for additional approval of credit for the cashless treatment.</p> <p>TPA analyses the same and approves the additional amount.</p>
<p>Step 6</p>	<p>Patient pays the non-admissible charges and gets discharged. He will be asked to sign the claim form and the bill, to complete the documentation.</p>
<p>Step 7</p>	<p>Hospital consolidates all the documents and presents to the TPA the following documents for processing of the bill:</p> <ul style="list-style-type: none"> i. Claim form ii. Discharge summary / admission notes iii. Patient / proposer identification card issued by the TPA and photo ID proof. iv. Final consolidated bill v. Detailed bill vi. Investigation reports vii. Prescription and pharmacy bills viii. Approval letters sent by the TPA

Step 8	<p>TPA will process the claim and recommend for payment to the hospital after verifying details such as the following:</p> <ol style="list-style-type: none"> i. The Patient treated is the same person for whom approval was provided. ii. Treated the patient for the same condition that it requested the approval for. iii. Expenses for treatment of excluded illness, if any, is not part of the bill. iv. All limits that were communicated to the hospital have been adhered to. v. Tariff rates agreed with the hospital have been adhered to, calculate the net payable amount.
---------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

The value of cashless facility is not in doubt. It is also important for the customer to know how to make the best use of the facility. The points to note are:

- i. Customer must make sure that he/she has his/her insurance details with him/her. This includes his:
 - ✓ TPA card,
 - ✓ Policy copy,
 - ✓ Terms and conditions of cover etc.

When this is not available, he can contact the TPA (through a 24 hour helpline) and seek the details.

- ii. Customer must check if the hospital suggested by his/her consulting doctor is in the network of the TPA. If not, he needs to check with the TPA the options available where cashless facility for such treatment is available.
- iii. He/she needs to make sure that the correct details are entered into the pre-authorization form. This form has been standardized by IRDAI as per Guidelines on Standardization in Health Insurance issued in 2013. If the case is not clear, the TPA could deny the cashless facility or raise query.
- iv. He/she needs to ensure that the hospital charges are consistent with the limits such as room rent or caps on specified treatments such as cataract.

In case he/she wants to spend more than what is allowed by the policy, it is better to know, in advance, what would be his/her share of expenses.

- v. The customer must inform the TPA in advance of the discharge and request the hospital to send to the TPA any additional approval that may be required

before discharge. This will ensure the patient does not wait unnecessarily at the hospital.

It is also possible that the customer requests and takes an approval for cashless treatment at a hospital but decides to admit the patient elsewhere. In such cases, the customer must inform and ask the hospital to communicate to the TPA that the cashless approval is not being used.

If this is not done, the amount approved could get blocked in the customer's policy and could prejudice the approval of the subsequent request.

C. Documentation in health insurance claims

Health insurance claims require a range of documents for processing, as explained earlier. Each document is expected to assist in answering the two key questions - admissibility (Is it payable?) and extent of claim (how much?).

This section explains the need for and content of each of the documents required to be submitted by the customers:

1. Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. It details the complete information about the condition of the patient and the line of treatment.

As per IRDAI Standardization Guidelines the contents of a standard Discharge Summary are as follows:

- 1 Patient's Name
- 2 Telephone No / Mobile No
- 3 IPD No
- 4 Admission No
- 5 Treating Consultant/s Name, contact numbers and Department / Specialty
- 6 Date of Admission with Time
- 7 Date of Discharge with Time
- 8 MLC No / FIR No
- 9 Provisional Diagnosis at the time of Admission
- 10 Final Diagnosis at the time of Discharge
- 11 ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis
- 12 Presenting Complaints with Duration and Reason for Admission
- 13 Summary of Presenting Illness
- 14 Key findings on physical examination at the time of admission
- 15 History of alcoholism, tobacco or substance abuse, if any
- 16 Significant Past Medical and Surgical History, if any
- 17 Family History if significant/relevant to diagnosis or treatment
- 18 Summary of key investigations during Hospitalization
- 19 Course in the Hospital including complications if any
- 20 Advice on Discharge
- 21 Name & Signature of treating Consultant/ Authorized Team Doctor
- 22 Name & Signature of Patient / Attendant

A well written discharge summary helps the claim processing person immensely to understand the illness / injury and the line of treatment, thereby speeding up the

process of settlement. Where the patient unfortunately does not survive, the discharge summary is termed **Death Summary** in many hospitals.

The discharge summary is always sought in original.

2. Investigation reports

Investigation reports assist in comparing the diagnosis and the treatment, thereby providing the necessary information to understand the exact condition that prompted the treatment and the progress made during the hospitalization.

Investigation reports usually consist of:

- a) Blood test reports;
- b) X-ray reports;
- c) Scan reports and
- d) Biopsy reports

All investigation reports carry the name, age, gender, date of test etc. and typically presented in original. The insurer may return the X-ray and other films to the customer on specific request.

3. Consolidated and detailed bills:

This is the document that decides what needs to be paid under the insurance policy. Earlier there was no standard format for the bill, but IRDAI Standardization Guidelines provide format for consolidated and detailed bills. The student is advised to understand the details available on the IRDAI website.

While the consolidated bill presents the overall picture, the detailed bill will provide the break up, with reference codes.

Scrutiny of non-payable expenses is done using the detailed bill, where the non-admissible expenses are rounded off and used for deduction under the expense head to which it belongs.

The bills have to be received in original.

4. Receipt for payment

Being a contract of indemnity, the reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid.

While the amount paid must correspond to the total of the bill, many hospitals do provide an element of concession or discount in the payable amount. In such a case, the insurer is called to pay only the amount actually paid on behalf of the patient.

The receipt should be numbered and or stamped and be presented in original.

5. Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer. The claim form has now been standardized by IRDAI and broadly consists of:

- a) Details of the primary insured and the policy number under which the claim is made.
- b) Details of the insurance history
- c) Details of the insured person hospitalized.
- d) Details of the hospitalization such as hospital, room category, date and time of admission and discharge, whether reported to police in case of accident, system of medicine etc.
- e) Details of the claim for which the hospitalization was done including breakdown of the costs, pre and post-hospitalization period, details of lump-sum/cash benefit claimed etc.
- f) Details of bills enclosed
- g) Details of bank account of primary insured for remittance of sanctioned claim
- h) Declaration from the insured.

Besides information on disease, treatment etc., the declaration from the insured person makes the claim form the most important document in the legal sense.

It is this declaration which applies the “**doctrine of utmost good faith**” into the claim, breach of which attracts the misrepresentation clause under the policy.

6. Identity proof

With the increasing use of identity proof across various activities in our life, the general proof of identity serves an important purpose - that of verifying whether the person covered and the person treated are one and the same.

Usually identification document which is sought could be:

- a) Voters identity card,
- b) Driving license,
- c) PAN card,
- d) Aadhaar card etc.

Insistence on identity proof has resulted in a significant reduction of impersonation cases in cashless claims as the identity proof is sought before hospitalization, making it a duty of the hospital to verify and present the same to the insurer or the TPA.

In reimbursement claims, the identity proof serves a lesser purpose.

7. Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

- a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required. It states the cause of accident and if the person was under the influence of alcohol, in case of traffic accidents.
- b) Case indoor papers in case of complicated or high value claims. Indoor case paper or case sheet is a document which is maintained at the hospital end, detailing all treatment given to patient on day to day basis for entire duration of hospitalization.
- c) Dialysis / Chemotherapy / Physiotherapy charts where applicable.
- d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked.

The claims team uses certain internal document formats for processing a claim. These are:

- i. Checklists for document verification,
- ii. Scrutiny/ settlement sheet,
- iii. Quality checks / control format.

Though these formats are not uniform across the insurers, let us study the purpose of the documents with a specimen of the usual contents.

Table 2.2

1.	Document verification sheet	It is the simplest of all, a check mark placed on the list of documents received to note that these have been submitted by the customer. Some insurers may provide a copy of this as an acknowledgement to the customer.
2.	Scrutiny/process sheet	<p>It is usually a single sheet where the entire processing notes are captured.</p> <ol style="list-style-type: none"> Name of the customer and id number Claim number, date of receipt of the claim papers Policy overview, Section 64VB compliance Sum insured and utilization of sum insured Date of hospitalization and discharge Diagnosis and treatment Claim admissibility / processing comments with reason thereof Computation of claim amount Movement of the claim with dates and names of people who processed
3.	Quality checks / control format	<p>Final check or quality control format for checking of claim by person other than claim handler</p> <p>Besides check list and claim scrutiny questionnaire, the quality control/audit format shall also include information relating to:</p> <ol style="list-style-type: none"> Settlement of claim, Rejection of claim or Requesting for additional information.

Test Yourself 2

Which of the following document is maintained at the hospital detailing all treatment done to an in-patient?

- Investigation report

- II. Settlement sheet
 - III. Case paper
 - IV. Hospital registration certificate
-

D. Claims reserving

1. Reserving

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

Processing systems today have built in capability to compute the reserves as at any point of time.

Test Yourself 3

The amount of provision made for all claims in the books of the insurer based on the status of the claims is known as _____.

- I. Pooling
 - II. Provisioning
 - III. Reserving
 - IV. Investing
-

E. Role of third party administrators (TPA)

1. Introduction of TPAs in India

The insurance sector was opened to private players in the year 2000. Meanwhile, the demand for healthcare products was also growing with new products being launched. A need was therefore felt for the introduction of a channel for post-sale services in health insurance. This offered the opportunity for professional Third Party Administrators to be introduced.

Seeing this, the Insurance Regulatory and Development Authority allowed TPAs to be introduced into the market under license from IRDAI, provided they complied with The IRDAI (Third Party Administrators - Health Insurance) Regulations, 2001 notified on 17th Sept 2001.

Definition

As per Regulations,

"Third Party Administrators or TPA means any person who is licensed under the IRDAI (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

"Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

Thus the scope of TPA services starts after the sale and issue of the insurance policy. In case of insurers not using TPAs, the services are performed by in-house team.

2. Post sale service of health insurance

- a) Once the proposal (and the premium) is accepted, the coverage commences.
- b) If a TPA is to be used for servicing the policy, the insurer passes on the information about the customer and the policy to the TPA.
- c) The TPA enrolls the members (while the proposer is the person taking the policy, members are those covered under the policy) and may issue a membership identification in the form of a card, either physical or electronic.

- d) The membership with the TPA is used for availing cashless facility as well as processing of claims when the member requires the support of the policy for a hospitalization or treatment that is covered.
- e) TPA processes the claim or cashless request and provides the services within the time agreed with the insurer.

The cut-off point from which the role of a TPA begins is the moment of allocation of the policy in the name of the TPA as the servicing entity. The servicing requirement continues through the policy period and through any further period that is allowed under the policy for reporting a claim.

When thousands of policies are serviced, this activity is continuous, especially when the same policy is renewed and the same TPA is servicing the policy.

3. Objectives of third party administration (TPA)

The concept of Third Party Administration in health insurance can be said to have been created with the following objectives:

- a) To facilitate service to a customer of health insurance in all possible manners at the time of need.
- b) To organise cashless treatment for the insured patient at network hospitals.
- c) To provide fair and fast settlement of claims to the customers based on the claim documents submitted and as per procedure and guidelines of the insurance company.
- d) To create functional expertise in handling health insurance claims and related services.
- e) To respond to customers in a timely and proper manner.
- f) To create an environment where the market objective of an insured person being able to access quality healthcare at a reasonable cost is achieved and
- g) To help generate/collate relevant data pertaining to morbidity, costs, procedures, length of stay etc.,

4. Relationship between insurer and TPA

Many insurers utilize the services of the TPA for post-sale service of health insurance policies while few insurers, especially from the life insurance sector also seek assistance of a TPA for arranging pre-policy medical check-up service.

The relationship between an insurer and the TPA is contractual with a host of requirements and process steps built into the contract. IRDAI Health Insurance Standardization guidelines now lay down guidelines and provide a set of suggested standard clauses for contract between TPA and insurance company,

The services that an insurer expects out of the TPA are as follows:

A. Provider networking services

The TPA is expected to build a relationship with a network of hospitals across the country, with the objective of providing cashless claim payments for health claims to the insured persons. The recent guidelines by IRDAI require the relationship to be tri-partite including the insurer and not just between the TPA and the provider.

They also negotiate good scheduled rates for various hospitalization procedures and packages from such network hospitals reducing costs to insureds and also insurers.

B. Call centre services

The TPA is usually expected to maintain a call centre with toll-free numbers reachable at all times including nights, weekends and holidays i.e. 24*7*365. The call centre of the TPA will provide information relating to:

- a) Coverage and benefits available under the policy.
- b) Processes and procedures relating to health claims.
- c) Guidance relating to the services and cashless hospitalization.
- d) Information on network hospitals.
- e) Information on balance sum insured available under the policy.
- f) Information on claim status.
- g) Advice on missing documents in case of claims.

The call centre should be accessible through a national toll free number and the customer service staff should be able to communicate in the major languages normally spoken by the customers. These details are of course governed by the contract between the insurers and their TPAs.

C. Cashless access services

Definition

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

To provide this service, the requirements of the insurer under the contract are:

- a) All policy related information must be available with the TPA. It is the duty of the insurer to provide this to the TPA.
- b) Data of members included in the policy should be available and accessible, without any error or deficiency.
- c) The insured persons must carry an Identity Card that relates them to the policy and the TPA. This Identity Card must be issued by the TPA in an agreed format, reach the member within a reasonable time and should be valid throughout the policy period.
- d) TPA must issue a pre-authorization or a Letter of Guarantee to the hospital based on the information provided for requesting the cashless facility. It could seek more information to understand the nature of illness, treatment proposed and the cost involved.
- e) Where the information is not clear or not available, the TPA can reject the cashless request, making it clear that denial of cashless facility is not to be construed as denial of treatment. The member is also free to pay and file a claim later, which will be considered on its merits.
- f) In emergency cases, the intimation should be done within 24 hours of admission and the decision on cashless communicated.

D. Customer relationship and contact management

The TPA needs to provide a mechanism by which the customers can represent their grievances. It is usual for health insurance claims to be subjected to scrutiny and verification. It is also noted that a small percentage of the health insurance claims are denied which are outside the purview of the policy terms and conditions.

In addition, almost all health insurance claims are subject to deduction on some amount of the claim. These deductions cause customer dissatisfaction, especially

where the reason for the deduction or denial is not properly explained to the customer.

To make sure that such grievances are resolved as quickly as possible, the insurer requires the TPA to have an effective grievance solution management.

E. Billing services

Under billing services, the insurer expects the TPA to provide three functions:

- a) Standardized billing pattern that can help the insurer analyze the use of coverage under various heads as well as decide the pricing.
- b) Confirmation that the amount charged is relevant to the treatment really required for the illness.
- c) Diagnosis and procedure codes are captured so that standardization of data is possible across all TPAs in accordance with national or international standards.

This requires trained and skilled manpower in the TPA who are capable of coding, verifying the tariff and standardizing the billing data capture.

F. Claim processing and payment services

This is the most critical service offered by the TPAs. Claim processing services offered by the TPA to the insurer is usually end-to-end service from registering intimation to processing to recommending approval and payment.

Payment of claims is done through the funds received from the insurer. The funds may be provided to the TPA in the form of advance money or may be settled directly by the insurer through its bank to the customer or to the hospital.

The TPA is expected to keep an account of the monies and provide periodic reconciliation of the amounts received from the insurance company. The money cannot be used for any other purpose except for payment of approved claims.

G. Management Information Services

Since the TPA performs claim processing, all information relating to the claims individually or collectively is available with the TPA. The insurer requires the data for various purposes and such data must be provided accurately and on a timely basis by the TPA.

Thus the scope of a TPA's services can be stated as end-to-end service of the health insurance policies issued by the insurers, could be restricted to few activities, depending on requirements and MOU with particular insurer.

H. TPA Remuneration

For these services, the TPA is paid a fee on one of the following basis:

- a) A percentage of the premium (excluding service tax) charged to the customer,
- b) A fixed amount for each member serviced by the TPA for a defined time period, or
- c) A fixed amount for each transaction of the service provided by the TPA - e.g. cost per member card issued, per claim etc.

Thus through services of TPA, insurers gain access to:

- i. Cashless services
- ii. Data compilation and analysis
- iii. A 24 hour call centre and assistance for the customers
- iv. Network of hospitals and other medical facilities
- v. Support to major group customers
- vi. Facilitation of the claims interaction with the customer
- vii. Negotiation of tariffs and procedure prices with the hospitals
- viii. Technology enabled services to ease customer service
- ix. Verification and investigation of suspect cases
- x. Analysis of claim patterns across companies and provision of crucial information on costs, newer methods of treatment, emerging trends and in controlling frauds
- xi. Expansion of reach of services quickly

F. Claims management - personal accident

1. Personal accident

Definition

Personal accident is a benefit policy and covers accidental death, accidental disability (permanent / partial), Temporary total disability and may also have add-on coverage of accidental medical expenses, funeral expenses, educational expenses etc. depending on particular product.

The peril covered under the PA policy is “Accident”.

Definition

Accident is defined as anything sudden, unforeseen, unintentional, external, violent and by visible means.

Claims manager should mark caution and check following areas on receipt of the notification of the claim:

- a) Person in respect of whom the claim is made is covered under the policy
- b) Policy is valid as on date of loss and premium is received
- c) Loss is within the policy period
- d) Loss has arisen out of “Accident” and not sickness
- e) Check for any fraud triggers and assign investigation if need be
- f) Register the claim and create reserve for the same
- g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

2. Claims investigation

If any red alert is noticed in the claim intimation or on receipt of the claim documents, claim may be assigned to a professional investigator for verification simultaneously.

Example

Examples of red alerts for personal accident claims (for purpose of further investigation, but does not indicate positive indication of fraud or claim being fraudulent):

- ✓ Close proximity claims (claim within a short time of start of insurance)
 - ✓ High weekly benefit amount with longer period of disability
 - ✓ Discrepancy in the claim documents
 - ✓ Multiple claims by same insured
 - ✓ Indication of alcohol
 - ✓ Suspected suicide
 - ✓ Late night Road Traffic Accident while vehicle was being driven by insured
 - ✓ Snake bite
 - ✓ Drowning
 - ✓ Fall from height
 - ✓ Suspected sickness related cases
 - ✓ Poisoning
 - ✓ Murder
 - ✓ Bullet injury
 - ✓ Frost bite disappearance
 - ✓ Homicide etc.
-

The main objectives of investigation are:

- a) Examine the cause of loss.
- b) Ascertain the extent and nature of loss.
- c) Collection of evidence and information.
- d) To ascertain if there is element of fraud or exaggeration of claim amount.

Please note: the objective of investigation is to verify the facts of the case and gather necessary evidence.

It is important that Claims examiner guides the investigator as to the focus of investigation.

Example

Example of case guideline:

Road traffic accident

- i. When did the incident take place - exact time and date place? Date and time
- ii. Was the insured a pedestrian, traveling as passenger/pillion rider or driving the vehicle involved in accident?
- iii. Description on the accident, how did it take place?
- iv. Was the insured under the influence of alcohol at the time of accident?
- v. In case of death, what was the exact time and date of death, treatment provided before death, at which hospital etc?

The possible reason for the accident:

Mechanical failure (steering, brake etc. failure) of the insured's or opponent vehicle, due to any sickness (heart attack, seizure etc.) of the driver of the vehicle, influence of alcohol, bad road condition, weather condition, speed of the vehicle etc.

Some examples of possible fraud and leakage in personal accident claims:

- i. Exaggeration in TTD period.
- ii. Illness presented as accident e.g. backache due to pathological reasons converted into a PA claim after reported 'fall/slip' at home.
- iii. Pre-existing accidents are claimed as fresh, by fabricating documents-Natural death presented as accidental case or pre-existing morbidity leading to death after accident
- iv. Suicidal deaths presented as accidental deaths

Discharge voucher is an important document for settlement of personal accident claim, especially those involving death claims. It is also important to obtain nominee details at the time of proposal and the same should form part of policy document.

3. Claim documentation

Table 2.3

Death claim	<ul style="list-style-type: none"> a) Duly completed Personal Accident claim form signed by the claimant's nominee/family member b) Original or Attested copy of First Information Report. (Attested copy of FIR / Panchnama / Inquest Panchnama) c) Original or Attested copy of Death certificate. d) Attested copy of Post Mortem Report if conducted. e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport / PAN card / Voter's ID / Driving license) for address verification (Telephone bill / Bank account statement / Electricity bill / Ration card). f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized
Permanent Total Disability (PTD) and Permanent Partial Disability(PPD) Claim	<ul style="list-style-type: none"> a) Duly completed Personal Accident claim form signed by the claimant. b) Attested copy of First Information Report if applicable. c) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.
Temporary Total Disability(TTD) Claim	<ul style="list-style-type: none"> a) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer. b) Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Test Yourself 4

Which of the following documents are not required to be submitted for Permanent Total Disability claim?

- I. Duly completed Personal Accident claim form signed by the claimant.
- II. Attested copy of First Information Report if applicable.
- III. Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.

IV. Fitness certificate from the treating doctor certifying that the insured is fit to perform his normal duties.

G. Claims management- Overseas travel insurance

1. Overseas travel insurance policy

Though Overseas travel insurance policy has many sections covering non-medical benefits, its underwriting and claims management has traditionally been under health insurance portfolio because medical and sickness benefit is the main cover under the policy.

The covers under the policy can be broadly divided into following sections. A specific product may cover all or few of the below mentioned benefits:

- a) Medical and sickness section
- b) Repatriation and evacuation
- c) Personal accident cover
- d) Personal liability
- e) Other non-medical covers:
 - i. Trip Cancellation
 - ii. Trip Delay
 - iii. Trip interruption
 - iv. Missed Connection
 - v. Delay of Checked Baggage
 - vi. Loss of Checked Baggage
 - vii. Loss of Passport
 - viii. Emergency Cash Advance
 - ix. Hijack Allowance
 - x. Bail Bond insurance
 - xi. Hijack cover
 - xii. Sponsor Protection
 - xiii. Compassionate Visit
 - xiv. Study Interruption
 - xv. Home burglary

As the name suggests, the policy is intended for people travelling abroad, it is natural that loss would happen outside India and claims would need to be serviced appropriately as and when reported. In case of overseas travel insurance the claim servicing usually involves a **Third Party service provider** (Assistance Company) who has established a network for providing necessary support and assistance all over the world.

Claims services essentially include:

- a) Taking down the claim notification 24*7 basis;
- b) Sending the claim form and procedure;
- c) Guiding customer on what to do immediately after loss;
- d) Extending cashless services for medical and sickness claims;
- e) Arranging for repatriation and evacuation, emergency cash advance.

2. Assistance companies - Role in overseas claims

Assistance companies have their own offices and tie ups with other similar providers world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

- a) Medical assistance services:
 - i. Medical service provider referrals
 - ii. Arrangement of hospital admission
 - iii. Arrangement of Emergency Medical Evacuation
 - iv. Arrangement of Emergency Medical Repatriation
 - v. Mortal remains repatriation
 - vi. Compassionate visit arrangements
 - vii. Minor children assistance/escort
- b) Monitoring of Medical Condition during and after hospitalisation
- c) Delivery of Essential Medicines
- d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.
- e) Pre-trip information services and other services:
 - i. Visas and inoculation requirements
 - ii. Embassy referral services
 - iii. Lost passport and lost luggage assistance services
 - iv. Emergency message transmission services
 - v. Bail bond arrangement
 - vi. Financial Emergency Assistance

- f) Interpreter Referral
- g) Legal Referral
- h) Appointment with lawyer

3. Claims management for cashless medical cases

Claims management approach differs for cashless medical cases, reimbursement medical cases and other non-medical cases. Again, cashless medical claims management differs in US than cashless medical in other countries. We shall now study step by step process

a) Claim notification

As and when loss happens, the patient takes admission into the hospital and shows the insurance details to the admission counter. Assistance Company receives notification of a new case from hospital and/or from patient or relatives/friends. Claim procedure is then explained to the claimant.

b) Case management steps:

These may vary from company to company, common steps are listed below:

- i. Assistance Company case manager verifies the benefits, sum insured, policy period, name of the policy holder.
- ii. Case manager then gets in touch with the hospital to obtain clinical /medical notes for an update on the patient's medical condition, billing information, estimates of cost. Assistance Company receives the clinical notes and estimate of medical cost and send an update to the Insurer.
- iii. Admissibility of the claim is determined and Guarantee of payment is placed to hospital subject to approval from Insurance Company.
- iv. There can be scenario where investigation may be necessary in India (local place of insured) and/or in loss location. Process of investigation is similar to what is explained in personal accident claims section. Investigator abroad is selected with the help of Assistance Company or through direct contact of insurance company.
- v. Assistance Company's case manager continues to monitor the case on a daily basis to provide Insurer with a clinical and cost update, progress notes, etc. in order to obtain authorization for continuation of treatment.

- vi. Once the patient is discharged, case manager works diligently with the hospital to confirm final charges.
- vii. Assistance Company ensures that the bill is properly scrutinized, scrubbed and audited. Any error found is notified to the billing department of the hospital for rectification.
- viii. Final bill is then re-priced as per the rates agreed between the provider and Assistance Company or its associate reprising agent. The earlier the payment assurance made to hospital, better discount through re-pricing is possible.

Re-pricing is typically characteristic of US healthcare and as such, is not applicable for non US cases. This is a major difference between cashless medical case in US and non-US cases.

c) Claims processing Steps:

- i. The claims assessor receives the re-priced/original bill, verifies and ensures that coverage was in place for the dates of service and treatment rendered. The bill received by the Assistance Company is audited by the claims department to ensure the charges are in line and as per the treatment protocol. The discount is re-confirmed and the bill is processed.
- ii. The bill is then sent to Insurer for payment accompanied by re-pricing notification sheet and explanation of benefits (EOB).
- iii. Insurance company receives the bill and authorizes immediate payment to Assistance Company.

d) Payment process steps:

- i. Assistance Company receives authorization from Insurer to release payment to the hospital via local office.
- ii. The finance department releases the payment

e) Hospitalization Procedures

- i. The system in overseas countries, especially US and Europe are quite different from the hospitals in India since majority of population has universal health coverage either through private insurance or through government schemes. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

In most countries treatment is not delayed for want of confirmation of insurance coverage or cash deposit.

Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

If payment is immediate, hospitals tend to offer very high discounts for immediate payment. Re-pricing agencies generally negotiate with hospitals for discounts for early settlement of hospital bills.

- ii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.
- iii. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.
- iv. Hospitals usually contact the assistance companies/insurers on the call centre numbers to check the validity of the policy and verify coverage's.
- v. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.
- vi. Some basic information required by the insurer/assistance provider to determine admissibility are
 - 1. Details of ailment
 - 2. In case of any previous history ,details of hospital, local medical officer in India:
 - ✓ Past history, current treatment and further planned course in hospital and request for immediate sending of
 - ✓ Claim form along with attending physicians statement
 - ✓ Passport copy
 - ✓ Release of medical information form

f) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made through cheque or electronic transfer.

- i. **Personal accident claims** are processed in similar fashion as explained in personal accident claims section.
- ii. **Bail bond cases and financial emergency cases** are paid upfront by Assistance Company and later claimed from insurance company.
- iii. **Claims repudiation** of untenable claims follows the same process as for all other claims.

g) Claim documentation for Medical Accident and Sickness Expenses

- i. Claim form
- ii. Doctor's report
- iii. Original Admission/discharge card
- iv. Original Bills/Receipts/Prescription
- v. Original X-ray reports/ Pathological/ Investigative reports
- vi. Copy of passport/Visa with Entry and exit stamp

The above list is only indicative. Additional information/documents may be required depending on specific case details or depending upon claim settlement policy/procedure followed by particular insurer.

Test Yourself 5

_____ are paid upfront by Assistance Company and later claimed from insurance company.

- I. Bail bond cases
- II. Personal accident claims
- III. Overseas travel insurance claims
- IV. Untenable claims

Summary

- a) Insurance is a 'promise' and the policy is a 'witness' to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise.
 - b) One of the key rating parameter in insurance is the claims paying ability of the insurance company.
 - c) Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.
 - d) In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer / TPA and later submits the documents for settlement of the claim.
 - e) In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer / TPA for payment.
 - f) Claim intimation is the first instance of contact between the customer and the claims team.
 - g) If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/TPA or be entrusted to a professional investigation agency.
 - h) Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.
 - i) In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer forums or even the legal authorities.
 - j) Frauds occur mostly in hospitalization indemnity policies but Personal accident olicies also are used to make fraud claims.
 - k) The TPA provides many important services to the insurer and gets remunerated in the form of fees.
-

Self-Examination Questions

Question 1

Who among the following is considered as primary stakeholder in insurance claim process?

- I. Customers
- II. Owners
- III. Underwriters
- IV. Insurance agents/brokers

Question 2

Girish Saxena's insurance claim was denied by insurance company. In case of a denial, what is the option available to Girish Saxena, apart from the representation to the insurer?

- I. To approach Government
- II. To approach legal authorities
- III. To approach insurance agent
- IV. Nothing could be done in case of case denial

Question 3

During investigation, of a health insurance claim presented by Rajiv Mehto, insurance company finds that instead of Rajiv Mehto, his brother Rajesh Mehto had been admitted to hospital for treatment. The policy of Rajiv Mehto is not a family floater plan. This is an example of _____ fraud.

- I. Impersonation
- II. Fabrication of documents
- III. Exaggeration of expenses
- IV. Outpatient treatment converted to in-patient / hospitalization

Question 4

Under which of the following condition, is domiciliary hospitalization is covered in a health insurance policy?

- I. The condition of the patient is such that he/she can be removed to the Hospital/Nursing Home , but prefer not to
- II. The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein
- III. The treatment can be carried out only in hospital/Nursing home

IV. Duration of hospitalization is exceeding 24 hours

Question 5

Which of the following codes capture the procedures performed to treat the illness?

- I. ICD
 - II. DCI
 - III. CPT
 - IV. PCT
-

Answers to Self-Examination Questions

Answer 1

The correct option is I.

Customers are primary stakeholder in insurance claim process

Answer 2

The correct answer is II.

In case of insurance claim denial, individuals can approach legal authorities.

Answer 3

The correct option is I.

This is an example of impersonation, as the person insured is different from person treated.

Answer 4

The correct answer is II.

Domiciliary treatment is provided in health insurance policy, only when the patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

Answer 5

The correct option is III.

Current Procedure Terminology (CPT) codes capture the procedures performed to treat the illness.

CHAPTER 8

HEALTH INSURANCE SELLING PROCESS

Chapter Introduction

This chapter aims to provide an understanding of the insurance sales process and its various steps.

Learning Outcomes

A. Sales process

After studying this chapter, you should be able to:

- a) Explain the various stages involved in the sales process
- b) Understand the policy delivery procedure
- c) Know the importance of ensuring policy renewal

A. Sales process

Every one of us is engaged in selling almost from the day we were born. Even as babies, we influence our parents by crying when we want something and laughing happily to please them. Each day we try to persuade, influence and convince one another to do (or not to do) things in the way we want. However this does not mean that we are all sales professionals.

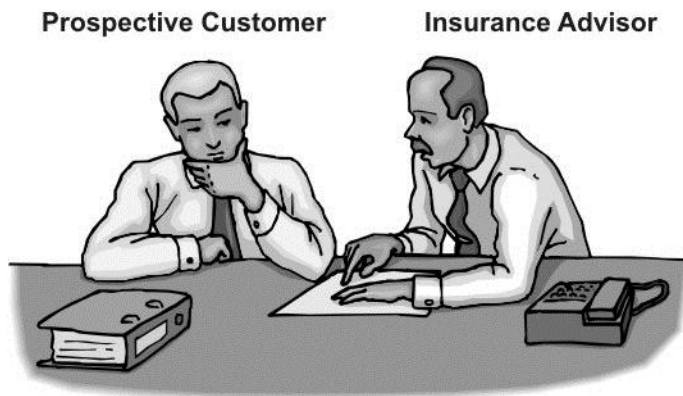
Definition

Selling as a profession refers to the act of completing a commercial transaction through inducing the purchase of a product or service, such act being carried out with the intent of earning remuneration.

The salesperson thus seeks to make a livelihood out of selling.

Insurance agents are sales persons who seek to influence members of the community to buy insurance contracts offered by the insurance company that they represent. The remuneration they enjoy in return is known as a commission.

Diagram 1: Insurance sales



Types of sales in other industries and health insurance

While all selling involves influencing someone to buy, the nature of the sales process can differ from industry to industry and would depend on the nature of the product and the industry. The sales person's role also consequently changes.

Example

- i. **Fast Moving Consumer Goods (FMCG):** are typically mass marketed through malls and other retail sales outlets. A product like soap, for example, is promoted through mass media (particularly ads in TV and other visual media) and the customer asks for it at a retail outlet (e.g. a shopkeeper or mall).
 - ii. **Showroom sales:** A car in a show room costs much more than a bar of soap and the buyer has to be naturally careful when taking a decision to buy. The sales person does not go to the prospect but instead it is the prospect who visits the showroom. The sales person has to win the prospective customer's confidence and make a convincing case for purchase of the car. The role is essentially to convert an enquiry into a sale.
 - iii. **Medicines and Drugs:** are usually brought from a chemist after being prescribed by a doctor. Medical Representatives of pharmaceutical companies visit doctors' clinics to sell their company's products and their features to the doctor. Here the target of sales efforts is a medical expert who prescribes the brand for the end buyer who buys it from the pharmacy. The salesman's role is basically sharing hard medical information with a professional.
 - iv. **Business to Business (B2B sales):** Here the customer is another firm. The decision to buy may be taken by multiple individuals and often it is a panel who decides. Purchase is typically through floating a tender and the selection criteria are fixed and measurable. Decisions are taken on the basis of careful consideration and evaluation of alternatives. The sales person's role is to effectively demonstrate how the product and company meets the buying criteria and is also better than the competition. It requires presentation skills, building good relations with multiple players and being sensitive to feedback and information that can help clinch the deal.
-

There are two points which distinguish any type of insurance selling from other products and industries:

- i. Firstly it is said that '**insurance is sold, not bought**'. In case of many other products, the prospect has a need for the product and initiates the enquiry. In the case of insurance, it is typically the sales person who has to go to the prospect and induces the need to buy.
- ii. The second major difference is that in insurance, unlike most other products, one is **not selling any tangible product but only an idea**. The prospect cannot see, feel, touch or operate the product. The insurance product is only a promise that can be experienced only in the future. And, it is quite possible that the buyer may never get to see the promise in action if there is no claim.

The role of the insurance salesman is to sell this promise and relate to the prospective customer in such a way as to win trust and confidence about the fulfilment of the promise far into the future. The element of person to person, eye to eye selling is perhaps far more in insurance than any other business. It is one of the reasons why insurance is considered difficult to sell. It is also for this reason that some of the world's greatest and best known salesmen won their wings in the insurance industry.

Sales Process

Selling is both an art and a science. It is an art in the sense that every sales person brings his own distinct style in the way he communicates, builds rapport and relations with prospective customers, engages in fact finding and presents solutions. Does this mean that only a few individuals who have these distinctive skills can succeed?

It is true that sales people may differ much in style and skills and their chances of success may vary. Some of them may be able to quickly make contacts with a lot of prospects and convert them effectively into customers in a short time. Others may be slower to learn and may move more slowly. The truth one needs to know is that **so long as one does not give up or slacken but persists on the path, even when there are failures, the law of averages would come to one's aid.**

What is this law? It means that if a sales person on average is able to convert one out of every twenty or thirty persons contacted into a customer, he or she simply needs to adopt a standard process and keep contacting more and more persons without giving up. The customer base will begin to build over time. Some sales persons may take longer than others but success is sure. Persistence and perseverance is what pays off in the business.

This brings us to the importance of adhering to a well-defined sales process with clearly sequenced steps. Let us outline the steps:

Diagram 2: Sales Process



Let us look at each of these processes in some detail.

1. Step I: Prospecting (To identify and build up a list of prospects)

Prospects are people to whom you can sell your products. Prospecting is the process of gathering names of people whom one can approach to secure a sales interview. Continuous prospecting is absolutely vital to a successful sales career.

The key to effective prospecting is to target particular markets where you will be calling on people who have one or more characteristics in common. By cultivating strong relationships with these people, you can get them interested in the products you sell immediately, making the process of prospecting much easier. Let us look at some of these markets.

a) Immediate group

The easiest people to approach would be one's family and friends. You know the needs of these people and would be able to approach them on a favourable basis. Also relatively easy to approach are people with whom you do business; people who work in the food stores, clothing stores, banks, etc. Other such people would be those who know you such as friends, acquaintances, people who belong to the same organisations, and so forth. They are people who should at least grant you an interview if you contact them.

b) Natural market

A second source of contacts is the natural market. This consists of people who may not be part of one's immediate circle of relatives, friends and other acquaintances but one is in a position to know and get acquainted with them because of sharing something in common with these people. If you just look around you would see many groups who may form part of your natural markets:

- ✓ members of a caste or community association;
- ✓ members of a church congregation or a Satsang group;
- ✓ members of a parents - teachers association (PTA);
- ✓ members of a cultural association or a temple festival committee or a trade union

c) Centres of influence (COIs)

One way to get to a large number of prospects is by taking help from people who are visible and influential leaders and whose words are valued by others. We are referring to centres of influence - community leaders, social and political workers, professionals like Chartered Accountants or Lawyers or well-known businessmen.

The secret is to secure this person as a satisfied client whom you have served well and then to seek his or her help to find other new prospects. Even if he or she is not yet your client, it is enough he or she should know about your dedication and passion to help other people and should be confident about your knowledge and sense of professionalism. Another important condition is that he or she should like you and be interested in helping you.

d) References, introductions and testimonials

Just as you can tap a centre of influence, you can also seek the help of other satisfied customers as well as prospects who have not yet bought or may not buy from you for some reason, but still have been impressed and favourably disposed to you by your dedication and professionalism.

- i. A **reference** is a name of another potential prospect which is provided as a lead, by your client or prospect or centre of influence or any other person, whom you may be able to support with your solutions.
- ii. **Introduction:** An even better way may be to ask for an **introduction**. Here the salesperson asks for a small letter of introduction or a note to the person referred. Typically one could ask for a visiting card at the back of which or attached to which, a small note may be added, introducing one to the referred person.

The best form of introduction would of course be where one's benefactor picks up the phone and calls his or her contact to introduce the agent, intimating that she would be contacting that person shortly. One's chances of success would multiply, especially if the person who refers is one whose word is respected and taken seriously.

- iii. A **testimonial** is a kind of statement which one may seek from a satisfied customer, affirming that the latter has done business with the salesperson and has been very satisfied with the services and solutions rendered. It is a kind of vouching for the sales person's credentials. A testimonial would be very relevant when one is dealing with a circle of professionals who want adequate proof about the sales person's professional credentials.

e) Other service providers

There is a whole range of service providers who are not your competitors. They may include laundry men, real estate agents, lawyers, shop keepers, doctors and others whose services are regularly needed and sought by members of the lay public. The basic principle applied here is that of reciprocity. The agent agrees to be the eyes and ears for the other party, and in turn gets them to make him/her visible and recommended.

Good agents use this source very effectively. Indeed if you were to make a visit to your milkman or laundryman, you may see a sign board asking one to contact so and so, with a contact number, for all one's insurance needs.

f) Conducting seminars and events

This is a professional, efficient method of selling, on a group basis. You can use it to attract both new and existing customers alike. If you are already dealing with existing customers, you can always ask them to invite a friend or partner along with them. Advertisements in the area of the seminar can also increase the numbers. However, it may not be easy or even viable to conduct seminars and events on a regular basis without the support of one's own organization.

g) Information pieces, newsletters, blogs and web based networking

The coming of computers and internet has made this world a smaller place. It is now possible to reach a much wider, in fact, a worldwide audience through this medium.

i. Email

One way to get your message and presence registered in the minds of a large number of prospects is to send them information by mail or hand drops on a regular basis. This can be done almost free of charge today in the form of e-mails.

ii. Newsletter

Another way to communicate regularly is through a newsletter. In both cases, the purpose is to inform readers about various subjects in the form of well-informed write ups. In designing newsletters you can involve some of your important customers and prospects, especially if their views are sought by members of their network.

iii. Personal website or blog

Yet another approach is to have a presence on the worldwide web in the form of a personal website. It may be a little expensive to begin with but it is a good way for getting across to a wide circle of individuals who today spend a lot of their time in cyber space.

iv. Social networking sites

Finally there is Facebook and WhatsApp and other similar social networking sites and apps where you can access millions of others almost anywhere in the world.

h) Cold calling

This approach is used by many sales people in many different industries, not just financial services. This is where you can make approaches to people or companies unannounced. It is tough and you have to be able to accept rejection, but it can be a very quick way of gathering names and getting to see people. A good number of top sales people allocate some of their time to cold calling simply because it works.

i) A prospects file

It is most important that you establish a prospect file. This is simply a book or register or database containing all the vital information about each of your prospects with details and date when the prospect should be called on. A prospect file is an ever-changing tool. New names must be added continuously on a daily basis and old names must be discarded if the individual is not receptive to your sales efforts. You must make sure that you have enough prospects to call on each day.

2. Step II: The pre-interview approach

Qualifying every prospect in the prospects' list and getting appointments is the next step.

Definition

"Qualified" prospects are those people

- ✓ who can pay for insurance,
- ✓ who can pass the company underwriting requirements,
- ✓ who have one or more needs for insurance products, and
- ✓ who can be approached on a favourable basis

You need to gather enough meaningful information on each name in your prospect list before you can call on them. The process is called qualifying the prospect.

It is important to collect as much relevant information as possible so as to proactively ensure that one's efforts are in the desired direction. This also enables you to convince the prospect that you do possess necessary knowledge and skills to meet his or her particular needs, thus making a favourable impression.

The initial contact can be made through a letter, by telephone or e-mail, or in a face-to-face meeting. Whatever method is used, the objective is the same: to get the prospect to consent to an interview where you can understand his or needs and in turn get an opportunity to explain the service that you have to offer.

In order to do this, your pre-approach communication should include:

- ✓ Something that will arouse the prospect's interest
- ✓ Offering of a valuable service
- ✓ Making it clear that no commitment is being made
- ✓ Use of a third party influence, if possible
- ✓ Use of alternatives in order to get an affirmative response
- ✓ Obtaining a definite appointment

It is important that during your first contact with the client, you introduce yourself in a manner that can generate rapport and also some trust and a feeling of comfort.

3. Step III: The sales interview:

After being successful in obtaining an interview, it is vital to conduct it in a systematic and professional manner. The first step is to make a proper approach which automatically and smoothly leads to the fact finding part of the sales interview. The approach basically consists of an introductory conversation in the course of which you are able to identify one or more needs of the prospect. The next step is to get the latter to agree that these are significant needs for insurance protection. Once there is mutual agreement on this, one can move forward.

In a technique called **need gap analysis** one engages in a process of gathering detailed information about the prospect's insurance requirements, to identify and determine the assets and perils for which there is inadequate coverage. The objective here is to collect as much additional information about the prospect as possible. This additional information helps to identify specific needs of the prospect in a more rational way, to suggest solutions to those needs, and to help the prospect find the money to pay the premiums, if required.

When a person has no health cover, it may be easy to induce him to buy a hospitalization indemnity policy for himself and perhaps for his family too. But when he is already covered by his employer for a sum insured of Rs. 3 Lacs while he would want to increase it to Rs. 5 Lacs, the agent could bridge this need gap with a Top-up cover of Rs. 2 Lacs. He may also seek to cross-sell the prospect with a personal accident policy too.

When dealing with a new client, it is often wiser to take a soft sales approach and expect a longer sales cycle. Often, the first step is simply education, as many prospects will find health plans complex and confusing. This may be done even as you find out the prospect's insurance needs. Pointing out the high and rising medical costs of today, chances of people living longer and the increased need for medical care at least during old age, will make prospects more ready to be educated about health insurance.

The above broadly covers all the foreseeable needs and substantially defines the ambit that an insurance salesperson can address.

4. Step IV: Designing the solution

After completing the previous steps, you should know enough about the prospect to design and recommend a solution that is best for him or her at this point in time given all of his or her financial circumstances. In many cases, especially if the problems and

solutions are of a simple nature, you would be able to recommend a solution and move on to closing the sale in one interview.

In other cases, where the situation is more complicated, you may need to spend some time in your office for developing the proper solution, then return to the prospect and make your recommendation in a second interview.

If you attempt to conduct the fact-finding session and present your solution all in one interview, you must be prepared to build a bridge from the fact-finding phase to the solution and recommendation phase. This requires identifying the prospect's most critical need, pointing out that need and getting an affirmative reaction from the prospect that this is indeed a very important need in his or her mind. You would then be in a position to present our prospect with a solution to the problem.

Typically one should conclude the initial fact finding interview with a promise to return soon with appropriate solutions to the prospect's identified needs. One should then return to one's office where one can analyse the prospect's problems in depth, design one or more solutions to these problems, prepare one's proposals and recommendations which would lead to the sale, then make an appointment with the prospect for the second interview.

There is no specific rule which states the number of interviews one must have with the prospect. It will depend from case to case. There may be situations where you may have to conduct more interviews to develop a satisfactory solution and also win the prospect's consent to listen to the solution and consider it.

5. Step V: Presenting the solution

The most important point to remember when presenting your solution is to be thoroughly prepared. Prior to making your proposal you may need to review the prospect's needs in detail, go over your solution one final time, and plan to make your presentation so that it will appeal to your prospect's buying motives. You would also want to anticipate what objections the prospect might raise to our proposal.

It is necessary to arrange for presenting your proposal to the prospect, at a time and place that will be free from interruptions and distractions. As you begin presenting your solution, you must put the prospect at ease while at the same time making sure that he or she understands that this is a decision-making session.

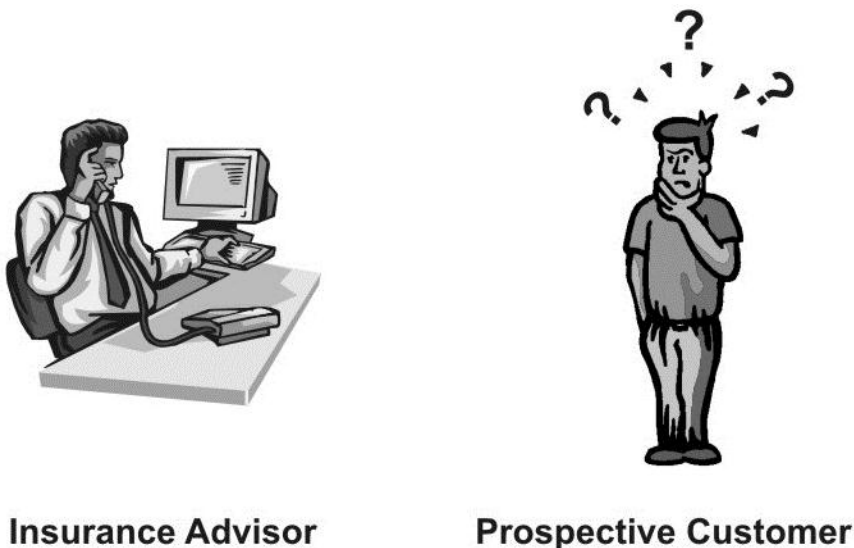
You need to begin by reviewing all the data you obtained in the fact-finding session and stating each of the prospect's problems in an affirmative manner. You must ensure that you convey to your prospect that you have spent a lot of time reviewing his / her situation, and that you are quite confident your recommendations are the best possible solutions to these problems.

Since health insurance plans may be confusing to the prospect, it may be advisable to present a limited number of policy choices that have distinct differences between them. You can provide other options later if necessary, but make the first choice simple. Using a simple diagram or flow chart may be useful and so also presenting the prospect with a prospectus detailing the plan.

It is very important that you relate each feature of your recommendation to some particular benefit which the prospect will gain from, if he or she buys your proposal. Rather than describing what you have to offer in technical terms, you should explain how the prospect will be getting what he or she wants and needs.

6. Step VI: Handling objections (if any)

Diagram 3: Handling objections



The list of possible objections is a long one. It ranges from prospect being busy, not interested, thinks he has all the insurance he needs, already has an agent he deals with, has no money etc.

Finally there is the prospect who may agree with all that you say and have no objections, but decides to buy the product solutions from someone else. In all instances it means that the prospect does not have sufficient information to help him make the decision to buy from you.

If a prospect is “too busy now,” it means you have not provided information that could trigger his interest or overcome his wariness of being ‘sold to’. Similarly the objection of “no money” can mean that he is not convinced adequately about why and how he

can pay for the insurance. If he does not trust you, it is because you have not communicated enough information to overcome his doubts.

The least a salesperson can do is to accept and take responsibility for the fact that he has not adequately done the job of giving the prospect the information he wants to hear; and see if there is anything he can do about it. Whatever the type of objection, one can handle it with this approach. The idea is not to treat it as a battle between you and the prospect where you win and he loses, but a discussion in which your sharing of what you know helps to convince him about the importance of meeting and buying from you.

a) Handling objections through LAPAC

One of the important techniques that one can use for handling objections is known as **LAPAC (Listen, Acknowledge, Probe, Answer and Confirm)**. This method can be used to deal with objections at any stage of the sales process. It respects the prospect's point of view, shows that you are listening and persuades rather than attacks the prospect. Let us look at its elements:

i. Listen

Actively pay attention to all statements and gestures. This becomes important especially to know what the underlying concern is. Sometimes the prospect may need to be gently probed with questions to clarify the issue.

Example

Try to understand what the term 'no money' means.

- ✓ Is it that there is no money now or
 - ✓ Is it that the price is too high to buy it or
 - ✓ Is it that the prospect does not feel that the money is worth spending?
-

ii. Acknowledge

It is very important to affirm aloud so that both the prospect and the salesperson are on the same page. Acknowledgement is also linked to another very critical act, namely empathizing with the prospect. Empathy does not mean that one necessarily agrees with the position taken by the other party. But it certainly means that one respects and tries to see it from the other person's point of view.

Example

Once you are able to see the prospect's reluctance to spend the money, you must express that you can see and understand how he feels. Probably you have faced a similar situation and some sharing on your part could demonstrate your understanding of what the other party is going through.

iii. Probe

This step is intended to seek more information about the prospect's concern area. Remember that if the prospect has a problem in buying, that problem or set of problems have to be sorted out by the prospect himself, either by making a change in his thinking and mindset or his action.

Example

If the prospect is too busy, he / she must find the time and inclination to meet you. If money is the problem, he / she needs to find ways to generate it.

Probing can do two things. If done in a counseling oriented and friendly manner, a set of gentle questions could guide the prospect towards finding answers to his / her own concerns. Probing can also help to elicit further details of the problem situation which causes the objection. Such information could be important and cannot be overlooked when one is answering the objection.

iv. Answer

The task here is to obviously provide a carefully worded reply that suits the situation and is convincing to the prospect. Answers must be directed at and address the concerns that are raised. They must not be evasive or seek to deflect the concerns.

v. Confirm

The last step is to confirm whether the prospect is satisfied with the answer and if there is anything else to be known. If the body language and other signals make you feel that the prospect is not fully convinced, you may need to offer alternative options that he could consider. Getting this confirmation is very important because once a prospect says he / she is satisfied, the ground is laid for moving to the close of the sale.

7. Step VII: Closing the sale

Definition

Closing is the process of persuading the prospect to buy now. The key to successful closing lies in helping the prospect to want to say "yes".

We begin by summarising the presentation, making sure that the prospect understands exactly what the proposal is, and then leading the prospect into an affirmative answer. At this point, when we know that the prospect understands the proposal and is in an affirmative mood, we can conduct a definite close.

a) Closing methods

i. Implied consent

One approach often used is the "implied-consent" method. We simply start filling out the application asking a simple question such as "now, your last name is spelled as _____". If the prospect does not stop us, the sale has probably been made.

ii. Offering alternatives

Another closing method is to offer the prospect an alternative between two minor decisions, either of which would lead to a close. For example, we may ask the prospect if she would prefer to take the individual policy or the floater policy. Here assumed consent is combined with a seemingly minor decision.

While making a close it is important that one should not try high pressured tactics to make a prospect buy something for which there is no real need or where the prospect cannot afford what is being recommended. Such practices of selling are unethical.

In other cases where one is persuading the prospect to take positive action, we must be aware that we are actually rendering an important service to the prospective customer, which the latter would eventually recognise and appreciate.

8. Step VIII: Sales follow-through

Between the time that the proposal is submitted and the policy is completed and delivered, the four most important responsibilities of the agent are:

- i. to see that the proposal is clear, complete and accurate
- ii. to be actively involved in making sure that any further investigations that are required gets completed in a convenient and timely manner

- iii. to ensure that the client's advisors, such as accountants or attorneys, are treated in the same manner that our client is treated and that we do not invade their areas of expertise, and
- iv. to make sure that all questions and requests are promptly followed up.

9. Step IX: Policy delivery

Delivering the policy is an extremely important step in the insurance sales cycle. It provides the agent with the opportunity to perform four important functions:

- i. To resell and reaffirm the need
- ii. To get the client thinking about the next purchase
- iii. To get referrals and
- iv. To build prestige

a) Policy delivery procedure

As with the sales process, a proper policy delivery requires a structured, step-by-step procedure such as:

- i. Checking the entire policy for accuracy
- ii. Preparing the policy and the policy docket, if available
- iii. Telephoning the client for an appointment
- iv. Thoroughly preparing for the delivery interview
- v. Congratulating the client for purchasing the insurance
- vi. Explaining the features, advantages, and benefits of the policy. Relate all benefits to the client's actual situation using names of family members, motivational stories, etc.
- vii. Preparing the client for the next sale. Remind the client of the needs that have not yet been covered. Tell him or her of the need to periodically review these
- viii. Committing sincerely to the client's service. Tell the client that you will contact him / her regularly and that he / she should call you immediately if there are any questions or problems
- ix. Asking the client for referred leads

10. Step X: Commitment to service

Service on the part of the agent is an integral element of the sales cycle. Essential to a commitment to service is a structured program for maintaining contact with clients. Such a program could consist of:

a) Conveying clearly

At the time of the policy delivery, you need to make a service commitment to your client. We should tell the client that at least once a year you will call to carefully review his / her insurance program. Many good agents set the exact date for this service call before leaving the delivery interview.

b) Committing to continuous contact

Throughout the year a good agent should keep in touch with the client in as many ways as possible. The agent may want to send greeting cards on birthdays, wedding anniversaries, etc. A small gift that is personal and useful may be sent from time to time. Newspaper clippings, insurance related items, picture postcards when on trips, are all tokens of the agent's thoughtfulness and may be sent to the client on a random basis.

c) Annual service review plan

At least once a year, one must schedule an annual service review with the client. You should schedule this service call well in advance. During the annual service review, one can take the opportunity to remind the client why he / she purchased his / her latest policy, may discuss any needs of the client which are yet unfulfilled, and if appropriate, can suggest to the client that additional insurance be purchased at this time to cover his / her outstanding needs.

Continuous renewal

One of the important reasons for having a proper sales and service follow up is to ensure that the policy holder continues to renew the policy annually.

When policies are not renewed, the company loses, because heavy costs that have been incurred at the time of acquiring new business may not have been recovered. More significantly, it is also often a symptom of dissatisfaction and loss of confidence of the insured with the insurer. If the agent does not take care of his or her client, both during the sales and post sales stages, such dissatisfaction can soon lead to loss of credibility of both the agent and the company he or she represents. Hence it is very necessary to carefully monitor policy renewal ratio as it is a sure sign of the health of the company.

Continuous service is also of the greatest importance and can never be ignored. It is one of the critical keys to high renewal business. All people, particularly in insurance sales, always need to remember that while their purpose is to provide a need based solution to the customers they must also sincerely commit to a continuous service that cannot be matched by any other competitor.

Test Yourself 6

Which of the below statement best describes a “testimonial”?

- I. An endorsement from a satisfied customer
 - II. Test result for a product in a benchmarking test
 - III. List of tests that a product must pass
 - IV. Money required to test a product
-

Summary

- a) Selling as a profession refers to the act of completing a commercial transaction through inducing the purchase of a product or service, such act being carried out with the intent of earning remuneration.
- b) Insurance agents are sales persons who seek to induce members of the community to buy insurance contracts written by the insurance company that they represent.
- c) Prospecting is the process of gathering names of people who can be approached for a sales interview.
- d) Target markets for prospecting include:
 - ✓ Immediate group
 - ✓ Natural market
 - ✓ Centres of influence
 - ✓ References, introductions and testimonials
 - ✓ Other service providers
- e) A professional, efficient method of selling on a group basis includes conducting seminars and events.
- f) An easy and viable means of reaching out to prospects on a mass scale include emails, newsletters, personal website or blog, social networking websites etc.
- g) "Qualified" prospects are those people:
 - ✓ who can pay for insurance,
 - ✓ who can pass the company's underwriting requirements,
 - ✓ who have one or more needs for insurance products, and
 - ✓ who can be approached on a favourable basis
- h) During a sales interview with the prospect; the agent should do a need gap analysis
- i) In need gap analysis we engage in a process of gathering detailed information about the prospect's insurance requirements, to identify and determine the assets and perils for which there is inadequate coverage.
- j) After completing the sales interview successfully, the agent should design a solution based on the prospect's need and present the solution.
- k) The agent may handle client objections using the LAPAC (Listen, Acknowledge, Probe, Answer and Confirm) approach.

- l) Closing a sale involves persuading the prospect to buy now. While closing the agent may use the 'implied consent' method or offer alternatives to the prospect.
 - m) Once the sale is closed, the agent should do a sale follow-through and deliver the policy
 - n) Service on the part of the agent is an integral element of the sales cycle. Essential to a commitment to service is a structured program for maintaining contact with our clients.
-

Key Terms

- 1. Selling as a profession
 - 2. Sales process
 - 3. Prospecting
 - 4. Natural market
 - 5. Centres of influence
 - 6. Reference
 - 7. Testimonial
 - 8. Qualified prospects
 - 9. Need-gap analysis
 - 10. LAPAC (Listen, Acknowledge, Probe, Answer and Confirm)
 - 11. Closing
 - 12. Implied consent
-

Answers to Test Yourself

Answer 1

The correct answer is I.

A testimonial is an endorsement from a satisfied customer.

Self-Examination Questions

Question 1

The key to successful closing lies in helping the prospect to say _____.

- I. No
- II. Don't know
- III. Yes
- IV. Maybe

Question 2

Which of the following is not part of sales process?

- I. Prospecting
- II. Sales interview
- III. Loss assessment
- IV. Closing

Question 3

Prospecting in an insurance sale is _____.

- I. Gathering the names of people who may be interested in insurance
- II. Preparing a list of all the persons in the city
- III. Enlisting all the policyholders of the branch office
- IV. Preparing list of all the agents in the neighbourhood

Question 4

In insurance, need gap analysis involves _____.

- I. Identifying the areas where the prospect needs insurance protection
- II. Identifying people to work as insurance agents
- III. Identifying how much assets a prospect has
- IV. Identifying the poverty level of the prospects

Question 5

Cold Calling is _____.

- I. Meeting customers in winter
- II. Meeting customers when they are suffering from cold
- III. Meeting people unannounced
- IV. Meeting customer after fire was extinguished

Question 6

_____ as a profession refers to the act of inducing a commercial transaction through inducing the purchase of a product or service, such act being carried out with the intent of earning remuneration.

- I. Marketing
- II. Selling
- III. Advertising
- IV. Promotion

Question 7

Which of the below statement is correct?

- I. Insurance is sold, not bought
- II. Insurance is bought, not sold
- III. Insurance is neither bought nor sold; it is a necessity and hence should be bought by every individual.
- IV. None of the above

Question 8

Which of the below statement is correct?

- I. Selling is an art and not a science
- II. Selling is a science and not an art
- III. Selling is neither an art or a science
- IV. Selling is both an art and a science

Question 9

While prospecting for selling insurance, approaching the members of a caste or community association will be classified under which category?

- I. Immediate group

- II. Natural market
- III. Centres of influence
- IV. References and introductions

Question 10

Identify the incorrect statement with regards to a 'qualified' prospect.

- I. A qualified prospect is one who can pay for insurance
 - II. A qualified prospect is one who can be approached on a favourable basis
 - III. A qualified prospect is one who is academically well qualified to buy insurance
 - IV. A qualified prospect is one who can pass the company underwriting requirements
-

Answers to Self-Examination Questions

Answer 1

The correct option is III.

The key to successful closing lies in helping the prospect to say "Yes".

Answer 2

The correct option is III.

Loss assessment is not a part of the sales process.

Answer 3

The correct option is I.

Prospecting in an insurance sale is gathering the names of people who may be interested in insurance.

Answer 4

The correct option is I.

Need-gap analysis involves identifying the areas where the prospect needs insurance protection.

Answer 5

The correct option is III.

Cold calling involves meeting people unannounced.

Answer 6

The correct option is II.

Selling as a profession refers to the act of inducing a commercial transaction through inducing the purchase of a product or service, such act being carried out with the intent of earning remuneration.

Answer 7

The correct option is I.

The correct statement is “Insurance is sold, not bought”.

Answer 8

The correct option is IV.

Selling is both an art and a science.

Answer 9

The correct option is II.

While prospecting for selling insurance, approaching the members of a caste or community association will be classified under natural market category.

Answer 10

The correct option is III.

Option III is incorrect.

In insurance, while qualifying prospects, their academic qualification does not have much role to play with the decision for buying insurance.

CHAPTER 9

CUSTOMER SERVICE AND PROTECTION OF CUSTOMERS' INTERESTS

Chapter Introduction

In this chapter you will learn the importance of customer service and the role of agents in providing service to customers. You will also get to know how to communicate and relate with the customer.

This chapter will also educate you about the different measures taken by the regulator and the government to protect customers and the grievances redressal mechanisms available to Insurance policyholders.

Learning Outcomes

- A. Customer service - General concepts
- B. Insurance agent's role in providing great customer service
- C. Communication process
- D. Non-verbal communication
- E. Ethical behaviour
- F. Protection of policyholders' interests
- G. Grievance redressal

After studying this chapter, you should be able to:

1. Appreciate the importance of customer services
2. Describe quality of service
3. Examine importance of service in the insurance industry
4. Discuss the role of an insurance agent in providing great service
5. Explain the process of communication
6. Demonstrate the importance of non-verbal communication
7. Recommend ethical behaviour
8. Discuss how policyholders' interests are protected
9. Review grievance redressal mechanism in insurance

A. Customer service - General concepts

1. Why Customer Service?

Customers provide the bread and butter of a business and no business can afford to treat them in a casual way. The role of customer service and relationships is far more critical in the case of insurance than in other products.

This is because insurance is a service and very different from real goods.

Let us examine how buying health insurance differs from purchasing a car.

A Car	Health Insurance
It is a tangible good that can be seen, felt, test driven and experienced.	It is a contract to compensate for expenses during hospitalization due to an unforeseen event like an illness or an accident in the future. One cannot see or touch or experience the insurance benefit till the unfortunate event occurs.
The buyer of the car has an expectation of some pleasure at the time of purchase. The experience is real and easy to understand.	The purchase of insurance is not based on expectation of immediate pleasure, but fear/anxiety about a possible tragedy. It is unlikely that any insurance customer would look forward to a situation where the benefit becomes payable.
A car is produced in a factory assembly line, sold in a showroom and used on the road. The three processes of making, selling and using usually take place at three different times and places.	In case of insurance it can be seen that production and consumption happen simultaneously. This simultaneity of <i>production and consumption</i> is a distinctive feature of all services.

In the case of insurance, what the customer really derives is a service experience. If this is less than acceptable, it causes dissatisfaction. If the service exceeds expectations, the customer would be delighted. The goal of every business should thus be to delight its customers.

2. Quality of service

It is necessary for insurance companies and their personnel, which includes their agents, to render high quality service and delight the customer.

But what is high quality service? What are its attributes?

A well-known model on service quality [named “**SERVQUAL**’] would give us some insights. It highlights five major indicators of service quality:

- a) **Reliability:** the ability to perform the promised service dependably and accurately. Most customers regard reliability as being the most important of the five indicators of service quality. It is the foundation on which trust is built.
- b) **Responsiveness:** refers to the willingness and ability of service personnel to help customers and provide prompt response to the customer’s needs. It may be measured by indicators like speed, accuracy, and attitude while giving the service.
- c) **Assurance:** refers to the knowledge, competence and courtesy of service providers and their ability to convey trust and confidence. It is given by the customer’s evaluation of how well the service employee has understood needs and is capable of meeting them.
- d) **Empathy:** is described as the human touch. It is reflected in the caring attitude and individualised attention provided to customers.
- e) **Tangibles:** represent the physical environmental factors that the customer can see, hear and touch. For instance the location, the layout and cleanliness, the sense of order and professionalism that one gets when visiting an insurance company’s office can make a great impression on the customer. The physical atmosphere or ambience becomes especially important because it creates first and lasting impressions, before and long after the actual service is experienced.

3. Customer service and insurance

Ask any leading sales producers in the insurance industry about how they managed to reach the top and stay there. You are likely to get a common answer, that it was the patronage and support of their **existing** clients that helped them build their business.

You would also learn that a large part of their income comes from the commissions for renewal of the insurance contracts. Their clients are also the source for acquiring new customers.

What is the secret of their success?

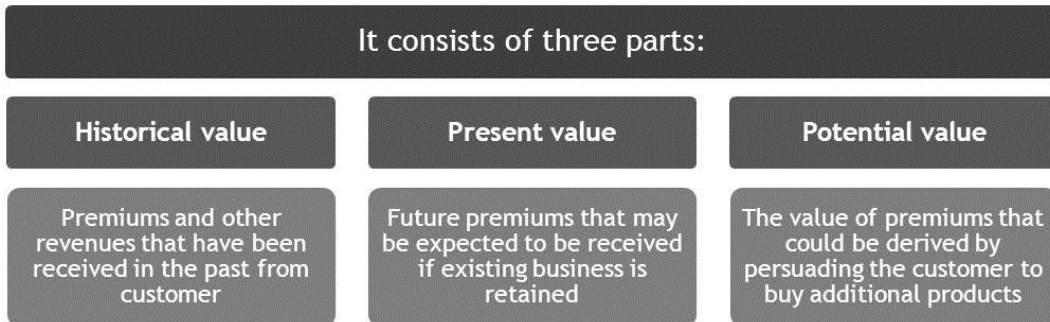
The answer, most likely is, **commitment to serving their customers.**

How does keeping a customer happy benefit the agent and the company?

To answer this question, it would be useful to look at customer’s lifetime value.

Customer lifetime value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.

Diagram 1: Customer Lifetime Value



An agent who renders service and builds close relationships with his/her customers, builds goodwill and brand value, which helps in expanding the business.

Test Yourself 1

What is meant by customer lifetime value?

- I. Sum of costs incurred while servicing the customer over his lifetime
 - II. Rank given to customer based on business generated
 - III. Sum of economic benefits that can be achieved by building a long term relationship with the customer
 - IV. Maximum insurance that can be attributed to the customer
-

B. Insurance agent's role in providing great customer service

Let us now consider how an agent can render great service to the customer. The role begins at the stage of sale and continues through the duration of the contract, and includes the following steps. Let us look at some of the milestones in a contract and the role played at each step.

1. The Point of Sale - Best advice

The first point for service is the point of sale. One of the critical issues involved in purchase of any Insurance, and particularly health insurance, is to determine the **amount of coverage [Sum Insured] to be bought.**

Here it is important to keep a basic principle in mind - Do not recommend insuring where the risk can be managed otherwise. The insured needs to make sure that the possible expected loss involved is greater than the cost of insurance.

If the premium payment is high compared to the loss involved, it may be advisable to just bear the risk.

On the other hand, if the occurrence of any unfortunate event would lead to severe financial burden, it is wise to insure against such contingency.

Whether insurance is needed or not, depends on the circumstances. If the probability of loss or damage to an asset (including one's body or health) due to a peril is negligible, one may retain the risk rather than insure it. Similarly if an item has insignificant value, one may not insure it.

Example

For a lady who is young and married, purchasing maternity cover under a health policy would prove to be helpful.

On the other hand, for a lady who is too old to conceive, purchasing maternity cover under a health policy may not be necessary.

In case a portion of the possible loss can be borne by oneself, it would be economical for the insured to opt for a **deductible**. A corporate customer may have varied needs, right from the coverage of factory, people, cars, liability exposures etc. He/she needs the right advice for the coverage and the policies to be taken.

Most non-life insurance policies broadly fall in two categories:

- ✓ Named peril policies
- ✓ All risk policies

The latter are costlier as they cover all losses which are specifically not excluded under the policy. Hence opting for 'named peril' policies where the most probable causes of loss are covered by the perils named in the policy may be more beneficial, as such a step could save premiums and provide need based cover to the insured.

The agent really begins to earn her commission when she renders best advice on the matter. It would be worthwhile for the agent to remember that while one may view insurance as the standard approach for dealing with the risk, there are other techniques like risk retention or loss prevention that are available as options for reducing the cost of insurance.

From the standpoint of an insured the relevant questions for instance may be:

- ✓ How much premium will be saved by considering deductibles?
- ✓ How much would a loss prevention activity result in reduction in premiums?

When approaching the customer as a health insurance sales person the question an agent needs to ask herself is about her role vis-à-vis the customer. Is she going there just to get a sale or to relate to the customer as a coach and partner who would help him to manage his risks more effectively?

The customer's angle is different. He is not so much concerned with getting maximum insurance per rupee spent, but rather in **reducing the cost of handling risk**. The concern would be thus on identifying those risks which customer cannot retain and hence must be insured.

In other words the role of an insurance agent is more than that of a mere sales person. She also **needs to be a risk assessor, underwriter, risk management counsellor, designer of customised solutions and a relationship builder who thrives on building trust and long-term relationships**, all rolled into one.

2. The proposal stage

The agent has to support the customer in filling out the proposal for insurance. The insured is required to take responsibility for the statements made therein. The salient aspects of a proposal form have been discussed in a previous chapter.

It is very important that the agent should explain and clarify to proposer the details to be filled as answer to each of questions in the proposal form. In the event of a claim, a failure to give proper and complete information can jeopardise the customer's claim.

Sometimes there may be additional information that may be required to complete the policy. In such cases the company may inform the customer directly or through the

agent. In either case, it becomes necessary to help the customer complete all the required formalities and even explain to him or her why these are necessary.

3. Acceptance stage

a) Delivery of the policy document

Delivery of the policy is another major opportunity that an agent gets to make contact with the customer. If company rules permit a policy document being delivered in person, it may be a good idea to collect it and present the document to the customer.

If the policy is being sent directly by mail, one must contact the customer, once it is known that the policy document has been sent. This is an opportunity to visit the customer and explain anything that is unclear in the document received. This is also an occasion to clarify various kinds of policy provisions, and the policy holder's rights and privileges that the customer can avail of. This act demonstrates a willingness to provide a level of service far beyond just the sale.

This meeting is also an occasion to pledge the agent's commitment to serving the customer and communicating full support.

The next logical step would be to ask for the names and particulars of other individuals the customer knows who can possibly benefit from the agent's services. If the client can himself contact these people and introduce the agent to them, it would mean a great breakthrough in business.

b) Policy renewal

All health insurance policies have to be renewed each year and the customer has a choice at the time of each renewal, to continue insuring with the same company or switch to another company. This is a critical point where the goodwill and trust created by the agent and the company gets tested.

Although there is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date, yet as a matter of courtesy and decidedly a healthy business practice, insurers issue a **"Renewal Notice"** one month in advance of the date of expiry, inviting renewal of the policy. The agent needs to be in touch with the customer well before the renewal due date to remind the latter about the renewal so that he can make provision for the same.

The relationship gets strengthened by keeping in touch with the client from time to time, by greeting him on some occasions like festivals or a family event. Similarly, the relationship gets more cemented when there is a moment of difficulty or sorrow by offering assistance in any way possible.

4. The claim stage

The agent has a crucial role to play at the time of claim settlement. It is her task to ensure that the incident giving rise to the claim is immediately informed to the insurer and that the customer carefully follows all the formalities and assists in all the investigations that may need to be done to assess the loss.

The agent must be sincere in his attitude and advice and walk the extra mile to make sure that at the time the customer needs him most, he is available.

Test Yourself 2

Identify the scenario where a debate on the need for insurance is not required.

- I. Property insurance
 - II. Business liability insurance
 - III. Motor insurance for third party liability
 - IV. Fire insurance
-

C. Communication process

Communication skills in customer service

One of the most important set of skills that an agent or service employee needs to possess, for effective performance in the work place, is **soft skills**.

Unlike hard skills - which deal with an individual's ability to perform a certain type of task or activity, **soft skills relate to one's ability to interact effectively with other workers and customers, both at work and outside. Communication skills are one of the most important of these soft skills.**

1. Communication and customer relationships

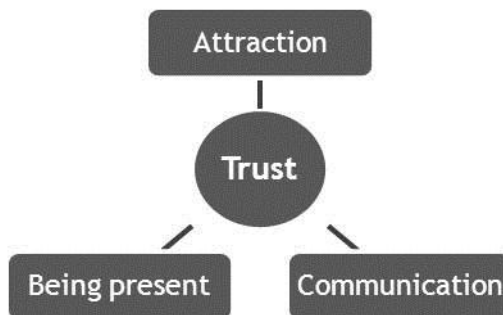
Customer service is one of the key elements in creating satisfied and loyal customers. But it is not enough. Customers are human beings with whom the company needs to build a strong relationship.

It is both the service and the relationship experience that ultimately shapes how the customer would look at the company.

What goes to make a healthy relationship?

At its heart, of course, there is trust. At the same time there are other elements, which reinforce and promote that trust. Let us illustrate some of the elements

Diagram 2: Elements for Trust



- i. Every relationship begins with **attraction**:

One needs to be simply liked and must be able to build a rapport with the customer. Attraction is very often the result of first impressions that are derived when a customer comes in touch with the organisation or its representatives. Attraction is the first key to unlocking every heart. Without it a relationship is hardly possible. Consider a sales person who is not liked. Do you really think she will be able to make much headway in a sales career?

- ii. The second element of a relationship is one's **presence** - being there when needed.

The best example is perhaps that of a marriage. Is it not important for the husband to be available when the wife needs him? **Similarly in a customer relationship, the issue is whether and how the company or its representative is available when needed. Is she or he fully present and listening to the customer's needs?**

There may be instances when one is not fully present and do justice to all the expectations of one's customers. **One can still maintain a strong relationship if one can speak to the customer, in a manner that is assuring, full of empathy and conveys a sense of responsibility.**

All of the above points like:

- ✓ The impression one creates or
- ✓ The way one is present and listens or
- ✓ The message one sends across to another

are dimensions of communication and call for discipline and skills. In a sense, what one communicates is ultimately a function of how one thinks and sees.

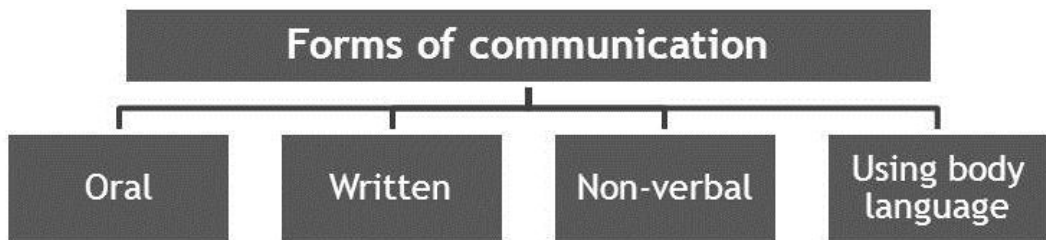
Businesses emphasise a lot on customer relationship management as the cost of retaining a customer is far lower than acquiring a new customer. The customer relation occurs across many touch points e.g. while understanding customers insurance needs, explaining coverage's, handing over forms, helping him to fill up forms, interacting with him during the time of a claim. So, there are many opportunities for the agent to strengthen the relation at each of these points.

2. Process of communication

What is communication?

All communications require a sender, who transmits a message, and a recipient of that message. The process is complete once the receiver has understood the message of the sender.

Diagram 3: Forms of communication



Communication may take place several forms

- ✓ Oral
- ✓ Written
- ✓ Non-verbal
- ✓ Using body language

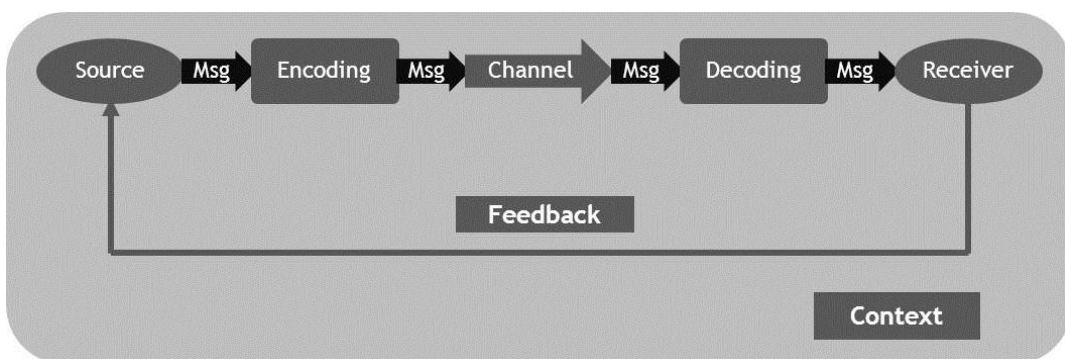
It may be face to face, over the phone, or by mail or internet. It may be formal or informal. Whatever the content or form of the message or the media used, the essence of communication is given by what the recipient has understood as being communicated.

It is important for a business to choose how and when it will send messages to intended receivers.

The communication process is illustrated below.

Let us define the terms in the diagram:

Diagram 4: Communication process



Definition

- i. **Source:** As the source of the message, the agent must be clear about why she is communicating, and what she wants to communicate, and confident that the information being communicated is useful and accurate.
 - ii. **Message** is the information that one wants to communicate.
 - iii. **Encoding** is the process of transferring the information one wants to communicate into a form that can be sent and correctly decoded at the other end. Success in encoding depends on how well one is able to convey information and eliminate sources of confusion. For this it is necessary to know one's audience. Failure to do so can result in delivering messages that are misunderstood.
 - iv. A Message is conveyed through a **channel**, which has to be selected for the purpose. The channel may be verbal including personal face-to-face meetings, telephone and videoconferencing; or it may be written including letters, emails, memos, and reports.
 - v. **Decoding** is the step wherein the information gets received, interpreted and understood in a certain way, at its destination. It can be seen that decoding [or how one receives a message] is as important as encoding [how one conveys it].
 - vi. **Receiver:** Finally there is the receiver, the individual or individuals [the audience] to whom the message is sent. Each member of this audience has his own ideas, beliefs and feelings and these would influence how the message is actually received and acted upon. The sender obviously needs to consider these factors when deciding what message to send.
 - vii. **Feedback:** Even as the message is being sent and received, the receiver is likely to send feedback in the form of verbal and non-verbal messages to the sender. The latter needs to look for such feedback and carefully understand these reactions as it would help to determine how the message has been received and acted upon. If necessary the message could be changed or rephrased.
-

3. Barriers to effective communication

Barriers to effective communication can arise at each step in the above process. Communication can get distorted because of the impression created about the sender, or because the message has been poorly designed, or because too much or too little has been conveyed, or because the sender has not understood the receiver's culture. The challenge is to remove all these barriers.

Test Yourself 3

What does not go on to make a healthy relationship?

- I. Attraction
 - II. Trust
 - III. Communication
 - IV. Scepticism
-

D. Non-verbal communication

Let us now look at some concepts that the agent needs to understand.

Important

Making a great first impression

We have already seen that attraction is the first pillar of any relationship. You can hardly expect to get business from a customer who does not like you. In fact many individuals need just a quick glance, of maybe a few seconds, to judge and evaluate you when you meet for the first time. Their opinion about you gets based on your appearance, your body language, your mannerisms, and how you are dressed and speak. Remember that first impressions last for long. Some useful tips for making a good first impression are:

- i. **Be on time always.** Plan to arrive a few minutes early, allowing flexibility for all kinds of possible delays.
- ii. **Present yourself appropriately.** Your prospect, whom you are meeting for the first time, does not know you and your appearance is usually the first clue he or she has to go on.
 - ✓ Is your appearance helping to create the right first impression?
 - ✓ Is the way you dress appropriate for the meeting or occasion?
 - ✓ Is your grooming clean and tidy - with good haircut and shave, clean and tidy clothes, neat and tidy make up?
- iii. **A warm, confident and winning smile** puts you and your audience immediately at ease with one another.
- iv. **Being open, confident and positive**
 - ✓ Does your body language project confidence and self-assurance?
 - ✓ Do you stand tall, smile, make eye contact, greet with a firm handshake?
 - ✓ Do you remain positive even in the face of some criticism or when the meeting is not going as well as expected?
- v. **Interest in the other person** - The most important thing is about being genuinely interested in the other person.
 - ✓ Do you take some time to find out about the customer as a person?
 - ✓ Are you caring and attentive to what he or she says?
 - ✓ Are you totally present and available to your customer or is your mobile phone engaging you during half your interview?

1. Body language

Body language refers to movements, gestures and facial expressions. The way we talk, walk, sit and stand, all says something about us, and what is happening inside us.

It is often said that people listen to only a small percentage of what is actually said. What we don't say speaks a lot more and a lot louder. Obviously, one needs to be very careful about one's body language.

a) Confidence

Here are a few tips about how to appear confident and self-assured, giving the impression of someone to be seriously listened to:

- ✓ Posture - standing tall with shoulders held back.
- ✓ Solid eye contact - with a "smiling" face
- ✓ Purposeful and deliberate gestures

b) Trust

Quite often, a sales person's words fall on deaf ears because the audience does not trust her - her body language does not give the assurance that she is sincere about what she says. It is very important to be aware of some of the typical signs that may indicate when one is not honest and believable and be on guard against them as listed below:

- ✓ Eyes maintaining little or no eye contact, or rapid eye movements
- ✓ Hand or fingers are in front of one's mouth when speaking
- ✓ One's body is physically turned away from the other
- ✓ One's breathing rate increases
- ✓ Complexion changes colour; red in face or neck area
- ✓ Perspiration increases
- ✓ Voice changes such as change in pitch, stammering, throat clearing
- ✓ Speech - slow and clear with tone of voice kept moderate to low

Some body movements that indicate defensiveness and non-receptivity include:

- ✓ Hand/arm gestures are small and close to one's body
- ✓ Facial expressions are minimal
- ✓ Body is physically turned away from you
- ✓ Arms are crossed in front of body
- ✓ Eyes maintain little contact, or are downcast

If your customer expresses any of these, perhaps it is time you checked yourself and paid more attention to what is going on in the customer's mind.

2. Listening skills

The third set of communication skills that one needs to be aware about and cultivate are listening skills. These follow from a well-known principle of personal effectiveness - 'first to understand before being understood'.

How well you listen has a major impact on your job effectiveness, and on the quality of your relationships with others. Let us look at some listening tips.

a) Active listening:

It is where we consciously try to hear not only the words but also, more importantly, try to understand the complete message being sent by another.

Let us look at some of the elements of active listening. They are:-

i. Paying attention

We need to give the speaker our undivided attention, and acknowledge the message. Remember, non-verbal communication also "speaks" loudly. Some aspects of paying attention are as follows:

- ✓ Look at the speaker directly
- ✓ Put aside distracting thoughts
- ✓ Don't mentally prepare a different point of view
- ✓ Avoid all external distractions [for instance, keep your mobile on silent mode]
- ✓ "Listen" to the speaker's body language

ii. Demonstrating that you are listening:

Use of body language plays an important role here. For instance one may:

- ✓ Give an occasional nod and smile
- ✓ Adopt a posture that is open and draws out the other to speak freely
- ✓ Have small verbal comments like "Yes", "I agree" or "I understand".

iii. Provide feedback:

A lot of what we hear may get distorted by our personal filters, like the assumptions, judgments, and beliefs we carry. As a listener, we need to be aware of these filters and try to understand what is really being said.

- ✓ This may require you to reflect on the message and ask questions to clarify what was said
- ✓ Another important way to provide feedback is to paraphrase or repeat the speaker's words

- ✓ Yet a third way is to periodically stop the speaker and make a summary of what the speaker has said and repeat it back to him or her.

Example

Asking for clarity - From what I have heard, am I right in assuming, that you have issues about the benefits of some of our health plans, could you be more specific?

Paraphrasing the speaker's exact words - So you are saying that 'our health plans are not providing benefits that are attractive enough' - have I understood you correctly?

iv. Not being judgemental:

One of the biggest hurdles to active listening is our **tendency to be judgmental and biased about the speaker**. The result is that the listener may hear what the speaker says but listens according to her own biased interpretation of what the speaker might be saying.

Such judgmental approach can result in the listener being unwilling to allow the speaker to continue speaking, considering it a waste of time. It can also result in interrupting the speaker and rebutting the speaker with counter arguments, even before he or she has been able to convey the message in full.

This will only frustrate the speaker and limits full understanding of the message. Active listening calls for:

- ✓ Allowing the speaker to finish each point before asking questions
- ✓ Not interrupting the speaker with any counter arguments

v. Responding appropriately:

Active listening implies much more than just hearing what a speaker says. The communication can be completed only when the listener responds in some way, through word or action. Certain rules need to be followed for ensuring that the speaker is not put down but treated with respect and deference. These include:

- ✓ Being candid, open, and honest in your response
- ✓ Asserting one's opinions respectfully
- ✓ Treating another person in a way you would like to be treated yourself

vi. Empathetic listening:

Being empathetic literally means putting yourself in the other person's shoes and feeling his or her experience as he or she would feel it.

Listening with empathy is an important aspect of all great customer service. It becomes especially critical when the other person is a customer with a grievance and in a lot of pain.

Empathy implies hearing and listening patiently, and with full attention, to what the other person has to say, even when you do not agree with it. It is important to show the speaker acceptance, not necessarily agreement. One can do so by simply nodding or injecting phrases such as "I understand" or "I see."

Test Yourself 4

Which among the following is not an element of active listening?

- I. Paying good attention
 - II. Being extremely judgemental
 - III. Empathetic listening
 - IV. Responding appropriately
-

E. Ethical behaviour

1. Overview

Of late, serious concerns are voiced about the proprieties in business, because increasingly there are reports of improper behaviour. Some of the world's biggest companies have been found to have cheated through false accounts and dishonest audit certification. The funds of banks have been misused by their managements to satisfy the greed of some friends and themselves. Officials have used their authority to promote personal benefits. Increasingly, people who are trusted by the community to perform their tasks are seen to have betrayed the trust. Personal pomp and greed prevails.

Consequently, there is increasing discussion about accountability and corporate governance, all of which together can be called "Ethics" in business. **Acts like the 'Right to Information Act' and developments like 'Public Interest Litigation' have assumed considerable importance as instruments to achieve better accountability and governance.**

Ethical behaviour automatically leads to good governance. When one does her duty conscientiously and sincerely, there is good governance. Unethical behaviour shows little concern for others and high concern for self. When one tries to serve self-interest through one's official position, there is unethical behaviour. It is not wrong to look after one's interests. But it is wrong to do so at the cost of the interests of others, including those of the organization.

Insurance is a business of trust. Issues of propriety and ethics are extremely important in this business of insurance. Breach of trust amounts to cheating and is wrong. Things go wrong when wrong information is given to the prospects tempting them to buy insurance or the plan of insurance suggested does not cater to all the needs of the prospect.

Unethical behaviour happens when the benefits of self are considered more important than of the other. The code of ethics spelt out by the IRDA in the various regulations is directed towards ethical behaviour.

While it is important to know every clause in the code of conduct to ensure that there is no violation of the code, compliance would be automatic if the insurer and its representatives always kept the interests of the prospect in mind. Things go wrong when the officers of insurers become concerned with the targets of business, rather than the benefits to the prospect.

2. Characteristics

Some characteristics of ethical behaviour are:

- a) Placing best interests of the client above one's own direct or indirect benefits
- b) Holding in strictest confidence and considering as privileged, all business and personal information pertaining to client's affairs
- c) Making full and adequate disclosure of all facts to enable clients make informed decisions

There could be a likelihood of ethics being compromised in the following situations:

- a) Having to choose between two plans, one giving much less premium or commission than the other
- b) Temptation to recommend discontinuance of an existing policy and taking out a new one
- c) Becoming aware of circumstances that, if known to the insurer, could adversely affect the interests of the client or the beneficiaries of the claim. An example of this is knowing that the customer has a pre-existing disease but inducing her to take a health policy without disclosing this material fact in the proposal form.

Test Yourself 5

Which among the following is not a characteristic of ethical behaviour?

- I. Making adequate disclosures to enable the clients to make an informed decision
 - II. Maintaining confidentiality of client's business and personal information
 - III. Placing self-interest ahead of client's interests
 - IV. Placing client's interest ahead of self interest
-

F. Protection of policyholders' interests

The insurance regulator IRDA is also keen to ensure that insurance customers are given the best experience when it comes to insurance services. All its regulations have an underlying principle of ensuring that policyholders' interests are not endangered.

All insurance policy wordings, rates and the documents issued by insurance companies are scrutinized and approved by IRDA. The advertisements issued by insurers are also regulated. There are guidelines on matters relating to the code of conduct of brokers and agents, issuance of policies, prompt settlement of claims, customer grievance handling systems and so on.

One of the specific regulations in this regard is the **Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations 2002**. Some of the important features of these regulations which may be of interest to agents are given below:

1. At Point of Sale

- a) Prospectus should clearly state the terms, conditions and warranties of the policy
- b) Insurer, agent or other intermediary should provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest.
- c) Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately.
- d) Where the proposal is not filled by the prospect, a certificate is to be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract.
- e) The insurer, agent or any intermediary should act according to certain prescribed codes of conduct.

2. Proposal forms

- a) Except in cases of a marine insurance cover, proposal forms must generally be collected and within 30 days of the acceptance of a proposal, a copy of the proposal form should be given to the insured.
- b) Forms and documents should be made available in languages recognized under the Constitution of India as far as practicable.

- c) Where a proposal form is not used, the insurer should record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its policy.
- d) Wherever the benefit of nomination is available to the proposer, the insurer, agent or other intermediary should draw the attention of the proposer to it and encourage the prospect to avail the facility. As per IRDAI guidelines, only nomination (and not assignment) facility is available for health insurance products. Assignment facility is available only in the case of Life-Health Combi products where assignment may be allowed only for the life insurance component.
- e) Proposals should be processed by the insurer with speed and efficiency and all decisions thereof should be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

3. Policyholders' Servicing

- a) The insurer is to issue a policy in all cases with all prescribed details
- b) The insurer should respond to all policyholders' servicing requests (such as recording changes, asking for information, changing an assignment, issuing a duplicate policy etc.) within 10 days of the receipt of any communication from policyholders. The regulation provided for the following specific measures in respect of claims servicing.

4. Claims

- a) Appointment of a surveyor within 72 hours of claim intimation.
- b) If there is any delay on the part of the insured in submission of documents in support of his claim or any lack of co-operation, the surveyor or the insurer is obliged to inform him in writing that his claim may be delayed due to this.
- c) Specific code of conduct for surveyors requires that the surveyor should submit his findings and recommendations to the insurer within 30 days of his appointment and submit a copy of the same to the insured also, if so desired by him. Any extension of time may be allowed by the insurer only on a request made by the surveyor describing the reasons for the same and with the knowledge of the insured. The maximum time limit for submission of his report is six months.
- d) In case the insurer requires any further clarification, he must seek an additional report within 15 days of receipt of the survey report. Not more than

one additional report can be sought per claim. The surveyor is to submit the additional report within 21 days of receipt of the request of the insurer.

- e) The insurer has to offer his settlement or his repudiation of the claim with reasons within 30 days of receipt of the surveyor's report or additional report as the case may be.
- f) On receipt of the insured's acceptance of his offer, the insurer is to settle his claim within 7 days, failing which interest @ 2% above bank rate is payable to the insured.

Policyholder's Obligations

At the same time, these regulations also mandate that the insured also has the following duties towards the insurer:

1. Just as the insurer is required to disclose all "material information" regarding a proposal or policy, the policyholder also has the duty to disclose all "material information" with regard to the proposal.
2. The policyholder is duty bound to furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy.
3. The policyholder has the duty assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties.

G. Grievance redressal

1. Overview

The time for high priority action is when the customer has a complaint. Remember that in the case of a complaint, the issue of service failure which has aggrieved the customer is only a part of the story. Service failure can range from delay in correcting the records of the insurer to a lack of promptness in settling a claim.

More than the service failure, customers get upset and infuriated because of their interpretations about such failure. There are two types of feelings and related emotions that arise with each service failure:

- ✓ Firstly there is a sense of unfairness, a feeling of being cheated
- ✓ The second feeling is one of hurt ego - of being made to look and feel small

A complaint is a crucial “**moment of truth**” in customer relationship; if the company gets it right there is potential to actually improve customer loyalty. The human touch is critical in this; customers want to feel valued.

If you are a professional insurance agent and advisor, you would not allow such a situation to happen in the first place. You would take the matter up with the appropriate officer of the company. **Remember, no one else in the company has ownership of the client’s problems as much as you do.**

Complaints / grievances provide us the opportunity to demonstrate how much we care for the customer’s interests. They are in fact the solid pillars on which an insurance agent’s goodwill and business is built. At the end of every policy document, the insurance companies have detailed the procedure of grievance redressal, which should be brought to the notice of the customers at the time of explaining the document provisions.

Word of mouth publicity (Good or Bad) has significant role in selling and servicing. Remember good service gets rewarded by 5 people being informed, where as bad service is passed on to 20 people.

What then are the various remedies available to the insurance customer for redressal of his grievances?

2. Insurers’ individual Grievance Cells

All insurers have to have in place a proper “grievance cell” to attend to complaints received from insureds.

Information about the existence of such grievance cells as well as that of Insurance Ombudsman has to be communicated to policyholders when issuing the policy.

If insureds are not satisfied with the response of the insurer's Grievance / Consumer Complaints Cell, they can approach the Grievance Cell of IRDA. However, IRDA can only follow up with the insurer but cannot adjudicate in any claim matter.

3. Integrated Grievance Management System (IGMS)

The insurance regulator, IRDA has launched an Integrated Grievance Management System (IGMS) which acts as a central data bank of insurance grievance data and as a tool for monitoring grievances and their redressal in the industry.

Policyholders can register on this system with their policy details and lodge their complaints. Complaints are then forwarded to respective insurance company. IGMS tracks complaints and the time taken for redressal. The complaints can be registered at:

http://www.policyholder.gov.in/Integrated_Grievance_Management.aspx

4. The Consumer Protection Act, 1986

This Act was passed *“to provide for better protection of the interest of consumers and to make provision for the establishment of consumer councils and other authorities for the settlement of consumer's disputes.”* The Act has been amended by the Consumer Protection (Amendment) Act, 2002.

a) Definitions under the Act

Some definitions provided in the Act are as follows:

Definition

“Service” means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information. But it does not include the rendering of any service free of charge or under a contract of personal service.

Insurance is included as a service

“Consumer” means any person who:

- i. Buys any goods for a consideration and includes any user of such goods. But does not include a person who obtains such goods for resale or for any commercial purpose or

- ii. Hires or avails of any services for a consideration and includes beneficiary of such services.

'Defect' means any fault, imperfection, shortcoming inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

'Complaint' means any allegation in writing made by a complainant that:

- i. An unfair trade practice or restrictive trade practice has been adopted
- ii. The goods bought by him suffer from one or more defects
- iii. The services hired or availed of by him suffer from deficiency in any respect
- iv. Price charged is in excess of that fixed by law or displayed on package

Goods which will be hazardous to life and safety when used are being offered for sale to the public in contravention of the provisions of any law requiring trader to display information in regard to the contents, manner and effect of use of such goods

'Consumer dispute' means a dispute where the person against whom a complaint has been made, denies and disputes the allegations contained in the complaint.

b) Consumer disputes redressal agencies

Consumer disputes redressal agencies are established in each district and state and at national level.

- i. **District Forum:** The forum has jurisdiction to entertain complaints, where value of the goods or services and the compensation claimed is up to Rs. 20 lakhs The District Forum is empowered to send its order/decreed for execution to appropriate Civil Court.
- ii. **State Commission:** This redressal authority has original, appellate and supervisory jurisdiction. It entertains appeals from the District Forum. It also has original jurisdiction to entertain complaints where the value of goods/service and compensation, if any claimed exceeds Rs. 20 lakhs but does not exceed Rs. 100 lakhs. Other powers and authority are similar to those of the District Forum.
- iii. **National Commission:** The final authority established under the Act is the National Commission. It has original, appellate as well as supervisory jurisdiction. It can hear the appeals from the order passed by the State Commission and in its original jurisdiction it will entertain disputes, where goods/services and the compensation claimed exceeds Rs.100 lakhs. It has supervisory jurisdiction over State Commission.

All the three agencies have powers of a Civil Court.

c) Procedure for filing a complaint

The procedure for filing a complaint for the three redressal agencies mentioned above is very simple. There is no fee for filing a complaint or filing an appeal whether before the State Commission or National Commission.

The complaint can be filed by the complainant himself or by his authorised agent. It can be filed personally or can even be sent by post. It may be noted that no advocate is necessary for the purpose of filing a complaint.

d) Consumer Forum orders

If the forum is satisfied that the goods complained against suffer from any of the defects specified in the complaint or that any of the allegations contained in the complaint about the services are proved, the forum can issue an order directing the opposite party to do one or more of the following namely,

- i. To **return** to the complainant **the price**, [or premium in case of insurance], the charges paid by the complainant
- ii. To award such amount as **compensation** to the consumers for any loss or injury suffered by the consumer due to negligence of the opposite party
- iii. To **remove** the defects or **deficiencies** in the services in question
- iv. To **discontinue the unfair trade practice** or the restrictive trade practice or not to repeat them
- v. To provide for **adequate costs** to parties

e) Consumer disputes categories

The majority of consumer disputes with the three forums fall in the following main categories, as far as the insurance business is concerned:

- i. **Delay in settlement of claims**
- ii. **Non-settlement of claims**
- iii. **Repudiation of claims**
- iv. **Quantum of loss**
- v. **Policy terms, conditions etc**

5. The Insurance Ombudsman

The Central Government under the powers of the Insurance Act, 1938 made **Redressal of Public Grievances Rules, 1998** by a notification published in the official gazette on November 11, 1998. These rules apply to life and non-life insurance, for all personal lines of insurances, that is, insurances taken in an individual capacity.

The objective of these rules is to resolve all complaints relating to settlement of claim on the part of the insurance companies in a cost effective, efficient and impartial manner.

The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

The decision of the Ombudsman, whether to accept or reject the complaint, is final.

a) Complaint to the Ombudsman

Any complaint made to the Ombudsman should be in writing, signed by the insured or his legal heirs, addressed to an Ombudsman within whose jurisdiction, the insurer has a branch / office, supported by documents, if any, along with an estimate of the nature and extent of loss to the complainant and the relief sought.

Complaints can be made to the Ombudsman if:

- i. The complainant had made a previous written representation to the insurance company and the insurance company had:
 - ✓ Rejected the complaint or
 - ✓ The complainant had not received any reply within one month after receipt of the complaint by the insurer
 - ✓ The complainant is not satisfied with the reply given by the insurer.
- ii. The complaint is made within one year from the date of rejection by the insurance company.
- iii. The complaint is not pending in any Court or Consumer Forum or in arbitration.

b) Recommendations by the Ombudsman

There are certain duties/protocols that the Ombudsman is expected to follow:

- i. Recommendations should be made within one month of the receipt of such a complaint
- ii. The copies should be sent to both the complainant and the insurance company
- iii. Recommendations have to be accepted in writing by the complainant within 15 days of receipt of such recommendation
- iv. A copy of acceptance letter by the insured should be sent to the insurer and his written confirmation sought within 15 days of his receiving such acceptance letter

If the dispute is not settled by intermediation, the Ombudsman will pass award to the insured which he thinks is fair, and is not more than what is necessary to cover the loss of the insured.

c) Awards by Ombudsman

The awards by Ombudsman are governed by the following rules:

- i. The award should not be more than Rs. 20 lakh (inclusive of ex-gratia payment and other expenses)
- ii. The award should be made within a period of 3 months from the date of receipt of such a complaint, and the insured should acknowledge the receipt of the award in full as a final settlement within one month of the receipt of such award
- iii. The insurer shall comply with the award and send a written intimation to the Ombudsman within 15 days of the receipt of such acceptance letter
- iv. If the insured does not intimate in writing the acceptance of such award, the insurer may not implement the award
- v. The award is binding on the insurer if accepted by the insured but the insured has the right to approach a court of law if still not satisfied.

Test Yourself 6

As per the Consumer Protection Act, 1986, who cannot be classified as a consumer?

- I. Hires goods / services for personal use
 - II. A person who buys goods for resale purpose
 - III. Buys goods and services for a consideration and uses them
 - IV. Uses the services of another for a consideration
-

Summary

- a) The role of customer service and relationships is far more critical in the case of insurance than in other products.
- b) Five major indicators of service quality include reliability, assurance, responsiveness, empathy and tangibles.
- c) Customer lifetime value may be defined as the sum of economic benefits that can be derived from building a sound relationship with a customer over a long period of time.
- d) The role of an insurance agent in the area of customer service is absolutely critical
- e) A good agent develops good communication skills - verbal and non-verbal
- f) Active listening involves paying attention, providing feedback and responding appropriately.
- g) Ethical behaviour involves placing the customer's interest before self interest
- h) The Protection of Policyholders' Interests regulation is evidence of IRDA's commitment to insurance customers
- i) IRDA has launched an Integrated Grievance Management System (IGMS) which acts as a central data bank of insurance grievance data and as a tool for monitoring grievance redress in the industry.
- j) The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference.

Key terms

- a) Quality of service
- b) Customer lifetime value
- c) Empathy
- d) Body language
- e) Active listening
- f) Ethical behaviour
- g) Policyholders' interest
- h) Integrated Grievance Management System (IGMS)
- i) Customer Protection Act, 1986
- j) Consumer Forum
- k) Insurance Ombudsman

Answers to Test Yourself

Answer 1

The correct option is III.

Sum of economic benefits that can be achieved by building a long term relationship with the customer is referred to as customer lifetime value.

Answer 2

The correct option is III.

Motor insurance for third party liability is mandatory by law and hence a debate on its need is not required.

Answer 3

The correct option is II.

As per the Consumer Protection Act, 1986, a person who buys goods for resale purpose cannot be classified as consumer.

Answer 4

The correct option is IV.

Scepticism does not go on to make a healthy relationship.

Answer 5

The correct option is II.

Being extremely judgemental is not an element of active listening.

Answer 6

The correct option is III.

Placing self-interest ahead of client's interests is not ethical behaviour.

Self-Examination Questions

Question 1

_____ is not a tangible good.

- I. House
- II. Insurance
- III. Mobile Phone
- IV. A pair of jeans

Question 2

_____ is not an indicator of service quality.

- I. Cleverness
- II. Reliability
- III. Empathy
- IV. Responsiveness

Question 3

In India _____ insurance is mandatory.

- I. Motor third party liability
- II. Fire insurance for houses
- III. Travel insurance for domestic travel
- IV. Personal accident

Question 4

One of the methods of reducing insurance cost of an insured is _____

- I. Reinsurance
- II. Deductible
- III. Co-insurance
- IV. Rebate

Question 5

A customer having complaint regarding his insurance policy can approach IRDA through

- I. IGMS
- II. District Consumer Forum
- III. Ombudsman

IV. IGMS or District Consumer Forum or Ombudsman

Question 6

Consumer Protection Act deals with:

- I. Complaint against insurance companies
- II. Complaint against shopkeepers
- III. Complaint against brand
- IV. Complaint against insurance companies, brand and shopkeepers

Question 7

_____ has jurisdiction to entertain matters where value of goods or services and the compensation claim is up to 20 lakhs

- I. High Court
- II. District Forum
- III. State Commission
- IV. National Commission

Question 8

In customer relationship the first impression is created:

- I. By being confident
- II. By being on time
- III. By showing interest
- IV. By being on time, showing interest and being confident

Question 9

Select the correct statement:

- I. Ethical behaviour is impossible while selling insurance
- II. Ethical behaviour is not necessary for insurance agents
- III. Ethical behaviour helps in developing trust between the agent and the insurer
- IV. Ethical behaviour is expected from the top management only

Question 10

Active Listening involves:

- I. Paying attention to the speaker
- II. Giving an occasional nod and smile

III. Providing feedback

IV. Paying attention to the speaker, giving an occasional nod and smile and providing feedback

Answers to Self-Examination Questions

Answer 1

The correct option is II.

Insurance is not a tangible good.

Answer 2

The correct option is I.

Cleverness is not an indicator of service quality.

Answer 3

The correct option is I.

Motor third party liability insurance is mandatory in India.

Answer 4

The correct option is II.

One of the methods of reducing insurance cost of an insured is the deductible clause in a policy.

Answer 5

The correct option is I.

A customer having complaint regarding his insurance policy can approach IRDA through IGMS.

Answer 6

The correct option is IV.

Consumer Protection Act deals with complaint against insurance companies, shopkeepers and brands.

Answer 7

The correct option is II.

District Forum has jurisdiction to entertain where value of goods or services and the compensation claim is up to 20 lakhs.

Answer 8

The correct option is IV.

In customer relationship the first impression is created by being confident, on time and by showing interest.

Answer 9

The correct option is III.

Ethical behaviour helps in developing trust in the agent and the insurer.

Answer 10

The correct option is IV.

Active Listening involves paying attention to the speaker, giving an occasional nod and smile and providing feedback.

CHAPTER 10

LEGAL AND REGULATORY ASPECTS OF INSURANCE AGENCY

Chapter Introduction

This chapter aims to provide you with the understanding of importance of insurance regulations. This chapter also provides you with an understanding of the legal status of an insurance agent. You will also learn the various rules and regulations applicable to agents in general; and to insurance agents in particular.

Learning Outcomes

- A. Importance of Insurance Regulations
- B. Insurance Regulatory Framework in India
- C. IRDAI (Health Insurance) Regulations 2013
- D. Regulations applicable to Insurance Agents
- E. Insurance Intermediaries and their Roles
- F. Indian Contract Act, 1972: Principal - Agent Relationship

After studying this chapter, you should be able to:

1. Illustrate the importance of insurance regulations
2. Explain the insurance regulatory framework of the country
3. Discuss IRDAI (Health Insurance) Regulations in detail
4. Interpret regulations that apply to insurance agents
5. Appreciate code of conduct applicable to agents
6. Explain relevance of the Indian Contract Act, 1972 to insurance agents

A. Importance of Insurance Regulations

1. Importance of Insurance Regulations

An insurance agent should always bear in mind that she is selling a promise that the insurance company will pay a certain amount of money if a misfortune occurs. The insured person would undoubtedly have many worries about the insurance purchased.

Some common concerns of an insured would be:

- a) Is insurance legal?
- b) Are insurance agents recognised by law?
- c) Are these insurance companies regulated or supervised?
- d) Is the document given to me by the insurer legally valid?
- e) Will the insurance company pay me the money if a loss happens?
- f) Will they pay me the full money that I lose?
- g) Are there any hidden provisions in the insurance contract, whereby the insurance company can avoid paying me a claim?
- h) Do I have to go through any complicated procedures to get my claim paid?
- i) If I do not get a claim, can I go to court based on the documents they have given me?

2. Need for insurance regulations

Why are insurance regulations required?

The prime purpose of insurance regulation is to protect the policyholder. The policyholder has paid the money and bought the insurance policy. She should be assured that the insurance policy she bought will be honoured by the insurance company.

- a) First and foremost, an insured should understand that **insurance is an absolutely legal contract**, in compliance with the provisions of the Indian Contract Act and other laws of the country.
- b) The Government is duty bound to protect all its citizens and all entities in the country through its legal and judicial systems.

Regulations made by IRDAI are to ensure that insurance companies should exist as financially sound organisations to honour the contracts that they have entered into. IRDAI regulates companies from their registration onwards and monitor all their major activities like underwriting, claims management, investments, accounting etc.

Information

In specialised sectors of economy, the Government creates bodies to regulate the sector. Thus we have bodies like Reserve Bank of India (RBI) to regulate banks and the Securities and Exchange Board of India (SEBI) to regulate the capital (share) market. Similarly, to regulate the insurance sector, the Government enacted the Insurance Regulatory and Development Authority of India (IRDAI) Act 1999 and created the IRDAI as an independent authority for the purpose of regulating the insurance industry.

All insurance policy wordings, rates, terms and conditions and the documents issued by insurance companies are regulated by IRDAI. The advertisements issued by insurers are also regulated. There are guidelines regarding prompt settlement of claims, grievance handling systems in every company and at IRDAI level to address complaints at the company and at IRDAI level.

IRDAI issues directions to ensure that the insurance company targets rural areas of the country and weaker sections of the population equally. All people dealing with selling and servicing of insurance policies, viz. agents, corporate agents, brokers, surveyors, Third Party Administrators and insurance companies are licensed registered as well as regulated by IRDAI as per various regulations.

Test Yourself 1

What is the primary purpose of insurance regulations?

- I. Protect the interests of policyholders
 - II. To settle customer disputes
-

B. Insurance Regulatory Framework in India

The Insurance Act, 1938 and the Insurance Regulatory and Development Authority, 1999 form the basis of insurance regulations in India. There are a few other legislations in the country that are directly or indirectly applicable to insurance business.

1. The Insurance Act, 1938

The Insurance Act, 1938 is the basic insurance legislation of the country, governing insurance business in India. It was created to protect the interest of the insuring public, with comprehensive provisions for effective control over the activities of insurers and came into effect on 1st July, 1939. This Act has been amended from time to time to strengthen the legal provisions of the Act.

The Insurance Act 1938 has provisions for monitoring and control of operations of insurance companies; some important sections of the Act are listed below:

- a) Registration of insurance companies and renewal of registrations
- b) Requirement to have sufficient capital for the company and to maintain solvency. (Solvency enables an insurance company to be able to pay claims and not go into bankruptcy).
- c) Compulsion that assets of insurance companies should be invested only as per norms prescribed for the same.
- d) Requirement to maintain audit and submit returns to the regulator
- e) Obligations of insurers towards the rural and social sectors
- f) Rules for assignment and transfer of policies and nominations
- g) Limitations on the expenses of the management
- h) Licensing of agents and their remunerations (Section 40 to 44)
- i) Prohibition of using rebates as an inducement to any person to take, renew or continue an insurance policy in India (Section 41)
- j) Advance payment of premium before assuming risk (Section 64VB)
- k) Need for survey of losses

2. The Insurance Regulatory & Development Authority Act, 1999

Insurance Regulatory and Development Authority of India (IRDAI) was established in 2000 as an independent authority to regulate and develop the insurance industry by an act of Parliament, [namely Insurance Regulatory & Development Authority Act, 1999].

The preamble of the IRDAI Act states:

“An Act to provide for the establishment of an Authority to protect the interests of holders of insurance policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto.”

IRDAI has prescribed regulations for protecting the interests of policyholders stipulating obligations on both insurers as well as intermediaries. These regulations prescribe insurers' obligations at the point of sale, towards policy servicing, claims servicing, and control on their expenses, investment and financial strength to meet the commitments to policyholders.

3. Other Acts / Regulations linked to insurance

In addition, insurance business in India is linked to various other Acts / legislations of the country, some of which are listed below:

- a) The Workmen's Compensation Act, 1923 [amended and renamed in 2010 as Employees Compensation Act in 1923]
- b) Employees' State Insurance Act, 1948
- c) Life Insurance Corporation Act, 1956
- d) Deposit Insurance and Credit Guarantee Corporation Act, 1961
- e) Marine Insurance Act, 1963
- f) Export Credit Guarantee Corporation Act, 1964
- g) General Insurance Business (Nationalisation) Act, 1972
- h) General Insurance Business (Nationalisation) Amendment Act, 2002
- i) Motor Vehicles Act, 1988
- j) Public Liability Insurance Act, 1991
- k) Consumer Protection Act, 1986

Apart from these general laws, there are many regulations, orders and circulars issued by IRDAI from time to time on specific matters relating to conduct of insurance business and policyholders protection.

Test Yourself 2

Which among the following activities is prohibited as per the provisions of Insurance Act, 1938?

- I. Keeping aside reserves to meet solvency requirements
 - II. Using rebates as a tool to sell insurance policies
 - III. Prospecting customers
 - IV. Limiting management expenses
-

C. IRDAI (Health Insurance) Regulations 2013

1. Although various regulations govern insurance and therefore health insurance too, IRDAI (Health Insurance) Regulations 2013 need special study by the health insurance agent. The important features of these regulations are summarized below:
2. **Some important definitions:**

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

Break in policy occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

Cashless facility means a facility extended by the insurer to the insured where the payments of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre-authorization approved.

Health plus Life Combi Products mean products which offer the combination of a Pure Term Life Insurance cover of a life insurance companies and a Health Insurance cover offered by non-life and/or standalone health insurance companies.

Network Provider means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Portability means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

Third Party Administrators or TPA means any person who is licensed under the IRDAI (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

3. Registration and Scope of Health Business:

1. Health Insurance products may be offered only by companies licensed by IRDAI.
 2. Life Insurance Companies may offer long term health products.
 3. Non-Life and Standalone Health insurance companies may offer individual health products for a minimum period of one year and a maximum of three years.
 4. Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts. However, the non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.
 5. Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.
4. **File and Use Procedure** for health insurance products. This has been discussed in an earlier chapter.

5. General Provisions relating to Health Policies

1. Health insurance product may be designed to offer various covers and all relevant details of the covers must be disclosed upfront and clearly in the product prospectus, documents and during the sale process.
2. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of insured.
3. Insurers shall ensure descriptions of their products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the File and Use Procedure, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable.
4. Nomination facilities should be available for all health insurance policies at the time of the proposal in accordance with Section 39 of the Insurance Act, 1938. No assignment of health insurance policies shall be allowed. However, in Life-Health Combi products, assignment may be allowed only for the life insurance component of the product in accordance with Section 38 of the Insurance Act, 1938.
5. All health insurance policies shall ordinarily provide for an entry age of at least up to 65 years and once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further lifelong renewal shall be allowed except in case of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

6. Renewal of a health insurance policy sought by the insured shall not be denied arbitrarily. If denied, the insurer shall provide the policyholder with clear reasons for such denial of renewal.
7. Renewal of a health insurance policy cannot be denied on the ground that the insured had made a claim or claims in the previous or earlier years (except for benefit based policies where the policy terminates following payment of the benefit covered under the policy). For example, in a critical illness policy on payment of the critical illness benefit, the policy terminates.
8. Break in policy is not immediate and delay in renewal has to be condoned up to 30 days from the due date of renewal. Benefits of the policy earned (cumulative bonus, waiver of pre-existing diseases etc.) shall continue if renewed within these 30 days. However coverage need not be available for such period when premium was due but not paid.
9. Promotion material and the policy document shall clearly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies.
10. Free Look Period: This has been discussed in an earlier chapter. (Recently IRDAI has extended this facility to health policies with a tenure of 1 year or more instead of 3 years)
11. Cost of pre-insurance health check-up: At least 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies where such costs need not be reimbursed.
12. Cumulative bonus: allowed for indemnity based health insurance policies. How it will be calculated shall be clearly stated in the prospectus and the policy document.
13. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it is accrued. Cumulative bonus shall not be allowed on benefit based policies.
14. Option to migrate to suitable health insurance policy: Credits earned by members of any family or group policy should be made available when any member exits that family/group to a similar policy or at the time of renewal provided the policy has been maintained without a break.
15. All health insurance policies shall allow the portability of any policy (continuation of existing benefits even after switching to another insurer). The procedure for the same has also been spelt out.
16. AYUSH Coverage: Insurers may provide coverage to non-allopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.
17. Prospectus of health insurance policy shall mandatorily contain all the information regarding the terms of its renewal, coverage and premium applicable as per the age progression, any changes in the scope of the cover after certain duration of the policy or after a certain age, whether renewal premium would be subject to revision, details of specific circumstances, if any. where premium could be loaded (or discount withdrawn) by the insurer and

also to the extent to which it could be done, procedure and terms for enhancing the sum insured or scope of cover, if any, all the exclusions, cancellation conditions and other aspects.

18. Declarations shall only form part of the proposal form and shall not be included in the policy document. Wordings of the standard declarations in the proposal form have also been spelt out in the IRDA (Health Insurance) Regulations, 2013.
19. Standard List of Excluded Expenses in Hospitalization Indemnity policies was also contemplated and followed up later by guidelines for Standardization in Health Insurance.
20. Special Provisions for Insured Persons were also contemplated for Senior Citizens such as fairness in premium and terms, establishment of a separate channel to address the health insurance related claims and grievances of senior citizens.
21. In case of multiple policies, if two or more policies are taken by an insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/benefit offered is fixed in nature and does not have any relation to the treatment
22. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insurer shall not apply the contribution clause, but the policyholder shall have the right to require a settlement of his claim in terms of any of his policies. Contribution would apply only if the treatment costs exceeded the allowable limit of the chosen policy.

6. Underwriting

1. All Insurance companies shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.
2. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. Denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.
3. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
4. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall
 - i. prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document
 - ii. Clearly state the events which will require the submission of such information.
 - iii. Clearly state the conditions applicable in such event.

5. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc. with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use guidelines.

7. Principles of Pricing of Health products

Broadly, the guidelines stipulate:

- a. premiums based on completed age of prospects at time of proposal / renewal
- b. No change of premium rates mid-term after issuance of policy
- c. Only prospective change of premium rates in case of revision

8. Protection of Policyholders' Interest

This has been discussed in a previous chapter.

9. Administration of Health Policies

These regulations relate to providing Cashless facility which has been discussed in a previous chapter. The regulations ensure that insured persons are informed of the details of the provider network, are allowed this facility at all network providers with whom the insurer has a service agreement whether or not the TPA has changed and sharing of provider networks with other insurers.

Other areas dealt with by these regulations concern

10. Payments to Network Providers and Settlement of Claims of Policyholders

These regulations describe how insurers should settle cashless claims with the help of TPAs.

11. Services offered by TPA in relation to Health Insurance Policies

This has been discussed in a previous chapter.

12. Agreement between a TPA and an Insurance company

These regulations describe what matters need to be set out in the agreement between the TPA and the insurer including servicing parameters, remuneration, termination etc. A copy of the agreement should be filed with the regulator.

13. Change of TPAs for servicing of Health Insurance Policies

These regulations describe what needs to be done in case of a change in TPA and how the insured is to be kept informed about any such change.

14. Data and related issues

These regulations stipulate that data has to flow between insurer and TPA in a smooth way and that all settled files should be sent by TPA to the insurer within 15 days of settlement.

15. Submission of Returns to the Authority

These regulations stipulate that all insurers should submit returns to the regulator as prescribed.

D. Regulations applicable to Insurance Agents

1. Regulations for insurance agents

As per the Insurance Act 1938 (section 42 as amended), one must be registered to work as an insurance agent. IRDAI has also issued regulations dealing with issuance of appointment letters and other matters relating to agents' recruitment. There are regulations which must be complied with at all stages in the process. Some of the important provisions relating to agents stated in the Insurance Act 1938, the Insurance Regulatory and Development Authority of India (IRDAI) Act 1999 and the latest Guidelines on Appointment of Insurance Agents, 2015 are discussed below:

- a) **The Insurance Act, 1938:** An insurance agent has to be registered (earlier it was licenced) under Section 42. Under the Section, an insurance agent receives or agrees to receive "payment by way of commission or other remuneration in consideration of his soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance".
- b) An agent can be an **individual agent** or a **corporate agent**. An individual agent is an individual representing an insurance company while a corporate agent is other than an individual, representing an insurance company. IRDAI has issued separate regulations for the different types of agents.

An agent can be issued an appointment letter for doing 'Life' or 'General' or "Health" insurance or all three. Insurance agents who hold such appointment letters that permit them to act as an agent for two or more insurers including a life insurer, a general insurer, a standalone health insurer and one of each of mono-line insurer are called "Composite Insurance Agents".

- c) The amended Insurance Act, 1938 mandates that to work as an insurance agent, one must be registered under Sec 42 as an agent. Insurance Regulatory and Development Authority of India (Licensing of Insurance Agents) Regulations, 2000 and Insurance Regulatory and Development Authority of India (Licensing of Insurance Agents) (Amendment) Regulations, 2002 give detailed provisions relating to "licensing" of agents as it was earlier called. The latest guidelines issued in March 2015, including provision for separate certification in health insurance, are very comprehensive. There is now a distinct change in the way of appointment of agents (and not licencing as it was earlier). These guidelines are available at the website of IRDAI: www.irda.gov.in.

Important

Adverse Selection (Anti-selection)

This denotes insurance firm's acceptance of applicants who are at a greater than normal risk (or uninsurable), but conceal/ falsify information about their actual

condition or situation. Acceptance of their application has an 'adverse' effect on insurance companies, because normally insurance premiums are computed on the basis of policyholders being in average circumstances (E.g. Enjoying good health/ employed in non-hazardous environments.)

Agents represent insurance companies and they act as the main link between the insurance company and the insured. 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 understanding the risk insured properly enough so as to avoid any adverse selection against the insurance company.

2. Rules governing “registration” of insurance agents

Rules relating to issuance and renewal of appointment letters to insurance agents and the procedures for obtaining the same as stated in the Insurance Act and various Regulations are summarised below:

a) Qualifications of the applicant

The applicant must possess the minimum qualification of a pass in 12th standard or equivalent examination conducted by any recognised Board/ Institution, where the applicant resides in a place with a population of five thousand or more as per the last census, and a pass in 10th standard or equivalent examination from a recognised Board / Institution if the applicant resides in any other place.

b) Disqualifications of the applicant

As per Section 42 subsection (4) of Insurance Act 1938, there are certain conditions that disqualify an applicant.

The applicant for agent registration is disqualified if he / she:

- i. Is a minor,
- ii. Is of unsound mind,
- iii. Has been found guilty of criminal misappropriation or criminal breach of trust / cheating / forgery / abetment of / attempt to commit any such offence, by a court of competent jurisdiction,
- iv. Has been found guilty of knowingly participating in or connived at any fraud, dishonesty or misrepresentation against an insurer or an insured,
- v. **[In the case of an individual]** if she/he does not possess the requisite qualifications and practical training for a period as may be specified by the regulations made by the Authority,
- vi. **[In the case of a company or firm]** if a director/ partner/ the chief executive officers/ other designated employee does not possess the requisite

qualifications and practical training and have not passed the prescribed examination

vii. Violates the code of conduct as specified by the regulations made by the IRDAI

c) Practical training

i. The first time applicant for agency registration shall have completed from an IRDAI approved institution, at least, **fifty hours'** practical training in life or general or health insurance business, which may be spread over two to three weeks.

ii. The first time applicant seeking registration to act as a composite insurance agent shall have completed from an IRDAI approved institution, at least, **seventy five hours** practical training in life and/or general insurance and/or health insurance business (as the case may be), which may be spread over two to three weeks.

iii. Where the applicant is

- ✓ An Associate / Fellow of the Insurance Institute of India,
- ✓ An Associate / Fellow of the Institute of Chartered Accountants of India,
- ✓ An Associate / Fellow of the Institute of Costs and Works Accountants of India,
- ✓ An Associate / Fellow of the Institute of Company Secretaries of India,
- ✓ An Associate / Fellow of the Actuarial Society of India,
- ✓ A Master of Business Administration of any Institution / University recognised by any State Government or the Central Government; or
- ✓ Possessing any professional qualification in marketing from any Institution / University recognised by any State Government or the Central Government she/he shall have completed, at least, **twenty five hours'** practical training from an approved institution.

d) Examination

The applicant shall have passed the pre-recruitment examination in life, general insurance or health insurance business, or a combination of these as the case may be, conducted by the Insurance Institute of India, Mumbai, or any other 'examination body'. The syllabus for such examination will be as prescribed by IRDAI.

e) Fees payable

Earlier the fees payable to the Authority for issue / renewal of licence to act as insurance agent or composite insurance agent was Rs. Two Hundred and Fifty. The new regulations do not contemplate payment of any fees.

f) Procedure to apply for agent's appointment (as per 2015 guidelines)

The agent appointment process usually starts with the insurer sponsoring a candidate for practical training. On completion of the mandated training, the applicant has to make an application in specified format for undergoing a written exam.

On clearing of her written exam, the applicant will make an application in form I-A along with her PAN card copy to the "Designated Official" of the sponsoring insurer. ("Designated Official" means an officer authorized by the insurer to make appointment of an individual as an agent).

The Designated Official has to satisfy himself that

- a. the application in form I-A is complete and accompanied by a copy of the applicant's PAN card
- b. the applicant has passed the requisite examination(s) for insurance agents
- c. the applicant is not otherwise disqualified from becoming an insurance agent as per Act
- d. the applicant has the required knowledge to solicit and procure insurance business and provide the necessary service to policyholders
- e. the applicant does not hold agency appointment of more than one life insurers, one non-life insurer, one health insurer or one of each of mono-line insurers
- f. the applicant has not been blacklisted

(The last two can be verified on the basis of PAN card details from the centralized list of agents and blacklisted agents maintained by IRDAI and accessible online)

Once satisfied that the applicant meets all the above requirements, and is fit and proper, the designated persons will issue an appointment letter to the agent within 15 days of receipt of application. The appointment letter should state the terms of appointment and the agent's functions as well as the code of conduct to be followed by her. The appointment letter, along with the agent's identity card identifying the applicant as an agent of the company should be dispatched to the agent within 7 days thereafter. The agent will have to be allotted an agent code prefixed by the initials of his name. The appointment is valid for a period of 3 years unless terminated or surrendered.

The details of all such appointments should be updated on the IRDAI portal immediately as also all cases of renewals or blacklisting.

The Designated Official may refuse to grant agency appointment if the applicant does not fulfil any of the conditions stipulated in the guidelines. If the Designated

Official refuses to grant or renew an agency appointment under this regulation, the reasons for the same should be given to the applicant in writing within 21 days. The prospective agent may appeal against this to the Appellate Authority appointed by the insurance company who shall consider the review application and give the final decision within 15 days.

An applicant for a Composite Insurance Agent must apply to the Designated Official of the concerned life, non-life, health or mono-line insurer in Composite Agency Application Form I-B instead of I-A.

3. Agents' code of conduct

IRDAI regulations stipulate that every person registered as an insurance agent shall adhere to the code of conduct specified below:-

a) Every insurance agent shall

- i. Identify herself / himself and the insurance company of whom she / he is an insurance agent;
- ii. Disclose her / his agency appointment letter to the prospect on demand;
- iii. Explain carefully the requisite information in respect of insurance products offered for sale by her / his insurer and take into account the needs of the prospect while recommending a specific insurance plan;
- iv. Advise the prospect in a fair way about products in case he represents more than one insurer offering competing products in the best interest of the customer;
- v. Disclose the scales of commission in respect of the insurance product offered for sale, if asked by the prospect;
- vi. Indicate the premium to be charged by the insurer for the insurance product offered for sale;
- vii. Explain to the prospect the nature of information required in the proposal form by the insurer, and also the importance of disclosure of material information in the purchase of an insurance contract;
- viii. Bring to the notice of the insurer any adverse habits or income inconsistency of the prospect, in the form of a report (called "Insurance Agent's Confidential Report") along with every proposal submitted to the insurer, and any material fact that may adversely affect the underwriting decision of the insurer as

regards acceptance of the proposal, by making all reasonable enquiries about the prospect;

- ix. Inform promptly the prospect about the acceptance or rejection of the proposal by the insurer;
- x. Obtain the requisite documents at the time of filing the proposal form with the insurer; and other documents subsequently asked for by the insurer for completion of the proposal;
- xi. Render necessary assistance to the policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims by the insurer;
- xii. Advise every individual policyholder to effect nomination or assignment or change of address or exercise of options, as the case may be, and offer necessary assistance in this behalf, wherever necessary;

b) No insurance agent shall

- i. Solicit or procure insurance business without being appointed to act as such by an insurer;
- ii. Induce the prospect to omit any material information in the proposal form;
- iii. Induce the prospect to submit wrong information in the proposal form or documents submitted to the insurer for acceptance of the proposal;
- iv. Resort to any kind of multi-level marketing for soliciting or procuring insurance business;
- v. Behave in a discourteous manner with the prospect;
- vi. Interfere with any proposal introduced by any other insurance agent;
- vii. Offer different rates, advantages, terms and conditions other than those offered by her / his insurer;
- viii. Demand or receive a share of proceeds from the beneficiary under an insurance contract;
- ix. Force a policyholder to terminate the existing policy and to effect a new proposal from him within three years from the date of such termination;
- x. Have, in case of a corporate agent, a portfolio of insurance business under which the premium is in excess of fifty percent of total premium procured, in

any year, from one person (who is not an individual) or one organisation or one group of organisations;

- xi. Apply for fresh agency appointment to act as an insurance agent, if her / his agency appointment was earlier cancelled by the Designated Official, and a period of five years has not elapsed from the date of such cancellation;
- xii. Become or remain a director of any insurance company;

c) Protection of business and renewals

Every insurance agent shall with a view to conserve the insurance business already procured through him; make every attempt to ensure remittance of the premiums by the policyholders within the stipulated time, by giving notice to the policyholder orally and in writing. It means the agent should ensure that premium is paid well in advance on renewal or else the risk will not be assumed by the insurer.

4. Penalties

- a. Any person who acts as an insurance agent in contravention of the Act is liable to pay a penalty which may extend up to Rs. 10,000.
- b. Any insurer or person acting on behalf of an insurer who appoints any person as an insurance agent not permitted to act as such or transacts any insurance business in India through such person is liable to pay a penalty which may extend up to Rs. 1 Crore.
- c. The insurer shall be liable for any acts or omissions of his agents including violation of code of conduct and is liable to pay a penalty which may extend up to Rs. 1 Crore.

5. Authority's right to inspect

The Authority may appoint one or more of its officers as an "Investigating Officer" to undertake inspection of affairs of an insurance Agent, to ascertain and see whether the business is carried on by him/her as per the Act, Regulations and the instructions issued by the Authority from time to time, and also to inspect the books of accounts, records and documents of the Agent. However, such inspection will be limited to the matters pertaining to insurance business undertaken by the Insurance Agent.

The purposes of inspection may include but are not limited to:

- 1. Monitoring compliance with the provisions of the Act, rules, regulations etc.

2. Investigation of the complaints of serious nature received from any insured, any insurers, other stakeholders or any other individual on any matter having a bearing on the insurance related activities of the Agent
3. Investigating into the affairs of the Insurance Agent in the interest of proper development of insurance business or in protection of policyholder's interest.

The Investigating Officer may, during the course of the inspection, examine on oath the insurance agent or any person who is found to be in possession or control of any books, accounts or other documents. Any statement made by the insurance agent or such person during such examination may thereafter be used as evidence in any proceedings under the Guidelines.

The Authority may also call for any information from the insurance agent and he shall submit the same within the time lines referred therein by the Authority.

6. Suspension of Appointment of an Agent

The appointment of an agent may be cancelled or suspended after due notice and after giving him/her a reasonable opportunity of being heard if he/she:-

1. violates the provisions of the Insurance Act, 1938, Insurance Regulatory and Development Authority of India Act, 1999 or rules or regulations, made there under as amended from time to time;
2. attracts any of the disqualifications mentioned above.
3. Fails to comply with the code of conduct stipulated above and directions issued by the Authority from time to time.
4. Violates the terms of appointment.
5. Fails to furnish any information relating to his/her activities as an agent as required by the Insurer or the Authority;
6. Fails to comply with the directions issued by the Authority;
7. Furnishes wrong or false information; or conceals or fails to disclose material facts in the application submitted for appointment of Agent or during the period of its validity.
8. does not submit periodical returns as required by the Insurer/Authority;
9. does not co-operate with any inspection or enquiry conducted by the Authority;

10. fails to resolve the complaints of the policyholders or fails to give a satisfactory reply to the Authority in this behalf.

7. Manner of holding enquiry before/after suspension of appointment of the insurance Agent:

1. The appointment of an insurance agent shall not be cancelled unless an enquiry has been conducted in accordance with the procedure specified in the regulations.
2. For the purpose of holding an enquiry under this clause, the insurer may appoint an Officer as an Enquiry Officer within 15 days of the issue of the suspension order;
3. The Enquiry Officer shall issue a show cause notice to the insurance agent at the registered address of the insurance agent calling for all information / data as deemed necessary to conduct the enquiry. The agent should be granted a time of 21 days from date of receipt of the show cause notice for submission of his/her reply and such information / data called for;
4. The insurance agent may, within 21 days from the date of receipt of such notice, furnish to the enquiry officer a reply to the show cause notice together with copies of documentary or other evidence relied on by him or sought by the Enquiry Officer;
5. The Enquiry Officer shall give a reasonable opportunity of hearing to the insurance agent to enable him to make submissions in support of his/her reply;
6. The insurance agent may either appear in person or through any person duly authorised by him to present his case, provided however that the prior approval of the Insurer is obtained for the appearance of the authorised person;
7. If it is considered necessary, the Enquiry Officer may require the Insurer to present its case through one of its officers;
8. If it is considered necessary, the Enquiry Officer may call for feedback/information from any other related entity during the course of enquiry;
9. If it is considered necessary, the Enquiry Officer may call for additional papers from the insurance agent;

10. The Enquiry Officer shall make all necessary efforts to complete the proceeding at the earliest but in no case beyond 45 days of the commencement of the enquiry;
11. Provided that in case the enquiry cannot be completed within the prescribed time limit of 45 days as mentioned above; the enquiry officer may seek additional time from the Insurer stating the reason thereof;
12. The Enquiry Officer shall, after taking into account all relevant facts and submissions made by the insurance agent, shall furnish a report making his/her recommendations to the Designated Official. The Designated Official shall pass a final order in writing with reasons. The order of designated official shall be signed and dated and communicated to the agent.

8. Procedure for Cancellation of Agency:

On the issue of the final order for cancellation of agency of the insurance agent, the agent shall cease to act as an insurance agent from the date of the final order.

9. Publication of order of suspension/ Cancellation

1. The order of suspension/cancellation of appointment of the insurance agent made under the above circumstances shall be displayed on the website of the Insurer and updated in the centralised list of agents maintained by the Authority, so that registration of new business by the suspended/Cancelled agent is stopped forthwith by the insurers.
2. On and from the date of suspension or cancellation of agency appointment, the insurance agent, shall cease to function as an insurance agent.

10. Effect of suspension/cancellation of Agency appointment

1. On and from the date of suspension or cancellation of the agency, the insurance Agent, shall cease to act as an insurance agent.
 - a. The insurer shall recover the Appointment letter and Identity card from the agent whose appointment has been cancelled under these Guidelines within 7 days of issuance of final order effecting cancellation of appointment.
 - b. The insurer shall black list the agent and enter the details of the agent whose appointment is suspended/cancelled into the black listed agents database maintained by the Authority and the

centralised list of agents database maintained by the Authority, in online mode, immediately after issuance of the order effecting suspension/cancellation.

- c. In case a suspension is revoked in respect of any agent on conclusion of disciplinary action by way of issuance of a speaking order by the Designated Official, the details of such agent shall be removed from list of black listed Agents as soon as the Speaking Order revoking his/her suspension is issued.
 - d. The insurer shall also inform other insurers, Life or General or Health Insurer or mono line insurer with whom he/she is acting as an agent, of the action taken against the Agent for their records and necessary action.
2. Nothing contained in the above regulation shall prevent the Authority to initiate penal action keeping in mind the extent of violation and level of violation as per the provisions of the Insurance Act, 1938, regulations and rules there under.

11. Appeal Provision

An agent who is aggrieved by the order of cancellation can appeal to the insurer within 45 days of the order. The insurer shall appoint an Appellate Officer who shall examine the appeal and give his decision in the matter in writing within 30 days of the receipt of the appeal.

12. Procedure to be followed in respect of resignation/surrender of appointment by an insurance agent:

1. In case an insurance agent appointed by an insurer wishes to surrender his agency with his/her insurer, he/she shall surrender his appointment letter and identity card to the Designated Official of the insurer with whom he/she is currently holding agency.
2. The Insurer shall issue the cessation certificate as detailed in Form 1-C within a period of 15 days from the date of resignation or surrender of appointment.
3. An agent who has surrendered his appointment may seek fresh appointment with another insurer. In such a case, the agent has to furnish to the new insurer all the details of his/her previous agency and produce Cessation Certificate issued by the previous insurer issued in Form I-C, along with his agency application form.

4. The insurer will consider the agency application as outlined as stipulated earlier after a period of NINETY DAYS from the date of the issue of the cessation certificate by the previous insurer.

13. General conditions for appointment of Agents by the insurer

1. The Insurer shall frame a 'Board Approved Policy' covering Agency Matters as prescribed and file the same with the Authority before 31st March every year.
2. No individual shall act as an insurance agent for more than one life insurer, one general insurer, one health insurer and one of each of other mono-line insurers
3. Any individual, who acts as an insurance agent in contravention of the provisions of this Act, shall be liable to a penalty which may extend to ten thousand rupees.
4. Any insurer or any representative of the insurer acting on behalf of the insurer, who appoints an individual as an insurance agent not permitted to act as such or transact any insurance business in India shall be liable to penalty which may extend to one crore rupees.
5. No insurer shall, on or after the commencement of the Insurance Laws (Amendment) Ordinance 2014 appoint any Principal Agent, Chief Agent, and Special Agent and transact any insurance business in India through them.
6. No person shall allow or offer to allow, either directly or indirectly or an inducement to any person to take out or renew or continue an insurance policy through multilevel marketing scheme.
7. The Authority may through an officer authorized in this behalf, make a complaint to the appropriate police authorities relating to the entity or persons involved in the Multi-Level Marketing schemes
8. Every insurer and every Designated Official who is acting on behalf of an insurer in appointing insurance agents shall maintain a register showing the name and address of every insurance agent appointed by him and the date on which his appointment began and the date, if any, on which his appointment ceased.
9. The records as mentioned in (8) above shall be maintained by the insurer as long as the insurance agent is in service and for a period of five years from the cessation of the appointment.

14. Existing Agents licensed by Authority

1. Insurance agents holding a valid license issued by the Authority to act as insurance agents of different insurers and agents whose licenses are tagged to standalone health insurers / Agriculture Insurance Company Ltd under special permission granted by the Authority to Standalone Health Insurers /AIC of India shall be deemed to have been appointed by the respective insurers, and shall continue to operate as insurance agents of the respective Standalone Health insurers /AIC of India.
2. The Designated Official of insurer shall recover the agency license and identity cards issued on behalf of the Authority to the agent before commencement of these Guidelines, and issue the agents, appointment letters and fresh identity cards under these guidelines within 90 days of commencement of these Guidelines.
3. The agency license and identity card issued on behalf of the authority and recovered by the insurer and the fresh appointment letter issued by the insurer should be carefully preserved by the insurer for submission to the Authority as and when called for.

15. Prohibition of rebates

No intermediary is allowed to offer rebates to induce anyone to take a policy. Section 41 of the Insurance Act, 1938 is hence an important section for an insurance agent. It reads as follows:

Section 41 of the Insurance Act, 1938

“41. (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 herself / himself on her / his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that she / he is a bona fide insurance agent employed by the insurer.”

“41. (2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.”

This states that an agent cannot offer any rebates on premium as an inducement to the policyholder, except as allowed by the insurer.

Test Yourself 3

Insurance agents who hold valid licence to act as agent for both life and general Insurance are called

- I. Common insurance agents
 - II. Composite insurance agents
 - III. Multiple insurance agents
 - IV. General insurance agents
-

E. Insurance Intermediaries and their Roles

1. Other insurance intermediaries

Apart from the agents, there are other insurance intermediaries like corporate agents including banks and brokers who intermediate between the customer and the insurance company.

a) Corporate agents

Like individual insurance agents, **corporate agents** are also licensed by the IRDAI and governed by the Insurance Regulatory and Development Authority of India (Licensing of Corporate Agents) Regulations, 2002. An agent represents only one insurance company (one general, one life, one health or one mono-line) or a combination of these if a composite agent.

b) Insurance brokers:

These are licensed by the IRDAI and governed by the Insurance Regulatory and Development Authority of India (Insurance Brokers) Regulations, 2002. These regulations lay down the code of conduct for the respective intermediaries. An insurance broker is licensed by IRDAI to arrange insurance contracts with insurance companies on behalf of clients. A broker operates independently and may deal with more than one life insurance company or general insurance company or both.

c) Web Aggregators:

These are also licensed by IRDAI and provide leads to insurance companies through web-based and/or tele-marketing facilities without face to face access to prospects. They may also provide outsourcing services to insurers with whom they have an agreement.

d) Insurance Marketing Firms:

These are the latest type of intermediaries also licensed by IRDAI. They are intermediaries licensed to solicit and procure both insurance and financial products and also provide insurance services to insurers. However, they can engage in only retail lines of business and market the products of two Life, two General and two Health Insurance companies at any point of time.

e) Surveyors and third party administrators:

These are intermediaries who are not involved in procurement of business. Surveyors assess losses on behalf of the insurance companies or insured. Third party administrators provide services related to health insurance for insurance companies.

Test Yourself 4

Which of the below intermediary is not involved in procurement of business?

- I. Insurance brokers
 - II. Individual agents
 - III. Surveyors
 - IV. Corporate agents
-

F. Indian Contract Act, 1972: Principal - Agent Relationship

An insurance contract is an agreement between the insurer and the insured and falls under the provisions of the Indian Contracts Act, 1872.

The contract of insurance

Definition

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

Insurance contracts, like other contracts, are governed by the general principles of the law of contract as codified in the Indian Contract Act, 1872. (This has been discussed in Chapter 2).

In addition to the general principles of law, insurance contracts are also governed by certain special principles evolved under common law and later codified in the Marine Insurance Act, 1963. The legal principles applicable to insurance contract are dealt in an earlier chapter.

Summary

- a) The prime purpose of insurance regulations is to protect the policyholder.
- b) Insurance Regulatory and Development Authority of India (IRDAI) Act 1999, created the IRDAI as an independent authority for the purpose of regulating the insurance industry.
- c) The Insurance Act, 1938 has provisions for monitoring and control of operations of insurance companies.
- d) An individual agent is an individual representing an insurance company while a corporate agent is other than an individual, representing an insurance company.
- e) Insurance agents who are registered to act as agent for more than one insurer (whether life, general, health, mono-line insurer and one each of) are called composite insurance agents.
- f) The first time applicant for appointment as an agent shall have completed from an IRDAI approved institution, at least, fifty hours' practical training in life or general or health insurance business.
- g) If the insurance agent suffers, at any time during the currency of the appointment as agent, from any of the disqualifications mentioned in the regulations, then her / his appointment can be cancelled.
- h) An agent cannot offer any rebates on premium as an inducement to the policyholder, except as allowed by the insurer.

Key terms

- a) Agent
- b) Rebate
- c) Intermediaries

Answers to Test Yourself

Answer 1

The correct option is II.

The primary purpose of insurance regulations is to protect the interests of policyholders.

Answer 2

The correct option is II.

Using rebates as a tool to sell insurance policies is prohibited under Insurance Act 1938.

Answer 3

The correct option is II.

Insurance agents who hold licence to act as an agent for both a life insurer and a general insurer are called composite insurance agents.

Answer 4

The correct option is III.

Surveyors are not involved in procurement of insurance business.

CHAPTER 11

HEALTH INSURANCE CAREER PROSPECTS

Chapter Introduction

In the previous chapters we studied various concepts and practices in the health insurance business, including the processes of selling and customer service. This final chapter is to introduce to you to the career of an agent in the health insurance industry and also offer a brief perspective about what you could look forward to in this industry.

Learning Outcomes

- A. Insurance agency as a career
- B. Different careers in insurance

After studying this chapter, you should be able to:

1. Assess insurance agency as a career.
2. Discuss different careers in insurance.

A. Insurance agency as a career

The first question that one might have while starting a career in sales is whether or not she is really suited for the job, and whether she would be successful. This raises the question of what makes a good sales person.

1. What makes a good sales person?

In 1964, an interesting study on “What makes a good salesman?” was published in the Harvard Business Review. The authors, David Mayer and Herbert M. Greenberg, after seven years of intensive field research, came up with an interesting insight.

They found that a good salesman should have two basic qualities - empathy and ego drives.

Empathy is the ability to feel as the other person does in order to be able to sell him a product or service. A sales person needs to be sensitive to what goes on in the customer's mind and adopt an appropriate approach and communicate accordingly.

Ego drive refers to the sales person's intense drive and effort to make the sale, not merely for the money to be gained, but because it gives a feeling of self-achievement.

In other words great sales people typically have a massive hunger to excel and to improve their financial standing in the process. They also have an entrepreneurial spirit - the ability to see their work as an exciting adventure and a belief in their own ability to succeed in life and look forward to a job where security comes from the ability to achieve results. They also have the ability to relate and connect with people. They are comfortable in networking with others, making friends and influencing them.

2. Rewards of a career in non-life insurance sales

By now you would also be aware that the nature of the selling business in insurance is quite different from others. Unlike other products, insurance is intangible. One has to often create a need in the prospect's mind and motivate the latter to buy insurance.

This involves a very high level of concept selling and thus insurance sales persons are generally among the best sales professionals. They are remunerated through commissions so that there is no limit to what an agent can earn. The limit is set in their own minds - by whatever premium revenues the agent generates.

Apart from the scope to earn high incomes, an insurance agent can also attract tremendous amount of job satisfaction and social respect if one's job is done in an ethical and professional manner. The rewards and recognitions can be listed as:

- i. Being recognised by the society as a knowledgeable professional
- ii. Being able to provide insurance solutions to problems of people is a matter of immense social value that insurance agents enjoy
- iii. Social prestige that comes from being instrumental in financially helping out people who are affected by a misfortune
- iv. Being able to help people by advising them to take the right policy to cover an accident or an illness, is a matter of immense personal satisfaction for health insurance agents
- v. Agents deal with multiple clients and keep learning during their interactions. Over a period of time, insurance agents become fairly knowledgeable in many areas simply through dealing with multiple experts
- vi. Successful insurance agents are able to build a brand around them and are recognised as single window for acquiring insurance knowledge and claims advice

Insurance agents are present in practically every nook and corner of the world. **They are called insurance advisors in some markets.** They are regarded as people with good product knowledge in the realm of insurance, who can advise people regarding the right kind of insurance cover required to cover personal or industrial risks.

Important

Unique advantages of insurance agents

Insurance agents have unique advantages of working as per their own career ambitions.

- a) If a person wants to work for himself and not for a “boss” this is a great opportunity
- b) If an agent wishes to have a regular commission income, she can meet a fixed number of prospects or a fixed number of existing customers for renewal.
- c) If she wants to earn more commission, she can step up her efforts depending on her appetite for growth.
- d) She can work at her own terms and when she pleases and not have a 10 to 5 schedule. She may even decide to be more active in some months and less active in other months based on her other priorities.
- e) If she has an appetite for sales, she may be able to combine her efforts in insurance with other fields like banking or even other fields such as teaching or whatever else that interests her.

The work - life balance that one can achieve when one is working as per her own career and ambitions is a plus point for insurance agents.

3. The emerging environment

An agent should be aware of the external environment in which she is working.

- a) The insurance industry in India has seen a high growth in the last decade, both in the life and non-life segments.
- b) The gross direct business of general insurance business in India for the year 2013-14 was Rs. 77,550 crore and the industry is growing at a healthy rate of about 15 per cent.
- c) Of this, the health insurance business was Rs 19,700 crore and growing rapidly.
- d) India's insurable population is anticipated to touch 75 crore in 2020, with life expectancy reaching 74 years.
- e) Even today, approximately 75% of medical expenses of a family are borne by itself and therefore the opportunity for health insurance is immense.

Indian insurance market is still at a stage of growth and the potential for growth of the health insurance sector is even more with rising medical costs and incidence of diseases. Today, more people are also becoming aware of the need to insure themselves.

The penetration [given by premiums as a percentage of GDP] of the non-life sector in India, as per 2012 data is still around 0.7 % and the density [premiums per capita] is still around Rs. 550/-. This shows that the market is virtually still untapped and there is tremendous scope for growth in the sector.

At the end of the financial year 2013-14, there are 24 companies in the life sector and 28 companies in the general insurance industry of which 5 are standalone health insurance companies. Many more companies may enter the market in future as there is huge untapped potential. This potential can be realised through the agency channel of selling. Along with the growth of the sector, there would also be openings for new jobs, particularly in insurance selling.

Test Yourself 1

Which among the following are the two basic qualities that make a good sales person?

- I. Empathy and ego drive
- II. Prejudice and loathing
- III. Pride and honesty
- IV. Scepticism and perseverance

B. Different careers in insurance

A career as an insurance agent is for many, a starting point for an opening in other areas in the insurance segment. There are jobs available, both at the field level and also the office level of insurance companies. An insurance agent who seeks to move into these careers would of course need to equip herself with the required knowledge and skills that are needed for respective roles.

Some of these careers are discussed below:

1. Corporate agents

This is a channel that has emerged only in recent years as a part of the liberalisation process. It is similar to the “Individual Agency” model. Here a corporate body, which has its own set of customers, tries to reach out and sell insurance products.

Example

A large co-operative society, which is engaged in distributing various products to its members, may decide to become a corporate agent of an insurance company.

The corporate agent could be:

- a) A firm
- b) A company formed under Companies’ Act, 1956
- c) A Banking Company
- d) A Regional Rural Bank
- e) A Co-op. Society/Co-op. Bank
- f) A Panchayat/Local Authority

IRDA’s regulations require that the corporate agent needs to set up a separate unit with a Principal Officer and trained manpower which has undergone compulsory training from an institute recognised by the regulator.

One can have a career as an insurance executive in a corporate agency. One would need to be properly trained, skilled and knowledgeable in insurance products.

2. Insurance brokers

IRDA (Insurance Brokers) Regulations, 2002 gives details of the broking profession. Brokers are insurance intermediaries representing the customer. A broking firm requires a minimum amount of capital and its officers are required to undergo 50 hours training and pass an examination.

A career with a broking firm would be an attractive option for those who are interested in insurance marketing and sensitive to customers' insurance needs.

Both agents and brokers are intermediaries who interact with the insurance company and the customer.

There are however differences between the two as given in the box below.

Agent	Broker
Is a representative of the insurance company and is governed by the principal - agent relationship.	An insurance broker represents the insured. His principal is the client/insured.
The agent's primary relationship and responsibility is to the insurance company and not the insurance buyer.	Does not have any contractual agreements to exclusively serve any one insurance company and is expected to represent the customer's interest in choosing the right product and company that would best fit the customer's particular needs.
The agent is expected to faithfully represent his or her company and offer whatever is available in the company's product line to the customer.	Brokers assist their customers and prospective customers in developing risk management strategies appropriate to their risk profiles. They also work with their customers to find out what kinds of risks they regularly encounter, and educate them about what policies are available in the market for each type of risk. Brokers also advise and assist their customers in carefully selecting their insurance policies and reducing their premiums through the use of deductibles or self-insured retentions.

3. Bancassurance

The term 'Bancassurance' broadly refers to the tie up between banks and insurers to distribute insurance products to their customer base. It has emerged as an important distribution channel globally and has risen in a relatively short time due to the mutual benefits it offered in terms of operational cost and efficiencies. This was due to the wide consumer network that banks had access to.

In India, bancassurance is still quite new. However it has immense potential which is seen from the rapid strides it has already made. India has two broad bancassurance models:

- a) One, where a bank becomes a corporate agent of an insurer and taps its customer base to sell insurance products. In this case the employees of the bank take up the task of selling the products of the insurance company.
- b) A referral model, where the bank supports the insurance company with the data base while the sale of insurance products is done by the insurance company.

The first one, where banks become corporate agents of an insurance company, is gaining momentum. The potential is immense for this channel, as banks have a huge reach, across the entire geographical spread and are a strong brand supported by their customers.

Bancassurance is growing rapidly and needs a large number of insurance sales personnel. This offers attractive prospects for the insurance agent. Already this channel has taken a position of having almost a “monopoly” when it comes to distributing the insurance products of some of the companies.

4. Third Party Administrators (TPA)

We also discussed how TPAs assist the insurance companies in servicing their clients from the aspect of policy administration like issuance of identity cards right up to claims settlement. This is another area which is growing even as the health industry keeps growing and provides another avenue as a career for health insurance professionals.

5. Other career opportunities

In the previous paragraphs we considered various types of distribution channels in addition to the individual agency channel that provides selling / marketing career opportunities in the insurance industry. Let us now examine some other areas of opportunity for growth in an insurance company.

a) Marketing professionals

The insurance agent’s work and career is likely to be connected with the branch to which they are attached or the professional executives who are responsible for guiding and supporting the agent to achieve success in the business. These include the following persons:

- i. **The Branch Manager:** is the key person for promoting an agreeable atmosphere for work and productivity in the branch. She represents the company in the branch area and is Head of the branch family. She has ultimate responsibility for the growth and profitability of the branch. Branch manager also plays the role of an administrator, responsible for managing the day to day service and administration functions of the branch.

- ii. **The Development Officer / Unit Manager / Sales Manager:** The immediate person to whom every agent reports and looks up to, for guidance and support, is the Development Officer or Sales / Unit Manager. She may also be known as an Agency Manager. The Agency Manager is responsible for recruitment, development, supervision and providing leadership to help the agent in building a successful agency career.

Sales managers may also be managing other kinds of sales forces. For instance, a company may have a direct sales force and appoint sales managers to look after these units.

The manager has also to take up certain administrative functions and spend time on:

- ✓ Follow ups on business logins / proposal introductions and conversions
- ✓ Follow-ups on claims and renewals etc.

iii. **Sales trainer**

Many insurance companies have established training departments to train the sales-force.

Trainers are engaged in varied types of training interventions:

- ✓ **Pre-recruitment training:** meant for prospective agent advisors, it consists of the IRDA stipulated 50 hours training to help prospects clear the IRDA examination.
- ✓ **Product training:** for introducing the advisor to the products and services offered by the principal. This training is meant for both new and existing advisors, normally after they clear licensing exams. Only then the advisor is considered ready to approach prospects in the market place. Training is also provided when a new product is launched in the market by the principal.
- ✓ **Sales training:** most of the agents need to get equipped with proper sales training to be effective in the field.
- ✓ **Process training:** every organisation (principal) has its own defined systems and processes. Agents are trained so that they can adhere to the same. It is also the responsibility of the principal to ensure that agents undergo trainings on AML (Anti-Money-Laundering) guidelines, underwriting guidelines etc.
- ✓ **Soft skills training:** another area of training where sessions are conducted on a continuous basis for behavioural and other topics like:

- Goal setting
- Time management
- Business planning
- Work habits
- Leadership and personal effectiveness

iv. Counsellor

Trainers also play the role of counsellors for the agents and agency or sales managers, especially when they are de-motivated and need a fresh dose of motivation to get up and start meeting customers all over again. Insurance agents who have got experience of the above and seek to enter a career in teaching and mentoring others can consider the option of a trainer.

b) Other roles beyond marketing

The marketing department is responsible for a range of activities related to understanding and satisfying the needs of customers in the marketplace.

Many aspirants to a marketing career are engaged in these and an agent can consider some of them in future.

- i. **Marketing research:** to determine who the customers are and build a profile of their needs and wants.
- ii. **Brand management:** Marketing determines how to position the company and its products in the minds of customers. This is done through branding. Marketing executives who are responsible for brand management may also have to work with media, ad agencies and other bodies for marketing communication campaigns and promotion activities.
- iii. **Product development:** The marketing department also initiates and is responsible for new product development on the basis of analysis of market studies and competitor activities. For this purpose marketing department executives may team up with officials from other departments like actuarial and legal.
- iv. **Promotion:** Marketing department is also responsible for promotion of the products and the company. Their executives develop marketing plans, design promotional material for the different products, market the products to the customers and provide them services. The marketing department's role starts even before the launch of a product and carries on well after the product has been sold to the customer.

- v. **Underwriters:** Every proposal [or application] for insurance has to enter through a gate where a gatekeeper determines whether the proposal should be admitted, whether the risk can be accepted, and if so, on what terms. This gatekeeper is known as the underwriter.

Underwriting essentially serves two purposes. Firstly the screening of applications and selection of risks for insuring is done to prevent anti-selection. Secondly underwriting helps in properly classifying and pricing the risk so that equity is maintained among policyholders.

An insurance agency career is just the beginning of a career in an industry that plays a critical role in advancing human and social welfare. It can not only be a gateway to financial success but also confers much satisfaction to those who embark upon it.

Test Yourself 2

Which among the following is the most likely to contain the IRDA stipulated 50 hours training to help prospects clear the IRDA examination?

- I. Process training
 - II. Product training
 - III. Pre-recruitment training
 - IV. Sales training
-

Summary

- a) A good salesman should have two basic qualities: empathy and ego drive.
 - b) The rewards of being an insurance agent include being recognised by the society as knowledgeable professional, ability to recommend insurance solutions to people in need etc.
 - c) Other career options in the field of insurance include corporate agents, insurance brokers and bancassurance etc.
-

Key terms

- a) Empathy
 - b) Ego drive
 - c) Broker
 - d) Bancassurance
-