Ref.No: IRDA/ENF/ORD/ONS/098/05/2016

Final Order in the matter of M/s Future Generali India Insurance Co. Ltd

Based on reply to the Show Cause Notice dated 26th August, 2015 and submissions made during Personal Hearing on 26th November,2015, 2015 at 10:30 am taken by Member (F&I) at the office of Insurance Regulatory and Development Authority of India , 3rd Floor, Parishrama Bhavanam, Basheerbagh, Hyderabad.

The Insurance Regulatory and Development Authority of India (hereinafter referred to as "the Authority") carried out an onsite inspection of M/s **Future Generali India Insurance Co. Ltd** (hereinafter referred to as "the General Insurer") from 19.08.2013 to 27.08.2013. The Authority forwarded the copy of the Inspection Report to the Insurer seeking comments on the same under the cover letter dated 20.11.2013. Upon examining the submissions made by the Insurer vide letter dated 28.12.2013, the Authority issued Show Cause Notice on 26.08.2015 which was responded to by the Insurer vide letter dated 21.09.2015. As requested therein, a personal hearing was given to the Insurer on 26.11.2015. Sh. K. G. Krishnamoorthy Rao, MD & CEO, Sh. Easwara Narayanan, COO, Sh. Shreeraj Deshpande, Head- Health Insurance and Sh. Manish Pahwa,, Company Secretary & Chief Compliance Officer were present in the hearing on behalf of the General Insurer. On behalf of the Authority, Ms. V. R.Iyer, Member (F&I), Sh. Lalit Kumar, FA & HOD (Enforcement), Mr. Suresh Mathur, Sr.JD (Non-life), Mr.Prabhat Kumar Maiti, JD (Enforcement), Ms. Jyoti Vaidya, DD (Enforcement) and Sh. Sankara Srinivas, OSD (Non-Life) were present during the personal hearing.

The submissions made by the Insurer in their written reply to the inspection observations, 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 General Insurer to the Show Cause Notice and the decisions thereon are detailed below.

1. **Charge – 1**

The insurer paid significant amount of payments in the name of support service, consultancy, to various service providers. However no record of continuous monitoring and assessment of the service providers engaged for such Support Services, Risk Inspection and Consultancy Services was made available. Also no records of due diligence carried out by the company while entering into such outsourcing agreements were documented. The above-mentioned

परिश्रम भवन, तीसरा तल, बशीरबाग, हैदराबाद-500 004. भारत
✆ : 91-040-2338 1100, फैक्स: 91-040-6682 3334
ई-मेल: irda@irda.gov.in वेब: www.irda.gov.in

Parisharam Bhavan, 3rd Floor, Basheer Bagh, Hyderabad-500 004. India.
Ph.: 91-040-2338 1100, Fax: 91-040-6682 3334
E-mail : irda@irda.gov.in Web.: www.irda.gov.in

services have not been reported to the Authority within 45 days from the end of every half year in the prescribed Form A.

This is violation of

a) Clause 9.3 of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No. IRDA/LIFE/CIR/GLD/013/02/2011 dated: 01/02/2011, wherein the Board of Directors of insurer shall review the performance of all third party service providers every year.
b) Clause 9.9 (iv) of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No. IRDA/LIFE/CIR/GLD/013/02/2011 dated 01/02/2011, wherein the written contract shall provide for the continuous monitoring and assessment by Insurer of the service provider so that any necessary corrective measures can be taken immediately.
c) Clause 11.2 of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No.IRDA/LIFE/CIR/GLD/013/02/2011 dated: 01/02/2011, wherein it is mentioned that insurer shall file a report in Form A within 45 days from the end of every half year in respect of each of the outsourced activities.
d) Clause 13 of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No. IRDA/LIFE/CIR/GLD/013/02/2011 dated: 01/02/2011 wherein it is mentioned that classification of any of the activities, that are not explicitly referred herein, as core or non-core shall be done after due diligence.

Submission of the insurer:

The performance evaluations of the outsourced activities were carried out by the Company and the performance evaluations were also placed before the Board of Directors every year for their review in accordance with the provisions of the Outsourcing Guidelines. The insurer had taken steps to ensure that the evaluation process was carried out for these services also.

The insurer submitted that they were taking steps to incorporate the relevant clauses in the agreements with outsourced entities. They also carried out the due diligence of the outsourced activities and also collected relevant information to assess the capability of the service provider to comply with obligations in the outsourcing agreement.

They had now also put in place additional controls to carry out the due diligence of activities relating to support services, customer awareness and marketing campaign. The insurer further submitted that they had already initiated collection of additional information and documents from such service providers for the purpose of carrying out the due diligence in accordance with the Outsourcing Guidelines.

As a part of due diligence exercise to ensure that the service providers were capable of delivering, monthly monitoring of their sales effectiveness was being done by correlating their services to the sales. The above exercise would ensure whether their standards of performance are acceptable or not.

In light of the directions of the Authority, the insurer had now taken note of the activities to be reported under outsourced activities with immediate effect and in furtherance to the inspection query, they had submitted the details of such services for the Financial Year 2013-14 and 2014-15 as an addendum to their earlier submission for the Financial Year 2014-15 in Form A.

Decision:

The Authority has noted insurer's submission regarding the corrective steps taken to carry out performance evaluation, due diligence exercise of outsourced activities.

Taking note of insurer's submissions, the Authority is not pressing any charge. However the insurer is directed to scrupulously comply with all clauses of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No. IRDA/LIFE/CIR/GLD/013/02/2011 dated 01/02/2011in true spirit at all times.

2. **Charge – 2**

It was found that the payments made to its intermediaries under the accounting heads such as Support Services, Consultancy etc. were not reported to the Authority in the 31B (2) statement.

The travel agents were acting as intermediaries without holding a valid license. Insurer had not submitted the statement with the Authority about the advances given to travel agents of Rs.414.85 Lakh as on 31.03.2013 towards support services like marketing of products, promotion campaign, etc.

Violation of

Para 2 of Annexure 3 of Circular No. IRDA/F&I/CIR/Data/ 066/03/2012 dated 02.03.2012 to be read with Section 31B(2) of Insurance Act, 1938, wherein it is mentioned to submit to the Authority a statement showing the remuneration paid, whether by way of commission or otherwise to any person where such remuneration exceeds Rs. 5 lakh per annum.

Submission of the insurer:

The insurer submitted that they were of the opinion that any type of remuneration or fees not related to procurement of insurance business would not fall under section 31B(2), in view of the Authority's observations the details of those intermediaries providing space for display of branding and publicity material at their premises (banners, standees, leaflets etc.) or organizing marketing and awareness campaigns under a contractual agreement had been incorporated to the revised statement of remuneration as per section 31B (2) for the Financial Year 2012-13 submitted to the Authority vide email dated Sept 21, 2015.

With regards to the advance to travel agents, the insurer submitted that it was given as per

the contract entered with the service providers and the same was recovered against the consideration agreed under the contract. The details of such service providers were not included in the Statement u/s 31B (2) since they were not the intermediaries. However, the details of all such service providers has been submitted to the Authority in the addendum to Form A for the Financial Year 2013-14 and 2014-15.

The insurer confirmed that the travel agents are not acting as intermediaries of the Company for solicitation of business in any manner.

Decision:

It was noted from the available documents that the insurer has made payments to intermediaries (brokers) under the accounting heads such as Support Services, Consultancy etc. were not reported to the Authority in the 31B (2) statement though the amount of payments was above Rs. 5 lakh.

This leads to violation of Circular No. IRDA/F&I/CIR/Data/ 066/03/2012 dated 02.03.2012 to be read with Section 31B (2) of Insurance Act, 1938 on the part of insurer. The Authority in exercise of powers conferred under Section 102(b) of Insurance Act imposes a penalty of Rs.5 lakh. Also the Insurer is directed to comply with the said requirement.

3. Charge – 3

Co-insurance balances due from other insurers are lying unconfirmed. The same is against the requirement of IRDA circular 12/IRDA/F&A/CIR/May-09 dated 26.05.2009 wherein it is directed that the insurer is required to put in place the process to reconcile the amount due to and due from other insurers.

This is a violation of circular 12/IRDA/F&A/CIR/May-09 dated 26.05.2009.

Submission of the insurer:

The insurer submitted that the co-insurance balances as at 31st August 2013 for the year ended 31st March 2013 was Rs. 5.3 Crs (due from). Subsequently, they had settled and had reconciled and cleared most of the balances with the co-insurers. The status as on 31st August 2015 for the period upto 31st March 2013 had been at Rs. 99 lacs (Due to) which pertains to 4 public sector transactions. Even within public sector, they had a dispute with New India Assurance Company Limited Division of Mumbai, relating to one single corporate client. They had taken up the issue with New India on continuous basis to sort out the dispute and the latest position was that they had a due to be paid to New India to the extent of Rs. 99 lacs. As they were seeking further information and claims details from New India, they had been assured by New India that the information sought would be provided shortly.

Decision:

The Authority accepts insurer's submission on reconciliation of co-insurance balances and no charge is pressed.

4. **Charge – 4**

The value placed on 'Leasehold Improvement' as on 31-03-2013 was Rs. 5.73 crores (Net Block), which need to be placed with 'zero' value for solvency purposes as per Sch.1 of IRDA (ALSM) Regulations.

Violation of

Para 2(1)(e) of Schedule I of IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000 read with Section 64 V (1) (i) (e) of Insurance Act 1938 where in it is mentioned that furniture, fixtures should be placed with value "zero".

Submission of the insurer:

The insurer submitted that as per IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000, only Furniture and Fixtures are to be treated as Zero value. Leasehold improvements are of the nature of capital expenditure incurred for providing infrastructure to the office premises in the form of interiors, electrical fittings. Currently these are depreciated under 'Leasehold improvements' over the lease period subject to a maximum period of 5 years. In case of pre-closure of lease of the premises, the same is written off to zero value immediately.

The insurer further submitted that even if they presumed an item to be valued at zero for solvency purpose, the solvency position would be at 1.75 times compared to the regulatory limit of 1.5 times.

Decision:

Considering that taking the value of "Leasehold improvements" as "zero", did not have major impact on solvency margin, no charge is pressed. The insurer is hereby, directed to henceforth place value of "zero" on leasehold improvements, which is not of realizable in nature, while calculating solvency margin and to comply with Para 2(1)(e) of Schedule I of IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000 as amended from time to time to be read with Section 64 V (1) (i) (e) of Insurance Act 1938 at all times.

5. **Charge – 5**

In the Form-AA statement of assets, insurer had not considered ageing of outstanding reinsurance balances receivable for the purpose of the computation of solvency margin.

Violation of

Para 2(1)(h) of Schedule I of IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000 read with Section 64 V (1) (i) (h)of Insurance Act where in it is mentioned that reinsurance balances outstanding for more than 3 months should be placed with value "zero."

<u>Submission of the insurer</u>:

The insurer submitted that the reinsurance balances in the normal circumstances would always be "Due to" in view of the lesser claims. However, in case of FAC and other treaties where the claims are more than the premium, the same for certain types of reinsurances can be 'Due from'. The insurer has inadvertently taken the whole reinsurance balance for the purpose of solvency calculation without going into participant wise balances due. This is a one off incident arising purely due to clerical mistake. The Company has now strengthened the internal process to check the solvency calculation in addition to the audit check points. The insurer assured the Authority that such type of mistake would not be repeated in future.

The insurer further submitted that even after considering the disallowances in excess of 90 days, the solvency position along with observation 18(a) would dip to 1.74 times compared to the regulatory limit of 1.5 times.

<u>Decision:</u>

Authority has noted insurer's submission and does not press any charge. The insurer is directed to comply with Para 2(1)(h) of Schedule I of IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000 as amended from time to time to be read with Section 64 V (1) (i) (h)of Insurance Act.

6. Charge – 6

It was noticed that the insurer had considered 'Shareholders' Application Money Pending Allotment' amounting to Rs.95 crore, while arriving at 'Available Solvency Margin (ASM)' for solvency purposes. In this regard, it was observed from the 'Share Application - date of receipt of funds' statement provided by the insurer that the amount of Rs. 48.45 crores had come from the insurer's foreign partner 'Participate Maatschappij Graafsschap Holland NV'.

Violation of

IRDA (Assets, Liabilities and Solvency Margin of insurers) Regulations, 2000 if the insurer would not allocate towards share capital, the amount should be treated as liability.

Submission of the insurer:

The insurer submitted that there is no specific guideline with regard to treatment of share application money received before allotment of equity shares in the IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000. In the absence of the same, they referred to the provisions of the Companies Act, 1956; wherein it is stated that the share application should be treated as 'Equity' in Schedule VI, if it is not refundable to the shareholders and subject to the same not exceeding the paid up capital of the Company. The insurer has taken proactive steps in calling for the rights issue when it estimated the solvency to drop below the 1.5 times requirement during the year. In the process of the rights issue, it is quite normal to receive the respective application money from different shareholders in different points of time. However, the time limits were well within the prescribed time limits as per the provisions of the Companies Act, 1956 and the allotments were made within the timelines prescribed under the said act.

Decision:

It is observed that insurer has received the foreign partner's money towards share capital on 13.01.2012 and 28.03.2012. The insurer has considered the entire share holder's application money while arriving at available solvency margin as on 31.03.2012, where as only a part was being received from the foreign partner. As a prudent measure this money need to have excluded while calculating the solvency ratio as on 31st March, 2012. For example, If the money would not have considered, the solvency ratio would be1.1% as against 1.69% as reported in Form KG as on 31st March, 2012.

By utilizing share application for calculation of ASM, the insurer did not comply with Para 8.4 Unlisted Public Companies (Preferential Allotment) Amendment Rules, 2011. The Authority directed the insurer to value Assets and Liabilities prudently, in order to ensure compliance of IRDA (Assets, Liabilities and Solvency Margin of Insurers), Regulations, 2000 while calculating available solvency margin and solvency ratio.

7. **Charge – 7**

The register of Agents maintained by the insurer is not giving a clear picture of Insurance Agents engaged by the Insurer, their appointment details and the number of insurance agents active on the rolls of the insurer. Further, the insurer is allowing the agents to solicit business even after expiry of their license.

Violation of

- Provisions of Sec. 43 (1) of Insurance Act, 1938, in maintaining the register of insurance agents, which mentions that every insurer shall maintain agent's register.
- Provisions of Reg. 8(1) (ii) (a) of IRDA (Licensing of Insurance Agents) Regulations, 2000, by allowing the individuals to solicit insurance business without holding a valid license.

Submission of the insurer:

The insurer submitted that the register of Agents had been rectified and updated correctly. The Register of Insurance Agents was properly maintained with all the details as prescribed in the Section 43 (1) of the Insurance Act. The Register of Insurance Agents was also now maintained in Insurance Agents Portal with all the details as prescribed in the Section 43 (1) of the Insurance Act.

The insurer further submitted that they had further strengthened the internal controls by implementing necessary changes in the Policy Asia core system whereby the system did not permit the booking of any insurance policy after the expiry of the intermediary license unless the license is renewed.

Decision:

Solicitation of insurance business even after expiry of the agent's license is treated as a serious violation of Reg. 8(1) (ii) (a) of IRDA (Licensing of Insurance Agents) Regulations, 2000 , the Authority in exercise of powers conferred under Section 102(b) of Insurance Act, imposes a penalty of Rs.5 lakh.

8. Charge – 8

No mechanism in place to ensure that the Corporate Agents engaged by the insurer have adequate number of Specified Persons, vis- a-vis the volume of business procured by the Corporate Agents and their geographical distribution. Also there are instances that proposals are signed by insurance executive who are not specified persons of corporate agents.

Violation of

Regulation 9(2)(ii)(a) of IRDA (Licensing of Corporate Agents) Regulations, 2002 which mentions that no corporate agent / corporate insurance executive / specified person shall solicit or procure insurance business without holding a Specified Persons(SP) license.

Submission of the insurer:

The insurer submitted that the Company monitored the volume of business of the Corporate Agent and as and when it reached a threshold, they insisted the Corporate Agent to enroll additional Specified Persons.

The cases mentioned in the inspection report about signing of proposal form by other than Specified person of the corporate Agent were not regular cases but were done in very few cases due to some extraneous circumstances. The corporate agent ensured always there were adequate specified persons recruited in order to take care of the requirement. Also recruiting specified person with requisites qualification becomes difficult in certain rural and semi urban areas in spite of genuine efforts made by the corporate agents and hence the

difficulty. However, continuous efforts are made to ensure that adequate specified persons were available in the corporate agency commensurate with the volume of business and geographical spread. It was to be noted that the number of specified person had been increased from 2 to 5 during this period and further 2 persons were in the process of becoming specified person.

Decision:

Insurance contracts being highly technical in nature, the Regulations issued by the Authority stipulated that the solicitation should be done only by "Specified Persons" engaged by the Corporate Agents and such specified persons should have the qualification prescribed by the Authority. Specified persons are given the responsibility for soliciting and procuring insurance business on behalf of the corporate agent. To ensure the compliance by insurer to this requirement, Authority has advised insurers to carry on regular, annual on-site Inspection of the tied Corporate Agents every year starting from September, 2010 vide circular no. *IRDA/CAGTS/CIR/LCE/093/06/2010, dated 7-6-2010.* Further, at checklist point A1 of the referred circular for on-site inspection of the corporate agent by insurer, insurers were also advised to examine whether the corporate agents are employing specified persons for solicitation.

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.

9. **Charge – 9 and 10**

Charge – 9:

It was observed that the insurer engaged unlicensed individuals / entities / motor dealers / travel agents / cooperative banks for soliciting insurance business and the remuneration was paid in the name of "Reimbursement of support services", "Consultancy fee", to these individuals / entities etc. It was further noticed that approximately 3000 intermediary code numbers were created in the agency master in the names of various individuals / entities / motor dealers/ travel agents / cooperative banks etc. Also these un-licensed entities are maintaining Cash Deposit account with insurer for adjustment of premiums, where the policies were solicited by them.

Violation of

a) Authority's circular IRDA/CIR/011/2003, dated 27-03-2003, which gives no insurer, shall distribute the product through any person who is not licensed as per provisions of Insurance Act 1938.
b) Para 2 of Annexure 2 & 3 of Circular No. IRDA/F&I/CIR/Data/ 066/03/2012 dated 02.03.2012 read with Section 31B(2) of Insurance Act, 1938, wherein it is mentioned that the Insurer should submit the Authority a statement showing the remuneration paid, whether by way of commission or otherwise to any person where such remuneration exceeds Rs.5 lakh per annum.
c) Clause 11.2 of "Guidelines on Outsourcing of Activities by Insurance Companies Circular No. IRDA/LIFE/CIR/GLD/013/02/2011 dated: 01/02/2011, wherein it is mentioned that insurer shall file a report in Form A within 45 days from the end of every half year in respect of each of the outsourced activities.

Submission of the insurer:

The insurer submitted that they had engaged service providers for creating awareness on branding and promotional activities, display of standees, leaflets and other promotional materials, etc. the details of such service providers are tagged to the Sales Managers depending upon the geographical locations etc in order to measure the effectiveness of services provided by them.

The insurer further submitted that M/s. Wasan Auto Sales Pvt. Ltd was a service provider engaged for carrying out customer awareness campaigns, display of branding materials at its showrooms and garages for advertisements etc. The payments made to the service providers were in the nature of services as outlined in their contracts and the service providers collected cash on insurer's behalf for exigencies, for which they maintained such deposits with the insurer.

Charge – 10

It was observed that the insurer further authorized the unlicensed individuals entities / motor dealers / insurance brokers to handle / issue the cover notes with regard to coverage extended to motor vehicles. This further evidence that the insurer apart from engaging the unlicensed entities in soliciting insurance business, had also delegated the power to collect the premium, allow discounts on files premiums, and accept the risk by issuing cover notes.

Violation of

Authority's circular IRDA/CIR/011/2003, dated 27-03-2003, which gives no insurer, shall distribute the product through any person who is not licensed as per provisions of Insurance Act 1938.

Submission of Insurer:

The insurer submitted that the unlicensed individuals entities / motor dealers were not engaged in solicitation of insurance business but were only involved in printing of the policy

documents on behalf of the Company through our online portal, to which access had been provided to such entities. Insurer's representatives were normally deputed at the office of motor dealers for issuance of cover notes and collection of documents from customers and the same were not directly issued by motor dealers. The discounts were not allowed by these individuals/entities but controlled by the underwriters of the Company strictly. As stated above, all these service providers were directly supervised and controlled by their full time sales managers who were responsible for ensuring that cover notes were issued and the premium was collected.

Decision:

On examining the available documents, it is noticed that

- **Insurer had created intermediary codes in their policy administration system for unqualified entities.**
- **Payments are made to them in name of support services which were also not disclosed to the Authority.**
- **Motor dealer has signed proposal forms in name of intermediary without holding a valid license to procure insurance business.**
- **The insurer further authorized the unlicensed individuals entities / motor dealers / insurance brokers to handle / issue the cover notes with regard to coverage extended to motor vehicles.**
- **The insurer apart from engaging the unlicensed entities in soliciting insurance business, had also delegated the power to collect the premium, allow discounts on files premiums, and accept the risk by issuing cover notes**

Insurer is procuring insurance business through the entities which are not licensed as per Insurance Act. This amounts a serious violation of Authority's circular IRDA/CIR/011/2003, dated 27-03-2003 on the part of the insurer, the Authority in exercise of powers conferred under Section 102(b) of Insurance Act, imposes a penalty of Rs.5 lakh.

Further, the insurer is directed to strictly adhere to Insurance Act/ Regulations and Guidelines while procuring insurance business.

10. Charge – 11

The premium register indicates that policies were solicited by "Support Direct India Pvt. Ltd.", however the proposals were signed by the various persons relating to M/s. Appco Marketing Pvt. Ltd., (a Corporate Agent of the insurer).

This is a violation of Clause 6 of Annexure II of IRDA Guidelines on Corporate Governance Circular no. IRDA/F&A/Cir/025/2009-10 dated 05/08/2009.

Submission of Insurer:

The insurer submitted that some of the proposal forms were inadvertently stamped by M/s. APPCO Marketing Pvt. Ltd., which also being a corporate agent, was assigned the activity of collection of proposal form from various locations on behalf of the Company. In view of the Authority's observations, the entire process of collection of proposal forms till submission to the Company was reviewed and effective controls are put in place to comply with the provisions and regulations. The Company has also reviewed the process of collection of proposal forms with our Corporate Agent M/s. Appco Marketing Pvt. Ltd and has centralized the policy issuance process at our Head office.

Decision:

The proposal forms are signed by the other corporate agent who is not authorized to sign the said proposal forms. This shows the inadequate internal control while dealing with proposal forms at insurer's end.

Authority takes note of the submissions of insurer and no charge is pressed. However, the insurer is directed to adhere to Clause 6 of Annexure II of IRDA Guidelines on Corporate Governance Circular no. IRDA/F&A/Cir/025/2009-10 dated 05/08/2009 which deals with internal control functions at insurer's end.

11. Charge – 12

It is also observed the insurer did not put in place systems to record the complete details of premiums received from the clients / intermediaries in its policy administration system (PASIA). On examination of sample premium receipts for a few policies, it was observed that the premium was received in (2) or (3) different receipts for a single policy issued through motor dealers, and in all the instances, the cheque status for 2nd instrument was shown as "CNS Pending".

Violation of

Sec. 64 VB (1) and (4) of Insurance Act, 1938 as the insurer is accepting the risk even before the amounts are received towards premium.

Submission of Insurer:

The insurer confirmed that they had not breached section 64VB of the Insurance Act as the risk commencement/ inception of the policies were only after receipt of premium, including in the case of short premium collections from the intermediaries.

Decision:

Authority takes note of the insurer's submission and noted that in cases of inspection observations, the risk is commenced only after receipt of the premium. In view of this, the Authority is not pressing any charges.

12. **Charge – 13**

It was observed that the insurer did not obtain the proposals for issue of policies as required under the provisions of Reg. 4(1) of the IRDA (Protection of Policyholders' Interests) Regulations, 2002. The name of the intermediary was not printed on the policy schedule.

Violation of

- Reg. 4(1) of the IRDA (Protection of Policyholders' Interests) Regulations, 2002 as insurer is issuing policies without obtaining proposal forms from the customers
- Authority's Cir. No. IRDA/CAD/CIR/ AGNI137/ 08/2010, dated 25.08.2010 wherein it is required to give code of intermediary in the policy schedule.

Submission of Insurer:

The insurer submitted that in case of travel policies, for the ease of the customer, a proposal cum insurance policy was issued to the customer based on the information received from the customers orally or through emails/ telephone. The proposal cum insurance policy was valid only if it was signed by both the Insured and the Insurer for confirmation of the details captured in it. The proposal cum policy schedule specifically states the same.

The insurer confirmed that in case of all other products except marine cargo, proposal forms from the customers were obtained.

In case of direct business, the insurer had made necessary corrections in the system which correctly captured the intermediary details and incase of direct business instead of leaving it blank it captured as "Direct" in the intermediary details

Decision:

A complete proposal form is the basis of accepting risk at the underwriting stage and settling the risk at the claims stage. Without obtaining a proposal form or incomplete proposal, the insurer did not comply with the Regulation 4 (1) of the IRDA (Protection of Policyholders' Interests) Regulations, 2002. Also, the insurer is directed to comply with the said regulation and Authority Cir. No. IRDA/CAD/CIR/ AGNI137/ 08/2010, dated 25.08.2010.

13. **Charge – 14, 15 and 16**

Charge- 14

The referral partners engaged by the insurer were involved in solicitation of insurance and the insurer had issued policies to the insured mentioning the name of the referral partner as "Intermediary" on the policy schedule.

Violation of

General provisions of Reg. 9(a) of IRDA (sharing of Database for distribution of Insurance Products) Regulations, 2010, wherein it is stated that the referral company shall not carry out the sale of insurance products in its premises or elsewhere at all times.

Submission of insurer:

The Referral Partners are not the intermediaries of the company however referral fees is paid to referral partners for the data bases converted into sales. In order to track the business sourced from the data base of Referral Partner, the name of the Referral Partner is linked with the Sales Mangers and accordingly the name of Referral Partner is captured on the Policy Schedule.

The insurer further confirmed that they were not printing the policy with the name of referral partner as intermediary. In case of any cover note, it was issued by FGI employees only.

Charge – 15 & 16

The insurer did not put in place a mechanism to ensure that the remuneration is not paid on the database converted into sales more than once during the referral arrangement period.

It was also observed the insurer had a tie up with Future Group to access the mall customers. The insurer entered into an agreement with M/s. Future Value Retail Limited, for advertisements and an amount of Rs. 74 lakhs were paid during the year 2012-13. It was found that the insurer's web site displays the names of "Mallasurance locations", where the Future Generali products are available.

Violation of

- Regulation 11 (8) of IRDA (Sharing of database for distribution of insurance products) Regulations, 2010 wherein it is mentioned that an insurer shall not pay any fees or remuneration for such database converted into sales more than once during the tenure of the referral arrangement.
- Reg. 11 (11) of IRDA (Sharing of database for distribution of insurance products) Regulation, 2010 as the insurer made payment to referral entities, under the head of account "Advertisement & Publicity".
- Authority's circular IRDA/CIR/011/2003, dated 27-03-2003 which gives no insurer shall distribute the product through any person who is not licensed as per provisions of Insurance Act 1938.

Submission of insurer:

Insurer submitted that initially the referral fees to Referral Company under the said regulations were inadvertently made on the basis of the policies sold to the same client however after July 2012; the error was noticed under the compliance review conducted for the said

arrangements. The insurer further confirmed that the remuneration to the referral partner was made as per the limits prescribed in the IRDA (Sharing of Database for Distribution of Insurance Products) Regulations 2010 and adequate checks and controls had been put in place to comply with the provisions of said Regulations. With regard to payment towards advertisement contract, though the company felt that the service contract entered into with the referral agent was an exclusive one, in view of the inspection observation, the insurer submitted that they had recovered the amount of Rs. 0.35 lac vide receipt no Z5416480 paid to the said bank under the head of account "Advertisement & Publicity", during the Financial Year 2012-13.

The Mallassurance is a pioneering distribution effort introduced by the company in the Indian Market. The Mallassurance model is operated out of various malls that are currently managed by the Future Group all over the Country

The company vide its agreement dated November 10, 2010, had tied up with M/s. Future Value Retail Limited ("FVRL") for Advertisement and In store Branding arrangement under which FVRL share's space at its malls and allowed the Company to display advertisement material for branding and increasing the visibility of the Company.

Decision:

The officials of referral entity have physically signed the proposal forms of the insurer. This amounts to procurement of new business by referral entities. This is a violation of general provisions of Regulation 9(a) of IRDA (sharing of Database for distribution of Insurance Products) Regulations, 2010 and violation of Authority's circular IRDA/CIR/011/2003, dated 27-03-2003.

It was noticed that the insurer has paid the remuneration on the database converted into sales more than once during the referral arrangement period and the referral fee was paid to these referral entities, as many times as the policies were issued on the same client.

The insurer has violated Regulation 11(8) and Regulation 11(11) of IRDA (Sharing of database for distribution of insurance products) Regulations, 2010. The Authority in exercise of powers conferred under Section 102(b) of Insurance Act imposes a penalty of Rs.5 lakh and directed to comply with the regulation.

14. Charge - 17

The insurer did not file any advertisements during the period from 01.07.2011 to 21.03.2013, as per the advertisement register maintained by the insurer as on the date of inspection. Further, the insurer had entered into service level agreements with various vendors for display of advertisements (standees), distribution of flyers, customer awareness campaigns etc., and made payments for the same.

Violation of

Regulation 3 (1) (ii) to (v) of IRDA (Insurance Advertisements) Regulations, 2000 wherein it has mentioned the timelines about maintaining the advertisement register, maintaining specimen advertisement and filing of advertisements with the Authority.

Submission of insurer:

The insurer submitted that they had used the previously released advertisement materials which were submitted to the Authority during any of the campaign in the malls of Pantaloons and Future group. They further stated and submitted that they had not prepared and used any customized advertisement material especially for the use in the campaign advertising in malls of Pantaloons and other Future Group.

They further confirmed that the company had not released any new advertisement material during the period between 01.07.2011 to 21.03.2013, and had used only previously released advertisement material which were submitted to the Authority.

Decision:

Authority takes note of the submissions of insurer and no charge is pressed. The insurer is further directed to adhere to different provisions of Regulation 3 of IRDA (Insurance Advertisements) Regulations, 2000 which deals with compliance and control on advertisements by the insurers.

15. Charge - 18

It is observed that the insurer solicited business in distance marketing mode under five products. However the insurer had filed the standardized script for the Distance Marketing only with regard to three products

Violation of

Provision of clause 6, clause 9.1 and clause 9.5 of Guidelines on Distance Marketing of Insurance Products dated 5th April, 2011 (IRDA/ADMN/G,'DUMISC/059/04/2011) wherein it is stipulated to prepare standardized scripts for presentation of benefits, features and disclosures under each of the products proposed to be sold over the distance modes.

Submission of insurer:

Insurer submitted that Health Suraksha was a hospitalization indemnity product available in Individual and family floater options. The product construct was exactly the same, the only difference being in offering either individual Sums insured or a floater sum insured Premiums were filed accordingly. Hence, the insurer was using only a single script. Further with regards to Future Secure Private Car and Future Secure Commercial Motor, they were only sourcing Private Car through distance marketing whereas, a very few policies had been issued under distance marketing for Commercial Vehicles which were our own renewal and was issued at the request of the customers. The insurer further submitted that in view of the above observations, they would file separate script for every product as and when they proposed to market new product through this channel.

Decision:

Considering that the distance marketing guidelines issued by the Authority were effective from 1/10/2011 and the insurer has procured only a few policies under direct marketing channel, no charge is pressed. However, the insurer is directed to comply with Provisions of clause 6, clause 9.1 and clause 9.5 of Guidelines on Distance Marketing of Insurance Products dated 5th April, 2011 (IRDA/ADMN/G,'DUMISC/059/04/2011).

16. Charge - 19

It is observed that the policy document printing had been outsourced to M/s Friends Colors Private Ltd., who prints the policy documents from different locations. Duplicate policies are printed and issued at branches. The copies of 'Policy Wordings' were not available for verification inthe policy dockets supplied for any LOB.

This is violation of Clause 6 of Annexure II of IRDA Guidelines on Corporate Governance Circular no. IRDA/F&A/Cir/025/2009-10 dated 05/08/2009 for lack of internal control mechanism.

Submission of insurer:

Insurer submitted that the policy wordings were standard and hence were not kept along with the policy dockets to save paper and cost, hence the copies of the policy wordings were not available with policy dockets. The soft copies of the policy wordings are maintained at the respective underwriter's level and were also displayed on the company website. (https://general.futuregenerali.in/general-insurance/forms-and-downloads).

The insurer stated that the policy wordings were maintained in electronic form for all LOBs and they had maintained one set of policy wordings for each LOB in physical printed file to save paper and cost. However if the Authority requires us to maintain printed copy of policy wordings for each customer, the Company would maintain the same.

Decision:

The insurer is required to maintain the policy wordings of each policy in the policy docket for correct disposal of contractual obligations to the customer at the time of settlement of claims. It also facilitates efficient servicing of the policy to the customer. Hence the insurer is directed to maintain copies of policy wordings in the policy docket for all lines of business. In this context the Insurer is also directed to follow various provisions of the guideline on electronic issuance of insurance policies dated 29th May 2015.

17. **Charge – 20 and 21**

Charge -20

The insurer offered discounts on premium in excess of the maximum discount filed under File and Use guidelines. It was observed from the Brochure that the applicable terms and conditions were not mentioned against the add-on covers though while approving the motor add-on covers, the Authority had specifically advised the insurer that all the terms and conditions applicable for different add-ons should be clearly mentioned in the brochures.

Violation of

- Para 2 of Circular No. 021/IRDA/F&U/Sep. 06, dated 28-9-2006 for allowing higher discounts in premium than approved by the Authority under "F&U" guidelines.
- Circular no. IRDA/NL/Cir/F&U/003/01/2011 dated 6th January, 2011.

Submission of insurer:

Insurer submitted that after receiving Authority approval letter reference no. 4 /RD/ FGIICL/ENGG/EAR/07-08 dated 08.11.2007 with regards to the Engineering and Fire Products, the Authority had issued circular on removal of controls on pricing of risk in general insurance business with effect from 1st Jan 2008 vide circular reference no 048/IRDA/De-tariff/Dec-07. The Company had accordingly re-filed revised rates and same was acknowledged by the Authority via email dated 28th Dec 2007.

The inspection team had referred to the original filed rates whereas we have refilled our rates subsequent to the IRDA circular ref: 048/IRDA/De-tariff/Dec-07 on removal of controls on pricing of risk in general insurance business with effect from 1st Jan 2008.

18. **Charge – 21**

It was observed that bundling of the benefits including add-on covers were offered resulting in mis-selling of the product. Moreover, the product offering in units and bundling was not filed with the Authority for approval.

In case of CGL policies, the rating filed by the insurer for 'loading for turnover' was in a range of '0.02% to 0.05%' of turnover. However, it was observed in the case of sample policies that the rate for turnover applied by the insurer was far below the 0.02% which was the minimum rate.

The Insurer sold any 'Special Contingency' policies although the same was not approved.

In case of motor package policies, 'portfolio discount' and 'special discount' were allowed which were not as per the filed product. Also, the premium for add-ons was not shown separately for each add-on in the policy schedules.

Violation of

- Clause 11 of File & Use Guidelines (Circular No. 021/IRDA/F&U/Sep. 06, dated 28-9-2006) by selling the customer the product with bundling the add-ons. Such

bundling is not approved by the Authority.

- Circular of Authority IRDA/NL/CIR /F&U/003/01/2011 dated 06.01.2011 by selling unapproved product.

Submission of insurer:

The unit concept was introduced only to ensure that proper relation is maintained between the sums insured of major covers as well as the optional add-ons and there was ease in calculations of premiums and simplicity in explaining the product specifications to the customer.

The insurer had clarified that the guide rates would be varied at Head Office based on claim experience and business of the insured as filed under Form A and accordingly the rates were in line with file and use guidelines.

The insurer confirmed that post audit observation, they had made amendments and discontinued with said offering to the customers and the product was sold exactly as per the brochures and respective risk class rates.

In case of CGL policies, those risk having large proposals for which the insurer generally did not get local market capacity automatically and in most of the cases, the rates and terms were provided by the reinsurer and the same was quoted with the insured. It was the normal market practice to follow the rates of the reinsures in such cases.

With regards to Special contingency Policy, the insurer submitted that the same are in the nature of all risk policy which is approved by the Authority.

With regards to Motor Package Policy, the insurer confirmed that the discounts allowed are in line with file and use guidelines.

The insurer further stated that premium bifurcation for add on covers was available with the changes in the IT system.

Decision on 20 and 21

It is observed from the "F&U" documents furnished for Fire Insurance that there is no provision of special discount on and above additional claim ratio discount. From the annexure, it is observed that the insurer has applied special discount over and above IAR discount. For the Engineering policy, the insurer is applying special discount which is not a part of "F&U" of the product. The brochure of the "Motor Secure" policy does not describe all terms and conditions applied to all add-ons.

Authority has noted that the insurer has offered a unit rate under the PA policy sourced through a corporate agent. It is also observed that bundling of products was done without considering the need of the customer for availing that particular add-on cover. The product offering in units and bundling was not filed with the Authority.

The insurer has sold CGL policies far below the filed rates under the "F&U" of the product. This has also violated "F&U" guidelines. The insurer has also sold special

contingency policies as a lead insurer in a co-insurance arrangement with L&T insurance company.

In case of motor package policies, the Authority has allowed portfolio discount of 5% and additional discount of 10% as per approval letter ref: 1/RD/FGIICL/Motor/FS/07-08 dated 04.11.2007. It is observed that the insurer has offered portfolio discount of 25% and additional discount of 12% in inspection sample cases. This is in violation of "F&U" guidelines.

The company has deviated from the discount structure approved by the Authority under F&U guidelines by offering discounts beyond as provided by under the Underwriting Policy. This is a violation "F&U" guideline under Circular No. 021/IRDA/F&U/Sep. 06, dated 28-9-2006 and Circular no. IRDA/NL/Cir/F&U/003/01/2011 dated 6th January, 2011, the Authority in exercise of powers conferred under Section 102(b) of Insurance Act imposes a penalty of Rs.5 lakh.

19. Charge -22

In case of Motor TP & Package policies, it was observed that the nomination details were not captured in the proposal forms and were not printed in the policy schedules.

Violation of

- Regulation 4(5) of IRDA (Protection of Policyholders Interest) Regulations,2002 by not drawing the attention of the proposer and encourage the prospect to avail the facility of nomination.
- IRDA Circular No. IRDA/NL/CIR/F&U/226/09/2011 dated 23rd April, 2011by not obtaining nomination details on proposal form

Submission of insurer:

Insurer submitted that the nomination details could not be captured in the system due to technical developments which took some time. They had effectively implemented the changes in the system and started capturing the nominee details w.e.f. 1st April-2012. The nominee details are available on the proposal forms as well as the policy schedules.

Decision:

The Authority has noted the submission of the insurer that the IT system of insurer is capturing nomination details in proposal / policies. In view of this the Authority is not pressing charges. The insurer is advised to comply with Regulation 4(5) of IRDA (Protection of Policyholders Interest) Regulations, 2002 and IRDA Circular No. IRDA/NL/CIR/F&U/226/09/2011 dated 23rd April, 2011 at all times.

20. Charge – 23

It is observed from motor package policies that copies of invoices were not collected and filed in the policy files to ascertain the Manufacturer's Selling Price (MSP) of the vehicles based on which the IDV should be fixed. Moreover, insurer had been offering 'Return to Invoice' add-on wherein the difference between 'purchase price of the vehicle as per invoice' and 'IDV' stands covered on payment of additional premium.

Violation of

GR-8 of IMT 2002 by not collecting copies of invoices to ascertain the Manufacturer's Selling Price (MSP) of the vehicles.

Submission of insurer:

Insurer submitted the step by step process of updating the IDVs masters of motor package: IDV Master were updated based on vehicle manufacturer price available on official website or price list available at dealership. There was a dedicated team who updates vehicle IDV on a regular basis. The data was stored in excel sheet to facilitate easy updation of IDV – Make and Model wise and for upload in our core system.

The data (IDV Master) was then uploaded in to their core system. They had also built depreciation matrix in their core system as per motor tariff.

On the basis on the above mentioned parameter, system fetches the vehicle IDV based on make, model and year of manufacture.

Decision:

The Authority had examined the submissions made by the insurer and no charges are pressed. The insurer is further advised to comply GR-8 of IMT 2002 all the time.

21. Charge – 24

It was observed that the terrorism risk premium was quoted differently and the same was not as per the terrorism risk pool rates for the FY 2012-13.

This is Violation of Para 6 of File & Use Guidelines (Circular No. 021/IRDA/F&U/Sep. 06, dated 28-9-2006) for not using terrorism risk pool rates.

Submission of insurer:

Insurer submitted that the terrorism premium collected includes marine transit terrorism cover premium also. The whole terrorism premium was wrongly booked under the terrorism pool premium which was a one off error and genuine mistake which has since been rectified at their end. The insurer had passed an endorsement to the said Policy for correcting the premium as per terrorism pool rates.

Decision:

In view of the corrective action taken by the company the charge is not pressed further.

22. Charge – 25

The cover notes books were issued to various Insurance Brokers including the Brokers whose license was cancelled.

Violation of

- Clause 14 of Reg. 21 of IRDA (Insurance Brokers) regulations, 2002 stipulates that an insurance broker as defined in these regulations shall not act as an insurance agent of any insurer under section 42 of the Act.
- Clause 4 of guidelines on outsourcing of activities by insurance companies (IRDA/LIFE/CIR/GLD/013/02/2011 dated 01.02.2011.)

Submission of insurer:

The insurer submitted that Cover note books are issued to Insurance Brokers having valid licensed issued by the Authority at their request for the ease and convenience of the customers, on the premise and assumption that the relevant regulations with respect to obtaining mandates from clients would had been duly complied by the brokers. They had strengthened the process to ensure that the cover notes were recovered once the license was cancelled by the Authority and confirm that all the cover notes books were recovered and reconciled. The insurer confirmed that they did not outsource this function to any broker or any unlicensed persons.

Decision:

Insurance brokers represent the clients and require mandate of client to place business with insurer. As per code of conduct clause 14 of Reg. 21 of IRDA (Insurance Brokers) regulations, 2002 'An insurance broker as defined in these regulations shall not act as an insurance agent of any insurer under section 42 of the Act.' In view of this the insurer is directed not to outsource this function to any broker or any unlicensed persons. The insurer is further directed to comply Clause 15 of Reg. 28 of IRDA (Insurance Brokers) regulations, 2013 and Clause 4 of guidelines on outsourcing of activities by insurance companies (IRDA/LIFE/CIR/GLD/013/02/2011 dated 01.02.2011.) at all times.

23. Charge – 26, 27 and 31

Charge 26 and 27

The insurer did not confirm the existence of the group before issuing the group policy. No

mechanism has been put in place to obtain a master proposal form from the master policyholder and to examine the membership forms for providing coverage through group insurance policy. It was also observed that the policy was issued to those groups with membership size of less than 10 members, and even for one member.

Violation of

- Clause A (2) and C (1) of Guidelines of Group Insurance Policies (015/IRDA/Life/Circular/ Guidelines/ 2005, dated 14.07.2005) states that no group should be formed with the main purpose of availing insurance and the premium charged and benefits admissible to each member of the group shall be clearly specified.
- Clause A (3) of Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005) wherein it is mentioned that insurers will exercise prudence in requiring a minimum group size.

Submission of insurer:

The insurer confirmed that the polices issued to a specific Group were to cover their investors, agents and employees after asserting that this constituted a group as per group guidelines and the premiums were entirely borne by the said group and documentary submissions had been made to this regard in their earlier replies.

The fact that the Group Policy was issued with a claims review clause of 80 % indicates the stand that the client was bearing the premiums towards these policies. The insurer also confirmed that all those who were covered under the group health policy were issued Health Cashless cards.

The insurer submitted that the additional premium was payable only if the loss ratio reaches an agreed threshold limit and not on the basis of the number of policies becoming claims.

The premium for these policies was paid entirely by the master policyholder and not collected from their investors/ depositors/ employees nor was the burden of the premium or part of the premium being passed on to the said investors/depositors/employees. The insurer stated that in no way the insured members were affected nor any premiums from individuals was collected and it was only agreed that if the loss ratios goes higher than a certain limit, Master policyholder was committed to pay additional premiums.

Insurer submitted that there was also a special request that separate policies be issued location wise as their data was more localized. Also some of the policies had been issued in a split manner to ensure coverage is given for a period of 1 year and corresponds with the membership period , therefore the group size in some policies were below the minimum.
The insurer further submitted that the reason why group policies were issued for small groups was because of some IT system constraints.

Charge – 31

The insurer made payments to various master policyholders in the name of support service

charges in violation of the provisions of para C-4 of Authority's Group Insurance Guidelines.

Violation of

Para C (4) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005) which stipulates that there should not be any other payment to group manager.

Submission of insurer:

The insurer submitted that the payments made to the Master policyholders were made for the services rendered by them under the separate contractual arrangement which was not related to the Group Insurance Policies availed by them. The Company has placed banners and standees at the premises of the various branches of a specific Group to increase health awareness and spread the name of the Company amongst the rural and semi urban population. The insurer had been conducting customers' meet at various branches to increase the awareness of our products and services. Group policyholder and the other accounts mentioned above had been paid for the limited usage of space at their various Branch offices for branding and advertising purpose. The insurer further submitted that all the payments made to them were as per contracts for provisions of services.

Decision on 26, 27 and 31

It is observed that the insurer has violated the definition of a group which is given in their own underwriting manual of "Group Health Policy". In this definition it is clearly stated that The Group Mediclaim policy would be available to any Group / Association / Institution / Corporate Body of 50 and above provided it has a central administration point. Each Insured should cover all eligible members (insured persons) under one group policy only. The group policy should have single start date and end date. Multilevel marketing for sales to common public do not form a part of group.

The insurer has issued different group policies at different locations without considering the minimum group size and risk commencement date. It defeats the basic purpose of group insurance.

The insurer has also imposed a claim review clause of 80 %. This indicates that the pricing is not done on scientific basis. The insurer has not put in place to obtain a master proposal form from the master policyholder and to examine the membership forms for providing coverage through group insurance policy. Insurer has not put in place the mechanism to confirm the existence of the group before issuing the group policy.

It is evident that the insurer had made payments to various policy holders in name of support charges which violates para C (4) of Group Insurance Guidelines. Combining this violation with other violations of Group Guideline under charge 26 and 27, the Authority in exercise of powers conferred under Section 102(b) of Insurance Act imposes a penalty of Rs.5 lakh.

24. Charge – 28

It was noted that the premiums quoted under group health policies were neither based on tariff filed with the Authority, nor based on sound actuarial principles. The premiums were quoted arbitrarily and are based on commercial call taken by the insurer. It was noticed that the insurer did not adhere to terms and conditions, exclusions, benefits and policy wordings filed with the Authority while issuing the Group Personal Accident policies

Violation of

- Clause A (1) of Guidelines of Group Insurance Policies 015/IRDA/Life/Circular /GI Guidelines/ 2005, dated 14.07.2005) which prescribes the nature of the group for insurance.
- Clause 3 (vi) of File & Use Guidelines (Circular No. 021/IRDA/F&U/Sep. 06, dated 28-9-2006) for not pricing the products based on appropriate data and with technical justification.
- Circular of Authority IRDA/NL/CIR /F&U/003/01/2011 dated 06.01.2011for selling product with non-approved rates/ terms &conditions.

Submission of insurer:

The insurer submitted that the Group Health policies covered in the inspection are all employee-employer policies, whereas Group personal accident policies include employee–employer, as well as account holders of banks. The insurer confirmed that these are in no way groups formed for the purpose of Insurance.

The insurer was using sound actuarial practices for underwriting Group Health policies as well as Group Personal Accident Policies which was based on the past experience and other factors.

The insurer had already filed the Health Underwriting policy duly approved by the Board to the authority. The insurer had also submitted Our Group Health pricing approach to the authority. All quotes were prepared after calling for entire data for which they used data templates and quotes were generated by underwriters only if entire data was made available and with proper technical justifications.

Any deviations were decided by competent authority as per the underwriting policy of the company and all such deviations were duly recorded.

The insurer confirmed and assured the Authority that they did not quote premiums arbitrarily for group health and group PA policies and the loss ratios of the portfolios had already been submitted to justify the same.

Decision:

The insurer stated that the group health insurance portfolio mainly comprises employer-employee policies. The group personal accident portfolio is a mixed portfolio with employer-employee groups and non-employer-employee groups. It is observed

that for group personal accident policies, the insurer has not adhered to different provisions / terms & conditions/ rules of "F&U" of the product. The insurer, therefore, did not adhere to the pricing methodology mentioned in the product F&U document. In none of the Group PA policies, the insurer obtained a written proposal form from the master policyholder, in the absence of which it could not be ensured whether the benefits offered by the insurer were in line with the requirements of the insured. In view of the above the insurer is directed to follow a robust methodology for determination of price for group health insurance portfolio without any deviations from the filed product as per the F&U Guidelines.

25. Charge – 29

Citical illness cover extended as part of Group Health Insurance Policy issued to one Master Policyholder, was worded as "Critical Illness cover with per family limit of INR 500,000 on indemnity basis subjected to maximum 50 cases. This is applicable only after the exhaustion of the principal sum insured". The critical illness list is containing diseases like malaria, enteric fever, ureteric stones etc. The benefit offered was not in line with the policy conditions as per the product F&U.

It was noted that the insurer had issued Group Health Insurance Policies to a specific Group with a claim review clause, which says "If the claims Ratio on Earned Premium basis exceeds 80% on annual review of the policy, additional premium will be payable by the master policyholder to adjust the Claims Ratio 80%.

It was noticed that the Group Health Policies issued to different wings of the master policyholder were issued for tenure of 2 years, though the product F&U did not provide for issue of long term policies. Similarly, there was no basis for charging a premium of Rs. 1000/- per family under the said policy. The premium computation was not provided for examination.

Violation of

- IRDA/NL/CIR/F&U/003/01/2011 dated 06.01.2011, as premiums are not calculated on sound actuarial principles and by deviating from F&U Guidelines.
- Point 1, 3(vi), 3(ix), 8, 11, and 17.1 of Guidelines on "File &Use" dated 28.09.2006.
- Para A-1 of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/2005, dated 14.07.2005) which gives the nature of the group for insurance.
- Violation of section 52 of Insurance Act 1938 which Prohibits business on dividing principle

<u>Submission of insurer</u>:

The insurer submitted that the nomenclature used for this listed conditions in the referred policy was 'Critical Illnesses' and they had not granted 'Critical Illness' cover separately under the policy.

The nomenclature of "critical illness cover" here was not referring to any benefit coverage but covers just certain listed conditions for which enhancement of the sums insured limits for treatment cost was provided. The nomenclature of "critical illness" was used to differentiate these listed conditions from the other covered illnesses. The insurer had not offered any special critical illness product but had only offered to increased indemnity limits for certain listed conditions.

The insurer had already initiated the internal process to remove the said term and just mention "Listed conditions" instead of using the words "Critical illness".

The master policy though indicated the policy period as two years (inadvertently issued), the pricing was calculated only for one year and each member was covered for one year only. This issue arose purely due to a system error but when this was noticed it was immediately rectified at our end, and all policies were rectified to have a period of one year only, with coverage for each member also for one year only.

The GMC policy offered to the referred group covered their employees, agents, investors/ depositors and the entire premium for the same was paid by the employer. The employer had fixed a budget of Rs. 1000/- per family for this benefit to be offered to their members for which they were the cost and we were approached to propose a cover within built sublimit, etc., for their benefits within the budgeted premiums.

Decision:

The insurer has offered a critical illness cover to clients of one master policyholder under Group Health Policy. The terms and condition under this critical illness cover is not as per the product filed with IRDAI under "F&U" procedure.

The insurer had issued Group Health Insurance Policies to another master policyholder, with a claim review clause. Issue of group health insurance policies with such restrictive clauses does not fall under the definition of "insurance business". Also the policy is issued as a long term policy (for 2 years) which is in violation of "F&U" of the product.

The insurer has violated the policy terms and conditions as stated in the product F&U, with regard to claims handling in Group Health Insurance policies. In view of the violation of "F & U" Guidelines and "F&U" Circular, the Authority in exercise of powers conferred under Section 102(b) of Insurance Act imposes a penalty of Rs.5 lakh.

26. Charge – 30

- The insurer did not put in place any mechanism to ensure that the master policyholder had the mandate of the members covered and did not issue Certificate of Insurance with regard to members covered under non-employer- employee group insurance policies issued.

- The claims settled with regard to Group Health policies, and Group Personal Accident policies issued to all non-employer-employee groups, the payments were made to the master policyholders by drawing a cheque in the name of master policyholder and did not put in place any mechanism to ensure that the payments were settled by the master policyholder to the beneficiaries of the insured members.

Violation of

Para C (7) and C (11) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005.

Submission of insurer:

Insurer submitted that wherever any premium has been collected from the individuals an appropriate CoI has been given which gives details of the coverage as well as premiums. Wherever the premium has not been collected from the members and the entire premium has been borne by the Bank/Company, the company has not issued any CoI.

The insurer further submitted that post the observations made in the inspection we have adopted the following process to strictly conform to the guidelines on group Insurance:

- *Corrections to the certificate of insurance issued which included the claims procedure.*
- *Issuance of corrected certificates to all the members under the non-employer - employee policies issued.*
- *Claims Payment to the individual members covered in the policy or nominee as declared by individual member.*

The insurer confirmed that the company had strictly started following the guidelines for issuance of certificates of insurance and direct settlement of claims to the members or nominees. All payments were transferred to the bank account of the member/nominee.
The insurer further stated that in non-employee-employer policies, wherein premium was being paid by the banks, the group organizer communicated the coverage details to the individual members. Further in case of claim payments, the claims were being paid to the individual member or the nominee and directly being transferred to the Bank accounts of the nominee / Insured member.

Decision:

Considering the submissions made by the insurer that CoI is issued to every member of non employer- employee group, the Authority is not pressing any charge. However the insurer is further directed to comply with provisions of clause C (7) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005.

The insurer is further directed to comply with provisions of clause C (11) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005, in the context of conducting surprise inspection.

27. Charge – 32

It was observed that the sum insured offered to various members in a specific group personal accident policy was varying between Rs. 25,000 to Rs. 1,00,000 without any pre-determined basis. Similarly, the insurer offered long term policies ranging from 1 year to 5 years without any basis. The term of the policy is as per the period of deposit.

Violation of

Para C (1) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005) which requires that Sum Assured shall be in accordance with some pre-determined basis.

Submission of insurer:

The insurer submitted that the sum insured under the policy varied from Rs. 25,000/- to 1,00,000/- for different category of people covered. Since the sum insured was nominal and didn't have high risk exposure they had not insisted for any documentary basis for justifying the sum insured for different categories of insured persons for practical and simplicity purpose.

Decision:

In this regard, the Authority is not pressing any charges but advises the insurer to comply with Para C (1) of Group Insurance Guidelines of Group Insurance Policies 015/IRDA/Life/Circular/GI Guidelines/ 2005, dated 14.07.2005) in true spirit.

28. Charge – 33

Proper mechanism was not put in place to handle the claims on policies issued under Janata Personal Accident product. Claims were rejected on the grounds of "late intimation of claim". It was also noticed that the insurer did not put in place any documented policy for closing rejection/repudiation of claims for non-submission of documents and delayed intimation or for any other reasons

Violation of

- IRDA/HLT/Misc/CIR/216/09/2011 dated 20.09.2011 for repudiating claims for delay in submission of requirement.
- It is a violation of clause 6 of Corporate Governance Guidelines(IRDA/F&A/CIR/025/2009-10 dated 05.08.2009)

Submission of insurer:

The insurer submitted that it was a Group JPA Policy issued to the Government of Maharashtra covering the farmers of the state. They had participated in the scheme along with other Public Sector Insurance Companies. The State Government themselves had incorporated certain points in the SLA to avoid incidences of late reporting of claims. All the points in the SLA were mutually agreed by the State Government/Insurers/Brokers to ensure that the scheme was smoothly implemented in the State of Maharashtra. The insurer had also always endeavored to insist on including clauses to comply with provisions of IRDAI Group Insurance Guidelines in various Government contracts to ensure complete compliance with the IRDAI regulations.

The insurer further submitted that the Brokers were entrusted by the State Government for helping the documentation of claims, collection and collation of claim documents and submitted for further processing and settlement by the insurers to ensure that unjust repudiation of claims does not take place. The State Government also regularly conducted review meeting with Insurers and Brokers to address any grievances if any and all claims which were repudiated by insurers were also reviewed jointly by the Government, Insurers and Brokers and even reconsidered. The insurer confirmed that they were not repudiating any claims in any line of business on a unilateral basis just because of delay in reporting and further confirmed that they followed well-documented processes for settlement of all claims.

Decision:

The Authority has noted submissions of the insurer and no charges are pressed. The insurer is advised to adhere to all relevant regulations/ guidelines while settling health insurance claims.

29. Charge – 34

The inward register of policy dispatch for 91904 policies examined shows that about 256 new policies were dispatched between 30 to 120 days. As regards, renewal of policies, there were about 55 policies dispatched between 30 to 80 days. In case of cover note issued in 970 cases, the policy was dispatched between 30 to 120 days.

Violation of

- Reg. 4(6) and 4 (1) of IRDA (Protection of Policyholders Interests) Regulations, 2002 wherein it is stated that proposals shall be processed by the insurer within 15 days and share a copy of proposal form within 30 days of receipt of proposal form.
- Clause 6 of Corporate Governance Guidelines (IRDA/F&A/CIR/025/2009-10 dated 05.08.2009) by accepting the proposal without all relevant requirements obtained from the proposer.

Submission of insurer:

The insurer submitted that the risk commencement was from the date receipt of premium and on receipt of all relevant information to underwrite the risk. However the policy was issued only after all necessary details necessary for issuance of policy are received from the

customers. The Company contacts the customers via letters, emails and phones to get the missing information. Intermediaries were also informed of the missing information in order to expedite policy issuance and dispatch.

The insurer ensured that their sales force was adequately trained to accept only proposals which were complete in all respects so that the policies could be issued within the timeframe.

Decision:

The insurer's reply seems to be contradictory about the commencement of risk and issue of policy document. The risk can only be commenced on receipt of all documents along with the premium amount by the insurer. Insurer's reply does not support the same.

As the general insurance policies are usually short term policies with term of one year, delay in issue of policy with the time limit of nearly 120 days defeats the purpose of the insurance in hands of the insured persons.

The insurer has violated Regulation 4(6) and Regulation 4 (1) of IRDA (Protection of Policyholders Interests) Regulations, 2002. There is also no adequate internal controls about acceptance of proposals and issue of policies at insurer's end.

The insurer is warned for the violation and directed to strictly comply with Regulation 4(6) and Regulation 4 (1) of IRDA (Protection of Policyholders Interests) Regulations, 2002 and to strengthen the internal controls relating to all processes which involve policyholders' interests.

30. Charge – 35

It was noted that the insurer had settled the claims for reduced IDV in theft claims for whatever reasons was contrary to the provisions of GR-8 of Insured Declared Value of IMT, 2002. The insurer, therefore, absolved itself the responsibility of paying due attention to the IDV in the policies and settled claims for less than IDV.

Even though the vehicle was repairable and insurer was obliged to consider the same mode of settlement, it was noted that in such cases, the consent of claimants were obtained for settlement under salvage loss or cash loss by taking into account the settlement amount which was less than the eligible amount. Apparently, the settlement value was negotiated and the concept of total loss and constructive total loss was wrongly tagged.

Violation of

GR.8 of IMT 2002: Insured's Declared Value (IDV) as insurer has absolved itself the responsibility of paying due attention to the IDV in the policies and settled claims for less than IDV.

Submission of insurer:

The insurer has submitted that all these claims were considered for settlement for less than IDV on non- standard basis on account of deficiencies in submission of documents or compliance with requirements. As a matter of grace the company considered such claims for settlement subject to some minor deductions with full consent of the insured. Based on requests from Insured for Cash loss mode, claims are considered for Cash loss with mutual agreement. This also helps customer with greater flexibility on finalizing repairs or retention of vehicle. Observation on incorrect tagging is noted and necessary changes implemented.

Decision:

The Authority has noted submission of the insurer. The insurer submitted that in all claims there is lapse on the part of the insured and only after insured's consent, the insurer had applied deduction on IDV. In view of this the Authority is not pressing any charges but advised the insurer to comply with the Regulation GR8 of IMT 2002 scrupulously.

31. **Charge – 36**

The acceptance of offer of settlement by insured is not collected by insurer in majority of the claims nor the date of last document is captured in the system for ascertaining whether the insurer settled the claims in stipulated time prescribed under the said regulation.

Violation of

Regulation 9(6) of IRDA PPI Regulations, 2002: (Payment of Interest on delay in settlement of claims) as the delay in claim payment cannot be captured by the system.

Submission of insurer:

The insurer submitted that with regards to the observation relating to non-capturing of the date of submission of last requirement in the system, the insurer submitted that the relevant changes in the system to capture the last document receipt date had been made and implemented.

Decision:

The Authority has noted submission of the insurer. The insurer submitted that they had system in place to capture the date of submission of last requirement. In view of this the Authority is not pressing any charges. The insurer is directed to comply with Regulation 9(6) of IRDA PPI Regulations, 2002 at all times.

32. Charge – 37

In the absence of providing reasons for repudiation/closure of claims and arranging the selected claim files, the compliance of the insurer with Policy Holders Protection Regulations, 2002 could not be ascertained.

Violation of

Section 33 (3) of Insurance Act, 1938 which states that it is duty of insurer to make available books of accounts, registers and all documents to investigating Authority.

Submission of insurer:

The insurer submitted that the reasons for repudiation of claims are captured in the respective physical claims files which require time for retrievals. The Company had proactively provided all the information which was sought by the Authority prior to the Inspection date. However only physical claims files which were stored with the document management vendors place, across the various location pan India; required reasonable time for retrieval and was therefore not possible to retrieve at short notice during the last few days of inspection.

The insurer expressed their inability to provide the documents at the said time, they were not able to make the physical files available for the aforesaid for reasons beyond their control. The insurer submitted that there was no deliberate intention for denial of books of accounts, registers and other documents to the investigating authority at any point of time during the inspection of company's records. However, only due to the short notice, the required documents could not be retrieved in time and provided to the inspection team. The insurer once again reaffirmed their readiness to produce the files anytime should the Authority so desire. In view of the practical difficulties and short period of time provided to us to provide the documents, the insurer requested the Authority not to consider the same as violation of requirement of section 33(3) of the Insurance Act, 1938.

Decision:

The insurer was unable to furnish the requisite records to the inspection team at the time of inspection. Due to this, the inspection team was unable to verify the settlement of claims / repudiation of claims, closure of claims, etc. under the policies. In short, the compliance of IRDA (Protection of Policyholders'), 2002 could not be verified due to non availability of records. It is also noted that the insurer has failed to provide documents as asked for other inspection observations till last day of inspection signifies that the insurer failed to fully adhere to provisions of Sec. 33 (3) of Insurance Act, 1938. In view of this the insurer is warned for not providing requisite data to the inspecting team and is directed to ensure maintenance of all type of data specially the premium and claims related data in a form which is easily retrievable at short notices.

33. Charge – 38

The insurer appointed the in-house surveyors who are not possessing license for assessment

of Motor Own damage claims with estimated loss /assessed loss exceeding Rs. 20,000/- in contravention of -section 64UM of Insurance Act, 1938.

Violation of

Section 64UM (2) of Insurance Act, 1938: (Utilization of In house Surveyors) as the report of the licensed surveyor was not obtained as required under this section.

Submission of insurer:

The insurer submitted that in respect of the subject observations wherein the Authority had specifically raised this observation for claim no. CV260230 which was estimated for Rs. 455,942/-. As per the Preliminary Report loss was assessed for Rs. 449,247/- and Final settlement amount arrived was Rs 460,375/-. This claim was initially attended by Mr. G. Ramesh Babu but was subsequently surveyed by our in-house surveyor Mr. V. Thiruvambalam having license no. 73371. The insurer confirmed that utilization of all In-house assessors is in accordance with 64UM of Insurance Act, 1938.

Decision:

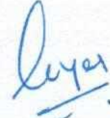
Taking into account the submission made by the insurer, no charges are pressed. Insurer is directed to comply with Section 64 UM (2) of Insurance Act, 1938 in true spirit.

In conclusion, as directed under the respective charges, the penalty of Rs. 35 lakh (Rupees Thirty Five Lakh only) shall be debited to the shareholders' account of the general 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.Lalit Kumar, FA & HOD-Enforcement.

Further,

a) The General 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 general 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: 16.05.2016

(V R IYER)
Member (F&I)