



Volume II, No. 9

# Journal

AUGUST 2004

A Kind Word

बीमा विनियामक और विकास प्राधिकरण



Volume II, No.9

**Journal**  
AUGUST 2004

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## *From the Publisher*

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 31<sup>st</sup> 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 50<sup>th</sup> year of service. We are sure it will thrive and grow with the insurance industry as it has in the past.

*C.S. Rao*

C.S.RAO

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# A kind word

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 post 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. Yegnariya 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 then 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 **IRDA 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

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## Let's take a look at how companies manage their risks internally.

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(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.



Next Issue

## COMMITTEE TO OVERSEE BIRTH OF NEW SURVEYORS' INSTITUTE

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

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**A Nominee of the Government and IRDA.**

A Special invitee to be decided from time to time by the Ad-hoc Committee for the specialised inputs.

**Mr. Atul Dutt - an invitee.**

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# 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.”

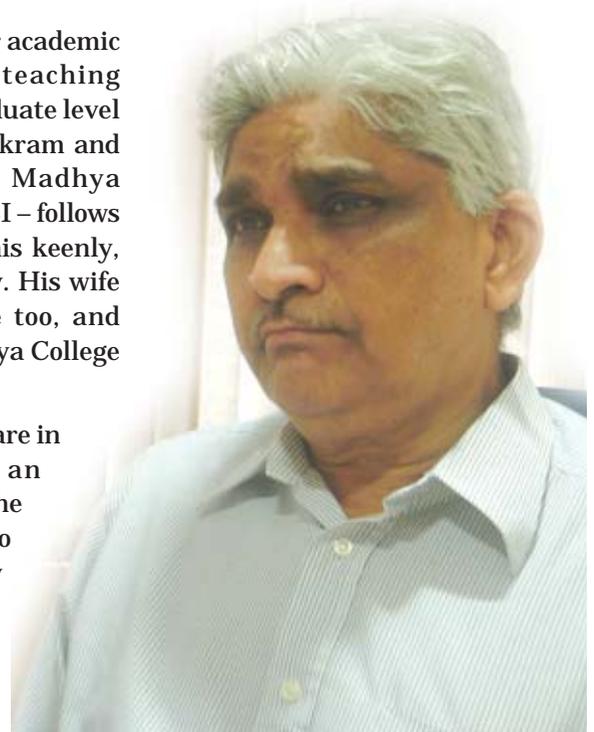
He intends to build up an information and research system to aid the Authority gain insights into the performance of companies and their role in the future integration of the financial system.

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.

# Report Card:LIFE

## June New Business grows at 64 % Annual

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.

### First Year Premium – June 2004

(Rs. in lakhs)

Sl No.	Insurer	Premium		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		June	Upto June	Upto June	June	Upto June	Upto June	June	Upto June	Upto June
1	<b>Allianz Bajaj</b>	<b>2,858.35</b>	<b>6,581.08</b>	<b>1.80</b>	<b>14,841</b>	<b>32979</b>	<b>0.83</b>	<b>19,561</b>	<b>21,312</b>	<b>1.78</b>
	Individual Single Premium	971.02	2,035.96		1,168	2623				
	Individual Non-Single Premium	1,832.42	4,459.92		13,660	30335				
	Group Single Premium Group Non-Single Premium	54.90 85.19			13 21			19,561 21,312		
2	<b>ING Vysya</b>	<b>622.49</b>	<b>1,159.43</b>	<b>0.32</b>	<b>9,178</b>	<b>17,888</b>	<b>0.45</b>	<b>157</b>	<b>3,827</b>	<b>0.32</b>
	Individual Single Premium	0.86	32.25		123	4,744				
	Individual Non-Single Premium	588.67	1,069.87		9,054	13,141				
	Group Single Premium Group Non-Single Premium	30.32 2.64	42.25 15.06		1 3			95 62	130 3,697	
3	<b>AMP Sanmar</b>	<b>385.89</b>	<b>933.24</b>	<b>0.26</b>	<b>2,432</b>	<b>6,910</b>	<b>0.17</b>	<b>10,051</b>	<b>15,359</b>	<b>1.28</b>
	Individual Single Premium	131.79	384.92		272	808				
	Individual Non-Single Premium	216.51	499.70		2,151	6,090				
	Group Single Premium Group Non-Single Premium	2.50 35.09	2.50 46.12		9 12			10,051 15,359		
4	<b>SBI Life</b>	<b>2,320.44</b>	<b>5,103.01</b>	<b>1.39</b>	<b>7,002</b>	<b>17,641</b>	<b>0.44</b>	<b>57,097</b>	<b>92,533</b>	<b>7.73</b>
	Individual Single Premium	498.91	1,280.54		337	726				
	Individual Non-Single Premium	418.07	1,064.84		6,576	16,718				
	Group Single Premium Group Non-Single Premium	1,036.41 367.05	2,211.52 546.11		89 196	1		14,857 42,240	26,784 65,749	

*(Rs. in lakhs)*

SI No.	Insurer	Premium u/w		% of Premium	No. of Policies / Schemes		% of No. of Policies	No. of lives covered under Group Schemes		% of lives covered under Group Schemes
		June	Upto June		Upto June	June		Upto June	Upto June	
5	<b>Tata AIG</b>	<b>1,497.72</b>	<b>4,995.26</b>	<b>1.37</b>	<b>13,442</b>	<b>46,591</b>	<b>1.17</b>	<b>40,844</b>	<b>81,849</b>	<b>6.84</b>
	Individual Single Premium									
	Individual Non-Single Premium	1,310.00	4,016.03		13,419	46,547				
	Group Single Premium	50.68	151.15					9,775	22,492	
	Group Non-Single Premium	137.04	828.08		23	44		31,069	59,357	
6	<b>HDFC Standard</b>	<b>1,961.91</b>	<b>5,310.88</b>	<b>1.45</b>	<b>9,732</b>	<b>26,752</b>	<b>0.67</b>	<b>16,045</b>	<b>34,322</b>	<b>2.87</b>
	Individual Single Premium	441.05	1,462.55		1,152	2,977				
	Individual Non-Single Premium	1,380.97	3,580.40		8,565	23,730				
	Group Single Premium	50.26	166.11		14	42		8,733	26,973	
	Group Non-Single Premium	89.64	101.82		1	3		7,312	7,349	
7	<b>ICICI Prudential</b>	<b>8,556.17</b>	<b>22,181.48</b>	<b>6.06</b>	<b>36,177</b>	<b>1,00,358</b>	<b>2.53</b>	<b>1,325</b>	<b>5,985</b>	<b>0.50</b>
	Individual Single Premium	1,958.34	4350.49		877	2,554				
	Individual Non-Single Premium	5,976.22	14,814.74		35,286	97,766				
	Group Single Premium	1.31	7.01			3		444	658	
	Group Non-Single Premium	620.30	3,009.24		14	35		881	5,327	
8	<b>Birla Sunlife</b>	<b>3,380.34</b>	<b>9,362.15</b>	<b>2.56</b>	<b>9,468</b>	<b>23,788</b>	<b>0.60</b>	<b>4,266</b>	<b>7,217</b>	<b>0.60</b>
	Individual Single Premium	102.70	294.10		1,420	4,004				
	Individual Non-Single Premium	2,982.95	6,845.79		8,042	19,768				
	Group Single Premium	33.71	99.42					259	807	
	Group Non-Single Premium	260.99	2,122.84		6	16		4,007	6,410	
9	<b>Aviva</b>	<b>1,468.16</b>	<b>3,259.53</b>	<b>0.89</b>	<b>7,545</b>	<b>17,462</b>	<b>0.44</b>	<b>14,878</b>	<b>28,458</b>	<b>2.38</b>
	Individual Single Premium	41.66	132.24		51	105				
	Individual Non-Single Premium	1,405.46	3,071.99		7,491	17,346				
	Group Single Premium	0.33	2.47			1		1	29	
	Group Non-Single Premium	20.71	52.83		3	10		14,877	28,429	
10	<b>Kotak Mahindra Old Mutual</b>	<b>800.83</b>	<b>1,733.60</b>	<b>0.47</b>	<b>3,394</b>	<b>7,792</b>	<b>0.20</b>	<b>4,826</b>	<b>26,418</b>	<b>2.21</b>
	Individual Single Premium	218.06	293.76		152	192				
	Individual Non-Single Premium	506.57	977.38		3,240	7,595				
	Group Single Premium									
	Group Non-Single Premium	76.19	462.46		2	5		4,826	26,418	
11	<b>Max New York</b>	<b>1,572.90</b>	<b>3,033.19</b>	<b>0.83</b>	<b>16,829</b>	<b>30,887</b>	<b>0.78</b>	<b>3,019</b>	<b>27,216</b>	<b>2.27</b>
	Individual Single Premium	28.69	65.90		19	42				
	Individual Non-Single Premium	1,539.24	2,926.48		16,807	30,827				
	Group Single Premium									
	Group Non-Single Premium	4.98	40.81		3	18		3,019	27,216	
12	<b>MetLife</b>	<b>408.76</b>	<b>804.41</b>	<b>0.22</b>	<b>2,238</b>	<b>4,704</b>	<b>0.12</b>	<b>51,575</b>	<b>67,009</b>	<b>5.60</b>
	Individual Single Premium	10.64	20.95		25	58				
	Individual Non-Single Premium	241.70	554.85		2,206	4,624				
	Group Single Premium									
	Group Non-Single Premium	156.42	228.61		7	22		51,575	67,009	
13	<b>LIC</b>	<b>1,09,566.54</b>	<b>3,01,472.50</b>	<b>82.39</b>	<b>1,60,1565</b>	<b>36,31,919</b>	<b>91.58</b>	<b>2,98,024</b>	<b>7,85,746</b>	<b>65.63</b>
	Individual Single Premium	17,195.54	29,609.41		40,029	68,633				
	Individual Non-Single Premium	79,210.37	1,82,903.60		1,56,0491	35,60,657				
	Group Single Premium	13,160.63	88,959.49		1,045	2,629		2,98,024	7,85,746	
	Group Non-Single Premium									
	<b>Total</b>	<b>1,35,400.50</b>	<b>3,65,929.75</b>	<b>100.00</b>	<b>1,73,3843</b>	<b>39,65,671</b>	<b>100.00</b>	<b>5,21,668</b>	<b>11,97,251</b>	<b>100.00</b>

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)

INSURER	PREMIUM 2004-05		PREMIUM 2003-04		MARKET SHARE UPTO JUNE, 2004	GROWTH % YEAR ON YEAR
	FOR JUNE 04	UPTO JUNE 04	FOR JUNE 03	UPTO JUNE 03		
Royal Sundaram	2,475.65	8,120.65	2,215.86	7,048.86	1.67	15.21
Tata-AIG*	3,588.00	13,621.07	2,566.62	11,425.14	2.80	19.22
Reliance General	1,466.07	5,235.55	2,142.13	5,228.51	1.08	0.13
IFFCO-Tokio	3,953.78	13,709.74	1,628.16	10,407.33	2.82	31.73
ICICI-Lombard	5,325.24	22,048.38	2,478.21	12,615.42	4.53	74.77
Bajaj Allianz	4,980.27	21,031.22	3,280.48	11,904.75	4.32	76.66
HDFC Chubb	1,189.64	3,784.35	503.62	1,192.69	0.78	217.30
Cholamandalam	1,052.30	4,627.17	367.87	2,416.22	0.95	91.50
New India*	31,260.00	108,260.00	29,085.00	105,682.00	22.23	2.44
National*	32,307.00	105,469.00	26,193.00	83,464.00	21.66	26.36
United India*	21,714.00	85,802.00	22,356.00	85,251.00	17.62	0.65
Oriental*	23,227.00	83,928.00	21,480.00	80,861.00	17.23	3.79
ECGC*	4,457.96	11,336.03	3,353.21	9,449.33	2.33	19.97
<b>TOTAL</b>	<b>1,36,996.91</b>	<b>4,86,973.16</b>	<b>1,17,650.15</b>	<b>4,26,946.24</b>	<b>100.00</b>	<b>14.06</b>

\* 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

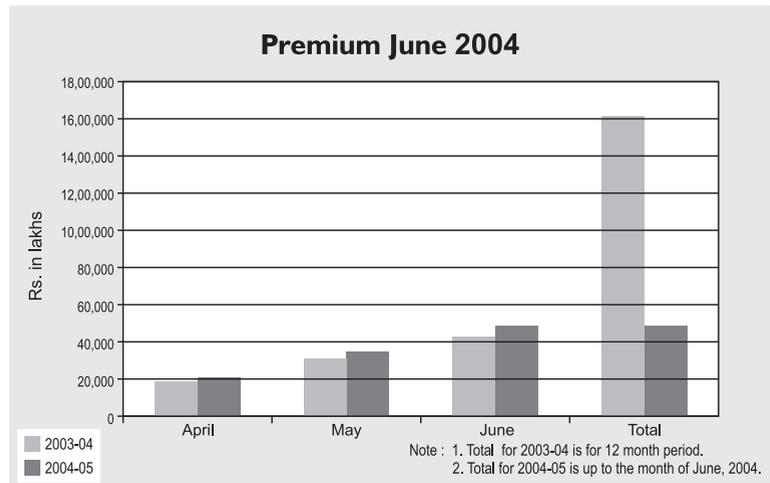
performance by it last year as well is quite significant. Oriental with an accretion of Rs. 31 crore has a growth rate of four per cent and New India with an accretion of Rs. 21 crore a growth rate of 2.4 per cent. United India's premium is almost stagnant. The established players are finding the competitive 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.



# 'Structured Compensation Based Award is Final'

- Supreme Court rules on the controversy

D. Varadarajan

The Supreme Court has finally settled the question as to the scope of section 163-A to the effect that remedy for payment of compensation both under sections 163-A and 166 are independent of each other and that a claimant cannot pursue his remedies under them simultaneously, says the author.

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 *Deopalal 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 :

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**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.**



"The 1988 Act provides for enhanced compensation for hit and run cases as well as for no fault liability cases. It also provides for payment of compensation on proof-of-fault basis to the extent of actual liability incurred, which ultimately means an unlimited liability in accident cases.

It is found that the determination of compensation takes a long time. According to information available, in Delhi alone there are 11,214 claims pending before the Motor Vehicle Accidents Tribunals, as on 31.3.1990. Proposals have been made from time to time that the finalisation of compensation claims would be greatly facilitated to the advantage of the claimant, the vehicle owner as well as the insurance company if a system of structured compensation can be introduced.

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 Not similar**

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

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**“Section 163-A was introduced in the year 1994. Having regard to the inflation and fall in the rate of bank interest; it is desirable that the Central Government bestows serious consideration to (amending it).”**

**- Supreme Court**

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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 or 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

### The recent ruling of the Supreme Court in Deepalal 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.



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 proceeding 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 Deepalal 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.

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# 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 extinguishees 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:-

$$CG \propto 1/CA$$

Where CG = Customer Grievance and CA = Customer Awareness.

When there is true awareness, a customer is nested 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

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**The regulations try to contain the root causes that lead to consumer grievance and then details how to handle them, when they arise.**

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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,

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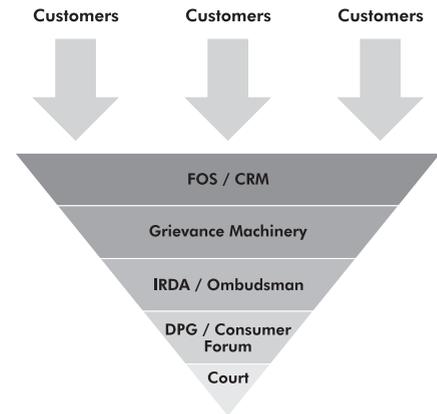
**Officials manning grievances positions need to appreciate that survivors of a peril are a heartbeat away from destitution, but for the insurance claim.**

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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.

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.

FRONT END	BACK END
1. Registration of insurance companies regulation	Yearly renewal
2. Advertisements & disclosure regulation	Advertisement returns
3. Financial statement & auditor's report regulation	Surprise checks
4. Distribution of surplus regulation	Reviews
5. Appointed Actuary regulation	Direct reporting to IRDA
6. Investment regulation	Solvency margin
7. Service benchmarks	Compliance reports
8. Customer awareness building	Supervision
9. File and use system for products	Control fine print
10. Free look period	Policy benefits
11. Grievance redressal mechanism	IRDA's Grievances Cell

- 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

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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.

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 be 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.

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

record saying, "As business is up, blood pressures are up too."

**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.

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

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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.

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*The author is Vice President, Reliance General Insurance Company. The views expressed here are his own.*

# What do Your Customers Really Want

G. V. Rao

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.

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 insuring 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? Why are more customers complaining against insurers and airing their grievances most of the time? Why are customers so unfair to the insurers that believe they are doing their 'best' to treat their customers with a sense of equity and fairness?

## 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?

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

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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 have we seen 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 enquires 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.

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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 any one 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 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

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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.*

# Going the Extra Mile

Yegnapriya Bharath

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

From the average customer's perspective, claims management is a slow irritating process with practically no transparency.

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

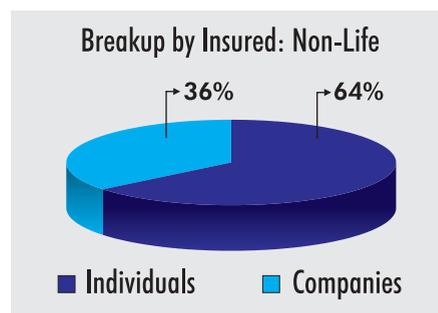
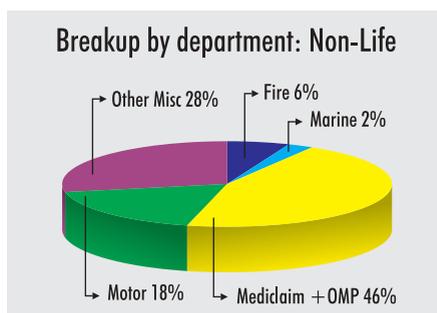
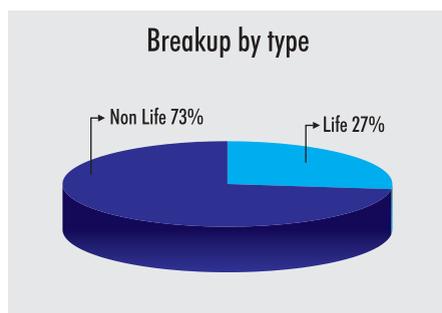
choice of products he sets about weighing the pros and cons to decide on the right one. In the process he becomes well informed. A few years back, when people had little or no choice and had to settle for whatever products were thrust upon them, they learnt very little about them. Today, a policyholder 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

## COMPLAINTS RECEIVED BY IRDA'S PUBLIC GRIEVANCES CELL



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 is 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 Mediclaim 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

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**It has been observed that many of the complaints are a result of communication and administrative failures.**

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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 upto 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.

*The author is Deputy Director, IRDA and handles consumer grievances. The views expressed here are her own.*

# 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 where 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 there on 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

**A grievance redressal authority, to be effective, has to be available at the door step of consumers.**

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

### The question will 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.

concerned, life insurance companies take over the said policies in their fold and collect future premia and make payment on maturity or death of life insurance policyholders as and when they occur. It would also be done in the same proportion having regard to their insurance premium income after assessing notional accrued liability on the date of bankruptcy.

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. This is the heart of the matter, rather than trying to deal with the refusal to issue the cover.

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.*

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# Perception Vs Reality

H. K. Awasthi

- Communication Failures lead to Unhappy Customers

Lack of proper explanation of the terms of insurance contracts, and misconceptions about their nature as fixed income investments are leading reasons for consumer grievances says the author.

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

**For a layman insurance is a source of ever available fixed compensation / income. Such misconception needs to be eliminated urgently.**

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 a mutual distrust between the insurer and the insuring 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 misguiding 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 misguiding 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 telephones 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 per cent of the cases decided pertained to services and 8.89 per cent 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 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.

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# GOOD AND BAD



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## 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 साधारण दायित्व के निपटान के प्रति कैसा पिछला कार्य-निष्पादन रिकार्ड रहा है। लोग बीमा खरीदते हैं, अनजान विपत्तियों से सुरक्षा के लिए। वह ऐसा महसूस करते हैं कि वह इन विपत्तियों के शिकार नहीं होंगे। बीमा कंपनी द्वारा किसी दावे को निरस्त करने से बड़ी विपत्ति नहीं हो सकती, जबकि अभाग्य शिकार पहले ही विपरीत परिस्थितियों से ग्रस्त हो चुका होता है। इसलिए शिकायत निपटान बीमा उद्योग में विशेष महत्व रखता है।

विनियामक का एक महत्वपूर्ण कार्य इस बात को सुनिश्चित करना है कि उद्योग एक शय, पारदर्शी तथा प्रभावशाली शिकायत निपटान प्रणाली स्थापित करे। साधारणतः यह माना जाता है कि प्रतिस्पर्धा के इस संसार में बचे रहने के लिए जीवन बीमा जैसी सेवा प्रदान करने वालों के लिए मापदण्ड यह होगा कि वह कैसे अपने ग्राहकों की शिकायतों का निपटान करते हैं। पॉलिसीधारक के लिए ऐसा महसूस करना कि उसे जो मिलना चाहिये था नहीं मिला तथा वह एक षडयंत्र का शिकार हुआ है, साधारण सी बात है। जब एक दावा बीमा कंपनी द्वारा निरस्त किया जाता है, तब वह महसूस करते हैं कि कंपनी अपने वचन से पीछे हट गई है। यह इसलिए होता कि पॉलिसी दस्तावेज के विभिन्न खंडों की अलग-अलग प्रकार से व्याख्या

की जाती है। यह भार कंपनी पर होता है कि बीमा बेचते समय वह यह स्पष्ट करे कि बीमा समझौते के अनुसार किन परिस्थितियों में कौन से जोखिमों को सुरक्षा प्रदान की जा रही है। यह भी समान रूप से महत्वपूर्ण है कि एक तंत्र बनाया जाए जो सतत रूप से उन शिकायतों पर पुनर्विलोकन करे तथा उन पर तुरन्त निणर्य ले, जिनको ग्राहकों द्वारा उठाया गया हो जिससे शिकायतों को कम किया जा सके। शिकायत निपटान एक महत्वपूर्ण कार्य है तथा इस बार के जर्नल में इस तथ्य को विनियामक के पक्ष से उद्योग तथा ग्राहक के बीच से देखा गया है। प्रयास यह रहा है कि उद्योग बेहतर ग्राहक प्रबन्धन तथा समाधानपद सेवा के लिए कार्यरत रहे।

इस अंक में 31 मार्च, 2004 को समाप्त हुए वित्त वर्ष के वार्षिक व्यवसाय आंकड़े भी दिये गये हैं। इसमें रुचिकर बात यह है कि पिछले वर्ष गैर-जीवन बीमा क्षेत्र में व्यक्तिगत व्यवसाय-क्रम में वृद्धि देखी गई। क्या यह झुकाव है अथवा विचलन यह आने वाले वर्षों में ज्ञात हो जायेगा।

आईआरडीए ज्यादा दबाव बीमा उद्योग में व्यावसायिक शिक्षा तथा प्रशिक्षण पर देना चाहता है, जिससे यह सुनिश्चित किया जा सके कि बाजार की मांग के अनुसार उच्च गुणवत्ता की व्यावसायिक योग्यता उपलब्ध हो। भारतीय बीमा संस्थान एक योग्य साझेदार इस बात को आगे ले जाने में रहा है। उनके 50वें सेवा वर्ष में उनको हमारी बधाई। हमें यह विश्वास है कि यह बीमा उद्योग की प्रगति के साथ पिछले वर्षों की तरह विकास करेगा।

सी. एस. राव  
सी. एस. राव

# ६६ कुछ तो लोग कहेंगे ९९

राष्ट्रीय सीमाओं में तथा वित्तिय सेवा उद्योग के विभिन्न क्षेत्रों में प्रचलन करने वाले समूहों में वृद्धि हुई है। यह नियम हमें मदद देगा हुरे समूहों के विनियमन के लिए, बजाय इसके कि विभिन्न क्षेत्रों के व्यापार को स्वतन्त्र रूप से चलाया जाए।

श्री माईकल फोल्जर, निदेशक थोक तथा प्रुडेंशल पालसी, वित्तिय सेवा प्राधिकरण (एफएसए), यूके विनियामक के लिए वित्तिय समूह पर दिशानिर्देश

साधारण बीमा उद्योग ने उत्पादों के मूल्य को कम रख कर किसी प्रकार की प्रसिद्ध प्राप्त नहीं की है। क्योंकि जो वित्तिय स्थिरता पालसी होल्डर चाहता है- सुरक्षा तथा दर में स्थायित्व- इसका वितरण नहीं हुआ है।

श्री नीक प्रीटजोन, मुख्य कार्यपालक, लायड्स आफ लंदन

खुदरा बाजार में, एक प्रभावशाली तथा उचित बाजार में ऐसे ग्राहको कि आवश्यकता है जो इस योग्य हो कि अपने निर्णय भरोसे के साथ ले सकें, इसके लिए सेवा की आवश्यकता है जो व्यापक, सुसंगत तथा समय पर उपलब्ध हो तथा इसके लिए ऐसी सेवा उपलब्ध करवाने की जरूरत है जो अभिज्ञात हो उत्तरदायित्व समझती हो।

श्री कालउम मैकार्टनी, अध्यक्ष, वित्तिय सेवा प्राधिकरण (एफएसए), यूके विनियामक की वार्षिक बैठक में।

एपीआरए स्टाफ अच्छी तरह समझता है- तथा इस लडाई में सिद्ध करने में लगे है- समुदाय उनकी तरफ जोरदार तथा प्रभावशाली कार्यनिष्पादन के लिए देखता है... यह मदद करता है आवश्यक विश्वास पैदा करने के लिए जो वित्तिय प्रणाली में कम हुआ था, जो सम्पूर्ण आस्ट्रेलिया की वित्तिय प्रणाली को सशक्त करेगा।

डा० जान लेकर, अध्यक्ष, आस्ट्रेलिया प्रुडेंशल विनियामक प्राधिकरण (एपीआरए) एचआईएच के गिरने के बारह माह बाद

जीवन तथा गैर जीवन दोनों उद्योग पिछले वर्ष के अधिक हानि अनुभव तथा अशान्त वित्तिय बाजार के बाद वापसी का अनुभव कर रहे हैं। इस वर्ष प्रिमियम में आपेक्षित वृद्धि तथा लाभ प्रक्रिया को तेज कर देंगे।

श्री थोमस हैंस, अध्यक्ष आर्थिक अन्वेक्षण तथा परामर्श कार्य, स्वीस री

जहाँ हम अपना व्यापार खोते हैं, वहाँ कोई दरों में 25 से 40 प्रतिशत की कटौती करता है। मैं समझता हूँ यह पागलपन है।

श्री मोरिस ग्रीनबर्ग, अध्यक्ष अमरिकन इंशुरेन्स ग्रुप

# जिला फोरम में शिकायत दायर करने के लिये न्यायालय शुल्क

एच.के. अवस्थी

रियायत और निःशुल्क सेवा का दौर समाप्त हो गया है। उपभोक्ता सुरक्षा अधिनियम, 1986 को उपभोक्ता विवादों के तीव्र, साधारण एवं गैर-खर्चीले समाधान के लिये अधिनियमित किया गया है। लोगों में उपभोक्ता अधिकारों के प्रति जागरूकता बढ़ने, ग्राहकों व उपभोक्ताओं में एकता बढ़ने और स्वयंसेवी संगठनों द्वारा जागरूकता लाये जाने से उपभोक्ता फोरमों में दर्ज कराई जाने वाली उपभोक्ता शिकायतों में भारी वृद्धि हुई है।

इस अधिनियम के प्रावधानों के अंतर्गत देश में त्रिस्तरीय अर्धन्यायिक तंत्र - एक राष्ट्रीय आयोग, 35 राज्य आयोगों तथा 571 जिला फोरमों - की स्थापना की गई है। उपभोक्ता विवाद समाधान फोरमों से कहा गया है कि वे मामलों का निपटारा जहां तक संभव हो सके 90 से 150 दिन के भीतर कर दें। उपभोक्ताओं को यह फोरम सिविल कोर्टों तथा अन्य विधिक फोरमों के अतिरिक्त उपलब्ध हैं। जून 2003 की तिमाही की समाप्ति तक राष्ट्रीय आयोग, राज्य आयोगों तथा जिला फोरमों में दर्ज कराये गये कुल मामलों तथा उसमें से निपटारे गये मामलों का विवरण इस प्रकार है :

समाधान एजेंसी	मामले दर्ज	मामले निपटारे गये	प्रतिशत
i) राष्ट्रीय आयोग	30,799	22,958	74.5
ii) राज्य आयोग	2,72,396	1,77,269	65.1
iii) जिला फोरम	17,48,905	15,05,744	86.1
कुल	20,52,100	17,05,971	83.1

कई उपभोक्ता फोरमों को पर्याप्त स्थान, संरचनात्मक सुविधा तथा कर्मचारी उपलब्ध नहीं कराये गये हैं। फोरमों की समुचित कार्यविधि तथा उनके मामलों के निपटारे को प्रभावित करने के कारणों में से यह एक कारण है। अपर्याप्त बजटीय प्रावधान, वित्तीय एवं प्रशासनिक अधिकारों का प्रत्यायोजन न होना तथा राज्य आयोगों/जिला फोरमों की आवश्यकताओं को पूरा करने के लिये वित्तीय स्वीकृति में विलंब होना फोरमों द्वारा मामलों के निपटारे में विलंब का एक और कारण है।

यद्यपि उपभोक्ता मामलों के विभाग ने राज्य आयोगों एवं जिला फोरमों की संरचना को सुदृढ़ बनाने के लिये राज्यों/केंद्र शासित प्रदेशों के प्रयासों का अनुपूरण करने के लिये वर्ष 1995-99 के दौरान 61.80 करोड़ रुपये की एकमुश्त वित्तीय सहायता की योजना प्रारंभ की। प्रत्येक राज्य आयोग को 50 लाख रुपये और प्रत्येक जिला फोरम को 10 लाख

2002 ने अब धारा 12 में यह प्रावधान किया है कि जिला फोरम में दर्ज कराई गई प्रत्येक शिकायत शुल्क की निर्धारित राशि के साथ दर्ज होगी। अब 5 मार्च, 2004 से प्रभावी उपभोक्ता सुरक्षा (संशोधन) नियम, 2004 के नियम 9ए के अनुसार जिला फोरम में कोई भी शिकायत दर्ज कराने के लिये निम्नलिखित कोर्ट शुल्क निर्धारित किये गये हैं :

सामग्रियों या सेवाओं का मूल्य तथा जिला फोरम के समक्ष दावा किया गया मुआवजा	रुपयों में देय शुल्क
1) 1,00,000 तक	100
2) 1,00,000 तथा उससे अधिक, लेकिन 5,00,000 से कम	200
3) 5,00,000 तथा उससे अधिक, लेकिन 10,00,000 से कम	400
4) 10,00,000 तथा उससे अधिक, लेकिन 20,00,000 से अधिक नहीं	500

रुपये चार समान किशतों में दिये गये, इसलिये वे पिछले लंबित मामलों को निपटा सके।

चूंकि उपभोक्ता सुरक्षा अधिनियम, 1986 में फोरम में शिकायत दर्ज कराने के लिये न्यायालय शुल्क के भुगतान का प्रावधान नहीं है, इसलिये उपभोक्ता तुच्छ आधारों पर अधिक दावों के साथ

शिकायतें दर्ज करा रहे हैं। सुनवाई के दिन उपभोक्ता अपने मामलों की पैरवी करने के लिये नहीं आते, इसलिये फोरमों पर ऐसे उपभोक्ताओं की शिकायतों का बोझ बढ़ जाता है, जो मामले में को आगे बढ़ाने के प्रति गंभीर

किसी राष्ट्रीयकृत बैंक से राज्य आयोग के रजिस्ट्रार के पक्ष में बनवाये गये रेखित डिमांड ड्राफ्ट के माध्यम से या रेखित भारतीय डाक आर्डर के माध्यम से इस शुल्क का भुगतान किया जा सकता है। यह राज्य आयोग जहां स्थित है, उस स्थान पर भुगतान योग्य होना चाहिये।

राज्य आयोगों तथा राष्ट्रीय आयोग के समक्ष शिकायत तथा अपील दर्ज कराने के लिये कोर्ट शुल्क की दरें भारत सरकार के समक्ष विचाराधीन हैं तथा यह शीघ्र ही सूचित की जाएंगी। इसलिये आज उपभोक्ता कोर्ट शुल्क का भुगतान किये बिना जिला फोरम के समक्ष शिकायत दर्ज नहीं करा सकता।

नहीं होते।

हालांकि इस अधिनियम की धारा 26 में निरर्थक और पूर्वग्रहपूर्ण शिकायतों को रद्द करने तथा लागत का भुगतान करने का प्रावधान है, लेकिन फोरमों ने कड़ी कार्रवाई नहीं की तथा शिकायतकर्ताओं को अपना मामला रखने का अवसर दिया।

तथापि निरर्थक शिकायतें दर्ज कराने को रोकने के क्रम में उपभोक्ता सुरक्षा (संशोधन) अधिनियम,

लेखक VOICE के प्रबंधक (विधि) हैं। उनसे ई-मेल : [cvoice@vsnl.net](mailto:cvoice@vsnl.net) पर संपर्क किया जा सकता है।

# आपकी मुट्ठी में

## दिनेशचंद्र खंसिली

जीवन बीमा कंपनियों का संचालन बीमा अधिनियम 1938 एवं बीमा विनियामक और विकास प्राधिकरण के प्रावधानों के अनुसार होता है इसलिए उनकी पेन्शन योजनाओं में निवेश करना बुद्धिमानी भी है और ये पूरी तरह सुरक्षित भी हैं। पेन्शन योजनाओं में निवेश करने का मतलब है कि जीवन में आने वाले खतरों से सुरक्षा।

वृद्धावस्था सामाजिक एवं आय सुरक्षा (ओएसआईएस) की प्रथम परियोजना रिपोर्ट में भारत की जनसंख्या में वृद्धों के बढ़ते अनुपात को दिखाया गया है। रिपोर्ट के मुताबिक भारत तेज़ी से जननांकीय संक्रमण की अवस्था से गुजर रहा है। जीवन प्रत्याशा बढ़ रही है। 60 वर्ष से अधिक आयु के लोगों का अनुपात तेज़ी से बढ़ रहा है। 60 वर्ष की आयु पूर्ण कर चुके लोग लंबे समय तक जीना चाहते हैं।

विश्व भर में बुजुर्गों की संख्या में वृद्धि हो रही है। भारत में जबकि संपूर्ण जनसंख्या की संवृद्धि 49 प्रतिशत होने की संभावना है (1991 में 846.2 मिलियन से 2016 तक 1263.5 मिलियन)। इसमें बुजुर्गों की संख्या (60 वर्ष से ऊपर) 107 प्रतिशत तक बढ़ने की संभावना है, जो 1991 की जनगणना के मुताबिक 54.7 मिलियन से बढ़कर 2016 में 113.0 मिलियन हो जाएगी।

दूसरे शब्दों में, कुल जनसंख्या वृद्धि में बुजुर्गों की हिस्सेदारी 2016 में 8.9 प्रतिशत होगी। 1991 की जनगणना के मुताबिक बुजुर्गों की आबादी का हिस्सा 6.4 प्रतिशत है। जनसंख्या अकड़े यह भी बताते हैं कि बुजुर्गों की जनसंख्या 2026 तक तेज़ी से बढ़कर 179 मिलियन से अधिक हो जाएगी। यह भारत की संपूर्ण जनसंख्या का 13.3 प्रतिशत होगा, यानी 2026 में भारत की कुल आबादी 1331 मिलियन होगी। 2026 तक भारत की कुल जनसंख्या 1331 मिलियन में वृद्धों की जनसंख्या 13.3 प्रतिशत होगी।

बुजुर्गों के कल्याण के लिए भारत ने कई कदम उठाये हैं। ऐसा इसलिए भी ज़रूरी है कि बुजुर्गों को सामाजिक सुरक्षा दिए बग़ैर देश को गौरवान्वित नहीं किया जा सकता। इसकी आवश्यकता बहुत पहले से ही महसूस की जा रही थी। भविष्य निधि अधिनियम 1925 में चुने हुए सार्वजनिक निगमों में लागू किया गया। 1952 में कर्मचारी भविष्य निधि एवं विविध प्रावधान अधिनियम (ईपीएफएमपी) बनाया गया। इसके दायरे में आज 177 उद्योग आते हैं। 1995 से कर्मचारियों को ईपीएफएमपी के दायरे में लाया गया। यह अधिनियम कर्मचारी पेन्शन योजनाओं पर भी

लागू है। स्वरोज़गार कर रहे लोग एवं ऐसे कर्मचारी, जो ईपीएफएमपी के अधिनियम के अंतर्गत नहीं आते, उनके लिए सार्वजनिक भविष्य निधि योजना चलाई जाती है।

जनवरी 1999 में बुजुर्गों के लिए बनाई गई राष्ट्रीय नीति में उनकी सामाजिक एवं आर्थिक सुरक्षा को सुनिश्चित करने हेतु कुछ प्रावधान किए गए। इसके मुताबिक बढ़ती आयु में बुजुर्गों एवं उनकी पत्नियों को व्यक्तिगत रूप से प्रोत्साहित करना, परिवारों द्वारा की जा रही देखभाल बढ़ाने के लिए स्वैच्छिक एवं गैर-सरकारी संगठनों को सक्षम बनाना एवं सहायता देना, असुरक्षित बुजुर्ग लोगों की सुरक्षा एवं देखभाल, स्वास्थ्य सुविधाएँ प्रदान करना, बुजुर्ग लोगों के लिए अपनी सेवाएँ दे रहे संगठनों एवं चिकित्सकों को प्रशिक्षित करने के लिए अनुसंधान एवं प्रशिक्षण सुविधाओं को प्रोत्साहित करना और वृद्धों को आत्मनिर्भर नागरिक बनाने के लिए उनमें जागरूकता पैदा करना आदि शामिल किया गया।

वृद्धों की कठिनाइयों का सामना करने के लिए अनेक संगठन अपनी नई योजनाओं के साथ आगे आए। दिल्ली के बुजुर्गों का अंतर्राष्ट्रीय महासंघ वरिष्ठ नागरिकों को निःशुल्क चिकित्सा प्रदान करने के लिए अभियान चला रहा है। यह संस्था सामाजिक सुरक्षा योजना को लागू करने एवं रचनात्मक बनाने के लिए पेन्शन के लिए आयु सीमा घटाने, सम्मानपूर्ण जीवन यापन के लिए पर्याप्त भत्ता, संयुक्त परिवारों की आय, जिनकी कुल आमदनी प्रति माह 8000 रुपये है, उन परिवारों के लिए वरिष्ठ नागरिकों को दी जा रही पेन्शन के योग्यता मानक को बदलने के लिए अभियान चला रही है।

अपेक्षाकृत धनी लोग, जो वृद्धावस्था में अपनी मदद खुद कर सकते हैं, वे साथ चाहते हैं। वे चिकित्सा सेवा सहित देखभाल एवं समुचित सुविधाओं की इच्छा रखते हैं। देश में 1,200 ऐसे गृह हैं, जो नाममात्र के शुल्क पर वृद्धों के रहने एवं ठहरने की व्यवस्था करते हैं। महाराष्ट्र सरकार द्वारा संचालित मातोश्री वृद्धाश्रम इसी तरह की संस्था है।

हेल्पेज इंडिया बहुत पहले से ही सरकार से वृद्धाश्रमों में प्रदान की जा रही सुविधाओं के लिए मानक निर्धारित करने की मांग कर रही है। वरिष्ठ नागरिकों के लिए पहली बार 1999 में मुंबई के चौपाटी में एक पार्क बनाया गया। यह पार्क वरिष्ठ नागरिकों के लिए आरक्षित है। पार्क में बैठने के लिए बेंच की व्यवस्था की गई है, इन बेंचों को बैंकरों ने अनुदान में दिया है और सप्ताह में एक बार लीलावती अस्पताल यहाँ आने वाले वरिष्ठ नागरिकों के रक्तचाप एवं

डायबिटीज़ का परीक्षण करता है। वैन में ही चिकित्सा चार्ट तैयार किया जाता है।

भारत में बुजुर्गों के साथ अनेक दुर्भाग्य जुड़े रहे हैं। ओएसआईएस की रिपोर्ट भी इस बात को साबित करती है। रिपोर्ट में स्पष्ट कहा गया है कि यद्यपि उक्त सराहनीय कदम उठाये जा रहे हैं और श्रमिक वर्ग की बेहतर सेवा की जा रही है, फिर भी यह सब बहुत कम है। यह चिंता का विषय है कि इनकी पहुँच भारत की जनसंख्या का मात्र 11 प्रतिशत है।

वृद्धों की समस्या गाँव से शहरों की ओर पलायन एवं बच्चों के विदेशों में पढ़ने के लिए जाने के साथ ही बढ़ी है। इनमें संयुक्त परिवार का विखंडन भी एक प्रमुख कारक है। नौजवान पीढ़ी बुजुर्गों को बोझ के समान समझती है। संयुक्त परिवारों में उनका सम्मान घट रहा है। मानसिक एवं शारीरिक कठिनाइयाँ उन्हें झेलनी पड़ रही हैं।

मुंबई में एक दंपति अपनी 68 वर्षीय वृद्ध माँ को दिन भर के लिए घर से बाहर निकालकर घर को ताला लगाकर काम पर चले जाते थे। बिना भोजन और पानी के वह वृद्धा घर से बाहर पड़ी रहती थी, उसे शाम को उस वक़्त घर के अंदर जाने को मिलता था, जब दंपति काम से वापस लौटता था। दंपति का कहना था कि वे यह कदम उसके हित में उठाते थे, क्योंकि वह गैस का स्विच बंद करना भूल जाती थी, जबकि वही वृद्धा सारी संपत्ति की मालकिन थी। बाद में उसके पड़ोसियों की शिकायत पर इस मामले में पुलिस ने हस्तक्षेप किया।

वरिष्ठ नागरिकों के साथ अपराध बढ़ रहा है। अकेले मुंबई में वर्ष 2002 में 192 अपराध वरिष्ठ नागरिकों के साथ हुए, इसमें अधिकांश बुजुर्गों की मृत्यु तक हो गई। हम एक संक्रमणकालीन समाज में रह रहे हैं। पश्चिमी देशों की तरह न तो हमारे पास सुविधाएँ हैं और न ही चिकित्सा सुविधाएँ। हम अपनी संस्कृति से कटते जा रहे हैं। बुजुर्गों का परंपरागत सम्मान बरकरार नहीं है। जीवन की इस सच्चाई का सामना करने के लिए हमें समय रहते बचत करनी शुरू कर देनी चाहिए। ओएसआईएस की रिपोर्ट में प्रतिदिन की छोटी-छोटी बचत की आवश्यकता पर जोर दिया गया है। 25 से 60 वर्ष के बीच प्रतिदिन पाँच-पाँच रुपये की बचत करने से 36 लाख रुपये की बचत हो सकती है।

आम आदमी के लिए जीवन बीमा कंपनियाँ सेवानिवृत्ति योजनाएँ चला रही हैं। जीवन बीमा कंपनियाँ बीमा अधिनियम 1938 एवं बीमा विनियामक एवं विकास प्राधिकरण से संचालित होती हैं। वे स्वास्थ्य, पेन्शन एवं

सामान्य वार्षिक तौर पर बीमा के क्षेत्र में व्यवसाय कर सकती हैं। आज-कल बाजार में विविध प्रकार की पेन्शन योजनाएँ एवं तात्कालिक वार्षिक योजनाएँ सार्वजनिक रूप से चल रही हैं।

यहाँ पर ऐसी ही कुछ योजनाओं के बारे में जानकारी दी गई है, जो आम लोगों के लिए महत्वपूर्ण हो सकती हैं। पेन्शन योजनाओं के आधार को एक बार जान लेने के बाद देश एवं विश्व की विविध पेन्शन योजनाओं को समझने में आसानी हो सकेगी।

### क्या है दीर्घकालीन पेन्शन योजना?

एक दीर्घकालिक वार्षिक योजना में आपका नियमित योगदान होता है। यह योगदान निश्चित जमा राशि के रूप में हो सकता है। एक 25 वर्षीय व्यक्ति अपनी सेवानिवृत्ति होने की आयु 58 या 60 अथवा जो भी इच्छा हो, में यदि 25 लाख रुपये चाहता है, या कोई व्यक्ति सेवानिवृत्त होने तक एक निश्चित राशि अदा करने का निर्णय लेता है और बीमा कंपनी से निश्चित ब्याज पर वापसी चाहता है, उस व्यक्ति को यह पता नहीं होगा कि सेवानिवृत्ति के समय पूरी जमा राशि कितनी होगी।

सहभागी पॉलिसी भी हो सकती है, इसके अनुसार पॉलिसी में लाभ अधिशेष राशि में भागीदारी होती है, जिसकी घोषणा बीमा करने वाली कंपनी करती है। इन सभी पेन्शन योजनाओं पर अलग-अलग नियम व शर्तें लागू होती हैं। जिसमें समय पूर्व मृत्यु या बीमा वापस लेने पर एक निश्चित राशि काटकर बीमा धारक या पॉलिसी धारक को सकल राशि वापस की जाती है। इसका मतलब है कि बीमा धारक को एकमुश्त या बचत राशि प्राप्त हो सकती है।

किसी भी सूरत में कुल जमा राशि का भुगतान एक तिहाई प्राप्त ही होगा। इसका मतलब यह है कि यदि आप ३ लाख रुपये की पॉलिसी ले रहे हैं तो उसकी कुल स्वीकार्य राशि एक लाख रुपये होगी और बाकी राशि २ लाख रुपये का उपयोग वार्षिक पॉलिसी खरीदने में किया जा सकेगा।

इस पॉलिसी में जमा की गई राशि आयकर अधिनियम की धारा 80 सीसीसी के अंतर्गत आयकर मुक्त होगी। यहाँ 10 हजार रुपये की अधिकतम प्रीमियम राशि दीर्घकालीन वार्षिक योजना सकल आय के रूप में आंकलित की जाएगी और उसी आधार पर आयकर छूट होगी।

### तात्कालिक वार्षिक योजना क्या है?

दीर्घकालिक पेन्शन योजना एवं तात्कालिक वार्षिक योजना में इतना ही फ़र्क है कि दीर्घकालिक पेन्शन योजना

में जहाँ आप 33 वर्ष या 35 वर्ष (25-58), (25-60) के दौरान निश्चित राशि जमा करते हैं, वहीं तात्कालिक वार्षिक योजना में आप सेवानिवृत्त होते समय ही एक वार्षिक योजना खरीद लेते हैं। इस तरह से आप आनंदपूर्वक अपना जीवन बिता सकते हैं।

तात्कालिक वार्षिक योजना में किसी व्यक्ति के पास पर्याप्त धन होना चाहिए। इस तरह की थोक राशि घर बेचने से, लॉटरी खुलने से, पुत्र या पुत्री से उपहार के रूप में, सेवानिवृत्त होने पर भविष्य निधि/ग्रेच्युटी, ड्यूटी के बदले मिलने वाली राशि, कुछ पुरस्कार जैसे मैग्सेसे आदि पाने पर, मॉडल या फ़िल्म अभिनेता को विज्ञापन या फ़िल्म से प्राप्त हो सकती है और यह राशि वार्षिक योजना खरीदने में इस्तेमाल की जा सकती है। उल्लेखनीय है कि इस वार्षिक राशि पर जमाकर्ता को आयकर चुकाना होता है। वार्षिक राशि सामान्य तौर पर खरीद राशि पर निर्भर होती है। (जितनी अधिक राशि की पॉलिसी खरीदेंगे, उतनी ही अधिक वार्षिक आय प्राप्त होगी।) व्यक्ति की आय के हिसाब से (अधिक आय पर अधिक वार्षिक राशि, क्योंकि जोखिम अधिक होता है यानी पॉलिसी में कम समय का योगदान हो सकता है।) वार्षिक योजना का चयन किया जा सकता है। पॉलिसी की अवधि जितनी ही कम होगी, उतना ही ज्यादा प्रीमियम जमा करना होगा। इसके लिए निम्नलिखित विकल्प उपलब्ध हैं :-

- ◆ वार्षिक योजना जीवनपर्यंत के लिए खरीदी जा सकती है। इसका मतलब यह है कि जब तक आप जीवित हैं, तब तक आप वार्षिक प्रीमियम राशि देते रहिए। पॉलिसी धारक की मृत्यु के बाद वार्षिक राशि देना बंद हो जाएगा। खरीदी गई पॉलिसी मान लीजिए की दो लाख रुपये की है तो मृत्यु होने की दशा में उसके नामिती को उतनी ही राशि वापस नहीं होगी, लेकिन पॉलिसी धारक को उससे कहीं ज्यादा राशि वापस मिल जाएगी।

- ◆ मूलधन वापसी के साथ आजीवन वार्षिकी भी खरीदी जा सकती है। इसका अर्थ यह है कि पॉलिसी धारक जब तक जीवित रहेगा, तब तक वह प्रीमियम देता रहेगा। उसकी मृत्यु के साथ ही प्रीमियम बंद हो जाएगा, लेकिन खरीदी गई राशि मान लीजिए 2 लाख रुपये है तो मृत्यु होने की दशा में उसके नामिती को पूर्ण राशि वापस कर दी जाएगी। इस योजना को आजीवन प्लस आरओसी (मूलधन की वापसी/खरीदी गई वापसी) के रूप में भी जाना जाता है। यह कोई भी समझ सकता है कि आजीवन प्लस आरओसी योजना में

पॉलिसी धारक को जीवन योजना की अपेक्षा कम लाभ है। बाकी शर्तें समान हैं।

- ◆ वार्षिक पॉलिसी एक निश्चित समय के लिए भी हो सकती है। यह 5/10/15/20/25 में भी हो सकती है और मृत्यु के बाद भी चल सकती है। इसका मतलब यह है कि मान लिया जाए कि पॉलिसी धारक ने 10 वर्ष की अवधि निश्चित की है और सात वर्ष बाद ही उसकी मौत हो जाती है, तब शेष तीन वर्ष के लिए प्रीमियम का भुगतान नामिती को करना होगा और अवधि खत्म होने पर पॉलिसी समाप्त हो जाएगी, लेकिन यदि पॉलिसी धारक उसके बाद भी जीवित रहता है, तो जीवित रहने तक पॉलिसी का भुगतान कर सकता है। उसकी मृत्यु के बाद उसके नामिती को सकल राशि वापस की जाएगी।

- ◆ चौथा विकल्प संयुक्त पॉलिसी का है। इसके मुताबिक खरीदी गई पॉलिसी की राशि पति या पत्नी में से जो भी जीवित है, उसे वापस की जाती है। संयुक्त पॉलिसी योजना में प्रीमियम का भुगतान पति या पत्नी (किसी एक की मृत्यु की दशा में) में से जो जीवित रहेगा, प्रीमियम का भुगतान करता रहेगा या पॉलिसी के समय तय की गई शर्तें लागू होंगी। यदि पति की मौत हो जाती है तो पत्नी को शर्तों के मुताबिक आधी राशि या पूरी राशि वापस की जाएगी या जो भी शर्त मानी गई होगी, उसके अनुसार भुगतान किया जाएगा।

### जीवन बीमा निगम की वरिष्ठ पेन्शन बीमा योजना

सरकार ने इस योजना को भारतीय जीवन बीमा निगम के सहयोग से शुरू किया है। इस योजना में मूलधन का नौ प्रतिशत वापस करने की गारंटी होती है। ब्याज आय पर भारत सरकार का जो भी निर्देश होगा, जीवन बीमा निगम उसे स्वीकार करेगा।

54 वर्ष से अधिक आयु का बुजुर्ग व्यक्ति 2,66,665 रुपये जमा करता है तो वह प्रथम 2,000 रुपये प्राप्त करेगा और 2,66,665 रुपये उसकी मृत्यु के बाद उसके नामिती को वापस कर दिए जाएंगे। 54 वर्ष से अधिक आयु वाले बुजुर्ग की पॉलिसी राशि का निर्धारण सामान्य वार्षिकी की तरह नहीं किया जाएगा। न्यूनतम मासिक वार्षिकी 250 रुपये होगी और अधिकतम वार्षिकी 2,000 रुपये होगी।

लेखक आईआरडीए के उप-निदेशक (बीमांकन) हैं यहाँ व्यक्त विचार उनके अपने हैं।

# वैकल्पिक माध्यमों पर एक दृष्टि

के. नित्या कल्याणी

नई पहल हमेशा सुलझाने के लिए नई पहेलियाँ लाती हैं, इसलिए यह वितरण के वैकल्पिक माध्यमों पर निर्भर है। तकनीकी सहायता प्रदान करती है और पुराने प्रश्नों का उत्तर देते हुए आपको और अधिक नए प्रश्नों से चुनौती देती है।

बीमा वितरण के वैकल्पिक माध्यमों को स्थूल रूप से दो श्रेणियों में बांटा जा सकता है। वह जो तकनीकी की उपलब्धता के कारण खुले हैं और वह जो अभी तक ठीक से अन्वेषित नहीं हो पाये बाजारों तक पहुँचने के लिए बनाये गए हैं।

पहले वाले शहरी बाजारों के लिए अधिक प्रासंगिक हैं तथा यह इंटरनेट, कॉल सेंटर, टेलीमार्केटिंग और सीधे प्रेषण को शामिल करता है। दूसरे वाले स्थानीय सेवा संस्थान हैं, जो ग्रामीण एवं सामाजिक रूप से पिछड़े समुदायों को समझते हैं और उनके साथ कार्य करते हैं। ये उनमें शिक्षा का प्रसार करते हैं, कार्यक्रमों का सृजन करते हुये उनकी आजीविका को मदद देते हैं और धारणीय विकास एवं आर्थिक सुरक्षा को बढ़ाते हैं। ये बमुश्किल पहुँच वाले इन समुदायों के निर्णय नेता होते हैं तथा उन्होंने माइक्रो फ़ाइनांस कार्यक्रमों के द्वारा सफलतापूर्वक कार्य किया है। बीमा उनके लिये एक और आयाम है और नजदीक आ रहा दो क्षेत्रों का अनुभव दोनों ओर से अस्थिर होते हुये भी ढाढस बंधाने वाला है।

बीमा के लिए बाजार समरूप नहीं है। इस बात पर विचार करते हुए कि जोखिम का विस्तार आधारभूत सिद्धांत है, जिस पर बीमा का व्यापार तर्क टिका हुआ है, यह प्रत्यक्ष है कि उत्पादों एवं उसके लाभों के लिए बीमा का बाजार समरूप नहीं होना चाहिए। इसलिए अधिक से अधिक बाजारों तक ऐसे माध्यमों से पहुँचने की आवश्यकता है, जो इन क्षेत्रों में श्रेष्ठ वापसी पाने के लिए उचित मार्ग हों।

निबद्ध एजेंसी प्रणाली - जिसका पालन एलआईसी, पूर्ववर्ती जीआईसी कंपनियाँ और निजी क्षेत्र की कई कंपनियाँ भी व्यापक तौर पर करती हैं

- अभी भी बीमा उत्पादों के वितरण का वृहद् माध्यम है। कार्पोरेट एजेंसियाँ कुछ उल्लेखनीय उदाहरणों के साथ इसमें आ रही हैं। आढ़तिया भी इसकी प्रारंभिक भारी कठिनाइयों से गुजर रही है तथा यह केवल उच्च समाप्ति गैर-जीवन पॉलिसियों के लिए प्रामाणिक विपणन मॉडल है, हालांकि जीवन (अनिवार्य रूप से फुटकर) बीमा बाजार में आढ़तियों द्वारा नए स्वरूप सृजित किए गए हैं।

यह देखना दिलचस्प है कि उद्योग अपने बाजारों तक पहुँचने के लिए नवीनतम पद्धतियों के द्वारा क्या करना चाहता है, जबकि बीमा के विक्रय में मानव भूमिका को कोई पछाड़ नहीं सकता।

वे अभी भी अधिक व्यापार नहीं प्राप्त कर रहे हैं, लेकिन नई विपणन पद्धतियाँ (बीमा के लिये नई) जैसे सीधे प्रेषण या इंटरनेट का उपयोग शीर्ष प्रबंधन में निश्चित रूप से विशेष स्थान रखती हैं। अब हम देखते हैं कि कंपनियाँ बाजार में किस प्रकार अपने माध्यमों का चयन करती हैं।

रॉयल सुंदरम एलायंस इंश्युरेंस लि. (आरएसए) के मामले को ही ले लीजिए। इसने कार्य के एक भाग, जो इसका कार्पोरेट एजेंट, स्टैंडर्ड चार्टर्ड ग्रिन्डलेस (एससीजी) करता है, के रूप में सीधा प्रेषण प्रारंभ किया।

आरएसए के प्रबंध निदेशक श्री एंटोनी जैकब कहते हैं कि एससीजी ग्राहक आधार के अनुरूप उत्पाद का चयन पहली सीढ़ी है। वे कहते हैं “-यदि आवश्यक हुआ तो एक नया उत्पाद तैयार किया जाता है तथा इसके बाद एससीजी उस रूपरेखा के साथ ग्राहकों को विशेष रूप से सृजित विपणन साहित्य भेजता है।”

आरएसए ने आठ से दस प्रतिशत तक सफलता दरें हासिल कीं, जबकि अंतर्राष्ट्रीय स्तर पर दो प्रतिशत को एक अच्छी औसत के रूप में देखा गया है। वह कहते हैं कि एशिया में ग्राहकों को लक्ष्य करने तथा उत्पादों की उपयुक्त पैकेजिंग में आरएसए की विद्वता का उपयोग किया गया। उदाहरण के लिये, एक बीमा उत्पाद में प्रथम

प्रस्तावक लाभ अधिक नहीं होता - दूसरी कंपनी उसकी अनुकृति को कुछ सप्ताहों के बाद जारी कर सकती है। वह कहते हैं कि यहां अत्युत्तम साहित्य एवं प्रस्ताव पत्र - विशेष पैकेजिंग - एक अंतर पैदा करते हैं।

वह कहते हैं कि दूसरी ओर, टेलीमार्केटिंग एक अलग खेल है। टेलीमार्केटिंग के प्रति आरएसए के ध्रिकोण में यह देखा गया कि एक विशिष्ट राष्ट्रीयकृत बैंक से विदेशी बैंक का एक ग्राहक अच्छा लक्ष्य है। यहां भी स्ट्राइक दर फिर लगभग एक से आठ प्रतिशत तक है, जबकि व्यक्तिगत दुर्घटना पॉलिसियाँ तीन से चार प्रतिशत तक बिक्री दर प्राप्त कर रही हैं। आरएसए के व्यक्तिगत श्रृंखला व्यापार का लगभग पांच प्रतिशत टेलीमार्केटिंग के माध्यम से प्राप्त किया जाएगा। टेलीमार्केटिंग कंपनी के लिये एक नया माध्यम है, जो फ़ोन कॉलों के मूल्य के कारण अधिक महंगा माध्यम साबित हो रहा है।

क्या यह व्यवधान की तरह नहीं दिख रहा है? वह व्यक्तिगत रूप से स्वीकार करते हैं कि - ‘यह निश्चित रूप से व्यवधान है’, विशेषकर यदि वह कार्य समय के दौरान फ़ोन करते हैं। स्थापित किये जाने वाले अपरिहार्य डेटा प्राइवैसी मानकों पर टिप्पणी करते हुये वह कहते हैं कि यह संभवतः उनके स्ट्राइक दरों को बढ़ाने में सहायक होगा। जब कोई ग्राहक विपणन उद्देश्य से उससे संपर्क करने की स्वयं अनुमति देता है तो विपणन पर और अधिक प्रकाश डाला जा सकता है।

आरएसए ने अभी तक इंटरनेट को नहीं आजमाया है। वह कहते हैं कि - ‘हमें नहीं दिखता कि बिक्री की पूर्णता के लिये अभी तक बाजार अधिक परिपक्व है।’ ग्रामीण क्षेत्र में आरएसए ने पाया कि माइक्रो फ़ाइनांस संस्थान अपने क्रेताओं के लिये ग्रुप पॉलिसियों के अंतर्गत सुरक्षा चाहते हुये ऋणदाताओं के बढ़ते समुच्चय की स्थापना करते हैं। ‘वे अच्छा विस्तार प्राप्त कर रहे हैं तथा एक श्रेष्ठ कार्य कर रहे हैं।’

आंध्र प्रदेश की एनजीओ बासिक्स, जो अभियान में आठ वर्ष से है, ग्रामीण क्षेत्र में जीविका

को प्रोत्साहन देने का मिशन रखती है। ग्रामीण लोगों की गरीबी दूर करने के लिये आर्थिक गतिविधियों चलाने तथा आय प्राप्त करने के लिये इसकी शुरुआत की गई। इसके बाद यह उनकी आर्थिक स्थिति तथा जीविका की सुरक्षा करने के लिये बीमा क्षेत्र में चला गया। बासिक्स के सहायक उपाध्यक्ष श्री देवरकोण्डा सत्तय्या, जो अविवा रिलेशनशिप के कार्पोरेट बीमा कार्यकारी प्रभारी भी हैं, कहते हैं - 'हम इसे दीर्घकालीन बचत सेवाओं के लिये एक अच्छी योजना के रूप में देखते हैं। पांच राज्यों तथा 28 क्षेत्रों में कार्य करने वाली बासिक्स के लिये बीमा बिक्री एक नई गतिविधि है। इसके पास 280 ग्राहक सेवा एजेंट हैं, जो स्थानीय ग्रामों से स्नातक हैं। प्रत्येक एजेंट 10 से 12 ग्राम देखता है।

बासिक्स इनपुट-आउटपुट लिंकेजिस, क्षमता निर्माण, कृषि प्रणाली विकास, बाजार सहलग्नता तथा स्थानीय किसानों के लिये कपास एवं तरकारी कृषि व रेशम उत्पाद के लिये संभावना उपलब्ध कराते हुये व्यापार विकास सेवाओं में कार्य करती है। इसकी संस्थागत विकास सेवा ग्रामीण संगठनों के विकास के लिये संगठनों से उसे प्राप्त होने वाली निविधियों का उपयोग करती है। इसके पास एक काफ़ी सुदृढ़ प्रबंधन सूचना प्रणाली है, जो क्षेत्रीय विकास के लिये 26 संगठनों को क्षमता निर्माण उपलब्ध कराती है।

बासिक्स अब ऋणोत्तर ग्राहकों को भी व्यक्तिगत पॉलिसियां बेचने के लिये एक प्रायोगिक कार्यक्रम पर कार्य कर रही है। इस वर्ष के जनवरी माह से यह कार्यक्रम 12 क्षेत्रों में चल रहा है। श्री सत्तय्या कहते हैं कि हम प्रत्येक सीएसए से प्रति माह आठ से नौ पॉलिसियां बेचने की आशा रखते हैं तथा बासिक्स के एक्ज़िक्यूटिव आईआरडीए द्वारा नियत प्रशिक्षण ले रहे हैं। एक्ज़िक्यूटिव बिक्री का कार्य करते हैं, जबकि सीएसए साप्ताहिक आधार पर अनुवर्ती कार्य कर रहे हैं।

सीएसए को बिक्री केंद्र बनाने का लक्ष्य है तथा इसके लिये वह कहते हैं कि उप-एजेंटों को रखने पर आईआरडीए की रोक एक बाधा है। कारण? सीएसए के साथ वह तत्काल अच्छा प्रदर्शन कर सकते हैं तथा रोज़गार जाल में उलझे बिना वह खराब परिणाम के लिये दंडित कर सकते हैं। वह सलाह देते हैं कि कार्पोरेट एजेंट पर मामला से मामला आधार पर उप-एजेंटों को नियुक्त करने की अनुमति दी जानी चाहिये।

श्री सत्तय्या के साथ बातचीत में कुछ दिलचस्प अंतिष्ठियां सामने आईं। वह कहते हैं कि बीमा खरीदने की प्रारंभिक अनिच्छा पर काबू इसलिये पा लिया गया है, क्योंकि ग्राहक बाक्सिस की प्रतिष्ठा जानता है। बीमा कंपनी की पहचान असंगत है, क्योंकि एनजीओ ने साख और प्रतिष्ठा बना दी है। यह ग्राहकों, उनकी नकदी प्रवाह तथा वित्तीय आवश्यकताओं को काफ़ी नज़दीकी से जानती है तथा उसने वित्तीय मामलों पर उसकी सलाह लेने के लिये उनमें विश्वास पैदा किया है। श्री सत्तय्या कहते हैं "वह हमें सात-आठ वर्षों से देख रहे हैं। वह हमारे कौशल और सहायता की प्रवृत्ति से परिचित हैं।"

यद्यपि आगे बढ़ने की गति धीमी है तथा यह बाज़ार की विशेषता है। औसत आश्वासित राशि 23000 रुपये तथा प्रीमियम 220 रुपये है। बासिक्स अभी एक अवधि उत्पाद तथा एक प्रीमियम वापसी उत्पाद उपलब्ध करा रही है तथा साथ ही वह अन्य ग़ैर-जीवन उत्पाद बेचना प्रारंभ कर रही है।

गुप पॉलिसियों के अंतर्गत उसके पास पिछले वर्ष 53,000 ग्राहक थे। उनके 50 करोड़ रुपये में से कवरेज के लिये 40 करोड़ रुपये मूल्य के ऋण योग्य थे। कवरेज ऋण राशि से 150 प्रतिशत अधिक हो सकती है तथा इसलिये लगभग 8.6 लाख रुपये के प्रीमियम के साथ 60 करोड़ रुपये की राशि आश्वासित की गई। मास्टर पॉलिसी धारक होते हुये बासिक्स इस गतिविधि के द्वारा

आय नहीं प्राप्त करती, लेकिन बीमा कंपनी प्रशिक्षण रियायत और संभावना उपलब्ध कराकर बिक्री में प्रवेश करने में सफल रही।

एनजीओ अपने दावे ई-मेल के द्वारा करता है तथा पिछले वर्ष आये 72 दावों में से 53 का निपटारा किया गया। जिन बाधाओं का वह सामना करता है, वह ग्रामीण स्थिति में अपूर्व हैं। दावा निपटारा में मुख्य चुनौती मृत्यु का विशिष्ट कारण प्रस्तुत करना है। वह कहते हैं कि वहां मौतें दर्ज नहीं की जाती हैं तथा ग्रामीण चिकित्सा संरचना इस प्रकार के दस्तावेज़ीकरण का समर्थन नहीं कर पाती है और किसी ग्रामीण से यह आशा नहीं की जा सकती कि इस उद्देश्य के लिये पुलिस आने पर वह उसे जानकारी दे।

हम बीमा कंपनियों को ग्रामीण वास्तविकताओं का लेखा-जोखा रखने के प्रति जागरूक कर रहे हैं। उन्हें यह सुनिश्चित करने के योग्य बनना चाहिये कि इस प्रकार की छोटी पॉलिसियों के लिये नैतिक जोखिम (आत्महत्या) मामूली हो।

अन्य समस्याएं आयु प्रमाण तथा एनजीओ के स्वयं के संचालन खर्च हैं और इसलिये दूसरा सुझाव : यदि हमारी इकाइयां हमें सलाह भेज सकती हैं और हम कंपनी को भुगतान कर सकते हैं तो संचालन खर्च स्वतः पूर्ण किया जा सकता है। नियमों के अनुसार प्रीमियम भेजने के लिये बहुविकल्प लेखा रखने (पांच राज्यों और 28 क्षेत्रों में - सभी छोटे शहर) से कार्य व संचालन ढ़्क बढ़ता है।

बासिक्स बीमा कंपनियों के लिये वैकल्पिक माध्यमों के सृजन पर भी कार्य करती है। उदाहरण के लिये उर्वरक डीलर। यह मिशन को पूरा करने की उसकी रणनीति के तहत आता है। यह मिशन सभी बीमा उत्पादों, जो सदस्यों की जीविका पर सकारात्मक प्रभाव डालती हैं, का वितरण करना है। वह ऐसी कंपनियों के साथ काम करने को



# Costs & Benefits of Hi-Tech

## - Technology & the Indian Insurer

*M. Arunachalam*

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 needs 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 of insurers had a customer service web site,

and 98 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,

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**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.**

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 claim 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. Everyday 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)

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**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.**

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#### 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 time 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.

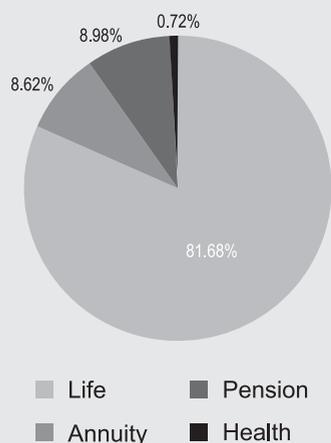
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# FY 2003-04:LIFE

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. 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 towards 16.58 lakh policies, i.e., a growth of 101 per cent. The share of premium underwritten by the new insurers increased to 13.01 per cent as against 5.66 per cent in the year 2002-03. Individually, all the new insurers increased their market share over the previous year.

Breakup of first year premium by class of business: 2003-04



LIC underwrote a premium of Rs.16,24,042.67 lakh towards 269.68 lakh policies capturing 86.99 per cent and 94.21 per cent, respectively of the market share, i.e., a growth of 1.65 per cent in terms of premium and 9.87 per cent in terms of policies over the previous year. The share of premium underwritten by LIC in the year 2002-03 was 94.34 per cent. In addition, under the Varishtha 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 being 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.1,53,609.12 lakh and Rs.83,247.95 lakh.

### Group new business: Non-single premium (GNSP)

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.1,60,355.85 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**

(Rs.in lakhs)

SI No.	PARTICULARS	PREMIUM	POLICIES	SUM ASSURED
<b>1</b>	<b>Non linked*</b>			
	<b>Life</b>			
	with profit	32,050.24	56,070	40,861.80
	without profit	62,016.10	1,75,131	1,00,967.36
<b>2</b>	<b>General Annuity</b>			
	with profit	22.07	18	38.60
	without profit	18.29	2	
<b>3</b>	<b>Pension</b>			
	with profit	10,505.44	65,168	712.52
	without profit	13,928.71	24,879	1.00
<b>4</b>	<b>Health</b>			
<b>A.</b>	<b>Sub total</b>	1,18,540.86	3,21,268	1,42,581.27
<b>1</b>	<b>Linked*</b>			
	<b>Life</b>			
	with profit	228.01	196	225.74
	without profit	46,368.76	96,555	63,032.32
<b>2</b>	<b>General Annuity</b>			
<b>3</b>	<b>Pension</b>			
	without profit	3,310.46	2,516	537.97
<b>4</b>	<b>Health</b>			
<b>B.</b>	<b>Sub total</b>	49,907.22	99,267	63,796.03
<b>C.</b>	<b>Total (A+B)</b>	1,68,448.08	4,20,535	2,06,377.30
	<b>Riders:</b>			
	<b>Non linked</b>			
<b>1</b>	Health#	13.50	78	222.70
<b>2</b>	Accident# #	19.91	1,183	1,664.73
<b>3</b>	Term	1.24	41	36.79
<b>D.</b>	<b>Sub total</b>	34.65	1,302	1,924.22
	<b>Linked</b>			
<b>1</b>	Health#	3.40	21	36.55
<b>2</b>	Accident# #	1.48	54	77.43
<b>3</b>	Term	1.47	11	20.45
<b>E.</b>	<b>Sub total</b>	6.35	86	134.43
<b>F.</b>	<b>Total (D+E)</b>	41.00	1,388	2,058.65
<b>G.</b>	<b>**Grand Total (C+F)</b>	1,68,489.08	4,20,535	2,08,435.95

**NON-SINGLE PREMIUM**

(Rs.in lakhs)

SI No.	PARTICULARS	PREMIUM	POLICIES	SUM ASSURED
<b>1</b>	<b>Non linked*</b>			
	<b>Life</b>			
	with profit	10,70,899.85	2,54,90,262	1,77,80,153.19
	without profit	72,219.50	16,13,963	32,96,706.26
<b>2</b>	<b>General Annuity</b>			
	with profit	348.81	3,395	7,141.51
<b>3</b>	<b>Pension</b>			
	with profit	31,822.65	3,02,552	99,804.98
<b>4</b>	<b>Health</b>			
	with profit	2,096.72	49,235	61,038.92
	without profit	11,241.90	1,33,194	2,86,319.60
<b>A.</b>	<b>Sub total</b>	11,88,629.43	2,75,92,601	2,15,31,164.47
<b>1</b>	<b>Linked*</b>			
	<b>Life</b>			
	with profit	2,449.28	19,267	35,312.72
	without profit	77,963.65	3,64,183	8,14,845.56
<b>2</b>	<b>General Annuity</b>			
<b>3</b>	<b>Pension</b>			
	with profit	296.74	2,318	
	without profit	23,953.72	2,10,651	45,498.07
<b>4</b>	<b>Health</b>			
<b>B.</b>	<b>Sub total</b>	1,04,663.38	5,96,419	8,95,656.34
<b>C.</b>	<b>Total (A+B)</b>	12,93,292.80	2,81,89,020	2,24,26,820.81
	<b>Riders:</b>			
	<b>Non linked</b>			
<b>1</b>	Health#	592.88	92,810	64,087.27
<b>2</b>	Accident# #	787.65	4,82,493	4,94,009.34
<b>3</b>	Term	186.52	38,680	29,812.91
<b>4</b>	Others	365.59	80,726	37,151.15
<b>D.</b>	<b>Sub total</b>	1,932.62	6,94,709	6,25,060.68
	<b>Linked</b>			
<b>1</b>	Health#	135.51	16,720	35,794.20
<b>2</b>	Accident# #	81.95	50,221	72,187.14
<b>3</b>	Term	109.59	12,293	22,941.80
<b>4</b>	Others	80.86	15,163	1,693.31
<b>E.</b>	<b>Sub total</b>	407.91	94,397	1,32,616.45
<b>F.</b>	<b>Total (D+E)</b>	2,340.54	7,89,106	7,57,677.13
<b>G.</b>	<b>**Grand Total (C+F)</b>	12,95,633.34	2,81,89,020	2,31,84,497.94

**GROUP NEW BUSINESS (INCLUDING RURAL & SOCIAL) 2003-04 (PROVISIONAL)**

**SINGLE PREMIUM**

**NON-SINGLE PREMIUM**

(Rs.in lakhs)						(Rs.in lakhs)					
SI No.	PARTICULARS	PREMIUM	NO.OF SCHEMES	LIVES COVERED	SUM ASSURED	SI No.	PARTICULARS	PREMIUM	NO.OF SCHEMES	LIVES COVERED	SUM ASSURED
<b>Non linked*</b>						<b>Non linked*</b>					
<b>1</b>	<b>Life</b>					<b>1</b>	<b>Life</b>				
<b>a)</b>	<b>Group Gratuity Schemes</b>					<b>a)</b>	<b>Group Gratuity Schemes</b>				
	without profit	99,731.92	2,387	4,33,238	2,63,670.19		without profit	99,731.92	2,387	4,33,238	2,63,670.19
<b>b)</b>	<b>Group Savings Linked Schemes</b>					<b>b)</b>	<b>Group Savings Linked Schemes</b>				
	without profit	3,488.81	1,041	1,74,258	1,66,298.41		without profit	3,488.81	1,041	1,74,258	1,66,298.41
<b>c)</b>	<b>EDLI</b>					<b>c)</b>	<b>EDLI</b>				
	without profit	310.30	1,077	2,87,626	1,22,653.11		without profit	310.30	1,077	2,87,626	1,22,653.11
<b>d)</b>	<b>Others</b>					<b>d)</b>	<b>Others</b>				
	with profit	29.00	1	2,197	14,019.00		with profit	29.00	1	2,197	14,019.00
	without profit	33,753.84	11,373	37,15,230	17,21,943.75		without profit	33,753.84	11,373	37,15,230	17,21,943.75
<b>2</b>	<b>General Annuity</b>					<b>2</b>	<b>General Annuity</b>				
	with profit	42,601.70	32	9,388			with profit	42,601.70	32	9,388	
	without profit	1,11,007.42	1	13,916	470.30		without profit	1,11,007.42	1	13,916	470.30
<b>3</b>	<b>Pension</b>					<b>3</b>	<b>Pension</b>				
	without profit	83,198.02	441	1,44,862	1,412.20		without profit	83,198.02	441	1,44,862	1,412.20
<b>4</b>	<b>Health</b>					<b>4</b>	<b>Health</b>				
<b>A.</b>	<b>Sub total</b>	3,74,121.01	16,353	47,80,715	22,90,466.96	<b>A.</b>	<b>Sub total</b>	3,74,121.01	16,353	47,80,715	22,90,466.96
<b>Linked*</b>						<b>Linked*</b>					
<b>1</b>	<b>Life</b>					<b>1</b>	<b>Life</b>				
<b>a)</b>	<b>Group Gratuity Schemes</b>					<b>a)</b>	<b>Group Gratuity Schemes</b>				
	without profit	546.94	4	813			without profit	546.94	4	813	
<b>b)</b>	<b>Group Savings Linked Schemes</b>					<b>b)</b>	<b>Group Savings Linked Schemes</b>				
	without profit	196.33					without profit	196.33			
<b>c)</b>	<b>EDLI</b>					<b>c)</b>	<b>EDLI</b>				
<b>d)</b>	<b>Others</b>					<b>d)</b>	<b>Others</b>				
	without profit	49.93	1	376			without profit	49.93	1	376	
<b>2</b>	<b>General Annuity</b>					<b>2</b>	<b>General Annuity</b>				
<b>3</b>	<b>Pension</b>					<b>3</b>	<b>Pension</b>				
	without profit	49.93	1	376			without profit	49.93	1	376	
<b>4</b>	<b>Health</b>					<b>4</b>	<b>Health</b>				
<b>B.</b>	<b>Sub total</b>	793.20	5	1,189		<b>B.</b>	<b>Sub total</b>	793.20	5	1,189	
<b>C.</b>	<b>Total (A+B)</b>	3,74,914.21	16,358	47,81,904	22,90,466.96	<b>C.</b>	<b>Total (A+B)</b>	3,74,914.21	16,358	47,81,904	22,90,466.96
	Riders:						Riders:				
<b>1</b>	<b>Non linked</b>					<b>1</b>	<b>Non linked</b>				
	Health#	87.19	37	8,728	2,615.00		Health#	87.19	37	8,728	2,615.00
<b>2</b>	<b>Accident##</b>	20.95	38	9,202	1,579.00	<b>2</b>	<b>Accident##</b>	20.95	38	9,202	1,579.00
<b>D.</b>	<b>Sub total</b>	108.14	75	17,930	4,194.00	<b>D.</b>	<b>Sub total</b>	108.14	75	17,930	4,194.00
	<b>Linked</b>						<b>Linked</b>				
<b>E.</b>	<b>Total (D+E)</b>	108.14	75	17,930	4,194.00	<b>E.</b>	<b>Total (D+E)</b>	108.14	75	17,930	4,194.00
<b>G.</b>	<b>**Grand Total (C+F)</b>	3,75,022.34	16,358	47,81,904	22,94,660.96	<b>G.</b>	<b>**Grand Total (C+F)</b>	3,75,022.34	16,358	47,81,904	22,94,660.96

\* 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.

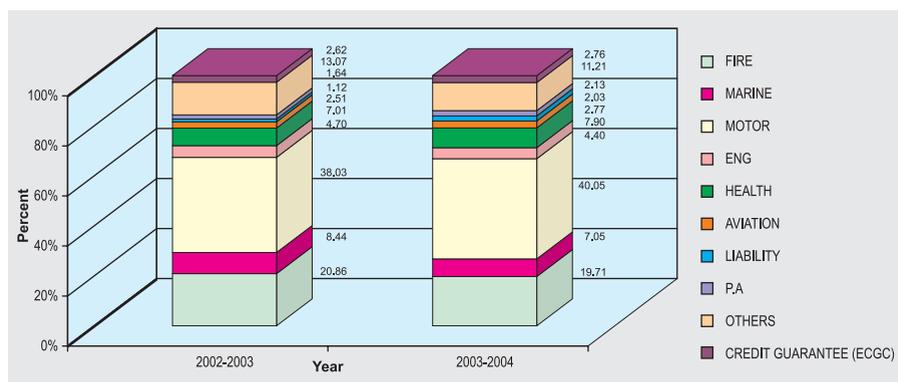
National Insurance, the star performer among them, with an accretion of Rs. 530 crore (accounting for 60 per cent of the growth of the industry) for the year has recorded Rs. 380 crore increase in Motor, Rs. 85 crore in Health and Rs. 97 crore in liability, It has recorded a fall in Fire of Rs. eight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

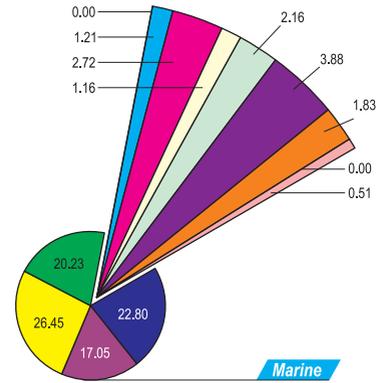
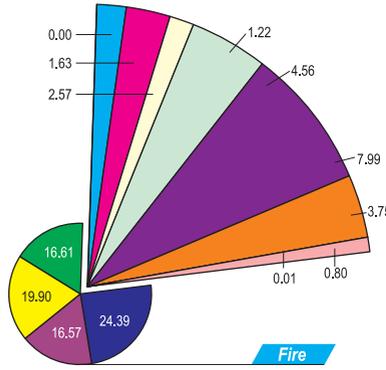
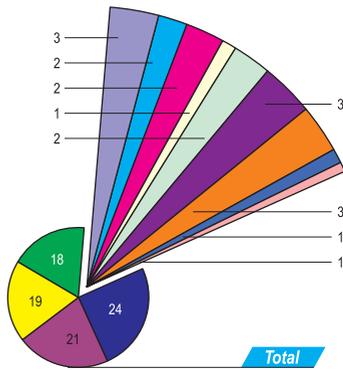
### Is this what was expected?

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.*

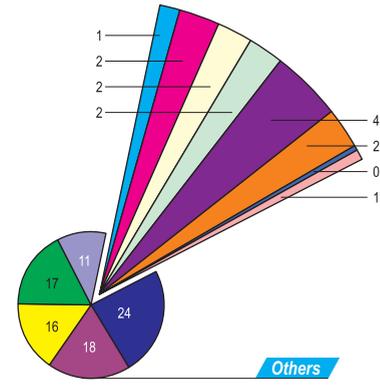
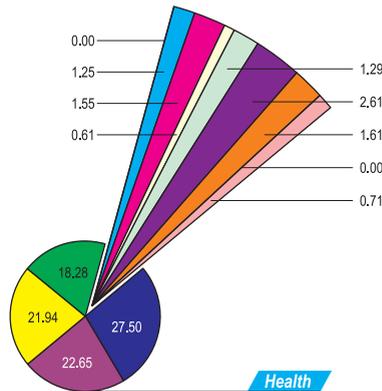
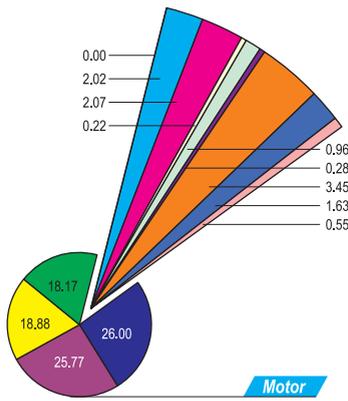
**COMPOSITION OF NON-LIFE PREMIUM INCOME WITHIN INDIA: 2003-04**





**SEGMENT-WISE GROSS DIRECT PREMIUM WITHIN INDIA**

Insurer	Year	Fire	Marine Cargo	Marine Hull	Engg.	Motor OD	Motor TP	Motor (Total)***	Health
Royal Sundaram	2003-04	51.79	13.77		18.93	114.95	15.50	130.45	15.90
	2002-03	38.27	12.98		13.07	NF	NF	84.72	9.53
Tata AIG	2003-04	81.75	30.90		10.36	NF	NF	133.58	19.69
	2002-03	52.88	27.58		12.20	NF	NF	82.18	13.56
Reliance	2003-04	38.84	11.86	1.34	13.19	12.88	1.46	14.34	7.79
	2002-03	54.82	8.34	0.57	15.52	6.68	0.87	7.55	5.18
IFFCO-Tokio	2003-04	144.80	22.17	2.39	37.44	53.83	8.31	62.14	16.37
	2002-03	103.53	13.88	4.53	27.28	22.38	3.27	25.65	9.89
ICICI Lombard	2003-04	253.87	22.22	21.94	51.03	16.34	1.46	17.80	33.27
	2002-03	131.50	6.14	3.00	23.00	NF	NF	2.82	13.42
Bajaj Allianz	2003-04	119.27	18.57	2.22	31.41	190.71	31.98	222.69	20.57
	2002-03	55.08	7.39		17.84	148.22	23.52	171.74	9.00
HDFC Chubb	2003-04	0.36	0.02		0.24	99.22	6.27	105.49	
	2002-03					8.38	0.51	8.89	
Cholamandalam	2003-04	25.45	5.24	0.59	8.41	30.16	5.48	35.63	9.08
	2002-03	5.32	0.16		1.73	3.21		3.21	1.09
New India	2003-04	775.20	158.21	101.01	142.00	1,088.71	590.49	1,679.20	350.34
	2002-03	870.67	194.26	137.63	119.54	1,250.47	298.98	1,553.89	255.65
National	2003-04	526.70	149.39	44.41	109.46	1,107.17	557.44	1,664.61	288.47
	2002-03	535.45	162.77	60.36	136.18	NF	NF	1,283.11	202.64
United India	2003-04	632.41	133.89	166.85	142.88	767.31	452.34	1,219.66	279.53
	2002-03	604.20	152.26	186.87	152.75	756.24	418.06	1,174.18	252.17
Oriental	2003-04	527.83	137.66	92.33	143.54	833.31	340.71	1,174.02	232.85
	2002-03	532.64	135.37	92.70	153.87	708.33	334.71	1,043.05	230.05
ECGC#	2003-04	NA	NA	NA	NA	NA	NA	NA	NA
	2002-03	NA	NA	NA	NA	NA	NA	NA	NA
<b>Total</b>	2003-04	<b>3,178.27</b>	<b>703.89</b>	<b>433.08</b>	<b>708.89</b>	<b>4,314.60</b>	<b>2,011.43</b>	<b>6,459.61</b>	<b>1,273.86</b>
	2002-03	2,984.34	721.15	485.67	672.99	2,903.91	1,079.92	5,440.98	1,002.18



: 2003-04 (PROVISIONAL)

Rs. in Crores

	Aviation	Liability	Personal Accident	All Others	Total	Market Share
		3.20	20.75	3.23	258.02	1.60
		1.57	18.85	2.79	181.77	1.27
	0.91	44.10	27.26	4.77	353.32	2.19
		30.85	19.59	2.04	240.87	1.68
	6.53	12.04	4.18	51.12	161.24	1.00
	4.25	12.88	2.84	73.08	185.02	1.29
		7.79	3.97	28.24	325.30	2.02
		5.24	3.00	20.32	213.33	1.49
	7.59	21.01	11.57	66.42	506.72	3.14
	1.38	1.64	5.62	26.70	215.22	1.50
	1.19	7.03	7.56	45.80	476.31	2.95
	0.57	2.89	3.31	21.45	289.28	2.02
		0.14	0.90	4.52	111.67	0.69
			0.02	0.53	9.44	0.07
	1.83	7.42	1.03	2.38	97.05	0.60
		2.73	0.12	0.42	14.79	0.10
	265.47	41.62	73.56	453.46	4,040.07	25.05
	19.53	11.67	39.73	718.62	3,921.19	27.41
	47.52	126.80	48.01	411.64	3,417.00	21.19
	68.89	30.53		409.24	2,889.16	20.20
	25.57	22.66	88.63	354.74	3,066.82	19.02
	27.69	24.85	82.99	310.10	2,968.06	20.75
	90.36	33.06	56.52	380.89	2,869.08	17.79
	236.16	35.45	59.05	285.07	2,803.41	19.60
	NA	NA	NA	#445.13	445.13	2.76
	NA	NA	NA	#374.65	374.65	2.62
	<b>446.98</b>	<b>326.87</b>	<b>343.94</b>	<b>2,252.32</b>	<b>16,127.72</b>	<b>100.00</b>
	358.47	160.29	235.13	2,245.01	14,306.20	100.00



\* 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

## INSURANCE CONTRIBUTION TO GDP DECLINES

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. IIA 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.

Insurance Institute of India, governed by the governing bodies of LIC and GIC, conducts examinations every month for around thirty thousand insurance agent hopefuls for Licentiate, Associate, and Fellowship certifications. As of now at one hundred and seventy five locations in the country the exams are held offline, while at twenty-six locations (mostly urban areas) it is held online.

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.

### Insurance Institute of India's exams online

## CONSUMER FORUM ORDERS COMPENSATION PAYMENT

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 Shelbhai 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.

While taking the policy in 1993, the highest amount available as the insured sum was Rs. 70,000. In 1998, the insurance company itself raised the maximum cover to Rs. two lakh. The couple opted for the Rs. two lakh cover.

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. Suparas Bhandari has been quoted saying, if the Government provided subsidy of 75 per cent of commercial premia, 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 (JV) company in collaboration with global insurance and financial services major, Principal of the US, it is reported. The other partners in the JV will be Punjab National Bank and Berger Paints.

The bank has decided on the insurance JV 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 JV, 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. "ICCI 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 Syroka 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**

Albeit 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.

## 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.

## 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 web site," 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.

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

## US ACTUARIES LOOK AT TERRORISM COVER

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.

# Felicitations!

No other insurance institute in the world examines more than 3,00,000 a year candidates for insurance qualifications. This distinction goes to Insurance Institute of India (III) which entered its 50<sup>th</sup> year of operations on June 30.

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 there because the insurance industry is there. We rededicate 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 India.

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.**

unhampered and in a similar manner the same enthusiasm permeates local institutes, and these local institutes fully support the local Federation.... In other word Federation will, to all intents and purpose become a University of Insurance Knowledge.... This I hope is not a vision, but will become a reality".

"You will have full knowledge of the formation of the Federation of Insurance Institutes, are aware that it is now affiliated to the Chartered Insurance Institute in England, has its own Offices, and hoped in due course that it will develop and take its rightful place in this country on similar lines to what

the Chartered Insurance Institute does in England."

III started its life 49 years ago when the insurance industry with more than 400 insurers operated in the private sector, save postal life insurance and Oriental Government Security Life Insurance Company. The very next year in the 1956, 245 life insurance companies were amalgamated to form the Life Insurance Corporation of India but the general insurance industry, consisting of over 100 non-life companies remained in the private sector.

In the year 1973 the general insurance business was nationalised. After the liberalisation of the insurance industry in the year 2000, both private sector and public sector operate in the industry. Through all these changes, the III continued its tradition of serving the industry, training, examining and certifying professionals.

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.



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*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**

*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**

*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

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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.