In a free and competitive insurance market, the consumer has a choice and he exercises it based on his perceptions about the cost of service, quality of service and the track record of the company in meeting its obligations. People purchase insurance to cover unforeseen calamities. They, however, hope that they would not be victims of such calamities. There cannot be a greater calamity than the repudiation of a claim by the insurance company, when the unfortunate victim is already overwhelmed by adverse circumstances. Grievance redressal, therefore, assumes greater significance in the insurance industry.

One of the major functions of the Regulator is to ensure that the industry establishes a grievance redressal mechanism that is visible, transparent and efficient. It is normally assumed that in a competitive world the survival of the provider of a service like insurance would depend on how efficiently he attends to the grievances of his customers. It is, however, not uncommon for the policyholders to feel that they had not received what is due and they were the victims of a conspiracy. When a claim is repudiated they feel that the company has gone back on its promises. This is, sometimes, due to differing perceptions about the clauses contained in the policy document. It is incumbent on the company to explain at the time of sale of an insurance contract what risks are covered and specially emphasise under what circumstances those risks are covered. It is equally important to put in place a mechanism that continuously reviews the kind of grievances voiced by the customers and address them imaginatively so that complaints are minimised. Grievances redressal is an important function and this month's Journal looks at this aspect from the points of view of the regulator, the industry and the consumer. The endeavour is to see that the industry works towards better consumer management and satisfaction.

This issue also contains detailed annual business statistics of the companies for the year ending 31st March, 2004. An interesting feature of the non-life business last year was the growth witnessed in personal lines of business. Is this a trend or an aberration would be known in the years to come.

The IRDA places much emphasis on professional education and training in the insurance industry to ensure the high quality of professional abilities that the market demands and deserves. The Insurance Institute of India has been an able partner in this pursuit and deserves our heartfelt felicitations as it enters its 50th year of service. We are sure it will thrive and grow with the insurance industry as it has in the past.

C.S. RAO
Most of us must have gone through this. A reasonable and responsible response from a service provider satisfies us more than their actually solving our problem. Because unhappy customers are not only unhappy with the product or service purchased, but also the level of response or the total lack of it past the purchase.

In the insurance industry the problem takes on some dimensions peculiar to the business. One is that the customer when he faces problems with claims is already in the throes of distress and requires sensitive handling. The second is that given the way the industry is composed, the individual customer is one among a million, and has no real power in the transaction to ensure that his needs are met.

It is to correct this asymmetry that there are layers of grievances redressal mechanisms up to the level of consumer and civil courts and including formalised adjudication processes for out of court settlements like the Lok Adalats and special courts like the Motor Accident Claims Tribunals. It is testimony to their necessity and to their utility that they are flooded with complaints of varying nature. The fact that the single largest category of complaints under the services sector is insurance says a lot about what is being done and what is yet to be done.

The Grievances Cell set up by the IRDA was another step in this direction. While providing comfort to customers of insurance it also gives the IRDA the opportunity to get a feel of what kinds of unresolved complaints customers have. The purpose of this exercise was not for the IRDA to take upon itself redressal of the complaints or settlement of claims but to speed up handling of the situation by companies.

The duty of the IRDA to protect policyholders' interests is achieved through ensuring the financial strength of companies so that they can fulfill their role of paying claims when they arise and through ensuring that good business practices, including setting and maintaining acceptable service levels, are established in the industry.

In fact the clauses relating to consumer protection and grievances redressal in the various regulations are only stepping stones for the companies, through the self regulatory mechanism of insurance councils, to adopt these and higher standards of conduct and customer service.

The industry has, in the past fashioned suitable mechanisms to deal with problem areas. Some of these have worked very well and others not. But initiatives like the Lok Adalats or Third Party cells, which were common endeavours by the public sector companies in the past, have shown that the industry will get together to solve some problems that are common to all. The shape and scope of the initiatives could be different with the mixed nature now of the industry and also the change in the way business is done and in the expectations of the customers, but happen it will!!

In this issue of IRDA JOURNAL we bring you a selection of articles that give an idea of the grievance redressal situation in the industry and the importance of this activity.

Mr. Debapriya Ray of Reliance General Insurance writes from his experience in the non-life industry, and earlier with LIC in the life industry, on the various angles from which grievances redressal can be undertaken while Mr. G. V. Rao gets to the heart of the matter – what the customer wants.

Ms. Yegnaniyra Bharath, Deputy Director, IRDA who handles the grievances cell work at the Authority gives a snapshot of work at this end.

Two consumer activist groups share with us their experiences with the consumer grievances redressal mechanism in the industry and make their suggestions. Prof. Manubhai Shah of Consumer Education and Research Centre (CERC), Ahmedabad and Mr. H. K. Awasthi of Consumer Voice, Delhi are the writers, and our readers are quite familiar with them.

A recent Supreme Court judgement has clarified an important point pertaining to motor accident case awards that an award based on structured compensation is final and we have Mr. D. Varadarajan, IRDA's Legal Adviser giving us the in depth details about it.

The much awaited detailed annual statistics, though provisional, for the life and non-life industries are carried in this issue and, as usual, we are sure that this will be read with great interest by all our readers.

It is only left to celebrate with the Insurance Institute of India, through whose hands all of us have passed at one time or another, their entry into the 50th year of service. The institute has seen the industry grow through successive changes over half a century and there is no doubt that the industry and the institute will jointly see many more changes, development and growth!

K. Nitya Kalyani
Life is Risk

K. Nitya Kalyani

Life is all about risk. And who knows this better than insurance companies that make a living out of assessing and accepting it? How they manage risk is what we will explore in the next issue of IRDAJ Journal.

No, it’s not an issue devoted to underwriting, though we should do that some time, but a look at the kind of risk management an insurance company, or an intermediary, has to do within its organisation.

And they run many risks day in and day out. Not even taking into account the customer who may or may not bite, now that there are over two dozen tasty baits!

Each day the insurance company, like any complex business enterprise, runs the risk of guessing consumer needs and satisfying them. If product development and marketing are huge challenges, pricing is equally frustrating. The interest rates are not as well behaved as, say, a decade ago, and the work of the actuaries must have got drearier, and more difficult vis-à-vis making the returns or pricing attractive.....

Once the premiums come in is the old, renewal risk for non-life companies and persistency for life companies. Assuming these hurdles are crossed is the investment risk – interest rate risk, reinvestment risk for long term investments, and default risk, not to speak of the risk of erosion of portfolio worth - that insurance companies face, given that their prime earner is the investment activity, over and above (sometimes against) the earnings through underwriting alone.

With all this on their hands, it’s a tremendous leap of faith that the company underwrites the risks of other businesses and of individuals. Or is it a leap of faith on the part of the customers that they willingly and trustingly transfer their risk to insurance companies!

Coming to intermediaries, agents today face the risk of increased competition. Not only from agents of other companies but also from a breed of intermediaries. They, and more so brokers, face the risk of competition even from insurance companies themselves that can and do practise active disintermediation up to the point of undercutting! That’s serious disintermediation risk! But that’s a way for the company to manage the risk of rising intermediation costs! That way, risk management seems to be a zero sum game!

Speaking of brokers, they have been facing protracted regulatory risk, and things seem to be settling down slowly for them, though not entirely to their initial expectations.

The list is long and it can all be funny as far as it is someone else’s risk. But seriously, let’s take a look at how companies manage their risks internally. We hope to bring you a clutch of articles that look at this from various points of view.
The IRDA has constituted an Ad-hoc Committee on Surveyors and Loss Assessors for the purposes of setting up of an independent Institute of Surveyors & Loss Assessors.

This is part of the work being undertaken by IRDA following Government advice to take action based on the report of the K. N. Bhandari committee constituted by the latter, which recommended that a self-financing and self-regulated institute on the model of Institute of company Secretaries or the Chartered Accountants should be set up for surveyors. The institute is to set norms and standards, conduct examinations, undertake teaching and research and enforce a code of conduct for its members.

Following this IRDA appointed Mr. G. V. Rao to assist it in processing the recommendations and taking necessary steps to establish the institute.

On his recommendation an ad-hoc committee is being formed with the responsibility to form and establish the institute of surveyors and loss assessors. It will invite applications from the licensed surveyors to become members of the proposed new institute. It will thereafter call a general body meeting for adopting the Memorandum and Articles of Association and for conducting election of office bearers of the proposed new institute who will then carry on the purposes and responsibility of the institute.

Mr. G. V. Rao can be contacted at #106, Shanti Nagar, Masab Tank, Hyderabad – 500 028 or on his e-mail - gvrao70@hotmail.com

**Members of the committee**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
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<tr>
<td>Mr. C. Srivatsan</td>
<td>28/29, Shivangi Shopping Centre, M.G. Road, Bangalore – 560 001, Karnataka</td>
</tr>
<tr>
<td>Mr. N. Shamhughavelu</td>
<td>6-4, Appaswamy Sreet, Umapathy St. Elm., West Mambalam, Chennai – 600 033, Tamil Nadu</td>
</tr>
<tr>
<td>Mr. Milin Mehta</td>
<td>Edna Building, 4-B, 4th Floor, 97, Mahasashakti Road, Mumbai – 400 020</td>
</tr>
<tr>
<td>Mr. Arun Gupta</td>
<td>M/s Associated Surveyors &amp; Consultants (P) Ltd., S-547-A, 1st Floor, School Block, Vikas Marg, Delhi – 110 092</td>
</tr>
<tr>
<td>Mr. B. L. Subramaniam</td>
<td>Sir &amp; Associates, 27-B/3, Takshila, Mahakali Road, Andheri (East), Mumbai – 400 093, Maharashtra</td>
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**Licensed Brokers**

- **Vimal Goyal**
  - Chartered Insurance Brokers Pvt. Ltd.
  - 308, Skipper Corner, B.B., Nehru Place, New Delhi-110019
  - Ph: (011)51618423

- **Vasant Kakirwar**
  - Jaika Insurance Broking Pvt. Ltd.
  - Jaika Bldg., Commercial Road, Civil Lines, Nagpur, Maharashtra
  - Ph: (0712)2520169

- **K.V. Srinivasa Gupta**
  - Sapthagiri Insurance Services Pvt. Ltd.
  - D.NO: 1-3-2, C/19, Penugonda Road, II Floor, Hindupur-515 201, Andhra Pradesh
  - Ph: (08556)226969

- **Manohar Kumar**
  - NewQuest Insurance Broking Services Pvt. Ltd.
  - Thanap House, 124 Janpath, New Delhi-110 001
  - Ph: (011)23368332

- **Sanjay Jain**
  - Image Insurance Brokers Pvt. Ltd.
  - 13, Community Centre, East of Kailash, New Delhi-110 065
  - Ph: (011)26472557
Welcome...

It was a tough choice between IIM (A) and IRDA. And the insurance regulator won! That is how Dr. D. V. S. Sastry, who joined IRDA on July 27 as Director General (Research and Development), came back home to Hyderabad after 40 years!

Twenty five of those were spent with the Reserve Bank of India where he started in 1979 as Research Officer and retired in November 2003 as Principal Advisor, Monetary Policy Department. And now at the IRDA, his immediate task will be to set up a research cell and to develop a statistical information system with orientation towards analysis for the Regulator.

“The role envisaged here was more challenging given my background,” Dr. Sastry says. “Insurance is a growing sector and needs to be integrated with the financial system and research in this area is scarce, but imminent.”

He intends to build up an information and research system to aid the Authority gain insights into the performance of companies and their role in the future integration of the financial system.

The 61 year old former academic - he spent 15 years teaching Statistics at the post-graduate level and doing research at Vikram and Indore universities in Madhya Pradesh before joining RBI – follows cricket, football and tennis keenly, all games he used to play. His wife is on the academic side too, and teaches Physics at Somaiya College in Mumbai.

His son and daughter are in the US, the former, an engineer with GE and the latter, a doctor. So travelling is obviously something he enjoys! And his eyes light up at the mention of his other hobby – reading.

“Anything,” he says, “and any amount of fiction.”

Now that would be an obvious respite from daylong work with statistics!

IRDA DEALS WITH FILE AND USE BREACHES

IRDA has advised general insurance companies to withdraw package insurance policies that contravene the tariff and to file revised products with it that conform the requirements.

The advice, dated July 21, follows discovery by the Authority that some insurers were deviating from the tariff rates and terms under the guise of offering package products and were also charging commission and brokerage beyond the limits prescribed for tariff business, in the process.

These products were mainly fire and related covers for industries packaged with non-tariff covers related to burglary, theft, personal accident, cash in transit, and the like.

The IRDA Chairman, in the circular, has said that the Authority wishes to make it clear that the file and use procedures for such package products were strictly subject to compliance with tariffs and brokerage/commission norms. However it was found that the operational offices of the insurers were marketing them as non-tariff products in violation of IRDA’s regulations relating to protection of policyholders’ interests and advertisements and disclosure, and hence the direction to withdraw the products.
The life insurance industry underwrote a premium of Rs.1,35,400.50 lakh during the month of June, 2004, taking the cumulative premium underwritten during the current year 2004-05 to Rs.3,65,929.75 lakh.

LIC underwrote premium of Rs.3,01,472.50 lakh i.e., a market share of 82.39 per cent, followed by ICICI Prudential and Birla Sunlife with premium underwritten (market share) of Rs.22,181.48 lakh (6.06 per cent) and Rs.9,362.15 lakh (2.56 per cent) respectively. While LIC’s market share declined from 89.91 per cent for the quarter ended June, 2003, all new life insurers except one increased their market share, over the corresponding previous year numbers. Cumulatively, the new players underwrote first year premium of Rs.64,457.25 lakh. In terms of policies underwritten, the market share of the new players and LIC was 8.42 per cent and 91.58 per cent as against 6.40 per cent and 93.60 per cent respectively of the corresponding period in the year 2003-04.

The premium underwritten by the industry towards individual single and non-single policies stood at Rs.39,963.07 lakh and Rs.2,26,785.58 lakh respectively accounting for 87,466 and 38,75,144 policies. The group single and non-single premium accounted for Rs.91,641.92 lakh and Rs.7,539.17 lakh. The number of lives covered by the industry under the various group schemes was 11,97,251 during the first quarter. LIC covered 7,85,746 lives under the group schemes accounting for 65.63 per cent of the market, followed by SBI Life with 92,533 lives (7.73 per cent) and TATA-AIG with 81,849 lives (6.84 per cent).

The accompanying table does not include the numbers under the Varishtha Pension Bima Yojana. Premium underwritten by LIC under this pension scheme during the quarter ended June, 2004 was Rs.98,469.50 lakh towards 50,541 policies.

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<th>% of Premium</th>
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<th>No. of lives covered under Group Schemes</th>
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### Statistics - Life Insurance

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Note: LIC’s business figures exclude Varishtha Pension Bima Yojana.
Report Card: GENERAL

June Growth Hits 16.5 %

G. V. Rao

Performance in June 2004

The non-life industry has recorded an impressive growth of Rs. 194 crore (16.5 per cent growth) in the month of June 2004. (It was 15.6 per cent in May 2004). The new players have chipped in about Rs. 88 crore (58 per cent growth) and the established players Rs. 93 crore (9.4 per cent).

ICICI-Lombard continues to spearhead the growth among the new players with an accretion of Rs. 28 crore (112 per cent), followed by IFFCO-Tokio with Rs. 24 crore (160 per cent) and Bajaj-Allianz with an accretion of Rs. 17 crore (52 per cent). The cumulative monthly premium of the new players is Rs. 240 crore up from Rs. 152 crore in June 2004. Tata AIG, HDFC Chubb and Cholamandalam have also done well contributing about Rs. 24 crore among themselves.

The four established players together have performed quite well to record an accretion of Rs. 93 crore (9.4 per cent growth) in June 2004. They have recorded a premium of Rs. 1,085 crore in June 2004 as against Rs. 992 crore in June last year.

Spearheading this growth is National Insurance that has completed Rs. 323 crore against Rs. 262 crore for the month of June 2003. Its premium is also the highest among the four players in June 2004, with an accretion of Rs. 61 crore and a growth rate of 23 per cent.

The non-life industry has recorded a growth of Rs. 194 crore (16.5 per cent) in June 2004 against 15.6 per cent in May 2004.

New India and Oriental have recorded accretions of Rs. 22 crore and Rs. 17 crore respectively each with a growth rate of about eight per cent. United India has shown a fall in business of Rs. seven crore and that comes as a bit of a surprise. One reason for it could be the enforcement of a stricter discipline in underwriting. National Insurance incidentally has recorded the highest premium of Rs. 323 crore among the four of them in June 2004.

The performance of the established players despite the Special Voluntary Retirement scheme of staff is indeed impressive; but the trends of development of department wise premiums up to March 2004 showed that the increases are coming in mainly from Motor and Health segments that are usually customer driven.

The industry has certainly reasons to be pleased to record a growth of 16.5 per cent in June 2004 due to the robust contribution from most of the new players.

GROSS DIRECT PREMIUM (within India) JUNE, 2004

(Rs.in lakhs)

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<th>INSURER</th>
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<th>METHKAR SHARE</th>
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* Data revised by the respective insurers for the corresponding month of the previous year.
Performance up to June 2004

The performance in the month of June 2004 has lifted the growth rate from 13.2 per cent at the end of May 2004 to 14 per cent the end of June 2004. The industry has recorded an accretion of Rs. 600 crore at the end of the first quarter of 2004/2005 to achieve Rs. 4,870 crore as the premium volume. Of this Rs. 600 crore, 50 per cent of the quantum of accretion has come in from the new players, which is indeed commendable.

ICICI Lombard with an accretion of Rs. 94 crore and Bajaj Allianz with Rs. 91 crore dominate the league of the new players. The next ranked player is IFFCO-Tokio with an accretion of Rs. 33 crores. With the exception of Reliance all have recorded good increases, particularly the new entrants Cholamandalam and HDFC Chubb.

The four established players have recorded an increase of Rs. 282 crore (eight per cent growth) with the ECGC adding an additional Rs. 22 crores. It is, however, National Insurance with a contribution of Rs. 220 crore increase (26 per cent growth) that continues to outperform all the players in the market. That this growth has been achieved on the back of a fine performance by it last year as well is quite significant. Oriental with an accretion of Rs. 31 crore has a growth rate of four per cent and New India with an accretion of Rs. 21 crore a growth rate of 2.4 per cent. United India’s premium is almost stagnant. The established players are finding the competitive environment quite tough and are not seen improving on their premium volumes barring National Insurance.

Future prospects

The market share of the new players at the end of the first quarter 2004-05 is about 19 per cent up from the 14 per cent as at the end of the last fiscal. The gains made by them notably are in the profitable segments of Fire, Marine and Engineering. These trends seem to be continuing in the current fiscal too.

The Motor and Health segments are booming for the established players; and the new players continue to zero in on competing for the cost effective profitable tariff segments like Fire and Engineering and other corporate accounts. Neither of them seems to be contemplating a change in the strategy they have been pursuing.
Since the insertion of section 163-A in the Motor Vehicles, 1988 (M.V. Act) by the Motor Vehicles (Amendment) Act, 1994, general insurers have been saddled further with the unenviable task of contesting plurality of claims. Section 163-A provides for a structured compensation formula for the legal heirs or the victims of motor accidents, as the case may be.

However, controversies arose as to the real scope and purpose of that section, and also the vexed question as to whether the relief enshrined in that section is only interim or final. Claimants chose to file compensation claims both under section 163-A and section 166 of the M.V. Act.

However, recently, in Deepalal Girishbhai Soni & Ors. v. United India Insurance Co. Ltd. [C.A. No. 3126 of 2002, etc., decided on March 19, 2004], a bench of three judges of the Hon’ble Supreme Court has laid to rest this controversy, with its sage counsel and observations as regards the entire gamut of structured compensation as envisioned in section 163-A, read with the Second Schedule appended to the M.V. Act, and its independent operation without its inter-dependence on section 166 of that Act. This article highlights and analyses the ruling of the apex court in the aforesaid case.

Section 163-A of the M.V. Act: Legislative history and intention

Section 163-A was introduced by way of a social security scheme. It is a code by itself. It appears from the Objects and Reasons of the Motor Vehicles (Amendment) Act, 1994 that after enactment of the M.V. Act several representations and suggestions were made from state governments, transport operators and members of public in relation to certain provisions thereof. Taking note of the observations made by the various courts and the difficulties experienced in implementing the various provisions of the M.V. Act, the Government of India appointed a Review Committee. The Review Committee in its report made the following recommendations:

One must opt / elect to go either for a proceeding under section 163-A or under section 166 of the Act, but not under both.

Under such a system of structured compensation that is payable for different clauses of cases depending upon the age of the deceased, the monthly income at the time of death, the earning potential in the case of the minor, loss of income on account of loss of limb, etc., can be notified. The affected party can then have the option of either accepting the lump sum compensation as is notified in that scheme of structured compensation or of pursuing his claim through the normal channels.

The general insurance company with whom the matter was taken up, is agreeable in principle to a scheme of structured compensation for settlement of claims on ‘fault liability’ in respect of third party liability under Chapter XI of M.V. Act, 1988. They have suggested that the claimants should first file their claims with the Motor Accident Claims Tribunals and then the insurers may be allowed six months time to confirm their prima facie liability subject to the defences available under Motor Vehicles Act, 1988. After such confirmations of prima facie liability by the insurers the claimants should be required to exercise their option for conciliation under structured compensation formula within a stipulated time.

The recommendations of the Review Committee and representations from the public were placed before the Transport Development Council for seeking their views following which several sections were amended.

Section 163-A was inserted in the M.V. Act to provide for payment of compensation in motor accident cases in accordance with the Second Schedule.
providing for the structured formula which may be amended by the Central Government from time to time. Section 163-A was inserted by Act 54 of 1994 which came into force from November 14, 1994. The said provision has been inserted to provide for a new pre-determined structured formula for payment of compensation to road accident victims on the basis of age/ income of the deceased or the person suffering permanent disablement. The provisions as regards no fault liability evidently were inserted having regard to the fact that the road accidents in India had touched a new height and at least in some of the cases it was found that rash or negligent driving causing death or injury to the innocent persons could not be proved.

Whereas in terms of section 140 of the M.V. Act a statutory liability has been cast upon the owner in case of death or permanent disablement; both under section 163-A as also section 166 of the Act, the insurer had been made responsible.

Remedy under sections 140 & 163-A

It was contended, inter alia, before the apex court to the effect that sections 140 and 163-A provide for a similar scheme. Rejecting the contention, the Court observed that section 140 of the Act dealt with interim compensation but by inserting section 163-A, the Parliament intended to provide for making of an award consisting of a pre-determined sum without insisting on a long-drawn trial or without proof of negligence in causing the accident. The Amendment was, thus, a deviation from the common law liability under the Law of Torts and was also in derogation of the provisions of the Fatal Accidents Act.

The heirs of the deceased or the victims in terms of the said provisions were assured of a speedy and effective remedy which was not available to the claimants under section 166 of the Act. Chapter XI was, thus, enacted for grant of immediate relief to a section of people whose annual income is not more than Rs. 40,000 having regard to the fact that in terms of section 163-A of the Act read with the Second Schedule appended thereto, compensation is to be paid on a structured formula not only having regard to the age of the victim and his income but also the other relevant factors.

An award made under section 163-A, therefore, shall be in full and final settlement of the claim as would appear from the different columns contained in the Second Schedule appended to the M.V. Act. The same is not interim in nature.

The note appended to column 1 (of Second Schedule), which deals with fatal accidents makes the position clearer stating that, from the total amount of compensation one-third is to be reduced in consideration of the expenses which the victim would have incurred towards maintaining himself had he been alive. This together with the other heads of compensation as contained in column Nos. 2 to 6 leaves no manner of doubt that the Parliament intended to lay a comprehensive scheme for the purpose of grant of adequate compensation to a section of victims who would require the amount of compensation without fighting any protracted litigation for proving that the accident occurred owing to negligence on the part of the driver of the motor vehicle or any other fault arising out of use of a motor vehicle.

The Supreme Court ruled that payment of the amount in terms of section 140 of the Act is ad hoc in nature. A claim made under it is in addition to any other claim which may be made under any other law for the time being in force. Section 163-A of the Act does not contain any such provision. The Court contrasted further the provisions of sections 140 and 163-A as follows:

Section 163-A of the Act is interlinked with several sections of its Chapters XI and XII. section 140 imposes a liability upon the owner of the vehicle to pay compensation where death or permanent disablement of any person has resulted from accident arising out of the use of a motor vehicle. By reason of the said provision a fixed sum is to be paid.

Sub-section (4) of section 140 provides that the claim for compensation under sub-section (1) thereof shall not be defeated by reason of any wrongful act, neglect or default of the person in respect of whose death or permanent disablement the claim has been made nor the quantum of compensation recoverable in respect of such death or permanent disablement be reduced on the basis of the share of such person in the responsibility for such death or permanent disablement.

Sub-section (5) of section 140 of the Act categorically provides that the obligation of the owner of the vehicle shall not be in derogation of any statutory law cast upon the owner of the vehicle to pay compensation under any other law for the time being in force subject, however, to the condition as has
been laid down in the proviso that the amount of such compensation to be given under any other law should be reduced from the amount of compensation payable under this section or under section 163-A.

Section 163-A, which has an overriding effect provides for special provisions as to payment of compensation on structured formula basis. Sub-section (1) of section 163-A contains non-obstante clause under the terms of which the owner of the motor vehicle or the authorised insurer is liable to pay in the case of death or permanent disablement due to accident arising out of the use of motor vehicle, compensation as indicated in the Second Schedule, to the legal heirs or the victim, as the case may be.

Sub-section (2) of section 163-A is in pari materia with sub-section (3) of section 140 of the Act. section 163-A does not contain any provision identical to sub-section (5) of section 140 which is also indicative of the fact that whereas in terms of the latter, the liability of the owner of the vehicle to give compensation or relief under any other law for the time being in force continues subject of course to the effect that the amount paid thereunder shall be reduced from the amount of compensation payable under the said section or section 163-A. By reason of section 163-A, therefore, the compensation is required to be determined on the basis of a structured formula whereas in terms of section 140 only a fixed amount is to be given.

A provision of law providing for compensation is presumed to be final in nature unless a contra indication for it is found to be in the statute either expressly or by necessary implication. While granting compensation, the Tribunal is required to adjudicate upon the disputed question as regards age and income of the deceased or the victim, as the case may be. Unlike section 140 of the M.V. Act, adjudication on several issues arising between the parties is necessary in a proceeding under section 163-A of the Act.

**Conclusion**

The Supreme Court, after a detailed examination of the entire statutory matrix, has finally settled the vexed question as to the scope of section 163-A to the effect that that remedy for payment of compensation both under sections 163-A and 166 are final and independent of each other, and that a claimant cannot pursue his remedies under them simultaneously. One must opt/ elect to go either for a proceeding under section 163-A or under section 166 of the Act, but not under both. Unlike sections 140 and 141 of the M.V. Act, the Parliament did not want to provide additional compensation in terms of section 163-A of the M.V. Act.

Accordingly, the Bench of three judges of the Supreme Court also upheld the earlier decision of a bench of two judges in Oriental Insurance Co. Ltd. v. Hansrajbhai V. Kodala and Others[(2001) 5 SCC 175], (under which the proceedings under section 163-A have been held to be final proceedings), except its observations therein that if a person invokes provisions of section 163-A, the annual income of Rs. 40,000 shall be treated as a cap.

The three judge bench of the Supreme Court in Deepal Girishbhai Soni’s case (ibid) opined that the proceedings under section 163-A being a social security provision, providing for a distinct scheme, only those whose annual income is upto Rs. 40,000 can take the benefit of it. All other claims are required to be determined in terms of Chapter XII of the Act.

Reacting to the ceiling on annual income at Rs. 40,000 as provided for in the Second Schedule to the M.V. Act for the purpose of calculation of structured compensation per annum, the Apex Court has stated: “section 163-A was introduced in the year 1994. The executive authority of the Central Government has the requisite jurisdiction to amend the Second Schedule from time to time. Having regard to the inflation and fall in the rate of bank interest; it is desirable that the Central Government bestows serious consideration to this aspect of the matter.”

The recent ruling of the Supreme Court in Deepal Girishbhai Soni’s case is a welcome relief to the general insurers, as they can no more be asked to face dual claims both under section 163-A and 166 of the M.V. Act.

The author is a Delhi-based Advocate and a member of the Insurance Advisory Committee of the IRDA. He can be reached at dvarada@hotmail.com.
Regulations for Unhappy Customers

Debapriya Ray

The insurance industry is oriented to the long term and so, should build deeper relationships with its customers, says the author.

When I hear 'Customer is King' my mind rephrases it as "The Customer is dead. Long live the Customer." The Japanese paradigm 'Consumer is God' triggers an amusing remembrance of a lecture I heard on customer relationship management where the speaker, tripping over his words, said "Customer is dog." Both situations bring us to how the Indian insurance industry deals with its unhappy customers and how the regulations impact on this area.

**Consumer Awareness:** There is tremendous increase in consumer awareness in general and about insurance in particular. One can see this in the aftermath of the prolific post-liberalisation publicity campaigns in any metropolis with one out of every four outdoor advertisement being from the insurance sector.

But we are still far from a stage where the 'Caveat Emptor' (Let the buyer beware) signboard extinguishes all liabilities of insurance companies, and makes consumers free of grievances.

Management Guru Charles Handy once remarked, "Markets do not look much beyond tomorrow, or at least next year." But in the interest of this long-term-commitment-driven industry, weaving customer relationship over a longer time timeframe is integral to sustainability in the market. A grievance redressal mechanism as a symbiotic part of customer relationship management therefore assumes pivotal importance here.

At the outset of this discussion I would like to propound a simple arithmetical formula:-

\[
CG \propto \frac{1}{CA}
\]

Where \( CG = \) Customer Grievance and \( CA = \) Customer Awareness.

When there is true awareness, a customer is nestled in a comfort zone and this obviates possible customer grievance. Whether it is selecting the right product or making substantive service efforts during the currency of the policy, customer-company pairing is subject to delicate pressures. Essentially, shorn of all frills, customers expect fair deals, value for money and compassionate handling. Towards this end IRDA has made important advances by putting out regulations relating to protection of policyholders' interests. We shall see more of this a little later.

**Legislative History:** Let us trace the genesis of legislations regarding consumers' grievances. The Consumer Protection Act (COPRA) fired the first salvo in this direction in 1986. Albeit covering various types of consumers this was perceived by the aware section of the insuring public as a powerful tool to address their unattended woes.

Organisations sprang up which took up the cause of policyholders and fought cases in consumer forums. This was created at three levels e.g. district forums, state forums and the National Forum.

This gave rise to high expectations and enrolled a lot of cases from policyholders. But over the years the feeble voice of the consumers of insurance seemed lost amidst the melee of the host of cases emanating from the consumers of other goods and services.

In order to get a better deal and specific attention the consumers of insurance had to wait till 1998 when the Government enacted the 'Redressal of Public Grievance Rules.' This gave rise to the office of the Insurance Ombudsman in 12 centres. In tune with the European experience of grievance settlement this system of one-man-army tried to mitigate the grievances of dissatisfied policyholders. Although governed by the Insurance Councils and in many places adorned by the erstwhile top officials of insurance companies, this is a body outside the direct purview of insurers. Thus the grievance redressal platform in insurance had a layer between the company's internal machinery and the external mechanism of consumer/civil courts.

The Insurance Ombudsman has the authorities of i) Conciliation and ii) Award. He may receive and consider complaints of any claim delay or repudiation (partial/total), dispute in regard to premium paid/payable, non-issuance of insurance document or dispute on legal construction of the policies relating to claims. The complainant should have come to the Ombudsman within one year of rejection by an insurer and the value of his contract should not exceed Rs. 20 lakh.

Then came the IRDA Protection of Policyholders' Interests Regulations, 2002. This was a shot in the arm for the insuring public. While charting out in details all the aspects of consumer expectation, it introduced some revolutionary concepts e.g. the option to...
return a policy and receive refund (Free-
look period) etc.

Starting with the point of sales it goes through the entire gamut of the Proposal, the Policy, Servicing aspects and Claims and says, “Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed”. In fact from all possible angles it tries to contain the root causes that lead to consumer grievance and then details how to handle them, when they arise.

**Regulatory impact:** The regulator has put up a lot of checks and balances in place to ensure that policyholders are protected. It has devised a dual control system effective from the front end and the back end (See table).

Besides these, by introducing brokers as intermediary for the first time in the Indian insurance market, IRDA has initiated a big change. Brokers are representatives of clients and not the companies. Naturally customer interests are better taken care of by them. Even in case of tied agents of insurance companies the insistence of IRDA on mandatory training through accredited institutes has injected a fair degree of professionalism in the industry. But despite all these, problems do arise and grievances do emerge.

Insurance ‘statistics’ (according to Mark Twain, it is the third stage of mendacity, after ‘lies’ and ‘damn lies’), may say that complaints registered by policyholders are declining and the disposal of registered complaints are increasing, thereby leaving the number of unsolved complaints microscopically miniscule. But if we lend our ear carefully to the insured public, we see the ground reality which may be contrary to the statistics. This is due to the fact that out of eleven dissatisfied customers only one picks up a pen and paper to lodge a complaint and others prefer to either quit or quietly bear the brunt. In order to open a window to taste first hand the levels of consumers’ grievance, the IRDA started its own Grievance cell in December 2002.

**Grievance redressal model:** We have seen many market-movers of yesterday as fallen-angels today because of neglecting customers angered beyond endurance. In the changed business paradigm today the inverted pyramid structure of attending to policyholder grievance should look like this:

1) In any insurance company typically it is the FOS (feet on street) agents and the front-desk service officials who face the major flak from aggrieved customers. In the face of torrential competition, no insurer can afford improper handling of customer grievances. This prompts companies to lay more and more emphasis on breeding a new-generation of customer savvy front-end staff that swears by CRM. Applying their skills in understanding customer behaviour, they preempt problems so that complaints do not arise at all. Another method adopted by companies nowadays is choosing the right customer (read ‘target segment’) and attending to them well, which again nips in the bud possible detractors.

2) In the next layer lie in-house grievance handling procedures through arbitration or through earmarked Grievance Redressal Officers (GRO). In hierarchical organisations, there may be several strata of such GROs, starting at the branch and ending at the corporate office level.

The question here is a right blend of mindset, inclination and authority. The officials manning such positions need to appreciate that survivors of a peril are a heartbeat away from destitution, but for the insurance claim.

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<td>Yearly renewal</td>
</tr>
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<td>2. Advertisements &amp; disclosure regulation</td>
<td>Advertisement returns</td>
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<td>3. Financial statement &amp; auditor's report regulation</td>
<td>Surprise checks</td>
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The emotive power of insurance is at its full play at the time of a claim. Therefore it is imperative that discarding the hopelessly antiquated method of ‘case-paper analysis’ and new and rich techniques of merit-based decision-making must be employed in settling grievances.
3) The third level consists of quasi-judicial bodies like the Insurance Ombudsman or the IRDA Grievance Cell, related to the insurance industry at a macro level but distanced from the insurance company at the micro level.

4) Fourthly, avenues outside the industry e.g. Directorate of Public Grievances, consumer forums or alternate redressal channels like newspaper articles are used by policyholders who are not satisfied with the interventions at earlier stages.

5) Finally at the apex level the option of moving to civil court is there for the complainant.

**Future Course:** Insurance laws are the most grueling shibboleths in our country. Recently Law Commission has suggested a thorough overhaul of the archaic Insurance Act, 1938.

Among many other watershed changes proposed to take care of grievance settlement, ‘Grievance Redressal Authority’ (GRA) model on the SEBI pattern is suggested. GRAs would be set up in major cities. This three-member body would be presided over by a sitting or a retired district judge and have two members who have expertise in the field of insurance. This would assume all the powers and functions of the institution of Ombudsman and replace them. It could also be provided that all pending disputes arising under the Insurance Act, 1938 before the consumer fora would be transferred to the GRAs for disposal.

It is further proposed that Adjudicating Officers will be appointed by IRDA for matters of contravention of the Acts, Rules and Regulations made by IRDA. It is also proposed to provide for the establishment of an Insurance Appellate Tribunal (IAT) to hear appeals from the orders of the adjudicating officers and also from the decisions of the GRAs.

Again with a view to encourage Alternate Dispute Resolution (ADR) mechanisms it may be provided that a claimant may be first referred to an ADR mechanism for mediation/conciliation, failing which the matter will be placed before GRAs. It is therefore evident that sometimes through support and at other times through secondment, regulations are always wide-awake to address to issues of consumer grievance in insurance sector.

**The Turf:** Ostensible concern about settling grievances should not only get primacy but also create infectious impatience in each and every person in the company. Many a time reasons for problems are obvious and do not require a microscope. But as the customer as human being and have genuine concern. Any mechanical process would never achieve this aim. It is pertinent here to recount a real life incident. Once a retired military officer visited the office of an insurance company to sort out a delay in claim settlement. Immediately his case was attended to and after completing all the formalities his claim cheque was handed over to him in one hour.

After this the policyholder wrote a letter to the chairman of that company, telling him about the quick settlement; but he also wrote that for that one full hour he was standing as nobody offered him a chair to sit on.

This episode is an achingly poignant description of the plight of the insured. In a service industry, to ensure managing ‘Moments of Truth’ the point of contacts need good inter-personal skills and appropriate body language. To fill the seemingly unbridgeable chasm between customer expectation and delivery of services insurers have to hone up their skills!

We find that the incumbent public sector units (PSUs) in the insurance industry have formidable strengths in:

a) Vast network of offices
b) Experienced manpower
c) Established brand recognition
d) Market confidence and credibility

The new age private insurers on the other hand are endowed with certain advantages:

a) No backlog or legacy
b) Best practices in process chain
c) Flexibility of rules/resources
d) Alacrity as a marketing organisation

Both types can reinforce their own strengths and overcome their weaknesses to build up a stable edifice and deliver service to the customer. Any insurance company worth the name has to totally geared up to the last man, who would travel an extra mile to ensure the smile of a client.

Since appreciable differentiation in Product-Price-Placement-Promotion is hardly possible, companies must internalise relationship models. There, let alone talking about customer grievance, customer delights are aimed at so that goodwill is generated.

**Let alone talking about customer grievance, customer delight is aimed at so that goodwill is generated.**

legendary insurance-man Mehedi Fakarzada said, “Nothing is so hard to learn as the obvious.”

Often, a very important dimension of grievance redressal is to treat the customer as human being and have genuine concern. Any mechanical process would never achieve this aim. It is pertinent here to recount a real life incident. Once a retired military officer visited the office of an insurance company to sort out a delay in claim settlement. Immediately his case was attended to and after completing all the formalities his claim cheque was handed over to him in one hour.

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As the operations are widened and volumes grow, chances of hitting some discordant note somewhere also increases and every company has to be wide awake to tackle that. That is why Peter Caldwell, Chairman of Deloitte, Touche and Tohmatsu has gone on
International scenario: Now let us have a brief look at the laws of some other countries to understand how they deal with unhappy insurance policyholders.

In the US two special doctrines govern the contract of insurance:
1. Doctrine of ambiguities i.e. whenever a term of the policy is unclear it should be interpreted against the drafter (Contra Proferentem).
2. Doctrine of reasonable expectations i.e. A standard clause in an insurance policy even if not ambiguously drafted, is not enforceable when it contravenes the reasonable expectations of the insured, according to an objective test.

Thus the framework of American insurance laws is very pro-policyholder.

In the UK probably the legacy of honest and reputed insurers made the Law of Insurance contract interpretation and construction much less favourable to policyholders. In the English legal system there is no general duty to perform a contract in good faith. In the recent years, however, English courts have been called to resolve insurance disputes based on the same factual circumstances that led to the development of the laws.

In Italy the guiding lights of insurance grievance resolution are good faith and fair dealing.

i) Uberrima fidae - The principle of good faith of disclosing everything material binds both the insured and the insurers on the offer and counter-offer.

ii) Mala Gestio - The violation of good faith standard by the insurer allows courts to award consequential economic damages in excess of policy limits to the insured.

In China protection of the policyholder is a central concern of the modern Chinese Insurance Regulation of 1995. Stringent Chinese laws provide that if the insurer fails to perform its obligation and delays or denies valid claims, it is liable for the economic loss caused to the insured party in all cases of consumer grievances.

In India the mood in this respect is reflected in – to hire a phrase from Gurcharan Das’ ‘India Unbound’ – “Ranting in English and Chanting in Sanskrit.” While we follow the good British tradition and basically go by the legal interpretation of contracts et-al; the moorings in our rich Sanskrit heritage cannot be forgotten.

Grievances emanating from the issues of disagreement, delay and dealings, in that order of priority, have changed to dealings, delay and disagreement.

At the time of taking decisions on customer grievance cases, the cause of an innocent policyholder should not be lost in the dreary dry desert of dead legalities. Rather a human touch is required to converge with a ‘high-tech’ platform. Maybe this would enable admission of claims beyond the strictest scope of contract wordings, when there is no malafide intention to defraud the insurer. In our value system we call it “Satyameva Jayate.”

Baptised in the first hand experience of sorting out consumer grievances as GRO of a life insurer and then of a general insurer I may say with authenticity that the tone and tenor of consumer grievance has undergone a sea change over the years. The voice of the consumer was never so loud and clear.

Grievances emanating from the issues of Disagreement, Delay and Dealings, in that order of priority, have changed to Dealings, Delay and Disagreement. The sensitivity towards behaviour - other than pleasing - and impatience on the slightest delay have started assuming overbearing importance.

Closing in: The opening up of the insurance sector under the aegis of a regulator like the IRDA has ushered in new hopes and aspirations for the consumers of insurance. Partly due to competition compulsions, partially controlled by regulatory supervision and to a large extent through progressive outlook of corporate governance, insurance companies have started to inculcate, in increasing quantity and quality, customer value propositions, throughout customer life cycles.

All this points to a bright and luminous future. A period where a lackadaisical approach to consumer grievance is shed and utmost sensitivity takes its place. Where the attitude that tries to explain every grievance as something beyond individual’s control or responsibility is the disdained. Where Customer is Everything.
Redressal of customers' grievances is just a reactive way of insurers providing the minimum expected customer service. A grievance is defined ‘as a complaint from a person that he has been treated unfairly.’ If he does not complain, or chooses not to, despite suffering from a poor service quality, it is assumed that he has received a satisfactory service.

This is the present mental and psychological yardstick that is employed by insurers in India to judge the customers’ service standards they provide.

Whether this is how a customer should be perceived — as a whining party in a policy contract of equal status — as they are both the seekers and providers of mutual obligations, is arguable.

It is not surprising that this attitude typifies the public sector culture of responding to the premium paying public’s demands. A commercial culture, however, would be constantly seeking ingredients of what additional service elements would satisfy customers more and more to create new customers and to retain the existing ones; particularly in a rapidly changing competitive environment.

Insurers are now under pressure to provide customers more than a service; they have to deliver ‘customer satisfaction.’ What is the difference? The author explains.

**Why should insurance service standards go up?**

Since almost all the insurance products are just commodities with the price tags affixed, and as new product development in insurance marketing is rather slow, the only way an insurer can keep his customers happy, and with him, is to raise his service standards.

**What are his current standards?**

Does he consciously review them from time to time? Are they designed to keep the conveniences and changing expectations of the customers in mind?

Redressal of customers’ grievances is just a reactive way of insurers providing the minimum expected customer service.

Or are they designed to suit the best interests of the insurer? Are these standards helping an insurer to grow and to profit?

The purpose of this article is to get under the skin of the customer and understand what makes him tick; and how insurers should respond to his real and imaginary grievances and earn his trust, his satisfaction marketing opportunity to create a brand name and is no longer to be regarded as a cost item; providing after-sales service costs more money for insurers than in most trades, as the performance of insurers is really judged in their claim settling procedures.

Improving customer service standards, therefore, is a strategic opportunity to cut administrative costs in a big way. Is it possible to perceive delivery of superior customer service in this perspective of cost savings? Insurers should change their mental caps by discarding the current ones that happily suit them.

**Customer delight**

Many terms are employed in relation to and in describing ‘service’. Customer service; customer satisfaction; customer care. Is there any real difference in the terminology used in each? Yes. ‘Customer service’ is what insurers provide and deliver to their customers as the minimum. ‘Customer satisfaction’ is what a customer experiences in a sensory way by the delivery of that service. ‘Customer care’ is what insurers regularly perform to provide the customer a series of such pleasant experiences that he comes to believe that he is treated as a special and exclusive customer of the insurer.

**Does a customer have a voice? Are you listening to him?**

But what does a customer experience in reality? Service is currently delivered mostly by stressing it in negative terms. Let us take the banks. How often do we see signs such as: “No admission without permission”; “The account will not be opened unless the client furnishes all particulars”; “A penalty will be levied if the balance in the savings account goes below Rs…”

Why are these banks stressing on what a customer cannot do and scare him? Why not rewrite them all and tell a customer of what needs to be done to make it convenient for him to transact...
business? The examples quoted are from banks in both the sectors. Yet, no bank management saw anything wrong in their approach, as these service placards are openly displayed in all their branches. Does the customer have a voice in how he wants to be treated? Has he an alternative view point from theirs? Does the bank want to listen to him? Or simply does it not care?

How thick-skinned can service providers get? Wanting customers, but yet unconsciously treating them in an unwelcoming manner? Service provision is a mind game and one should put oneself in the shoes of the customer to realise how better service can be provided.

**What do customers really want?**

Customers really do not know what they want. But one does not choose to ask them either. And even if one did ask them, they will only tell them what is currently wrong with the insurers; but not of what really they would want from insurers.

They look for experiences, and often want to be pleasantly surprised by the services provided exceeding their expectations. I had one such. When the computers were down and I wanted to draw a substantial amount of money from a public sector bank, a known staff member asked the cashier to pay me the cash on the spot. I was surprised that he trusted me to that extent; and even more when the cashier paid it out and the usual supervisor had not cleared the cheque yet. I am not saying the procedure was right; but I felt like I owned the bank! How can I forget that experience?

Customers look to three aspects in service delivery. They want that the product sold is reliable and will perform the way he perceives it. No surprises when the benefit is called in. But if he is surprised by the fine print that prevents him from getting what he thought was his due, which party is responsible for it? Insurers have to inform the customer of each others’ responsibilities.

Secondly, a customer expects empathy — a communicated concern that a service provider does care and feel for his problems and is doing his best to resolve them.

Thirdly, when a customer makes enquiries of where his concerns stand, he expects a fast response and in the promised time frame. On these three service standards, how does the insurers’ service now measure up? If one really analysed the customer grievances made on them, almost all of them would relate to one of the missing elements pointed above.

**It is also observed that the customers’ expectations of service standards are changing fast. Satisfied customers belong to yesterday.**

Traditional service consists of providing what the customers want and ask for; modern service, however, calls for anticipating the future expectations of customers and building a structure and a system that would provide them an enjoyable experience. It calls for a leap of imagination and that is where innovation and creativity by insurers is required.

Discharging policy obligations may be considered as offering a customer service but there is no value element attached to it. A ‘value’ is defined as the quality of how a customer personally experienced the actual service that an insurer provided him; that is the difference between ‘customer satisfaction’ and ‘customer service’. Insurers should endeavour to add that kind of ‘value’ to service that is now perceived as just a discharge of contractual obligations.

**Customers’ changing expectations**

It is also observed that the customers’ expectations of service standards are changing fast. Satisfied customers belong to yesterday; the same customers today could be dissatisfied with the same standards of services earlier provided, as their expectations of what they should be getting as service now have gone up.

In a consumerist society, where cultural and social trends are changing fast, one should take a note of what is happening around the customers who are interacting with several other service providers. They begin comparing and ask why their insurers are not changing fast enough in the quality of their service provisions like anyone else? How does one keep pace with these rising tide of customer expectations? New customer options have to be created to keep them interested that their insurers as well are changing, even as their customers are changing in their tastes, perspectives and service requirements.

Unfortunately, when the present service standards are going down, how can one even consider upgrading the present standards? That is the dilemma facing the current crop of insurers.

**Customers have several needs**

The needs and wants of customers are several; but all of them come under the categories of articulated needs or unarticulated needs or emergency needs.

While articulated needs are served and are easily identified, unarticulated needs are uncovered by superior marketing aids. Products such as the Walkman or personal computers were brought into the market not by the demands made by the customers but by technological advancements and enterprising entrepreneurs that
anticipated customers’ needs and built products. Rural sector, personal lines business, other voluntary insurance needs come under the category of unarticulated needs.

**Why are insurers at their worst in the fulfillment of ‘emergency needs’?**

‘Emergency needs’ are those needs that relate to claims settlement. How quickly does an insurer respond to such needs? A customer is nearly in a state of panic when huge amounts of his claims are at stake. How does an insurer handle such customers that number about 10 per cent of all policyholders? It is this segment that has grievances, complaints and dissatisfaction with the attitude and responses of insurers.

It is here that insurers are at their most vulnerable situation; and usually have failed to measure up to the satisfaction of independent legal centres like the ombudsmen, consumer forums, courts of law and the regulator as well. If insurers perceived this as an opportunity to improve current service standards, it will lead to improving brand images of insurers. Listening to customers and empathising with their concerns will throw up where improvements are needed most. But one needs to be prepared to listen to customers.

That they are oblivious of their reputation and their future ability to retain customers does not seem to bother them at all. Delays are endless and are used often as strategies to tire out claimants of their dues. Even rejections of claims are not communicated to customers, nor do they observe regulations in force to protect the customers’ interests.

**What are the remedies?**

This is an attitudinal issue and there is very little advice one can offer to insurers. Their present stand seems deliberate and is perceived as anti-customer. It is not that insurers are unaware of what they are doing to defeat the grievances of customers.

It could be true that customers have moral hazard that needs strict scrutiny; but today the moral hazard of insurers is equally a matter of concern or so it should be for the insurance regulator. Moral hazard is not a one way street any more.

The service standards of insurers have deteriorated as the ability of their insurance staff to interpret legal terms is of low quality. Safety lies in rejection, repudiation and delays in not taking decisions. With such strategies as a part of serving emergency needs, only courts are the source for grievance redressal at present.

But insurers can redesign their grievance redressal cells by outsourcing them to outside experts of repute and professional knowledge as members, in addition to their staff; and be guided by their speaking orders on specific issues. LIC has a better system in vogue to minimise the number of dissatisfied customers. What customers want is only to be heard by independent experts and know that there is no personal prejudice in repudiation or in causing delays in settlement of claims. Is this too much to ask of insurers?

The regulator too has a grievance redressal cell located in his office. The performance of this cell should be outsourced, so that the Regulator can confront the insurers with the opinion of experts, who would have expressed their views after having access to the files of insurers for their independent scrutiny; the costs of such reviews should be borne by the respective insurers.

These two measures to start with seem eminently suitable to alleviate to some extent the numerous grievances of customers who seem to have lost faith in insurers and in the whole system of how the market operates.

Consumer activists are not properly organised to have a strong voice. The General Insurance Council that has a legal status under the Insurance Act, 1938 for setting up a code of market conduct does not seem to have come to grips with customer-related problems yet.

Customers are now in need of weapons to fight insurers for justice; and the legal process at present is too costly for them in terms of money and time. In terms of equity and fairness, one has to devise newer procedures to redress and restore a little bit of power to customers to make insurers answerable to some authority other than courts.

The author is retired CMD, The Oriental Insurance Company.
Anyone who has had to deal with an irate complainant knows the job can be very difficult. Yet there are some very good reasons to make that extra effort or ‘Go the extra mile.’ Rewiring the usual attitude towards complaining customers so that you not only welcome them but even seek them out can be a fruitful exercise. Handling complaints well is an integral part of delivering excellent customer services and can grant valuable privilege. Bending over backwards could be worth it after all.

Studies have shown that businesses receive complaints from less than five per cent of dissatisfied customers. The majority is silent. Most of them may never come back and some will also dissuade friends from coming. When customers complain, at least there is an opportunity to satisfy, an opportunity to rectify. A well structured grievance or customer complaint mechanism can become an aid to marketing and business growth. A grievance or complaints redressal cell can become the best advertisement for a company depending on the manner in which genuine complaints are dealt with.

An ideal redressal mechanism should have a Code of Good Practice for Complaints Resolution. A specific process for handling of complaints and specific time-frames for the processes should be an integral part of it. Complaint handling procedures should be made known to all. It is necessary to respond to complaints promptly, accurately and with utmost courtesy.

Customers should be provided with accessible means with which to communicate their complaint. For receiving and registering complaints, it would be helpful to have a standard format so that the complainant gives at least the minimum information that is required.

Time-frames for acknowledgement, processing and resolution should be laid down and adhered to as far as possible. All complaints whether written or oral should be handled not only in a timely and professional manner but also confidentially. Customer concerns have to be handled fairly and efficiently.

When a complainant contacts the consumer complaints cell, the effort should be to resolve it at the same level, failing which the complaint ought to be escalated within the organisation. In many organisations, the formation of a designated complaints resolution committee has been working successfully. The members of the committee have decision making powers and are expected to make objective decisions that promote equity and fairness. Once the committee takes a final decision, the complaint is regarded as closed. It would be useful to log all such decisions for future reference.

In India today, the consumers of insurance products are becoming an enlightened lot. When a consumer has a choice of products he sets about weighing the pros and cons to decide on the right one. In the process he becomes well informed. A few years back, when people had little or no choice and had to settle for whatever products were thrust upon them, they learnt very little about them. Today, a policyholder is more aware about the product he has bought. He knows his rights and entitlements.

While insurance companies and agents may be committed to providing quality services and products to consumers, there are still those entities and individuals that fall prey to omissions and commissions by these companies and or agents.

With a view to protecting the interests of policyholders, the IRDA brought out The Insurance Regulatory and Development Authority (Protection of Policyholders’ Interests) Regulations, 2002. The Regulations apply to all insurers, insurance agents, insurance intermediaries and policyholders. It deals with the responsibilities at the point of sale, matters relating to policyholders servicing, matters to be stated in a life and general insurance policy, the claims procedure in respect of a general and a life insurance policy and certain other general matters. In other words, customer service tenets are encoded in the regulations themselves which the companies and intermediaries are bound to follow.

Recognising the need to redress the grievances of customers, the Regulations also stipulate that every insurer shall have in place proper procedures and an effective mechanism to address complaints and grievances of policyholders efficiently and
with speed. This information, along with information in respect of Insurance Ombudsman is to be communicated to the policyholder along with the policy document and as may be found necessary.

The IRDA itself set up a Consumer Grievances Cell that started functioning with effect from January, 2003. The prime objective of the Cell was to assist policyholders in getting an early resolution of their grievances. The redressal mechanism is an administrative one. The focus is on the decision making at the company level.

The Authority has received more than 4,800 complaints (life and non-life) since it started functioning and as at the end of June, 2004 has disposed of nearly 65 per cent of them. Around 27 per cent of the complaints received pertain to life and the rest to non-life.

Nearly 50 per cent of the non-life complaints pertain to medical claim policies and/or claims under them. Specifically, they relate to denial of renewal of a policy, arbitrary loading of premium for bad claims experience, denial of claim due to pre-existing disease condition, exclusion of a disease because of a claim having been made etc. Of these, disputes pertaining to ‘pre-existing diseases’ are the most in number triggering off a requirement to review the area.

In general, the Authority receives several complaints regarding slow handling of claims. From the average customer’s perspective, claims management is a slow, irritating process with practically no transparency. Complaints relating to underwriting practices including charging of excessive rates, misleading advertisements etc are also quite a few. Many customers also complain about how they were misled about products when they were solicited by the marketing personnel of insurers or by their agents. Quite a few realised they did not get the right product only when a claim arose. A single complaint may have more than one reason for the complaint.

It has been observed that many of the complaints are a result of communication and administrative failures. Especially on matters of claims, it would appear that quite a few are made to run from pillar to post to get a response to a query or the status of their claim. Customers expect to be spoken to politely when they approach the company with their problems. They need to be given a hearing and are not to be dealt with in an impersonal manner.

The Authority has several complaints pouring in everyday and quite a few of them are about rude behaviour on the part of employees of insurers or intermediaries. Not all of them would be genuine, of course. There are customers who are forever at the complaints counter for little or no reason. But it would appear that many of them do have a point to make.

Consumers want insurance issues resolved in a thorough and timely manner. They want satisfactory results. They expect premiums refunded, claims paid or policies reinstated within days rather than months. So, quick resolution is very important. If complaints are simple and the insurance companies respond promptly, complaints can be resolved within 60 days. If a complaint is complex and requires multiple requests to an insurance company for documents, policies, explanation, survey reports etc, it may take up to 120 days to close. The complexity of the complaint and the responsiveness of the insurance company are major features in achieving the goal.

Complainants not only want quick resolution, but also satisfactory results or a positive outcome. They may be monetary as in a claim being paid or premium refunded or non-monetary as in a policy reinstatement, renewal or issuance. When a complaint is disposed of, it does not necessarily mean the outcome is positive. It could be a negative outcome from the complainant’s point of view and a positive one from the insurer’s or the agent’s.

Here is the indication that the consumer needs to be educated. Perhaps, Regulations may also require a re-look.

A negative outcome might also be that complaints involve questions of ‘facts’ surrounding a claim which the Authority cannot adjudicate upon and so, cannot be disposed of. The Authority also receives quite a number of complaints where it has no jurisdiction.

We are in the age of ever increasing expectations. It is said that consumer complaints increase by over 25 per cent on an average each year. It does not necessarily mean that problems are on the rise. It is because the consumer today is more aware—a healthy sign for any industry. It pushes businesses to improve. An informed consumer is the greatest asset of any consumer protection programme. An outreach and education programme designed to assist consumers in making informed purchasing decisions and educating consumers on their rights under the insurance laws is the key to increasing consumer protection. Developing a two-way communication with consumers provides information to the consumer as well as feedback to the company.

The Authority’s objective is to handle a consumer complaint so that it results in insurance companies and their agents acting in accordance with the Laws and Regulations. In handling consumer complaints, the Authority seeks to work with the industry and the consumers on the most common reasons for complaints and if possible remedy the issues in order that future complaints do not occur. This would mean that complaints in those targeted areas should decrease. From the Authority’s point of view, constant communication and feedback with consumers, the industry and the intermediaries is crucial.

It has been observed that many of the complaints are a result of communication and administrative failures.
Creating an Effective System

Manubhai Shah

The author takes a larger look at some mechanisms relating to consumer grievances that the IRDA, the insurance councils and the Government need to put in place.

Over the last more than two decades, we at the Consumer Education and Research Centre (CERC) have had occasion to deal with all kinds of insurance complaints, both life and non-life.

What I propose to deal with in this article are issues with larger implications are IRDA and/or insurance councils have a role to play to review the functioning of the insurance companies in the context of consumer complaints. Of course, there are other larger issues besides the consumer complaints on claims. But that is a separate area. I therefore deal with the subject matter on the aforesaid lines.

Relevant to the redressal of the policyholders’ grievances, the Law Commission of India has made recommendations for creating a separate Grievances Redressal Authority (GRA) with certain powers. Their recommendations and my views and comments thereon are as follows:

The consultation paper has made a number of recommendations on the aforesaid subject. Major features are that they recommend a Grievance Redressal Authority (GRA) in major cities, and Appellate authorities in four metropolitan cities of India. It also seeks to cover the possible disputes between insurance agents, surveyors and loss assessors besides the grievances of the policyholders.

With due respect to the Hon’ble Members of the Law Commission, I do not agree with the aforesaid recommendations.

One of the four basic rights of consumer is to have a quick and inexpensive grievance redressal mechanism. With the size of the country like India even if we have grievance redressal authorities in large number of major cities of India namely each state capital, the same will be still grossly inadequate and expensive.

A grievance redressal authority, to be effective, has to be available at the door step of consumers. In that context the model of Consumer Protection Act having district, state and national level forums and commissions is much better alternative for any and every citizen. If consumers have to go to the state capital every now and then, it is easier said than done and it shall be quite expensive and time consuming.

This is not to suggest that everything is fine with district forums, state commissions and the National Commission set up under the Consumer Protection Act. It does need some addition, alteration and improvement. But in terms of basic infrastructure it is a better alternative than the Grievance Redressal Authority suggested by the Law Commission of India.

Some of the changes which are required to be carried out to make district forums and state commissions more effective are being discussed in the paper. But in any case the recommendation of Law Commission on the aforesaid lines will do more harm than good to the policyholders, denying the basic right of quick and inexpensive grievance redressal.

Over the last 14 years, a number of amendments have been made to make the functioning of district forums, state commissions and the National Commission more effective. Of course there is still scope for improvement. The latest amendments made by the Parliament of India and made effective from March 15, 2003 have considerably improved the functioning of the forums and commissions.

However there are suggestions already made for making district forums and state commissions more effective, which are under the consideration of the Government of India, Ministry of Consumer Affairs.

Today we have about 500 district forums and that too with a pecuniary jurisdiction to entertain claims up to Rs.20 lakhs.

State commissions have original pecuniary jurisdiction of more than Rs.20 lakhs and up to Rs. one crore with appellate jurisdiction above district forums.

The National Consumer Disputes Redressal Commission at Delhi is the apex body having original pecuniary jurisdiction above Rs. one crore without any upper limit and with appellate jurisdiction over state commissions. The appeal against original decisions of the National Commission lies with the Supreme Court of India.

An interesting healthy practice which is followed in the US and other industrially advanced countries is the rating of the insurance companies, both life and general, by independent, professional evaluators. The insurance companies are rated in terms of their quality of services, dealing with...
policyholders, settlement of claims, time taken for the same, fair or unfair dealing with them, terms and conditions of contracts and the like.

Eminent consulting firms, like Standard and Poor's and others are carrying out such rating and companies officially publish them.

The time has come for India to make a modest beginning by directing insurance companies to appoint such evaluating independent professional consultants to bring out a rating of the companies and to publish and publicise the same for the benefit of the general public.

The phenomenon which was absent earlier and remedial measures not called for, have now undergone a radical change since competition was allowed into the industry.

When only Government companies were in insurance, there was hardly any question of insurance companies becoming bankrupt, by their very nature.

With denationalisation, now there are a number of privately owned companies in the life and non life insurance business. God Forbid, but any company could go bankrupt at any time.

The question will then arise as to how to take care of the interest of the policyholders whose claims have become due and payable but whose insurance company has become bankrupt. I can do no better than recommend the UK Model for India to take care of such contingencies.

The UK passed a law called Policyholders' Protection Act in 1975 amended in 1997. The said Act allows for the constitution of a Board of Directors representing multiple interests of relevant stakeholders. It aims to create a Fund to take care of policyholders' interest in the event of any insurance company becoming bankrupt. It has different approaches for general and life insurance companies.

If general insurance company becomes bankrupt an assessment will be made as to the total liability of the company and then each of the companies in the general insurance industry will contribute proportionately towards the fund in relation to its premium income. The fund will then take care of all the assessed liabilities of the bankrupt general insurance company.

In case of life insurance companies, their normal plans and policies are for long term and therefore immediate liability to the policyholders for settlement may not be as high as general insurance company becoming bankrupt. Therefore it has made a different kind of provision.

For immediate total liability, the life insurance companies will make contribution in proportion of their premium income. But so far as the continuity of the long term policies are concerned, life insurance companies take over the said policies in their fold and collect future premia and make settlement may not be as high as general insurance company becoming bankrupt. Therefore it has made a different kind of provision.

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The aforesaid model to the best of my information and knowledge is working well. During the years of nationalisation, we in India did not run the risk of bankruptcy and winding up since they were Government of India companies.

Now that we have denationalised and opened up the insurance sector and encourage public limited companies and cooperative societies to enter into insurance field, the sooner we frame a similar legislation, the better.

Our insurance companies by and large either accept or reject the total claim but do not think in terms of policyholder friendly approach of making a certain part payment to take care of immediate needs of policyholders and settle the full claim in course of time. The concept of 'on-account' payment, where an immediate payment is made on a quick appraisal of liability though not its quantum, is followed for industrial insurances but not usually for personal insurance.

Take for example, if the policyholder's house is damaged due to earthquake or fire, an insurance company may need time to look into all details for settlement of claims. But in industrially advanced countries, insurance companies first help the policyholder by making a certain ad hoc payment to enable him to move to new premises, settle down and start living a normal life.

It is high time that insurance companies in India begin to have a second look at interim, on account payments, before the claim is finally settled.

Even in the case of motor accidents, non-life insurance companies should be very keen to see if the issues can be settled at the earliest so that unnecessary costs can be avoided. This is specially so in view of the larger compensations awarded by MACT with interest for a number of years causing quite a strain on the resources of the company.

I in fact remember when I was on the GIC Board, an initiative was taken by the then Chairman of New India who organised a meeting with the Director General of Police for the State of Gujarat to see that when a motor accident takes place how the matter, including compensation, could be resolved quickly so that the family members of the victim get early payment on one hand and additional cost to insurance company because of delays can be avoided on the other.

Such initiatives, like dealing with consumer grievances quickly and with
an understanding of human misery, will help the insurance companies and their customers immensely.

By and large in the literature or reported motor accident cases, we do not see reference to corruption on the part of surveyors and/or agents, officers of the insurance company, garage mechanics, policemen and even in a few cases even the policyholders themselves.

We are being told time and again that motor insurance is a losing proposition and therefore all kinds of fair and unfair means are adopted by general insurance companies to avoid issuing compulsory third party liability cover even though law requires that the consumer cannot drive the vehicle on the road unless he has this cover.

The question that survives is why is it that the motor vehicle insurance business is a losing proposition and what kinds of measures need to be taken.

There is an interesting report by a Working Group headed by Mr. Bibek Debroy confined to Delhi cases of motor vehicles accident claims including the cost of repairs to the vehicles by the garage.

The question that survives is why is it that the Motor insurance business is a losing proposition and what kinds of measures need to be taken.

The report very elaborately analysed the prevalent corrupt practices in case of two wheelers, three wheelers, four wheelers, buses and trucks in respect of one and all of the aforesaid players in the market including differential percentages of corruption in different kinds of vehicles and repairs.

What measures are being taken by the insurance companies to curb the corruption? If these are looked into, then a mass of consumer complaints relating to non-issuance of cover and delays in settlement of claims can be avoided.

Without any exaggeration, I as a member of the Board of Governors of General Insurance Corporation of India had submitted the aforesaid report to the Board with a request that the matter should be thoroughly investigated in the context of four general insurance companies to find out what the status of the matter was, what measures can be taken, how we can curb corruption, which is one of the factors leading to motor vehicle insurance being a losing proposition.

A consultant was appointed by the GIC. Till today, ten years later, we do not know what is being done.

The author is Chairman (Emeritus), Consumer Education and Research Centre, Ahmedabad.
The Supreme Court of India in the case of United India Insurance Company Ltd. Vs. MKJ Corp. CTJ 1997, (5) 69 said “It is a fundamental principle of insurance law that utmost good faith must be observed by the contracting parties. Just as the insured has a duty to disclose, similarly it is the duty of the insurer and their agents to disclose all material facts within their knowledge, since the obligation of good faith applies to them equally with the assured.”

For a layman insurance is a source of ever available fixed compensation / income irrespective of the nature of the contingencies and causes of perils. Such misconception needs to be eliminated urgently for the healthy growth of the insurance business environment. This calls for creating awareness through proper education.

With the opening up of the insurance sector the monopoly of Life Insurance Corporation of India (LIC) in the life insurance sector and other general insurance companies has come to an end. Many new companies have entered the field with more innovative insurance products and grand promises of better servicing of policyholders. Competition is supposed to hold promise of better servicing of policyholders but, unfortunately, the truth is otherwise because the agents in their zeal to earn more commission do not disclose all the terms and conditions of the insurer.

In a case we came across, the agent secured the signature and premium of the customer for a cashless health insurance by tempting the customer that no pre-underwriting test was required for the policy. After a few days he advised him to go for pre-test in his own interest and everything was alright. However, after about six months he had heart ailment and had to go in for an angioplasty and incurred an expense of about Rs. 28,500 which the insurance company did not pay on the usual plea that the disease was pre-existing. So the insured had to take the help of the consumer forum.

This is not a solitary case. There are complaints that, after paying the premium and signing the papers on the promises of the agent, the customer is advised to go for medical tests, at times, at his cost. This, we feel, is hidden tactics to earn commission.

Rejection of a claim for wilful and fraudulent suppression of facts by the insured is of course unquestionable, but the onus is on the insurer to show that the suppressed facts were material. The most notorious ‘pre-existing illness’ exclusion and its interpretation has led to mutual distrust between the insurer and the insured public. Insurance companies need to create an atmosphere of trust so that the insurer is not perceived as profiteering, unresponsive and non-cooperative and thriving at the cost of consumers’ ignorance of procedure. The consumer feels that he is continuously defrauded, misguided and misled into believing what is unbelievable as per the statement of the agents.

Delays in settlement of claim on account of non-availability/ misplacement of records, non-receipt of surveyor’s report due to non-greasing of his palm etc. are common grounds for harassing the claimant who has to run after the company’s office for months and, ultimately, being tired, knock the doors of the Insurance Ombudsman or the consumer forum for relief.

Here are two examples of delaying settlement of claim and misleading the customer. An officer of the Quality Council of India took a Mediclaim policy from a public sector insurance company for his family. His wife was treated for trogonitis and he forwarded his claim in June 2003 to the company for an amount of Rs. 38,628, which in turn forwarded it to its third party administrator (TPA), on June 18 for processing.

After a great deal of follow-up the company offered on February 20, 2004 to make full and final settlement of the claim for Rs. 19,314 only. No reason was given for reducing the claim to 50 per cent. Ultimately the officer has now lodged his complaint with the office of the Insurance Ombudsman for decision.

The second case relates to refusal to pay a claim by a private insurance company. One Mr. V.R. Jain took a cashless hospitalisation policy for his wife and himself on October 16, 2003 for a period of one year. The policy provided reimbursement @Rs. 1,000 per
day for each day of hospitalisation. His wife underwent an angioplasty on November 10, 2003.

He put up a claim for Rs. 3,000 for three days stay in hospital but the claim was rejected by the company that his wife was already suffering from heart disease prior to policy date. Interestingly Mr. Jain had already in the application form while applying for policy indicated that she was suffering from heart disease etc. for several years. In the circumstance the insurance company should not have issued the policy and he could have saved Rs. 1,700 which he paid as premium on policy. This is a glaring example of an act of misleading the customer.

Another instance of delay in issuing a cover note is that of Voice itself. A liability insurance policy was taken from a public sector company at New Delhi for a sum of Rs. 10 lakh. The policy was expiring on April 22, 2004 and a cheque for Rs. 8,400 was sent on April 27, 2004 for renewing the policy for one year. Unfortunately despite several telephone calls to the company, the policy renewal cover note has not been received till writing of this article i.e. July 15, 2004 for the reason that the old record was not available or the cheque was misplaced.

If we examine the data of cases decided by the district fora during the year 1998 and 2001 a large majority of cases, say out of 83 per cent pertaining to services, 4.21 percent were relating to insurance. At the state commission level also, during the same period, an overwhelming majority 84.91 percent of the cases decided pertained to services and 8.89 percent pertained to insurance services.

With regard to the cases decided by the National Commission from the year 1998 to 2000, the largest share of 36.99 per cent of cases pertained to insurance. It shows that the in house claim settlement system of insurance companies is not consumer friendly, transparent and quick.

With regard to the cases decided by the National Commission from the year 1998 to 2000, a large majority of cases, 79.35 per cent, involved grievances pertaining to services, in which the insurance service accounted for the largest share of 36.99 percent of cases.

It shows that the in house claim settlement system of insurance companies is not consumer friendly, transparent and quick.

However, the Law Commission of India has proposed a comprehensive law to replace the existing Insurance Act, 1938 and IRDA Act, 1999. The Commission is also proposing a full fledged redressal mechanism, comprising Grievance Redressal Authorities (GRAs) to replace the current system of ombudsman at various locations. A GRA would consist of one judicial and two technical members to deal with complaints / claims of policyholders against insurers.

We would suggest that there should be a time limit, say 90 days, for final decision by the authority and also that the advocates should not be allowed appearance against a claimant who pleads his own case. Appeal to the Supreme Court should be allowed only for cases where the claim amount is over Rs. 20 lakhs.

We at Consumer Voice hope that GRAs would meet the expectations of the claimants / policyholders.

The author is Manager (Legal), Consumer Voice. He can be reached at cvoice@vsnl.net.
प्रकाशक का संदेश

स्वतंत्र तथा प्रतिस्पर्धात्मक बीमा बाजार में ग्राहक के पास एक विकल्प होता है तथा वह इसका उपयोग इस अपनी इस अवधारणा के आधार पर करता है कि सेवा की लागत, सेवा की गुणवत्ता तथा कंपनी का अपने साधरण दावक के प्रभाव के प्रति केसा पिछला कार्य-निषेधान त्रिकार रहा है। लोग बीमा बढ़ाते हैं, अनजान विमानों से सुरक्षा के लिए वह ऐसा महसूस करते हैं कि वह इन विवरणों के शिकार नहीं होंगे। बीमा कंपनी द्वारा किसी दावे को निरस्त करने से बढ़ी विवाद नहीं हो सकती, जबकि अभाव शिकार पहले ही विवरण विधिक से प्रतिपल हो बुक करता है। इसलिए, शिकायत निपटने बीमा उद्योग में विशेष महत्व है।

विनियमक का एक महत्वपूर्ण कार्य इस बात को सुनिश्चित करना है कि उड़ाँग एक स्व., पारदर्शिता तथा प्रभावशाली विकार्य निर्देशनाओं की ध्यानचिह्न का साधनारूप: यह माना जाता है कि प्रतिपर्य के इस संसार में बचे रहने के लिए जीवन बीमा जैसी सेवा प्रदान करने वालों के लिए ममतवा यह होगा कि वह कैसे अपने ग्राहकों के शिकारों का निपटाते हैं। पालिका द्वारा के लिए ऐसा महसूस करते हैं कि उन्हों जो मिलने चाहिए था नहीं मिला तथा वह एक बड़ा बात का शिकार हुआ, साधारण सी बात है। जब एक बार बीमा कंपनी द्वारा निरस्त किया जाता है, तब वह महसूस करते हैं कि कंपनी अपने व्यय से पीछे हट गई है। यह इसलिए होता है कि पालिका वस्तुदार के विभिन्न खंडों की अलग-अलग प्रकार से व्यावहारिक की जाती है। वह भारत कंपनी पर होता है कि बीमा वेतन समय वह यह स्पष्ट करे कि बीमा समझौते के अनुसार जिन परिस्थितियों में क्रौल जो जोड़ी को सुरक्षा प्रदान कर जा रही है। वह भी समान रूप से महत्वपूर्ण है कि एक तंत्र बनाया जा जो सत्ता रूप से उन शिकारों को पुनर्विस्तार करने का तथा उन पर तुलना प्रणय ले, जिनके ग्राहकों द्वारा उद्योग गया हो जिसमें शिकारों को कम किया जा सके। शिकायत निपटने एक महत्वपूर्ण कार्य है तथा इस बारे के जरूर है कि विनियमक के रहे उद्योग तथा ग्राहक के बीच से देखा गया है। विरामस यह रहा है कि उद्योग वेतन हार्ड ग्राहक पक्ष तथा समाधान पाने देखे लिए कारण रूप है।

इस अंत में 31 मार्च, 2004 को समाप्त हुए सिंह वर्ष के एक व्यापारिक व्यवसाय आंकड़े भी दिखे गये है। इसमें रिपोर्ट व्यापार आंकड़े यह है कि पिछले वर्ष गर-जीवन बीमा क्षेत्र में रिस्किए व्यवसाय- क्रम में बढ़ी देखा गया चयन यह दुसरा है अब धमकते वह भारत के यह देखा वर्ष में आता हो जाएगा।

आईआईटीएंजिया ज्ञान तथा बीमा उद्योग में व्यवसायिक शिक्षा तथा प्रशिक्षण पर चर्चा करता है, इसमें यह प्रत्यक्ष विचार जा सकता है कि बाजार की बाजार के अनुसार उच्च गुणवत्ता की व्यवसायिक योजना उपलब्ध हो। भारतीय बीमा संयोजन एक योजना साइंसर के बाद को आगे चलते रहा है। उनके 50वें सेवा वर्ष में उनका हमारी बढ़ाई हमें यह निवास है कि यह बीमा उद्योग की प्रभाव के साथ पिछले वर्षों की तरह विकास करेगा।

भूा: तम. राप्र.
सी. एस. राव
“कुछ तो लोग कहेंगे”

राष्ट्रीय संगठन में तथा वित्तिय सेवा उद्योग के
विभिन्न क्षेत्रों में प्रचलन करने वाले समूहों में वृद्धि हुई है।
यह नियम हमें मदद देंगे हो समूहों के विनियमन के लिए,
जब वे इसके कि विभिन्न क्षेत्रों के व्यापार को स्वतंत्र रूप से
चलाया जाए।
श्री माइकल प्रोजेक्ट, निदेशक भोक तथा पुर्वपाल, वित्तिय सेवा पारंपरिक (एफएसए)।
इन्होंने विनियमन
के लिए वित्तिय समूह पर विश्वासिया।

साधारण बीमा उद्योग ने उत्पादों के मुख्य को कम
रख कर बिस्मुक प्रार की प्रभिद्ध प्राप्त नही की है।
क्योंकि जो विभिन्न स्थिता पालती होल्ड
बाहर है। सुरक्षा तथा वर में स्वयंकर- इसका
विषय नही शुरुआ है।
श्री नाक्स प्रोजेक्ट, सुस्थ कार्यालय, लाहौस
आफ लंडन

बूढ़ा बाजार में, एक प्रभावशाली तथा
उन्नत बाजार में ऐसे प्राको कि आपकरकता है जो इस
योजना हो कि अपने मामलों भरोसे के साथ ने सब, इसके लिए सेवा
की आपकरकता है। जो व्यापक, सुमार तथा समय पर उपलब्ध हो
तथा इसके जो ऐसी सेवा उपलब्ध कराने की जरूरत है जो
अभिव्यक्त हो उत्तराधिकारी सम्मिलि।
श्री कालाम मैक्लैंडर, अध्यक्ष, वित्तिय सेवा पारंपरिक (एफएसए)।
इन्होंने विनियमन की वार्ता बैठक में

एपीएसए, स्टाफ अधिक तरह समस्या है-
तथा इस लाइज में विद्य करने में लोग है- समुदाय उनकी
तरफ़ जोरदार तथा प्रभावशाली कार्यनिगमन के लिए रहता
है...। यह मदद करता है आपकरक विनियम पाठ करने के लिए
जो विभिन्न प्रणालियों में कम हुआ था, जो समूपण आस्ट्रेलिया
की विभिन्न प्रणालियों को रक्षा करेगा।
डा. जान लेफर, अध्यक्ष, आस्ट्रेलिया पुर्वशात
विनियमन पारंपरिक (एपीएसए)।
किसी के कार्य में गाड़ बाद

जीवन तथा गरीब जीवन दोनों उद्योग पिछले वर्ष के अधिक
हानि अनुभव तथा अभियंता वित्तिय बाजार के बाद बायोसी का
अनुभव कर रहे है। इस वर्ष प्रमियम में आपसिल वृद्धि तथा लाभ
प्रक्रिया को तेज कर देंगे।
श्री योमस हैंस, अध्यक्ष आर्यिक अनुस्थत तथा परामर्श
कार्य, ब्लॉज सी
जिला फोर्म में शिकायत दायर करने के लिये न्यायालय शुल्क

एवं अवस्थित

रिपोर्ट और नियुक्ति सेवा का दौर समाप्त हो गया है। उपभोक्ता सुरक्षा अधिनियम, 1986 को उपभोक्ता विवादों के लिए, साधारण एवं सैकरनियम समाधान के लिए अधिनियमित किया गया है। लोगों में उपभोक्ता अधिकारों के अनुसार जागरूकता बढ़ने, सरकार और उपभोक्ता शक्तियों में एकता बनाने और उसके संदर्भ में जागरूकता बढ़ाने जाने वाले उपभोक्ता विवाद शुल्कवार्त्तों में भाग लेने के लिए इतना वृद्धि हुई है।

इस अधिनियम के प्रावधानों के अनुसार देश में सरकारी अधिकारिक तत्व - एक राष्ट्रीय आयोग, 35 राज्य आयोगों तथा 571 जिला फोर्म - की स्थापना की गई है। उपभोक्ता विवाद समाधान शक्तियों से बाहर है की वे मामलों का निर्धारण जांच संभव हो जाने 90 से 150 दिन के भीतर कर दें। उपभोक्ता को यह फोर्म शिविर कोर्ट तथा अन्य संविधानीय जिला फोर्मों के अतिरिक्त उपभोक्ता है। जुलाई 2003 की तिथियों की समाप्ति तक राष्ट्रीय आयोग, राज्य आयोगों तथा जिला फोर्मों में दर्ज करने वाले कुल मामलों तथा उनमें से निर्देशांक देने वाले मामलों का विवरण इस प्रकार है:

<table>
<thead>
<tr>
<th>सामाधान एजेंसी</th>
<th>मामलों की दर</th>
<th>मामले मिट्टी देने वाले प्रति मास</th>
<th>प्रतिशत</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) राष्ट्रीय आयोग</td>
<td>30,799</td>
<td>22,958</td>
<td>74.5</td>
</tr>
<tr>
<td>ii) राज्य आयोग</td>
<td>2,72,396</td>
<td>1,77,269</td>
<td>65.1</td>
</tr>
<tr>
<td>iii) जिला फोर्म</td>
<td>17,48,905</td>
<td>15,05,744</td>
<td>86.1</td>
</tr>
<tr>
<td>कुल</td>
<td>20,52,100</td>
<td>17,05,971</td>
<td>83.1</td>
</tr>
</tbody>
</table>

यदान होने पर उपभोक्ता मामलों के निर्धारण के राज्य आयोगों के मामलों में एक अवस्था है, जिसके बाद उनके अनुसार अदालत उनके निर्धारण के अनुसार की जाती है, तथा उनके मामलों में जो अवस्था बनाने के प्रति गिरकर नहीं होते।

हालांकि इस अधिनियम की धारा 26 में निर्धारित और पूर्वांगूर्धूण शिकायतों का रूप देने वाला सेवाएं का भुगतान करने का प्रावधान है, लेकिन फोर्मों के कर्तव्यों के अनुसार कार्यरतों को अपने मामलों रहने का अन्तर्गत नहीं किया जाता है, कहीं अन्य फोर्मों के निर्धारण के एक अवस्था है।

किसी राष्ट्रीय कुंडे से राज्य आयोग के राष्ट्रीय फोर्म के प्रमुख से बिना दिये किया गया था इसके लिए ब्राह्मण तथा अलीगढ़ आयोग के मामले के लिए अन्तर्गत नहीं किया जाता है।

राज्य आयोगों तथा राष्ट्रीय आयोगों के समय सिविल तथा अन्य संबंधित दर्ज करने के लिए अवस्था शुल्क की दर्ज भारत सरकार के समय खर्च करता है तथा यह श्रद्धा ही सूचित की जाती है। इसके अलावा आयोग के कोई अवस्था का भुगतान किया जा सकता है।

लेखक VOICE के प्रबंधक (विषय) हैं। उन्हें ई-मेल : cvoice@vsni.net पर संपर्क किया जा सकता है।
अपकी मुद्दों में
वरिष्ठ नागरिक

जीवन बीमा कंपनियों का संचालन नीमा अधिनियम 1938 एवं बीमा नियमिताओं और बीमा प्रक्रियाओं के प्राप्तकर्ता के अनुसार होता है इसलिए, उनकी पेंशन प्रणालियों में निवेश करना विदेशी भी है और ये पूरी तरह सुरक्षित भी है। पेंशन प्रणाली में निवेश करने का मतलब है कि जीवन में अच्छे तरह से सुरक्षित हो।

वृद्धाश्चरण सामाजिक एवं आय सुरक्षा (एमोएजबीएस) की प्रणीत परियोजना परिफार में भारत की जनसंख्या में बुढ़ी के बढ़ते अनुपात को कमी नहीं करता, हालांकि परियोजना की लागत मुक्त है। परियोजना के मार्गदर्शक भारत तेजी से जनसंख्या संख्या के अनुसार गुज़र रहा है। जीवन प्राप्ता बढ़ रही है। 60 वर्ष का आय आय के कुछ लोग मंगे लक्ष्य तक जीना चाहते है।

विष्णु मुंडों ने कुल जनसंख्या में मुड़ी होने की जानकारी की। भारत में बंगाल मुंडों जनसंख्या की संख्या 1999 में 49 प्रतिशत होने की संभावना है। (1991 में 846.2 लाख में से 2016 में 1263.5 लाख) 60 वर्ष के जन्म 2017 के 107 प्रतिशत बढ़ने की प्रगति है, जिसकी 1991 की जनसंख्या का माता पिता 54.7 लाख में से बढ़कर 2016 में 113.0 लाख हो गई।

युवाओं में, कुल जनसंख्या में मुंडों की विस्तार से 2016 में 8.9 प्रतिशत होने होगा। 1991 की जनसंख्या के मुक्तियों मुंडों की अभाव का हिस्सा 6.4 प्रतिशत है। जनसंख्या बढ़ने के यह बढ़ते हैं कि बुढ़ों की जनसंख्या 2020 में 179 में से अधिक हो जाएगा। भारत की मुर्गी जनसंख्या का 13.3 प्रतिशत होगा, 2026 में भारत की कुल आबादी 1331 में होगी, अब 2026 के भारत की कुल जनसंख्या 1331 में मुंडों की जनसंख्या 13.3 प्रतिशत होगा।

मुंडों के क्रांतियों के लिए भारत ने बड़े कदम उठाए। यह इसलिए भी जरूरी है कि मुंडों को सामाजिक सुधार निइ और देश को नीतिगत तरीके से जाना जा सकता है। इसकी आवश्यकता बढ़ाते हैं इस हरसुधार की जारी भी भी भारतीय निर्माण 1925 में क्या तरीके सामाजिक निर्माण में निर्माण किया गया। 1925 में क्रांतियों भारत निर्माण एवं विश्वास प्रणाली अधिनियम 1938 के माध्यम से कार्य करना शुरू करते हैं। बैंक क्रांतियों के लिए पहले 1999 में मुंडों के चीफ एवं मुंडों का प्रतिशत मुंडों में धन जी रही सुधारों के लिए इसके बावजूद निर्माण किया गया।

धन मुंडों की गतिविधियों का समाप्त करने के लिए हमें अनेक समाज के विभिन्न योजनाओं के साथ साथ आगे आना होगा। हां हमें विभिन्न निर्माण तथा सामाजिक निर्माण के लिए अलग प्रकार का घर बनाना होगा। एसबीसी बैंक के लिए हमें इस प्रति करने के लिए अलग प्रकार का घर बनाना होगा। बैंक क्रांतियों के कारण अनेक समाज के विभिन्न योजनाओं के साथ साथ आगे आना होगा। हां हमें विभिन्न निर्माण तथा सामाजिक निर्माण के लिए अलग प्रकार का घर बनाना होगा।
वरिष्ठ नामित

सामान्य वार्षिक तीर्थ पर बीमा के श्रेणि में व्यवसाय कर सकती है। आज-नव बाराम में विस्मित प्राची की प्रदेश योजनाएं एवं तालाबाली वार्षिक योजनाएं सामान्य कार्य से समाप्त रहती हैं।

यहाँ पर ऐसा बोलना चाहिए कि जो लोग अपनी राहत की तलाश करने के सामने आए तो वहें योजनाओं के लिए महत्वपूर्ण हो सकती है। पेश किए बीमा अधिकार की तरह जनता के बाद तेजी की विद्यमान पेश किए जा सकते हैं।

यह प्रकार के गृहीत पुस्तकों में भी समाप्त हो सकती है। यह वरिष्ठ नामित प्रकार के योजनाओं को प्रस्तुत करने के लिए समस्या में आती है।

बाबा है दोस्तकालीकृत पेश किए योजनाओं?

एक दोस्तकालीकृत योजना में आपका सम्पूर्ण योजना होता है। यह पेश किए विचार जीवन राम के वृत्त व्यवस्थापित करता है। वस्तु व्यवस्थापन साधन में भाग लेने वाले समस्या समाप्त हो सकती है।

सहायता के परिमाण से भी सम्पूर्ण हो सकती है, इसके अनुसार परिस्थितियों में समान अवसर राम के भाषणों के तरीके से हो सकती है। दस अबधि पेश किए जाने वाले अवसर निर्माण पर मानक करने के हैं।

बिना भी सुत्र में कुल राम राय का भूतान एक सिद्धार्थ राम होता है। इसका मतलब यह है कि राम राम के बाद राम को साधक करने वाले समस्या समाप्त हो सकती है।

निम्नलिखित विश्लेषण निर्मला इंद्राजित से ज्ञात होता है कि राम राम के बाद राम का भूतान एक सिद्धार्थ राम होता है।

लाभ हैं: वार्षिक योजना जीवन लाभ के लिए वरिष्ठ नामित के सामने है। इसका मतलब है कि राम राम के बाद राम का भूतान एक सिद्धार्थ राम होता है। इस वरिष्ठ नामित राम के बाद राम का भूतान एक सिद्धार्थ राम होता है।

जीवन राम लाभ योजना का वरिष्ठ पेश किए योजनाओं से विरुद्ध में जीवन निवेश के लिए अपने करोड़ों के सामने बांटे जा सकते हैं।

54 वर्ष में अद्वितीय आयु का भूतान वार्षिक 26,665 रुपए जमा करता है तो यह प्रभाव 2,000 रुपए के बाद अधिकतम प्राप्त कर सकता है।
वैकल्पिक माध्यमों पर एक दृष्टि
के. नित्या कल्याणी

नई पहल हमेशा सुलझाने के लिए नई पहेलियाँ लाती है, इसलिए यह वितरण के वैकल्पिक माध्यमों पर निर्माण है। बहुत से प्रश्न उठते हैं और अर्थ नए कोस्मो से चुनौती देते हैं।

बीमा वितरण के वैकल्पिक माध्यमों को स्पष्ट रूप से दो श्रेणियों में बांटा जा सकता है। यह जो तकनीकी की सहायता के कारण हुआ है और जो अभी तक ठीक से अस्पष्ट नहीं हो पहले बाजारों तक पहुँचाने के लिए आवश्यक है।

पहले बाले शहरी बाजारों के लिए अधिक प्रामाण्य है तथा यह इंटरनेट, काल सेंटर, टेलीमार्किंग और सोशल मीडिया प्रकोप को शामिल करता है। दूसरे में स्थायी संबंध संस्था है, जो ग्रामीण और संपादक रूप से छाँटे समुदायों को समझता है और उनके साथ कार्य करते हैं। यह उनमें सिद्धांत का प्रामाण्य करते हैं, कार्यक्रमों का सुनहरा करते हुए उनकी आकर्षणशक्ति को मदद देते हैं और धारणाएं नवीकरण और आत्मविश्वास को बढ़ाते हैं।

बीमा के लिए बाजार अन्यथा नहीं है। हम बात पर विचार करने हैं कि जीवन का वितरण आधारभूत सिद्धांत है, जिस पर बीमा का व्यवस्था तक हिस्सा हुआ है, तो वितरण है इस कारण। उनमें उसके लाभ के लिए बीमा का बाजार अन्यथा नहीं होगा चाहिए। इसलिए अधिक से अधिक बाजारों तक ऐसे माध्यमों से पहुँचे की आवश्यकता है, जो इन क्षेत्रों में बेहतरीन पत्र पत्र के लिए उल्लोह गर्म हो।

निवृद्ध एड्जेसी प्राप्ती - जिसका पात्र एडवार्ड, पूर्वकालीन इंस्यायर और निजी क्षेत्र की कई कंपनियों भी व्यापक तरी पर करते हैं - अभी भी बीमा उपयोगों के वितरण का वृद्ध माध्यम है। कार्पोरेट एड्जेसी कुछ उद्ध्वस्तक उपयोगों का साथ इसमें आ रहे हैं। बीमा भी इसकी प्रारंभिक भारी कलिंग्स से गुजर रही है। तथापि हमें उस समाज से जीवन पालन्तिकों के लिए प्रामाण्यवाल वितरण मान्यता है, हालांकि जीवन (अनुष्ठान रूप से तुड़ता) बीमा बाजार में आस्थायों द्वारा नए स्थल सुनिश्चित किए गए हैं।

यह देखना दिल्लिख्य है कि उद्योग अपने बाजारों पर फैलने के लिए नवीनतम प्रकारों के द्वारा बढ़ाना चाहता है, जबकि बीमा के विकास में मानव व्यवस्थापन को बोहे पछाड़ नहीं सकता।

अब हम देखें कि कंपनियां बाजार में बढ़ते प्रकार अपने माध्यमों का चर्चा करते हैं।

रायमंड सुंदरम एक्स्क्रिम्यस इंडिया लित. (आरएसए) के मामले को ही ले लीजिए। इसके बाद एक मामले, जो तभी कार्पोरेट एट, टेलीफोन फ्लोटिंग (एससी) करता है, के रूप में सिद्धांत प्राप्त करता है।

आरएसए का प्रयोग लिस्टिक बी एंटीज रैल्यू कहते हैं कि उसों साथ आधार के अनुसार उपयोग का चर्चा पालनी चाही है। इसके बाद में "प्रदर्शन हुआ तो एक नया उपयोग परिवार किया जाता है।" इसके बाद उसका इस्तेमाल को सुनिश्चित किया जाता है।

आरएसए ने व्यक्ति तट का प्रतिष्ठत तट का नतीजे हासिल की, जबकि अंतराष्ट्रिय स्तर पर योग का एक अधिक सीता के रूप में देखा गया। इन्हें ही एड्जेसी के लिए काफी सहायता का लाभ प्राप्त किया गया।

उदाहरण के लिए, बीमा उपयोग में प्रत्यास्त लाभ अधिकता नहीं होता। दूसरी कंपनी उसके अनुकूल का कुछ समाहों के बाद जारी कर सकती है। बचा कब जा कहते हैं कि यहां अनुसूचित माहौल एवं प्रताप नहीं - विशेष रूप से - एक अंतर्दी-परिसर करते हैं।

बीमा वितरण के वैकल्पिक माध्यमों को स्पष्ट रूप से दो श्रेणियों में बांटा जा सकता है। यह जो तकनीकी की सहायता के कारण हुआ है और जो अभी तक ठीक से अस्पष्ट नहीं हो पहले बाजारों तक पहुँचाने के लिए आवश्यक है।

बीमा वितरण के वैकल्पिक माध्यमों को स्पष्ट रूप से दो श्रेणियों में बांटा जा सकता है। यह जो तकनीकी की सहायता के कारण हुआ है और जो अभी तक ठीक से अस्पष्ट नहीं हो पहले बाजारों तक पहुँचाने के लिए आवश्यक है।
विवेक

को प्रोसाहन देने का मित्वन रखती है। ग्रामीण
tोगों की मरनों तूटने के लिए आर्थिक
gतिविधियों बनाने तथा आय प्राप्त करने के लिये
इसीकी भूमिका की गई। इसके बाद यह उनकी
आर्थिक स्थिति तथा जीविका की सुधार करने के
लिये बीमा क्षेत्र में चला गया। बालिकार के सहायक
उपयोग को दूर करने की सफलता प्राप्त करने के
लिये इसकी भूमिका दर्ज की। बालिका के
सहायक के साथ, जीवित बचने की सीमा की वृद्धि निकाय
भी है, कहते हैं - "हम इसे धीरजणाली सवाल
सेवाओं के लिये एक अद्वितीय योजना के रूप में
देखते हैं।" पंचायतों तथा 28 शहरों में वातावरण
tकरने वाली बालिकार के लिए बीमा बिक्री का एक
गतिविधि है। इसके पास 280 ग्राहक सेवा एजेंट
हैं, जो व्यापारी ग्राहकों से संवाद करते हैं।
प्रधान एजेंट
10 से 12 हां देखता है।
बालिकार इंटरनेट-आक्षरण सिक्योज, धर्मता
निम्नां, कृषि गणना विकास, बाजार सहलता
tथा व्यापारिक विकासों के लिए काराय एवं
tकाराय कृषि व रेंज उद्योग के लिए संस्थाना उपलब्ध
कराने वाले व्यापार विकास सेवाओं में कार्य
tो है। इसकी संस्थापक विकास सेवा ग्रामीण संस्थाओं
के विकास के लिये संस्थान से उन्हें ग्राहक होने वाली
निर्देशित का उपयोग करती है। इसके पास एक
कारीगरी है जो बाजार सीमा में योगदान
hै, जो व्यापारी
विकास के स्तर 26 संस्थाओं को धर्मता
निम्नां संवाद करते हैं।
बालिकार अब अंग्रेजी ग्राहकों को भी
व्यक्तिगत पाठवियों बनाने के लिए एक प्रायोगिक
कार्यक्रम पर कार्य कर रहे हैं। इस कार्य के जनरल
महां से यह कार्यक्रम 12 महीनों में चल रहा है।
भी
संस्था कहते हैं कि हम इसके सीमा के रूप
महां आदेश ने उन पाठवियों को आधार रखते
है तथा बालिका के एक्सप्रेस बाजार
tथा बालिका के एक्सप्रेस बाजार
tथा बालिकार के एक्सप्रेस बाजार
tथा बालिकार के एक्सप्रेस बाजार
tथा बालिकार के एक्सप्रेस बाजार
विकल्प

प्रायविष्कार से हैं, जो छोटे समय के साथ काम करती है तथा वह उन्हें सीख सके और उपयोगी का विकास कर सके। एक बड़ी बाधा है कि बीमा कंपनियों ने ग्रामीण शाखाओं के व्यापार आवश्यकताओं को समाप्त करने के लिए समय उच्चतम नहीं लगाती हैं।

प्रत्येक विषय प्रश्न कई तरह से हो सकता है। ग्रामीण शाखाओं और उपयोगी का उत्तर दिनेवाले हैं। इसे समझने के लिए एक और उपयोगी यह है कि वह निर्धारित कर जाए कि एक ग्रामीण से कितने बार सपने किया जा सकता है।

बहुतायत के बाद की वार्ता में झील बीमा आयुष्मान एक अनुभव जीवन है। इसका विषय उद्योग मूलभूत है, बीमा कंपनी तथा कार्यालय क्वालिटेटिव विभाग के बाँट लैपटॉप या अन्य कार्यकुल वे आईटी सेवा का रुपांतरण कर सकती है जो ग्रामीण को संयुक्त तत्त्वविद्या उपलब्ध कराते हैं। इसके लिए उनकी आयुष्मान और नौसिखर उपयोगी का भूमिकाबद्धता करती है।

हालाँकि ग्रामीण शाखाओं के मामले में उनकी कंपनी पूर्णता के लिए एक नया सपना के बारे में विचार करते हैं, लेकिन वह उन्हें भी समय नहीं देता।
Some steps have to be taken to introduce hi-tech processes in a phased manner, after insurers settle down with technology-based process discussed in the earlier issues. It is important to evaluate the high cost of applying technology against the benefits and proceed selectively.

**Internet**

The use of Internet has become ubiquitous due to the easy delivery of information. Policyholders/agents can be serviced from anywhere in the globe, regardless of their location. Internet technology now delivers on-demand functions by dynamically connecting to backend systems and extracting online real-time information. Many health insurance companies attempt to drive insured persons to self-service over the Internet.

A portal for policyholders can be envisaged where the policyholder can log in and request for the various functions. This portal should deliver information in local languages like Hindi, Tamil or Telugu depending on the choice of the policyholder. Functions that can be delivered through the Internet include:

- **Quotation and proposal creation**
- **Outstanding premium and payment of premium/loan**
- **Premium history**
- **Request for loan against the policy**
- **Claim intimation and status of claim**
- **Basic endorsements like change of address and beneficiary details**

The Internet can deliver all the information that a customer may need such as:

- **Status of a proposal**
- **Policy premium, outstanding premium/loan**
- **Commission details and production history**
- **New product introduction**

A portal with the above functions will obviate the need for the agent to visit the insurance office and help him focus more on bringing more business. It is more beneficial when agents are located in remote locations and rural areas without local offices.

In the US, by 2002, 42 per cent had corporate Intranet, which in some cases contain updated procedural manuals, which provide ‘help’ for various business activities.

**Telecommunication-based technology**

It is no longer feasible to expect the policyholder to walk to the branch of the insurance company for information. Insurers in India have to use telecommunication technology to deliver service to policyholders. Some of these are relevant now or will be in due course:

- IVR: Interactive Voice Response system is the preferred way of servicing customers. IVR obviates the need for an insurance company to have human support to answer basic questions about policies like premium due date, outstanding premium, loan outstanding etc. IVR links to the core system of the insurance company to provide information.
- Telephone support: There are scenarios where a policyholder would like to talk to a customer service executive for questions, which are not answered by the IVR or for human-to-human interactions. This service will allow them to talk to the customer service executive.
- Mobile Technology: It allows employees to work as productively outside the office (especially on the general insurance side), as they are at their desks. It allows users to remain in contact with customers and employees while out in the field and to have real time access to information. There is, though, a limitation on the quantity of data that can be delivered on the mobile phone due to size of the screen. The possible uses of mobile technology are for information like:
  - Outstanding premiums and renewals
  - Reminders for claim requirements
  - Claim settlement status
  - Birthday greetings to the policyholder

In India, it has a special significance because of the rapid penetration of mobile devices.

**Document management**

Many futurists and forecasters have been predicting a paperless society, every business transaction and storage of all information being handled electronically, reducing paper files including images. Underwriting, customer service, legal, investments and claim processing areas are some examples of functional areas that require storing, retrieving, and accessing large numbers of documents.

**Benefits are:**

- No search time, no need to make copies, no misplacement of files and simultaneous use by different users
- Saves a great deal of space, high rent infrastructure.
- Electronically controlled access, e.g., photograph or x-ray of injuries in health claim.

The importance of document management for storing images can be explained briefly in the context of a Motor claim: When a car accident is intimated, the adjusters normally take photos of the car using a digital camera. But this has still to be linked to the core business process, for example, claim processing. This linking can also help in controlling frauds. For example, when a second claims is intimated for the same car and the damage reported at the same portion, the previous claim along with image can be retrieved for reference.

Described below is the process used by a leading US corporation providing end-to-end services for about twenty small-size general insurance companies.

- At the entry point, the proposals are imaged, and proposal forms are physically seen only till the
data capture is completed in the next seat; the forms are rarely required for any reference thereafter and are not seen at all.

- The entire processes thereafter including underwriting, policy issue, and the customer service and claim settlement are based on images in electronic form and workflow.
- After the policy is underwritten through an expert system, the system prints policies and schedules (depending on the insurer, products and underwriting decisions), assembles, folds, places them in window envelopes and sorts them zip code wise before mailing. All these steps are performed without manual intervention.
- The system interacts with external databases such as motor vehicle information before the policy is underwritten.
- The system also provides capture of acknowledgements and tracking of undelivered policies.

The company provides the entire gamut of services (not discussed in detail but it includes loss adjustment and control on subrogation) to 20+ insurers. Every day the service provider makes the servicing details transparent and puts on the scoreboard the different items of work performed as per service level agreement and publishes the average time taken for each of the operations with comparative figures. The success of the operation rests on an efficient document management system.

Incidentally, the largest company in the world maintains a centralised document repository for its general insurance business although physical paper is received from all over the country. Different agencies and regions have the facility to view the documents anytime. The documents are categorised and placed in a directory to facilitate retrieval; this eases the entire operation through the policy’s life cycle. In another life company, several million records are maintained in a jukebox system and any person within the company can access any record on his/her screen instantaneously. While major insurers may find it difficult to digitise the existing mass of document, it is ideal for the new insurance companies to introduce this practice from the very beginning.

Electronic publishing
Technology can produce professional-quality visual and printed material without expensive typesetting and graphics equipment, and in significantly less time. This system can
- Combine data, text, graphics, and other images (input)
- Format them into a design of the user’s choice (Process)
- Generate the result onto disk, paper, film or other media of the user’s choice (Output)

While major insurers may find it difficult to digitise the existing mass of documents, it is ideal for the new insurance companies to introduce this practice from the very beginning.

Kiosks
In the US, at least for insurance, kiosks have not come in in a big way. Kiosks are like ATM centres, which are located at important locations including worksites to deliver service to the customer. As there is an explosion of ATMs in India, the ATM can be used to deliver the kiosk function but this will most likely involve integrating the system with the banking system. LIC has introduced kiosks in certain locations. The utility can be improved upon still further. Two aspects of the current functionality need review:
- Premium position for SSS policies to be included
- Premium position only for policyholders with authentication only, and not otherwise

As a step in this direction, bank depositors (starting with Corporation bank) can pay LIC premiums through ATMs. This technological integration provides new methods of payment.

Personal Digital Assistants (PDAs)
PDAs can deliver applications with limited functionality. Insurers are empowering agents with this device for delivering ‘on-demand’ information. For example, illustrations, premium calculations for both life and non-life products can be done using input of limited information when the agent meets a prospect and this information can be transferred electronically to back-end system for further processing. Agents use palmtops to view billing status, register customer requests, and submit financial questionnaire (moral hazard reports) and so on.

E-learning
As the word indicates, it is electronic learning. Sales representatives and the managers of field offices can access a full range of learning that includes online curricula, tests, and programme reports. The training is available on a 24/7 basis; its objective is to enhance knowledge and performance. Insurance companies spend considerable time, effort and money keeping agents, brokers and clients abreast of new developments. Insurers extensively use this for new product introduction, campaigns etc.

For example, commercial risks such as professional and product liability are complicated. Without training, intermediaries may not be able to communicate and discuss these products with prospects. When time, cost and geography constrain face-to-face learning, online education can fill the void better than any other media, with comfort, convenience and above all the expense. In the Indian context, the E-learning materials need to cater for local languages especially in case of agency training.

The author is Advisor, Insurance, HCL Technologies Ltd. The views expressed here are his own.
FY 2003-04: LIFE

The financial year 2003-04 saw most of the new crop of life insurance companies completing four years of operations. The ensuing paras briefly analyse the performance of the life insurers in the year 2003-04. The analysis covers the overall growth patterns in the industry and the contributions made by the first year premium to the various segments of the life insurance market.

The total premium underwritten by the life insurers during the year was Rs.18,66,939.69 lakh towards 286.26 lakh policies, recording a growth in premium and policies underwritten of 10.24 per cent and 12.83 per cent, respectively over the previous year. During the year 2002-03, the first year premium was Rs.16,93,489.00 lakh towards 253.71 lakh policies and the new players underwrote premium of Rs.2,42,897.02 lakh, viz., a growth of 153.51 per cent in terms of premium over the previous year. The total premium underwritten by LIC in the year 2002-03 was Rs.14,64,122.42 lakh towards 286.09 lakh policies, i.e., a growth of 101 per cent. The share of premium underwritten by LIC in the year 2003-04 was 94.34 per cent.

In addition, under the Varishta Pension Bima Yojana, announced by the Government of India in July, 2003, LIC underwrote premium of Rs.6,07,050 lakh towards 3.33 lakh policies.

Total Individual business

Premium under individual policies for the life insurance industry accounted for Rs.14,64,122.42 lakh towards 286.09 lakh policies, i.e., 78.42 per cent of the business underwritten by them.

Individual new business: Single premium (ISP)

The industry underwrote a premium of Rs.1,68,489.08 lakh towards 4.20 lakh individual single premium policies. Of this, non-linked business comprised Rs.1,18,540.86 lakh towards 3.21 lakh policies, while linked business comprised Rs.49,907.22 lakh towards 0.99 lakh policies. The premium towards riders under the non-linked and linked individual single premium were Rs.34.65 lakh and Rs.6.35 lakh, respectively.

The premium underwritten for the individual single premium towards life business, annuity and pension was Rs.1,40,663.11 lakh, Rs.40.36 lakh and Rs.27,744.61 lakh, respectively.

Individual new business: Non-single premium (INSP)

The premium underwritten by the life insurers under individual non-single premium category was Rs.12,95,633.34 lakh towards 281.89 lakh policies. The break-up into the linked and non-linked categories was Rs.11,88,629.43 lakh towards 275.92 lakh policies and Rs.1,04,663.38 lakh towards 5.96 lakh policies. The premium collected on riders was Rs.2,340.54 lakh.

Under the individual (single and non-single) non-linked category, insurers underwrote premium of Rs.12,37,185.69 lakh, Rs.389.17 lakh, Rs.56,256.80 lakh and Rs.13,338.62 lakh towards into life, annuity, pension and health categories. As against this, under the linked category insurers underwrote premium of Rs.1,27,009.70 lakh and Rs.27,560.92 lakh towards life and pension categories.

Total Group business

Premium under group schemes for the life insurance industry accounted for Rs.4,02,817.27 lakh towards 0.17 lakh schemes, i.e., 21.58 per cent of the business underwritten by them.

Group new business: Single premium (GSP)

The industry underwrote a premium of Rs.3,75,022.34 lakh towards 0.16 lakh group single premium schemes. Of this, non-linked business comprised Rs.3,74,121.01 lakh towards 0.16 lakh schemes, while linked business comprised Rs.793.20 lakh towards five schemes. The premium towards riders under the non-linked group single premium was Rs.108.14 lakh.

The premium underwritten under the GSP towards life business, general annuity and pension was Rs.1,38,057.14 lakh, Rs.1,33,609.12 lakh and Rs.83,247.95 lakh.

Group new business: Non-single premium (GNPSP)

The premium underwritten by the life insurers under group non-single premium category was Rs.27,794.93 lakh towards 1,003 schemes, with the break-up into the linked and non-linked categories being Rs.2,578.61 lakh towards 18 schemes and Rs.25,156.99 lakh towards 985 schemes. The premium collected on riders was Rs.59.33 lakh.

In the group business as a whole, under the non-linked category, insurers underwrote premium of Rs.1,55,459.44 lakh, Rs.60,355.85 lakh and Rs.83,462.71 lakh under the life, general annuity and pension categories. As against this, under the linked category insurers underwrote premium of Rs.3,248.28 lakh and Rs.123.53 lakh towards life and pension categories.
### Individual New Business (Including Rural & Social) 2003-04 (Provisional)

#### Single Premium

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM</th>
<th>POLICIES</th>
<th>SUM ASSURED (Rs. in lakhs)</th>
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<tbody>
<tr>
<td>1</td>
<td>Non linked*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>with profit</td>
<td>32,050.24</td>
<td>56,070</td>
<td>40,861.80</td>
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<tr>
<td>1.2</td>
<td>without profit</td>
<td>62,016.10</td>
<td>1,75,131</td>
<td>1,00,967.36</td>
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<td>2</td>
<td>General Annuity</td>
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</tr>
<tr>
<td>2.1</td>
<td>with profit</td>
<td>22.07</td>
<td>18</td>
<td>38.60</td>
</tr>
<tr>
<td>2.2</td>
<td>without profit</td>
<td>18.29</td>
<td>2</td>
<td>36.57</td>
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<tr>
<td>3</td>
<td>Pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>with profit</td>
<td>10,505.44</td>
<td>65,168</td>
<td>712.52</td>
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<tr>
<td>3.2</td>
<td>without profit</td>
<td>13,928.71</td>
<td>24,879</td>
<td>1,00</td>
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<tr>
<td>4</td>
<td>Health</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>A. Sub total</td>
<td>1,18,540.86</td>
<td>3,21,268</td>
<td>1,42,581.27</td>
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</tr>
<tr>
<td>1</td>
<td>Linked*</td>
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</tr>
<tr>
<td>1</td>
<td>Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Pension</td>
<td></td>
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</tr>
<tr>
<td>3.1</td>
<td>without profit</td>
<td>3,310.46</td>
<td>2,516</td>
<td>537.97</td>
</tr>
<tr>
<td>4</td>
<td>Health</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Sub total</td>
<td>49,907.22</td>
<td>99,267</td>
<td>63,796.03</td>
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</tr>
<tr>
<td>C. Total (A+B)</td>
<td>1,68,448.08</td>
<td>4,20,535</td>
<td>2,06,377.30</td>
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</table>

#### Non-Single Premium

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM</th>
<th>POLICIES</th>
<th>SUM ASSURED (Rs. in lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non linked*</td>
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<td></td>
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<tr>
<td>1</td>
<td>Life</td>
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<tr>
<td>1.1</td>
<td>with profit</td>
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<tr>
<td>2.1</td>
<td>with profit</td>
<td>348.81</td>
<td>3,395</td>
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<td>Pension</td>
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<td>3.1</td>
<td>with profit</td>
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#### Riders:

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<th>POLICIES</th>
<th>SUM ASSURED (Rs. in lakhs)</th>
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**Linked**

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<th>POLICIES</th>
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**Total (D+E)**

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<th>POLICIES</th>
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### Statistics - Life Insurance
### GROUP NEW BUSINESS (INCLUDING RURAL & SOCIAL) 2003-04 (PROVISIONAL)

#### SINGLE PREMIUM

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<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
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</thead>
<tbody>
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<td>1</td>
<td>Non linked*</td>
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</tr>
<tr>
<td>a)</td>
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<td>c)</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d)</td>
<td>Others</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>General Annuity</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>4</td>
<td>Health</td>
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</table>

**A. Sub total**

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Linked*</td>
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<td>b)</td>
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<tr>
<td>d)</td>
<td>Others</td>
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<tr>
<td>2</td>
<td>General Annuity</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>4</td>
<td>Health</td>
<td></td>
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</table>

**B. Sub total**

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A. Sub total</td>
<td></td>
<td>16,353</td>
<td>47,80,715</td>
<td>22,90,466.96</td>
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<tr>
<td>2</td>
<td>B. Sub total</td>
<td></td>
<td>5</td>
<td>1,189</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C. Total (A+B)</td>
<td></td>
<td>16,358</td>
<td>47,81,904</td>
<td>22,90,466.96</td>
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</tbody>
</table>

#### NON-SINGLE PREMIUM

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non linked*</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
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<td>b)</td>
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<tr>
<td>c)</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d)</td>
<td>Others</td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>General Annuity</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Pension</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Health</td>
<td></td>
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</table>

**A. Sub total**

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Linked*</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>a)</td>
<td>Life</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>Group Gratuity Schemes</td>
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</tr>
<tr>
<td>2</td>
<td>General Annuity</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Pension</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Health</td>
<td></td>
<td></td>
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</table>

**B. Sub total**

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>PARTICULARS</th>
<th>PREMIUM (Rs in lakhs)</th>
<th>NO.OF SCHEMES</th>
<th>LIVES COVERED</th>
<th>SUM ASSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A. Sub total</td>
<td></td>
<td>16,353</td>
<td>47,80,715</td>
<td>22,90,466.96</td>
</tr>
<tr>
<td>2</td>
<td>B. Sub total</td>
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<td>1,189</td>
<td></td>
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<tr>
<td>3</td>
<td>C. Total (A+B)</td>
<td></td>
<td>16,358</td>
<td>47,81,904</td>
<td>22,90,466.96</td>
</tr>
</tbody>
</table>

* Excluding rider figures.
** for no.of schemes & lives covered Grand Total is C.
# All riders related to critical illness benefit, hospitalisation benefit and medical treatment.
## Disability related riders.

The premium is the actual amount received and not annualised premium.
FY 2003-04: GENERAL

Customer driven businesses spurt in 2003 - 04

G. V. Rao

Market trends

The provisional department-wise premium figures for the fiscal 2003 - 04 show a few remarkable trends. Though the market grew by about Rs. 1,820 crore (13 per cent) to record a premium of Rs. 16,130 crore, it was the Miscellaneous business that includes Motor, Health, Liability, Aviation etc. that grew by Rs. 1,700 crore (17 per cent). The traditional Fire business grew by only Rs. 195 crore (6.5 per cent) and the Marine business actually showed a drop of Rs. 67 crore (six per cent). Engineering grew by only Rs. 36 crore (five per cent).

The spectacular premium driver, Motor grew by Rs. 1,020 crore (20 per cent); Health by Rs. 270 crore (27 per cent); liability by Rs. 165 crore (100 per cent); aviation by Rs. 90 crore (25 per cent). Unfortunately the growth in the market has taken place in the portfolios that are traditionally regarded as loss-prone.

Fire, Marine and Engineering businesses have struggled to grow. Motor, Health and Liability premiums have boomed. The premium trends have also shown that the four established players have lost considerable premiums in Fire, Marine and Engineering to the newer entrants. The pattern of the previous year has been further reinforced.

Health business now ranks third

Next to the Motor business of Rs. 6,500 crore (40 per cent of the total premiums), the dominant portfolio ranking next is the Rs. 3,200 crore Fire business (20 per cent). It is interesting to note that Health portfolio now ranks third and accounts for Rs. 1,300 crore (eight per cent). Marine business (seven per cent) ranks next to Health business, a late entrant to the market, at Rs. 1,140 crore; and Engineering a poor fifth at Rs. 710 crore (four per cent). Both Motor and Health are essentially customer-driven covers and it is arguable to what extent insurers can claim to have influenced the market growth trends.

Marine business has shown a surprising drop of Rs. 70 crore despite the economy looking up and exports booming. Is this due to decline in the rates charged to attract Fire business that is tariff driven? It is difficult to predict any other reason for this trend.

New companies

The eight new market players with a premium accretion of Rs. 940 crore have recorded a growth of Rs. 170 crore in Fire, Rs. 70 crore in Marine, and Rs. 60 crore in Engineering in total contrast to the average market trends of relatively lower performances in these departments. In the loss-prone departments like the Motor their growth is Rs. 335 crore and in Health Rs. 61 crore. Their strategic objective to target profit-oriented portfolios is quite evident. The star performer among the new companies, ICICI Lombard, has shown an accretion of Rs. 290 crore. Its Fire business increased by Rs. 120 crore; Marine by Rs. 35 crore, Engineering by Rs. 28 crore and Health by Rs. 22 crore.

Old companies

For the four established players that recorded a total accretion of Rs. 880 crore (seven per cent growth), the performance trends are quite the opposite. Their Fire business dropped by Rs. 80 crore, Marine dropped by Rs. 140 crore and engineering by Rs. 25 crore. They grew in Motor by Rs. 685 crore, in Health by Rs. 210 crore and in liability by Rs. 120 crore.

Their strategy appears to be to target premium volumes to generate higher investment income and to maintain their market shares.

National Insurance, the star performer among them, with an accretion of Rs. 530 crore (accounting for 60 per cent of the growth of the industry) for the year has recorded Rs. 380 crore increase in Motor, Rs. 85 crore in Health and Rs. 97 crore in Liability. It has recorded a fall in Fire of Rs. 8 crore and of Rs. 30 crore in Marine.

Is this what was expected?

Is the picture now projected in tune with what the new and established players had desired to achieve? They must ponder over the changing trends, as the market is now shifting to cater to customer-driven preferences, as shown by the fact that the biggest growths came in customer driven covers. Proactive strategies to harness and even to change and influence customer preferences must be attempted. Demand for new and affordable insurance covers has to be created. A reactive market is not going to be a healthy one.

The author is retired CMD, The Oriental Insurance Company.
## Segment-Wise Gross Direct Premium Within India

<table>
<thead>
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<th>Insurer</th>
<th>Year</th>
<th>Fire</th>
<th>Marine Cargo</th>
<th>Marine Hull</th>
<th>Engg.</th>
<th>Motor OD</th>
<th>Motor TP</th>
<th>Motor (Total)**</th>
<th>Health</th>
<th>Other</th>
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## Statistics - Non-Life Insurance

### : 2003-04 (Provisional)

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* Previous year data may not be comparable with the audited published figures.

# Pertains to Credit insurance.

*** In cases where the breakup of Motor OD and TP are not furnished, the numbers have been included under Motor Total. Hence, the totals of columns pertaining to Motor OD and TP need not necessarily match with Motor Total.

NA - Not Applicable

NF - Not Furnished

Royal Sundaram
TATA-AIG
Reliance
IFFCO Tokio
ICICI Lombard
Bajaj Allianz
HDFC Chubb
Cholamandalam
New India
National
United India
Oriental
ECGC**

* Previous year data may not be comparable with the audited published figures.

# Pertains to Credit insurance.

*** In cases where the breakup of Motor OD and TP are not furnished, the numbers have been included under Motor Total. Hence, the totals of columns pertaining to Motor OD and TP need not necessarily match with Motor Total.

NA - Not Applicable

NF - Not Furnished
The contribution of insurance to India’s gross domestic product (GDP) has slipped from 3.3 per cent last year to 2.9 per cent during the current financial year, it is reported. This is in contrast to the international trend where the ratio of world insurance premium to global GDP has improved from 3.4 per cent to 3.5 per cent.

Both the life and non-life insurance businesses have contributed to the decline. The contribution of life insurance premium to GDP has come down to 2.3 per cent from 2.6 per cent a year ago while the contribution of non-life insurance has declined to 0.6 per cent from 0.7 per cent.

This is a reversal of a three-year trend where the contribution of insurance was rising steadily. The good news is that the average premium per Indian has gone up slightly from $14.7 in ’02-03 to $16.4 in ’03-04. This has helped move India two notches up the ranking ladder to the 78th position in terms of premium per capita.

Life Insurance Corporation saw a fall in that class of business due to withdrawal of tax benefits on single premium policies.

As a result, the corporation saw premiums from single premium policies fall by Rs 1,845 crore to Rs 1,165 crore. Tax continues to be a big driver of life insurance business in developing markets as demonstrated globally. Among the emerging markets, tax related factors led to high growth of 27 per cent in Russia and 22 per cent in Brazil. Tax issues also caused a 25 per cent slump in the Mexican markets.

In India, the premium growth of the non-life industry also could not keep pace because of premium rates being driven down by competition coupled with the fact that the high growth areas of services and retail sector which are not effectively targeted by the non-life insurers.

According to figures released by Swiss Re in its latest Sigma report, India’s ranking in total premium volume has remained unchanged at 19 ahead of most of the Asian countries except Japan, Korea, China and Taiwan.

In terms of life insurance premiums too the country has retained its ranking on the number 18 position while in non-life it has slipped one place to the 28th position. In dollar terms, India’s total life insurance premium accounts for $13,590m while non-life premium amounts to $3712m. India’s total premium of $17.3bn represents an inflation-adjusted growth of 8.3 per cent, which is much lower than 25.5 per cent for the People’s Republic of China.

An interesting change is that there has been a big decline in United States’ market share of global insurance premium. In ’02, The US premium crossed $1trillion for the first time and US market share of world premium rose to 38.1 per cent. In ’03, the US accounted for 35.9 per cent of world premium. Another change is that Germany has now become the third largest non-life market with non-life premium of $94bn replacing United Kingdom.

The Insurance Institute of India has retained NSE.IT, the IT arm of the National Stock Exchange (NSE), to develop and implement an application for conducting online examinations for insurance agents.

The Institute, which is entering its 50th year of operations wants to expand the reach of its examination system, reduce the time taken for the process and to automate the process to bring it on par with other countries in the world. III has seventeen examination centres abroad for foreign candidates.

With an online system in place, each candidate will now get a unique ID while filling up the exam form from the Insurance Institute. Accordingly, for each such ID, question papers will be generated automatically from a pool of questions from the question bank when the candidate appears for the exam online. Since the questions are of objective type, the responses from candidates are captured into the database, evaluations are done automatically, and the results are announced.

Oracle 8i database supported by IBM servers have been purchased for the infrastructure. The institute has also taken a 128 kbps leased line bandwidth towards this end.
The Consumer Disputes Redressal Forum, Ahmedabad City, has ordered United India Insurance Company to pay Rs 2,07,149, with 10 per cent interest from February 18, 1999 till the date of payment, to Ms. Kashiben R. Patel, Ahmedabad, in settlement of her complaint on mediclaim.

Consumer Education and Research Society (CERS), Ahmedabad, and Kashiben Patel had filed a complaint in the Forum against United India Insurance Company. Kashiben and her husband had taken a joint medical insurance policy in 1993. From 1993 to 1998 they had paid the premium, renewed the policy regularly and had not made any claim.

On 18 January 1999, she was operated on at the Sathbai Orthopaedic Hospital in Ahmedabad. She produced bills of all her expenses and claimed Rs 2,07,109 from United India.

But the company repudiated her claim, saying the disease had been pre-existing during the renewal of the policy and that Kashiben and her husband had raised the insurance cover from Rs 70,000 to 2,00,000 with mala fide intentions.

On May 4, 2004, the Forum ordered United India Insurance Company to pay Rs 2,07,149 with 10 per cent interest to Kashiben. A compensation of Rs 5,000 towards mental harassment and a cost of Rs 2,000 were also awarded to the complainant.

AIC SEeks SOPS FOR CROP INSURANCE

Agriculture Insurance Company (AIC) has reportedly asked for an increase in the subsidy element in the Farm Income Insurance Scheme (FIIS) to 75 per cent of the premium calculated on commercial basis to all categories of farmers.

At present, the government subsidises up to 75 per cent for small and marginal farmers and up to 50 per cent for others.

AIC is also negotiating with the Government to revise the premium upwards on commercial basis, it is reported.

Under FIIS, AIC CMD Mr. Sugarsar Bhandari has been quoted saying, if the Government provided subsidy of 75 per cent of commercial premium, the company was confident of giving coverage to 50 per cent of farmers, which account for sum assured of Rs 60,000 crore.

According to one estimate, this would require commercial premium of Rs 6,500 crore. That means, the subsidy element in providing the risk coverage against loss due to below normal rain fall would be Rs 5,000 crore per annum.

The company has already launched the National Agriculture Insurance Scheme (NAIS). But, by the end of 2003-04, only 11 per cent of all farmers were insured for a sum of Rs 12,000 crore at a flat low premium of Rs 375 crore.

The scheme is implemented in 20 MET rain gauge stations in Andhra Pradesh, Karnataka, Rajasthan and Uttar Pradesh, taking into account negative deviations in rainfall.

VIJAYA BANK TO ENTER LIFE INSURANCE

Vijaya Bank will soon enter the life insurance business by floating a joint venture (J V) company in collaboration with global insurance and financial services major, Principal of the US, it is reported. The other partners in the J V will be Punjab National Bank and Berger Paints.

The bank has decided on the insurance J V encouraged by an impressive performance in the last two years and to increase its non-interest/fee-based income further. Vijaya Bank netted Rs 32,350.10 crore in 2003-04 compared to Rs 25,203.80 crore in total business, registering a 28.35 per cent growth. The non-interest income during last fiscal was Rs. 526 crore.

The bank has already tied up with National Insurance for distribution of non-life products, and its foray into life insurance will be a step further to enlarge its presence in the insurance market.

Mr. M. S. Kapur, Chairman and Managing Director, Vijaya Bank is reported saying “We have applied to the Reserve Bank of India and Insurance Regulatory and Development Authority of India for approval.”

“The bank is working out the legal formalities with the partners and expect to finalise the shareholding pattern of the new company soon,” Mr Kapur said. However, it is expected that Vijaya Bank will hold a 12 per cent stake in the J V, while Punjab National Bank and Berger Paints will have 25 per cent and 35 per cent stake respectively. The remaining would be with Principal, Mr Kapur explained.

WORLD BANK, ICICI TIE UP FOR WEATHER INSURANCE

World Bank’s commodity risk management group with a technical collaboration with ICICI Lombard General Insurance has developed weather-based loan portfolio insurance in the country, it is reported.

The first weather insurance policy was offered to Bharatiya Samraddhi Finance Ltd (BSFL), the non-banking finance arm of Basix group. “ICICI Lombard would compensate BSFL for deviations in rainfall below the threshold level, which is fixed as a percentage of the average rainfall in the area,” ICICI Lombard’s Head, Reinsurance Mr. Ritesh Kumar is quoted saying. “This portfolio insurance deal breaks new ground in the world of finance. For the first time, an agricultural finance institution has transferred the systematic risk of its crop lending portfolio to the international weather risk market,” Ms. Joanna Syrko of World Bank said.
Insurance industry on the road to recovery: Swiss Re sigma study

The direct insurance industry is on the road to recovery with further progress expected this year, according to Swiss Re’s latest sigma study. Worldwide premiums for life and non-life insurance grew by an inflation-adjusted two per cent to $2,941 billion in 2003. Sigma’s annual review of developments in world insurance premiums shows premiums and results in non-life business increased markedly in 2003. Life insurers reported improved profitability despite a slight decline in premium income. The recovery is set to continue in 2004.

Mr. Thomas Hess, Head of Economic Research and Consulting at Swiss Re, commented: “Both the direct life and non-life insurance industries are experiencing a turnaround following the turbulent financial markets and extreme loss events of past years. The expected growth in premiums and profits this year should speed up this process.”

According to the sigma study, global premium income for direct insurers in 2003 totalled $2,941 billion, up two per cent compared with the previous year. As in past years, the life and non-life sectors showed conflicting trends. In 2003 non-life insurance premiums rose six per cent to $1,268 billion while life insurance premiums fell 0.8 per cent to $1,673 billion. Industrialised countries generated just under 90 per cent of the premium volume, with emerging markets accounting for around 10 per cent.

Life insurance: falling premiums, less pressure on balance sheets and income statements

The 0.8 per cent decline in life premiums in 2003 reflects falls in life business in the US and UK and below-average growth recorded in other industrialised countries and a number of emerging markets. Consumers remained cautious about buying unit-linked policies and traditional products due to a lack of confidence in the sustainability of the stock market recovery and the decrease in profit sharing and guaranteed returns. The erosion in equity capital of previous years - precipitated by investment writedowns on equity holdings and corporate bonds - has forced a large number of life insurers to reduce their with-profit payouts and guaranteed returns.

Life insurers’ balance sheets improved against a backdrop of improved economic conditions. Although investment income remained below average, the pressure exerted by writedowns on corporate bonds and equity holdings relaxed. Cost savings and business restructurings contributed to the improvement in results. Life insurers’ equity bases stabilised, indicating that the outlook is brighter for the life insurance industry.

Non-life insurance: premium growth and improved results

Although at a slower pace than in the previous year, the 6.0 per cent growth reported in non-life insurance was twice as high as the ten-year average, with price increases in virtually all regions. Following the increases in property rates of previous years, substantial rate rises were registered, particularly in third party liability. Since 2000 non-life premium income has grown at a cumulative real rate of 22 per cent, mainly on the back of an increase in premium rates.

Rate increases together with more stringent underwriting standards, and comparatively few extreme losses resulted in a marked improvement in non-life underwriting results in 2003. However, investment results remained poor and overall profits are likely to be average. Although insurers’ equity capital bases improved, capital remained scarce.

Emerging Asia: Further strong growth recorded

Life insurance business in emerging Asia improved, mainly due to robust economic growth in the region. In 2003, premiums rose by 10.2 per cent, compared to 14.8 per cent in 2002. Growth in China (+27.2 per cent) in particular remained at a very high level whereas the outbreak of SARS has apparently boosted demand. Life premium volume also continued to rise in Southeast Asia and India. A high growth rate will persist in most emerging Asia markets as incomes rise and customers become more risk aware.

Non-life business in emerging Asia increased significantly by 8.8 per cent in 2003. Profitability also improved particularly as there were no exceptionally large losses. South Korea proved to be an exception as the market was adversely affected by Typhoon Maemi. Business in China meanwhile expanded by 21.6 per cent, as price pressure in the wake of the motor market deregulation faded towards the end of the year.

Outlook for 2004: The recovery is set to continue

The pick-up in the global economy and the expected rise in both interest rates and stock markets are set to further improve conditions for life insurers and spur demand in life and non-life business. Price-driven growth in non-life insurance will slow as rates gradually stabilise. Premium growth for direct insurers will consequently be less pronounced than in 2003. Assuming average claims levels in 2004, results may well improve further. Life insurers’ equity capital and profits should witness some sustained recovery given the improved conditions.

Swiss Re sigma study “World insurance 2003” examines the insurance markets of 152 countries, making explicit reference to 88.
Insurers Must Go Paperless Correctly!

A report issued by the Agents Council for Technology, the US said that if the move by insurers to “turn off” paper documentation is not done in the right way it could seriously set back agency efficiency.

The report, “Turning off the Paper to Agents: Recommended Agent and Carrier Workflows”, is the second phase of an earlier report by the group, a partnership of independent agents, companies and technology vendors, user groups and associations dedicated to enhancing the use of technology.

The primary conclusion of the report is that carriers should not go paperless unless an effective download is already in place.

“Download continues to be very important to agents in this new environment even though the electronic information should also be accessible to agents on the carrier’s website,” ACT Executive Director Mr. Jeff Yates said in a statement.

The report provides a series of recommendations to agents and carriers depending on whether the transaction is downloaded or not. Where there is an effective download, agents should be able to rely on “spot checking” the downloaded items for accuracy and viewing the electronic documents on the carrier’s web site when needed.

Even where download is in place for a line of business, there are likely to be some transactions relating to that business that are not downloaded, according to the report. Examples might include notices of cancellation, audits, property valuations and correspondence regarding underwriting issues sent directly from the carrier to the insured. The carrier should either continue to send the paper for these transactions or “push” the electronic information, or links to it, to the agent. The ACT report also praises carriers that e-mail or download daily transaction reports to their agents with links to electronic documents.

Where an effective download is not in place, the report urges carriers not to turn off paper unless the agency agrees.

US ACTUARIES LOOK AT TERRORISM COVER

With the uncertainty of the occurrence and magnitude of another terrorist attack on American soil, the Extreme Events Committee of the American Academy of Actuaries has released a monograph examining the impact of terrorism on property and casualty insurers.

This analysis will reportedly be helpful in evaluating the merits of legislation to extend the Terrorism Risk Insurance Act of 2002 (TRIA), which recently was introduced in the US House of Representatives.

The Terrorism Risk Insurance Act of 2002, implemented by the US Department of the Treasury, is a federal program providing reinsurance to property and casualty insurers in the event of terrorism from a foreign source. The act helps commercial property owners obtain affordable terrorism insurance by requiring insurers to offer terrorism insurance while providing reinsurance to cover much of the large terrorism losses. Insurance availability is reportedly essential for construction, business expansion, and economic growth. The program will end on December 31, 2005.

The Academy’s Extreme Events Committee monograph analyses four major points about the need for a federal backstop program: the difficulty of quantifying the losses from an extreme terrorist attack, making it difficult to understand and pool the risk, 2) the perceived concentration of terrorism targets in major urban areas, making it difficult for an insurer to diversify the risk, 3) the threat of insurer insolvency(ies) from an extreme terrorist attack, and 4) the legal, regulatory, financial, and actuarial hurdles the industry will have to overcome in finding a new way to manage the risk.

HEALTHCARE FRAUD IN THE US GROWING

Blue Cross and Blue Shield Association says an estimated $85 billion was lost to health insurance fraud in the United States last year.

That is five per cent of the $1.7 trillion spent on healthcare nationwide in 2003, the association said in a report released in Washington.

One symptom of the increasing problem is physicians putting patients at risk, said Mr. Tim Delaney of the FBI’s healthcare fraud unit, citing a California case in which a cardiologist performed unnecessary open-heart surgeries, it was reported.

Common types of healthcare fraud include improperly prescribing drugs, performing unnecessary medical procedures, billing for services never provided, masquerading as healthcare professionals and billing for a more expensive service than the one performed.

“Every dollar stolen from the healthcare delivery system by fraud perpetrators is a dollar not available for necessary life-saving treatments, drugs, research or emergency services,” said Mr. Byron Hollis, anti-fraud director for the trade association of the independent Blue Cross and Blue Shield insurance plans.
Mr. S. J Gidwani, Secretary General of III plans to celebrate the milestone by taking the examinations process online!

The institute pioneered insurance education in India and, "is a creation of the labour of love of countless dedicated insurance personnel who toiled to bring about an institute with a mission to spread insurance education. We are here because the insurance industry is there. We dedicate ourselves to the objectives set forth in the constitution of the institute viz. to spread insurance education among persons interested in or engaged in insurance," Mr. Gidwani says.

Last year III acquired a plot of land at Bandra Kurla Complex, Mumbai to set up its own building in order to expand its academic and training activities. The institute is a member of the Institute of Global Insurance Education (IGIE) which is co-founded by the insurance institutes of America, Canada and Great Britain.

The qualifications of the institute are also integrated with the insurance institute of America for CPCU and the Chartered Insurance Institute of London. The Fellows of the Insurance Institute of India enjoy seven exemptions out of 10 subjects in the ACII qualification of the Chartered Insurance Institute of London. The CPCU (USA) offers three exemptions, so also LOMA to the Fellows of the Insurance Institute of America.

These developments, says a proud Mr. Gidwani, reflect the wishes of the founding professionals of the institute.

III was formerly known as "Federation of Insurance Institutes - J.C.Setalvad Memorial" and was the creation of the insurance industry as an academic arm to usher in professional education in insurance in India.

To quote its first President Mr. C.R.C. Gardiner “...An Institution like the Federation has a very important part to play not only in the present but in the future economy of this great country, and the Federation can progress only if the enthusiasm of its Council, its Fellows and Associates continue.

The institute has produced more than 60,000 diploma holders both Associates and Fellows and, during the last three years, it has also examined more than 1.2 million candidates for pre-recruitment examination for insurance agents.

The institute has produced more than 60,000 diploma holders both Associates and Fellows and, during the last three years, it has also examined more than 1.2 million candidates for pre-recruitment examination for insurance agents, apart from being the examining body for licensing of surveyors and providing certificate and diploma courses for life and non-life industry.

The institute’s Associateship qualification finds a mention in the Insurance Act and the regulation in Nepal, and Sri Lanka requires as a licensing requirement for its brokers, an Associateship Diploma of the III.
Both the direct life and non-life insurance industries are experiencing a turn-around following the turbulent financial markets and extreme loss events of past years. The expected growth in premiums and profits this year should speed up this process.

Mr. Thomas Hess, Head of Economic Research and Consulting, Swiss Re

Growing number of such groups operate across different sectors within the financial services industry, and across national borders. These rules will enable us to regulate on the basis of the whole group, rather than regulating different sectors of the business independently of each other.

Mr. Michael Folger, Director of wholesale and prudential policy at Financial Services Authority (FSA), UK on the regulator’s new directive on financial groups

In the retail market, an efficient and fair market requires customers who are capable and confident to make decisions; it requires information about services which is comprehensible, relevant and timely; and it requires providers of services to recognise and meet their responsibilities.

Mr. Callum McCarthy, Chairman, Financial Services Authority (FSA), UK at the regulator’s Annual Public Meeting

APRA staff understand well - and have the battle scars to prove it - that the community looks to them for vigorous and effective performance... that helps foster the essential trust and confidence that underpins the financial system, and that strengthens the financial security of all Australians.

Dr. John Laker, Chairman, Australian Prudential Regulation Authority (APRA) about the progress in twelve months after the new dispensation at APRA was put in place the HIH collapse and its aftermath

Where we lose business is to somebody who's cutting our price between 25 and 40 per cent. I think that's insane.

Mr. Maurice ‘Hank’ Greenberg, Chairman, American Insurance Group

The (general insurance) industry has not bought popularity by under-pricing its product because the financial stability that policyholders want - security and pricing stability - has not been delivered.

Mr. Nick Prettejohn, Chief Executive, Lloyd’s of London
Events

09 - 14 August 2004
Venue: Pune
Website Design by National Insurance Academy

1 - 2 September 2004
Venue: Mumbai
4th Asian Healthcare Insurance Conference by Asia Insurance Review
With a Special Focus on Coping with Healthcare Needs of the Indian Market

4 - 8 September 2004
Venue: Monaco
Monte Carlo Rendezvous

2 - 4 September 2004
Venue: Pune
Management of Executive Stress by NIA

6 - 11 September 2004
Venue: Pune
Data Warehousing and Data Mining by NIA

13 - 18 September 2004
Venue: Pune
Insurance Management of Infrastructure Projects by NIA

13 - 18 September 2004
Venue: Pune
Research Methodology and Market Research by NIA

13 - 14 September 2004
Venue: Pune
C.D. Deshmukh Seminar on Agenda for Growth of Insurance Industry by NIA

18 - 19 October 2004
Venue: Agra
Third International Symposium on New Technologies for Urban Safety of Mega Cities in Asia organised by Indian Institute of Technology (IIT), Kanpur, and International Center for Urban Safety Engineering, Institute of Industrial Science, University of Tokyo, Japan

27 - 29 October 2004
Venue: Hyderabad
A Billion Lives to Cover: Working together to expand Health Insurance in India organised by USAID, IRDA and Bearing Point.