Ref.No: IRDA/ENF/ORD/ONS/ 247 / 12 / 2016

Final Order in the matter of M/s Birla Sun Life Insurance Company Ltd.

Based on reply to the Show Cause Notice dated 19th August, 2016 and submissions made during Personal Hearing on 5th October, 2016 at 11.30 Am taken by Member (F&I) at the office of Insurance Regulatory and Development Authority of India, 3rd Floor, Parishrama Bhavan, Basheerbagh, Hyderabad.

The Insurance Regulatory and Development Authority of India (hereinafter referred to as "the Authority") carried out an onsite inspection of **M/s Birla Sun Life Insurance Company Ltd** (hereinafter referred to as "the life insurer") during 21st to 30th October, 2013. The Authority forwarded the copy of the Inspection Report to the life insurer on 21st January, 2014 and the life insurer responded vide letter dated 14th February, 2014 & 30th March, 2016. Upon examining the submissions made by the life insurer, the Authority issued Show Cause Notice on 21.07.2016 which was responded to by the life insurer vide letter dated 19.08.2016. As requested therein, a personal hearing was given to the life insurer on 05.10.2016. Sh Pankaj Razdan, MD & CEO, Sh Lalit Vermani,Chief Legal, Compliance and Risk Officer, Sh Ashok Suvarna, Chief Operations Officer, Sh Amit Jain, Chief Finance Officer, Sh Anil Kumar Singh, Appointed Actuary, Sh Shailendra Kothavale, Head-Risk Management & Sh Ramsubhag Singh, DVP – Risk Management were present in the hearing on behalf of the life insurer. On behalf of the Authority, Ms. V.R.Iyer, Member (F&I), Ms.Mamata Suri, CGM (F&A), Sh Prabhat Kumar Maiti, GM (Enforcement), Sh Gautam Kumar, DGM (Life) & Sh K.Sridhar, AGM (Enforcement) were present during the personal hearing.

The submissions made by the life insurer in their written reply to the inspection observations, to the Show Cause Notice and also those made during the course of the personal hearing have been taken into account.

The findings on the explanations offered by the life insurer to the Show Cause Notice and the decisions thereon are detailed below.

1. **Charge – 1**

a) In case of ULIP products, amount up to annualized premium was utilized at the time of issuance and any amount which exceeds annualized premium up to Rs.1,000/- was parked in the advance premium account and gets adjusted against subsequent premiums due in the policy.

b) It was observed from premium accounting for ULIP plans that the insurer had adjusted the excess premiums received over and above the annualized premium on the day of receipt of premium itself instead of adjusting the premiums at the respective due dates. Such adjustment of advance premium is done in all the ULIP plans wherever the insurer had received advance premiums.

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Violation of Regulation 52 of IRDA (Linked insurance products) Regulations, 2013 read with point 12 in page 6 of circular ref.no.IRDA/ACT/cir/PRD/119/06/2013-14 dated 20th June, 2013.

Submission of the insurer:

We hereby submit that excess premium in respect of ULIP policies up to annualized premium used to be unitized as on policy issue date in order to pass on the benefit to the customer so that the invested amount could generate returns. The same also was communicated to customers by providing them with 'Unit Statement' along with Policy documents.

However, after issuance of IRDA (Linked Insurance Product) Regulations, 2013 and subsequent clarification issued in June 2013, BSLI initiated the system enhancement to ensure adherence to the requirements of treatment of Advance Premium as per Regulations. The system enhancement was completed and requirements implemented with effect from July 2014 and thereafter any excess premium received up to the financial year end, is parked in Advance Premium and applied to the policy on the effective due date.

Decision:

Advance premium shall be collected by insurer only of premiums falling due within the same financial year and such collected advance premium shall be adjusted on the due date of premium. Insurer has not only accepted advance premiums of dues beyond the financial year but has also unitized the same on the date of receipt of deposit instead adjusting on due date. IRDA (Linked insurance products) Regulations, 2013 was notified on 16th Feb, 2013 and clarificatory circular on the Regulation relating to advance premium was issued on 20th June, 2013. Insurer took more than a year to implement the Authority directions and that too only after the observation by the inspection team.

In view of the violation of the Regulation and Authority guidelines on acceptance and adjustment of advance premium, the Authority in exercise of the powers vested under Section 102 (b) of the Act imposes a penalty of Rs.5 lakhs.

2. **Charge – 2**

Delay observed in making the refund of initial premium to the policyholders wherein the policyholders complained of mis-selling.

Violation of Regulation 5 & 11(4) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 and point 4(f) & 5 of Authority circular No.3/CA/GRV/YPB/10-11 dated 27-07-2010.

Submission of the insurer:
Depending on the complexity of the case some time investigations may take time. The company follows a process of investigating mis-selling complaints before cancelling policies. Once a decision is arrived at the refund is made with in the TATs. The refund of sample cases referred by inspection team has been processed within TAT of 15 days from the date of receiving the complete documents from the customer. BSLI has also put in place grievance redressal system/ procedure in line with clause 4 and 5 of Authority's circular dated July 27, 2010. A proper procedures and effective mechanism to address complaints and grievances of policyholders also exists in line with Regulation 5 of IRDA (PPH) Regulations, 2002.

Decision:
Delay in investigation has been observed and also accepted by insurer in respect 2 of the 13 sample cases referred by inspection team. The Life insurer's submission of having taken proper initiatives in processing the mis-selling complaints is taken on record and hence no charge is being pressed.

Insurer is advised to comply with the Board approved timelines on investigation; grievance redressal policy, SOP on mis-selling complaints handling management process, Authority guidelines and Regulations in this regard on timely resolution of grievances and to ensure that any delay on the part of insurer should not put financial loss to insured.

3. **Charge – 3**
On examining sample policy it was observed that, the insurer had not provided the Free Look Cancelation (FLC) option to the policyholders', where the previous policy had been cancelled under FLC option and fund transferred to the new policy issued. The insurer had not provided FCL option to the policyholder for newly issued policy stating 'the new policy document does not entitle the policy owner to opt for a Free Look'.

Violation of Regulation 6(2) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.

Submission of the insurer:
We have re-considered the process and now as per revised procedure, free look option is being made available to customer even in the new policy which is being issued after conversion from free look of the earlier policy.

Decision:
Every contract of insurance is an independent contract and insured has to be provided the right to opt for Free Look Cancellation if he is not satisfied with the policy terms and conditions, as he would come to know the terms and conditions only after receipt of policy document from insurer. Since, insurer has taken a corrective action, no charge is pressed.

4. **Charge – 4**

From the data submitted by the insurer, it was observed that few death claims were pending for more than 180 days due to non completion of investigation.

Violation of Regulation 8 of IRDA (Protection of Policyholders' Interests) Regulations, 2002

Submission of the insurer:

During the financial year end 2012-13, there were few claims which were highly suspicious. We faced difficulties while investigating these cases as there was a racket involving doctors, hospital and other authorities. This made investigation extremely difficult and we have reinvestigated some of these cases. All except two of the sample cases referred in the observation have been closed. In case any claim gets paid due to lack of evidences we pay the penal interest for delayed payment. In case we breach the TAT due to unavoidable circumstances especially with frauds and if payable BSLI has always been proactive in paying the penal interest as applicable.

We re-iterate that as a process, interest is paid for delayed processing beyond 180 days. In support of submission, insurer submitted a certificate stating that penal interest has been paid for claims settled beyond 180 days from the date of intimation and also informed that system level changes are being evaluated for automation of penal interest payment.

Decision:

On observing the insurer submission on the sample 12 claims examined by the inspection team, it is noted that

- Delay observed in getting the investigation report and also in settling claim after getting the investigation report.
- Requirements were sought in piece meal basis thereby delaying the process of claim settlement.
- Penal interest was paid on the two admitted claims only after inspection observation.
- In respect of one claim, documents with regard to source of income were sought at claim stage rather than at acceptance stage.

However, taking note of the insurer submission on payment of penal interest in all delayed cases, the life insurer is hereby directed to strengthen their processes & internal controls, to follow the Board approved policy & SOPs on claim settlement practices and to ensure continued compliance with the requirements under the IRDA (Protection of Policyholders' Interests) Regulations, 2002.

5. **Charge – 5**

As per F&U document of 'Group Capital Assurance Traditional Plan', at the end of every financial year interest will be credited to the policy account and the interest rate will be declared by insurer based on the size of policyholder's total assets managed by it.

However, on examining the sample policies, it was observed that the insurer had credited differential rate of interest to different customers and deviated from the actual declared interest rate for the pool of assets under this scheme.

Thus the insurer had credited discretionary differential rates of interest to the different master policyholders, which is not in line with the provisions of approved 'File & Use' application for 'the Group Capital Assurance Traditional Plan'.

Violation of F&U guidelines.

Submission of the insurer:

We submit to the Authority that BSLI follows the declared table for all the clients. However in few cases returns were provided in excess of those given by the table. We submit to the Authority that no policy has been credited interest less than the declared rate and the declared rate has been set in a consistent manner year on year. In respect of policies where excess interest is paid, the resulting gap is financed by the shareholder fund by reducing their margins. Thus at the policyholder level, there is no financial impact.

Decision:

As per the F&U approval, interest rate will be declared by insurer based on the size of policyholder's total assets managed by it. Whereas insurer had credited differential rate of interest to different customers and interest paid by insurer to few customers is different from the outcome of Actuarial Valuation.

Since, the difference of declared interest rate being borne by the shareholders, no charge is pressed. However, herein after **insurer is advised** to strictly comply with the terms and conditions cleared under 'File and Use' guidelines'.

6. **Charge – 6**

a) On examining sample group term policy document no. 502302, it is noted that there is an exclusion clause which says that 'In case of non-accidental death, a waiting period of 45 days is applicable for a member who has not undergone medical examination, starting from the coverage effective date or effective date of revival'. However, the approved 'File & Use' application did not have the above stated exclusion clause.

b) Death Claim under Single Premium Group term policy was denied quoting exclusion clause in the policy schedule which states that the coverage amount will not be payable for non- accidental deaths that occurs within the first 90 days from the date

of commencement of coverage of each member. Insurer submitted that 4 group claims amounting to Rs.25.41 lacs has been repudiated during the period 2010 to 2016 under the 90 day exclusion clause.

However, it was observed that such exclusion clause was not mentioned in the F&U application which was approved for the Single Premium Group term policy (UIN 109N004V01).

Violation of F&U guidelines.

Submission of the insurer:

a) The 45 day waiting period, while omitted from the File and Use application, does appear in the filed sales brochure. *We would like to submit to the Authority that this condition has been mentioned in our Sales Literature under "Exclusions" section filed with IRDAI along with the File & Use Application while seeking product approval. Further, such conditions also appeared in proposal form and policy terms. In all the communications made to the policyholder said clauses are mentioned, hence requisite disclosures are given to the clients.* We believe clients have not been misled in this regard. For members who have undergone medical examination, there is no exclusion. For other members, no life insurance cover shall be available during a period of 45 days starting from the coverage effective date, except for death due to accident. Therefore we are of the opinion that we have not violated file and use condition in its spirit. We would take the necessary steps to communicate the exact clause to all the policyholder.

b) For members who have undergone medicals, we have never rejected a claim on the basis of the 90 days waiting period condition, and this condition is clearly stated in the policy document.

While this waiting period condition was not expressly mentioned in the File and Use at the time of filing, we refer you to our letter, BSLI/2005/IRDA/ACTL/551 dated 3/05/2005, wherein we responded to the Authority's request for information on our experience rating and underwriting process for Single Premium Group Term. Attached in the letter was a complete description of our underwriting process, and it includes the 90 day waiting period. While we agree that this document does not form part of the File and Use, we believe it enhances our contention that BSLI has not tried to conceal our intention to apply this condition.

Decision:

It is an important clause which needs to be part of policy document filed with Authority under File and Use guidelines. If insurer missed anything related to the product terms and conditions in the original filing, they need to approach the Authority for approval under F&U guidelines for modification/revision, if any. It is not in the right spirit of insurer referring to other documents filed with Authority either under F&U or for any other

requirement and expecting Authority to cross check with original filing and insurer assuming on its own a deemed approval. Further, no where in the other documents filed, insurer referred to or drawn attention of the Authority to the change in original terms of the policy. The explanation offered by the insurer is untenable and is not expected from a company which has been in business for several years.

It is the duty of the insurer to take prior approval from Authority before making modification to any of the approved policy wordings and is expected to ensure full compliance to F&U guidelines in letter and spirit at all times.

As per the general underwriting practice, waiting period is applied in case of non-medically underwritten and non-accidental deaths. However no specific approval in F & U of the said clause is taken by the Insurer and hence it is a violation of F & U guideline. Considering that waiting period clause is mentioned in the sales literature, Proposal form and T & C in policy bond, policyholders are expected to buy the policy as an informed choice.

In view of the violation of the F&U guidelines, the Authority in exercise of the powers vested under Section 102 (b) of the Act imposes a penalty of Rs.5 lakhs.

7. **Charge – 7**

As per the details of servicing agent printed on the policy documents, it was observed that the insurer had involved the referral Company in the sale and service of insurance policies sold through the leads obtained.

Violation of Regulation 9(b) of IRDA (Sharing of Database for Distribution of Insurance Products) Regulations, 2010 and Authority's Circular IRDA/CIR/ 010/2003 dated 27-03-2003.

Submission of the insurer:

We would like to submit Authority that this policy was not sourced by the Referral bank partner. The name of the Bank has been erroneously mentioned on the form for ease of identification. As per the agreement, the Bank is expected to share the data of its customers and BSLI licensed representative explains the policy features to the customer and closes the sale. In the said case, while the lead was received from the Bank and the closure of the case has been done by our representative. This is also evident from the fact that in this case only a referral fee was paid to the Bank and no commission was paid to the referral partner. We shall build the System based controls to prevent such errors.

Decision:

On examining the proposal form & policy document, it is noted that the referral partner code was mentioned as insurance advisor code in proposal form, referral bank representative has signed the proposal form as intermediary and the policy document issued to customer mentioned the referral partner as advisor. All this indicate that the referral partner was involved in other activities beyond providing the database of its customers.

However, from the insurer submission it is noted that the referral partner name was erroneously mentioned in the bank statement and also informed that except referral fees no commission was paid. In support, insurer has provided the TDS certificate and this has been cross checked with Form 31B filed with Authority and payment figures in both the documents are identical. Further, it is also noted that the error observed and accepted by insurer has happened during the first week of license granted to the referral partner. As such, being one off case, no charge is pressed.

Insurer is cautioned to be vigilant henceforth and any non compliance noticed hereinafter would be viewed seriously.

8. Charge – 8

The Insurer had appointed Individuals and firms on an "exclusive basis" as "Business Mentors", who will mentor the advisors (including licensed individual/corporate agents) of the insurer and develop them to become professionals. The services which are ought to be done by the insurer through its employees were outsourced to the individuals (vendors). However, all such activities of the business mentors were not disclosed as outsourced activity as required under the Guidelines on Outsourcing of Activities. Further on examining the sample, it is noted that agents were also appointed as mentors

Violation of

- Para 8.4/5 and 19 of outsourcing guidelines dated 1st Feb,2011 by outsourcing jobs to licensed entities during the FY 2011 to 2015.
- Clause 6 of Corporate Governance guidelines of annexure II of circular no.IRDA/F&A/ Cir/ 025/ 2009-10 dated 05/08/2009, as it is noted from the observation that few mentors doesn't have a single advisor.

Submission of the insurer:

Mentor is usually a local influential and successful businessman or an individual responsible for mentoring the advisors. BMN is providing their professional service in grooming the Advisors (selling skills, motivation, skill building) who are from their catchment area and paid a professional fee for their services based on the advisor's performance. The payments being made are essentially in the nature payment for hiring their professional expertise and cannot be equated to outsourcing of activities.

With respect to the point raised in regards to maximum amount being paid as "Productivity Incentive", we would like to highlight that productivity incentive is also based upon the performance driven by the underlying advisors and not on the business generated by them directly. Productivity incentive is in the nature of success fee on assignments that is a standard practice for professional engagements.

We would like to submit to the Authority that:

- As per the licensing process the mentor cannot recruit advisors from their immediate family. We also ask the Business mentors to declare the same in the appointment form. As per the data also there is no such cases registered under the following codes.
- Mentors hired from the market directly cannot have advisor code, however any BSLI advisor who got promoted to Business mentor can continue his old advisor code (to solicit the new business).

Hence, we believed that clause 8.5 and clause 19 of outsourcing guidelines dated 1st Feb, 2011 would not apply in these cases and accordingly the payments were not reported under Outsourcing Reporting.

Further, in case of payouts to Business Mentors who are also Advisors, we report the payouts as Business Mentor fees in 31B (2) reporting of payouts done to advisors.

Further, the Authority has raised a concern that few mentors have no advisors mapped. We submit to the Authority that the revised data submitted by us provide an advisor under the mentor in every instance. Further, we submit that there is no payment to any mentor in a situation where there is no advisor mapped under him/ her.

Decision:

From the data available, it is noted that the insurer has a total of 1130 business mentors mentoring 1522 advisors. The productive incentive payable to the mentors was in the range of 8% to 36% on the basis of the total business achievement of all the advisors tagged to the business mentor with additional incentive for activisation of advisors and for recruitment and licensing of advisors.

The training / mentoring activity of the Insurer appears to be of regular nature and hence it would come under the ambit of outsourcing and hence as per clause 11.2 of Outsourcing Guidelines dated 1/2/2011, this activity needs to be reported to the Authority in Hly reporting on Outsourcing of activities in Form 'A' filed with Authority. In case of any ambiguity on reporting of the outsourcing activities, insurer should have approached the Authority as per Para 13 of the Outsourcing guidelines dated 1/2/2011 either before or after the inspection observation. **Insurer is advised** to submit the details of all the payouts to various entities/individuals under this activity since the applicability of outsourcing guidelines to till date as a one-time exercise and continue to report the same in their outsourcing reports, in future.

On further examining the data of top 5 mentors, it is also observed that

- No prior training was provided to mentors by insurer and the qualification of three mentors was graduation and of two others was Higher Secondary.
- Two mentors each were mentoring only a single advisor and the payout during FYs 2009-15 to the mentor with code 55B024 was Rs.1.62 cr and to mentor with code BF2232 during FYs 2011-15 was Rs.38.94 lacs.

Thus insurer is advised to do a cost benefit analysis of all the engaged mentors as per para 9 & 10 of Outsourcing guidelines dated 01/02/2011 **and to provide a report** to the Authority within 3 months of the order, as insurer carries the responsibility of maintaining the policyholders funds with utmost care and due diligence.

On examining the details of top 5 mentors, it is also noted that two of them are also acting as advisors to insurer. As per clause 8.4/5 19 of the Outsourcing guidelines dated 1st Feb, 2011 an insurer cannot outsource any activity to a licensed entity after the issue of Outsourcing guidelines. **In view of the violation of the guidelines, the Authority in exercise of the powers vested under Section 102 (b) of the Act imposes a penalty of Rs.5 lakhs**.

Further, insurer **shall discontinue** the practice of engaging a licensed entity as business mentor after 31/03/2017.

9. Charge – 9

On scrutiny of sample proposal forms (applications), it was observed that the insurer had no control over who was soliciting the insurance and who was giving the agent confidential report and also who was signing on the proposal forms. It was observed that some unlicensed individuals were soliciting the insurance business.

On sample examination, it was found that in respect of some corporate agents, the SP code was not captured in the insurer's policy administration front-end system (ingenium). Further it is noted that the corporate agent Maa Durga Insurance Advisors has only 1 SP during FY 2010-11 & 2011-12 and solicited 5065 policies during 2011-12.

Violation of Authority's Circular IRDA/CIR/ 010/2003 dated 27-03-2003

Submission of the insurer:

We submit to the Authority that we undertake business only with licensed entity/intermediary permitted by the Authority. The process of checking for Specified person was completely manual at the branches. This was prone to errors and the support team audited the process regularly and found some gaps in the process. Based on these learning from these audits a change was suggested in the process and system

controls were built in. These system controls came into effect from August 2013. All the sample cases examined by team are of period before the new process was put in.

Further we would like to inform that after modifying the process, the specified person signature is checked twice – once at the branches during login by our branch executive and secondly at Central Operations. This system was put in place w.e.f August 2013 after the Authority had raised a concern in their earlier inspection report bearing reference number Ref: IRDA/Life/ORD/MISC/086/04/2012 dated 13-04-2012, where we had submitted the action plan. Since this revised process had manual intervention, our process team noted gaps during audit and hence system controls were built in place effective August 2013. We submit to the Authority that the observation pertains to period where we were already working on an action plan on the issues highlighted by the Authority earlier.

Decision:

It is noted that Authority in its order ref.no.IRDA/Life/Ord/Misc/086/04/2012 dated 13-04-2012 has taken note of insurer submission of initiating a project, wherein the process of verification of the licensed specified persons' signatures would be automated at the branch level with target date of implementation being 1/4/2012. Whereas, inspection team on examining the sample cases of FY 2012-13 of the three corporate agents has noted similar lapses on controls not being in place at the time of risk acceptance.

Authority notes from insurer submission that manual controls were in place effective from 1/04/2012 and after observing some gaps in the process, the process and system controls were revised effective August, 2013. It is also noted that there is a drastic fall in the business upto 75% from these three corporate agents during the FY 2012-13 after the Authority order on 13/04/2012 and insurer also informed of carrying on annual on-site inspection of corporate agents and terminating agreements wherein discrepancies are noted.

Taking note of the insurer submission, no charge is pressed.

Here after, the **insurer is directed to mandate** the corporate agent to provide details of specified person involved in soliciting the business in the proposal form and also insurer to capture the details of the specified person involved in soliciting the business in its database, if it is through a corporate agent. Further, insurer to ensure that the corporate agent has adequate number of specified persons based on their geographical presence, business turnover etc., to ensure compliance of Regulation 14(v) and 14(vi) of IRDA (Corporate Agent) Regulation 2015. If the corporate agent is not compliant with the Regulations, insurer to re-examine its tie up with corporate agent.

10. **Charge – 10**

It was observed that the insurer had 'Joint Sales Campaign' arrangements with its corporate agents and incurred huge expenses on account of the joint sales campaigns. The insurer did not file the co-branding advertisements or the nature of co-branding sales activities with the Authority as required under Advertisement Regulations and Guidelines. In most of the cases the expenses incurred was not reasonable as to the commission paid to the corporate agents.

The insurer had arrangement with its corporate agents for sending mailers to the customers of corporate agents, for which the insurer had arrangement of paying Rs.5/- per mailer. The expenses incurred in **2011-12** in respect of some of the corporate agents is highly unreasonable that such a huge number of mailers would not have been sent by them but just to make extra payouts to the corporate agents, the insurer had resorted to such arrangement.

Violation of

- Clause 21 of Corporate Agents guidelines circular ref.no.017/IRDA/Circular/CA guidelines 2005 dated 14-07-2005.
- Para 3.7-1 of Circular no.007/IRDA/Cir/Adv/May-07 dated 14-05-2007 on filing of Joint Sale Advertisements and guidelines of Authority on advertisements.

Submission of the insurer:

We would like to mention that the expenses under question are incurred towards joint marketing activities undertaken along with corporate agents. The main objective of these activities is to create awareness about life insurance products, increase distribution reach and create customer connect. The joint sales promotion expenses would not in any way be linked to the success in sale or premium earned.

As suggested by the authority and our subsequent communication basis that suggestion, we had initiated the recovery of the expenses so incurred from the respective corporate agents as highlighted in the referred show cause to be in excess of allowable commission as a percentage of the total premium collected. We have also shared the updated status of that recovery to the authority vide letter dated 31st January 2014 whereby seven out of nine cases of 2011-12 (Rs.4.45 cr of Rs.6.03 cr) and one out of four cases of 2012-13 (Rs.4.79 cr out of Rs.7.78 cr) have been completely recovered. It is also pertinent to note that, BSLI had submitted the status of recovery of excess payout and requested to condone the remaining recovery. With reference to the same the Authority vide its letter reference no: 464.1/F&A/ 9/RLD /2011-12/2012-13/169/March 2015 dated 17th March 2015 condoned the further recovery.

As a suggested measure from the authority, we are ensuring that the corporate agents remain within the 35% limit for the FY 2013-14. With respect to the non filing of cobranding material, we would like to highlight that the marketing material being used are the standard leaflets or product brochures that are being filed with the authority. These promotional inserts are sent in a cobranded envelope to the target segments. We

would like to submit to the Authority that these co-branded envelops were **erroneously missed** and were not filed with the Authority.

In case of Citibank & Duetsche bank, the contractual arrangement was to reimburse **100% of** expenses basis supporting provided for joint promotional campaign.

Decision:

On examining the insurer submission along with copies of agreements and invoices, it is noted that

a) Insurer has not filed the co-branded envelops with Authority. All the co-branded advertisements/marketing material **needs to be filed with the Authority** and should have a unique identification number. The life insurer is advised to put in place effective internal controls hereafter so as to ensure compliance at all times to the Advertisement Regulations and guidelines issued from time to time.

b) Insurer in one of its submission with regard to two of its corporate agents informed that the contractual agreement was to reimburse 100% of expenses basis supporting provided for joint promotional campaign. On seeking clarification, insurer submitted that the company had borne only 100% of its share of joint sales expenses out of the total joint sales promotion activity and provided copy of agreement with few sample invoices. However, none of the documents show the total expenditure incurred/expected to be incurred by the corporate agent for the co-branding activity and insurers share of the co-branding expenditure, but only gives information on the amount payable by insurer towards its share for each co-branding activity carried on through inserts/emailer/statement back etc. payable to corporate agent towards its share of administrative cost incurred by corporate agent. As such, it cannot be ascertained whether the insurer has fully borne the expenses or at an agreed proportion of total expense. Further, insurer has not responded on seeking clarification whether the corporate agents had that no of customers equivalent to the mailers sent by the corporate agents. In this regard, **insurer is advised** to ensure transparency in agreement terms and payments.

Further, Authority notes from the submission that an amount of Rs.4.45 cr has been recovered by the insurer from its corporate agents with regards to reimbursement of co-branding expenses in line with Authority direction dated 31st January, 2014, as such no charge is pressed and insurer is advised to ensure compliance to Clause 21 of Corporate agent guidelines dated 14-07-2005.

11. Charge – 11

The insurer has resorted to arranging foreign trips and distribution of gift cards to the employees of corporate agents and brokers. It is pertinent to note that the gift cards were given by the insurer to the specified persons and also to the employees of the corporate agents who were not licensed specified persons or qualified persons of the brokers..

Violation of

- Clause 2,8 & 21 of Corporate Agents guidelines circular ref.no.017/IRDA/Circular/CA guidelines 2005 dated 14-07-2005.
- Circular: No. IRDA/CIR/010/2003, dated 27-3-2003.
- Regulation 19 of IRDA (Insurance Brokers) Regulations, 2002.

Submission of the insurer:

We would like to highlight that the contest were designed only for the employees of the corporate agents and brokers and not to the corporate agents/brokers themselves. This was done with full cognizance of clause 21 of the regulation that disallows any incentive payment to the corporate agents. The sales need support of other support functions. It is important to recognize the role of these teams and provide them regular training and motivate them to get the best results. With this intent we have provided training to support staff also.

Further, we would like to share that the contests were intended to reward the performance purely as a motivational initiative to drive long term business goals and were definitely not intended to circumvent any provisions of regulation. These contests were designed in 2011-12 and basis further internal deliberations, we discontinued the same completely in 2012-13.

Decision:

Insurer accepted on providing gift cards/ foreign trips / contests to the employees of the corporate agents and brokers during the FY 2011-12 amounting to Rs.3.80 cr. Any payout to an employee of the corporate agent in relevance to solicitation is deemed to be a payment to the corporate agent himself or as an unlicensed individual encouraged to be involved in soliciting of insurance business.

In view of the violation of the Regulation and Authority guidelines, the Authority in exercise of the powers vested under Section 102 (b) of the Act imposes a penalty of Rs.5 lakhs.

12. **Charge – 12**

Insurer is in the practice of considering the group gratuity and group term as regular premium and classifying it as first year and renewal business. Since these policies are one year contracts without any specific premium paying term. The insurer had taken Rs.336 crore (Rs.436Crore) as a first year premium and Rs 50 Crore (Rs.29Crore) as renewal premium for the year 2012-13(Previous FY 2011-12). Insurer considering the group term premium as regular premium is not in line with the prescribed guidelines.

Violation of

- Para 3(ii) (c) of circular No. IRDA/F&I/CIR/EMT/085/04/2012 dated 12th April, 2012.

- Provisions of Section 40B read with rules 17(d) of Insurance Rules 1939.

Submission of the insurer:
We submit to the Authority that Group Gratuity Policy Contracts are treated as regular business with due classification into first year premium and renewal premium. The group gratuity policies are generally perpetual in nature and are automatically renewed on the renewal date every year, unless specifically terminated. The treatment related to Group Gratuity Policy Contracts has been mentioned in the report submitted to the regulator for the respective years. The same is also disclosed as part of foot note in every EOM statement submitted to the Authority for transparency and clarity.

However, hereinafter we confirm that any plan other than regular premium with limited premium payment term and or pre-determine policy term shall be treated as single premium in considering the group insurance premium for EOM.

Decision:
Considering the corrective action taken by the insurer, no charge is pressed. The Authority vide circular no.IRDAI/F&A/Cir/FA/059/03/2015 dated 31st March, 2015, advised all insurers to comply with existing circulars and provisions of Rule 17D of Insurance Rules, 1939 until further orders. As such, insurer is advised to ensure compliance to the circulars and guidelines in arriving at EOM limits and any future re-occurrence of non-compliance would be viewed seriously.

13. **Charge – 13**
It was observed that the insurer was in practice of issuing policies despite of shortfall in the scheduled premium in excess of Rs. 250. Further, it was observed that the short collection of premiums was made good by the insurer by debiting the same to operating expenses. The amount debited to the short and excess collection of premium account for the year 2012-13 (G.L. Code: 786101) was Rs. 56 lakh. Such cross subsidies shall have adverse impact on other continuing policyholders.

Violation of provisions of 64VB (1) of the Insurance Act, 1938.

Submission of the insurer:
The policy of adjusting shortage/excess upto a threshold amount is purely to take care of operational challenges and also majority of these entries are on account of upward revision of Service Tax rate. The impact if any on the other policyholders is negligible. We will start booking these expenses in shareholders a/c going forward and also reduced this limit to Rs 100 with effect from July 2014.

Decision:
Taking note of the insurer submission, no charge is pressed. Insurer is advised to ensure strict compliance to Sec.64VB(1) of Insurance Act, 1938.

14. **Charge – 14**

The insurer had entered into a leasing agreement for leasing of Furniture & Fittings and IT related equipments. On examination of Clause 4.6 of the said agreement it was observed that all risks associated with the assets are with insurer and insurer's obligation to pay lease rent is unconditional. On further examination of the termination clause 11 of the lease agreement, it was observed that if either party cancels the lease the insurer is required to pay all losses associated with termination of lease agreement including liquidated damages equal to the aggregate amount of the present value of all future rentals payable under the agreement. The agreement shall be classified as 'finance lease' instead of 'operating lease' as classified by the insurer. As per break up provided by insurer on note 7 to schedule 16 to the financial statements, Operating lease commitments relating to rent works is Rs.30 Crore of which around Rs.20 Crore (Percentage of last two years payment) relates to furniture and fittings. As a consequence of such accounting process, the solvency margin computation had not recognized the liability in respect of the above lease agreement.

Violation of Point I under Part I and Point B under Part II of Schedule B read with Regulation 3 of IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002.

Submission of the insurer:

We submit to the Authority that presently we do not have any lease agreements with any vendor. The agreement/s referred in IRDAI observations has been terminated. We further submit that we have taken note of the concerns raised by the Authority and will ensure adherence to the same in all future arrangements.

Decision:

The accounting treatment of finance lease as per AS 19 Leases is different when compared to operating lease. The termination clause 11 of the referred lease agreement renders the lease as finance lease as per para 9(a) of AS-19. However considering the insurer submission on adherence to the Regulations in all future arrangements, no charge is pressed.

15. **Charge – 15**

The insurer had considered the Service tax unutilized credit: Rs. 35.54 Crore as an asset in demonstration of statutory solvency as at 31st March, 2013. It was also observed that the insurer had taken credit in respect of reinsurance claims receivable of Rs. 7.893 Crore in demonstrating solvency as at 31/03/2013. These claims are outstanding for more than 90 days. Further, the insurer is in practice of presenting reinsurance in annual accounts after netting of reinsurance payable against reinsurance receivable.

Violation of Regulation 2 of IRDA (Assets Liabilities and Solvency Margin of Insurers) Regulations, 2000.

Submission of the insurer:

a) We confirm to the Authority that service tax unutilized credit is not considered while calculating solvency effective March 2014 computation. However, we would submit to the Authority that even if we were to exclude the service tax unutilized credit in solvency calculations as at March 2013, we would be in compliance with the minimum required ratio of 1.50 – as our ratio would stand at 2.62 instead of 2.67.

b) We have examined and basis the guidance of the Authority we will start excluding reinsurance claims outstanding for more than ninety days from the value of assets used for solvency calculation from the next quarter (Oct-Dec 2016).

Decision:

a) Taking note of the insurer submission on not considering service tax unutilized credit for solvency margin calculations effective from March, 2014 onwards, no charge is pressed. Insurer is advised to ensure compliance to Regulation 1(10) of 'Valuation of assets' given at Schedule of IRDAI (Assets, Liabilities and Solvency Margin of Life Insurance Business) Regulations, 2016 wherein it is stated that any asset of unutilized service tax credit outstanding for more than 90 days shall be placed with zero value.

b) Insurer is expected to value both assets and liabilities separately as prescribed at Regulation 3 & 4 of IRDAI (Assets, Liabilities and Solvency Margin of Life Insurance Business) Regulations, 2016. Insurer should have placed value of reinsurance receivables due for more than 90 days with zero value in arriving at solvency margin as per Regulation 1(8 & 4) of 'Valuation of assets' given at Schedule of IRDAI (Assets, Liabilities and Solvency Margin of Life Insurance Business) Regulations, 2016. Taking note of the insurer submission to ensure compliance with Schedule I & II read with Regulation 3 & 4 of IRDAI (Assets, Liabilities and Solvency Margin of Life Insurers) Regulations, 2016, the charge is dropped.

16. Charge – 16

a) BSLI Group Superannuation product: On observation related to this product, insurer stated that the guarantee is applicable on Net Contribution only. As per the F&U document, insurer to pay higher of FV or NAV whichever is higher where face value (FV) of the contribution will the amount of contribution paid.

b) BSLI Group Unit Linked plan and BSLI Group Superannuation products: In regard to these products, it was observed that the insurer had not compared the guaranteed benefits with the fund value in respect of each policy to arrive at the ultimate reserves to be held under the above products as at 31st March, 2013. This had resulted into under reserving of liabilities. Fund values, as per the actuarial report of 2012-13, are Rs. 380.10 Crore and Rs. 473.02 Crores against Group Unit Linked Plan and Group superannuation product respectively.

Violation of F&U guidelines and point 2, 7d & 8d under Schedule IIA of IRDA (Assets Liabilities and Solvency Margin of Insurers) Regulations, 2000.

Submission of the insurer:

a) The file & use of BSLI Group Superannuation Plan (BSL-GSP) states (under section 7) that: "At the time of exit by a member from the scheme, BSLI guarantees protection of the face value of the contributions received to date. The Face Value of the Contribution will be the Amount of contributions paid."

BSL-GSP was a defined contribution superannuation plan where the member level accounts are maintained and no withdrawals are allowed under this policy other than benefit payments. As such net contribution is same as gross contribution or the face value. So our approach of calculating the guaranteed value of the benefit complies with the above formula of benefit calculation and hence we submit that it is in line with the File and Use.

b) We confirm that system is in place for all new schemes under the above mentioned products. Also, data migration for existing schemes to new system has already been initiated. Also, as a part of ALM analysis we have found that the guaranteed cost as at Oct'13 is much smaller than the current IGR (Investment Guarantee Reserve) and there is no need to keep any separate reserves for this guarantee. The calculation of guarantee cost is done for each scheme separately.

Decision:

a) Insurer submission is noted. In this regard insurer is advised to ensure compliance at all times to the F&U guidelines and with the documents filed under these guidelines for product approval. Though insurer states that both net and gross contribution are same under the referred product, insurer has to state clearly in all policy related documents that the guarantee is for the face value of the contributions received i.e for the actual contribution paid and accordingly claim payments would be done under BSLI Group Superannuation Plan.

b) Submission of insurer on calculation of guarantee cost is noted, charge is dropped.

17. Charge - 17:

The insurer is in the practice of collecting premiums in advance with an average period of 5 years premium and the discount of 5% was made applicable depending on the due dates for which the premiums are paid in advance. On examination of F&U application, it was found that the F&U application in respect of the six products (Classic Child / Classic Life / Classic Endowment / Dream Child / Dream Endowment / Secure 58) had no such provisions for advance premium.

Violation of F&U guidelines issued by Authority

Submission of the insurer:

BSLI offered Advance payment option as a service to our customers as clients expressed a desire to fund multiple payments in advance. The details of the program were filed and approved in the F&U for BSLI Foresight at that time confirmed that the practice was acceptable. We would like to submit Authority that this was permitted by Authority vide the email dated December 31, 2009 on the subject Advance premiums subject to certain conditions. We collected the advance premium in respect of above policies in line with above conditions. In July 2012, we were instructed by the IRDA to discontinue the practice of Advanced Premiums for all plans where it was not formally approved in the product's F&U. At that time we stopped allowing Advance Payment of Premium for all plans except BSLI Foresight as BSLI Foresight was the only plan which contained the Advance Payment of Premium option within the F&U.

Decision:

Insurer submission is noted and is advised to take specific approval hereinafter under F&U procedure from Authority before offering any such options to customers.

In conclusion, as directed under the respective charges, the penalty of Rs. 20 lakh (Rupees Twenty lakh only) shall be debited to the shareholders' account of the life insurer and the amount shall be remitted to Insurance Regulatory and Development Authority of India within a period of 15 days from the date of receipt of this Order. The penalty shall be remitted through the NEFT as per details being intimated to the insurer as per a separate e-mail. The transfer shall be made under intimation to Mr.Prabhat Kumar Maiti, JD-Enforcement.

Further,

a) The Life Insurer shall confirm compliance in respect of all the directions referred to in this Order, within 15 days from the date of issuance of this order. Timelines, if any as applicable shall also be communicated to the Authority.
b) The Order shall be placed before the Audit committee of the insurer and also in the next immediate Board meeting and to provide a copy of the minutes of the discussion.
c) If the Life insurer feels aggrieved by any of the decisions in this order, an appeal may be preferred to Securities Appellate Tribunal as per Section.110 of the Insurance Act, 1938.

Place: Hyderabad
Date: 08.12.2016

(V R IYER)
Member (F&I)