DRAFT REGULATIONS

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

NOTIFICATION No. _____

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (PROTECTION OF POLICYHOLDERS' INTERESTS) REGULATIONS, 2014

In exercise of the powers conferred by clause (zc) of sub-section (2) of section 114A of the Insurance Act, 1938 (4 of 1938) read with clause (b) of subsection (2) of sections 14 and sub-section(1) of section 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), the Authority, in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:

1 Short title and commencement

1.1 These regulations may be called the Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2014

1.2 They shall come into force on the date of their publication in the Official Gazette and supercede IRDA (Protection of Policyholders Interests) Regulations, 2002 from such date.

1.3 These Regulations are in addition to any other regulations made by the Authority, which may, inter alia, provide for protection of the interest of policyholders.

1.4 These Regulations apply to all insurers, insurance agents, insurance intermediaries, prospects and policyholders.

2 Definitions

In these regulations, unless the context otherwise requires:

2.1 "Act" means the Insurance Act, 1938 (4 of 1938);

2.2 "Advice" means a recommendation, opinion, statement or any other form of personal communication directed at a prospect that is intended, or could reasonably be regarded as being intended, to influence the prospect in making a transactional decision.

2.3 "Authority" means the Insurance Regulatory and Development Authority established under the provisions of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999);

2.4 "Citizens Charter" means a document declaring the functioning, obligations, duties, commitments of an insurer for providing services effectively and efficiently with acceptable levels of standards and time limits for delivery and grievance redress.

2.5 "Combi product" means an insurance product which offers a combination of Life Insurance, general insurance and / or health insurance covers.

2.6 "Complaint" or "Grievance" means an oral or written expression of dissatisfaction about an action or lack of action about the standard of service or deficiency of service of an insurer, insurance agent or insurance intermediary made by, or on behalf of, a consumer.

Explanation: An inquiry or request would not fall within the definition of the "complaint" or "grievance". However, an unattended inquiry or request may lead to a complaint or grievance.

2.7 "Complainant" means a consumer who has filed a complaint or grievance against an insurer, insurance agent or insurance intermediary.

2.8 "Conduct" includes any act or omission.

2.9 "Consumer" with reference to this regulation means a person who has availed, avails, or intends to avail of an insurance service or has a right or interest in an insurance product.

2.10 "Contract of Insurance" means a contract under which an insurer, for consideration, assumes the risk of one or more persons.

2.11 "Cover" means an insurance contract whether in the form of a policy or a cover note or a Certificate of Insurance or any other form prevalent in the industry to evidence the existence of an insurance contract;

2.12 "Group" for the purpose of these regulations shall mean persons with a commonality of purpose or persons who are engaged in a common economic activity and include the following:

a) employees of a company or any such entity, or
b) non-employee groups like employee welfare associations, holders of credit card issued by a specific company, customers of a particular business where insurance is offered as an add-on benefit, borrowers of a bank, professional associations or societies

Provided the President, Secretary, Manager or Group organizer has the authority from majority of the members of the group to arrange insurance on their behalf or is doing so as part of a necessary security such as a bank on the life of the borrowers

2.13 "Insured" – means person or persons covered by an insurance policy.

2.14 "Policyholder" for the purpose these regulations includes insured, individual members of group policy and beneficiary of insurance policy

2.15 "Proposal form" means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of a cover to be granted.

Explanation: "Material" for the purpose of these regulations shall mean and include all important, essential and relevant information that enable the insurer to take informed decision in the context of underwriting the risk.

2.16 "Prospect" means any person who enters or proposes to enter into an insurance contract directly with the insurer, or through an insurance agent or insurance intermediary.

2.17 "Prospectus" means a document issued by the insurer or in its behalf to the prospective buyers of insurance, and should contain such particulars as are mentioned in Rule 11 of Insurance Rules, 1939 and includes a brochure or leaflet serving the purpose. Such a document should also specify the type and character of riders on the main product indicating the nature of benefits flowing thereupon;

2.18 "Transactional decision" means a decision taken by a prospect

a) whether, how, and on what terms, to avail of an insurance product or insurance service; or
b) whether, how, and on what terms, to exercise a right in relation to an insurance product or insurance service or to demand the discharge of a duty owed to the prospect in terms of such product or service.

2.19 Words and expressions used and not defined in these regulations, but defined in the Act, or the Life Insurance Corporation Act, 1956, (31 of 1956) or the General Insurance Business (Nationalization) Act 1972 (57 of 1972), or the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) or the Insurance Rules, 1939 or any other regulations issued by IRDA shall have the meanings respectively assigned to them in those Acts or Rules or Regulations.

3 Rights of Prospects Policyholders:

3.1. The Regulations envisage providing operational framework for basic rights of prospects and policyholders at the point of sale, proposal, insurance contract and during the subsistence of the insurance contract:

(1) Right to Professional diligence
(2) Right to protection against unfair contract terms
(3) Right to protection against unfair market conduct
(4) Right to protection of personal information
(5) Right to requirement of fair disclosure
(6) Right to receive suitable advice
(7) Protection from conflict of interest of advices

The scope and purport of these rights are indicated in Annexure IV.

3.2. The insurers, insurance agents and insurance intermediaries as well as the Insurance Councils shall work towards ensuring the enforcement of the above Rights to the prospects and policyholders. .

3.3. The Board of every insurer shall ensure the following:

(1) Formulate an Insurance Awareness Policy for educating customers about insurance, products and benefits; rights and responsibilities as policyholders.
(2) Frame a Citizens' Charter specifying the service standards both in qualitative and quantitative terms as per the Model stipulated in Annexure I to these regulations.
(3) Constitute Policyholder Protection Committee and ensure its proper functioning in accordance with the Corporate Governance guidelines relating to policyholder protection as stipulated in Annexure V to these regulations.
(4) Formulate a Grievance Redressal Policy for expeditious resolution of policyholder grievances including the grievances arising out of deficiency of service to prospects and policyholders by insurance agents and insurance intermediaries
(5) All insurance agents and insurance intermediaries associated with the insurer, besides complying with the provision of the IRDA regulations, operate in accordance with the Code of Conduct for policyholder service as framed by the IRDA, respective Insurance Council and governing bodies.

4. Product Related Information Sharing with Prospective Consumers

4.1 Prospects generally depend on the information, advice, and guidance provided by the insurer, insurance agent, and insurance intermediary in the purchase of insurance products. The insurer, insurance agent or the insurance intermediary shall hence provide a product prospectus to the prospect containing all material information in respect of a proposed insurance product to enable the prospect to decide on the best cover that would be in his or her interest.

4.2 Where the prospect depends on the advice of the insurer, insurance agent or insurance intermediary, such a person must advice the prospect dispassionately.

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

4.4 The product prospectus shall, besides other information, provide comprehensive, dispassionate, and true information about the insurance product on

4.4.1 characteristics of the insurance product, including its features, benefits, risks to be covered and risks to the prospect;

4.4.2 consideration to be paid by the prospect for the insurance product and the manner in which the consideration is calculated;

4.4.3 existence, exclusion or effect of any term in the insurance product or insurance contract;

4.4.4 identity, regulatory status and affiliations of the insurer, insurance agent or insurance intermediary

4.4.5 contact details of the insurer, insurance agent or insurance intermediary and the methods of communication to be used between the prospect and the insurer, insurance agent or insurance intermediary;

4.4.6 rights of the prospect to avail of free look option in case of life and health insurance policies and to rescind a general insurance contract within a specified period; or

4.4.7 rights of the consumer under the applicable law or regulations.

4.5 Notwithstanding anything mentioned in regulation 2.18 above, a prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to health related or critical illness riders in case of term or group products shall exceed 100% of premium under the basic product. All other riders put together shall be subject to a ceiling of 30% of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product.

Provided that the benefit amount under riders in a life insurance policy shall be subject to section 2(11) of the Insurance Act, 1938.

Explanation: The rider or riders attached to a life insurance policy shall bear the nature and character of the main policy, viz. participating or non-participating and accordingly the life insurer shall make provisions, etc., in its books."

4.6 The insurer shall ensure that, during a policy solicitation and sale, whether directly or through insurance agent or insurance intermediary, the prospects are fully informed and made aware of the benefits of the product being sold vis-à-vis the product features attached thereto. The insurers shall ensure that the benefits / returns of the policy are not mis-stated / mis-represented or the prospect is not forced to buy a policy. Insurers shall disclose restrictions/ conditions of all aspects of benefits that are material.

4.7 This entails that the advice is proper and complete at all stages - pre-sale, sale and post-sale.

4.8 The insurer, insurance agent and the insurance intermediary shall also ensure the suitability of the product with relevance to prospects' income, personal and family circumstances, life stage, financial goals and risk appetite. It shall be the duty of the insurer to ensure that the insurance agents or insurance intermediaries treat the prospect with due fairness and through all their dealings, acknowledge that the prospect has a right to service of the proper kind.

4.9 The Insurers shall ensure, that a sale executed over distance-marketing modes such as Internet, SMS, Mobile phone, interactive electronic medium etc., shall be undertaken by authorized and qualified sales persons who hold valid licence in this behalf, as per Regulations of the Authority. It is mandatory that the consent of the policyholder shall be obtained before canvassing can be initiated. Care should be exercised to ensure that the policyholder contacted has clarity as to the identity of the insurer, insurance agent or insurance intermediary, the product, benefits and conditions of offer etc. The canvassing so made shall be precisely on lines of standard script filed with the Authority and shall not involve compulsion, inconvenience or nuisance of any kind to the policyholder.

4.10 The Insurer, the Insurance agent and the Insurance Intermediary shall inform and sensitize the Group policyholders and beneficiaries under these policies, through their various publicity efforts, regarding insurance products that are offered to groups of individuals/ members, either through employer-employee mode or through the group mode or otherwise. Insurers shall ensure that the master policyholders make the beneficiaries aware of the insurance benefit.

4.11 Insurers shall ensure that life, general and health insurance agents and intermediaries shall sell only insurance products including combi-products that are approved by the Authority in Life Insurance, General Insurance and Health Insurance category. This will entail policyholders buying integrated products approved by the Authority with relevant benefit illustrations etc.

4.12 Every Life Insurer should provide a customized benefit illustration for all Life Insurance products to every prospect giving not only the benefit illustrations as mandated by regulation but also the illustration of amount payable at the end of each year after policy date till the date of maturity of the policy

i. in case the policy lapses
ii. in case policy is surrendered
iii. in case policy becomes paid up

4.13 The prospect should know the name and address of the agent / insurance intermediary who shall provide insurance services under the policy. The name and address of the agent / intermediary should be clearly stated in the policy document and premium notices; premium receipts or any other communications of the insurer to the client.

4.14 **Products on offer / products withdrawn**:

a) Every insurer shall place in public domain complete details of product particulars of each and every product that was offered for sale by the insurer as it was filed and approved by IRDA, including products modified or products withdrawn etc.
b) The insurer shall keep the list updated at all times.
c) The information placed in public domain should include policy document with detailed terms and conditions, proposal document, benefit illustrations and publicity material submitted and approved as per the File and Use requirements specified by IRDA.

4.15 Responsibility towards policyholders: In the process of insurance solicitation and sale, the insurer, or insurance agent or any insurance intermediary shall act according to the code of conduct prescribed respectively by:

i) Councils established under -the Act for this purpose;
ii) The recognized professional body or association of which the insurance agent or insurance intermediary or insurance intermediary is a member
iii) Code of Conduct prescribed in the IRDA (Licensing of Insurance Agents) Regulations 2000
iv) Code of Conduct prescribed in the IRDA (Licensing of Corporate Agents) Regulations 2002
v) Code of Conduct prescribed in the IRDA (Insurance Brokers) Regulations 2013
vi) Code of Conduct prescribed in the IRDA (Web Aggregators) Regulations 2013
vii) Code of Conduct prescribed in the IRDA TPA Regulations 2001 and
viii) Any other regulations, guidelines issued by the Authority from time to time.

4.16 The Insurers, Insurance agents and insurance intermediaries shall strictly adhere to IRDA Advertisements Regulations 2000 and other instructions issued by the Authority in the matter of Advertisements and shall not issue any misleading or unfair advertisement in any form or through any medium.

4.17 Violations of any provisions of the Advertisement Regulations and guidelines issued by the Authority in this regard from time to time shall be dealt with as per the provisions of the relevant regulations or under the provisions of the Act.

5 Proposal for Insurance

5.1 When buying an insurance policy, a prospect or proposer has a right to receive insurance advice consistent with his / her financial needs, investment objectives, age, and other relevant information, and the insurer, insurance agent and insurance intermediary shall provide such insurance advice dispassionately.

5.2 Except in case of a marine insurance cover, where current market practices do not insist on a written proposal form, in all other cases, a proposal for grant of insurance cover, either for life insurance business or for general insurance business or for health insurance business, must be evidenced by a written document, referred to as the proposal form. It is the duty of the insurer to furnish to the insured, free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.

Explanation: Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded, where the insurer claims that the proposer suppressed any material information or provided misleading or false information on any matter material to the grant of a cover.

5.3 Proposal form and other documents used in the grant of insurance cover may, depending upon the circumstances of each case, be made available in languages recognized under the Constitution of India.

5.4 In filling the form of proposal in case of life insurance, the prospect is to be guided by the provisions of Section 45 of the Act. Any proposal form seeking information for grant of life cover may prominently state therein the requirements of Section 45 of the Act.

5.5 Insurers shall ensure that the insurer, insurance agent or insurance intermediary enlightens the policyholders regarding the need to comply with the minimum requirements of Know your customer (KYC) norms, such as photograph on proposal form, proof of identity and proof of address. It is mandatory to furnish the contact details such as email, phone number including mobile phone number, and bank details so as to enable the policyholder to get intimation of the benefits under the Policy and receive the amounts due expeditiously.

5.6 Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer, insurance agent or insurance intermediary shall draw the attention of the proposer to it and encourage the prospect to avail the facility.

5.7 Insurer shall process the proposals submitted to the insurer with speed and efficiency in all cases; and the decision on the proposal thereof shall be communicated by it in writing to the proposer within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

6 Matters to be stated in life insurance policy

6.1 A life insurance policy shall clearly state:

a) the name of the plan governing the policy, its terms and conditions;
b) whether it is participating in profits or not;
c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;
d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

e) the details of the riders attaching to the main policy;
f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;
g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value.
h) the age at entry and whether the same has been admitted;
i) the policy requirements for (a) conversion of the policy into paid up policy, (b) surrender (c) non-forfeiture and (d) revival of lapsed policies;
j) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;
k) the provisions for nomination, assignment, loans on security of the policy and a statement that the rate of interest payable on such loan shall be as prescribed by the insurer at the time of taking the loan;
l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and
m) the address of the insurer to which all communications in respect of the policy shall be sent.
n) the documents that are normally required to be submitted by a claimant in support of a claim under the policy.

6.2 The insurer, while forwarding the policy document to the insured, shall explicitly inform the policy holder in the forwarding letter about the provisions of FREE LOOK. The insurer shall inform that the policyholder 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, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

6.3 In respect of a linked policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

6.4 All life Insurers shall attach a 'Key Feature Document' to the Policy Document that is being dispatched to Policyholder. The 'Key Feature Document' shall carry in bold and attractive print, the key features of the Policy in very simple jargon-free, easy to read, language, with the intention of making the policy holder aware of the most important features of the insurance product. The Envelope carrying the Policy document shall also attract attention of the policyholder to the Key Feature Document. The Key Feature Document shall reiterate the policyholder's right of availing Free-look Option to cancel the policy should his current understanding of terms and conditions of the policy, make him decide so.

6.5 Life Insurers shall take special efforts to inform and educate Policyholders in the Key Feature Document regarding the risk features of the Linked Insurance

Products, including risk of investments arising due to market fluctuations. The various 'Charges' applicable to linked policies and 'Switching and Redirection Options' shall also be highlighted to the policyholders in the Key feature Document. They shall highlight to policyholders important terms and conditions of the products so as to provide full transparency and disclosure. The following facts should be indicated clearly:

a) Minimum Lock-in Period for the polices;
b) Switching and redirection options under linked policies
c) Charges applicable to linked policies
d) Net Annual Reduction in yield as applicable to the policies;
e) Cap on Discontinuance charges;
f) Higher Risk in linked policies as compared to non-linked policies;
g) Repurchase provisions of units under linked policies by the Insurer
h) Reasonable insurance coverage with a linkage
i) Adequate Disclosure of information pertaining to investment of Funds and element of Risk involved
j) Standard method across industry for computation of NAV.

6.6 In respect of a cover, where premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before issuance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon as possible.

7 Matters to be stated in general insurance policy

7.1 A general insurance policy shall clearly state:

a) the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance;
b) full description of the property or interest insured;
c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;
d) period of Insurance;
e) sums insured;
f) perils covered and not covered;
g) any franchise or deductible applicable;
h) premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;
i) policy terms, conditions and warranties;
j) action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;
k) the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;
l) any special conditions attaching to the policy;

m) provision for cancellation of the policy on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured;
n) the address of the insurer to which all communications in respect of the insurance contract should be sent;
o) the details of the endorsements attaching to the main policy;
p) proforma of any communication the insurer may seek from the policyholders to service the policy.
q) The renewal terms and conditions, cancellation conditions and co-insurance terms in case of more than one policy of the insurer.
r) Portability conditions as applicable in case of health insurance

7.2 In stipulating the exclusions of the policy, insurers shall endeavour to classify the exclusions appropriately as under:

a. Standard exclusions applicable in all policies
b. Exclusions specific to the policy which cannot be waived.
c. Exclusions specific to the policy, which can be waived on payment of additional premium.
d. Exclusions, which can be covered in another standard policy.

7.3 Policy conditions can be categorized into following:

a. Conditions precedent to the contract
b. Conditions applicable during the contract
c. Conditions when a claim arises
d. Conditions for renewal

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

8 Micro Insurance policies

8.1 The Insurer, insurance agent or insurance intermediary shall provide micro insurance consumers, appropriate and relevant product-specific information in the form of Product Feature Document / Sales Literature etc. at the insurance solicitation stage to enable the policyholder to

a. Make decisions about the insurance,
b. To understand their rights and obligations, and
c. To use the product effectively (including maintaining and renewing the policy, filing claims and resolving questions or problems when necessary)

8.2 Life Insurers shall make Benefit illustration available in respect of all life micro insurance products, illustrating the guaranteed and non-guaranteed benefits at gross investment returns as specified by IRDA or Life Insurance Council from time to time.

8.3 Agents and Intermediaries interacting with micro insurance consumers shall have the appropriate training and support to inform consumers of their rights and obligations and to play their roles in delivering and servicing products effectively; and the information in this regard should be provided to the policyholder on demand.

8.4 The Insurer, insurance agent and insurance intermediary shall ensure that Products are appropriate to the clients to whom the product is offered in terms of the risks

covered, the level of coverage, premiums, exclusions and other product characteristics.

8.5 The Insurer, insurance agent and insurance intermediary shall ensure that Products are marketed and explained to consumers before enrollment in a manner that is transparent, not misleading, and provides sufficient and appropriate information.

8.6 The Insurer, insurance agent and insurance intermediary shall ensure that an Advertising of Micro Insurance product is done explicitly identifying the product as "Insurance". The advertisement should not be misleading, and all advertisements should be adequately supervised.

8.7 The Insurer, insurance agent and insurance intermediary shall ensure that Proposer data recording / capture procedures are sufficiently clear, simple and fair. The consumers should be provided with sufficient information, disclosures, and documentation to use the product effectively.

8.8 The micro insurance policyholder should know the insurer of the policy and hence the insurer's name and address should be clearly stated in the sales documents, the policy document and any Key Features documents.

8.9 The micro insurance policy document should provide adequate and comprehensible disclosure of the price of the policy, what it does (and does not) provide, the premium payment obligations, when and how a claim can be made under the contract, and for how much, including any exclusions or limitations on cover arising out of explicit or implied warranties.

8.10 The micro insurance policy document shall provide adequate and comprehensible disclosure of claims procedures and how to access recourse mechanisms if things do not go as expected.

8.11 The insurer shall set in such mechanisms include post-sale call-back by the insurer (using electronic means where possible) and free look periods.

8.12 The Insurer, insurance agent and insurance intermediary shall ensure that Procedures for maintaining and renewing the micro insurance policies should be accessible and appropriate to minimize the risk of an unintended cancellation or lapse of policy and risk coverage.

8.13 The Insurer shall ensure that Procedures and documentation requirements for filing and supporting a claim are as accessible, understandable and flexible as possible. Additional documentation or information required for the claim process should be simple in Micro Insurance products.

8.14 The Insurer shall ensure that micro insurance policyholders receive adequate and timely notification of approval and rejection of claims. The Insurer shall ensure that Claims are paid in a sufficiently timely manner.

8.15 The Insurer shall ensure that the micro insurance policyholders or beneficiaries receive all claim amounts by specifically drawing the cheques in the name of the respective policyholders / beneficiaries in order to protect the financial interests of the policyholder / beneficiary. No portion of claim amounts shall be paid to any third party other than the policyholder or the beneficiary.

8.16 The Insurer shall ensure that micro insurance policyholders have adequate and accessible opportunities to seek redress for denied claims and other problems or complaints, through internal and/or external channels. The details of such redressal processes should be informed to the policyholders lodging claims with the insurer.

8.17 Given the profile of micro insurance consumers who have low levels of income, experience and formal education, such disclosures shall be as simple, comprehensible and accessible as possible. .

8.18 Standardization of disclosure formats and wordings shall help facilitate consumer understanding and comparison of the different products available.

9 Group Insurance Policies-

9.1 A group shall consist of only persons who assemble together with a commonality of purpose or engaging in a common economic activity like employees of a company. Non-employer-employee groups, like employee welfare associations, holders of credit cards issued by a specific company, policyholders of a particular business where insurance is offered as an add on benefit, borrowers of a bank, professional associations or societies may also be treated as a group provided there is an official to address organizer of the group based on authority from majority of members of the group to arrange insurance on their behalf or is doing so as part of a necessary security for other matters such as a bank on the life of borrowers.

9.2 No group shall be formed with the main purpose of availing insurance. No group insurance can be negotiated and then sold to the public who will be enrolled as members after the policy is negotiated.

9.3 Marketing of group policy will be only directly by the insurer, insurance agent or insurance intermediary.

9.4 Premium charged and benefits admissible to each member of the group shall be clearly specified in the group policy and the group administrator / group manager cannot vary the premium or benefits with regard to individual members.

9.5 Group discounts on premium have to be passed on to the member concerned and should not be appropriated by the group administrator / intermediary / agent. There shall be no other payment under any name whatsoever payable to the agent / intermediary / group. If the group wishes to collect a service charge from the members to cover their cost, it should be disclosed as an additional cost and not as premium.

9.6 Every group policy should have complete list of members who are insured with proper ID proof. In case of large groups (100 members or above), the list may be maintained in the books of the organizer by way of a proper non-tamperable register, duly verified by the insurer. The records can also be maintained in electronic form with adequate safeguards for information security.

9.7 Normally in Group Insurance, the beneficiary would be the member and the group organizer will only be the holder of the policy. Every member shall be given a Certificate of Insurance containing information of schedule of benefits, the premium charged, date of payment of premium, benefits, exclusions and other important terms and conditions including the claim procedure and the insurer's office details.

9.8 Insurer shall make available the complete policy document for access to the group administrator and the members to refer to.

9.9 Where the premium is paid by the members, the group administrator should give a notice of payment of premium to the member at least 30 days prior to the renewal in such form as is deemed fit indicating therein the consequences of non-payment of premium.

9.10 Where the group administrator decides to terminate the group policy, he must give 30 days prior notice to all the members so that they can explore the possibility of negotiating for an appropriate cover with the insurer as per terms and conditions decided by the insurer.

9.11 Insurer shall make payment of the benefit from the group policy to the beneficiary unless there is a written consent from the beneficiary to pay the amount to the group administrator.

10 Claims procedure in respect of a Life Insurance Policy

10.1 A life insurance policy shall state the primary documents, which are normally required to be submitted by a claimant in support of a claim.

10.2 A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible**,** shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

10.3 A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 60 days from the time of lodging the claim.

10.4 Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

10.5 Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount from the date of receipt of last requirement to the date of payment of the claim amount at a rate which is 2% above the bank rate as prevalent on the first day of the month in which the claim is paid by the insurer.

11 Claim procedure in respect of a General and Health Insurance Policy

11.1 An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 48 hours of the receipt of intimation from the insured. Insurer should communicate the details of the appointment of surveyor, including the role, duties and responsibilities of the

surveyor to the insured by letter / email immediately after the appointment of the surveyor.

11.2 The insurer / surveyor shall within 7 days of the claim inform the insured / claimant of the essential documents and other requirements that the claimant should submit in support of the claim. Where documents are in public domain or with a public authority, the surveyor/insurer shall obtain them using the available recourses of accessing these documents and furnish the same to the insurer / surveyor.

11.3 The surveyor should take photographs of the loss and have them immediately (not later than 24 hours) uploaded/forwarded to the insurer and the insured/claimant for record. Interim report of the physical details of the loss may be recorded and uploaded/forwarded to the insurer and the insured / claimant within the shortest time but not later than 15 days from the date of first visit of the surveyor.

11.4 Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor, as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim.

11.5 In respect of retail and micro insurance claims and all other claims below Rs. 25 lakhs, the claim should be settled within 45 days of intimation unless the re-instatement / repair takes more than 45 days.

11.6 The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and subject to sub-regulation 11.5, shall communicate his findings to the insurer within 30 days of his appointment. A copy of the surveyor's report shall be furnished to the insured/claimant.

In special circumstances of the case, either due to its special or complicated nature of the claim, the surveyor shall, under intimation to the insured / claimant, seek an extension from insurer for submission of his report. Surveyor and insurer shall inform the insured of additional time required. The insurer may make provisional/ on account payment if liability is admitted. In case the surveyor or insurer needs more time, updates of the status shall be given to insured/claimant fortnightly. In no case shall the time be extended beyond six months.

11.7 If an insurer, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor, under intimation to the insured/claimant, to furnish an additional report on certain specific issues as may be required by the insurer. Such a request may be made by the insurer within 15 days of the receipt of the original survey report.

Provided that the facility of calling for an additional report by the insurer shall not be resorted to more than once in the case of a claim.

11.8 The surveyor, on receipt of this communication, shall furnish an additional report within three weeks of the date of receipt of communication from the insurer.

11.9 On receipt of the survey report or the additional survey report, as the case may be, an insurer shall, within a period of 30 days offer a settlement of the claim to the insured/claimant. If the insurer, for any reasons to be recorded in writing and communicated to the insured/claimant, decides to reject a claim under the

policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.

11.10 In all cases, the insurer shall inform the insured / claimant in writing about the basis of settlement in case the amount paid is less than amount claimed. In particular, where the claim is rejected, the insurer shall give the reasons for the same in writing drawing reference to the specific terms and conditions of the policy.

11.11 Upon acceptance of an offer of settlement as stated in sub-regulation 11.10 by the insured/claimant, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured/claimant. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate, which is 2% above the bank rate prevalent on the first day of the month in which the claim is reviewed by it.

12 Services under Life Insurance Policies.

12.1 An insurer carrying on life insurance business shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters, such as:

(a) recording change of address;
(b) noting a new nomination or change of nomination under a policy;
(c) noting an assignment on the policy;
(d) providing information on the current status of a policy including information on accrued bonus, surrender value and loan entitlement.
(e) processing papers and disbursal of a loan on security of policy;
(f) issuance of duplicate policy;
(g) issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and
(h) guidance on the procedure for registering a claim and early settlement thereof.

12.2 In case of linked policies, the insurer shall at all times respond to any communication from its policyholders in the following additional matters:

(a) Issuing of a statement of account
(b) Complying with a request for switching or redirection of premiums as per terms of the policy

13 Services under General Insurance Policies.

13.1 All policyholders must be given renewal notices by electronic means 30 days before date of renewal.

13.2 All policies need to give the circumstances under which renewal should not be invited and only those policyholders will be left out from the renewal notice obligation.

13.3 Notice need to be given to the policyholder that premium is to be paid before the date of renewal in order to have continuity of benefits. The insurers should honor the GRACE PERIOD, where regulation allows grace period.

13.4 Policyholders should be informed of discounts, no claim bonus, etc. and the benefit should be passed on to the policyholders at renewals

13.5 Malus, if applicable, should be informed in the policy document.

13.6 All policyholders must be advised to disclose any change in risk, addresses and other information, and revised sum insured keeping in mind their new requirements as well as inflation factors.

13.7 Any new add-ons and value additions that insurer has launched should also be advised for the policyholders consideration.

13.8 Rate and premium changes should be advised as per the File and Use approval.

14 Grievance Redressal Procedure

Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same, along-with the information in respect of Insurance Ombudsman, shall be communicated to the policyholder along-with the policy document and as maybe found necessary.

The Guidelines on Grievance Redressal Framework outlined in Annexure II and Complaint Handling Procedure as indicated in Annexure III shall be followed scrupulously by all Life and General Insurers.

15 General

15.1 The requirements of "disclosure of material information" regarding a proposal or policy apply, under these regulations, both to the insurer and the insured.

15.2 The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims, which the insurer has against third parties.

15.3 The policyholder shall furnish all information that is sought from him by the insurer and also any other information, which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered under a proposal for insurance.

15.4 Every insurer shall constitute a Policyholders' Protection Committee in terms of the Corporate Governance Guidelines indicated in Annexure V to the Regulations.

15.5 Insurers shall at all times maintain total confidentiality of policyholder information, as part of the trust reposed in the organization by the policyholder unless it becomes necessary to disclose the information due to operation of any law.

15.6 Any breach of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.

(Chairman)

ANNEXURES TO REGULATIONS

List of Annexures

- **Annexure I – Model Citizens Charter for Insurer**
- **Annexure II – Guidelines on Grievance Redressal Framework**
- **Annexure III- Complaint Handling Procedure**
- **Annexure IV – Enforcement of Rights of policyholders**
- **Annexure V – Corporate Governance Guidelines for Policyholder Protection**

ANNEXURE – I

MODEL CITIZENS' CHARTER FOR INSURER

Preamble

1.1. Citizen's Charter of an insurer is a document, which represents the commitment of the insurer towards its clients in respects of Standard of Services, Information, Choice and Consultation, Non-discrimination and Accessibility, Grievance Redress, Courtesy and Value for Money. This also includes expectations of the insurer from the Citizen for fulfilling the commitment of the insurer.

1.2. The twin objectives of the Citizens Charter are:

(a) To empower consumers with information about standards of service, time limits that the consumers can reasonably expect, value added services and avenues of grievance redress

(b) To provide insurers with an opportunity of coming out with a statement of quality/best practices in the form of Charter to differentiate themselves from their competitors and also help them in measuring quality improvements at regular intervals.

1.3. The Citizen's Charter shall provide for the following matters, namely: —

a) the details of all the services rendered by the insurer, the name of person or agency through which such services are rendered and timings during which such services are supplied or services rendered;
b) the conditions under which a person becomes entitled for services, and the class of persons who are entitled to avail services;
c) the quantitative and tangible parameters of the services available to the public;
d) complaint redressal mechanism including the time within which the complaint be disposed of and the officer of the insurer to whom such complaint may be made;
e) the name and addresses of individuals responsible for the rendering of services mentioned in (a) above;
f) any other functions, obligations, responsibilities or duties required or reasonably expected of the insurer;
g) any other information relevant to delivery of provision of services or such other information as may be prescribed.

1.4. Model Citizen's Charter for Life Insurers is enclosed hereinafter and the Citizen's Charter for General and Health Insurance is enclosed as **Part II**. The list is indicative and not exhaustive. **The time indicated by the insurer for services should not be greater than the time as prescribed in the Regulations.**

1.5. Information and Facilitation Centers:

a) The charter shall be widely publicized by conducting awareness campaigns through print media, posters, banners, leaflets, handbills, brochures, local newspapers and most importantly, electronic media.

b) For efficient and effective delivery of information and service to consumers, insurers may establish Information and Facilitation Centre, which may include

establishment of Client Care Centre, call center, help desk and people's support centre

1.6. Website

Every insurer shall have a comprehensive website which contains information about services offered, FAQs, facilities for enquiry, lodging of complaints, etc. in addition to the information mandated to be disclosed as per any law or regulation in force.

Citizens' Charter enshrines the trust between the insurance service provider and the end users with the primary objective of empowering clients in relation to insurance service delivery.

PART-I

MODEL CITIZENS CHARTER – LIFE INSURANCE

Basic Service Standards

S. No	Policy Stage	SERVICE	DESCRIPTION OF ITEM OF SERVICE	Company Turnaround Time
1	New Business Proposal Processing.	Insurance (Individual Life)	Acknowledgement of Proposal Form and all documents papers	
			Processing of Insurance Proposal and communication of decision on the proposal including • Requirements for consideration of the proposal • Non-acceptance of proposal	
			Issuance of policy	
			Final Decision on completion of proposal where the Insurer had called for requirements.	
			Refund of Proposal deposit etc. if any	
			Sharing a copy of proposal form (from date of acceptance of proposal)	
		Insurance (Group plans)	Collection of proposal paper, etc.	
			Issuance of Policy	
		Insurance (Micro-Individual Life)	Conveying acceptance on receipt of all papers	
			Issuance of Policy	
		Insurance (Micro-Group Plan)	Collection of proposal paper, etc.	
			Issuance of Policy.	
2	Post Policy Service Request		Post Policy Service Requests concerning mistakes / corrections in the Policy document	
			Obtaining copy of the Proposal, Medical documents, declarations, supporting documents etc.	
3	Free-Look Cancellation		Free Look Cancellation & Refund from the date of receipt of request	
4	Issues pertaining to Mis-selling of Insurance		Redressal action by the Insurer	
5	Policy Servicing (For Individual / Group / Micro / Health policies of Life Insurers) TAT from date of receipt of request for the service specified		Change of Address (KYC Norms to be complied)	
			Registration /Change of Nomination, Assignment.	
			Alteration in ORIGINAL POLICY CONDITIONS (where applicable)	
			Policy loan.	
			Surrender of Policy	
			Confirmation of action on Unit Linked Insurance Policy (ULIP) related requests – Switch, Top-up, and other NAV related Services.	
			Decision on Policy Revival after receipt of all requirements.	

		Issue of Premium Payment Certificates (PPC)	
		Issue of Duplicate Policy	
6.	Claim Services	Settlement of Maturity Claims	
		Settlement of Survival Benefits (or from the date of receipt of discharge)	
		Death claims settlements – No requirement cases –	
		Death claims – calling for additional requirements (from date of making claim)	
		Death Claim cases – Requirement cases Settling death claims after receipt of all documents **– decision and payment**	
		Early death claims requiring investigations – decision & payment	
		Annuity payments / Pension Payment (on due date or from the date of receipt of discharge)	
		Health Insurance Claims after receipt of all documents	
7	System generated action and Intimation	Premium Due Intimation	
		Policy Premium Default intimation	
		Policy Lapse information	
		Policy payments information (Survival benefit)	
		Policy payments information (Maturity)	
		Change in Policy conditions such as • Inclusion of Accident Benefit • Withdrawal of Accident Benefit • Other Changes as per Policy Conditions	
8	Complaints	Acknowledgement of complaint	
		Action on Complaint & Intimation of Decision to the complainant	
		Closure of IGMS entry after resolution of complaint	
9	General	Response to any communication received from prospect / Client on any General matter	

PART-II
MODEL CITIZENS CHARTER (GENERAL INSURANCE)
Basic Service Standards

S. No	Policy Stage	DESCRIPTION OF ITEM OF SERVICE	Company Turnaround Time
1	AT THE TIME OF SALE.	Processing of Proposal and communicating the acceptance /rejection	
		Sharing the copy of proposal form	
		Issuance of premium receipt	
2	POST SALE	Issuance of Policy Document	
		Issuance of duplicate policy on request	
		Endorsement: - a) Increase/Decrease in sum Insured b) Change of Location of risk c) Change of Address d) Change of Nominee e) Correction of errors in the policy f) Inclusion and deletion of financial interest g) Inclusion of new members in case of Group policies h) Any other non-claim related changes	
		Cancellation Policy and refund of Premium	
3	CLAIMS	Appointment of Surveyors	
		Issuance of Claim form	
		Surveyors report after appointment	
		Addendum Survey Report sought by the Insurer	
		Submission of final report after receiving Insurer's request	
		Communicating acceptance or rejection of the claim	
		Offer for settlement after receipt of the addendum report-IncaseWhere Investigation is not required	
		a) Personal line and retail insurance claims	
		b) Commercial line insurance claims	
		Offer for settlement where the claim requires investigation after receipt of addendum Survey Report	
		Payment of Claim on acceptance by the Insured	
4	Complaints	Action on Complaint & Intimation of Decision to the complainant	
		Closure of IGMS entry after resolution of complaint	
5	General	Response to any communication received from prospect / Client on any General matter	

PART-III
MODEL CITIZENS CHARTER (HEALTH INSURANCE)
Basic Service Standards

S. No	Policy Stage	DESCRIPTION OF ITEM OF SERVICE	Company Turnaround Time
1	AT THE TIME OF SALE.	Processing of Proposal and communicating the acceptance /rejection	
		In general cases where medical examination to be done and certificates are to be produced	
		Sharing a Proposal form copy	
		Issuance of premium receipt	
2	POST SALE	Issuance of Policy Document	
		Free look cancellations and refund of deposit from the date of receipt of the request	
		Issuance of duplicate policy on request	
		Endorsement: - a) For inclusion/deletion in Group Policies b) Cancellation and refund c) Correction of errors d) Change of Nominee e) Correction of errors in the policy f) Inclusion of new members in case of Group policies g) Any other non-claim related changes	
		Uploading of proposal and policy documents in TPA system	
		Issuance of ID cards by TPA /Company after the uploading of documents	
3	CLAIMS	Acceptance of cashless claims by TPA /company to Hospital and communicate to them	
		Communicate of acceptance /rejection of claim	
		TPA's offer of settlement to the Insurer / Hospital after submission of document	
		Payment of Claims on acceptance by the insured by discharging voucher	
		Offer for settlement where the claim requires investigation after receipt of addendum Survey Report	
		Payment of Claim on acceptance by the Insured	
4	Complaints	Action on Complaint & Intimation of Decision to the complainant	
		Closure of IGMS entry after resolution of complaint	
5	General	Response to any communication received from prospect / Client on any General matter	

ANNEXURE – II

GUIDELINES ON GRIEVANCE REDRESSAL FRAMEWORK

(1) Grievance Officer/s and Nodal Officer

a. Every insurer shall have a designated Grievance Redressal Officer (GRO) of a Senior Management level at the corporate level. Senior Management would mean either the CEO or the Compliance Officer of the company. This Officer shall coordinate with IRDA in respect of grievances and policy holder protection.
b. Every Regional Office / Divisional Office / Branch office of the insurer shall have a designated Grievance Officer for that office.
c. Every insurer shall also name an officer as a Nodal Officer for each Office of the insurance Ombudsman to coordinate with the Office of Insurance Ombudsman, furnish information and also represent the insurer in hearings before the Ombudsman. A Grievance Officer can also be designated as a Nodal Officer.
d. The details of the GRO, Grievance Officers and Nodal Officers, along with the contact details, in full shall be published in the website of the insurer.

(2) Grievance Redressal System/Procedure

a. Every insurer shall have a system and a procedure for receiving, registering and disposing of grievances in each of its offices. The compliant handling procedure on receipt, acknowledgement, resolution, disposal etc. is indicated in Annexure IV. This and all other relevant details along with details of Turnaround Times (TATs) shall be clearly laid down in the Grievance Redressal Policy. While insurers may lay down their own TATs, they shall ensure that the minimum time frames prescribed in the citizen's charters at Annexure I and Annexure II to these Regulations are not exceeded:
b. Any failure on the part of insurers to follow the procedures and time-frames prescribed in the citizen's charters in Annexure I and Annexure II would attract action including penalties by the Insurance Regulatory and Development Authority.

(3) Categorisation of complaints

a. Categorisation of complaints as prescribed by the IRDA from time to time shall be adopted by insurers and incorporated in their systems.
b. All insurers shall provide for the classification categories as prescribed by IRDA in their respective systems.

(4) Minimum software requirements

a. It is necessary for insurers to have automated systems that will enable online registration, tracking of status of grievances by complainants and periodical reports as prescribed by IRDA.
b. The system should also be one which can integrate seamlessly with the IRDA's system in the manner prescribed by IRDA. IRDA shall define these requirements from time to time and

insurers shall ensure that they provide for such software/system modifications as may be required.

c. The objective is to create the required industry level database and systems that would enable speedy and effective redressal of complaints and monitor grievance redressal systems.
d. The system would also facilitate analysis of complaints, mitigation and improvement of processes and systems through constant review.

(5) Calls relating to grievances

Insurers shall also have in place a system to receive and deal with all kinds of calls including voice/e-mail, relating to grievances, from prospects and policyholders. The system should enable and facilitate the required interfacing with IRDA's system of handling calls/e-mails.

(6) Publicizing Grievance Redressal Procedure

Every insurer shall publicize its grievance redressal procedure and ensure that it is specifically made available on its website.

ANNEXURE – III

COMPLAINT HANDLING PROCEDURE

I. Making an Insurance Complaint or Grievance:

A complaint or a grievance can be filed by a consumer or on behalf of such person.

II. Complaint resolution by the respondents:

The respondents should aim to resolve complaints at the earliest possible opportunity and shortest possible time complying with the following aspects.

a) Registration of complaint;
b) Action on receipt of complaint
c) Complaint Forwarding;
d) Acknowledgement of complaint;
e) Assessment of complaint;
f) Resolution of the complaint and its quality; and
g) Closure of complaint.

III. Registration of complaint:

a) A complaint received on a 'business day / working day' shall be treated as complaint received on the 'business day / working day' and registered with the 'date of receipt' accordingly.
b) A complaint received on any day other than a 'business / working day', or after close of business on a business day, may be treated as received on the next business day / working day and registered with the 'date of receipt' accordingly
c) Every complaint other than a request or an inquiry shall be registered as a complaint irrespective of the time taken for resolution.

IV. **Action on receipt of Complaint**:

Once a complaint is received from a complainant, the respondent should:

a) Investigate the complaint comprehensively, diligently and impartially and if felt necessary, by obtaining additional information;
b) Examine fairly, consistently and promptly:
    i. The subject matter of the complaint;
    ii. The remedial action or redress or both sought by the complainant;
    iii. Whether the respondents in the complaint are solely or jointly responsible for the matter alleged in the complaint, and if so act accordingly;

V. Complaint Forwarding:

a) Where the complaint does not pertain to the respondent receiving it but to another respondent, he should forward the complaint in its entirety to the other respondent and advise the complainant in writing.
b) In cases where other respondents mentioned in the complaint may be solely or jointly responsible for the issues alleged in a complaint, the main respondent to whom the complaint is

addressed shall forward the complaint or the relevant part of the complaint, in writing, to that other respondent, provided the following conditions are fulfilled:

i. The respondent should forward the complaint to the other respondent(s) promptly, and in no case later than three days from the receipt of the complaint;
ii. The respondent should comply with its own obligations in respect of that part of the complaint it has not forwarded.

c) A respondent, who is in receipt of a complaint that has been forwarded to it, should treat the complaint received as if it was made directly to that respondent.

VI. Acknowledgement of complaint:

On receipt of a complaint, a respondent must do the following:

a) Send the complainant a prompt written acknowledgement at the earliest stating therein that the complaint has been received and is being dealt with.
b) Inform the name, designation and contact details of the officer who will deal with the complaint.
c) Indicate the grievance redressal procedure and the time taken for resolution of complaint.
d) Where the respondent resolves the complaint within 3 days, the respondent may communicate the resolution along with the acknowledgement.
e) Where the complaint is not resolved within 3 working days, the respondent shall resolve the complaint within fifteen days of its receipt and send a final letter of resolution.

VII. Assessment of complaint:

General factors that may be relevant in the assessment of a complaint and arriving at a resolution are as follows:

a) The details of the complaint
b) Relevant details / enclosures / attachments sent with the complaint or called for additionally to substantiate the complaint
c) Relevant Terms and conditions of product, service rules and conditions;
d) Similarities with complaints received by the respondent and other respondents on the same subject, if any;
e) Relevant Insurance Laws, Rules, Regulations, Guidelines or instructions issued from time to time as applicable to the complaint;
f) Previous decisions by the Courts / Ombudsman in similar matters

VIII. Resolution of complaint and its quality:

a) Based on the assessment of the complaint as indicated above, the respondent may decide any of the following courses of action in respect of the complaint:
    i. Accepts the deficiency brought out in the complaint and offers redressal or remedial action sought in the complaint; or
    ii. Offers partial redressal or remedial action without accepting the deficiency; or
    iii. Rejects the complaint with reasons
b) Where the respondent accepts the deficiency in full or offers redressal or remedial action, it should
    i. give a detailed written response indicating in a way that is fair, clear and not misleading,
        a. It's assessment of the complaint,

b. It's decision on the complaint with reasons, and
c. The offer of remedial action or redress.

ii. comply promptly with the offer of remedial action or redress accepted by the complainant

c) Where the respondent rejects the complaint, it should do so in writing explaining the reasons for rejection of the complaint which shall include
   i. The relevant policy conditions / procedures / insurance laws / regulations, explaining reasons as to why the respondent is not in a position to accept the complaint;
   ii. Intimation to the complainant that if the response is not satisfactory, the complaint may refer the complaint to the Insurance Ombudsman within one year of the receipt of letter from the respondent; and enclose a copy of the Insurance Ombudsman details.
   iii. Where the ground of complaint does not fall within the purview of Ombudsmen, the respondent may advise accordingly.
d) The respondent shall ensure that the complaint is resolved within fifteen days of the receipt of the complaint.
e) Where the complainant does not furnish the particulars required by the respondent or where the respondent does not receive the full cooperation of the complainant, the respondent shall inform the complainant in writing about the delay that may result in the resolution of the complaint.
f) Where the complaint has been forwarded to other respondent(s), the respondent should inform the complainant in a final response as to why the complaint has been forwarded by it to the other respondent(s) along with the other respondent's contact details
g) The respondent should ensure consistency of resolution for similar complaints.
h) The respondent should bring improvements in their systems so as avoid such complaints in future.

IX. Closure of complaint:

A complaint shall be considered as disposed of and closed when

a) The respondent has acceded to the request of the complainant fully and communicated the same to the complainant.
b) Where the complainant has indicated in writing, acceptance of the resolution offered by the respondent.
c) Where the complainant has not responded to the respondent within 8 weeks of the respondent's written response.
d) Where the Grievance Redressal Officer of the respondent has certified that the respondent has discharged its contractual, statutory and regulatory obligations and therefore closes the complaint.

X. Maintenance of Records regarding Complaints:

a) A respondent must preserve the record of each complaint received including the details of the resolution of the complaint, for at least three years from the date the complaint was received.
b) The records of the complaints received and disposed by the respondent and the measures taken for resolution of complaints may be used by the regulator in the analysis of Complaint Management Information and Systems of the Insurer.

XI. **Reporting of Complaints:**

a) An Insurer must provide to IRDA a complete report of complaints received and the disposal of the complaints in the formats prescribed and within the time limits stipulated therein.

b) In respect of forwarded complaints, the insurer must mention clearly in its report whether
    i. The insurer forwarded the complaint in its entirety to another respondent in terms of provisions of complaint forwarding or
    ii. The insurer forwarded only part of the complaint to the other respondent / respondents and has responded to the complainant on the part relevant to the Insurer.

c) The formats of Reports to be submitted to IRDA, the periodicity of their submission and due date by which the Reports should be submitted shall be prescribed by IRDA from time to time.

ANNEXURE – IV

ENFORCEMENT OF RIGHTS OF CONSUMERS

For the purposes of this Annexure, "***insurance service provider"*** means Insurers, insurance agents and insurance intermediaries and "***insurance advisor"*** means an insurance service provider or its authorized representative who is eligible to solicit insurance under the extant regulatory framework.

The insurance service providers and Insurance advisors shall secure the following Rights to Consumers:

1) Right To Professional Diligence

a) "Professional diligence" means the standard of skill and care that an insurance service provider would be reasonably expected to exercise towards a consumer, commensurate with–
   i. Honest market practice;
   ii. The principle of good faith;
   iii. The level of knowledge, experience and expertise of the consumer;
   iv. The nature and degree of risk embodied in the insurance product or service being availed by the consumer; and
   v. The extent of dependence of the consumer on the insurance service provider

b) Every insurance service provider shall ensure that any interaction that they have with consumers shall be carried out in good faith and in line with honest market practices. Every insurance service provider shall exercise professional diligence as explained above in their dealing with prospects and policyholders.

2) Right To Protection Against Unfair Contract Terms

a) A contract term which is not contained in the insurance product documents approved by IRDA under the File and Use Guidelines relevant to the insurance product issued by IRDA from time to time shall be deemed to be an 'unfair term'. Such an unfair term is void ab initio.
b) Subject to (a) above, an unfair term in a non-negotiated insurance contract will be void.
c) A term is unfair if it
   i. causes a significant imbalance in the rights and obligations of the parties under the insurance contract, to the detriment of the consumer; and
   ii. is not reasonably necessary to protect the legitimate interests of the insurance service provider.
d) The factors to be taken into account while determining whether a term is unfair include
   i. the nature of the insurance product or service dealt with under the insurance contract;
   ii. the extent of transparency of the term;
   iii. the extent to which the term allows a consumer to compare it with other contracts for similar products or services; and
   iv. the contract as a whole and the terms of any other contract on which it is dependent.
e) IRDA, from time to time, would give illustrative list of terms which are considered unfair.
f) A term is transparent if it
   i. is expressed in reasonably plain language that is likely to be understood by the consumer;

ii. is legible and presented clearly; and
iii. is readily available to the consumer affected by the term

g) A non-negotiated contract means a contract whose terms are not negotiated between the parties to the contract and includes
   i. A contract in which, relative to the consumer, the insurance service provider has a substantially greater bargaining power in determining the terms of the contact; and
   ii. A standard form contract. i.e. a contract that is substantially non-negotiable for the consumer, except for the terms contained in item h below

h) Even if some terms of an insurance contract are negotiated in form, the insurance contract may be regarded as non-negotiated contract if so indicated by –
   i. An overall and substantial assessment of the contract and
   ii. The substantial circumstances surrounding the contract

i) In a claim that an insurance contract is a non-negotiated contract, the onus of demonstrating otherwise shall be on the insurance service provider.

j) If a term of contract is determined to be unfair, the parties will continue to be bound by the remaining terms of the insurance contract to the extent that the insurance contract is capable of enforcement without the unfair term.

k) The protection against unfair contract terms contained above **does not apply** to a term of an insurance contract if it —
   i. defines the subject matter of the contract;
   ii. sets the price that is paid, or payable, for the provision of the insurance product or service under the contract and has been clearly disclosed to the consumer
   Provided the term does not deal with payment of an amount which is contingent on the occurrence or non-occurrence of any particular event; or
   iii. is required, or expressly permitted, under any law or regulations

3) Right to Protection Against Unfair Market Conduct

a) Unfair conduct in relation to insurance product or service is prohibited.

b) Unfair conduct means an act or omission by an insurance service provider or its financial representative that significantly impairs, or is likely to significantly impair, the ability of a consumer to make an informed transactional decision and includes
   i. Misleading conduct;
   ii. Abusive conduct; and
   iii. Such other conduct as may be specified.

c) **Misleading conduct** - Conduct of an insurance service provider or its financial representative in relation to a determinative factor is misleading if it is likely to cause the consumer to take a transactional decision that the consumer would not have taken otherwise, and the conduct involves
   i. Providing the consumer with inaccurate information or information that the insurance service provider or financial representative does not believe to be true; or
   ii. Providing accurate information to the consumer in a manner that it is deceptive.

   Explanation: In determining whether a conduct is misleading, the following factors must be considered to be "determinative factors" —
   - the main characteristics of the insurance product or service, including its features, benefits and risks to the consumer;
   - the consumer's need for a particular insurance product or service or its suitability for the

consumer;

- the consideration to be paid for the insurance product or service or the manner in which the consideration is calculated;
- the existence, exclusion or effect of any term in an insurance contract, which is material term in the context of that financial contract;
- the nature, attributes and rights of the insurance service provider, including its identity regulatory status and affiliations; and
- the rights of the consumer under any law or regulations.

d) **Abusive conduct**: Conduct of an insurance service provider or its financial representative in relation to an insurance product or service is abusive if it –

i. involves the use of coercion or undue influence; and
ii. causes or is likely to cause the consumer to take a transactional decision that the consumer would not have taken otherwise.

Explanation: In determining whether a conduct uses coercion or undue influence, the following must be considered —

- the timing, location, nature or persistence of the conduct;
- the use of threatening or abusive language or behaviour;
- the exploitation of any particular misfortune or circumstance of the consumer, of which the insurance service provider is aware, to influence the consumer's decision with regard to the insurance product or service;
- any non-contractual barriers imposed by the insurance service provider where the consumer wishes to exercise rights under a contract; and
- a threat to take any action, depending on the circumstances in which the threat is made.

e) Protection From Conflict of Interest of Advisors: To ensure that the interests of consumers take precedence over that of financial service provider

4) Right To Protection of Personal Information

a) 'Personal information' means any information that relates to a consumer or allows a consumer's identity to be inferred, directly or indirectly, and includes –

i. name and contact information;
ii. biometric information, in case of individuals;
iii. information relating to transactions in or holdings of financial products
iv. information relating to use of insurance products and services
v. such other information as may be specified like information relating to personal health, income, assets etc.

b) An insurance service provider must —

i. not collect personal information relating to a consumer in excess of what is required for the provision of a insurance product or service;
ii. maintain the confidentiality of personal information relating to consumers and not disclose it to a third party, except in a manner expressly permitted herein.
iii. make best efforts to ensure that any personal information relating to a consumer that it holds is accurate, up to date and complete;
iv. ensure that consumers can obtain reasonable access to their personal information, subject to any exceptions that may be specified by IRDA; and

v. allow consumers an effective opportunity to seek modifications to their personal information to ensure that the personal information held by the insurance service provider is accurate, up to date and complete.

c) An insurance service provider may disclose personal information relating to a consumer to a third party only if —
   i. it has obtained prior written informed consent of the consumer for the disclosure, after giving the consumer an effective opportunity to refuse consent;
   ii. the consumer has directed the disclosure to be made;
   iii. the disclosure is directly related to the provision of the insurance product or service to the consumer, if the insurance service provider —
      - informs the consumer in advance that the personal information may be shared with a third party; and
      - makes arrangements to ensure that the third party maintains the confidentiality of the personal information in the same manner as required herein;
   iv. the disclosure is made to protect against or prevent actual or potential fraud, unauthorised transactions or claims, if the insurance service provider arranges with the third party to maintain the confidentiality of the personal information in the manner required herein;
   v. IRDA has approved or ordered the disclosure, and unless prohibited by the relevant law or regulations, the consumer is given an opportunity to represent under such law or regulations against such disclosure; or
   vi. the disclosure is required under any law or regulations, and unless prohibited by such law or regulations, the consumer is given an opportunity to represent under such law or regulations against such disclosure;

d) For the purposes of this provision, 'third party" means any person other than the concerned insurance service provider, including a person belonging to the same group as the insurance service provider.

5) Right To Requirement of Fair Disclosure

a) An insurance service provider must ensure fair disclosure of information that is likely to be required by a consumer to make an informed transactional decision.

b) In order to constitute fair disclosure, the information must be provided —
   i. sufficiently before the consumer enters into an insurance contract, so as to allow the consumer reasonable time to understand the information;
   ii. in writing and in a manner that is likely to be understood by a consumer belonging to a particular category; and
   iii. in a manner that enables the consumer to make reasonable comparison of the insurance product or service with other similar products or services.

c) IRDA may specify the types of information that must be disclosed to a consumer in relation to an insurance product or service, which may include information regarding —
   i. main characteristics of the product or service, including its features, benefits and risks to the consumer;
   ii. consideration to be paid for the product or service or the manner in which the consideration is calculated;
   iii. existence, exclusion or effect of any term in the insurance product or financial contract;

iv. nature, attributes and rights of the insurance service provider, including its identity regulatory status and affiliations;
v. contact details of the insurance service provider and the methods of communication to be used between the insurance service provider and the consumer;
vi. rights of the consumer to rescind an insurance contract within a specified period; or
vii. rights of the consumer under any law or regulations.

d) An insurance service provider must provide a consumer who is availing an insurance product or service provided by it, with the following continuing disclosures —
   i. any material change to the information that was required to be disclosed at the time when the consumer initially availed the insurance product or service;
   ii. information relating to the status or performance of an insurance product held by the consumer, as may be required to assess the rights or interests in the insurance product or service; and
   iii. any other information that may be specified.
e) A continuing disclosure must be made —
   i. within a reasonable time-period from the occurrence of any material change or at reasonable periodic intervals, as applicable; and
   ii. in writing and in a manner that is likely to be understood by a consumer belonging to that category.
f) IRDA may specify—
   i. the nature of information that must be disclosed on a continuing basis to a consumer who has availed of a specified insurance product or service;
   ii. the time-period within which continuing disclosures of information are to be made for a specified insurance product or service;
   iii. circumstances in which the consumer will have a right to terminate the insurance contract upon a continuing disclosure being made;

6) Right To Receive Suitable Advice

a) Every insurance advisor must
   i. make all efforts to obtain correct and adequate information about the relevant personal circumstances of a consumer; and
   ii. ensure that the advice given is suitable for the consumer after due consideration of the relevant personal circumstances of the consumer.
b) IRDA would take into account the following factors in relation to (a) above —
   i. the extent to which the cost of seeking information about the relevant personal circumstances of consumers might restrict the access of consumers to the insurance product or service; and
   ii. sufficiency of the disclosures made under 5 above to allow consumers to assess the suitability of the insurance product or service for their purposes.
c) If it is reasonably apparent to the insurance advisor that the available information regarding the relevant personal circumstances of a consumer is incomplete or inaccurate, the insurance advisor must warn the consumer of the consequences of proceeding on the basis of incomplete or inaccurate information.
d) If a consumer intends to avail of an insurance product or service that the insurance advisor determines unsuitable for the consumer, the insurance advisor —
   i. must clearly communicate its advice to the consumer in writing and in a manner that is likely to be understood by the consumer; and

ii. may provide the insurance product or service requested by the consumer only after complying with clause (i) and obtaining a written acknowledgement from the consumer.

e) IRDA may categorize certain consumers or class of consumers as retail consumers and specify the insurance products or services which may be provided to retail consumers or a class of retail consumers.

f) IRDA may specify —
   i. the type of enquiries that need to be made to determine the relevant personal circumstances of retail consumer for an insurance product or service; or
   ii. that certain types of communications issued by an insurance service provider to a retail consumer would not constitute advice.

7) **Protection From Conflict of Interest of Advisors**

a) An insurance advisor must-
   i. provide a consumer with information regarding any conflict of interests, including any conflicted remuneration that the insurance advisor has received or expects to receive for making the advice to the consumer. This information shall be given to the consumer in writing and in a manner that is likely to be understood by the consumer and a written acknowledgement of the receipt of the information should be obtained from the consumer.
   ii. give priority to the interests of the consumer if the insurance advisor knows, or reasonably ought to know, of a conflict between —
      - its own interests and the interests of the consumer; or
      - the interests of the concerned insurance service provider and interests of the consumer in cases where the advisor is a representative of the insurance service provider.

b) IRDA may specify
   i. the circumstances in which a benefit received by an insurance advisor would or would not be considered to be a conflicted remuneration; or
   ii. the nature, type and structure of benefits permitted to be received by an insurance advisor for an insurance product or service.

c) "Conflicted remuneration" means any benefit, whether monetary or non-monetary, derived by an insurance advisor from persons other than consumers that could, under the circumstances, reasonably be expected to influence the advice given by the insurance advisor to a consumer.

ANNEXURE – V

CORPORATE GOVERNANCE GUIDELINES FOR POLICYHOLDER PROTECTION

1.1. Protecting the interest of the policyholder demands that the insurers have in place good governance practices.

1.2. The Board of insurershould:

a) Have in place a corporate philosophy and governance system that will uphold the highest standards of business conduct and ethical behavior.
b) Define the standards of business conduct, ethical behavior for directors and senior management
c) Ensure that the policy of fair treatment of policyholders is embedded into all aspects of operation and is implemented at all stages of insurer-consumer transactions and relationship including the design, marketing, advice, point-of-sale and after-sale stages
d) Consider the interest of their prospects and policyholders as a specific group and ensure all the rights of consumers as mentioned in **Annexure IV.**
e) Develop a corporate culture that recognizes and rewards policyholder protection.
f) Establish Board level Committee for policyholder protection which will adopt sound and healthy market conduct practices and inculcate fair treatment of policyholders.
g) The responsibilities of the Policyholder Protection Committee shall include:
   i. Putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including mis-selling by insurance companies, insurance agents and insurance intermediaries.
   ii. Ensuring compliance with the statutory requirements as laid down in the regulatory framework.
   iii. Reviewing the mechanism at periodic intervals.
   iv. Ensuring adequacy of disclosure of "material information" to the policyholders. These disclosures shall comply with the requirements laid down by IRDA both at the point of sale and at periodic intervals.
   v. Reviewing the status of complaints at periodic intervals.
   vi. Providing the details of grievances at periodic intervals in such formats as may be prescribed by IRDA.
   vii. Ensuring that details of insurance ombudsmen are provided to the policyholders

1.3. Disclosure requirements:
As part of transparency, insurers must disclose at periodical intervals as per relevant regulations, financial and other disclosures to enable consumers to make reasoned choices regarding selection of the insurer. Towards protecting the interests of the policyholders the insurer must ensure complete transparency in service operations and make periodic disclosures. In particular, the disclosure requirements of the participating policyholders and the unit-linked policyholders must be duly addressed.

1.4. Board should conduct periodically "a Gap Analysis" to identify the areas of business where their organization is not meeting the obligation to ensure all the rights of the consumer.

1.5. With regard to the Citizen's Charter, the Board should:

(a) Ensure that appropriate policies and processes have been laid down in respect of design and implementation of the Charter as per details given in **Annexure I**.

(b) Ensure that the Charter is formulated through a consultative process involving staff from all the levels of organization and that the staff is orientated about the salient features and goals/ objectives of the Charter.

(c) Approve the Charter, review and verify every year the accuracy of the contents thereof, and mention the date of latest review and the next date of review in the Charter.

(d) See that the Charter is
    i. available free of cost
    ii. widely disseminated to the public,
    iii. is made available at the website of the insurer and in other electronic forms,
    iv. publicized by conducting awareness campaigns through print media, posters, banners, leaflets, handbills, brochures, local newspapers and most importantly through electronic media.

(e) Earmark budget for generating awareness amongst the consumers and for orientation of staff.

(f) Submit board approved copy of the Citizens Charter of the insurer duly certified by it to IRDA.