भारतीय बीमा विनियामक और विकास प्राधिकरण

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

Promoting insurance. Protecting insured.

www.irdai.gov.in www.policyholder.gov.in

CONSUMER AFFAIRS

BOOKLET

To register your grievance, visit www.igms.irda.gov.in
or Call 155255 or e-mail complaints@irdai.gov.in

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FOREWORD

Dr. Subhash Chandra Khuntia
Chairman

The ongoing pandemic has tested the mettle of the Regulator as a protector of policyholders' interest as well as its developmental role in nudging the uninsured population towards taking insurance.

One of the first steps taken by the Authority was to instruct Insurers to settle all Covid claims fast and repudiate liability only after being reviewed by the claims committee. The policyholders were assured that Covid 19 was covered in ail their indemnity based health insurance.

The Covid 19 being a health crisis also restated an already known fact that large section of population did not have health insurance. The Authority Designed Aarogya Sanjeevani a standard health insurance policy as well as Corona Kavach and Corona Rakshak which offers protection against Covid 19. The standardized products have been well received and has given the much needed relief to the general public. The Authority also encouraged insurers to device Covid specific products and fast tracked the approvals.

To ensure smooth operation of the insurers and intermediaries in providing seamless service to the policyholders IRDAI has ensured that Insurance is an “essential service”.

The extension of period for payment of premium for health insurance, motor third party insurance, payment of instalment premium in health insurance, issuance of electronic policies, setting time limit of two hours to authorize cashless claims has resulted in a hassle free experience for the policyholders.

This booklet brought out by the Consumer Affairs Department of IRDAI has data relating to number of policyholder complaints, analysis of such policyholder grievances for the Financial Year 2019-20 and steps being undertaken to reduce complaints.

It is hoped that the booklet would be provide valuable information to the policyholders and all stakeholders.

Regulatory Framework and Circulars issued by Consumer Affairs Department(CAD) during 2019-20

Regulatory Framework, Circulars issued by Consumer Affairs Department (CAD) during the past Financial year:

A. Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017.

IRDAI notified Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017 on 22nd June, 2017. (A copy of these regulations can be found on our website link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3191&flag=1.)

Key provisions of the above mentioned Regulations include:

1. Board approved policy: Insurers have been mandated to put in place Board approved policy for steps to enhance Insurance awareness, specify turnaround times for various services rendered (so as to provide transparency), procedures to deal with complaints and reduce their incidence.

2. Point of Sale:

i. It is mandated to include Important features of the policy in the prospectus.

ii. Insurer/its Agent/Intermediary are mandated to provide all material information to prospect so as to enable him to decide on best cover.

iii. In respect of Sales made over modes such as Internet, SMS etc. such sales should be undertaken only by authorised and qualified sales personnel who need to obtain consent before canvassing with a view to ensure privacy and to not cause any nuisance.

3. Proposal processing: Timeline for processing of proposals have been specified and it has also been mandated to provide a copy of proposal form to the prospect so as to enable him to verify that policy has been issued in line with the details provided in proposal.

4. Policy documents: Matters which are to be stated in policy documents have been clearly specified so that all the relevant information is provided to the policyholder.

5. Free look provision: In respect of Life insurance and individual Health insurance policies, a free look cancellation period of 15 days has been provided to provide sufficient time to policyholders to go through the policy and cancel their policies, if needed.

6. Claim processing: A policyholder expects that a claim will be paid as and when it becomes due. Any complicate procedure/delay would cause undue hardship to the policyholder. Therefore, procedure for claim processing and timelines have been clearly specified to ensure timely settlement of claim.

7. Grievance Redressal procedure: Insurers are required to put in place proper systems/channels to received and resolve the grievances. Further, a system called Integrated Grievances Management System (IGMS) has also been put in place by IRDAI to enable policyholders to register their grievances which will be resolved by Insurance Companies. Timelines to acknowledge and resolve a grievance have been specified vide other guidelines so as to ensure timely resolution.

B. Insurance Ombudsman Rules, 2017:

In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector by notifying Redressal of Public Grievances Rules, 1998 with effect from 11th November 1998.

Government of India vide Gazette Notification dated 25th April, 2017 had notified Insurance Ombudsman Rules, 2017 in supersession of the Redressal of Public Grievances Rules, 1998.

These rules cover important aspects such as appointment of Insurance Ombudsman; manner, timelines and grounds on which a complaint can be made to Insurance Ombudsman; timelines for disposal of complaints, compliance of awards by Insurers etc. (A copy of these rules can be found on our website link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3164&flag=1)

C. Circulars issued by Consumer Affairs Department during the past financial year.

1. Insurance Regulatory and Development Authority of India vide its circular Ref. IRDAI/CAD/CIR/PPHI/059/04/2019 dated 10-04-2019 directed all insurers to send communications relating to:

   i. issuance and servicing of insurance policies,
   ii. Brief messages for purpose of enhancing Insurance Awareness
   iii. Status of claim at various stages of processing etc.

   (Link:https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3776&flag=1)

2. It was reported to Insurance Regulatory and Development Authority of India that the members of public have been receiving spurious calls from un-identified individuals posing to be the officials of IRDAI / Integrated Grievance Management System (IGMS) making fictitious and fraudulent offers. In the earlier years IRDAI had already issued various public notices and carried out publicity/awareness activities advising public to be cautious of such spurious calls. IRDAI once again issued a Public Notice dated 05-03-2019 advising public to be cautious of such spurious calls.

   (Link:https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3895&flag=1)

D. Fraudulent Website impersonating IRDAI:

It was observed that a website using the address www.irdaionline.org was selling Insurance to general public. A public notice was placed on our website informing that the said website is not authorised by IRDAI and cautioned that action will be taken against any entity that tries to sell insurance without having proper registration.

Snapshot – Grievances

Integrated Grievance Management System (IGMS)

"Integrated Grievance Management System" (IGMS) is a comprehensive solution which not only has the ability to provide a centralized and online access to the insurance customer but also provides for access to IRDAI for customer grievances. IGMS provides an alternate channel for online registration and tracking of complaints by insurance customers. It captures the resolution provided by insurer to the complaints. It also captures complaints registered by insurers and resolution provided to these complaints by them by replicating the insurer database of complaints on IGMS and vice-versa. Thus, IGMS provides a standard platform to all insurance companies to resolve proposer or policyholder's grievances and provides IRDAI with a tool to monitor the effectiveness of the grievance redress system of insurance companies. Therefore, apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool of IRDAI.

Grievances handling at IRDAI

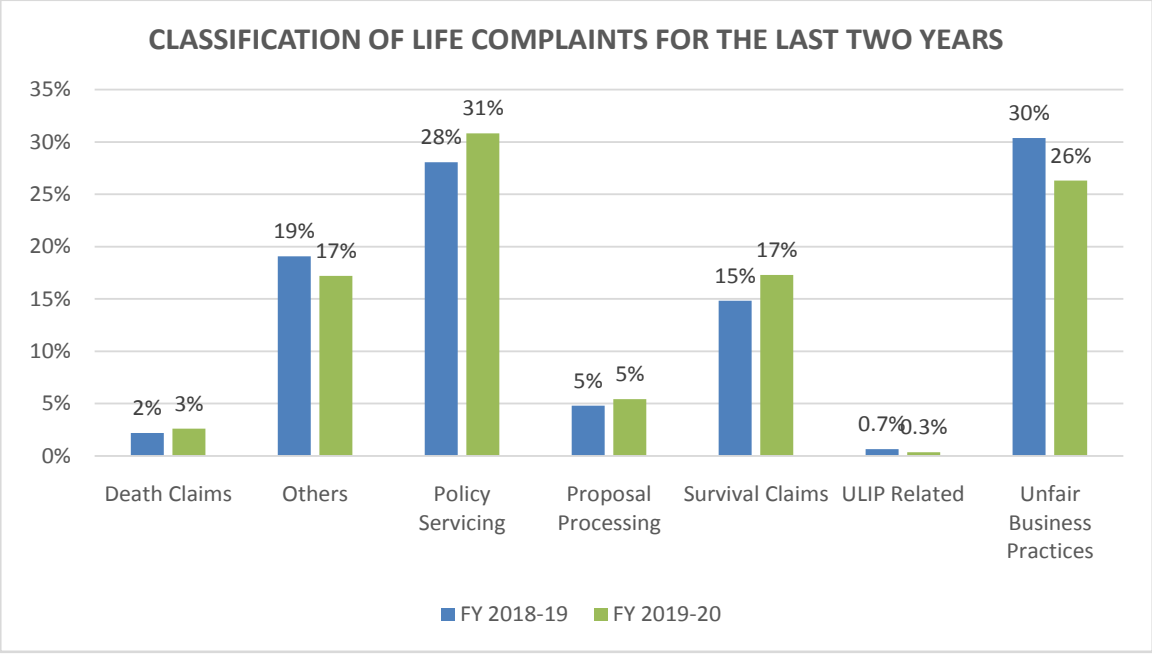
The complaint is registered with a unique token number. An acknowledgement of complaint with the complaint token number is sent to the complainant by email or if no email id is registered, by letter to his postal address. A brief description of the grievance is given on the IGMS. The documents relating to the complaint are captured and forwarded to the insurance company for resolution. The insurance company is required to examine the complaint and attend to it within two weeks by responding to the complainant. The action taken on the complaint has to be updated by the insurance company in the IGMS. The status of the complaint and the description of action taken can be checked by the complainant from the IGMS or by calling up the IRDAI Grievance Call Centre by using the token number assigned to the complaint. In case the complainant does not come back within 8 weeks of the insurance company attending to the complaint and recording the action taken, the complaint will be closed by the insurance company. In case the company does not respond even after 15 days or if the complainant is not satisfied with the action taken, he can again escalate the complaint to IRDAI. IRDAI will then take up the complaint with the company for its resolution and responding to the complainant. In case the complainant is not satisfied with the resolution of the insurance company, he may approach the Insurance Ombudsman or the appropriate legal authority.

STATUS OF GRIEVANCES – AS PER IGMS

Life Insurers

STATUS OF GRIEVANCES - LIFE INSURERS DURING 2019-20				
Insurer	**Outstanding as on 1st April, 2019**	**Grievances Reported during 2019-20**	**Resolved during 2019-20**	**Outstanding as on 31st March, 2020**
LIC	0	112005	109153	2852
PRIVATE	84	53212	53272	24
TOTAL	**84**	**165217**	**162425**	**2876**

During 2019-20, the life insurance companies resolved 98.26 per cent of the complaints handled. The private life insurers resolved 99.95 per cent of the complaints reported, while LIC resolved 97.45 per cent of the complaints.

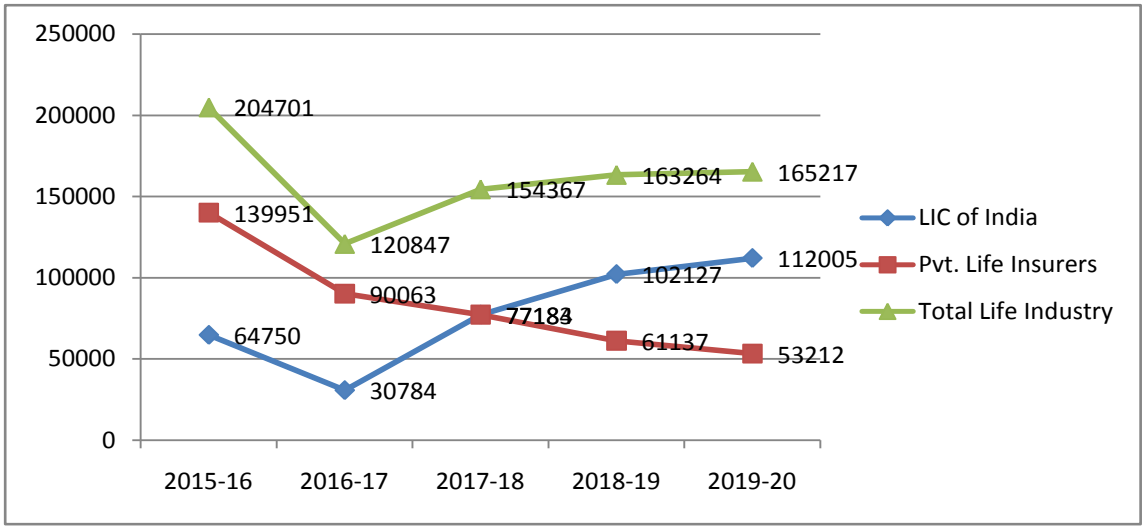


As can be seen from the above, the classification as per the IGMS in terms of grievance Redressal guidelines, indicates a substantial decrease of 4% in the complaints under Unfair Business Practices and marginal decrease of 2% in the complaints under Others during 2019-20 over 2018-19; increase of 3% in the complaints under Claims and increase of 3% in the complaints under Policy

Servicing during 2019-20 over 2018-19. The complaints under ULIP Related and Proposal processing have maintained relatively same share to the total complaints during the last 2 years.

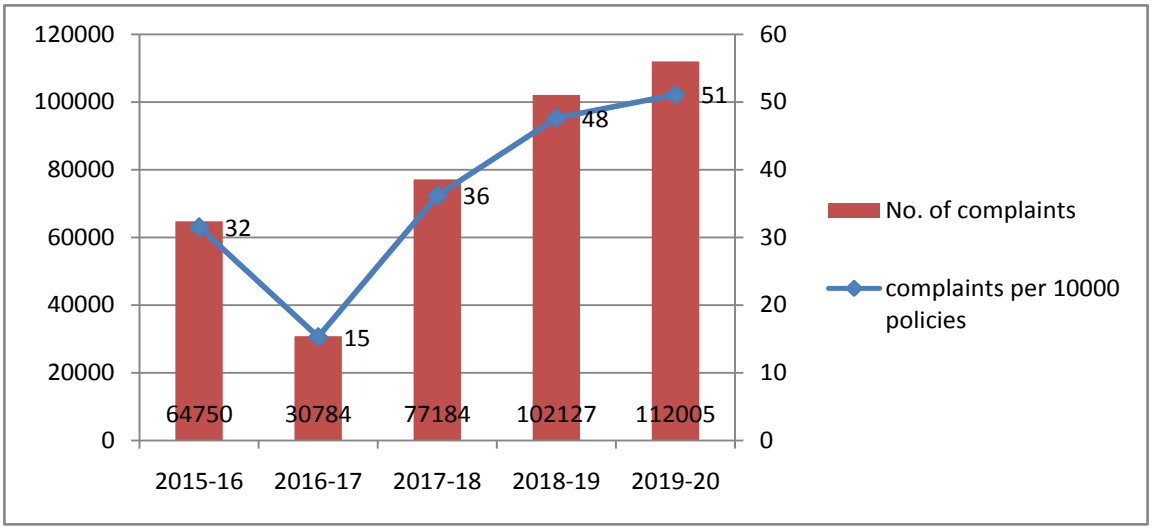
Trends in number of complaints over the past 5 financial years- IGMS:

a. Number of complaints over the Years-Total Life Insurance complaints:



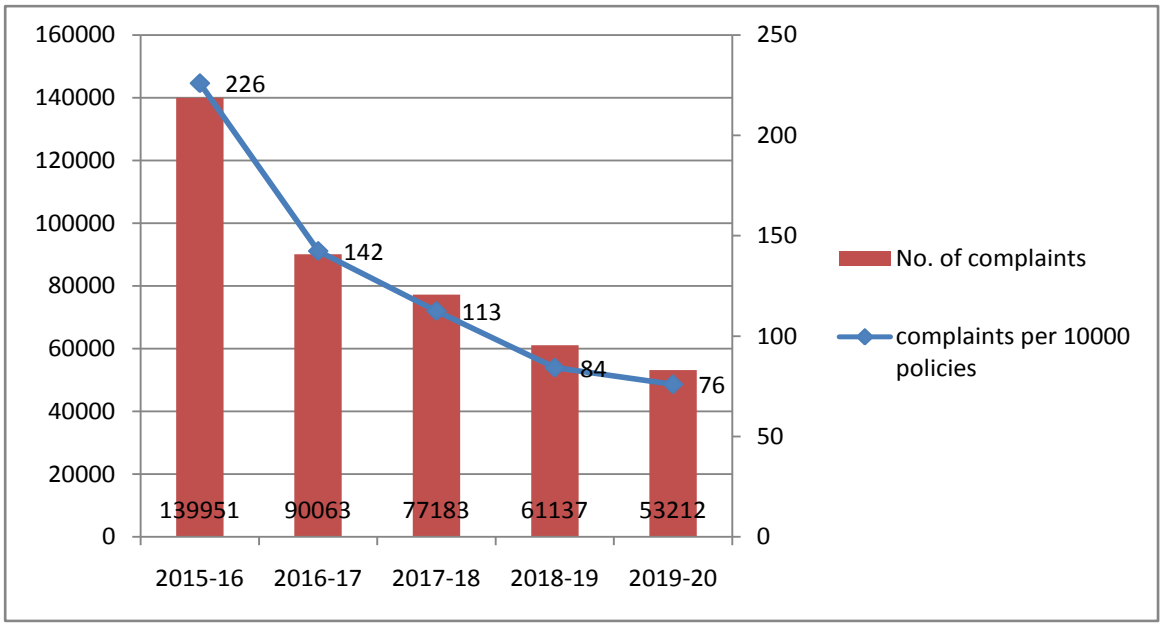
The number of Life Insurance complaints had reduced during the FY 2016-17 as compared to FY. 2015-16. However, number of Life Insurance complaints have increased from FY 2017-18 onwards. This is due to increase in number of complaints against LIC of India. Overall, there has been a decrease of 19% in number of complaints over the past 5 financial years (204701 in 2015-16 to 165217 in 2019-20).

b. Number of complaints vis-a-vis number of policies sold-LIC of India



There has been a reduction of 52.46% in number of complaints in F.Y. 16-17. However, there is an increasing trend in number of complaints against LIC of India from the FY 2017-18. Overall there has been an increase in number of complaints from 64750 in 2015-16 to 112005 in 2019-20.

c. Number of complaints vis-a-vis number of policies sold-Pvt Life Insurers



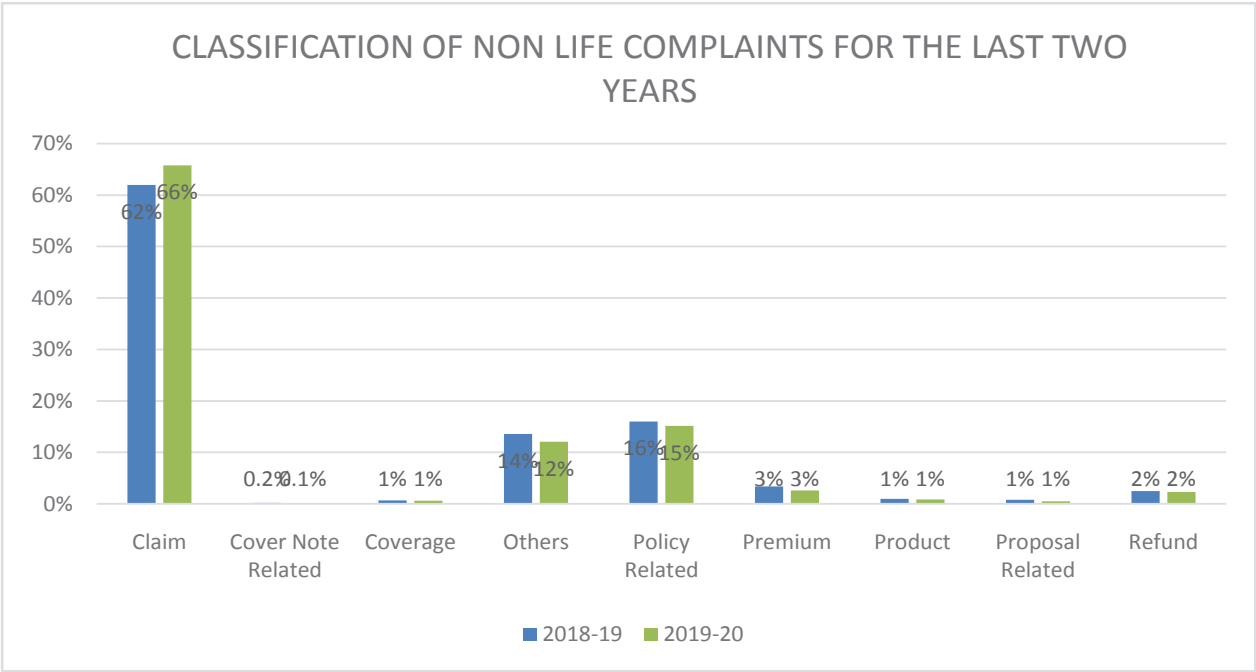
There has been a good reduction in number of complaints from 139951 in 2015-16 to 53212 in 2019-20 against Private Life Insurers over the years (62% reduction over the years). Further, incidence of complaints for every 10,000 policies has also reduced drastically over the years.

General Insurers

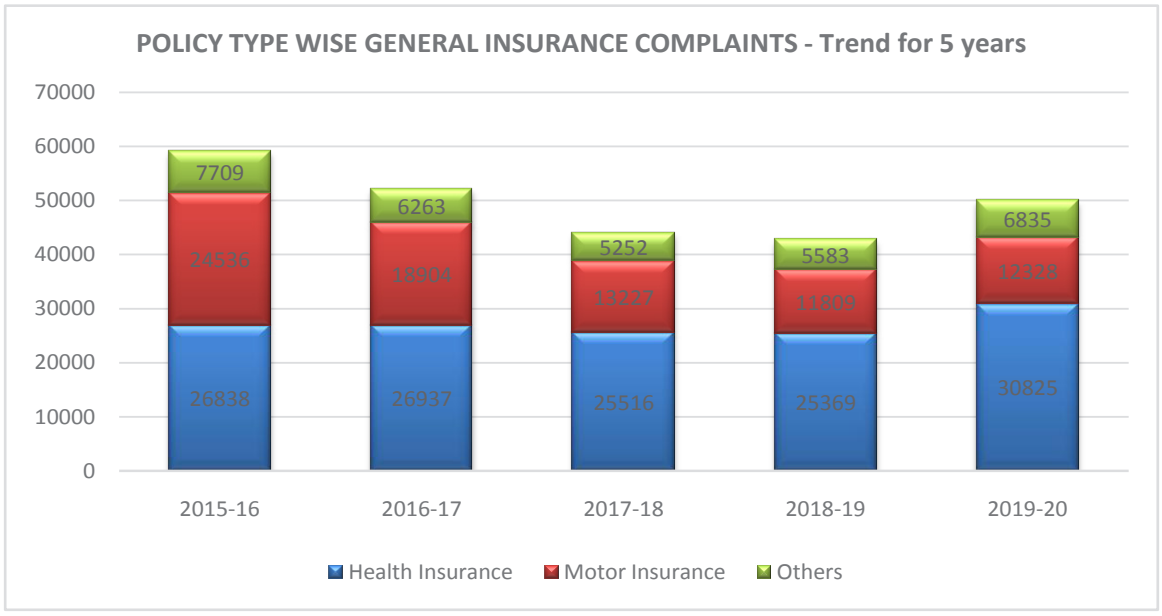
STATUS OF GRIEVANCES – GENERAL INSURERS DURING 2019-20				
Insurer	**Outstanding as on 1st April, 2019**	**Grievances Reported during 2019-20**	**Resolved during 2019-20**	**Outstanding as on 31st March, 2020**
PUBLIC	339	23002	22699	642
PRIVATE	261	26986	27218	29
TOTAL	**600**	**49988**	**49887**	**671**

The General insurance companies resolved 98.67 per cent of the complaints handled during the year 2019-20. The private General insurance companies resolved 99.89 per cent and public General insurance companies resolved 97.24 per cent of the complaints handled by them. As at 31st

March, 2020, a total of 671 complaints were pending for resolution, out of which 29 were belonging to private sector insurance companies and the remaining 642 were pertaining to public sector insurance companies.

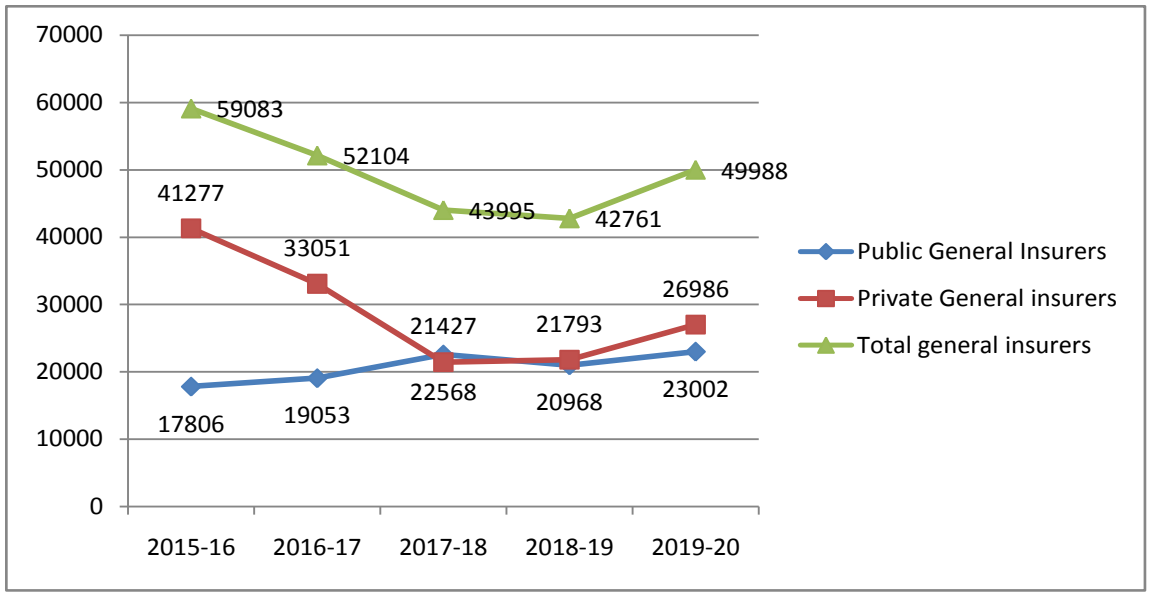


It can be seen from the above that there is a 1% reduction of the complaints reported under policy related and 2% reduction under others during 2019-20 over 2018-19. There is an increase of 4% in the complaints reported under Claims during 2019-20 over 2018-19. Complaints reported under all other categories have maintained relatively same share as that of the previous year.



The analysis of the complaints under policy type indicates that health insurance complaints are more during the last 5 years as compared to the complaints reported under other lines of business.

Number of complaints over the Years-Total General Insurance complaints:



Number of general insurance complaints has shown a decreasing trend over the years from 59083 in 2015-16 to 49988 in 2019-20 (reduction of 15%). In respect of Public General Insurers, there has been an increase in number of complaints from 17806 in 2015-16 to 23002 in 2019-20 (29% increase over the years). In respect of Private General Insurers, there has been a reduction in number of complaints from 41277 in 2015-16 to 26986 in 2019-20 (34% reduction over the years).

DATA ON INSURANCE OMBUDSMEN – 2019-20

Insurance type	O/S as on 1.4.19	Received during 2019-20	Total	Disposed during 2019-20	Number of Complaints disposed by way of					O/S as on 31.3.20
					(I)	(II)	(III)	(IV)	(V)	
Life	5076	13285	18361	14767	482	3732	2665	1132	6756	3594
					3.26%	25.27%	18.05%	7.67%	45.75%	
General	6205	3440	9645	7245	142	2833	1861	765	1644	2400
					1.96%	39.10%	25.69%	10.56%	22.69%	

Health	0	10532	10532	7804	56	2284	1184	448	3832	2728
					0.72%	29.27%	15.17%	5.74%	49.10%	
Combined	11281	27257	38538	29816	680	8849	5710	2345	12232	8722
					2.28%	29.68%	19.15%	7.86%	41.02%	

Note: O/S : Outstanding

(I) Recommendations (II) Awards (III) Dismissal awards fvg. Ins. Co.

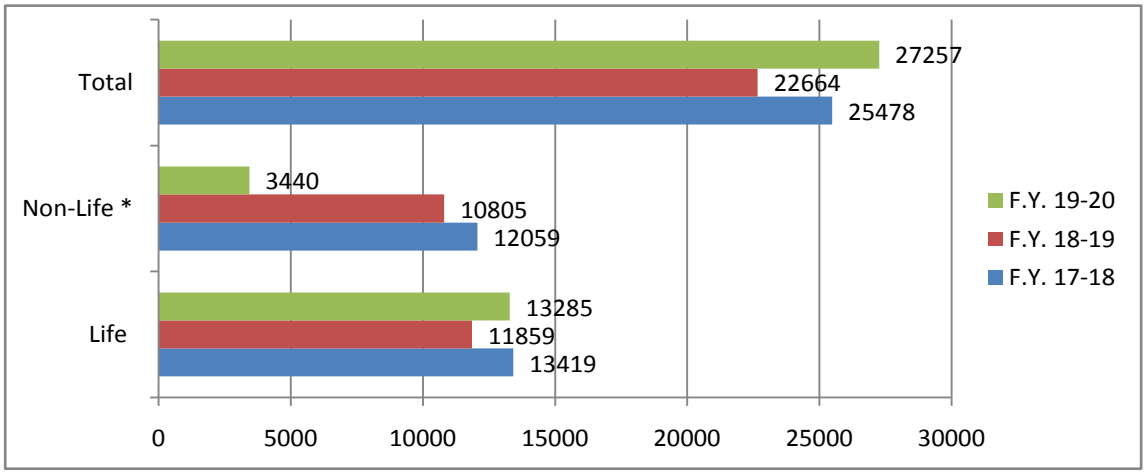
(IV) Withdrawal (V) Not-entertainable

During 2019-20, the Seventeen Ombudsmen centers spread across India have received a total of 27257 complaints. While 13285 complaints (about 48 per cent) pertained to life Insurance and 10532 complaints (about 39 per cent) pertained to Health Insurance, the remaining 3440 (about 13 per cent) pertained to General Insurance (other than Health). This was in addition to 11281 complaints pending with various offices of Ombudsmen as at the end of March 2019.

During 2019-20, Ombudsmen disposed of 29816 complaints. Out of these complaints, Ombudsmen declared 41.02 per cent of the complaints as Not-entertainable. Awards/recommendations were issued for 31.96 per cent of total complaints. Other than this, 7.86 per cent of the complaints were withdrawn/settled, while nearly 19.15 per cent of the complaints were dismissed. 8722 complaints were pending as on 31st March, 2020.

Trends in complaints received at Ombudsman Offices:

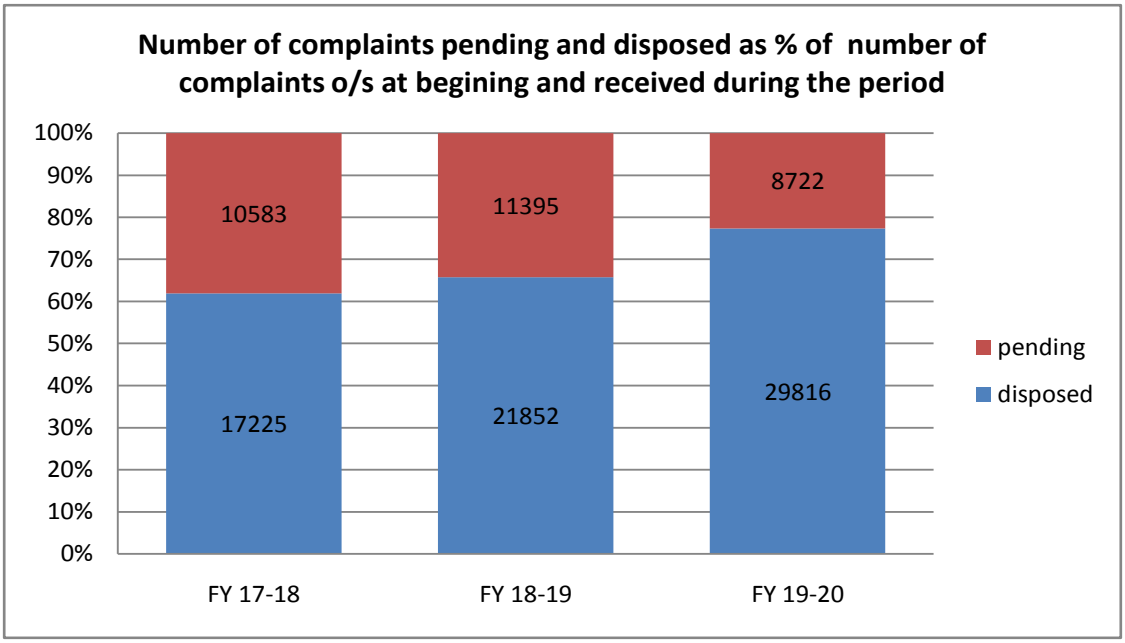
1. Number of complaints over the past 3 years:



*- NonLife including Health Insurance

Number of complaints being received across various Ombudsman centers has increased over the past 3 years from 25478 in 2017-18 to 27257 in 2019-20.

2. Pendency of complaints



Pendency percentage has been calculated as Number of complaints pending at the end of period/ (Number of complaints received during the period +Number of complaints pending at the beginning of the period).

Pendency percentage has decreased over the years.

COMPLAINTS RECEIVED THROUGH CENTRALISED PUBLIC GRIEVANCE REDRESS AND MONITORING SYSTEM – CPGRAMS PORTAL

Centralized Public Grievance Redress and Monitoring System (CPGRAMS) is an online web-enabled system developed by NIC, in association with Directorate of Public Grievances (DPG) and Department of Administrative Reforms and Public Grievances (DARPG).

The grievances pertaining to insurance are received by DFS-finance ministry directly in the portal and also from various sources – DARPG, DPG, PMO, President secretariat, Minister's office. Consumer

affairs department(CAD) receives the grievances from DFS that are pertaining to insurance companies, intermediaries and others that come under IRDAI purview. However if the grievances are related to Public sector insurance companies, DFS directly sends it to them and escalates to CAD only if such grievances require IRDAI intervention. Each grievance received is then examined by CAD and taken up with the concerned insurer(s) or taken up within office for speedy and proper redress of these grievances.

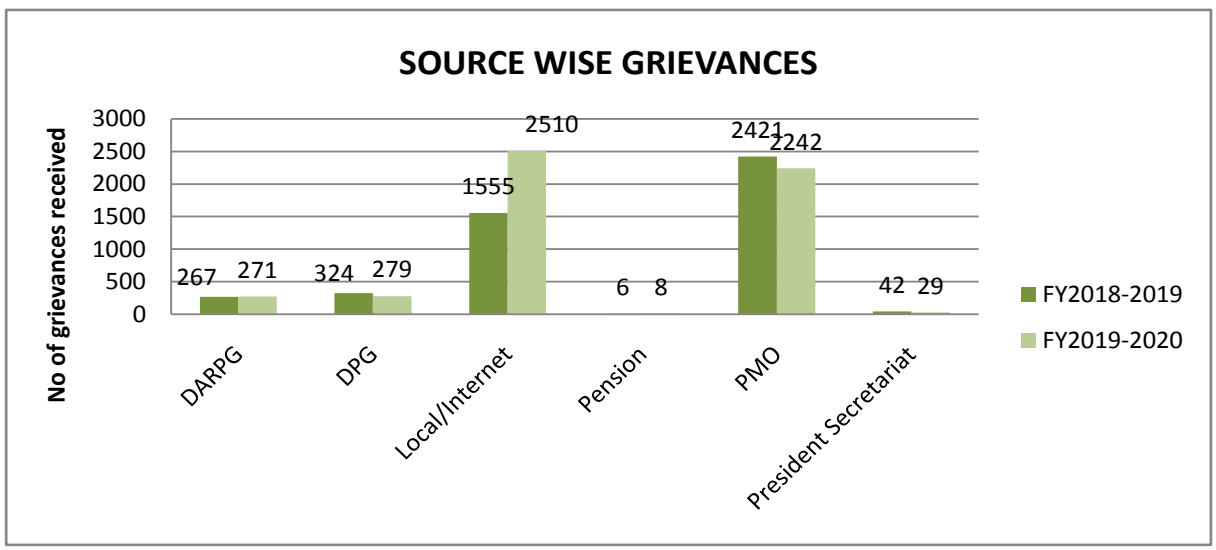
REPORT ON GRIEVANCES RECEIPT:

Number of Grievances received during financial year FY2019-2020 in CPGRAMS portal is 5339 as compared to the grievances receipt in FY2018-19 which was 4615.

STATUS OF GRIEVANCES RECEIVED AT IRDAI THROUGH CPGRAMS						
	Brought forward	Received	Disposed	% disposed	TAT	Pending as at end of period
FY2018-19	157	4615	4619	96.79%	20	153
FY2019-2020	159* (153+6)	5339	5372	100%	19	126

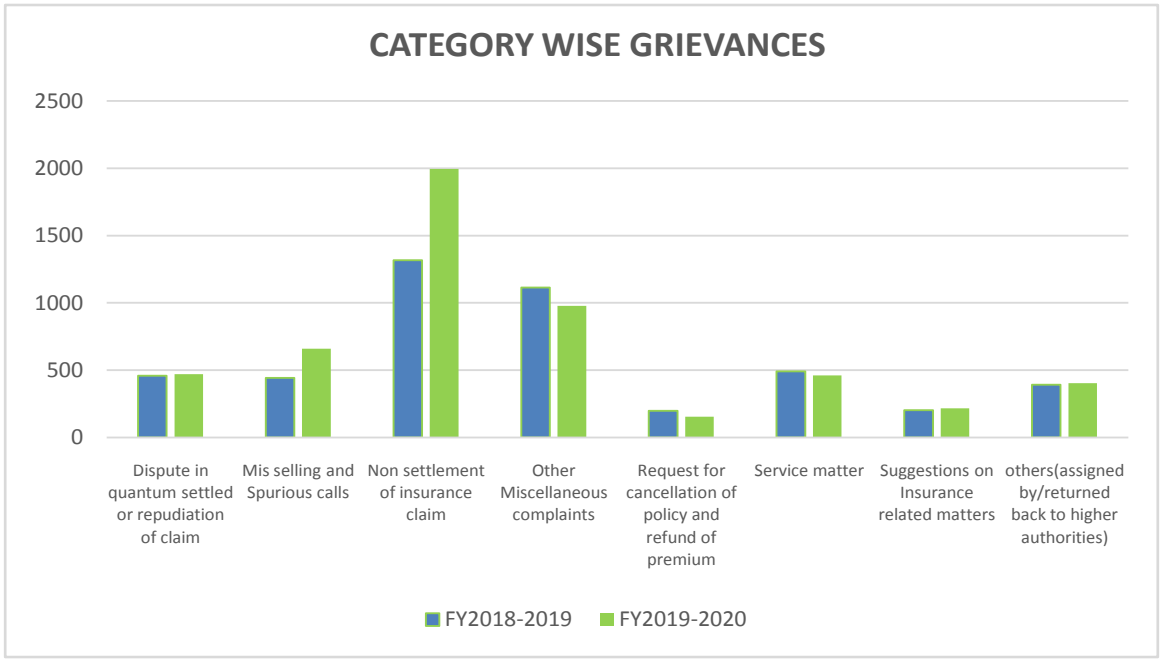
*Grievances pertaining to FY 2018-19 is escalated through portal in FY2019-2020 and added to opening balance

SOURCE WISE GRIEVANCES BREAKUP FOR FY2018-19 & FY2019-2020



It could be observed from the chart above that Majority of the grievances received from public are through PMO office and DFS- Finance ministry (referred as local/internet in graph) both of which constitute 86% & 89% of total grievances received in portal in FY2018-19 and FY2019-2020 respectively.

CATEGORY WISE GRIEVANCES BREAKUP FOR FY2018-19 & FY2019-2020



It could be observed from the chart above that the Highest number of grievances is from "Non settlement of insurance claim" category as majority of grievances received in portal are from PMO office on claim related issues of PMFBY crop insurance. Also numerous complaints are received on claim related issues in health insurance.

PRAGATI (Pro Active Governance and Timely Implementation).

Under PRAGATI initiative by government of India to ensure effective redress of public grievances, the CEOs of all Insurance Companies were advised to examine 20 grievances every week personally to assess the timeliness and quality of resolutions given. A Monthly Statement under PRAGATI is being submitted by insurers for review every month since June 2016.

Summary of Grievances - Industry (Life & General)

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & General)

01-Apr-2019 TO 31-Mar-2020

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	684	
Received during the period	217599	
Duplicate during the period	2394	
Actual during the period	215205	
Attended to during the period	212342	98.36%
Pending as at the end of the period	3547	1.64%

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**34892**	**16.21%**
○ Registered by IRDAI	27616	12.83%
○ Email	16764	
○ Letter	4130	
○ Telephone	6722	
○ Registered by Policy Holder	7276	3.38%
Complaints Registered in Insurer's portal	**180313**	**83.79%**
TOTAL COMPLAINTS	**215205**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Servicing	50902	23.65%
Unfair Business Practices	43444	20.19%
Survival Claims	28586	13.28%
Others	28400	13.20%
Proposal Processing	8973	4.17%
Death Claims	4335	2.01%
ULIP Related	577	0.27%
Claim	32880	15.28%
Policy Related	7584	3.52%
Others	6026	2.80%
Premium	1296	0.60%
Refund	1152	0.54%
Product	419	0.19%
Coverage	312	0.14%
Proposal Related	250	0.12%
Cover Note Related	69	0.03%
TOTAL	**215205**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.24

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR (Complaint Type wise)*			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	2960	407	631
Others	23574	1613	2451
Policy Servicing	45684	2959	1591
Proposal Processing	6446	394	1992
Survival Claims	24920	1552	1350
ULIP Related	344	42	186
Unfair Business Practices	13947	3698	25571
Claim	12893	5290	14350
Policy Related	5541	677	1322
Others	3768	589	1627
Premium	798	142	346
Refund	815	129	191
Product	220	48	149
Coverage	131	33	148
Proposal Related	127	18	102
Cover Note Related	53	5	11
TOTAL	**142221**	**17596**	**52018**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	362	10.21%
16 – 30 days	116	3.27%
More than 30 days	3069	86.52%
Total Pending	**3547**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Complaint raised with Insurer not addressed	Others	21812	10.14%
Malpractices or unfair business practices	Unfair Business Practices	16770	7.79%
Insurer not disposed of the claim	Claim	15880	7.38%
Survival Benefit is not paid	Survival Claims	12387	5.76%
No Response for recording Change of address	Policy Servicing	11833	5.50%
Illegitimate inducements offered	Unfair Business Practices	8635	4.01%
Maturity claim is not paid	Survival Claims	7054	3.28%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	6744	3.13%
Non-receipt of Premium receipt	Policy Servicing	6042	2.81%
Policy bond not received.	Policy Servicing	5369	2.49%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	136353	63.36%
Health Insurance Policy	2536	1.18%
Others	4070	1.89%
Pension Policy (other than Unit Linked)	4980	2.31%
Unit Linked Insurance Policy	17278	8.03%
Health Insurance	30825	14.32%
Motor Insurance	12328	5.73%
Others	5072	2.36%
Fire	940	0.44%
Crop	485	0.23%
Marine Cargo	207	0.10%
Engineering	53	0.02%
Marine Hull	47	0.02%
Credit	31	0.01%
TOTAL	**215205**	

COMPLAINTS vis-a-vis NO. OF POLICIES SOLD			
Top 5 companies	**No. of Complaints**	**No. of policies sold**	**% of complaints to policies sold**
Aviva Life	1779	20787	8.56%
Bharti Axa Life	9859	207628	4.75%
Future Generali Life	2924	65325	4.48%
Star Union Dai-ichi Life	1766	77620	2.28%
Aegon Life	807	37487	2.15%
TOTAL	**17135**		

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	142221	67.14%
Partially in favour	17596	8.31%
Reject	52018	24.56%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer

01-Apr-2019 TO 31-Mar-2020

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	84	
Received during the period	166729	
Duplicate during the period	1512	
Actual during the period	165217	
Attended to during the period	162425	98.26%
Pending as at the end of the period	2876	1.74%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Servicing	50902	30.81%
Unfair Business Practices	43444	26.30%
Survival Claims	28586	17.30%
Others	28400	17.19%
Proposal Processing	8973	5.43%
Death Claims	4335	2.62%
ULIP Related	577	0.35%
	165217	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.72

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**14825**	**8.97%**
○ Registered by IRDAI	12008	7.27%
○ Email	6859	
○ Letter	1930	
○ Telephone	3219	
○ Registered by Policy Holder	2817	1.71%
Complaints Registered in Insurer's portal	**150392**	**91.03%**
TOTAL COMPLAINTS	**165217**	

COMPLAINTS vis-a-vis NO. OF POLICIES SOLD			
Top 5 companies	**No. of Complaints**	**No. of policies sold**	**% of complaints to policies sold**
Aviva Life	1779	20787	8.56%
Bharti Axa Life	9859	207628	4.75%
Future Generali Life	2924	65325	4.48%
Star Union Dai-ichi Life	1766	77620	2.28%
Aegon Life	807	37487	2.15%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	160	5.56%
16 – 30 days	79	2.75%
More than 30 days	2637	91.69%
Total Pending	**2876**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	%
Complaint raised with Insurer not addressed	Others	21812	13.20%
Malpractices or unfair business practices	Unfair Business Practices	16770	10.15%
Survival Benefit is not paid	Survival Claims	12387	7.50%
No Response for recording Change of address	Policy Servicing	11833	7.16%
Illegitimate inducements offered	Unfair Business Practices	8635	5.23%
Maturity claim is not paid	Survival Claims	7054	4.27%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	6744	4.08%

Non-receipt of Premium receipt	Policy Servicing	6042	3.66%
Policy bond not received.	Policy Servicing	5369	3.25%
Surrender Value not paid	Survival Claims	4206	2.55%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	117875	72.62%
Partially in favour	10665	6.57%
Reject	33772	20.81%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	136353	82.53%
Health Insurance Policy	2536	1.53%
Others	4070	2.46%
Pension Policy (other than Unit Linked)	4980	3.01%
Unit Linked Insurance Policy	17278	10.46%
Grand Total	**165217**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	2960	407	631
Others	23574	1613	2451
Policy Servicing	45684	2959	1591
Proposal Processing	6446	394	1992
Survival Claims	24920	1552	1350
ULIP Related	344	42	186
Unfair Business Practices	13947	3698	25571
Grand Total	**117875**	**10665**	**33772**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - General Insurer

01-Apr-2019 TO 31-Mar-2020

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	600	
Received during the period	50870	
Duplicate during the period	882	
Actual during the period	49988	
Attended to during the period	49917	98.67%
Pending as at the end of the period	671	1.33%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	32880	65.78%
Policy Related	7584	15.17%
Others	6026	12.05%
Premium	1296	2.59%
Refund	1152	2.30%
Product	419	0.84%
Coverage	312	0.62%
Proposal Related	250	0.50%
Cover Note Related	69	0.14%
TOTAL	**49988**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	15.6

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**20067**	**40.14%**
○ Registered by IRDAI	15608	31.22%
○ Email	9905	
○ Letter	2200	
○ Telephone	3503	
○ Registered by Policy Holder	4459	8.92%
Complaints Registered in Insurer's portal	**29921**	**59.86%**
TOTAL COMPLAINTS	**49988**	

COMPLAINTS vis-a-vis NO. OF POLICIES SOLD			
Top 5 companies	**No. of Complaints**	**No. of policies sold**	**% of complaints to policies sold**
Manipal Cigna Health Insurance Co. Ltd.	922	2,50,164	0.37%
Aditya Birla Health Insurance Co. Ltd.	846	3,09,925	0.27%
Star Health Insurance Co. Ltd.	7835	44,62,963	0.18%
Max Bupa Health Insurance Co. Ltd.	1015	8,22,100	0.12%
Religare Health Insurance Co. Ltd.	874	8,07,660	0.11%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	202	30.10%
16 – 30 days	37	5.51%
More than 30 days	432	64.38%
Total Pending	**671**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	15880	31.77%
Insurer failed to clarify the queries raised by Insured.	Others	3192	6.39%
Difference between assessed loss and amount settled by Insurer.	Claim	3121	6.24%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	2573	5.15%
Certificate of Insurance / Policy not received by the Insured	Policy Related	2263	4.53%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	2122	4.25%

Claim repudiated without giving reasons	Claim	1597	3.19%
Details shown in policy or Add-on are incorrect.	Policy Related	1569	3.14%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	1157	2.31%
Delay on the part of TPA to arrange claim reimbursement.	Claim	1024	2.05%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	24346	49.16%
Partially in favour	6931	14.00%
Reject	18246	36.84%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	30825	61.66%
Motor Insurance	12328	24.66%
Others	5072	10.15%
Fire	940	1.88%
Crop	485	0.97%
Marine Cargo	207	0.41%
Engineering	53	0.11%
Marine Hull	47	0.09%
Credit	31	0.06%
TOTAL	**49988**	

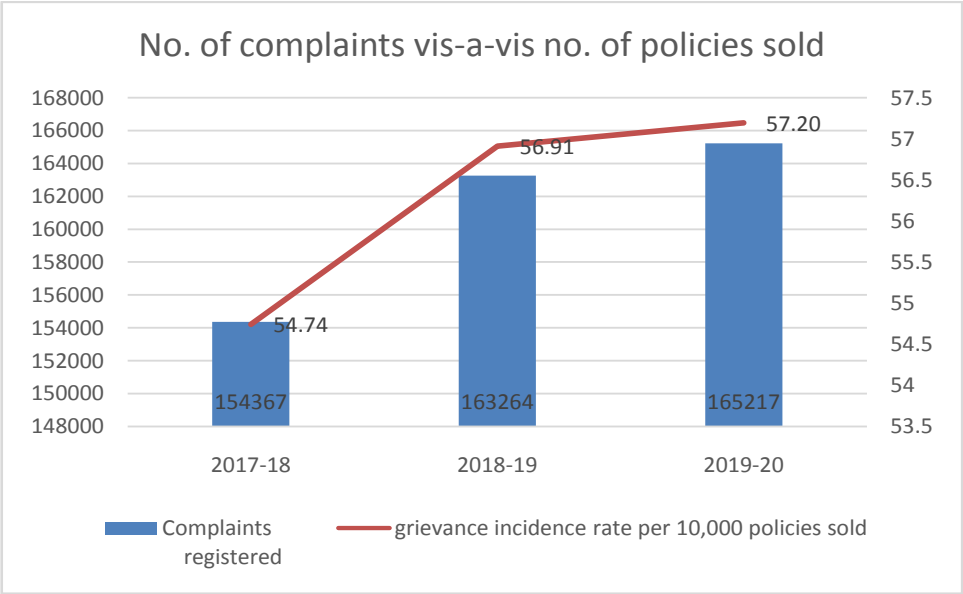
RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	12893	5290	14350
Policy Related	5541	677	1322
Others	3768	589	1627
Premium	798	142	346
Refund	815	129	191
Product	220	48	149
Coverage	131	33	148
Proposal Related	127	18	102
Cover Note Related	53	5	11
TOTAL	**24346**	**6931**	**18246**

* Out of the total complaints registered during the year

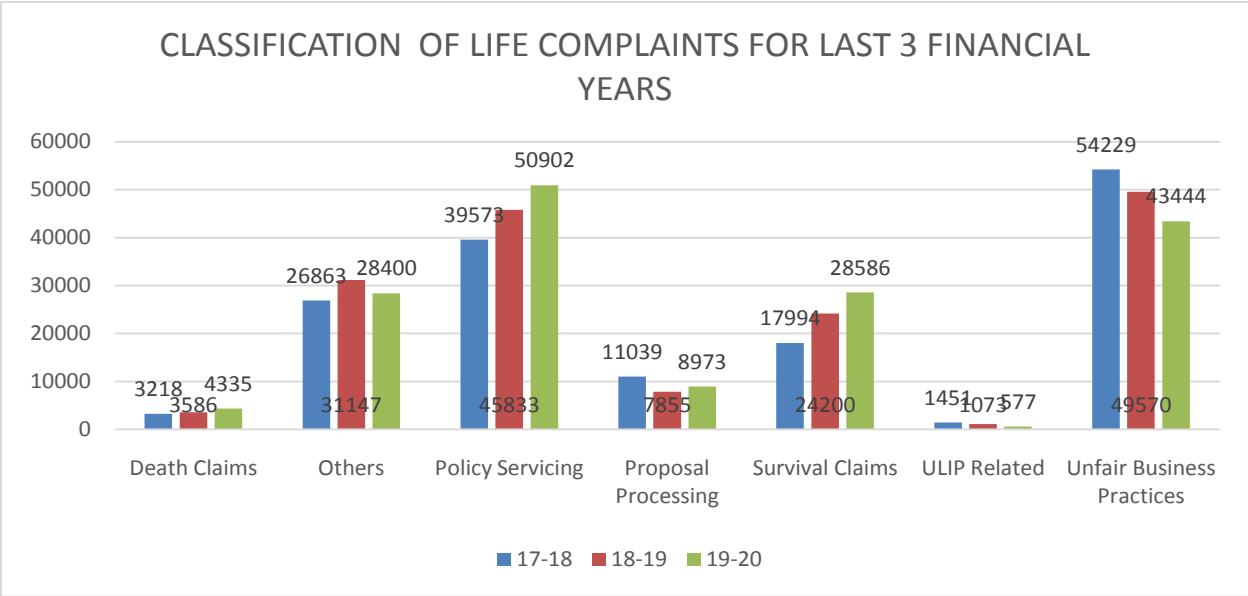
Analysis of the Grievances Reported against Life Insurers

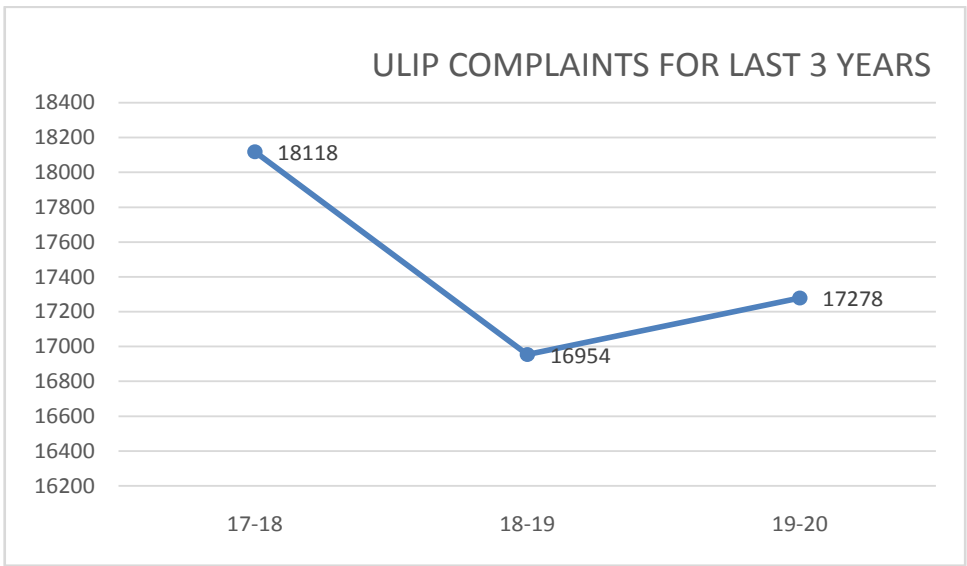
CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY LIFE INSURERS							
S.No.	Description	2019-20		2018-19		2017-18	
		Registered	Attended to	Registered	Attended to	Registered	Attended to
1	**Complaints registered by Policyholders directly in IGMS**	2817	2531	3266	3259	4029	4016
2	**Complaints of the Policyholders registered by IRDAI in IGMS**	12008	10550	11559	11539	10744	10711
3	**Compliants of the Policyholders registered by Life Insurers**	150392	149231	148439	148382	139594	139439
	Total:	**165217**	**162312**	**163264**	**163180**	**154367**	**154166**

* Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to , which relates to earlier year.



MOVEMENT OF COMPLAINTS - LIFE INSURERS							
01/04/2019 to 31/03/2020							
S.No	**Insurer**	**Opening Balance**	**Reported during the Period**	**Duplicate Compl**	**Actual Comp to during the Period**	**Attended to during the Period**	**Pending at the end of the Period**
1	LIC	**0**	112249	244	112005	109153	2852
(i)	***Public total:***	***0***	***112249***	***244***	112005	109153	2852
1	Aegon Religare	**0**	839	32	807	807	0
2	Aviva	**0**	1847	68	1779	1779	0
3	Bajaj Allianz	**2**	1624	52	1572	1574	0
4	Bharti Axa	**0**	9978	119	9859	9858	1
5	Birla Sun Life	**2**	3030	0	3030	3030	2
6	Canara HSBC	**3**	904	5	899	902	0
7	Edleweiss Tokio	**0**	592	0	592	592	0
8	Exide Life	**0**	2663	67	2596	2596	0
9	Future Generali	**0**	2925	1	2924	2924	0
10	HDFC Standard	**2**	4272	40	4232	4234	0
11	ICICI Prudential	**2**	3718	34	3684	3686	0
12	IDBI Federal	**0**	720	31	689	689	0
13	India First	**20**	2523	35	2488	2507	1
14	Kotak Mahindra	**11**	1154	20	1134	1145	0
15	Max Life	**0**	3160	108	3052	3052	0
16	PNB MetLife	**39**	2241	107	2134	2172	1
17	Pramerica	**0**	530	28	502	502	0
18	Reliance	**0**	2405	234	2171	2171	0
19	Sahara	**1**	84	0	84	67	18
20	SBI Life	**0**	4538	226	4312	4311	1
21	Shri Ram	**2**	527	4	523	525	0
22	Star Union Daichi	**0**	1773	7	1766	1766	0
23	Tata AIA	**0**	2433	50	2383	2383	0
(ii)	***Private Total:***	***84***	***54480***	***1268***	***53212***	***53272***	***24***
Grand Total [(i)+(ii)]		**84**	**166729**	**1512**	**165217**	**162425**	**2876**

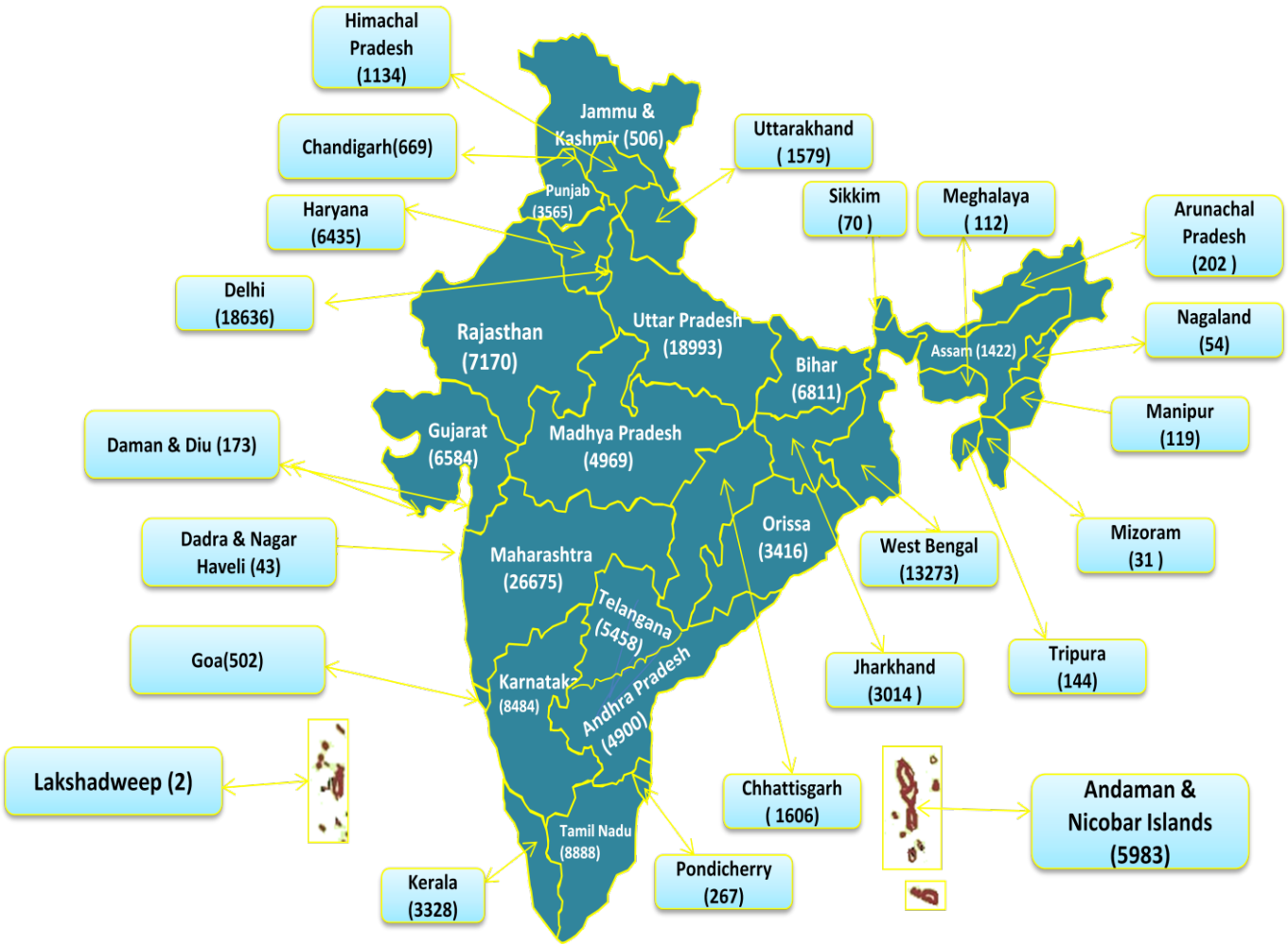

CLASSIFICATION OF LIFE COMPLAINTS FOR LAST 3 FINANCIAL YEARS
60000
50000
40000
30000
20000
10000
0
3218
3586
4335
26863
28400
31147
39573
45833
50902
11039
7855
8973
17994
24200
28586
1451
1073
577
54229
49570
43444
Death Claims
Others
Policy Servicing
Proposal Processing
Survival Claims
ULIP Related
Unfair Business Practices
17-18
18-19
19-20


ULIP COMPLAINTS FOR LAST 3 YEARS
18400
18200
18000
17800
17600
17400
17200
17000
16800
16600
16400
16200
18118
16954
17278
17-18
18-19
19-20

	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practices		Total		
	Non-ULIP	ULIP	Non-ULIP	ULIP	Non-ULIP	ULIP	Non-ULIP	ULIP	Non-ULIP	ULIP	ULIP	Non-ULIP	ULIP	Non-ULIP (A)	ULIP (B)	Total (A)+(B)
Life Insurance Corporation of India	3492	55	24026	1085	46990	1230	4229	94	25756	756	298	3740	254	108233	3772	112005
Public Total	**3492**	**55**	**24026**	**1085**	**46990**	**1230**	**4229**	**94**	**25756**	**756**	**298**	**3740**	**254**	**108233**	**3772**	**112005**
AEGON Life Insurance Company Limited	5	0	46	1	55	0	10	0	15	0	1	671	3	802	5	807
Aviva Life Insurance Company India Limited	20	0	47	7	522	19	67	1	102	9	19	959	7	1717	62	1779
Bajaj Allianz Life Insurance Company Ltd	58	0	192	19	54	3	55	4	88	6	12	1072	9	1519	53	1572
Bharti-Axa Life Insurance Company LTD	19	0	265	4	64	0	78	0	52	2	17	2361	6997	2839	7020	9859
Birla SunLife Insurance Company Limited	34	5	157	37	203	82	186	51	113	165	40	1499	458	2192	838	3030
Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited	19	11	31	1	15	21	34	59	10	19	7	388	284	497	402	899
Edelweiss Tokio Life Insurance	3	0	35	0	16	0	32	0	7	0	6	492	1	585	7	592
Exide Life Insurance Company Limited	11	0	129	2	22	1	47	0	34	1	0	2318	31	2561	35	2596
Future Generali India Life Insurance Company Limited	13	1	45	13	21	11	66	2	10	14	2	2541	185	2696	228	2924
HDFC Standard Life Insurance Co. Ltd	89	23	261	44	110	30	153	29	169	55	12	2816	441	3598	634	4232
ICICI Prudential Life Insurance Company Ltd	44	3	424	7	153	9	109	0	152	54	87	2544	98	3426	258	3684
IDBI Federal Life Insurance Co Ltd	12	1	20	0	48	4	51	4	75	34	30	342	68	548	141	689
IndiaFirst Life Insurance Company Limited	23	2	48	6	38	9	32	4	47	5	14	2105	155	2293	195	2488
Kotak Mahindra Old Mutual Life Insurance Ltd.	25	0	160	3	22	0	12	3	26	4	0	699	180	944	190	1134
Max Life Insurance Company Limited	140	17	370	6	47	11	62	4	88	3	4	1868	432	2575	477	3052
PNB MetLife India Insurance Company Ltd.	39	2	186	3	104	12	591	1	97	8	0	991	100	2008	126	2134
Pramerica Life Insurance Limited	13	0	78	9	9	1	24	2	13	2	0	332	19	469	33	502
Reliance Nippon Life Insurance Company Limited	29	0	116	2	37	0	516	43	77	3	1	1333	14	2108	63	2171
Sahara India Life Insurance Co. Ltd.	3	0	8	0	22	0	1	0	34	14	0	2	0	70	14	84
SBI Life Insurance Co. Ltd.	65	10	261	58	128	66	1174	933	216	62	22	705	612	2549	1763	4312
Shriram Life Insurance Company Ltd.	14	0	63	2	33	2	31	0	36	3	0	326	13	503	20	523
Star Union Dai-ichi Life Insurance Company Limited	23	1	39	8	179	42	30	3	58	34	1	1033	315	1362	404	1766
Tata AIA Life Insurance Company LTD	9	2	62	14	374	83	132	14	38	20	4	1230	401	1845	538	2383
Private total	**710**	**78**	**3043**	**246**	**2276**	**406**	**3493**	**1157**	**1557**	**517**	**279**	**28627**	**10823**	**39706**	**13506**	**53212**
Grand Total	**4202**	**133**	**27069**	**1331**	**49266**	**1636**	**7722**	**1251**	**27313**	**1273**	**577**	**32367**	**11077**	**147939**	**17278**	**165217**

Sl. No.	Complaint Description	Conventional Life Insurance Policy			Health Insurance Policy			Others			Pension Policy (other than Unit Linked)			Unit Linked Insurance Policy			Grand Total		
		2019-20	2018-19	2017-18	2019-20	2018-19	2017-18	2019-20	2018-19	2017-18	2019-20	2018-19	2017-18	2019-20	2018-19	2017-18	2019-20	2018-19	2017-18
1	Advice concerning Exclusions/limitations of cover not communicated	125	101	89	6	4	4	2		3	6	6	4	25	19	41	164	130	141
2	Annuity/Commutation/Cash Option /Rider/other Options not included as requested	122	135	91	2	2	2	2	2	4	52	65	25	22	14	10	200	218	132
3	Credit/Debit card debited without consent of Consumer	645	855	490	15	9	22	26	10	18	18	18	10	108	163	83	812	1055	623
4	DNC Registry	51	45	32	2	1		29	19	39	1		1	47	17	12	130	82	84
5	Free-look refund not paid	940	1200	1694	5	12	17	38	70	83	26	30	23	132	214	264	1141	1526	2081
6	Illegitimate inducements offered	3612	3574	3882	7	7	18	224	202	274	10	8	13	4782	1783	844	8635	5574	5031
7	Intermediary did not provide material information concerning proposed cover	1562	2265	1882	7	5	24	88	153	95	29	35	32	549	708	443	2235	3166	2476
8	Malpractices or unfair business practices	11585	15216	16858	95	82	85	1230	2124	3909	214	190	174	3646	3693	3739	16770	21305	24765
9	Misappropriation of premiums	767	824	953	7	15	13	58	44	63	17	17	15	246	148	241	1095	1048	1285
10	Mode of premium payment differs from requested or disclosed	249	273	279	8	7	9	4	5	18	3	9	4	28	34	32	292	328	342
11	Premium paying period projected is different from actual	626	711	744	2	3	9	22	13	21	11	7	9	102	92	122	763	826	905
12	Product differs from what was requested or disclosed.	2973	3624	4059	6	31	23	86	70	272	53	47	41	451	463	436	3569	4235	4831
13	Proposed Insurance not in the interest of proposer	646	1176	1421	2	7	52	46	52	42	24	29	24	142	286	234	860	1550	1773
14	Single premium Policy issued as Annual premium policy	1556	1955	2214	2	1	1	73	49	190	9	7	8	425	384	392	2065	2396	2805
15	Spurious calls or Hoax Calls							731	1202	1888							731	1202	1888
16	Surrender value projected is different from actual	262	320	294	3	3	4	7	14	24	13	14	9	45	68	59	330	419	390
17	Tampering, Corrections, forgery of proposal or related papers	2908	3537	3533	11	7	18	106	149	239	24	38	33	300	425	463	3349	4156	4286
18	Term(Period) of the policy is different/altered without consent	259	304	316	1	3	4	7	7	10	9	4	8	27	36	53	303	354	391
	Total	28888	36115	38831	181	199	305	2779	4185	7192	519	524	433	11077	8547	7468	43444	49570	54229

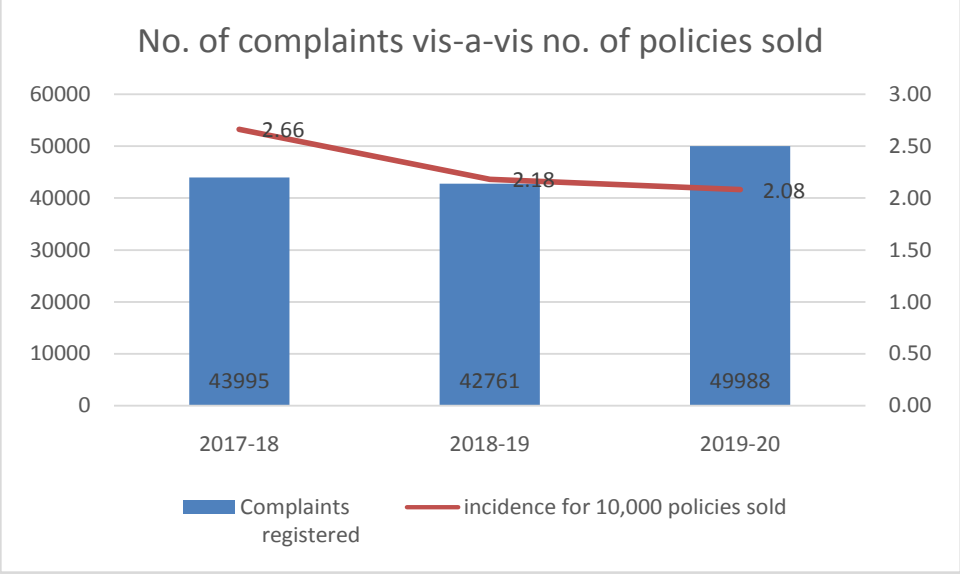
STATE/UT WISE DISTRIBUTION OF COMPLAINTS - LIFE – 2019-20



*The map is a generalized illustration only, and the representation does not reflect the official position of the Government of India.

Analysis of the Grievances Reported against General Insurers

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY GENERAL INSURERS							
S. No	Description	2019-20		2018-19		2017-18	
		Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly in IGMS	4459	4360	3824	3723	4888	4189
2	Complaints of the Policyholders registered by IRDAI in IGMS	15608	15440	12037	11833	10936	10385
3	Compliants of the Policyholders registered by Non Life Insurers	29921	29723	26900	26605	28171	27775
	Total:	**49988**	**49523**	**42761**	**42161**	**43995**	**42349**
* Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to , which relates to earlier year.							



MOVEMENT OF COMPLAINTS - NONLIFE INSURERS							
S.No	Insurer	01/04/2019 to 31/03/2020					
		Opening Balance	Reported during the year	Duplicate Compl	Actual Complaints	Attended to during the year	Pending at the end of the year
1	Agriculture Insurance	**0**	47	1	46	44	2
2	ECGC of India	**0**	6	0	6	0	6
(i)	**Specialised Insurers**	**0**	**53**	**1**	**52**	**44**	**8**
1	National Insurance	**17**	4752	0	4752	4662	107
2	The New India Assurance	**30**	5587	103	5484	5497	17
3	The Oriental Insurance	**27**	2965	71	2894	2872	49
4	United India Insurance	**265**	9820	0	9820	9624	461
(ii)	**PSU General Insurers**	***339***	***23124***	***174***	**22950**	**22655**	**634**
1	Acko General	**0**	622	2	620	620	0
2	Bajaj Allianz General	**2**	1630	78	1552	1553	1
3	Bharati Axa General	**4**	1019	52	967	971	0
4	Cholamandalam MS	**0**	272	4	268	268	0
5	DHFL General	**0**	59	2	57	57	0
6	Edelweiss General	**0**	23	0	23	23	0
7	Future Generali India	**0**	549	35	514	514	0
8	Go Digit General	**0**	134	0	134	133	1
9	HDFC ERGO General	**0**	1227	25	1202	1202	0
10	ICICI Lombard General	**74**	2916	43	2873	2946	1
11	IFFCO Tokio General	**1**	969	1	968	962	7
12	Kotak General	**2**	104	6	98	100	0
13	L&T General*	**0**	4	0	4	4	0
14	Liberty Videocon Genral	**0**	367	1	366	366	0
15	Magma HDI General	**0**	95	5	90	85	5
16	Raheja QBE	**0**	4	0	4	0	4
17	Reliance General	**0**	663	0	663	662	1
18	Royal Sundaram Alliance	**10**	581	19	562	572	0

19	SBI General	**11**	1094	30	1064	1075	0
20	Shriram General	**0**	326	0	326	326	0
21	Tata- AIG General	**4**	1426	122	1304	1308	0
22	Universal Sompo General	**0**	648	3	645	645	0
(iii)	**Private General Insurers**	***108***	***14732***	***428***	***14304***	***14392***	***20***
1	Aditya Birla Health	**0**	899	53	846	846	0
2	Apollo MUNICH Health	**12**	1191	36	1155	1167	0
3	Manipal Cigna	**3**	1010	88	922	925	0
4	Max Bupa Health	**0**	1029	14	1015	1015	0
5	Reliance Health	**0**	36	1	35	26	9
6	Religare Health	**3**	941	67	874	877	0
7	Star Health and Allied	**135**	7855	20	7835	7970	0
(iv)	**SAHI insurers**	***153***	***12961***	***279***	***12682***	***12826***	***9***
	Grand Total [(i)+(ii)+(iii)+(iv)]	**600**	**50870**	**882**	**49988**	**49917**	**671**

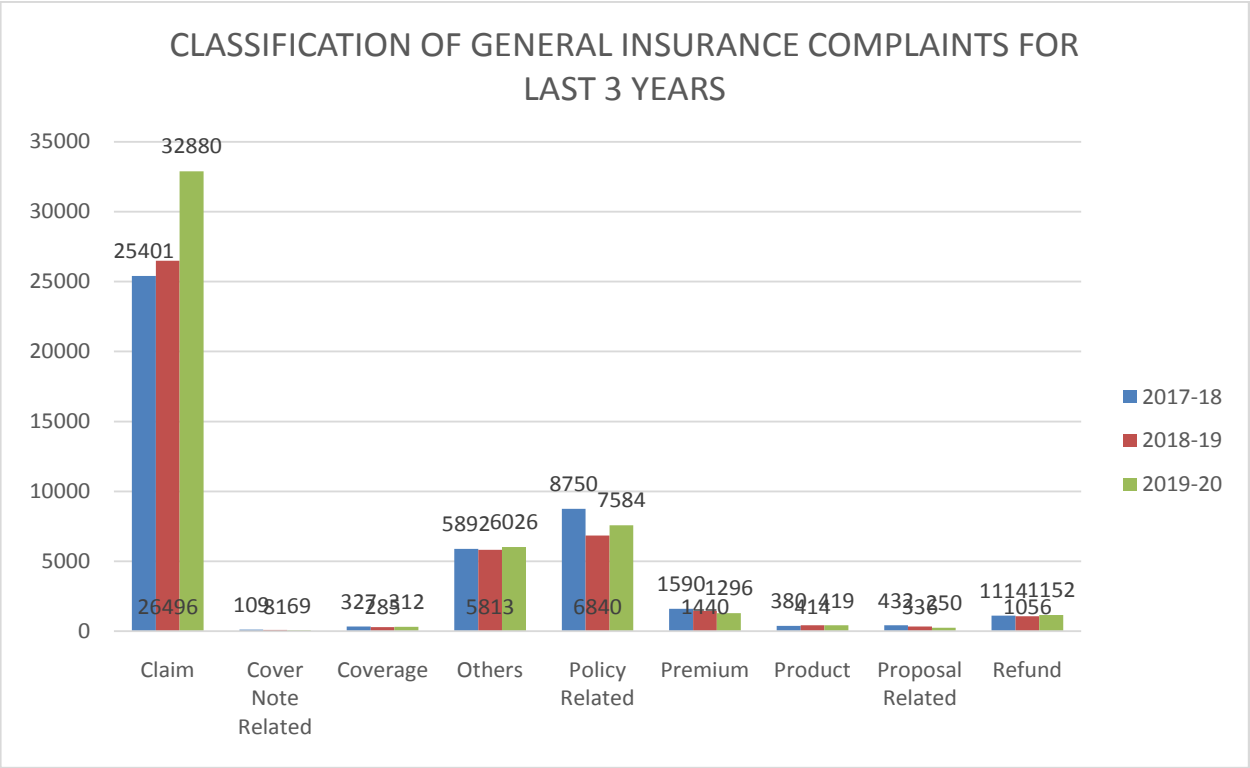
*merged with HDFC General Insurance company and merged entity is now known as HDFC ERGO General Insurance Company

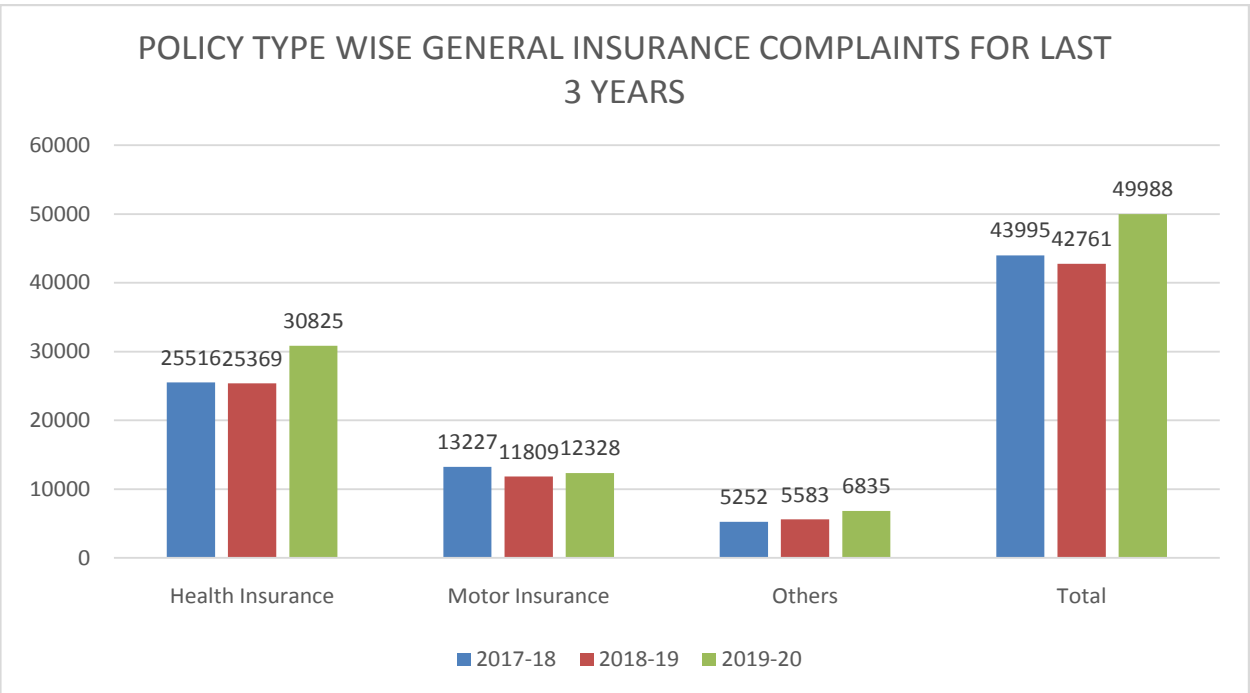
ANALYSIS OF THE REGISTERED GENERAL INSURANCE COMPLAINTS- 2019-20

S. No	Name of the Insurer	Claim	Cover Note Related	Coverage	Others	Policy Related	Premium	Product	Proposal Related	Refund
1	Agriculture Insurance	38	0	0	7	1	0	0	0	0
2	ECGC of India	2	0	0	1	0	0	1	2	0
(i)	***Specialised insurers***	**40**	**0**	**0**	**8**	**1**	**0**	**1**	**2**	**0**
3	National Insurance	3348	26	15	954	287	75	9	5	33
4	The New India Assurance	3929	4	28	430	896	119	10	6	62
5	The Oriental Insurance	1564	16	29	436	630	147	8	7	57
6	United India Insurance	7246	14	79	926	963	338	12	23	219
(ii)	***PSU General insurers***	***16087***	***60***	***151***	***2746***	***2776***	***679***	***39***	***41***	***371***
1	Acko General	303	2	3	84	183	3	20	4	18
2	Bajaj Allianz General	631	0	10	360	411	34	31	8	67
3	Bharati Axa General	519	3	6	104	235	19	21	6	54
4	Cholamandalam MS Gen	175	0	1	39	35	7	5	1	5
5	DHFL General	27	0	1	10	8	0	4	1	6
6	Edelweiss general	9	0	0	7	4	0	1	0	2
7	Future Generali India Ins.	287	1	1	66	68	4	30	46	11
8	Go Didit General	86	0	2	20	15	4	5	0	2
9	HDFC ERGO General	803	0	11	96	155	52	25	29	31
10	ICICI Lombard General	1222	0	0	723	592	248	26	14	48
11	IFFCO Tokio General	707	0	4	112	85	43	9	1	7
12	Kotak General	47	0	0	21	17	1	6	1	5
13	L&T General*	2	0	0	2	0	0	0	0	0
14	Liberty Videocon General	232	0	0	30	91	0	6	2	5
15	Magma HDI	51	0	1	21	15	0	0	0	2

	General									
16	Raheja QBE	0	0	0	0	2	0	0	0	2
17	Reliance General	492	0	1	82	53	12	9	1	13
18	Royal Sundaram Alliance	376	1	5	25	108	30	1	6	10
19	SBI General	345	1	4	97	543	8	25	13	28
20	Shriram General	259	1	1	25	29	0	5	0	6
21	Tata- AIG General	686	0	61	156	323	17	8	3	50
22	Universal Sompo General	581	0	3	31	22	5	2	1	0
(iii)	***Private General Insurers***	***7840***	***9***	***115***	***2111***	***2994***	***487***	***239***	***137***	***372***
1	Aditya Birla Health	328	0	3	198	151	10	84	12	60
2	Apollo MUNICH Health	457	0	22	165	415	41	13	10	32
3	Cigna Manipal	471	0	1	340	60	14	3	0	33
4	Max Bupa Health	570	0	9	168	136	48	21	22	41
5	Reliance Health	28	0	0	3	2	1	0	0	1
6	Religare Health	587	0	1	87	125	9	5	15	45
7	Star Health and Allied	6472	0	10	200	924	7	14	11	197
(iv)	***Stand Alone Health Insurers***	***8913***	***0***	***46***	***1161***	***1813***	***130***	***140***	***70***	***409***
	Grand Total [(i)+(ii)+(iii)+(iv)]	***32880***	***69***	***312***	***6026***	***7584***	***1296***	***419***	***250***	***1152***

*merged with HDFC General insurance company and merged entity is now known as HDFC ERGO General Insurance Company

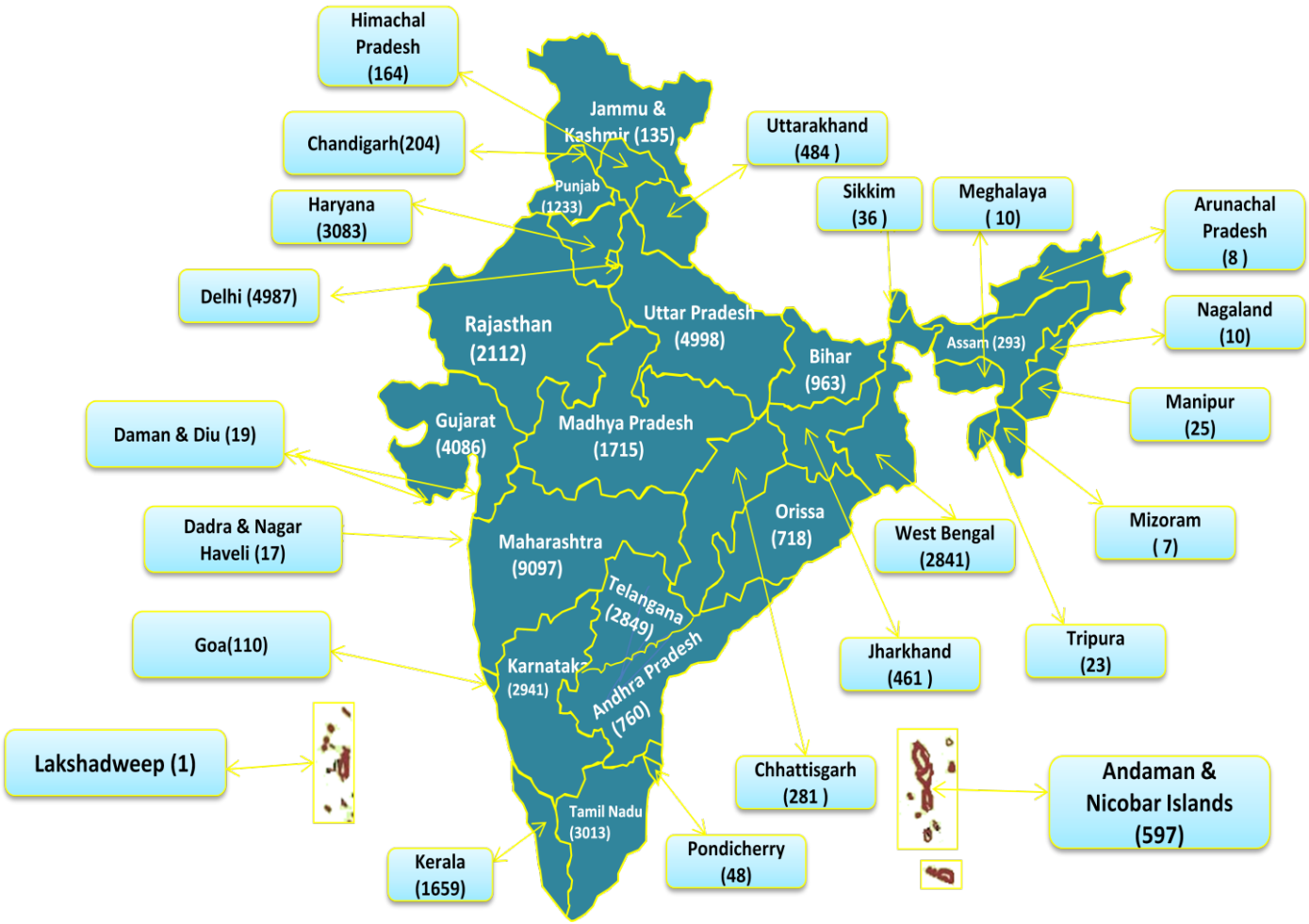

CLASSIFICATION OF GENERAL INSURANCE COMPLAINTS FOR LAST 3 YEARS
35000
30000
25000
20000
15000
10000
5000
0
25401
26496
32880
109
8169
327
285
312
5892
5813
6026
8750
6840
7584
1590
1440
1296
380
414
419
433
336
250
1114
1056
1152
Claim
Cover Note Related
Coverage
Others
Policy Related
Premium
Product
Proposal Related
Refund
2017-18
2018-19
2019-20


POLICY TYPE WISE GENERAL INSURANCE COMPLAINTS FOR LAST 3 YEARS
60000
50000
40000
30000
20000
10000
0
25516
25369
30825
13227
11809
12328
5252
5583
6835
43995
42761
49988
Health Insurance
Motor Insurance
Others
Total
2017-18
2018-19
2019-20

ANALYSIS OF HEALTH INSURANCE COMPLAINTS FOR THE LAST THREE YEARS				
S.No	**Complaint Type**	**2019-20**	**2018-19**	**2017-18**
1	Claim	21748	16275	14969
2	Coverage	207	197	234
3	Others	3295	3317	3482
4	Policy Related	3834	3539	4608
5	Premium	791	995	1131
6	Product	222	227	204
7	Proposal Related	128	201	201
8	Refund	600	618	687
	Total	**30825**	**25369**	**25516**

ANALYSIS OF MOTOR INSURANCE COMPLAINTS FOR THE LAST THREE YEARS				
S.No	**Complaint Type**	**2019-20**	**2018-19**	**2017-18**
1	Claim	7481	7173	7511
2	Cover Note Related	56	71	90
3	Coverage	69	61	59
4	Others	1569	1571	1735
5	Policy Related	2353	2207	2923
6	Premium	319	257	353
7	Product	80	60	94
8	Proposal Related	72	97	185
9	Refund	329	312	277
	Total	**12328**	**11809**	**13227**

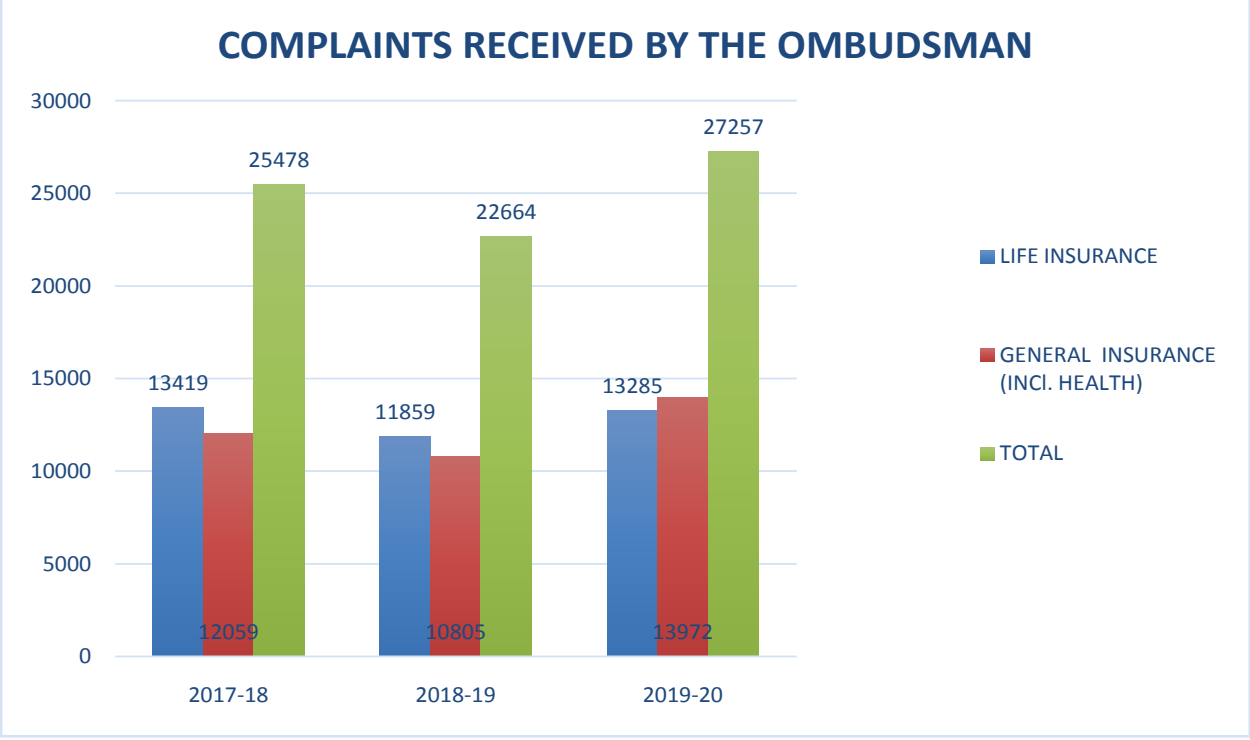
STATE/UT WISE DISTRIBUTION OF COMPLAINTS - NONLIFE – 2019-20



*The map is a generalized illustration only, and the representation does not reflect the official position of the Government of India.

Analysis of the Grievances Reported to Insurance Ombudsmen

COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN - CURSORY GLANCE			
Insurace Type	**2017-18**	**2018-19**	**2019-20**
LIFE INSURANCE	13419	11859	13285
GENERAL INSURANCE (INCl. HEALTH)	12059	10805	13972
TOTAL	**25478**	**22664**	**27257**



DISPOSAL OF COMPLAINTS BY THE INSURANCE OMBUDSMEN

Particulars	**2019-20**			
	O/S as on 01.04.2019	**Received**	**Disposed**	**O/s as on 31.03.2020**
1. Against Life Insuance	5076	13285	14767	3594
2. Against General Insurance	6205	3440	7245	2400
3. Against Health Insurance	0	10532	7804	2728
Total	**11281**	**27257**	**29816**	**8722**

CLASSIFICATION OF COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN (Life & General Insurers)	
	2019-20
Complaints which are not entertainable	12232
Partial or total repudiation of claim	9010
Dispute in regard to premiums paid or payable in terms of policy	1440
Disupute on the legal construction of the policies so far as such dispute relates to claim	69
Delay in settlement of claims	974
Non issuance of document to customer after receipt of premium	53
Misrepresentation of policy terms and conditions at any time in the policy document or policy contract.	2767
Policy servicing related grievances against insurers and their agents and intermediaries.	396
Issuance of policies which is not in conformity with the proposal form submitted by the proposer	30
Any other matter resulting from the violation of provisions	286
Total	**27257**

OFFICE OF THE EXECUTIVE COUNCIL OF INSURERS

Complaints Disposal statement for the period from 01.04.2019 to 31.3.2020

STATEMENT L2

LIFE INSURANCE

Name of the centre	Total No of Complaints			Complaints disposed by way of						Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the beginning of the year	Received upto March	Total	(I)	(II)	(III)	(IV)	(V)	Total Disposed	(A)	(B)	(C)	Total Disposed	(A)	(B)	(C)	Total Outstanding
Ahmedabad	718	602	1320	0	49	54	169	364	636	365	19	252	636	71	160	453	684
Bengaluru	126	688	814	6	275	185	25	294	785	603	182	0	785	29	0	0	29
Bhopal	106	627	733	90	20	193	36	364	703	560	143	0	703	30	0	0	30
Bubaneshwar	175	575	750	9	168	101	20	380	678	388	214	76	678	72	0	0	72
Chandigarh	932	1912	2844	0	1011	621	0	916	2548	1068	1054	426	2548	221	75	0	296
Chennai	42	697	739	5	100	93	34	485	717	570	147	0	717	22	0	0	22
Delhi	235	991	1226	0	469	275	84	344	1172	617	552	3	1172	54	0	0	54
Guwahati	0	365	365	0	53	57	14	225	349	349	0	0	349	16	0	0	16
Hyderabad	71	983	1054	0	246	89	55	591	981	777	202	2	981	72	0	1	73
Jaipur	0	376	376	17	45	45	43	210	360	355	5	0	360	16	0	0	16
Kochi	208	484	692	0	157	280	40	185	662	259	336	67	662	29	0	1	30
Kolkata	911	1413	2324	3	501	207	177	556	1444	579	137	728	1444	275	521	84	880
Lucknow	508	659	1167	196	100	232	96	383	1007	394	158	455	1007	73	76	11	160
Mumbai	142	974	1116	9	130	72	77	710	998	779	202	17	998	84	34	0	118
Noida	164	787	951	131	202	72	110	289	804	384	420	0	804	124	23	0	147
Patna	67	337	404	12	59	57	75	185	388	262	123	3	388	15	1	0	16
Pune	671	815	1486	4	147	32	77	275	535	289	23	223	535	113	407	431	951
Total	5076	13285	18361	482	3732	2665	1132	6756	14767	8598	3917	2252	14767	1316	1297	981	3594

Note:

O/S : Outstanding

(I) Recommendations

(II) Awards

(III) Dismissal awards fvg. Ins. Co.

(IV) Withdrawal

(V) Not-entertainable

(A) Within 3 months

(B) 3 months to 1 Year

(C) Above 1 Year

OFFICE OF THE EXECUTIVE COUNCIL OF INSURERS

Complaints Disposal statement for the period from 01.04.2019 to 31.3.2020

STATEMENT H2

HEALTH INSURANCE

Name of the centre	Total No of Complaints			Complaints disposed by way of						Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the beginning of the year	Received upto March	Total	(I)	(II)	(III)	(IV)	(V)	Total Disposed	(A)	(B)	(C)	Total Disposed	(A)	(B)	(C)	Total Outstanding
Ahmedabad	0	1552	1552	0	0	0	47	807	854	830	24	0	854	152	546	0	698
Bengaluru	0	531	531	2	167	137	3	183	492	462	30	0	492	39	0	0	39
Bhopal	0	282	282	4	26	71	16	153	270	185	85	0	270	12	0	0	12
Bubaneshwar	0	177	177	0	30	15	11	81	137	91	46	0	137	40	0	0	40
Chandigarh	0	769	769	0	166	93	0	325	584	340	244	0	584	112	73	0	185
Chennai	0	659	659	2	178	87	55	275	597	394	203	0	597	62	0	0	62
Delhi	0	562	562	0	135	196	29	185	545	299	246	0	545	17	0	0	17
Guwahati	0	150	150	0	42	19	12	72	145	145	0	0	145	5	0	0	5
Hyderabad	0	424	424	1	122	77	7	173	380	256	124	0	380	44	0	0	44
Jaipur	0	351	351	4	110	49	41	112	316	311	5	0	316	35	0	0	35
Kochi	0	744	744	0	239	191	30	250	710	385	325	0	710	31	3	0	34
Kolkata	0	584	584	0	18	6	24	106	154	125	29	0	154	90	340	0	430
Lucknow	0	198	198	9	19	18	14	107	167	123	44	0	167	20	11	0	31
Mumbai	0	2298	2298	4	917	187	94	661	1863	895	968	0	1863	343	92	0	435
Noida	0	348	348	13	88	24	40	122	287	171	116	0	287	58	3	0	61
Patna	0	132	132	0	27	14	16	60	117	69	48	0	117	11	4	0	15
Pune	0	771	771	17	0	0	9	160	186	175	11	0	186	161	424	0	585
Total	0	10532	10532	56	2284	1184	448	3832	7804	5256	2548	0	7804	1232	1496	0	2728

Note:

O/S : Outstanding

(I) Recommendations

(II) Awards

(III) Dismissal awards fvg. Ins. Co.

(IV) Withdrawal

(V) Not-entertainable

(A) Within 3 months

(B) 3 months to 1 Year

(C) Above 1 Year

OFFICE OF THE EXECUTIVE COUNCIL OF INSURERS

Complaints Disposal statement for the period from 01.04.2019 to 31.3.2020

STATEMENT G2

GENERAL INSURANCE

Name of the centre	Total No of Complaints			Complaints disposed by way of						Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the beginning of the year	Received upto March	Total	(I)	(II)	(III)	(IV)	(V)	Total Disposed	(A)	(B)	(C)	Total Disposed	(A)	(B)	(C)	Total Outstanding
Ahmedabad	1617	179	1796	0	187	101	198	108	594	124	21	449	594	12	47	1143	1202
Bengaluru	127	139	266	9	94	90	2	61	256	126	130	0	256	10	0	0	10
Bhopal	202	125	327	22	26	165	21	92	326	99	96	131	326	1	0	0	1
Bubaneshwar	50	223	273	0	60	43	21	108	232	128	56	48	232	41	0	0	41
Chandigarh	382	347	729	0	268	221	0	173	662	187	408	67	662	42	25	0	67
Chennai	144	265	409	2	159	45	33	150	389	195	194	0	389	20	0	0	20
Delhi	305	251	556	1	212	176	30	131	550	176	371	3	550	6	0	0	6
Guwahati	0	102	102	0	23	17	7	55	102	102	0	0	102	0	0	0	0
Hyderabad	107	419	526	4	299	91	9	116	519	162	357	0	519	7	0	0	7
Jaipur	0	178	178	0	38	19	9	100	166	165	1	0	166	12	0	0	12
Kochi	443	326	769	0	314	294	37	111	756	159	433	164	756	11	1	1	13
Kolkata	853	96	949	2	272	136	33	42	485	48	19	418	485	6	40	418	464
Lucknow	191	131	322	22	37	125	34	82	300	93	36	171	300	9	11	2	22
Mumbai	823	195	1018	1	572	196	109	109	987	117	828	42	987	24	7	0	31
Noida	163	233	396	31	116	66	47	111	371	143	223	5	371	25	0	0	25
Patna	155	96	251	4	22	17	139	49	231	61	104	66	231	15	5	0	20
Pune	643	135	778	44	134	59	36	46	319	53	23	243	319	18	64	377	459
Total	6205	3440	9645	142	2833	1861	765	1644	7245	2138	3300	1807	7245	259	200	1941	2400

Note:

O/S : Outstanding

(I) Recommendations
(II) Awards
(III) Dismissal awards fvg. Ins. Co.
(IV) Withdrawal
(V) Not-entertainable

(A) Within 3 months
(B) 3 months to 1 Year
(C) Above 1 Year

OFFICE OF THE EXECUTIVE COUNCIL OF INSURERS

Complaints Received & Disposal statement for the period from 01.04.2019 to 31.3.2020

STATEMENT L1G1H1

LIFE , GENERAL & HEALTH INSURANCE

Name of the centre	Total No of Complaints			Complaints disposed by way of						Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the beginning of the year	Received upto March	Total	(I)	(II)	(III)	(IV)	(V)	Total Disposed	(A)	(B)	(C)	Total Disposed	(A)	(B)	(C)	Total Outstanding
Ahmedabad	2335	2333	4668	0	236	155	414	1279	2084	1319	64	701	2084	235	753	1596	2584
Bengaluru	253	1358	1611	17	536	412	30	538	1533	1191	342	0	1533	78	0	0	78
Bhopal	308	1034	1342	116	72	429	73	609	1299	844	324	131	1299	43	0	0	43
Bubaneshwar	225	975	1200	9	258	159	52	569	1047	607	316	124	1047	153	0	0	153
Chandigarh	1314	3028	4342	0	1445	935	0	1414	3794	1595	1706	493	3794	375	173	0	548
Chennai	186	1621	1807	9	437	225	122	910	1703	1159	544	0	1703	104	0	0	104
Delhi	540	1804	2344	1	816	647	143	660	2267	1092	1169	6	2267	77	0	0	77
Guwahati	0	617	617	0	118	93	33	352	596	596	0	0	596	21	0	0	21
Hyderabad	178	1826	2004	5	667	257	71	880	1880	1195	683	2	1880	123	0	1	124
Jaipur	0	905	905	21	193	113	93	422	842	831	11	0	842	63	0	0	63
Kochi	651	1554	2205	0	710	765	107	546	2128	803	1094	231	2128	71	4	2	77
Kolkata	1764	2093	3857	5	791	349	234	704	2083	752	185	1146	2083	371	901	502	1774
Lucknow	699	988	1687	227	156	375	144	572	1474	610	238	626	1474	102	98	13	213
Mumbai	965	3467	4432	14	1619	455	280	1480	3848	1791	1998	59	3848	451	133	0	584
Noida	327	1368	1695	175	406	162	197	522	1462	698	759	5	1462	207	26	0	233
Patna	222	565	787	16	108	88	230	294	736	392	275	69	736	41	10	0	51
Pune	1314	1721	3035	65	281	91	122	481	1040	517	57	466	1040	292	895	808	1995
Total	11281	27257	38538	680	8849	5710	2345	12232	29816	15992	9765	4059	29816	2807	2993	2922	8722

Note:

O/S : Outstanding

(I) Recommendations **(III) Dismissal awards fvg. Ins. Co.**

(II) Awards **(IV) Withdrawal** **(V) Not-entertainable**

(A) Within 3 months

(B) 3 months to 1 Year

(C) Above 1 Year

CLAIMS

A brief on Claim Handling by Insurance Companies

CLAIM HANDLING BY INSURANCE COMPANIES

I. INTRODUCTION

Claim is a moment of truth as far as an Insurance policy is concerned. The expectation of the policyholder is whenever the claim amount has fallen due, the insurer honors the claim and makes the payment of the insured amount at the earliest and with least possible inconvenience whereas the insurer would want to pay the claims only after due satisfactory compliance of all the requirements for making the payment in accordance with the policy terms and conditions. Paying claims without proper examination can result in a situation where fraudulent claims also get entertained and paid. This could impact the financials of the company putting in jeopardy the very solvency of the insurance company.

Therefore, the claim handling is a critical function of an insurer which has to be carried out with diligence and prudence without adversely affecting the customer service.

II. Root cause of claim settlement related complaints

Based on consolidation of submissions made by Insurers and our own analysis, the following issues have been identified as root cause of claim settlement related complaints:

A. In respect of Life Insurance Companies

- Non- submission or delay in submission of documents like KYC, hospital/medical records or payment mandate details by the claimant.
- Delay in processing of claim due to Incorrect or incomplete contact details given by the claimant, as it become difficult to establish contact with the claimant for any requirement or clarifications.
- Non-availability of complete Police records such as Final Police Investigation Report, Chemical Analysis/ Viscera Report, etc which could take time.
- Claims coming from Tier 3 or rural areas take longer time as records are either not properly maintained or are maintained in manual registers
- Operational constraints in terms of geographies and climactic conditions i.e. customers based in remote locations, heavy rainfall / snowfall etc.

- In the absence of any law / guidelines, hospitals sometimes refuse to share information or provide the required information / documents causing significant delays in claim settlement.
- Absence of credible identity of customers like social security number etc. restricts ability at times to identify and establish the right identity of the customer at hospitals and from treatment records and this becomes a constraint in settling claims
- Non co-operation from Employers –when asked for pay slips, leave records.
- Authorities when hand in glove with fraudsters, especially Gram Panchayat and Aanganwadi workers
- Cases where title is not clear or pending in court for decision with respect to right beneficiary to whom payment is to be made, causes delay in settlement of such claims even though the decision has been taken to pay the claim.

B. In respect of General Insurance Companies

- Non-submission and non-cooperation in providing required document or information by insured or insured's representative.
- Non-submission of complete information in one go by the customer, majorly financial documents, KYC and NEFT details etc.
- Delayed submission of requirements by customer post communication of deficiency
- Some cases require further investigation to rule out suspected fraud / Abuse which requires additional time
- Dependency on leaders for Co-insurance & Re-insurance claims
- Delay in receipt of premium subsidy from Government for Govt. sponsored scheme
- Delay in reporting of claim by insured for survey
- dispute between insured and financier resulting in delays in the claim settlement process
- Delay in responding to the queries raised by Surveyor/ Insurance Company.

The following issues were observed to be concentrated to specific line of business:

1. In respect of health Insurance:
    a. Non-utilization of cashless facility by the customer even in case of network adequacy leading to higher requests for reimbursement

b. Non-standardized hospital documents leading to the need of verification to avoid any abuse scenario
c. Transition from one Third Party Administrator to another
d. Dependency on receipt of documents from hospitals causes delay
e. Non-disclosure of personal medical information at the time of buying of policy (which require verification at claim stage).
f. Verification of pre-existing conditions and/or ailments
g. Lack of previous claims history in case of ported policy
h. Detailed verification is done in case of claims from suspicious hospitals.

2. In respect of Motor Insurance:
   a. Delay in repair of vehicles in the workshop due to non-availability of spare parts, delayed clarification from customer on queries raised etc.
   b. Delay in cancellation of Registration Certificate of vehicle in respect of total loss claims.
   c. Delay in receiving the untraced report from police authorities in respect of theft claims
   d. Verification of Driving License with Road Transport Authorities in cases where details are not available online.
   e. Repair invoices are not handed over to the company / surveyors by the garages which results in delay of settlement of the claims.
   f. Vehicle produced with delay for inspection/survey due to vehicle being placed in police station, involvement of death in accident etc.

3. In respect of Fire and Marine Policies:
   a. Reinstatement of property consumes significant time

4. In respect of Agriculture Insurance:
   a. Issues of mapping of Villages with Notified units in Ministry of Agriculture, Government of India portal.
   b. Issues of non-uploading of farmers' data by some banks in Ministry of Agriculture, Government of India portal.

The above list is an illustrative one- not exhaustive.

III. INITIATIVES BEING UNDERTAKEN BY GENERAL INSURERS TO ENSURE EXPEDITIOUS SETTLEMENT OF CLAIMS:

Based on consolidation of submissions made by Insurers, various Initiatives being undertaken by the Insurers to ensure expeditious settlement of claims are reproduced below:

Cashless facility Awareness:

- Continuous communication with customer informing of availability and promotion of seamless claim experience using cashless facility.

Communications:

- Proactive communication- Emails, SMS and outbound calling to explain the documents requirement, computation of quantum of claim to be settled and reason for deductions if any through customer service executives.
- System triggered SMS to insured at various stages of the claim like – surveyor assignment (with surveyor details), post survey completion, post payment etc.
- Focus on the personal touch base with the customer via Outbound calling at each event, these are in other words customized assistance which help in understanding /answering the queries at first interaction.

Documents related:

- Claim form with checklist to assist the customer in submission of all information/documents in one go.
- Separate calling to insured to explain a complicated query (if any) raised in the claim
- Meetings with the Insured and/or Intermediary to ensure the documentation is completed in time for settlement.
- For Personal Accident claims a document collection agency is hired to reach the nominees in rural areas, to help in understanding the document requirement and to help in procuring the same, post which the documents available with the nominee will be shared with Insurer. This enable to process claims at the earliest
- Where the admissibility of the claim is otherwise established, requirement of submission of medical information (in Part B of the claim form) is waived off to expedite claim settlement. (Health)

- Wherever Registration certificate and driving license original is not available, the same is validated in the online government portals by the Company.
- Where the customer is unable to produce hospital records, Insurer contacts the hospital directly with the consent of the customer and obtains the relevant records.
- Explore / discuss and offer market value settlement as & when Insured is unable to Provide reinstatement documents. (Commercial claims)

Monitoring of Intermediaries (Surveyors, TPAs etc.):

- Periodic peer to peer review of claims.
- Frequent review of Surveyors for submission of survey reports ensuring strict surveyor management.

Monitoring and Review of claims:

- Monitoring of claims on a regular basis by a dedicated team at Corporate level.
- Robust monitoring system with daily, weekly and monthly frequencies for Review and Speedy settlement of claims

On account payment:

- "On Account" Payment: Pending final assessment of a claim, an "on account" payment is considered subject to confirmation of Loss due to Occurrence of a peril covered by the policy, Establishment of liability, The minimum liability that might arise under the policy.

Self-survey:

- With a view to provide seamless claims journey to the customer, the Insurer provides the customers an option to undertake self-survey in case of claims up to Rs. 50,000/-.

Travel claims:

- Direct initiation of claim based on delay information garnered by the Insurer for common carrier delay claims in domestic travel. Customer is only required to upload the boarding pass to receive claim amount.

Repair related:

- In case insured finds it difficult to comply with the requirement Insurer probes possibilities with the surveyor of arriving at the loss assessment for settlement of the claim
- Spot settlement facility to customers where immediate disbursement is made as per assessment without even waiting for the repairs to be completed

Website/Application/portal facility:

- The surveyors are equipped with Tab based application for end to end claim processing which improves the turn around time for settlement. An Application for conducting survey through live streaming is introduced to speed up the claim survey and settlement
- Hospital portal developed where network hospitals can upload the documents on the portal and get authorization approval within 30 minutes.
- Garage mobile app where workshops can also upload the documents in the event of the customer leaving the vehicle and the documents at the cashless workshops.
- Access to Claims module provided to Investigators for seamless submission of reports
- Launched Mobile app to enable customers to access all services over the phone. Tracking system, accessible by the insured to find out the status of his claim
- Quick claim settlement module developed where Health claims Upto Rs 25,000/- would be settled on submission of copy of documents through mobile app.

Motor Third Party Claims:

- For Third Party claims wherever the claims are prima facie admissible, approach the claimant for compromised settlements.

Decentralisation of authority:

- Decentralized claim approval to ensure quick settlement of claims within the respective zone
- Field settlement authority from the range of 10K to 50K to the surveyors for speedy settlement of claim.

Tieups with garages:

- Tied-ups with repair centers to convenience claim settlement for its customers. They are also given an option to get vehicles repaired at a garage of their choice and get the agreed claim

amount settled. In the latter, the Company also offers to make advance payment of a certain amount of the claim to the customer to enable claim servicing in case of admissible claims.

Crop Insurance:

- Co-observance of Crop cutting experiments along with use of mobile app for fast assessment of claims.

Miscellaneous:

- Concurrent processing of claims while the survey and assessment is still in progress.
- Joint Meeting are held with insured, surveyors and intermediaries to resolve disputes and other differences to take the claim forward for completion of survey report.
- In-house team of Claims surveyor for expeditious survey of claims
- Annual Functional Trainings in all Lines of Business

IV. INTERMEDIARIES IN HANDLING OF CLAIMS

Surveyors and loss assessors in non-life and third party administrators in health insurance are the most important intermediaries who have a significant role in claim handling. Ensuring that these intermediaries function properly is the most critical to the discharge of claim related functions by insurers.

Surveyors and loss assessors are appointed by the insurer for surveying and assessing the loss caused when a claim is reported. The report is required to be furnished to the insurer. The insurer would decide upon the claim and may use the report of the surveyors and loss assessors but are not bound by it. The timeliness in appointment and conduct of survey and furnishing a report, the professionalism displayed in their functioning and the quality of the report determines the speed and quality of settlement of claims by insurers.

In case of health insurance, Third party administrators are the most important intermediaries handling policyholder servicing issues. Providing of cashless facility and settlement of reimbursement claims is facilitated by TPAs. The professionalism in conducting both these functions determines the smoothness of claim handling by insurers.

V. COMPLAINTS RELATED TO CLAIMS

Once a claim has been unduly delayed or repudiated by the insurer, there is a cause for complaint. The claimant takes up the matter first with the insurer. All the insurers have put in place internal mechanism to deal with such grievances and resolve them. The resolution of claim related complaints also generally includes review of the decision on claims by a Committee. After review, the decision on the claim is conveyed to the complainant.

Once the complaint is not internally redressed, the claimant is forced to seek adjudication of the dispute. For this purpose, he may approach an insurance ombudsman, consumer forum or a civil court and later take it through the appellate channels if redress is not to his satisfaction.

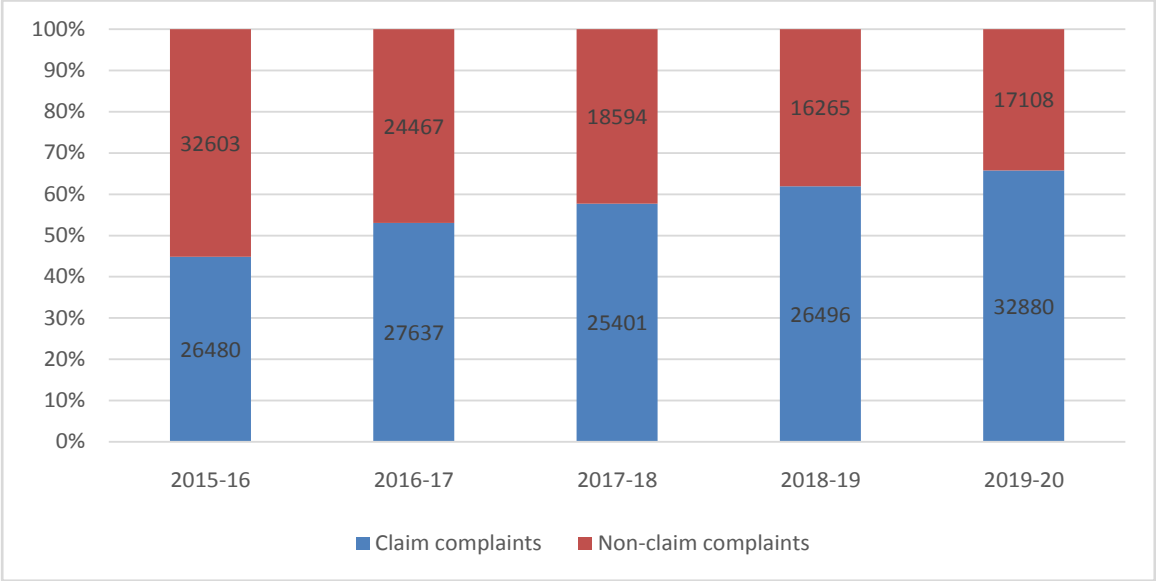
The statistics on claim related grievances indicate that in the Non-Life Sector, claim related complaints constitute a major proportion to the total complaints as compared to the life insurance sector.

The data relating to claim related complaints as obtained from the Integrated Grievance Management System, is as follows:

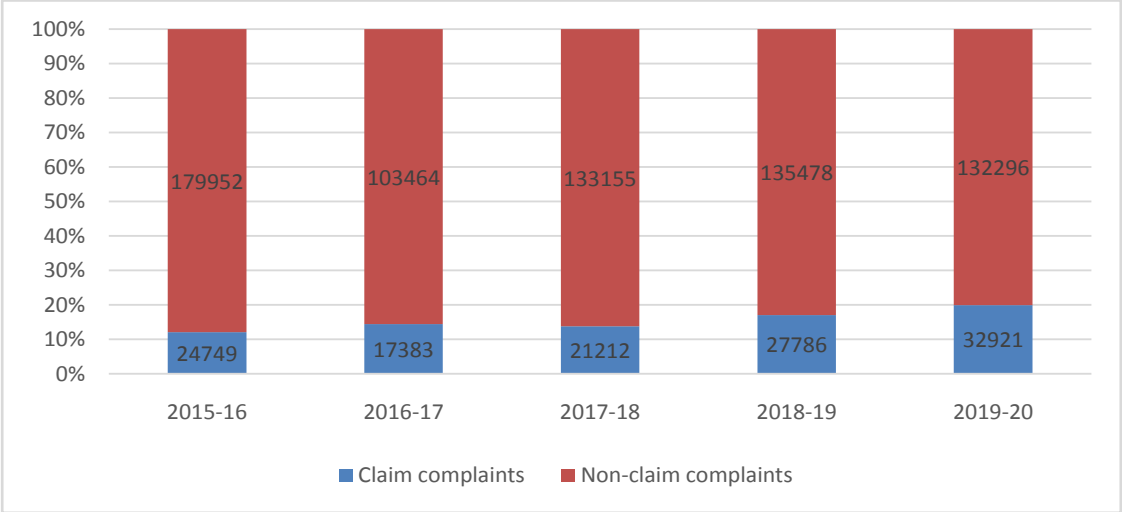
Year	No. of Claim complaints	% increase / decrease compared to last year	Total complaints	% of Claim related complaints to total complaints
NON-LIFE COMPLAINTS				
2015-16	26480	0.05%	59083	44.82%
2016-17	27637	4.37%	52104	53.04%
2017-18	25401	-8.09%	43995	57.74%
2018-19	26496	4.31%	42761	61.96%
2019-20	32880	24.09%	49988	65.78%
LIFE COMPLAINTS				
2015-16	24749	-20.36%	204701	12.09%
2016-17	17383	-29.76%	120847	14.38%
2017-18	21212	22.03%	154367	13.74%
2018-19	27786	30.99%	163264	17.02%
2019-20	32921	18.48%	165217	19.93%

(Source: Integrated Grievance Management System of IRDAI)

Trends in claim related complaints under Non- Life Insurance:



Trends in claim related complaints under Life Insurance:



Claim related complaints as % of total complaints has been increasing over the years in respect of Non-Life Insurance complaints. Claims related complaints constitute less than 20% of total complaints against Life Insurance companies whereas they are more than 50% in respect of Non-Life Insurance companies. This clearly shows that claim handling is a serious customer service issue in Non-Life insurance.

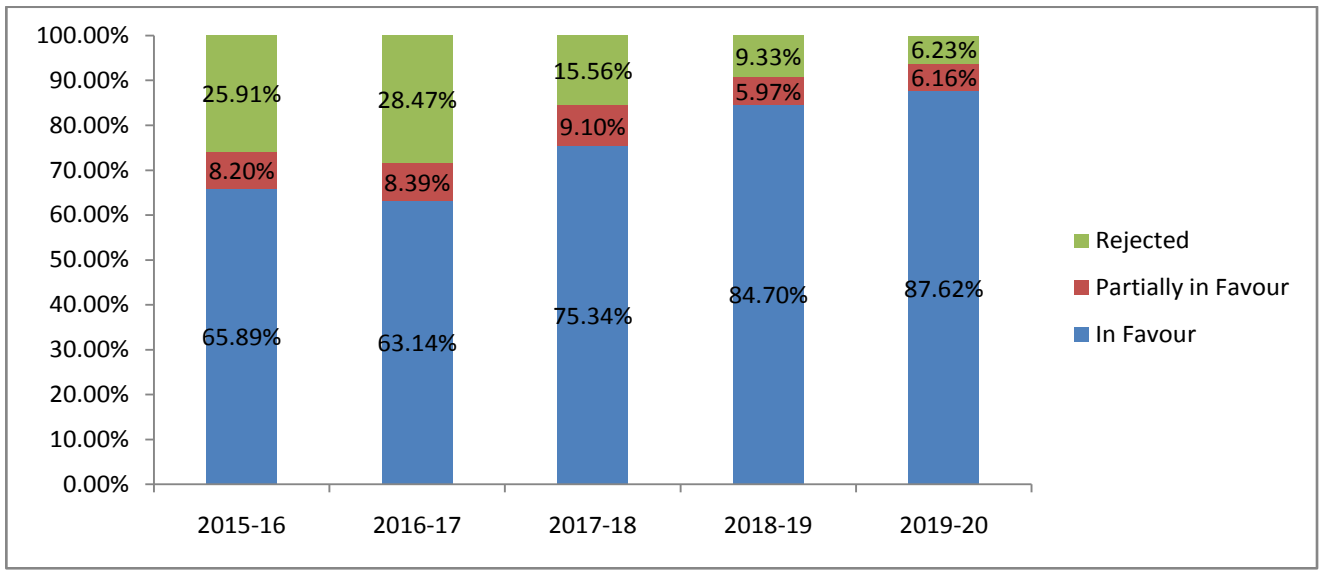
The major claim related complaints as per IGMS are as follows:

1. Insurer not disposing of the claim.
2. Difference between the amount claimed and the amount settled by the Insurer

3. Insurer reduced the quantum of claim without providing proper reasons.
4. Insurer repudiated the claim due to alleged breach of policy condition/ warranty.
5. Claim repudiated without giving reasons

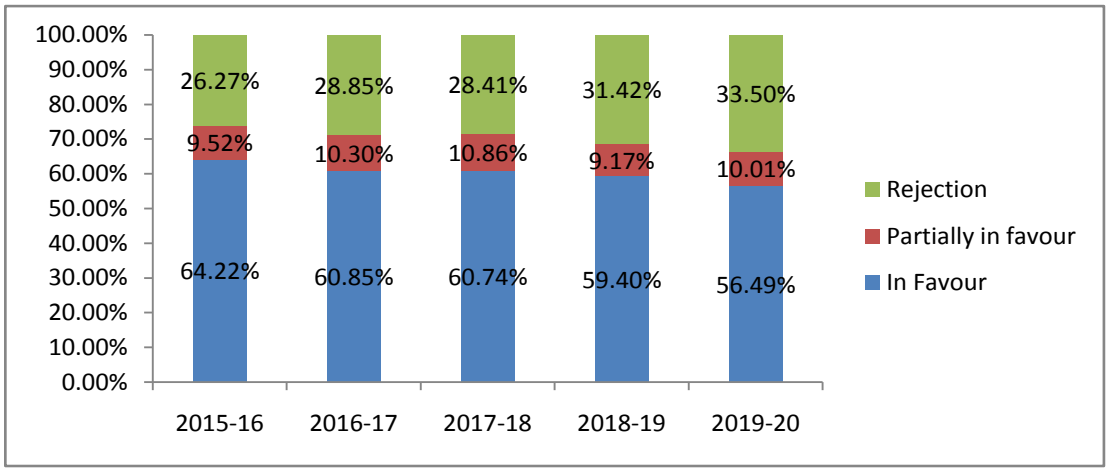
VI. DISPOSAL CLASSIFICATION OF CLAIM RELATED COMPLAINTS IN IGMS

In respect of Life Insurers (including survival and death claims):



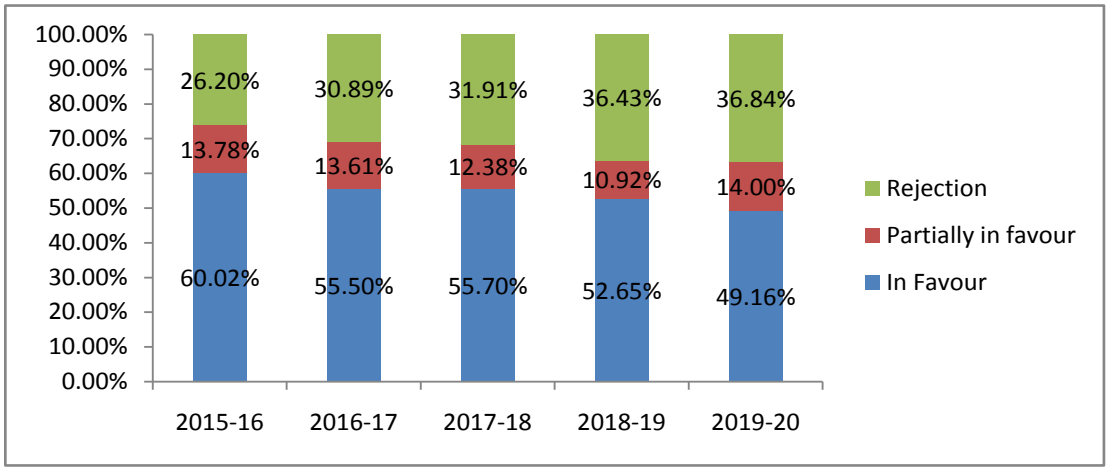
Percentage of complaints being disposed in favour of the complainant has shown a good increase over the years. (from 65.89% in 2015-16 to 87.62% in 2019-20).

In respect of General Insurers: (i.e., excl. Stand Alone Health)



Percentage of complaints being disposed in favour of the complainant has reduced over the years (from 64.22% in 2015-16 to 56.49% in 2019-20).

In respect of Stand Alone Health Insurers:



Percentage of complaints being disposed in favour of the complainant has reduced over the years (from 60.02% in 2015-16 to 49.16% in 2019-20)

VII. LEGAL AND REGULATORY FRAMEWORK

The regulatory framework and institutional arrangement for processing claims expeditiously and resolving grievances relating to claims is discussed below in brief:

Section 45 of Insurance Act, 1938:

Section 45 offers protection to policyholders of Life Insurance by holding that a policy cannot be questioned by the Insurer after 3 years from the date of issue of policy (or date of revival or date of rider) saying that there was a fraud or misrepresentation by the policyholder while taking the policy or revival.

A. Regulations:

- IRDA (Protection of Policyholders' Interest) Regulations, 2017 constitutes the regulatory framework for the protection of policyholders' interests. In terms of Regulation 17 of the above mentioned regulations, every insurer should have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed. Regulation 14, 15 and 16 deals with claims procedure in respect of life insurance, general insurance, and health insurance policy respectively.

The Turn Around Time (TAT) for claims related services as per the Regulations are as follows:

	CLAIM SERVICE	Turn Around Time
	LIFE INSURANCE CLAIM	
1.	Maturity claim / survival benefit / penal interest not paid	On/Before due date
2.	Raising claim requirements after lodging the claim	15 days
3.	Death claim settlement/ Repudiation (without investigation requirement)	30 days
4.	Death claim settlement / Repudiation (with investigation requirement)	4 months
	NON-LIFE INSURANCE CLAIM	
1.	Surveyor appointment	72 hours
2.	Survey report submission (except commercial and large claims)	30 days
3.	Insurer seeking addendum report	15 days
4.	Additional report submission	3 weeks
5.	Offer of settlement / Rejection of claim after receiving 1st / addendum survey report	30 days
	HEALTH INSURANCE CLAIM	
1.	Health claim settlement/ Repudiation(without investigation)	30 days
2.	Health claim settlement/ Repudiation(with investigation)	45 days

- In terms of Regulation 14(2)(iv), Regulation 15(10) and Regulation 16(2)(i) where there is a delay on the part of the insurer in payment of life insurance claims or non-life insurance claims or health insurance claims respectively, the insurer is required to pay interest @ bank rate plus two per cent for the delay.
- IRDAI (Appointment of Insurance Agents) Regulations, 2016, IRDAI (Registration of Corporate Agents) Regulations, 2015, IRDA (Insurance Brokers) Regulations, 2018**,** IRDAI (Third Party Administrators – Health Services) Regulations, 2016 and IRDAI (Insurance Surveyors and Loss

Assessors) Regulations, 2015 stipulate Code of conduct for insurance agents, corporate agents, Brokers, TPAs and Surveyors respectively wherein aspects relating to claims are also specified.

- IRDAI has issued Circulars Ref No IRDA/HLTH/MISC/CIR/216/09/2011 dated 20-9-2011, Ref. No: IRDA/NL/CIR/MISC/149/06/2017 dated 28-06-2017 in respect of delay in claim intimation/document submission with respect to all life insurance contracts and non-life individual and group insurance contracts. IRDAI advised all companies not to repudiate delayed claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.

B. Grievance Redressal System

- To enable timely resolution of grievances, IRDAI has issued Guidelines for Grievance Redressal by insurance companies on 27 July 2010 according to which every insurance company is required to acknowledge grievances within 3 working days and resolve complaints within two weeks.
- Grievance cell in the Consumer Affairs Department of IRDAI also receives complaints from policyholders which include those relating to claims. The complaints are registered and forwarded to the insurers for resolution under advice to the complainants. The insurers are required to examine the complaints and resolve the same within two weeks.
- Where the complaints are not resolved to the satisfaction of the complainant, the complainant can take up the matter with the Insurance Ombudsman or any other appropriate forum.

C. Insurance Ombudsmen in Mediation and Adjudication of Claim related grievances

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 17 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction
- The basic framework for functioning of Insurance Ombudsman is outlined in Insurance Ombudsman Rules, 2017.
- The grounds relating to claims for which a complaint can be made to the Insurance

Ombudsman are prescribed under Rule 13(1) of Insurance Ombudsman rules, 2017. Grounds under which a claim related complaint can be made with Ombudsman is as follows:

(a) Any partial or total repudiation of claims by an insurer.

(b) Any dispute on the legal construction of the policies in so far as such disputes relate to claims.

(c) Delay in settlement of claims.

- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the compensation amount sought is less than Rs.30 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 30 days of the receipt of the award from the Ombudsman and it shall intimate the compliance to the Ombudsman.
- IRDAI in order to monitor the non compliance of the award of Insurance Ombudsman has issued Circulars Ref: CAD/Insu.Omb/10-11 dated 23-11-2010, Ref: IRDAI/Cir/Misc/194/11/2015 dated 03-11-2015, Ref No. IRDAI/CAD/CIR/MISC/063/03/2016 dated 01-04-2016 and Ref No. IRDAI/CAD/CIR/MISC/038/03/2019 dated 05-03-2019. In cases where the Insurer prefers an appeal against the order of the Judicial/Quasi Judicial body, such appeal against the order should be preferred with the stipulated time limit as per the rules applicable.

D. Supervision and Regulatory action

- IRDAI monitors the claims payment position of the insurance companies by collecting the claims payment data quarterly.
- IRDAI monitors the claim handling systems based on the complaints registered in the IGMS.
- IRDAI regularly inspects the books of the insurance companies which includes the examination of systems and procedures relating to handling of claims, practices of making payment as well as compliance with various regulatory requirements relating to claim handling. Whenever any deviations are noticed regulatory action is initiated.

VIII. INITIATIVES BY INSURERS

Insurers themselves also take several steps for better claims handling. The steps include giving the claim related documents and the list of documents to be submitted along with the policy document itself, having a claim review committee headed by independent persons of repute from the industry / judiciary. The monitoring, supervision and constant interaction with the intermediaries like surveyors/loss assessors, TPAs etc. also enables these intermediaries to perform their responsibilities in accordance with regulations issued by IRDA and the Code of Conduct specified for them.

IX. CLAIMS AND LITIGATION

The basic principle on which insurance operates is 'uberrima fides' i.e. principle of utmost good faith. The good faith is applicable equally to insured as well as the insurer. The insured gives all the information required in the proposal form and the insurer has to give the information about the products like terms, conditions, warranties and exclusions in documents of offer like prospectus, brochure, advertisement etc. and also make them part of the policy document. The Insurer designs policy and the policy terms and conditions are prepared which could at times put customer to disadvantage. Since the insurer knows only those things about the insured and the risk as is disclosed by him in the proposal, any failure to disclose renders the position of insurer difficult. The insured has chosen to buy the insurance product and is presumed to have satisfied himself about the product as the principle of 'caveat emptor' or 'buyer beware' applies to insurance as well. Protection to an extent is provided to the insured through the 'contra proferentem' rule. As the decision to underwrite a policy is supposed to be taken by the insurer after obtaining all information necessary for understanding the risk and the policy terms and conditions being standard forms drafted by the insurer, while interpreting the clauses of contract, any unclear term is interpreted in favour of the insured and against the insurer. The interplay of these principles, provides reason for disputes in insurance.

Disputes in insurance are basically disputes in contract and have to be taken up in a civil court. To provide scope for settling the disputes through alternate dispute resolution mechanisms, the institution of Insurance Ombudsmen has been created by Government of India under the Redressal of Public Grievances Rules, 1998. However, only disputes on personal lines of insurance and where compensation sought is less than Rs. 30 lakhs can be taken up with Insurance Ombudsman. Absence

of mechanisms of appeal against Awards or for enforcement of Awards make the legal recourse the only alternative for persons or insurers aggrieved by unsatisfactory Awards.

In case of commercial lines of insurance, while resolution through Arbitration and Conciliation is provided for, the Arbitration Awards do not provide finality leaving room for litigation even after arbitration. Further arbitration clause is provided in general for partial repudiation cases of claim and not in cases of denial of claim.

With the increasing publicity about the recourse to Consumer Fora under the Consumer Protection Act, 1986 (now superseded by The Consumer Protection Act, 2019), the volume of cases before Consumer Fora on matters of insurance has also been increasing with more and more people taking recourse to Consumer Fora alleging deficiency of service. The delay in resolving a case before the District Forum and the several years taken in disposal of appeals by State Forum and National Forum because of the huge volume of cases pending before these fora have rendered the recourse to Consumer Fora ineffective in the expeditious resolution of insurance related disputes.

In order to provide a separate forum for dealing with cases relating to third party claims in case of motor accidents, the Motor Accident Claims Tribunals have been set up under the Motor Vehicles Act. Several of these Tribunals are in operation across the country. The number of cases pending before these Tribunals is huge and the time taken for disposal owing to the involved processes, is also substantial. There is no finality to the decisions as cases where the claimants feel that the compensation ordered is too low, they go for Appeal to the High Court and where the insurer feels that the compensation ordered is too high, the insurer goes on an Appeal leading to increased number of appeals before High Court and if further appealed against, before the Supreme Court. The difficulty in resolving disputes about motor accidents arise of the onerous task of assessing the value of human life lost in the accident and there can always be divergence of views of either party leading to litigation and escalations in the form of appeals. A straight jacketed formula is difficult to implement. However, there is sufficient scope of settlement of disputes at the earliest to save the financial burden in the form of absence of any earning of the deceased, cost of filing a case and pursuing it and the consequent time value of the money ordered at some remote time after the loss occurred.

In addition to these, disputes regarding claims in other non-life insurance policies which are not on personal lines are taken up before Civil Courts, where long time is taken in deciding the matter, owing

to the involved processes. Even after decision of the Court is received, there is the option of Appeal leading to delay in finality of the decision.

X. INSURANCE AWARENESS

Insurance awareness can help persons taking insurance to be more aware about the nuances of insurance, what to disclose and what to look for in an insurance product, how to understand the insurance product and comprehend the terms, conditions, exclusions and warranties in the insurance policy. When this meeting of minds of insurer and the policyholder/claimant about mutual rights and obligations is there, disputes warranting litigation would not arise. In non-life insurance, underwriting includes risk assessment. Therefore, suggesting the suitable insurance policy and also mechanisms of mitigating risks can be an important service provided by the insurer to the policyholder. Building insurance awareness and bringing in more transparency in policy terms and conditions through simplification of language can help in interpretational problems in claim handling, avoiding an important reason for a lot of litigation in claims.

XI. CONCLUSION

Insurers should have proper systems in place for quick and proper handling of claims. Providing a reasoned and timely decision about the claim can help mitigate the agony of the claimant in approaching various channels only to understand why there is a delay and what is the reason for repudiation of claim in full or in part. A suitable mechanism at insurer's level to ensure that this information would be provided promptly would reduce the number of complaints relating to claims.

MIS-SELLING & SPURIOUS CALLS

A brief on Mis-Selling and Spurious calls in the Life Insurance Sector

MIS-SELLING IN LIFE INSURANCE SECTOR

I. INTRODUCTION

Mis-selling in common parlance refers to unfair or fraudulent practices adopted at the time of soliciting and selling insurance and generally includes selling policies which have not been sought by the customer or which are different from what the customer wanted or was promised or where the product offered for sale is not suitable to the needs of the customer. Therefore, misselling in insurance could be described as selling a product/service to a customer in a manner which is detrimental to his/her interest.

II. CAUSES OF MISSELLING COMPLAINTS

The following issues have been observed as causes of mis-selling complaints:

a) Incorrect explanation of product features and benefits by Sales person sourcing the business.
b) Regular premium paying product is sold as single premium product.
c) Policy is sold to prospects assuring Loan / Bonus / Medical Benefits/ Gold coins/Mobile towers/other benefits upon purchase of insurance policy.
d) Tampering, forgery of proposal/ other related documents.
e) High attrition rate amongst Sales team wherein the sales person move from one Insurer/Intermediary to another and instigate policyholder to surrender the existing policy and to take a new policy
f) Inducements such as rebate (commission are offered while sourcing the policy)
g) Undue pressure on the sales person to meet sales target.
h) Free look cancellation requests are rejected by Sales personnel who are not authorized to take such decisions.
i) Splitting of policies wherein multiple policies are issued to the same proposer at the same time.
j) Life Insurance policies are sold as Tax saving/ Investment plans.
k) Sales personnel are inadequately trained, thereby recommending unsuitable products to prospects.
l) Improper/Incorrect financial needs assessment of Prospect is done while sourcing the policy by the sales personnel.
m) Charges under the policy and lock in period are not properly explained while sale of Unit Linked Insurance Policies.
n) Lack of awareness on insurance on the policyholder's part thus being misled into buying the insurance policy.
o) Policyholders not reading policy terms and conditions at point of sale
p) Policyholders failing to cross-check details

q) Financial Problems/incapacity of the policyholder to pay future premiums
r) Insurance made a condition to avail loan/locker facility etc. at bank
s) Debit of bank accounts with Insurance Premium without explicit consent

The following points may be borne in mind while buying Life Insurance:

- Buy only from a IRDAI registered insurer or through its authorized agent/intermediary. The list of registered insurers can be found on IRDAI website.
- Go through the contents of proposal from, benefit illustration and other enclosures provided by Sales Person before signing.
- Ensure that particulars of your existing policies are disclosed to the Insurer in the proposal form. This would not only help the Insurer in underwriting but could also prevent disputes in future.
- Ensure that complete and factual information is provided in the proposal form and no portion of the form is left unanswered. False or misleading information could lead to disputes.
- If you are not filling the proposal form yourself, ensure that the contents are fully explained to you.
- Do not fall prey to the spurious calls done in the name of IRDAI/Other governmental organizations promising bonus, loan or other benefits.
- Make sure you understand clearly:
    - Whether your policy has a single premium or regular premium
    - What your policy term and premium paying term are. They can be different
    - What your surrender value is. It can be less than the premiums you have paid
    - What is covered and what is not covered
    - Understand the returns and bonuses, what is guaranteed and what is not
- In the case of Unit-Linked insurance policies (ULIPs):
    - Make sure you understand the implications of bearing the investment risk yourself
    - Evaluate the performance of the funds before you invest
    - Understand the various charges levied under the policy
- When you receive the policy bond:
    - Make sure it matches the terms proposed/ agreed by you
    - If they don't, you can cancel Life Insurance policy during the 15 day "free-look" period from the date you receive the policy bond.(30 days if the Life Insurance policy is an electronic policy/purchased through Distance Mode)

III. IMPACT OF MIS-SELLING

Sales related complaints affect the sentiment about the insurance sector. This in turn may impact the initiatives aimed at enhancing the level of insurance inclusion as measured by indicators such as insurance penetration (measured as ratio of premium to GDP) and insurance density (measured as ratio of premium in USD to population). Increased incidence of mis-selling can adversely impact growth in the insurance industry which in turn would impact the availability of long term funds for economic development from the insurance sector. Hence, while there is need to assess and eradicate

mis-selling from insurance industry, there is also a need to reassure general public that the regulatory framework of life insurance business is sound enough to protect policyholders' interests and grievances, if any, are capable of being resolved by insurers or settled / adjudicated by insurance ombudsmen or consumer fora.

IV. COMPLAINTS OF MIS-SELLING

A. AS PER IGMS STATISTICS

Integrated Grievance Management System (IGMS) introduced by IRDAI in 2011 is a computerized industry-wide grievance repository for the insurance sector. In IGMS, the complaints relating to misselling are included under the broad category of "Unfair Business Practices".

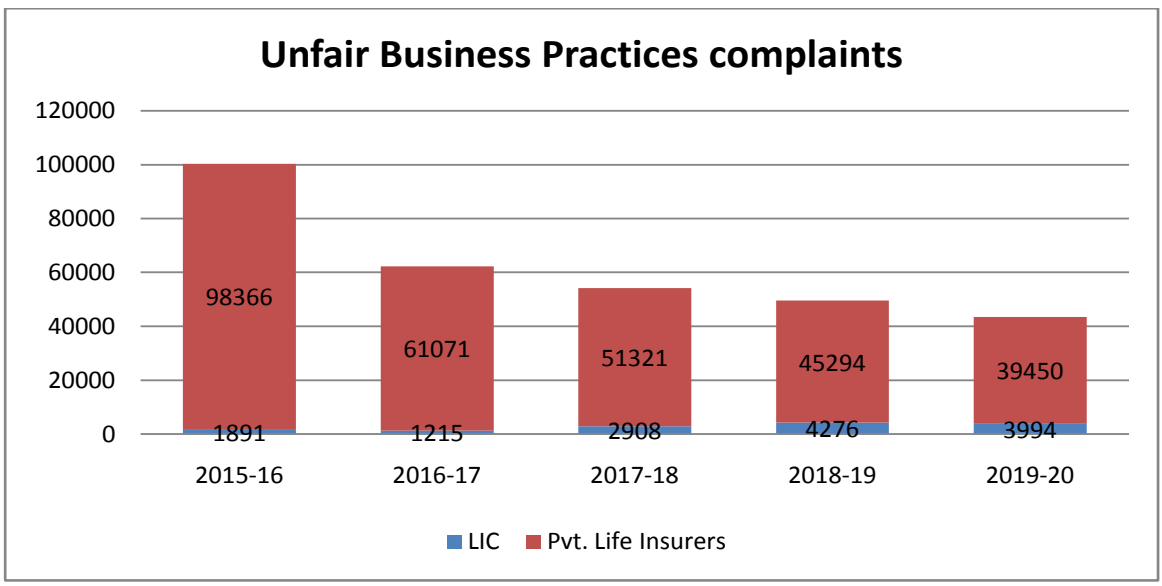
The complaints relating to broad head of 'unfair business practices' consist of complaints falling within the following complaint descriptions:

1. Product differs from what was requested or disclosed.
2. Term(Period) of the policy is different/altered without consent
3. Mode of premium payment differs from requested or disclosed
4. Annuity/Commutation/Cash Option /Rider/other Options not included as requested
5. Proposed Insurance not in the interest of proposer
6. Intermediary did not provide material information concerning proposed cover
7. Single premium Policy issued as Annual premium policy
8. Tampering, Corrections, forgery of proposal or related papers
9. Credit/Debit card debited without consent of Consumer
10. Premium paying period projected is different from actual
11. Surrender value projected is different from Actual
12. Free-look refund not paid
13. Spurious calls or Hoax calls
14. Advice concerning Exclusions/limitations of cover not communicated
15. Illegitimate inducements offered
16. Misappropriation of premiums
17. Malpractices or unfair business practices

The number of complaints relating to misselling in life insurance business as well as the percentage of such complaints to total complaints has reduced over the years. The details are provided in the table below:

Year	Insurer	No. of UFBP complaints	% change over last year	Total Life complaints	% of UFBP complaints	No. of new policies sold	% of UFBP to new policies sold
2015-16	LIC	1891	-19.97%	64750	2.92%	20546749	0.01%
	Pvt. Life Insurers	98366	-31.10%	139951	70.29%	6193339	1.59%
2016-17	LIC	1215	-35.75%	30784	3.95%	20131500	0.01%
	Pvt. Life Insurers	61071	-37.91%	90063	67.81%	6325145	0.97%
2017-18	LIC	2908	139.34%	77184	3.77%	21338176	0.01%
	Pvt. Life Insurers	51321	-15.97%	77183	66.49%	6860602	0.75%
2018-19	LIC	4276	47.04%	102127	4.19%	21433256	0.02%
	Pvt. Life Insurers	45294	-11.74%	61137	74.09%	7254556	0.62%
2019-20	LIC	3994	-6.59%	112005	3.57%	21925106	0.02%
	Pvt. Life Insurers	39450	-12.90%	53212	74.14%	6961463	0.57%

Source: Integrated Grievance Management System and Business Figures-Life of IRDAI



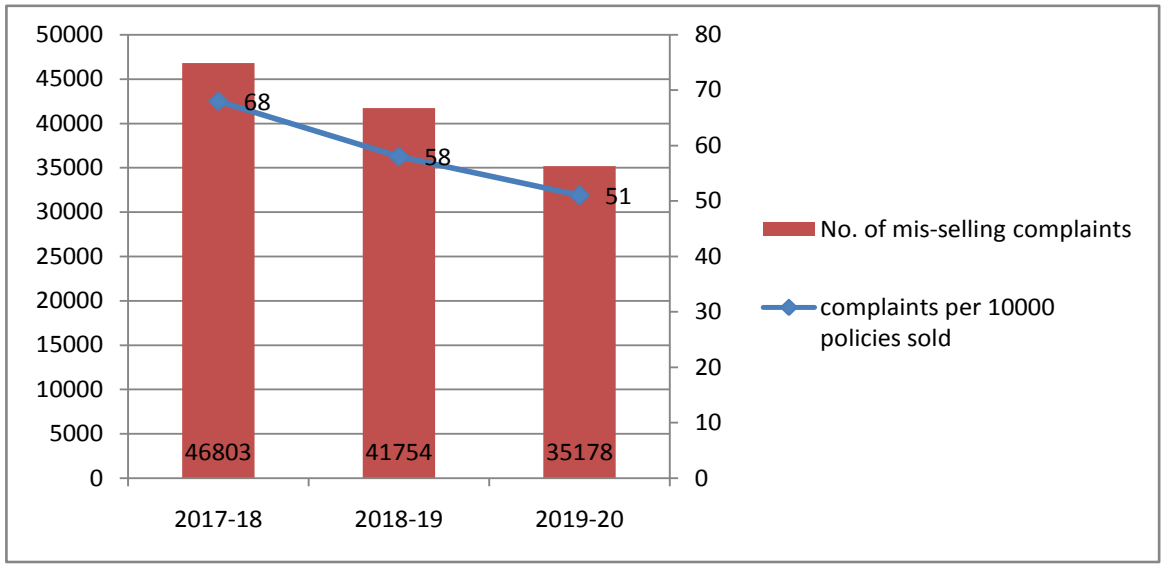
The number of complaints on unfair business practices has been on a declining trend over the past years. In the current year also, there has been 12.36% drop in the number of Unfair business practices complaints over previous year which can be attributed largely to the review made by IRDAI of the grievance redressal machineries of all life insurers and to the subsequent follow up measures taken up by IRDAI. This apart, based on the inputs provided during the review meetings with the GROs effective monitoring mechanism has been put in place by the Life Insurers towards arresting misselling. On the other hand, the multi-pronged insurance awareness campaign by IRDAI towards educating the general public has also resulted into creating awareness on the misselling and consequent reduction in such instances.

The proportion of the complaints on mis-selling to new policies has been on a declining trend over the past 5 years.

B. AS PER DATA SUBMITTED BY INSURERS

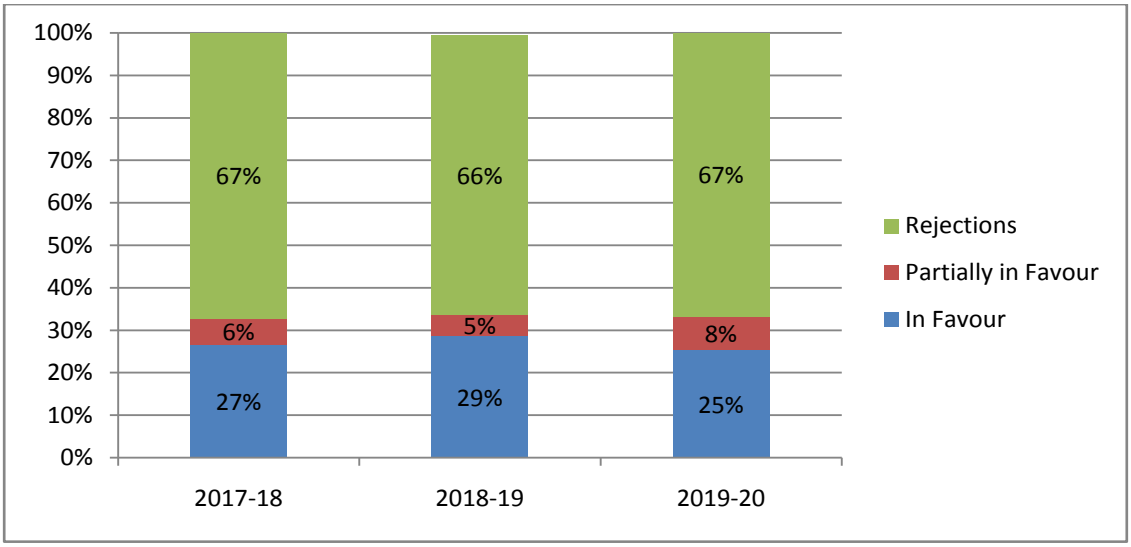
Based on consolidation of data submitted by Private Life Insurers, statistics pertaining to mis-selling complaints are reproduced below:

1. Incidence of mis-selling complaints per 10,000 policies sold



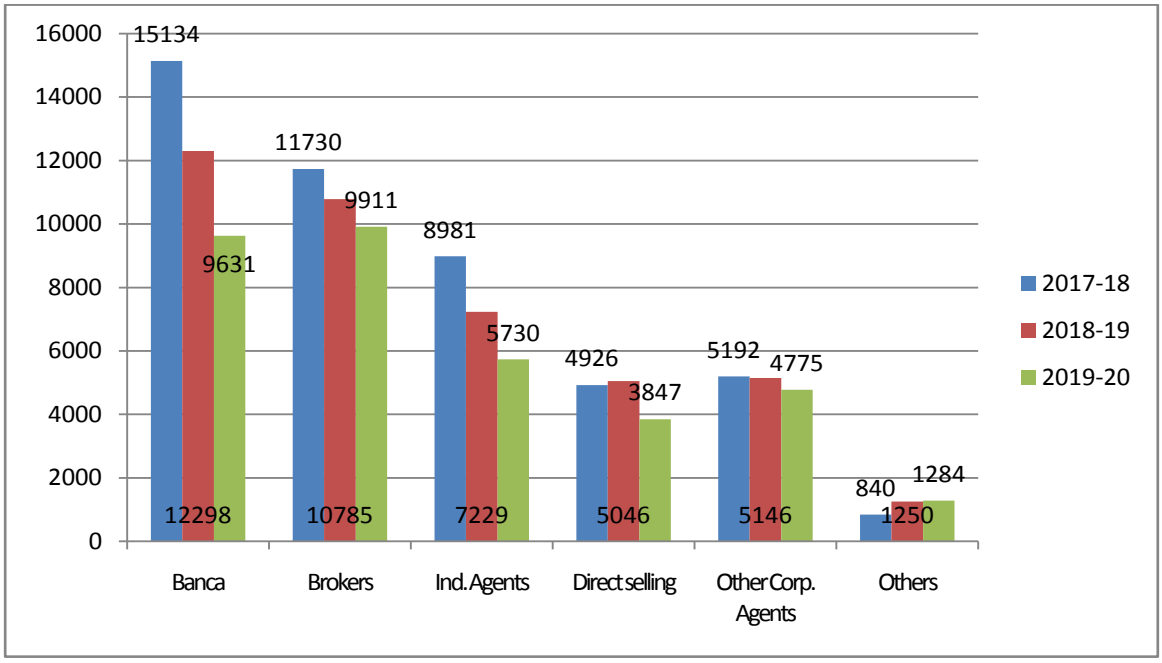
No. of mis-selling complaints have reduced from 46803 in 2017-18 to 35178 in 2019-20 in respect of Private Life Insurers. Incidence of mis-selling complaints per 10,000 policies sold has also reduced over the years.

2. Acceptance status of mis-selling complaints



Percentage of complaints being disposed in favour of complainant has reduced slightly from 27% in 2017-18 to 25% in 2019-20.

3. Channel wise Mis-selling complaints:



4. Major Intermediaries in mis-selling complaints:

			Out of (C) No. of complaints attended to and their resolution classification		
Name of the intermediary	Total Complaints	Mis-selling complaints	In favor	Partially in favor	Against
A	B	C	D	E	F
Smc Insurance Brokers Pvt Ltd	1720	1620	442	269	909
HDFC Bank Ltd	1744	1283	320	22	941
India Infoline Insurance Brokers Ltd.	1385	1205	283	144	778
Axis Bank Ltd	1318	1082	211	133	738
Punjab National Bank Ltd	1166	1023	525	0	498
State Bank Of India Ltd	2712	872	207	2	658
Bank of India Ltd	971	757	396	0	361
Union Bank of India Ltd	885	705	343	0	357
AB Insurance Brokers Pvt. Ltd	786	691	61	170	460
Bank of Baroda Ltd.	781	684	213	0	455
Dealmoney Securities Pvt Ltd	733	678	159	93	426
ICICI Bank Ltd	1220	618	111	5	502
But International Insurance Broker Pvt. Ltd.	627	592	109	56	420
RFL Insurance Broking Pvt Ltd	597	553	123	67	363
Mercury Insurance Brokers Pvt. Ltd	558	523	189	113	221
Indusind Bank Limited	823	507	62	25	420
S B INSURANCE BROKERS PVT LTD	575	490	57	82	351
North India Finserve Pvt Ltd	521	486	81	52	353
Sridhar Insurance Brokers Pvt Ltd	453	416	111	46	259

Note: An intermediary will only appear if it is in the top 10 Intermediaries list (against whom maximum mis-selling complaints were received) of an Insurance company. Therefore, these figures are not total number of complaints registered against the concerned Intermediaries.

V. REGULATORY FRAMEWORK

The regulatory framework for preventing mis-selling and to ensure right selling is discussed in brief.

A. Regulations issued by the Authority:

a. IRDA (Protection of Policyholders' Interests) Regulations, 2017

The basic framework for policyholder protection is contained in these regulations.

The regulations mandate insurer to have in place a Board approved policy for protection of policyholder's which shall at the minimum include steps to be taken for enhancing insurance awareness, Turnaround Time (TAT) for various services rendered, procedure for expeditious resolution of complaints, steps to be taken to prevent mis-selling and unfair business practices, steps to ensure that prospects are fully informed and made aware of the benefits of product being sold.

Insurers are required to display the service parameters and turnaround times as approved by the Board in its website.

Procedure to be followed at the 'point of sale', requirements to be complied with at the proposal stage and disclosures to be made in the life insurance policy are clearly stated in these Regulations.

These Regulations contain a **provision for free-look cancellation within 15 days of receipt of policy (30 days in case of electronic policies and policies obtained through distance mode).** Every life insurer, while forwarding the policy to the insured, should inform by the letter forwarding the policy that he has a **period of 15 days from the date of receipt of the policy document to review the terms and conditions** of the policy and where the insured disagrees to any of those terms or conditions, he has the **option to return the policy stating the reasons for his objection.** On availing of the free-look cancellation, the insured would be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period of cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In case of ULIPs, the insured would also be entitled to repurchase the units at the price of the units on the date of cancellation.

In respect of Individual health insurance policies there is a provision for free look cancellation within 15 days of receipt of policy except those with tenure of less than a year in accordance with Regulation 14 of **IRDAI (Health Insurance) Regulations, 2016**.

The Regulations clearly indicate that the requirements of **disclosure of "material information" regarding a proposal or policy apply both to the insurer and the insured**. Further, every insurer is required to have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed.

Therefore, the regulations ensure that the prospective policyholder is given a thorough understanding of the specific requirements and details required for taking an insurance policy. The insurer, agent or intermediary should enable the prospect to take the best cover that would be in his or her interest.

b. The IRDAI (Insurance Advertisements and Disclosure) Regulations, 2000`

These regulations require the insurers, agents or intermediaries not to issue "unfair or misleading advertisements" and follow the procedures laid down therein with respect to advertisements (including those on the internet) so that any communication directly or indirectly related to a policy and intended to result in the eventual sale or solicitation of a policy is not misleading or unfair. The Master Circular Ref: IRDAI/LIFE/CIR/MISC/189/10/2019 dated 17-10-2019 issued on Insurance Advertisements, clearly prescribes the details to be made available in the advertisements, and also indicates the do's and don'ts amongst other requirements."

c. IRDAI (Appointment of Insurance Agents) Regulations, 2016
d. IRDAI (Registration of Corporate Agents) Regulations, 2015
e. IRDA (Insurance Brokers) Regulations, 2018
f. IRDA (Web Aggregators) Regulations, 2017
g. IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015

These regulations prescribe code of conduct to ensure that the persons soliciting insurance business should be eligible persons and they disseminate the requisite information in respect of insurance products offered for sale, understand the policy being sold and should be capable of making suitable advice based on the customer needs so that the policy offered / sold meets the requirements of the prospect. Responsibilities are cast upon the agents and other intermediaries in terms of code of conduct, which are mainly aimed at curbing the mis-selling and to promote best practices during solicitation of the business.

The training curriculum of these intermediaries is also updated to ensure that the sales force is up to date with all the changes and is capable of providing necessary advice at the time of sale to the prospects.

h. Guidelines on Distance Marketing of Insurance Products, 2011

With the increasing recourse taken by insurers, corporate agents and brokers to solicit policies including lead generation through telecalling, SMS, email, internet, DTH, postal mail and other modes which do not involve communication in person as well as requests from clients seeking information and sale of insurance products in distance mode, IRDAI issued Distance Marketing Guidelines. These guidelines cover not only measures for policyholder protection at the time of offer, negotiation and conclusion of sale but also about preparation of standardized script, training of telecallers, monitoring of calls, preservation of call recordings etc.

i. IRDAI Regulations on Linked and Non-Linked Life Insurance Products

In order to standardize the minimum elements and attributes in the life insurance products with a view to protect the interests of policyholders, these regulations were initially notified in 2013. After taking into account the feedback received from various stakeholders, they were reviewed and Product Regulations 2019 have been issued.

A further circular Ref. No. IRDAI/MISC/LIFE/CIR/173/09/2019 dated 26.09.2019 has been issued on mandatory benefit illustration, suitability and other market conduct aspects.

These regulations ensured that the commission rates are consistent with the premium payment term. The customized benefit illustration requirements have been made applicable. The Regulations prohibited highest NAV guarantee products. They also dealt with splitting of policies, accepting advance premium, mis-leading names. The regulations also bring in transparency in terms of benefit payouts and enable the customers to choose the right policy.

In case of linked products, the regulations make it mandatory for separate training to all the insurance agents/intermediaries before they are authorized to sell linked insurance products, recommending a suitable product and collecting sufficient information about the potential policyholder, inform the upfront charges and indicate how premium paid is appropriated towards various charges from the unit fund and the balance of the fund at the end of the first year and subsequent years.

The customized benefit illustration shall be signed by the Agent/Intermediary as well as prospect signifying his consent after understanding the applicable charges and the risks in the investment.

j. Grievance Redressal Guidelines for Insurance Sector 2010

In addition to the above regulations, IRDAI has also issued Grievance Redressal Guidelines for insurance sector specifying the timelines for acknowledging, resolving and closure of grievances reported by the prospect and policyholders.. IRDAI has also provided channels for customers to raise grievances with insurers in the form of Integrated Grievance Management System, IRDA Grievance Call Centre and postal, fax and email channels, wherein IRDAI facilitates resolution of grievances by insurers.

Complainants who are not satisfied with the resolution provided by the insurer can take up with the Insurance Ombudsman or approach Consumer Fora or Courts.

k. Corporate Governance Guidelines – Policyholder Protection Committee

With a view to addressing the various compliance issues relating to protection of the interests of policyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer has been directed to set up a Policyholder Protection Committee which shall directly report to the Board. The responsibilities of the Policyholder Protection Committee include putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including mis-selling by intermediaries and reviewing the mechanism as well as status of complaints at periodic intervals. The Committee is also responsible for ensuring compliance with the statutory requirements as laid down in the regulatory framework and adequacy of disclosure of “material information” to the policyholders.

From the foregoing it can be seen that elaborate regulatory framework has been put in place to ensure that insurers, agents or intermediaries do not resort to mis-selling.

B. Insurance Ombudsmen in Mediation and Adjudication of MIs-selling complaints:

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 17 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction.

- The basic framework for functioning of Insurance Ombudsman is outlined in Insurance Ombudsman Rules, 2017.

- The grounds relating to mis-selling for which a complaint can be made to the Insurance Ombudsman is as follows:

  (a) Misrepresentation of policy terms and conditions at any time in the policy document or policy contract;

- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the compensation amount sought is less than Rs.30 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 30 days of the receipt of the award from the Ombudsman and it shall intimate the compliance to the Ombudsman.

C. Insurance Act, 1938 as amended by Insurance Laws(Amendment) Act, 2015

The amendments to the Insurance Act, 1938 have been made through the enactment of Insurance Laws (Amendment) Act, 2015. In terms of section 42 (A)(2) of the insurance act 1938, no person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy through multilevel marketing scheme. Further, section 42 (A)(3) of the insurance act 1938 prescribes that the Authority may through an officer authorised in this behalf, make a complaint to the appropriate police authorities against the entity or persons involved in the multilevel marketing scheme. This Amendment Act vide section 42(5) of the insurance act 1938 also prescribes that the insurers shall be responsible for all the acts and omissions of its agents including violation of code of conduct and liable to a penalty which may extend to one crore rupees. These changes will enable the interests of consumers to be better served through provisions

like those enabling penalties on intermediaries / insurance companies for misconduct and disallowing multilevel marketing of insurance products in order to curtail the practice of mis-selling.

VI. MONITORING COMPLIANCE AND REGULATORY ACTION

The compliance with the regulatory framework can be ascertained by way of on-site inspection or off-site monitoring through tools such as complaints, press reports, etc. IRDAI conducts on-site inspection of insurance companies, corporate agents and other intermediaries periodically to verify the books of accounts, examine the systems and procedures, compliance to the regulatory framework, etc. IRDAI also monitors the market conduct of the insurers, agents and intermediaries through complaints, their frequency and severity, press reports etc. Wherever it is found that the entities have not complied with the regulatory framework, IRDAI takes up regulatory action.

VII. CONSUMER EDUCATION

The definitive way of reducing mis-selling is to make the members of public aware of the concept of insurance, kinds of insurance policies, risks covered, benefits offered, exclusions, and conditions etc. This is sought to be achieved through various efforts of financial education to improve financial literacy

- Bima Bemisal campaign through print and electronic media,
- Cautioning public against fictitious offers and spurious calls
- Consumer education website www.policyholder.gov.in
- Devising various films, comics, games, handbooks and FAQs relating to insurance and initiatives of IRDAI and publicizing them
- Conducting regular seminars involving customer groups addressing policyholder concerns and policyholder education.

Considering the fact that several complaints were received from members of public relating to spurious calls and fictitious offers involving insurance products, IRDAI launched a multi-pronged campaign to caution members of public through print, electronic and mass media including Internet and by way of specific directions to insurers to incorporate the caution in their publicity material in policy related advertisements as well as advertisements in print, electronic media and TV.

VIII. ACTION BY INSURERS

Insurers have also been taking the issue of mis-selling seriously by doing a root cause analysis of mis-selling complaints to identify the major causes and have taken steps to prevent or reduce mis-selling through steps to ascertain suitability of product, place controls on the various channels, tuning it based on the vulnerability of the channel and have a strategy on dealing with complaints of mis-selling. Some Insurers are now conducting sales audit of the proposals that satisfy certain vulnerability criteria like First time ulip customers, Proposals from Senior Citizens , Premia payable not commensurate to the declared sources of income etc. to ensure right selling.

Further, every insurer has a Board approved policy to enhance insurance awareness; steps to prevent mis-selling and unfair business practices at point of sale and service; and to ensure that prospects are fully informed and made aware of benefits of product being sold at various stages of sale.

In addition to the action taken by IRDAI based on the examination of complaints by the insurers, Insurers also take up action against the agents or intermediaries in the form of issuing warning letters, terminating employees, filing police complaints and most commonly resorting to claw-back of commission wherever the policies have been cancelled as a consequence of proven mis-selling.

IX. CONCLUSION

To summarize, the problem of misselling in life insurance is a major hindrance in expansion of life insurance business. The regulatory framework is adequate to prevent misselling. The reduction in the number of mis-selling complaints (and also the reduction in the complaints per 10000 policies sold) reflects the outcome of the serious efforts put in by the industry. However, greater compliance with the relevant regulations, increased insurance awareness, simpler policy terms and conditions, greater adherence to code of conduct by agents and intermediaries, and self-discipline among insurance intermediaries & insurance companies can further significantly reduce the mis-selling complaints without affecting the volume of new business. Putting in place systems to examine complaints from the underwriting perspective and expeditiously redressing them where the policy appears inappropriate can help build trust in the public.

SPURIOUS CALLS – PROBLEM, IMPACT AND EFFORTS OF IRDAI TO CAUTION PUBLIC

I. INTRODUCTION

Spurious calls in the name of regulatory organizations and government or quasi government authorities has been a problem which has been in prevalence for quite sometime now. The calls contain offers of benefits of huge amounts to be released by authorities. As a pre-requisite for such payment, the callers insist upon payment of money for purchase of new policies or fulfilling certain regulatory requirements. The payments are made mostly in cash or sometimes through cheque or net banking. The persons who respond to such calls and who are lured by such offers lose their money and trust in the financial system.

II. OFFERS MADE BY SPURIOUS CALLERS

The general nature of fictitious offers made through such spurious calls, as discerned from the complaints received by IRDAI, are as follows:

- Claiming to be representatives of IRDAI/IGMS and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDAI is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDAI.
- Claiming that the policyholder would receive bonuses being distributed by IRDAI if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDAI.
- Advising existing policyholders that money in respect of their policy has been fraudulently transferred to someone else and for receiving that money back from IRDA, they have to fulfil certain formalities including payment of money
- Claiming that they are from the Grievance Cell or IGMS Department of IRDAI making a call in continuation with a complaint made against an insurer and for resolving the grievance and release of benefit, they have to fulfill certain formalities including payment of money.
- Advising customers to subscribe to a fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

The above list is indicative but not exhaustive.

III. IMPACT OF SPURIOUS CALLS

Spurious calls of the nature indicated above could dent the reputation to IRDAI and other agencies and also financial loss to the gullible public who pay money based on such calls in lure of the offers made. Considering the fact that the mission of Government as well as IRDAI is in promoting financial inclusion by improving access to insurance related services in both life and non-life segments, such spurious calls would adversely affect the general sentiment of general public in relation to insurance. Given the fact that insurance is a complex financial product and is a subject matter of solicitation, the trust deficit caused due to such spurious calls can dissuade those who are apprehensive but interested in buying insurance because of the benefits of insurance. Since insurance is a product of risk protection, this can impact the general risk coverage of members of public rendering them more vulnerable to risks to their life and property. The premiums received from insured public forms the corpus for insurance companies to make long term investments in instruments such as Government securities and other securities. The money so invested serves as the investment for nation building. As a result, spurious calls are also indirectly hindering not only growth in the insurance sector but also development of the country through the premium funds available for development.

IV. IRDAI'S CAUTION TO PUBLIC

Considering the extent of the problem and the impact of such calls on IRDAI's efforts in protecting the interests of policy holders and ensuring the orderly growth of the insurance sector, IRDAI has taken up a campaign to caution members of public. The emphasis is more on dissuading people from believing such spurious calls and acting upon them so that the problem does not manifest into a financial loss to members of public who make payment believing in the veracity of the calls and offers. Through the caution, IRDAI has been informing the members of public that:

- IRDAI does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDAI does not invest the premium received by insurance companies.
- IRDAI does not announce any bonus for policyholders or insurers.
- IRDAI has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDAI Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.

- IRDAI or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDAI as IRDAI plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person receiving such spurious calls may inform police.

V. EFFORTS BY IRDAI TO CAUTION PUBLIC

IRDAI has taken various initiatives to spread awareness among the members of the general Public particularly against the spurious calls through a multi-pronged strategy. The modes of campaign used by IRDAI directly for cautioning public about such offers are public notices, press releases, advertisements in newspapers, radio spots, television advertisements, caution on the Internet websites of IRDAI and its consumer education website etc.

IRDAI has already issued directions to all the life insurers to incorporate caution against such spurious calls in their publicity material – print, internet and electronic – as well as through SMS to their policy holders. Insurers themselves have also been independently taking up steps for cautioning public through print, electronic and internet media.

The following are the various efforts taken in the direction of cautioning public from spurious calls and fictitious offers

- A massive campaign **cautioning general public against spurious callers and fictitious offers** was carried out through **television** in 12 regional languages including Hindi.
- IRDAI has been spreading the awareness against the spurious calls by placing the relevant material i.e. radio jingles, TV Advertisements, press release etc. on IRDAI's Consumer Education Website (www.policyholder.gov.in), which is available both in Hindi as well as in English.
- The information sought by the visitors of IRDAI's Consumer Education Website as part of feedback w.r.t. spurious calls, IRDAI guides them to deal with it during the monthly review of the feedback.
- IRDAI would continue with the initiatives for protecting policyholders' interests and for promoting insurance awareness.

VI. RECOURSE FOR PERSONS WHO PAID MONEY BASED ON SPURIOUS CALLS

In spite of the best efforts in cautioning public there are several persons who complain about making payment to spurious callers. The various categories in cases where payment is made based on spurious calls and the recourse available are briefly indicated below:

i. The amount is paid to an individual

Being a fraud by an individual, the only recourse available is to take up the matter with police for necessary action.

ii. The amount is paid to a non-insurance related service provider or agency

In such cases, depending on whether the services promised by the agency have been provided or not, the individual has to take up the matter with such agency or the police for necessary action. IRDAI would not be in a position to intervene as the institution does not fall within its regulatory purview.

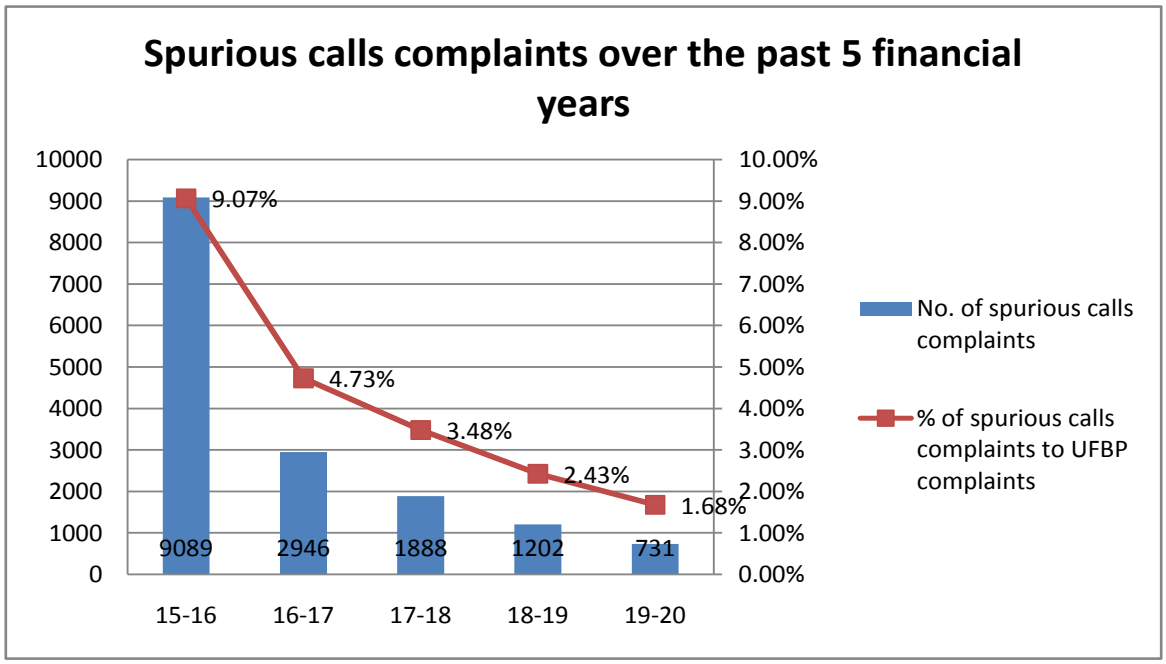
iii. The amount is paid to an insurance company and a policy is issued

Being a case of fraud, a complaint can be filed with police for necessary action against the telecallers as well as the insurance company whom they represent. However, as an insurance policy is issued by an insurance company, the person may make a complaint of mis-selling with the insurance company bringing to the notice unfair business practice adopted by the telecaller/agent/intermediary in selling the policy and seek changes in the policy or cancellation of the policy. The other channels of making a complaint offered by IRDAI can also be used for registering a complaint against the insurer such as writing to Consumer Affairs Department of IRDAI, sending an email to complaints@irdai.gov.in, making a call to toll free numbers (155255 or 1800 425 4732) of the IRDAI Grievance call centre or online on the Integrated Grievance Management System (IGMS) (www.igms.irda.gov.in).

VII. COMPLAINTS ON SPURIOUS CALLS

The complaints relating to spurious calls are included under the broader complaint category of unfair business practices in the Integrated Grievance Management System of IRDAI which is the industry-wide repository of insurance grievance related information. The number of complaints of this nature as per IGMS is as follows:

Sl. No.	Year	Number of complaints	% - variation over previous year	% of complaints on spurious calls to the total complaints under UFBP
1	15-16	9089		9.066%
2	16-17	2946	-67.59%	4.730%
3	17-18	1888	-35.91%	3.482%
4	18-19	1202	-36.33%	2.425%
5	19-20	731	-39.18%	1.68%



It can be seen that there has been a reduction of number of spurious calls complaints over the past 5 years from 9089 in 2015-16 to 731 in 2019-20 (overall reduction of 92% in the past 5 financial years). In terms of percentage share to the total UFBP complaints it has shown reduction of from 9.066% in 2015-16 to 1.68% in 2019-20. This indicates that the extensive campaign for building awareness amongst public and cautioning them from falling prey to spurious calls taken up by both IRDAI as well by the Insurers have shown positive results

VIII. ACTION BY IRDAI ON COMPLAINTS

On receipt of complaints under spurious calls made in the name of Insurance Companies, IRDAI forwards the complaint to the named insurer to investigate the complaint vis-à-vis the telephone numbers/Mobile numbers/Names of persons mentioned in the complaint for taking appropriate action under intimation to IRDAI.

Wherever the spurious calling has resulted into issuance of an insurance policy IRDAI takes up the complaint with the insurer concerned for resolution, which is updated by the insurer in IGMS. In case the complainant is not satisfied with the resolution provided by the insurer, he may take up the matter with insurance ombudsmen (for details visit www.ecoi.co.in) for amicable resolution or adjudication under the Insurance Ombudsman Rules, 2017 - Alternately, the complainant can file a complaint with Consumer Forum for deficiency of service; or take up before a criminal court for cheating or fraud; or file a suit in a civil court for breach of trust. -

However, through the volume of complaints, IRDAI monitors the market conduct of insurers, agents and intermediaries. Further, during the course of on-site inspection and off-site monitoring of regulated entities like insurance companies, insurance agents, corporate agents and insurance intermediaries (brokers) for examining the compliance of these entities with the extant regulatory framework, IRDAI focuses on the process of soliciting, offering and selling insurance. Based on the findings, IRDAI initiates regulatory action against the insurers or intermediaries as per the provisions of the Insurance Act and Regulations.

CONCLUSION

The realization of the fact that insurance is for risk protection and not for windfall gains can bring about caution in the members of public. So, there is a need for greater insurance awareness apart from the specific efforts taken by IRDAI in cautioning public against spurious calls. IRDAI on its part has been proactive in devising and implementing a multi-pronged strategy for spreading caution so that people do not fall prey to offers made by spurious callers.

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