# IC38 Chapter wise Key Notes

Chapter 01: Introduction to Insurance

- Insurance – in simple language it means to transfer risk to someone who is capable of handling it generally to insurer (Insurance Company).
- Life Insurance History and Evolution:-
  - The origin of insurance business started from London's Lloyd coffee house.
  - 1st Life insurance company in the world was Amicable society for Perpetual Assurance.
  - 1st life insurance company to be set up in India was The Oriental Life Insurance company ltd.
  - 1st Non-life insurance company established in India was Triton Insurance company ltd.
  - 1st Indi an insurance company was Bombay Mutual Assurance society ltd found in 1870 in Mumbai.
  - National Insurance company ltd. is the oldest insurance company founded in 1906.
  - 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.
  - The Insurance Act 1938 was the first legislation enacted to regulate the conduct of insurance companies in India.
  - Life insurance Business was nationalized on 1stSeptember 1956 by merging 170 insurance companies and 75 Provident Fund societies and Life Insurance corporation of India ( LIC ) was formed..
  - Non – Life insurance business was nationalized in 1972 by amalgamating 106 insurers, General Insurance Corporation of India (GIC) & its 4 subsidiaries was formed.
  - Malhotra committee and IRDA: Malhotra committee – setup in 1993 to explore and recommend changes for development & it submitted the report in 1994.
  - IRDAI – Insurance regulatory and Development Authority of India was setup by an act IRDA Act 1999 as a statutory regulatory body for both life and nonlife

Life Insurance Industry Today:

- Life Insurance Corporation (LIC) of India is a public sector company.
- There are 23 life insurance companies in the private sector
- The postal department, under the Government of India, also transacts life insurance business via Postal Life Insurance, but is exempt from the purview of the regulator

How Insurance Works:

- There must be an asset which has economic value (Car-physical; Goodwill-nonphysical; Eye-personal).
- These assets may lose value due to uncertain event. This chance of loss/damage is known as risk.
- The cause of risk is known as peril.
- Persons having similar risks pool (contribute) money (premium) together.
- Types of Risk Burdens
  - Primary burden of risk – losses actually suffered. E.g. Factory getting fire.
  - Secondary burden of risk – losses that might happen. Eg. Physical/mental Stress strain.

Risk Management Techniques: -

- The various types of techniques that can be used to manage risk are a) Risk avoidance - Controlling risk by avoiding a loss situation
- Risk retention - One tries to manage the impact to risk and divides to bear the risk and its effects by oneself.
- Risk reduction and Control - This is a more practical and relevant approach than risk avoidance. It means taking steps to lower the chance of occurrence of a loss and / or to reduce severity of its impact if such loss should occur.
- Risk Transfer: Insurance is a risk transfer mechanism.

Insurance As A Tool For Managing Risk:-

- Don't risk a lot for a little. E.g. there is no need to insure a ball pen as its cost is not high.
- Don't risk more than what we can afford to lose. E.g. we cannot afford to not insure our house as its cost is high.
- Don't insure without considering the likely outcome. E.g. can anyone insure a space satellite?
- Note: Insurance refers to protection against an event that might happen whereas Assurance refers to protection against an event that will happen

Role of insurance in Society:

- Insurance benefits society economically and socially.
- It also provides employment
- The money raised from premium is invested in to the development of infrastructure needs.
- Removes the fear, worry and anxiety associated with one's future.
- Govt. Sponsored Insurance Schemes like Employees state insurance corporation, Crop Insurance Schemes (RKBY), Rural insurance schemes.
- Run by insurer and not supported by Govt. schemes like Janata Personal Accident, Jan Arogya

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Chapter 02: Customer Service

- Customers provide the bread and butter of a business and no enterprise can afford to treat them indifferently.
- The role of customer service and relationships is far more critical in the case of insurance than in other products.
- Because Insurance is a Service. Insurance is a Intangible good.
- It is necessary for insurance companies and their personnel, which includes their agents, to render high quality service and delight the customer

Customer Service and Insurance:

- The Secret for success in insurance sales is commitment to serving their Customers.
- 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.
- Customer lifetime value consists of 3 parts :
    - Historic value – premiums and revenues received through the customer is past.
    - Present value – premiums that may be expected to be received if policies are to be retained.
    - Future value – premiums that can be derived by persuading customers to buy new policies.

Insurance Agent's Role In Providing Great Customer Service:

- Point of sale – The 1st point for service is the point of sale. The agent should be able to understand the needs and suggest products whose benefit features are best suitable. The role of an agent is like a personal financial planner and advisor.
- Proposal stage – the agent has to help customers in filling the proposal form. It is important that the agent explains and clarifies the proposers doubt while filling the form.
- Acceptance stage – the promptness of agent in handing over FPR to customer develops surety in customers mind. Delivery of policy bond is another major opportunity.
- Premium payment – agents can be in continuous touch with their customers through reminder calls for premium due's in order to avoid lapsation of policy.
- Claim settlement – agents play crucial role during claim settlement by providing policy holder details required during investigation stage.

Communication skills

- Communication skills - One of the most important set of skills that an agent needs to possess for effective performance is soft skills.
- Soft skills relate to one's ability to interact effectively with other workers, customers.
- What goes in to making of a good relationship is TRUST that you generate in your customers mind through
    - Attraction;
    - Being Present;
    - Communication.
- Communication can take place in several forms –
    - Oral;
    - Written;
    - Non-Verbal;
    - Body Language.
- Elements of effective listening:
    - Paying attention
    - Providing feedback
    - Responding appropriately
    - Empathetic listening
    - Not being judgmental
- Non Verbal Communication
    - Making a great first impression
    - Be on time always
    - Present yourself appropriately
    - A warm, confident and winning smile.
    - Being open, confident and positive
    - Interest in the other person.
- Body Language Refers To
    - Movements
    - Gestures
    - Facial expressions.
    - The way we talk, walk, sit and stand.

- Listening Skills
    - Active Listening where we consciously try to hear not only the words but try to understand the complete message being sent by another.
    - Paying Attention
    - Demonstrating that you are listening - Use of body language plays an important role here.
    - Provide feedback
    - Not being Judgmental - Such judgmental approach can result in the listener being unwilling allow the speaker to continue speaking, considering it a waste of time.
    - Responding appropriately
    - Empathetic listening - Being empathetic literally means putting yourself in the other and feeling his or her experience as he or she would feel it.

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Chapter 03: Grievance Redressal Mechanism

- A complaint is a crucial "moment of truth" in the customer relationship.
- If you are a professional insurance advisor, you would not allow such a situation to happen in the first place.
- IRDA has various regulations in order to render the consumers grievances/complaints which come under protection of policy holder's interests Regulation 2002.

Integrated grievance management system (IGMS) –

- IRDAI has launched an integrated grievance management system (IGMS) which acts as a central repository of insurance grievance data
- It is a tool for monitoring grievances in the industry.
- Policy holders can register on this system with their policy details. Complaints are then forwarded to the respective insurance company.
- IGMS tracks complaints and the time taken for redressal.

The consumer protection act 1986

- The 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.
- Key Definitions under This Act Service – any provision made available to potential users such as banking, financing, transport, insurance etc
- Consumer – any person who buys any goods for a consideration or hires or avails of any services for a consideration.
- Defect – it means any fault, imperfection, and shortcoming, inadequacy in quality, nature, manner or performance for any service that is taken by the customer.
- Complaint – it means any allegation given in writing regarding any unfair trade, defect in goods, deficiency in services hired or availed, excess pricing.
- Consumer dispute – it means a dispute where the person against whom the complaint is made, denies and disputes the allegations made on him.

Consumer Disputes Redressal Agencies

- District Forum: The forum has jurisdiction to entertain complaints up to 20 lacs value of goods and services+ compensation.
- State Commission: The forum has jurisdiction to entertain complaints above 20 lacs but less than 100 lacs value of goods and services+ compensation. It entertains appeals from the District Forum
- National Commission: The forum has jurisdiction to entertain complaints exceeding 100 lacs value of goods and services+ compensation. It has supervisory jurisdiction over State Commission.

All the three agencies have powers of a Civil Court.

- Consumer disputes categories with respect to Insurance are:
    - Delay in settlement of claims
    - Non-settlement of claims
    - Repudiation of claims
    - Quantum of loss
    - Policy terms, conditions etc
- Ombudsman :
    - Total office of ombudsman in India – 12.
    - The Ombudsman power is restricted to Rs.20 Lacs.
    - The objective of setting up Ombudsman 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
    - d) The Ombudsman, by mutual agreement of the insured and the insurer can act as a mediator and counselor within the terms of reference.
    - e) Recommendations should be made within 1 month of the receipt of a complaint
    - f) The complainant has to accept the recommendation in writing within 15 days of receipt of such recommendation.
    - g) The insurance companies are required to honor the AWARDS passed by Ombudsman within15 days.
    - h) If the dispute is not settled, the Ombudsman will pass an award to the insured within 3 months / 90 days from the date of receipt of the complaint.
    - The insured should acknowledge within 1 month of receipt of such award.
- Complaints can be made to the ombudsman if the complainant had made a previous written representation to the insurance company and the insurance company had
    - Rejected the complaint.
    - The complainant had not received any reply within one month from insurer.
    - The complainant is not satisfied with the reply given by the insurer.
    - The complaint is made within one year from the date of rejection by the insurance company.
    - The complaint is not pending in any court or consumer forum.

Important TATs:

- 10 days – Insurer has to communicate the policy holder on any inquery.
- 15 days – Customer can cancel the contract within 15 days of receiving the policy (Free look period/Cooling off period).
- 15 days – Insurer has to convey the policy holder about acceptance or rejection of proposal.

- 15 days – In case of claim insurer can ask for additional documents within 15 days of receiving the claim documents.
- 15 days – Insurer has to honor the Award passed by the ombudsman within 15 days.
- 15 days – Grace period in case of monthly mode of premium payment.
- 31 days or one month – Grace period in case of Quarterly/half yearly/annual mode.
- 30 days – ombudsman has to pass recommendation.
- 30 days – Insurer has to settle the claim within 30 days after receiving the claim document.
- 90 days – Ombudsman has to pass an award within 90 days.
- 180 days – maximum time in case of disputed claims.

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Chapter 04: Regulatory Aspects of Insurance Agents

Regulations of Insurance Agents:

- Appointment of Insurance Agent regulations came into force with effect from 1st April 2016.
- A letter of appointment issued by an insurer to any person to act as an insurance agent.
- "Insurance Agent" means an individual appointed by an insurer for the purpose of soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance.
- "Composite Insurance Agent" means an individual who is appointed as an insurance agent by two or more insurers subject to the condition that he/she shall not act as insurance agent for more than one life insurer, one general insurer, one health insurer and one each of the mono-line insurers.
- "Centralized list of Agents" means a list of agents maintained by the Authority, which contains all details of agents appointed by all insurers
- "Designated Official" means an officer authorised by the Insurer to make Appointment of an individual as an Insurance Agent
- An applicant seeking appointment as an insurance agent of an Insurer shall submit an application in Form I-A to the Designated Official of the Insurer
- The Designated Official shall communicate the reasons for refusal for appointment as agent to the applicant in writing, within 21 days of receipt of the application

Appointment of Composite Insurance Agent by the insurer:

- An applicant seeking appointment as a "Composite Insurance Agent" shall make an application to the Designated Official of respective life, general, health insurer or monocline insurer.
- Composite Agency Application Form I-B.
- Insurance Agency Examination:
- An applicant shall pass in the Insurance Agency Examination conducted by the Examination Body in the subjects of Life, General, or Health Insurance
- Disqualification to act as an Insurance Agent:
- The conditions for disqualification shall be as stipulated under Section 42 (3) of the Act

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Chapter 05: Legal Principles of an Insurance Contract

Insurance Contract – an insurance policy is a contract between 2 parties – Insurer (Insurance Company) and Insured (Policy holder) as per Indian Contract act 1872.

For any contract to be a valid contract following elements should be there –

- Offer and Acceptance – out of the 2 parties" one should offer and other party should accept. Usually offer is made by proposer (policy holder) and acceptance is made by insurer.
- Consideration – premium paid by policy holder and the promise to indemnify by insurer is known as consideration.
- Agreement between parties – both parties should agree to the same thing.
- Free consent – there should be no pressure on proposer while taking policy. Consent is free when the policy is taken under no-coercion; undue influence; fraud; misrepresentation; mistake.
- Capacity of the parties – proposer should be legally competent. I.e. Sound mind, not disqualified by law, should not be minor.
- Legality – the object of contract must be legal.

Special features of Insurance Contract)

- Uberima Fides (or) Utmost good faith – it means that every party to contract must disclose all material facts relating to the subject matter of insurance whether asked or not.
- Material facts/Information – proposers family history; medical history; financial details; occupational details; illness if any; habits etc. are known as material facts.
- Breach of utmost good faith: -
    - Non-disclosure – not informing certain details.
    - Concealment – intentionally not giving details.
    - c) Misrepresentation –
        - innocent – by mistake giving wrong information
        - Fraudulent – intentionally giving wrong information.
- Insurable Interest – it is the financial interest the proposer has in his belongings. I.e. Self; spouse; parents; house; car etc. is termed as insurable interest.
- In Life Insurance – Insurable interest should be present at the start of policy.
- In Non-life Insurance – Insurable interest should be present both at the start and during claim.
- In Marine Insurance – Insurable Interest should be present at the time of claim.
- Proximate Clause – it is the main reason behind the various activities taking place and there by resulting into any event.
- Free Look-In Period (or) Cooling off period – if any proposer after entering into a contract i.e. After taking a policy if he wants to cancel or reject the policy then he or she take this decision within 15days from receiving of policy.
- Indemnity - 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.
- Subrogation: It is the process an insurance company uses to recover claim amounts paid to a policy holder from a negligent third party.

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Chapter 06: What Life Insurance Involves

Life Insurance Business Components

- Assets – any physical or non-physical thing which has value i.e. Can measured in terms of money is known as Asset. Every human being has a value which can be determined and is termed as Human Life Value (HLV). HLV helps to determine how much insurance one should have for full protection.
- E.g. Mr. Mahesh earns Rs.120000 per annum and spends Rs.24000 on himself. Therefore net earnings for family in case of Mr. Mahesh"s death is Rs.96000 per annum. Suppose rate of interest is 8% then HLV = 96000/ 0.08 = 12,00,000.
- Risk – there are various types of risk involved for a human being such as dying too early; living too long; living with Disability.
- Indemnity – in the occurrence of an event, the procedure to assess the loss and pay the compensation for this loss is known as Indemnity.
- Level Premium – it is a premium fixed in such a manner that it does not increase with age but remains constant throughout the contact period
- Principle of Risk Pooling – it works on the principle of mutuality. Here premium collected from various people is collected in same pool for same risk and used for same kind of risk claim.
- Under no circumstances money collected under one risk pool is used for another pool.
- Mutuality is one of the important ways to reduce risk in financial markets, the other being diversification. The two are fundamentally different.
- Contract – taking insurance involves getting into a contract. Here the contract is between the Insurer (Insurance company) and Insured (Policy holder).

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Chapter 07: Financial Planning

Financial planning is a process to identify his goals; assess net worth; estimating future financial needs; and working towards meeting those needs.

- Goals
    - Short term – buying LCD Television; family vacation.
    - Medium term –buying a house
    - Long term – Children's education/ marriage; post-retirement provision.
- Economic Life Cycle:–
    - Student Phase – this is pre-job phase. One is getting ready for earning phase.
    - Working Phase – this phase starts around 20-25yrs of age and lasts for 35-40yrs.
    - Retirement Phase – this phase is where-in one has stopped working.
- Individual life cycle –
    - Learner [till age 25] – this is the learning phase of an individual.
    - Earner [25 onwards] – this is the phase when one starts earning.
    - Partner [28- 30yrs] – this is the phase when one gets married.
    - Parent [30-35yrs] – this is the phase when one move towards parenting.
    - Provider [35-55yrs] – this is the phase when parents have to fulfill children's needs.
    - Empty Nester [55-65yrs] – this is the phase when children get married.
    - Retirement [60 onwards] – this is the phase when one gets retired and there's no regular source of income. Health also gets deteriorating.

- Individual Needs –
    - Enabling future transactions – making provision for future transactions such as education marriage.
    - Meeting contingencies – keeping money for unforeseen events like unemployment, hospitalization, death etc.
    - Wealth accumulation – this is to be done for increasing your money value.
- Financial products – for above needs to be fulfilled following products can be used
    - Transactional product – bank deposits can be used for cash requirements.
    - Contingency product – Insurance can be used to protect against unforeseen events.
    - Wealth accumulation product – shares; bonds can be used to invest for wealth creation.
- Role of Financial Planning: –
    - It is a process in which clients current and future needs are considered and evaluated along with his risk profile and income assessment. Financial planning includes – Investing, Risk management, Estate planning, Retirement planning, Tax planning and financing daily and regular requirements.
- Note – The right time to start fanatical planning is when one starts receiving his first salary.
- Need for Financial Planning: –
    - Disintegration of joint family; multiple investment choices; changing lifestyles; inflation; other contingency needs.
- Financial planning – Types : Cash Planning, Investment Planning, Insurance Planning, Retirement Planning, Estate Planning, Tax Planning

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Chapter 08: Life Insurance Products - 1

What is a product?

- From a marketing standpoint, a product is a bundle of attributes.
- The difference between a product (as used in a marketing sense) and a commodity is that a product can be differentiated. A commodity cannot.
- Products may be
    - Tangible
    - Intangible
- Life insurance is a product that is intangible.
- A rider is a provision typically added through an endorsement, which then becomes a part of the contract.
- Traditional Life Insurance Products
    - Term Insurance Plans - A term insurance policy comes handy as an income replacement plan.
    - The unique selling proposition (USP) of term assurance is its low price, enabling one to buy relatively large amounts of life insurance on a limited budget.
        - Level Term Insurance
        - Decreasing term assurance
            - These plans provide a death benefit that decreases in amount with term of coverage e.q. A 10 years decreasing term policy may offer a benefit of Rs. 1, 00,000 for death in first year with amount decreasing by Rs. 10,000

on each policy anniversary, top finally come to zero at the end of the ten years.
        - Mortgage redemption Plan is of decreasing term insurance designed to provide death amount that related to the decreasing amount owned on mortgage loan in such loans, each equated monthly Installment (EMI) payment leads to a reduction of outstanding principal amount.
        - Increasing term assurance
        - Term assurance with return of premiums

    - Whole Life Insurance Plans
        - There is no fixed term of cover but the insurer offers to pay the agreed upon, death benefit when the insured dies, no matter whenever the death might occur.
    - Endowment Insurance Plans
        - Combination of 2 plans: A term assurance plan Pays the full sum assured in case of a death of the insured during the term A pure endowment plan pays this amount if the insured survives at the end of the term
    - Money back plan: It is typically an endowment plan with the provision for return of a part of the sum assured in periodic installments during the term and balance of sum assured at the end of the term.

- IRDA's new guidelines for traditional products.
    - New traditional products will give a higher death cover.
        - For single premium policies it will be 125% or the single premium for those below 45 Years and 110% of single premium for those above 45 years.
        - For regular premium policies, the cover will be 10 times the annualized premium paid for those below 45 and seven times for others.

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Chapter 09: Life Insurance Products – 2

- Cash value component
    - The savings or cash value component in traditional life insurance policies is not well defined
- Rate of return
    - It is not easy to ascertain what would be rate of return on traditional life insurance Policies
- Surrender value
- The cash and surrender values (at any point of time), under these contracts depend on certain values (amount of actuarial reserve and the pro-rata asset share of the policy)
- Yield
    - Finally there is the issue of the yield on these policies
- Appeal:
    - Major sources of appeal of the new genre of products that emerged worldwide are :
        - Direct linkage with the investment gains
        - Inflation beating returns
        - Flexibility
        - Surrender value

- Non-traditional life insurance products Universal Life Insurance
    - Universal Life Policy was first introduced in the USA. Universal life insurance is a form of permanent life insurance characterized by its flexible premiums, flexible face amount and death benefit amounts, and the unbundling of its pricing factors.
- Non-traditional life insurance products
    - Variable insurance plans
    - Unit linked insurance plans
- Break-up of ULIP Premium
    - Expenses
    - Mortality
    - Investment
- Investment fund options offered by ULIP Equity Fund :
    - This fund invests major portion of the money in equity and equity related instruments.
    - Equity Fund: Invests major portion of the money in equity and equity related instruments.
    - Debt Fund: Invests major portion of the money in Government Bonds, corporate Bonds, Fixed deposits etc.
    - Balanced Fund: Invests in a mix of equity and debt instruments
    - Money Marker Fund: Invests money mainly in instruments such as treasury bills, certificates of deposit, commercial paper etc.
- Variable Life Insurance:
    - This policy was first introduced in the United States in 1977.
    - Variable life insurance is a kind of "Whole Life" policy where the death benefit and cash value of the policy fluctuates according to the investment performance of a special investment account into which premiums are credited.
    - Theoretically the cash value can go down to zero, in which case the policy would terminate.
- Unit linked insurance
    - Unit linked plans, also known as ULIP"s emerged as one of the most popular and Significant products, displacing traditional plans in many markets.
    - These plans were introduced in UK, in a situation of substantial investments that life insurance companies made in ordinary equity shares and the large capital gains and profits they made as a result.
    - Unit linked policies thus provide the means for directly and immediately "cashing on the benefits of a life insurer's investment performance.

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Chapter 10: Applications of Life Insurance

- Married Women's Property Act:
    - Section 6 of the Married Women's Property Act, 1874 provides for security of benefits under a life insurance policy to the wife and children. Section 6 of the Married Women's Property Act, 1874 also provides for creation of a Trust.
- Beneficiaries under Section 6 of MWP Act :
    - Wife alone
    - Wife and one or more children jointly
    - One or more children

- Features of a policy under the MWP Act:
    - Each policy will remain a separate Trust. Either the wife or child (over 18 years of age) can be a trustee.
    - The policy shall be beyond the control of court attachment and even the life assured.
    - The claim money shall be paid to the trustees.
    - The policy cannot be surrendered and neither nomination nor assignment is allowed. .
    - If the policyholder does not appoint a special trustee to receive and administer the benefits under the policy, the sum secured under the policy becomes payable to the official trustee of the State in which the office at which the insurance was effected is situated.

- Key Man Insurance:
    - It can be described as an insurance policy taken out by a business to compensate that business for financial losses that would arise from the death or extended incapacity of an important member of the business.
    - Key man is a term insurance policy where the sum assured is linked to the profitability of the company rather than the key person's own income. The premium is paid by the company.
    - This is tax efficient as the entire premium is treated as business expense. In case the key person dies; the benefit is paid to the company.
    - Unlike individual insurance policies, the death benefit in key man insurance is taxed as income.
- Who can be a KEYMAN?
    - A key person can be anyone directly associated with the business whose loss can cause financial strain to the business. For example, the person could be a director of the company, a partner, a key sales person, key project manager, or someone with specific skills or knowledge which is especially valuable to the company.
- Mortgage Redemption Insurance (MRI) :
    - It is an insurance policy that provides financial protection for home loan borrowers. It is basically a decreasing term life insurance policy taken by a mortgagor to repay the balance on a mortgage loan if he / she dies before its full repayment.

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Chapter 10: Pricing and Valuation in Life insurance

- Premium:
    - Price for insurance.
    - Pricing refers to the process of calculating the rate of the premium that will be charged on insurance policy.
    - It is normally expressed as a rate of premium per thousand of Sum Assured
    - The policyholder can pay the premium in a number of ways:
        - Single Premium Plan
        - Level Premium Plan
        - Flexible Premium Plan
- Types of Premiums: Arriving at the rate is performed by an Actuary
    - Office Premium: These rates printed in the tables of insurance companies.
    - These are typically level premiums which need to be paid every year.
    - Risk Premium: Premium is charged to meet the claim for the year.
      Risk Premium = Mortality rate X Sum assured.

- Level Premium: Equal premium charge for entire term of the policy.
- Net Premium: The interest earned is also considered for the premium calculation. Net Premium = premium – interest earnings.
- Gross Premium :Net Premium + Loading for expenses + Loading for contingencies + Bonus Loading
- Higher the mortality rate, higher the premiums would be.
- Higher the interest rate assumed, lower the premium

- Rebates:
  - Life insurance companies may offer certain types of rebates on the premium that is payable.
  - Two such rebates are
    - For sum assured
    - For mode of premium.
- Extra charges: (Loadings):
  - Addition to net premium. Example: Administration charges, medical expenses, processing fees, profit margin bonus etc.
- Components of premium:
  Guiding principles of Determining amount of loading:
  - Adequacy: The total loading from all policies must be sufficient to cover the company's total operating expenses. It should also provide a margin of safety and finally it should contribute to the profits or surplus of the company.
  - Equity: Expenses and safety margins etc. should be equitably apportioned among various kinds of policies, depending on type of plan, age and term etc.
  - Competitiveness: The resulting gross premiums should enable the company to improve its competitive position.
- Assets are valued in one of the following three ways
  - The most common form of bonus is reversionary bonus.
  - Bonus are payable even on surrender of policy.
  - The various bonuses given on life insurance policies
  - Surplus is the excess of value of assets over value of liabilities.
    - For example Surplus = assets – liabilities.
    - The value of assets is determined using its book value (the price at which it was acquired); market value (the price of that asset in current market); discounted present value.
    - The surplus earned is also to be allocated in proper manner in which is done using solvency requirement and free assets.
- Bonus :
  - Bonus is paid as an addition to the basic benefit payable under a contract.
    - Simple reversionary bonus – it is the percentage of the basic cash benefit under the contract. In India it is an amount per thousand sum assured.
    - Compound bonus – it is a percentage of basic benefit and already attached bonus. It is thus bonus on bonus.
    - Terminal bonus – it is given at the contractual termination (ie. Death or Maturity). It depends upon the time duration of the contract.

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Chapter 12: Documentation – Proposal Stage

- Proposal stage documentation:-
- Prospectus
    - It is a formal legal document used by insurer that provides details about the product. It states the terms and conditions scope of benefits- guaranteed- nonguaranteed; entitlements; exception
- Proposal form
    - It is a form to be filled by the proposer for giving all material required by insurer in order to decide catheter the risk of the proposer to be acetated or rejected.
- Agent report
    - Agent is primary under writer. All material facts and particulars about the proposer such as health, habits, occupation, income, family etc.
- Medical examiners report
    - The medical examiner's report is required typically when the proposal cannot be considered under normal condition i.e. Sum proposed is high or age is high or there are certain characteristics which call for examination and report by medical examiner.
- Moral hazard report
    - It is the likelihood that a client's behavior might change as report of purchasing a life insurance policy and such a change would increase the chance of loss.
- Anti-money laundering (AML)
    - The prevention of money laundering is the process of bringing illegal money into economy by hiding its origin.
    - The act to curtail was paned in 2002 and person found guilty is perishable for 3-7 years imprisonment and fine unto 5 lakhs.
- Know Your Customer (KYC)
    - It is the process used to verify the identity of their clients.
    - The objective is to prevent financial institutions from being used by criminal elements for money laundering activities.
- KYC procedure:
    - Photographs
    - Age proof
    - Proof of address – driving license, passport, telephone bill, electricity bill, bank passbook etc.
    - Proof of identity – driving license, passport, voter ID card, PAN card, etc.
    - Income proof documents in case of high-value transactions
- Free-look period (or) Cooling off period
    - Suppose a person has purchased a new life insurance policy and received the policy document and if the policy holder is not satisfied with the terms and conditions of the policy then he can take his decision to continue stop such policy within 15 days from receipt of policy document / bond.
    - Thus free-look period of 15 days is available as privilege to policy holder in order to take decision to be continued or not.

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Chapter 13: Documentation – Policy Condition - 1

- First Premium Receipt (FPR):
  - An Insurance contract commences when the life insurance company issues a FPR. The FPR is the evidence that the policy contract has begun.
  - FPR contains the following information:
    - Name and address of the life assured
    - Policy number
    - Premium amount paid
    - Method and frequency of premium payment
    - Next due date of premium payment
    - Date of commencement of the risk
    - Date of final maturity of the policy
    - Date of payment of the last premium
    - Sum assured.
- The company may require a moral hazard report from an official of the insurance company.
- Policy Document:
  - It is the evidence of the contract between he assured and the insurance company.
  - If the insured person loses the original life insurance policy document, the insurance company will issue a duplicate policy without making any changes to the contract.
  - It has to be signed by competent authority and stamped according to Indian Stamp Act
- Policy Document components:
  - Policy schedule
    - It contains Policy owner's name & address, DOB, Age, Plan & Term, Whether the policy is Par / Non Par, Mode of Premium, Policy no, DOC,DOM, SA , Premium paid, nominee, details of riders etc.,
  - Standard provisions
    - These are normally present in all LI contracts. These provisions define the rights and privileges and other conditions viz; days of grace, non-forfeiture in case of lapse
  - Specific policy provisions
    - These may be printed on the face of the document or inserted separately in the form of an attachment.
    - Eg: A clause precluding death due to pregnancy for a lady who is expecting at the time of writing the contract

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Chapter 14: Documentation – Policy Condition – 2

- Grace Period:
  - The "Grace Period" clause grants the policyholder an additional period of time to pay the premium after it has become due.
  - The standard length of the grace period is one month or 31 days computed from next day after due date.
  - The premium however remains due and if the policyholder dies during this period, the insurer may deduct the premium from the death benefit. If premiums remain unpaid even after the grace period is over, the policy would then be considered lapsed and the

company is not under obligation to pay the death benefit but for the amount under Non Forfeiture provisions.

- Lapse:
  - If the policy premium has not been paid even during days of grace, the policy is deemed to be lapsed.
- Reinstatement / Revival:
  - Reinstatement is the process by which a life insurance company puts back into force a policy that has either been terminated because of non-payment of premiums or has been continued under one of the non-forfeiture provisions
- Conditions of Policy Revival:
  - Payment of outstanding premium with interest
  - Fee for reinstatement
  - Proof of continued good health & income
  - No increase in Risk cover
  - Within time frame – in India within 5 years from the date of lapse.
  - f) Payment of outstanding loan.
  - g) Fresh medical examination may be required if SA is large.
- REVIVAL IS MORE OFTEN ADVANTAGEOUS BECAUSE BUYING A NEW POLICY WOULD CALL FOR A HIGHER PREMIUM BASED ON AGE ON THE DATE OF REVIVAL
- Policy Revival Measures:
  - Ordinary Revival
    - Involves payment of arrears of premium with interest. When the policy has acquired surrender value.
  - Special Revival
    - If the policy has run for less than 3 years and has not acquired minimum surrender value, Special Revival is done .New policy has been written when the DOC is within two years of the original date of commencement of the lapsed policy.
  - Loan cum revival
    - The simultaneous granting of a loan and revival of the policy.
  - Installment Revival
  - When the policy holder is not in a position to pay arrears of premium in a lump sum and neither can the policy be revived under special revival scheme.
- Non Forfeiture Provision
  - If premiums have been paid for at least 3 consecutive years, the accrued Surrender Value will be paid.
- Surrender Value
  - It is a percentage of paid up value. Surrender value as a percentage of premiums paid is called Guaranteed Surrender Value.
- Policy Loan
  - When a policy acquires a cash value, policyholder can borrow money (loan) while keeping the insurance alive.
  - It is usually limited to a percentage of Surrender Value (say 90%).
  - The policy has to be assigned in favor of insurer.
  - Insurers charge interest on policy loans.

- Nomination
    - It is the process of life insured proposing the name of the person(s) to whom the sum insured should be paid by the insurance company after his/her death.
    - A nominee does not have any right to whole (or part) of the claim.
    - For an insurance policy nomination is allowed under Sec 39 of the insurance Act 1938.
- Provisions of Section 39:
    - Nomination can be made when the policy is bought or thereafter
    - Nomination is not applicable to sec 6 of MWP Act.
    - Policy moneys payment is made to surviving nominees
    - Assignment cancels nomination
    - Addition, change or cancellation of nomination is allowed.
    - Nomination shall be by endorsement.
    - Where the nominee is a minor, an Appointee needs to be appointed by policy holder.
    - The appointee loses the status when the nominee reaches majority age.
    - No specific share of nominee can be made.
- Assignment:
    - Transfer the rights of the property (Policy).
- Provisions of Section 38 (Assignment):
    - On assignment, nomination is cancelled, except when assignment is made to insurance company for a policy loan
    - The person who transfers the rights is called assignor and the person to whom it is transferred is called assignee.
- There are 2 types of assignment –
    - Absolute Assignment – In such assignment all rights, title and interest are transferred to assignee without any reversion in policy.
    - Conditional Assignment – In such assignment the policy shall revert back to assignor after the fulfillment of prescribed conditions in the policy.
- Conditions for valid assignment
    - First of the person who transfers ie. Assignor must have absolute right & title on policy.
    - Assignment should be supported by value consideration, which may include love affection etc.
    - It should not be opposed by any law in force.
    - Assignee can do another assignment but cannot do nomination.
- Duplicate Policy :
    - If the insured person loses the original life insurance policy document, the insurance company will issue a duplicate policy without making any changes to the contract.
    - The claim may be settled on furnishing an indemnity bond with or without surety Alterations:
        - Policy holder may seek to effect alteration in policy terms and conditions.
        - It is subject to the consent of both insurer and insured.
        - Normally alterations may not be permitted during 1st year of policy Except for some simple ones like change of mode of payment of premium, change in name, address, request for grant of DAB or PDB etc
    - Main Types of alterations that are permitted are:
        - Change in certain classes of insurance or term [where risk is not increased]
        - Reduction in the sum assured
        - Change in the mode of payment of premium

        - Change in the date of commencement of the policy
        - Splitting up of the policy into two or more policies
        - Removal of an extra premium or restrictive clause
        - Change from without profits to with profits plan
        - Correction in name
        - Settlement option for payment of claim and grant of double accident benefit.

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Chapter 15: Underwriting

- Underwriting – Basic concepts
    - The process of insurers to decide whether the proposal to be accepted or rejected depending from the proposal information and insurers requirements and procedure is known as underwriting.
- Underwriting purpose
    - To prevent anti selection or selection or selection against the insurer.
    - To classify risks and ensure equity among risks.
    - Equity among risks here refers to those applicants who are exposed to similar degree of risk and are to be grouped together and charged same premium.
- Risk classification
    - Standard lives – those applicants / proposers whose mortality rate is considered to be as per standard requirements.
    - Preferred lives – those applicants / proposers whose mortality rate is significantly low and hence can be charged lower premium.
    - Sub –standard lives – those applicants / proposers whose mortality rate is higher than standard lives but insurable. They are charged extra premium.
    - Declined lives – those applicants / proposers whose mortality rate is very significantly high and cannot be insured at affordable cost.
- Selection process
    - Underwriting or selection process takes place at 2 levels
        - Field level (or) primary level – it includes information gathering of proposer through agents. Hence agents are also termed as primary underwriters. He monitors if any information given by proposer is true or not as he is the person who is in direct contact with proposer. He sends his confidential report containing proposer's occupation, income, financial standing and reputation.
        - Department level – at office level a specialist person who is expert in judging the collected data and considering this relevant data decides whether to accept or not the proposal. Such experts are known as underwriters.
- Underwriting decisions
    - The various options available to underwriter besides accepting or rejecting the proposal are as follows.
        - Acceptance at ordinary rate (OR) – it is the most common decision where in the proposal is accepted at same premium as it would apply for standard lives.
        - Acceptance at extra rate (ER) – it involves charging extra premium for substandard lives.
        - Acceptance with lien – it is kind of hold on sum assured amount. It implies if a policy is accepted under lien and if the proposer dies within lien period then the nominee is

entitled to receive decreased sum assured. Lien is applicable normally for 1/3rd period of the total period.
        - Acceptance with restrictive clause – for certain kind of hazards or restrictive clause is applied; if tomorrow claim arises due to such clause then full sum assured is not payable.
        - Decline or postpone – if the proposer does not fit in any of the above conditions i.e. They are very adverse and there is little chance of improvement then such cases are declined or decision on them is postponed for certain time period
- Rating factors in underwriting
    - Female insurance – insurability of women depends upon various factors such as income source (own, heir); pregnancy problems; moral hazards- domestic violence.
    - Minors – insurability of minors look for capacity of parents; need for insurance; has properly developed physique; proper family history; parents adequately insured.
    - Large sum assured – insurability for large sum assured policies raise a doubt of concern. Generally S.A is to be 10-12 times of annual income.
    - Age – insurability for advanced age group is to be considered with utter care. As chances of moral hazard is very high. Some special reports may be called.
    - Moral hazard – it is termed as characteristics of an individual's financial situation, lifestyle, habits, reputation, mental health that indicate his / her intentions.
    - Occupational hazard – insurability for people with occupational hazard may arise due to accident; driver / circus artists / stuntmen's; health – chemical factory workers / nuclear plant / deep sea divers; moral – criminal mind / night club workers.
    - Lifestyle and habits – drinking and smoking.
- Non-medical underwriting
    - A large number of proposals get accepted without conducting medical examination. Such cases are termed as non-medical proposals. Depending upon the information given in proposal form such cases are underwritten under non-medical case.
    - Conditions for non-medical underwriting
        - Certain categories of female, like working women may be eligible.
        - Upper limit of sum assured for e.g. Cases above 5lac may need to undergo medical.
        - Entry level of age. Proposers above 40-45 age may compulsory need medical.
        - Term of the policy. Insurer might restrict term up to 20 yrs. or maturity age till 60.
        - Class of lives. Depending upon work area insurer might call for medical.
- Medical underwriting
    - The medical factors that would influence an underwriter's decision. They may often call for a medical examiner's report. Factors involved are-
        - Family history – 3 factors are taken into consideration in order to understand family history of the proposer
        - Heredity – certain diseases can be transmitted from one generation to another.
        - Average longevity of family – if parents have died early due to cancer, heart trouble.
    - Family environment – the environment in which the family lives.
    - Personal history – it refers to past impairment of various systems of human body which the proposer might have suffered.
    - Personal characteristics –
    - Build – for a given age & height there is a standard weight, if the standard weight is too high or too low then such proposals need to be checked.

- Blood pressure – another indicator to know personal characteristic. Average pulse rate should be 72 and varying between 50-90.
- Urine-specific gravity – one's urine indicates the salts in the body. Its mal-functioning can be indicated through its test.

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Chapter 16: Payments under a Life Insurance Policy

- Claims
  - A claim is a demand that the insurer should make good the promise specified in the contract.
- Types of claims and claims procedure:-
  - Survival claim - claims payable even when the life inured is alive.
  - Death claim – claims payable on the death of the life assured.
- A Claim event is said to have occurred when
  - For survival claim the event has to be occurred as per stipulated conditions.
  - Maturity claim & money back claims are given based on determined dates.
  - Surrender value are claims to be given based on decision taken by insured.
  - Critical illness claims are processed based on medical and other records provided.
- Payments to be done during the policy term
  - Survival benefits payment – payments made at regular intervals by insurer at specified time during the policy term.
  - Surrender of policy – the voluntary decision taken by the policy holder to stop the policy contract. The amount payable to insured is surrender value.
  - Rider benefit – a payment done by insurer on occurrence of specified event according to terms and conditions. The policy continues even after the rider benefit payment is done.
  - Maturity claim – a payment done by insurer at the end of the policy term, if the insured survives the entire term of the policy. The insurance contract comes to an end after maturity claim is paid.
  - Death claim – if the insured expires during the term of the policy, accidentally or otherwise, then the insurer pays the sum assured, bonus, etc. to nominee; assignee or legal heir. Such payments are known as death claim. Contract comes to an end.
- Death claim can be
  - Early death claim – claim that arises within 3yrs from start of policy.
  - Non-early death claim – claim that arises after 3yrs from start of policy.
- Forms to be submitted by nominee; assignee or legal heir on death are
  - claim form; certificate of burial or cremation; treating physicians certificate; hospitals certificate; employers certificate; certified court copies of police reports in case of accidental death; death certificate issued by municipal authority.
- Repudiation of death claim
  - if it is detected by insurer that the proposer had made any incorrect statements or had suppressed material facts relevant to policy, the contract becomes void.
  - All benefits under the policy are forfeited.

- Indisputability clause
    - A policy which has been in force for 2yrs cannot be disputed on the ground of incorrect or false information. The insurer will have to prove in order to repudiate a policy after 2 years period.
- Presumption of death
    - The Indian evidence act 1872 deals with presumption of death; under this act if an individual has not been heard off or seen for 7yrs then they are presumed to be dead.
    - It is necessary that premiums should be paid till the court decrees presumption of death.
- Claim procedure for life insurance policy
    - It is included in the IRDA (protection of policy holder's interests) regulation 2002.
    - Insurer will call upon the primary documents which are normally required.
    - Any query or requirements of additional documents are to be asked within 15days.
    - A claim is to be paid or be disputed giving all relevant reasons within 30days.
    - In case of any dispute over the claim, it shall initiate and complete within 6months from the time lodging the claim.
    - Claim is ready for payment but cannot be done due to lack of proper identification, the life insurer shall hold such amount and shall earn interest as per schedule banks saving accounts rate (effective from 30days following the submission of all papers and information).
    - On delay of payment of claim on its completion would earn an interest of 2%above the prevalent rate of interest.
- Role of agent
    - An agent shall render all possible service to the nominee, legal heir or the beneficiary in filling up the claim form accurately and assist in submission of these at insurer's office. Apart from discharging obligations, goodwill is generated from such a situation where by there exists ample opportunity for the agent to procure business or referrals in future.

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Chapter 17: Introduction to Health Insurance

- Health :
    - Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.
    - Health is the Word Derived from the "Health". This means the soundness of the body.
- Determinants of health:
    - Life Style factors: Lifestyle factors are those which are mostly in the control of the individual concerned. Eg : Smoking, abusing drugs.
    - Environmental factors: Certain diseases caused due to environmental factors .Eg. Safe Drinking water, sanitation and nutrition. Etc...
    - Genetic factors: Diseases may be passed on from parents to children through genes.
- Types of healthcare:
    - Primary Health Care :
        - 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.

        - Primary Health care centers are set up both by Government and private players.
        - Government primary health care centers are established depending upon the population size and are present right up to the village level in some form or the other.
    - 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.
        - Most of the times, the patients are referred to the secondary care by primary health care providers / primary physician.
    - Tertiary healthcare:
    - Tertiary Health care is specialized consultative healthcare, usually for inpatients and on referral from primary/secondary care providers.
    - Eg: ONCOLOGY (CANCER TREATMENT), ORGAN TRANSPLANT FACILITIES, HIGH RISK PREGNANCY SPECIALISTS ETC.

- Factors affecting the health systems in India:
    - Demographic or Population related trends
    - Social trends
    - Life expectancy
- Evolution of Health Insurance in India
    - Employees' State Insurance Scheme:
        - Introduced by ESI Act,1948.
        - 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:
        - Free comprehensive healthcare at ESIS facilities
        - Maternity benefit
        - Disability benefit
        - Cash compensation for loss of wages due to sickness and survivorship
        - Funeral expenses in case of death of worker
- Central Government Health Scheme:
    - Introduced in the year 1954.
    - This scheme is for central government employees including pensioners and their family members working in civilian job.
    - The contribution from employees is quite nominal though progressively linked to salary scale Rs.15 per month to Rs.150 per month
    - 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
- Commercial health insurance:
    - In 1986, Mediclaim Policy was introduced to provide coverage for the hospitalization expenses up to a certain annual limit of indemnity with certain exclusions such as maternity, pre-existing diseases etc.
    - Private players are introduced into the market in year 2001.
    - Today, more than 300 health insurance products are available in the Indian market.

- Health Insurance Market:
- Infrastructure
- Public Health Centre: (PHC)
    - It operates in National level, State level, District level and Village Level.
- Anganwadi Workers: (1 of every 1000 population) "FOR NUTRITION SUPPLEMENTATION PROGRAMME AND INTEGRATED CHILD" DEVELOPMENT SERVICE SCHEME.
- The Trained Birth Attendants (TBA) and the Village Health guides (an earlier scheme of health departments in states).
- ASHA (Accredited Social Health Activist) volunteers, selected by the community under the NRHM (National Rural Health Mission) programme.
- *Sub-centers :*
    - Established: 5000 population (Rural), 3000 population (Hilly, Tribal and backward areas).
    - One female worker and one male worker
- Primary Health Centers:
    - Referral units for 4 Primary health centers.
    - For 1 Lakh population
    - 30beds
    - One operation theatre, X ray machine, Labour room and laboratory.
    - Referral units for about six sub-centers
    - 30,000 Population ( rural), 20000 population ( Hilly, Tribal, backward)
- Provides Outpatient services
    - 4-6 beds
    - 14 Para medical workers
    - One medical officer.
    - Community Health Centers:
    - Four specialists: One surgeon, Physician, Gynecologist, a pediatrician.

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

- Private sector providers:
    - India has a very large private health sector providing all three types of healthcare services - primary, secondary as well as tertiary.
    - In India nearly77% of the allopathic (MBBS and above) doctors are practicing in the private sector.
    - Private health expenditure accounts for more than 75% of all health spending in India.
    - The private sector accounts for 82% of all outpatient visits and 52% of hospitalization at the all India level.

- Pharmaceutical industry:
    - India has a large pharmaceutical industry, which has grown from Rs10 crore industries 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.

    - National Pharmaceuticals Pricing Authority (NPPA) – Regulator for the Pharmaceutical Industry
- Insurance Providers
    - Insurance Companies especially in the general insurance sector provide the bulk of the health insurance services.
- Intermediaries
    - Insurance Brokers: Who may be individuals or corporate and work independently of insurance companies. Brokers represent the customers. Work for one or more insurance companies.
    - Insurance Agents: Are usually individuals but some can be corporate agents too. Agents represent the insurance company.( one Life, One General or One Health Insurance company.)
    - Third-party Administrators: 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.
    - Insurance Web Aggregators: 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.
    - Insurance Marketing Firms: They can perform the following activities by employing individuals licensed to market, distribute and service such products.

- Other important organizations
    - Insurance Regulatory and Development Authority of India (IRDAI)
    - General Insurance and Life Insurance Councils
    - Insurance Information Bureau of India.

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Chapter 18: Insurance Documentation

- The first stage of documentation is the proposal form through which the insured informs about herself and what insurance she needs
- The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the policy period
- Insurance companies usually add a declaration at the end of the Proposal form to be signed by the proposer.
    - Elements of a proposal form usually include:
    - Proposer's name in full
    - Proposer's address and contact details
    - Bank details in case of health policies
    - Proposer's profession, occupation or business
    - Details and identity of the subject matter of insurance
    - Sum insured
    - Previous and present insurance
    - Loss experience
    - Declaration by the insured
- 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.

- The process of scrutinising the proposal and deciding about acceptance is known as underwriting.
- 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
- 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.
- 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
- A certificate of insurance provides proof of insurance in cases where it may be required
- The policy is a formal document which provides an evidence of the contract of insurance.
- A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract.
- 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.
- 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.
- Money Laundering means converting money obtained through criminal means to legal money and laws to fight this have been introduced worldwide and in India
- An agent has a responsibility to follow the Know Your Customer guidelines and obtain documents as required by these guidelines.

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Chapter 19: Health Insurance Products

- Classification of health insurance products:
    - "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 can be broadly classified into 3 categories:

- Indemnity covers:
    - These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.
- 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.
- Critical illness covers:
    - This is a fixed benefit plan for pay out on occurrence of a pre-defined critical illness like heart attack, stroke, cancer etc.

Classification based on Customer Segment:

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

IRDA Guidelines on Standardization in health insurance

- The guidelines now provide for standardization of:
  - definitions of commonly used insurance terms
  - definitions of critical illnesses
  - list of excluded items of expenses in hospitalization indemnity policies
  - claim forms and pre-authorization forms
  - billing formats
  - discharge summary of hospitals
  - standard contracts between TPAs, insurers and hospitals
    - standard File and Use format for getting IRDAI for new policies

Hospitalization indemnity product:

- Basic Health insurance Policy – Mediclaim policy.
- 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 hospitalization.

Main features of Mediclaim policy:

- Inpatient hospitalization expenses:
- All expenses may not be payable and most products define the expenses covered which normally include:
  - 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
  - Intensive Care Unit (ICU) expenses
  - Surgeon, anesthetist, medical practitioner, consultants, specialists fees
  - Anesthetic, blood, oxygen, operation theatre charges, surgical appliances, Medicines and drugs,
  - Dialysis, chemotherapy, radiotherapy
  - Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents.
  - Relevant laboratory and medical test.
  - Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured

DAYCARE PROCEDURES (WITHIN 24 HRS OF HOSPITALIZATION) – EYE SURGERY, CHEMOTHREAPHY, DIALYSIS.

- Pre and post hospitalization expenses:
- Pre hospitalization expenses:
  - 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.
- Post hospitalization expenses:
  - After stay in the hospital, in most cases there would be expenses related to Recovery and follow-up.

DOMICILIARY HOSPITALIZATION

- 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.
- 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, Diarrhea and all type of Dysenteries including Gastroenteritis, Diabetes Mellitus Epilepsy, Hypertension, Influenza, Cough and Cold, fevers.

COMMON EXCLUSIONS:

*Pre-existing diseases:*

- "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."
- Exclusions for Pre-existing disease – 48 months from the day of Inception of the policy.
- Waiting periods: Depending on the product, waiting periods of one / two / four years apply for diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout and Rheumatism, Calculus Diseases, gout and rheumatism, age related osteoarthritis, osteoporosis.

- **COVERAGE OPTIONS AVAILABLE**
  - Individual Coverage
  - Family Floater

- Top-up covers or high deductible insurance plans:
  - 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).
- Senior citizen policy:
  - Coverage: People over 60 years of age.
  - Sum Assured: Rs.50, 000 to Rs.5, 00,000.
  - Entry age is mostly after 60 years and renewable lifelong.
- Fixed benefit covers -Hospital cash, critical illness:
  - HOSPITAL DAILY CASH POLICY:
  - Per day amount limit – Rs.1500 – 5000 per day.
  - Number of payment days linked to the disease for which treatment is being taken.
  - The hospital daily cash policy is available as a standalone policy as offered by some insurers.
- CRITICAL ILLNESS POLICY
  - Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.
  - 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
- 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

- Age Group: 21 years to 65 years.
- Waiting period: 90 days from the inception of the policy.
- Survival Clause: 30 days after diagnosis of the illness.
- Rigorous medical examination will be done for age of more than 45 years.

- Long term care insurance:
    - 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:
    - Pre-funded plans which are purchased by healthy insured to take care of their future medical expenses
    - Immediate need plans which are purchased by a lump sum premium when the insured is requiring long term care.
- Bhavishya Arogya policy:
    - Introduced in the year 1990.
    - Age: 25 years to 55 years.
    - This scheme provides assignment.
    - This policy does not have the exclusions of pre- existing diseases. Micro insurance and health insurance for poorer sections
- Jan Arogya Bima Policy:
    - This policy is designed to provide cheap medical insurance to poorer sections of the society.
    - The coverage is along the lines of the individual Mediclaim policy. Cumulative bonus andmedical check-up benefits are not included.
    - The policy is available to individuals and family members.
    - The age limit is five to 70 years.
    - Children between the age of three months and five years can be covered provided one or both parents are covered concurrently.

- The sum insured per insured person is restricted to Rs.5,000 and the premium payable as per the following table.

- Universal Health Insurance Scheme (UHIS):
  - This policy is available to groups of 100 or more families. In recent times even individual UHIS Policies were made available to the public.
  - Benefits under this policy are Medical Reimbursement, Personal accident cover, Disability cover.
- Rashtriya Swasthya BimaYojana(RSBY):
  - Total sum insured of Rs. 30,000 per BPL family on a family floater basis.
  - Pre-existing diseases to be covered.
  - Coverage of health services related to hospitalization and services of surgical nature which can be provided on a day-care basis.
  - Cashless coverage of all eligible health services.
  - Provision of smart card.
  - Provision of pre and post hospitalization expenses.
  - Transport allowance of Rs.100/-per visit.
  - The Central and State Government pays the premium to the insurer.
  - Insurers are selected by the State Government on the basis of a competitive bidding.
  - Choice to the beneficiary between public and private hospitals.
  - 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.
  - Contribution by the State Governments: 25 percent of the annual premium and any additional premium beyond Rs 750.
  - Beneficiary to pay Rs. 30/- per annum as registration fee/ renewal fee.
  - Administrative cost to be borne by the State Government.
  - Cost of smart card additional amount of Rs. 60/-per beneficiary would be available for this purpose.
- Pradhan Mantri Suraksha Bima Yojana (PMSBY).
  - Covering personal accident death and disability cover insurance.
  - Age : 18 yrs to 70 years
  - Sum assured : Rs.2,00,000
  - Premium: Rs.12 per annum.
  - The cover shall be for the one year period from 1st June to 31st May.
- Pradhan Mantri Jan Dhan Yojana (RMJDY)
  - Interest on deposit.
  - Accidental insurance cover of Rs.1.00 lac
  - No minimum balance required.
  - Life insurance cover of Rs.30,000/-
  - Easy Transfer of money across India
  - Beneficiaries of Government Schemes will get Direct Benefit Transfer in these accounts.
  - After satisfactory operation of the account for 6 months, an overdraft facility will be permitted
  - Access to Pension, insurance products.
  - Accidental Insurance Cover
  - RuPay Debit Card which must be used at least once in 45 days.
  - Overdraft facility upto Rs.5000/-is available in only one account per household, preferably lady of the household

- Personal Accident and disability cover
    - Types of disability which are normally covered under the policy are:
        - Permanent total disability (PTD): means becoming totally disabled for lifetime
        - Permanent partial disability (PPD): means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.
        - 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.

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- Chapter 20: Health Insurance Underwriting
    - Is a process of risk selection and risk pricing.
    - Underwriting is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be granted.
    - 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.

- Factors which affect chance of illness:
    - Age, Gender, Habits, Occupation, Family history, Past illness or surgery, current health status and Environment and residence.
- Underwriting purpose:
    - To prevent anti-selection that is selection against the insurer
    - To classify risks and ensure equity among risks
- 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
- Underwriting or the Selection Process:
    - Field or Primary level
    - Department level
- Risk classification:
    - Standard risks: These consist of those people whose anticipated morbidity (chance of falling ill) is average.
    - Preferred risks: These are the ones whose anticipated morbidity is significantly lower than average and hence could be charged a lower premium.
    - 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.
    - 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.
- 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.

- Basic principles of insurance and tools for underwriting
  - The core principles of Underwriting are: Utmost good faith (Uberrima fides) and the insurable interest
- Tools for underwriting:
  - 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.
  - Age proof: Standard age proof: Some of these include school certificate, passport, domicile certificate, PAN card etc
  - Non-standard age proof: Some of these include ration card, voter ID, elder's declaration, gram panchayat certificate etc.
  - Financial documents: Knowing the financial status of the proposer is particularly relevant for benefit products and to reduce the moral hazard.
  - 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.
  - 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.

Summary:

- Health insurance is based on the concept of morbidity which is defined as the risk of a person falling ill or sick.
- Underwriting is the process of risk selection and risk pricing.
- Underwriting is required to strike a proper balance between risk and business thereby maintaining the competitiveness and yet profitability for the organization.
- 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.
- The purpose of underwriting to prevent adverse selection against the insurer and also ensure proper classification and equity among risks.
- The agent is the first level underwriter as he is in the best position to know the prospective client to be insured.
- The core principles of insurance are: utmost good faith, insurable interest, indemnity, contribution, subrogation and proximate cause.
- The key tools for underwriting are: proposal form, age proof, financial documents, medical reports and sales reports.
- 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.
- Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.
- Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.

- The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.
- 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.

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Chapter 21: Health Insurance Claims

- Claims management in insurance
  - Insurance is a "promise" and the policy is a "witness" to that promise.
  - Insurance is the claims paying ability of the insurance company.
- Stakeholders in claim process
- Role of claims management in insurance company
  - 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".
  - This means that there is a great need to adopt sound underwriting practices and efficient management of claims to bring better results to the company and the policyholders Management of health insurance claims
- Challenges in Health insurance:
  - Common perception – "Health insurance is not for Healthy People"
  - Lack of awareness about the Health insurance Products.
  - c) Health care delivery systems focus only on top 20 Cities in India.
  - d) Lack of reliable data
  - e) Price sensitivity to buying.

EFFICIENT CLAIMS MANAGEMENT ENSURES THAT RIGHT CLAIM IS PAID TO RIGHT PERSON AT THE RIGHT TIME.

- 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.

Claim process broadly comprises of following steps

- 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.
- 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.
- 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:
    - The documentary evidence of the illness
    - Treatment provided
    - In-patient duration
    - Investigation Reports
    - Payment made to the hospital
    - Further advice for treatment
    - Payment proofs for implants etc.

- Capturing the billing information
    - Billing is an important part of the claim processing cycle.
        - Room, board and nursing expenses including registration and service charges.
        - Charges for ICU and any intensive care operations.
        - Operation theatre charges, anesthesia, 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, anesthetist, medical practitioner, consultants, specialists' fees.
        - Ambulance charges.
        - Investigation charges covering blood test, X-ray, scans, etc.
        - Medicines and drugs.

- 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:
        - Cardiac packages: Angiogram, Angioplasty, CABG or Open heart surgery, etc.
        - Gynecological packages: Normal delivery, Caesarean delivery, hysterectomy, etc.
        - Orthopedic packages
        - Ophthalmological packages
- 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
- Processing of claim
    - 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?
- Admissibility of a claim
    - The member hospitalized must be covered under the insurance policy
    - Admission of the patient within the period of insurance
    - Hospital definition

- Domiciliary hospitalization
- Duration of hospitalization
- OPD
- Treatment procedure/line of treatment
- Pre-existing illnesses
    - 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."

- Initial waiting period
    - A typical health insurance policy covers illnesses only after an initial 30 days (except accident related hospitalization).
        - There are lists of illnesses such as:
            - Cataract, Hernia, Hydrocele, Fistula, Sinusitis, and Piles, Knee/Hip Joint Replacement – One year/Two year / more than a year depends upon Insurance Company.
- 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.
- Arriving at the final claim payable
    - Sum insured available for the member under the policy
    - Balance sum insured available under the policy for the member after taking into account any claim made already:
    - Sub-Limits - percentage of Sum assured.
    - Check for any limits specific to illness
    - Check whether entitled or not to cumulative bonus
    - Other expenses covered with limitation
    - Co-payment
- 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.
- The order of arriving at the final claim payable is as follows:
- 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.
- 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.
- 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:
        - Date of admission is not within the period of insurance.
        - The Member for whom the claim is made is not covered.
        - Due to Pre-existing illness (where the policy excludes such condition).
        - Undue delay in submission without valid reason.
        - No active treatment; admission is only for investigation purpose.
        - Illness treated is excluded under the policy.
        - The cause of illness is abuse of alcohol or drugs
        - Hospitalization is less than 24 hours
- 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.
- Suspect claims for more detailed investigation
- Few examples of frauds committed in health insurance are:
    - Impersonation, the person insured is different from person treated.
    - Fabrication of documents to make a claim where there is no hospitalization.
    - Inflation of expenses, either with the help of the hospital or by addition of external bills fraudulently created.
    - Outpatient treatment converted to in-patient / hospitalization to cover cost of diagnosis, which could be high in some conditions.
- Claims are chosen for investigation based on two methods:
    - Routine claims and
    - Triggered claims
- Cashless settlement process by TPA
    - "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 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
- The services that an insurer expects out of the TPA are as follows:
    - 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.

- 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 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.
- "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 preauthorization approved.

- TPA Remuneration
  - A percentage of the premium (excluding service tax) charged to the customer,
  - A fixed amount for each member serviced by the TPA for a defined time period, or
  - A fixed amount for each transaction of the service provided by the TPA – e.g. cost per member card issued, per claim etc.
- Claims management – personal accident
  - 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.
- Claims manager should mark caution and check following areas on receipt of the notification of the claim:
  - Person in respect of whom the claim is made is covered under the policy
  - Policy is valid as on date of loss and premium is received)
  - Loss is within the policy period
  - Loss has arisen out of "Accident" and not sickness
  - Check for any fraud triggers and assign investigation if need be
  - Register the claim and create reserve for the same
  - Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.
- Claim documentation - Personnel Accident:
  - Claims management- Overseas travel insurance
    - The covers under the policy can be broadly divided into following sections.
    - Medical and sickness section
    - Repatriation and evacuation
    - Personal accident cover
    - Personal liability
    - Other non-medical covers:
      - Trip Cancellation
      - Trip Delay
      - Trip interruption
      - Missed Connection
      - Delay of Checked Baggage
      - Loss of Checked Baggage
      - Loss of Passport
      - Emergency Cash Advance
      - Hijack Allowance

- Bail Bond insurance
- Hijack Cover
- Sponsor Protection
- Compassionate Visit.
- Study Interruption
- Home burglary.

Summary:

- 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.
- One of the key rating parameter in insurance is the claims paying ability of the insurance company.
- Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.
- 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.
- In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer / TPA for payment.
- Claim intimation is the first instance of contact between the customer and the claims team.
- 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.
- Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.
- 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.
- Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.
- The TPA provides many important services to the insurer and gets remunerated in the form of fees.