Ref.No: IRDA/ENF/ORD/ONS/079/04/2016

Final Order in the matter of Max Bupa Health Insurance Company Limited

Based on reply to the Show Cause Notice dated 26th November, 2015 and submissions made during Personal Hearing on 22nd January, 2016 at 2.00 pm taken by Member (F&I) at the office of Insurance Regulatory and Development Authority of India, 7th Floor, United India Building, Basheerbagh, Hyderabad.

The Insurance Regulatory and Development Authority of India (hereinafter referred to as "the Authority") carried out an onsite inspection of **Max Bupa Health Insurance Company Limited** (hereinafter referred to as "the Health Insurer") from 12.12.2012 to 21.12.2012. The Authority forwarded the copy of the Inspection Report to the Health Insurer seeking comments on the same under the cover letter dated 13.05.2013. The Authority has organized a preliminary meeting with the insurer on 14.08.2015 to discuss the inspection observations in light of any recent corrective actions taken by the insurer. Upon examining the submissions made by the Insurer vide letter dated 14.06.2013 and 31.08.2015, the Authority issued Show Cause Notice on 26.11.2015 which was responded to by the Insurer vide letter reference MBHI/IRDA/SCN/12/15/838-L&C dated 18.12.2015. As requested therein, a personal hearing was given to the Insurer on 22.01.2016. Sh. Ashish Mehrotra, MD & CEO, Sh. R. Mahesh Kumar, Company Secretary & Director, Sh. Anand R. Choudhary, Head-Legal, Sh. Biresh Giri, Appointed Actuary, Sh. Rohit Kohli, Head Customer Services & Branch Operations were present in the hearing on behalf of the Health Insurer. On behalf of the Authority, Ms. V. R. Iyer, Member (F&I), Sh. Lalit Kumar, FA & HOD (Enforcement), Sh. Prabhat Kumar Maiti, JD (Enforcement), Ms. Jyoti Vaidya, DD (Enforcement), Sh. D. P. Pattanaik, OSD (Health-Products) and Ms. K. Naganalini, OSD (Health- Products) 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**

In respect of payments made to various entities towards outsourced activities, there is difference between the actual amount paid and the amount disclosed to Authority under Form-A during year 2011-2012.

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This is a violation of 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 insurer needs to furnish a report in Form "A" to the Authority within 45 days from the end of every half year.

Submission of the insurer:

Insurer has submitted that the report in Part A consists only those payments towards the vendor which are attributable to the activities falls under the purview of outsourced guidelines while the amount mentioned in Form MC 3 (the format prescribed during IRDA inspection) includes all payments made/invoices booked which are also engaged in doing other activities than outsourced and the invoices received but not paid during the period.

The insurer has further submitted that the artwork and media buying activities are not the activities which an insurer performs as part of business. The insurer would be buying out the activities in normal course and hence these activities are not to be treated as outsourcing.

Decision:

The Authority has examined the submissions of the insurer. The insurer is directed to refer to the two categories of outsourcing activities as listed in Clause 2, Clause 3 and clause 4 of Guidelines on Outsourcing of Activities by Insurance Companies, Circular number IRDA/LIFE/CIR/GLD/013/02/2011 dated 01.02.2011.

The insurer is further directed to ensure compliance of reporting requirements of outsourced activities to the Authority as stipulated in clause 11 of Guidelines on Outsourcing of Activities by Insurance Companies, Circular number IRDA/LIFE/CIR/GLD/013/02/2011 dated 01.02.2011 in true spirit.

2. **Charge – 2**

The insurer did not put in place any mechanism to communicate the underwriting decision in writing within 15 days from receipt of proposals or changes proposed at the time of renewals..

This is violation of Regulation 4(6) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 which stipulates that all decisions of proposals shall be communicated in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

Submission of the insurer:

The insurer submitted that they had modified its process and as a process a letter is sent to the Customers whose Proposals could not be processed within '15 days of receipt or from whom further details are required. Such communication is sent within 15 days stating the reason for delay and the further details required from the customer. The details pointed out in inspection report were during initial stages of the company operations and were in respect of few cases, which were all unintentional. The company has constantly improved its processes

and has a robust process in place for ensuring compliance with the requirement of Regulations in full.

Decision:

The Authority has noted the submission of the insurer. The insurer is hereby advised to comply with Regulation 4(6) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 in true spirit.

3. **Charge – 3:**

The Insurer had filed an amendment to the existing product (Heart Beat) and the same was cleared by the Authority on 26-12-2011. The amended product was on offer under product code 61106-Heart Beat-II Gold, 61107- Heart Beat-II Silver, 61108 – Heart Beat-II Platinum. However, it was observed that the insurer offered the product even before the product was cleared by the Authority (from July-2011).

Further, it was observed that the insurer continued to offer the old version of 'Heart Beat' product during the financial year 2012-13 also. It was noted that the insurer sold (both new policy issuance and renewals) approximately 18,300 policies under old version of 'Heart Beat' product during April to November 2012.

By offering the new version of product, before its clearance from the Authority, and continue to offer old version of products, even after approval of new version of products, the insurer has not complied with Authority's F&U guidelines dated 28-09-2006.

This is a Violation of Clause 11 of Authority's F&U guidelines dated 28-09-2006. (021/IRDA/F&U/SEP-06) which deals with file and use requirements of a product.

Submission of the insurer:

The insurer submitted that the deviation were only in 13,017 cases and not 18,300 cases as mentioned in the Observation of the Authority.

It was further submitted that the systems of the insurer had been built in a manner that a product could not be sold in the market without having necessary system developments in place. Further the system configurations were made live only after the Authority had approved the product. Thus any new product of the Company could be made available for sale through any channel only after the same is duly approved by the Authority.

The codes which were appearing in the systems were because of the system error. However, in actual the policies which were issued and given to the customers were those policies which were in confirmation with the correct version of the approved product only.

It was further submitted that no new product had been sold before approval by the Authority. In the current case, they had examined the systems and would like to confirm that the revised

version of the product Heartbeat (Version 2) was not sold prior to the date of approval by the Authority.

S. No	Particulars	Numbers of policies
1	Deviation noted in	13017
2	Policies given under renewal	9282
3	Code of earlier version picked up due to system error	3476
4	Renewals erroneously mapped to older version post 90 days	259

It was further submitted that 9,282 policies were the policies which came up for renewal within 90 days from the date of launch. The customers were offered renewal in old version for a window period of 90 days.

3,476 policies were cases where the system erroneously picked up / captured code of older version of the Product. This was due to a system error in respect of one channel. This had been corrected and they had ensured such errors do not reoccur.

It was humbly submitted that for all 3,476 cases, there were no price change which was observed on sourcing of the new version of the product. Also they had not repudiated any claim for any of these customers as a result of the system glitch observed.

Some of the renewals totaling to 259 were erroneously mapped to the older version of the product (Heartbeat version 1). This had been corrected.

Decision:

The insurer had sold the new version of the "Heart Beat" product before its clearance i.e. 26.11.2011 and had been offering old version of the product, even after approval of new version of products. The inspecting team has observed that the insurer accepted some proposal and issued policies under the new amended product before the same was approved by IRDAI in December 2011.

Further, the insurer continued to issue old version of the product even after the new product was marketed. The contention of the insure that the old version was sold to the customer approaching the insurer for renewal of their expiring policies within the 90 days from the approval of new product which is the requirement under the regulations. This is factually incorrect as at that point there was no health regulation and moreover the health regulation which came only in 2013 provides for 90 days of period for the insurer to inform the insured about the features of the revised product. The insurer cannot have two versions of a product in the market at the same time.

Insurer's explanation for the said lapse due to systemic error or deficiency is also not acceptable as the insurer is supposed to put in place all IT systems in place before indulging into sale of revised products. Thus, the insurer has violated Clause 11 of Authority's F&U guidelines dated 28-09-2006. (021/IRDA/F&U/SEP-06).

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.

4. Charge – 4

The insurer had filed (9) variants of 'Health Companion Health Insurance Plan', to be sold exclusively by (9) different Brokers. Authority conceded the request of the insurer to offer different variants under one "Master Product", vide its letter dated 16-09-2011. However, it was observed that the said plan was offered through other brokers (other than 9 brokers, as per product filing).

This is violation of "F&U" Guidelines 021/IRDA/F&U/SEP-06 dated 28.09.2006.

Submission of the insurer:

The insurer submitted that due to an inadvertent error, few of the sales teams sold the variant through the broker instead of direct sales team of the Company. However, when this was realized, the sales were discontinued. Further, in order to maintain the customer centricity, the already issued policies were not cancelled / withdrawn.

Further, insurer informed that that during the year 2012, only 23 policies of Health Companion were sourced by the Brokers M/s. K M Dastur, who is licensed broker, for a total premium of Rs. 1.44 Lakh. This is out of total 31,801 policies amounting to total premium of Rs. 1798.77 lakhs of Health Companion sold during the entire tenure of the version of the product being discussed. Policies issued through K.M. Dastur constitute only 0.07% in terms of Number of Policy and 0.08% in terms of Gross written premium. Insurer submitted that once the deviation came to their notice in September 2012, they took action and ensured that error pointed out does not continue.

Decision:

The product was supposed to be sold through the identified brokers whose names were informed to the Authority upfront with respective codes for selling the product which was kept on record at IRDAI. However, the insurer himself deviated from the list furnished by them and sold some polices through other entities and this is a clear violation of "F&U" Guidelines 021/IRDA/F&U/SEP-06 dated 28.09.2006. However keeping in view the submissions made by the insurer that sale of version of Health Companion was through a licensed broker, the number of policies sold through this broker was only 23 amounting to Rs.1.44 lacs of premium and the corrective action taken, the insurer is being warned for the violation and directed to ensure that such deviations do not reoccur.

5. Charge – 5

It was noticed that Under Group Micro Insurance product (Swasthya Pratham), during the financial year 2011-12, the significant proportions of the policies were issued in the last quarter of 2011-12 only. It was observed that the insurer had issued different policies to the same master policyholder spread over different financial years.

Violation of Authority's circular IRDA/F&A/012/2005-06 dated 08.06.2005 for uniformly spread social covers issued during any financial year and Circular IRDA/LIFE/Rural & Social Obligations /076/2004-05 dated 23.02.2005. (New lives to be insured for FY)

Submission of the insurer:

The insurer submitted that by comparing the business procured in each quarter during the FY 2011-12, under "Swasth Pratham" to total business, it indicates that the distribution is not concentrated at last quarter of the financial year.

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Decision:

Authority has noted the insurer's submission and Authority is not pressing the charge.

6. **Charge – 6**

In respect of the policies procured by the insurer during the year 2012-13, involvement of various unlicensed entities to solicit insurance business (For ex. Bid Associates, Assure Plus, One point Contact Consultants, Bonanza online.com, Zensar Technologies, Jekkula ShyamRaj & Co., Manjrak Marketing) was observed. Also the insurer made payment to such entities in the name of reimbursement of marketing expenses.

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 for the purpose of soliciting and procuring insurance business.

Submission of the insurer:

The insurer submitted that entities mentioned above were not involved in any solicitation activities and the payments made to these vendors were towards the marketing campaigns carried out as per the agreements entered into by the Company. The payments made to these entities were fixed and not related to any success of sale. However, just for the purpose of evaluating the effectiveness of the campaign, the system was capturing the details of the campaign as the campaign was being tracked internally by the name of the vendor who had carried out the campaign.

The insurer further submitted that the vendors were engaged to provide various digital marketing/ marketing and promotional campaigns for the Company such as mailer campaigns, data management etc. The amounts paid were fixed and is in no way connected with the success of sale or generation of lead.

These were not referral arrangement with these vendors. It is further submitted that the payments of remunerations to these vendors were not linked to the success of sale in any manner.

Decision:

On examining the available documents on record, it is noticed that

- **Insurer had created intermediary codes in their policy administration system for unlicensed entities.**
- **Payments are made to them in name of marketing services to these entities.**

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.

7. **Charge – 7**

It was observed as per internal audit reports of the insurer, the insurer had carried out "Reward and Recognition (R&R) Programmes" to Agents. However, the insurer did not made available the details of such programmes and the details of payments made there under. In the absence of the details, appropriateness of such additional payment/remuneration paid to the individual agents could not be examined.

Violation of

a) Section 31B(2) of Insurance Act, 1938 for not submitting to the Authority a statement showing the remuneration paid, whether by way of commission or otherwise to any person.

b) Para 2 of Circular No. IRDA/F&I/CIR/Data/ 066/03/2012 dated 02.03.2012 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.

c) Circular number 011/IRDA/Brok-Comm./Aug.8 dated 25.08.2008 which stipulates that no payment of any kind, including "administrative or service charges" is permitted to be made to the agent or to the broker.

Submission of the insurer:

The insurer submitted that the Company does not provide any cash/remunerative benefit to its agent other than the commissions as permitted under the regulations. The agents on basis certain criteria are placed into various groups known as clubs viz Summit Club, Superior Club, etc. and the members of these clubs are recognized by way of publicizing their name across

the organization and agents. Further, special training sessions are also organized for these agents and they are awarded with trophies and mementos in such sessions. No benefit on the basis of the total number of policies sourced or total premium collected is given to these agents under Rewards and Recognition programs. Hence, no record of any payment or remuneration is available as no cash benefit or monetary payout is given to the agents.

The insurer had submitted a copy of "R&R Scheme" vide their reply dated 31.08.2015.

Decision:

The internal audit report of the insurer clearly shows various reward and recognition functions conducted at insurer's end. But insurer did not provide any relevant documents to inspection team. On examination of the "R&R Scheme" document, it is observed that the insurer had given incentives in the form of kind to agents based on various criteria specified in the document. The insurer had not provided the complete information of this regard to the inspection team.
It is noted that the insurer has paid additional payment to agents over and above agency commission. Moreover, the payments are not reported to the Authority as required by Section 31B (2) of Insurance Act, 1938 to be read with Para 2 of Circular No. IRDA/F&I/CIR/Data/ 066/03/2012 dated 02.03.2012.

The insurer is warned for such non-compliance and directed to comply with by Section 31B of Insurance Act, 1938.

8. **Charge – 8**

The insurer was not obtaining signature of the person, on the Insurance Advisor's Report (IAR) section of the proposal form, responsible for solicitation of health insurance business under business procured by Brokers. Further, the insurer is not maintaining the record of the business locations of Insurance Brokers and the details of Qualified Persons authorized to solicit insurance business.

Violation of

a) Provisions of Sec. 64 VB (4) of the Insurance Act, 1938 and Reg. 9(3) of IRDA (Insurance Brokers) Regulations, 2002 for not maintaining the record of the business locations of Insurance Brokers and the details of Qualified Persons authorized to solicit insurance business.
b) Authority's circular IRDA/CIR/011/2003, dated 27-03-2003 which states that no insurer shall distribute the product through any person who is not licensed as per provisions of Insurance Act 1938.

Submission of the insurer:

The insurer submitted that they would tighten the process of obtaining signature in the proposal form for all cases. Further to ensure compliance with the regulations 9 (iii) of the IRDA Broker Regulations which casts responsibility on the broker that any employee

responsible for soliciting and procuring insurance business on behalf on an insurance broker would also have to fulfil the requirements mentioned in the Broker's Regulations and a list of such employees need to be provided to the Authority and acknowledged by it. Appropriate clauses had been provided in the agreement entered into between the broker and insurer. Further it had been explicitly provided for in the aforesaid agreements that only those employees of the Insurance Broker who meet with the requirements as laid down by the Authority would be allowed to represent products and services of Max Bupa.

Decision:

The Insurer is warned for the violation. However having considered the submission the insurer is directed to comply with Provisions of Sec. 64 VB (4) of the Insurance Act, 1938 and Reg. 9(3) of IRDA (Insurance Brokers) Regulations, 2002.

9. Charge – 9

The insurer had sourced close to 35,000 policies and Rs. 50 crore premium, i.e., approximately 50% of its business volumes under 'Direct Business' (for ex. Direct Sales Teams-DST, and Tele Sales Teams). In this regard, it was noted that the insurer had engaged good number of outsourced vendors for lead generation viz., Bima Deal, Air2Web, Resultrix, Hi-Marketing, HRH Next etc. The leads so generated by the outsourced vendors and through in-house marketing campaigns are distributed to the DST Executives, and Tele-sale executives of the insurer for conversion into sales. The insurer had used the services of various outsourced vendors to procure business by logging in the name of employees of the insurer.

Violation of

a) IRDA (Sharing of database for distribution of insurance products), Regulations, 2010 which stipulates referral arrangement.
b) Guidelines on Distance Marketing of Insurance Products (IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011.
c) Authority's circular IRDA/CIR/011/2003, dated 27-03-2003 which states that 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 vendors were engaged to provide various digital marketing/ marketing and promotional campaigns for the Company such as mailer campaigns, data management etc. However these were not referral arrangement with these vendors. It was further submitted that the payments of remunerations to these vendors were not linked to the success of sale in any manner. These vendors were service providers to the Company and the direct sales team of the Company was following up and closing the sale based on the

outcome of the activities done by the Vendors. Hence no amount had been paid as envisaged under the Regulations mentioned herein.

The insurer submitted that majority of the policies out of 963 policies mentioned were taken by the employee of the Company i.e. Max Bupa employees purchase individual policies from the Company itself. Since these are internal sales, these were logged under code of Mr. Amit Arora. These were marked in name of Mr. Amit Arora so that the payout or incentives are not released to any person. It is further humbly submitted that the Company has not used any outsourced vendor to procure/solicit of business and logged it in name of the employee.

Decision:

From the available documents from record, it is observed that the insurer has engaged outsourced vendors for lead generation. The leads so generated by the outsourced vendors and through in-house marketing campaigns are distributed to the DST Executives, and Tele-sale executives of the insurer for conversion into sales.

Insurer has violated duties and obligations stated in 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.

10. Charge – 10, 11 and 12

Charge – 10

It was observed that as per the Internal Audit Reports of the insurer, and the payment vouchers pertaining to payments made to the entities like Spot on Media, Netcore Solutions, Hi Marketing, Monster.com India Pvt. Ltd., Rediff.com India Ltd., Resultrix Media Pvt. Ltd., Infomedia 18, Spice Digital Ltd., etc, it was evident that these entities were engaged in 'lead generation' by way of sending SMS, e-mails, digital displays, internet and telephone calling etc. It was observed that the insurer had not prepared standardized scripts for presentation of benefits, features and disclosures under each of the products proposed to be sold over the distance modes. Further, no agreements were entered by the insurer with the entities for 'lead generation' and payments were made against a Purchase Order.

Violation of

a) Clause 9.1 of "Guidelines on Distance Marketing of Insurance products" (IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011 for not preparing standardized scripts for presentation of benefits, features and disclosures under each of the products proposed to be sold over the distance modes and taking approval of the same.

b) Clause 4 of "Guidelines on Distance Marketing of Insurance products" (IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011 which defines persons engaged for solicitation of insurance business.

Submission of Insurer:

Insurer submitted that the vendors were engaged to provide various digital advertising for promotional campaigns for the Company such as mobile web/mailer campaigns, data management etc. These were not referral and sale arrangement with these vendors. It was further submitted that the payments of remunerations to these vendors were not linked to the success of sale in any manner. These vendors were providing advertising service to the Company. As in any advertising/marketing campaigns, the intent generated was followed up for closure by the Company employees. Hence no amount had been paid as envisaged under the Regulations mentioned herein.

Charge – 11

It was observed that the insurer had not provided any standardized script to the tele-callers, except for 'Heart Beat' and 'Health Companion' plans of the insurer, though the insurer sold other plans viz., IMEP, Health Assurance etc., over distance mode. The scripts were filed with Authority on 12-10-2011. Revised standardized script was not filed for 'Heart Beat' plan, though an amendment to the product was filed with the Authority due to oversight as they were under the erroneous impression that it did not require filing.

Violation of

Clause 9.1. (i) & (ii) of the 'Guidelines on Distance Marketing of Insurance Products'(IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011 which deals with standard scripts of products which are to be sold through distant marketing.

Submission of insurer:

Insurer submitted that the Scripts for all products sold by outsourced and in-house teams had been filed with regulator. IMEP was only sold on customer request and not as a regular practice. Due to oversight, when the Heartbeat and Health Assurance products were revised, the scripts were not filed with the Authority.

Charge - 12

It was observed that the telemarketers engaged by the insurer and the tele-callers employed by the insurer are not adhering to the standard script of respective products.

Violation of

Clause 9.3 (Consent of client) and clause 9.5 (Product Features & Benefits) of 'Guidelines on Distance Marketing of insurance products' (IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011.

Submission of Insurer:

The insurer submitted that the opening of the call and need analysis to recommend the right product were standard across calls. However, on basis of the flow of call the queries of the customers were answered first instead of sticking to the standard flow. Further it was ensured that all the product features, risk factors, waiting periods, exclusions etc were detailed to the customer during the call itself. It would be ensured that the requirements of the processes were reiterated within the team.

Decision:

By not adhering to the standard script the insurer has violated Clause 9.1. (i) & (ii) and also clause 9.3 & clause 9.5 of the 'Guidelines on Distance Marketing of Insurance Products'(IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011.

The Authority warns the Insurer for the same and the insurer is further directed to comply with Clause 9.1 (i) & clause 9.1 (ii) and clause 9.3 & clause 9.5 of the 'Guidelines on Distance Marketing of Insurance Products' (IRDA/ADMN/GDL/MISC/059/04/2011) dated 05.04.2011.

11. **Charge – 13**

Some of the advertisements shown as cancelled / not released in the advertisement register are being used by the insurer. It was also observed that all the advertisements issued by the insurer during the financial year 2012-13, and a few advertisements issued during the financial year 2011-12 were filed with the Authority on 11-12-2012 (one day before the inspection period), with a delay of almost one year.

Violation of

Provisions of Regulations 3 (1) (ii), (iii) and (v) of IRDA (Insurance Advertisements) Regulations, 2000 which stipulates of maintaining control over all advertisements concerning its policies, maintaining an advertisement register and filing a copy of each advertisement with the Authority.

Submission of insurer:

Insurer submitted that both the Advertisements had been withdrawn from the market. Any further use of these advertisements would be only after filing the same with the Authority. The insurer requested the Authority to kindly condone the deviation.

The insurer submitted that the process followed earlier by the Company was dependent on the individuals and due to employee attritions, certain oversights occurred w.r.t. filing of the advertisements. The insurer further submitted that the company had revised its process of

filing to ensure proper monitoring and timely filing of the all advertisements. It would be ensured that such deviations did not recur.

Decision:

The Authority has noted the submission of the insurer. The insurer is advised to adhere to provisions of Regulations 3 (1) (ii), Regulation 3 (1) (iii) and Regulation 3 (1) (v) of IRDA (Insurance Advertisements) Regulations, 2000.

12. Charge – 14 and charge 17

The insurer was neither maintaining physical records of claims approvals by authorized officials nor the approvals are through insurer's IT system (Maximus). Thus, the process leaves no scope for identifying the persons responsible for any non-adherence to the insurer's board approved claims approval authority. It was also observed that the insurer had not adopted necessary process/system controls in claims handling.

Violation of

Clause 6 of Corporate Governance IRDA/F&A/CIR/025/2009-10 dated 05.08.2009 which deals with internal controls of the insurer

Submission of insurer:

The insurer submitted that all claims are adjudicated and approved through a Financial Authority Matrix approved by the Management and Board of Max Bupa. All the authority matrix controls were built into the core adjudicating system and could not be breached. The process had been further strengthened by overlaying the core adjudicating system with Workflow and Document Management system which maintained a complete audit trail of each touch-point in the claims life cycle till approval. It was further submitted that the above process was presently implemented.

It was further submitted that the Company had some systems issues and as a result some of the payments were delayed. The error had been rectified and the above delay should not recur.

The insurer submitted that the Company is in process of strengthening its the process to ensure that that appropriate controls are established in the claims handling process.

The insurer submitted that since the claim was filed, it was processed in normal course and the cheque was issued in the name if insured. However when the facts of insured having died came to the notice of the Company, the request for legal heir certificate was made. As the cheque was already banked, the Company could not go for reversal of the payment. As the claim was anyway payable, the Company treated the matter as closed.

The insurer submitted that In case of non receipt of necessary documents under a claim, the insurer was sending a missing documents letter initially and three reminders thereafter to the insured for submission of the same to process the claim. It was observed that all the four letters are being sent within a span of two months time and thereafter the respective claims are moved to CLOSED status, where ever documents are not received.

The insurer submitted that the Company had appropriately processed the claims even when the documents were subsequently submitted.

The insurer submitted that the erstwhile process had been strengthened and the actual date of receipt of claim documents was being captured in the core claims adjudication system since December 2011.

Charge 17

The average number of days taken for registration of a claim by the insurer from the date of event occurrence was 64 days for 2011-12 & 62 days for 2012-13, with highest time lag being 226 days and 198 days respectively.

The average number of days taken for settlement of a claim for the year 2011-12 was 70 days and for the year 2012-13 was 44 days with highest TAT of a single case registered being 226 days and 105 days respectively. In none of these claims, claim investigation was entrusted by the insurer and thus the delay appears to be at the insurer's place only.

Violation of

Clause 6 of Corporate Governance IRDA/F&A/ CIR/025/ 2009-10 dated 05.08.2009 which deals with internal controls of the insurer.

Submission of insurer:

It is humbly submitted that Swasthya Pratham claims come from very remote locations. Reimbursement claims dispatched from these locations by post take a long time in transit. Combined with a customer dependency in dispatching the documents, this result in the high timelines in registering a claim.

Decision:

From the available documents it is revealed that-

- **It was noticed that the insurer was not capturing the date of intimation of claims in the system.**
- **There was lack of proper internal controls and procedures while settling the claims at insurer's end.**
- **There was delay in settling the claims in majority of cases.**

The claims settlement is a core activity of the insurer which directly affects the customers. Lack of proper internal controls while settling the claims has resulted violation of Clause 6 of Corporate Governance IRDA/F&A/ CIR/025/ 2009-10 dated 05.08.2009 and IRDA (Protection of Policyholder interests') Regulations 2002, on the part of insurer hence, the Authority in exercise of powers conferred under Section 102(b) of Insurance Act, imposes a penalty of Rs.5 lakh.

The insurer is directed to strengthen the internal controls while carrying out the processing and settlement of claims at their end. The insurer is further directed to take corrective measures to ensure that such lapse does not occur in future.

13. **Charge - 15**

It was observed that though as per the product F&U (Employee First Classic), maximum discount allowed was only 40%, apart from basic discount of 15%, in some of the cases the discretionary discount allowed was more than 40%. In this regard, it is pertinent to note that, in respect of all group business (except micro business) of the insurer in 2012-13 (up to 30-11-2012) the net incurred claims were to the tune of Rs. 14.88 crore as against Net Earned premium of Rs. 14.51 crore.

It was observed that with regard to policy issued to one of the policyholder the insurer had not adhered to the policy conditions (as per the product F&U),

i) by waiving co-pay of 20% on claims of parents of members covered;
ii) by granting corporate floater option to the extent of Rs. 50 lakh, as against a maximum of Rs. 15 lakh.

Violation of

IRDA/NL/CIR/F&U/003/01/2011 dated 06.01.2011, violation of Guidelines on "F&U" requirements of GI products Reg.3 (vi) of 28.06.2006 and Section 41 of Insurance Act 1938.

Submission of insurer:

a. *The insurer submitted that the group product rate structures for Employee First Classic were generating manual rating. In the cases cited, the underwriting was done as a synthesis of manual rating as dictated by the actuarial rating model and experience rating that is based on the claims of the specific cases in the previous years. In some of the cases, the manual rates were found to be very high when compared to the past claims experience and projected claims (adjusted for IBNR, group size changes, benefit changes, medical inflation and internal expenses). In addition to this, the policies issued to some other policyholders either with no intermediation cost or at a minimal intermediation costs. The benefits of these were passed on to the client as a reduction in premium.*

   The insurer submitted that they had filed for a revised version of the product with revised premium rates and higher flexibility of premium rating.

b. *The computation of the premium was based on a synthesis of manual and experience rating and therefore the impact of 20% co-pay on parents not being there and Rs. 50 lakh corporate floater was factored into the past claims. In this case, the deviation was allowed based on the client request and in the customer's favour. In view of inflexibility of such nature in Employee First Classic, the insurer had already filed a new Group Health Insurance product with the regulator and is awaiting the approval.*

Decision:

Authority takes note of the submissions of insurer and no charge is pressed. The insurer is further directed to adhere to Section 3 (vi) of Guidelines on "F&U" requirements of General Insurance products dated 28.09.2006 and F&U circular IRDA/NL/CIR/F&U/003/01/2011 dated 06.01.2011.

14. **Charge – 16**

It was observed that the insurer had made payments to the Micro Insurance agent and Master Policyholder (in some cases) M/s. CDOT in the name of reimbursement of marketing expenses. The copies of sample vouchers (dated 04-08-2011) indicating payment made to M/s. CDOT are enclosed examined.

Violation of

Clause C-4 of Group Insurance Guidelines (015/ IRDA/Life/Circular/GI Guidelines/2005 dated 14.07.2005 which states that there should not be any payment whether as management expenses or documentation expenses or profit commission or payment of any other description to the agent or corporate agent or group organizer.

Submission of insurer:

The insurer submitted that at the time there was a need felt to create an awareness about the Company as it was initial days of the Company. Hence it was decided to carry out marketing activities. Since C-DOT had better access to the markets it was carried out through CDOT and reimbursement of expenses was done. The amount of marketing activity was not material. Hence it is humbly submitted to kindly condone the deviation considering that the amount of marketing done was not material.

Decision:

The Authority has examined the submission of the insurer. The insurer is directed to comply with Clause C-4 of Group Insurance Guidelines (015/ IRDA/Life/Circular/GI Guidelines/2005 dated 14.07.2005. processes at their end. The insurer is further directed to take corrective measures to ensure that such lapse does not be occur in future.

In conclusion, as directed under the respective charges, the penalty of Rs. 20 Lakhs (Rupees Twenty Lakhs 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 Sh. 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: 26.04.2016

(V R IYER)
Member (F&I)