Ref: IRDAI / Enf / ORD / ONS / 035 / 01 / 2020

**Order in the matter of ICICI LOMBARD GIC Ltd**

**Based on the**

(i) Show Cause Notice (hereinafter referred to as "SCN") reference No.IRDA/Enf/ SCN/2019/NL/icicil_Insp.rpt dated 16th July, 2019 in connection with the on-site inspection conducted by the Insurance Regulatory and Development Authority of India (herein after referred to as 'the Authority' or 'IRDAI') during 3rd to 14th August,2015.

(ii) ICICI Lombard GIC Ltd (hereinafter referred to as "ICICI Lombard" or as "General insurer") response dated 19th August, 2019 to the aforesaid SCN.

(iii) The submissions made by general insurer during the Personal Hearing held on 16th October, 2019 at 3.30 PM, taken by the Chairman of the Authority at its office at Hyderabad and subsequent submissions made by the general insurer vide letter dated 12th November, 2019 and 2nd January, 2020.

**Background:**

**2.** The IRDAI had conducted an onsite inspection of ICICI Lombard GIC Ltd during 3rd to 14th August, 2015. The inspection report, inter alia, revealed certain violations of provisions of the Insurance Act, 1938, Regulations, Guidelines and various circulars issued there under.

**3**. A copy of the inspection report was forwarded to ICICI Lombard GIC Ltd on 25th July, 2017 seeking their response. On examining the submissions made by ICICI Lombard vide letters dated 10th September,2017, 15th January 2018 and 15th February, 2018, a SCN was issued on 16th July, 2019, which was responded to by the general insurer vide letter dated 19th August, 2019. As requested by the general insurer therein, an opportunity for personal hearing was granted on 16th October, 2019.

**4**. Mr. Bhargav Das Gupta, MD & CEO, Mr.Loknath P Kar, CCO, Mr.Sanjay Dutta, Chief Underwriter, Mr.Vishu Arora, AVP (Legal) were present in the personal hearing on behalf of the general insurer. On behalf of the Authority, Mr. Prabhat Kumar Maiti, GM (Enforcement) and Mr. K.Sridhar, AGM (Enforcement) were also present.

**5**. The submissions made by the general insurer in reply to the SCN and those made during the personal hearing on 16th October, 2019 and submissions made post personal hearing vide letters dated 12th November, 2019 and 2nd January, 2020 have been considered by the Authority and on that basis the decision on each of the charges is given as under.



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**6. Charge no.1**

**Violation of**

- Regulation 4 (a & b) and 3(d) of IRDA (Health Insurance) Regulations, 2013.
- Para 8 & 11 F&U guidelines for General Insurance Products issued vide circular reference no. 021/IRDA/F&U/Sept-06 dated 28.09.2006.
- Circular no.IRDA/NL/Cir/ F&U/003/01/2011 dated 6th Jan, 2011.

**7. Inspection observation:**

**a)** The insurer issued 'Overseas Individual Student Insurance' policy cover for a risk period of 730 days, whereas as per the product documents filed with the Authority, the maximum number of travel days that may be insured under the policy shall be 365 days and may be extended only once beyond the initial period of 365 days during the trip duration by a maximum of additional 365 days.

**b)** On examining the policy documents submitted by insurer with regard to the "outstanding proposal deposits of TVS Credit services" which were converted to policies, it is noted that the Personal Accident policy term issued under group policies were of 2 & 3 years and individual policies under "Personal Protect (PA) cover" were for 5 years. On examining the policy wordings of Individual PA policy and of Group PA policy, it is noticed that the policy term referred in the F&U documents was only for 12 months.

**8. Summary of Insurer submissions**

**a)** Insurer submitted that the product provided for coverage of 365 days which can be further extended for another 365 days. Thus the product allowed for maximum trip duration of 730 travel days in total.

It was observed that many of the overseas universities and other academic / professional institutions were demanding coverage for period more than 365 days coinciding with the period of the course. Correspondingly, the company started receiving demands from students seeking coverage for more than 365 days. In most of the cases, the demand was for 2 years or 730 days coinciding with the course periods. Accordingly, such students were issued policies with coverage period of 365 days along with maximum extension period, making the total coverage period as 730 days. Thus the company issued the extension period along with the original coverage period to enable the Indian students fulfill the requirement of foreign universities, they were aspiring to take admission in.

It is submitted that the Company has not issued any cover more than 730 days in total. Further the Company has adhered to all other criteria of the product including the criteria of age and discontinued the practice of issuing policy for more than 365 days w.e.f. October 01, 2017.

In consequence of receipt of the observation from the Authority and having recorded its objection on providing the extension of policy immediately with the initial policy, the company has discontinued to accept any such request and had ensured that initial policy is issued with a period of one year only w.e.f 1st October, 2017.

**b)** Insurer submitted that the Group Accident Policy and Personal Protect policy provides comprehensive risk protection cover and mainly opted by policyholders to mitigate their loss on account of outstanding loans in case of unfortunate accidental event. It is further submitted that the outstanding loan amount is generally higher in initial 5 years and there is always demand from policyholders to provide policies for a period of 5 years without any hassle of renewing every year.

It is submitted that the Authority has considered the policyholders requirement and industry representation and allowed issuance of credit linked group health policies where the term can be extended up to the loan period not exceeding five years by introducing enabling clause 3(d) in IRDAI (Health Insurance) Regulations, 2016.

Further, insurer submitted the following additional information post personal hearing.

a) Details of group policies issued under Group Personal Accident with more than 1 year term and to individuals under Personal Protect product with more than 3 year term, is as below: In respect of FY 2013-14, the data of Group PA products is from 1st July 2013 to 31st March, 2014 and of Individual Personal Protect products, it is from 1st October 2013 to 31st March, 2014.

| Product | 2013-14 | 2014-15 | 2015-16 | 2016-17 | Total |
|---|---|---|---|---|---|
| Group Personal Accidental policy for more than 1 year | 14 | 16 | 8 | 6 | 44 |
| Personal Protect policy for more than 3 years | 37,662 | 79,707 | 77,344 | 21,858 | 2,16,571 |
| Grand Total | 37,676 | 79,723 | 77,352 | 21,864 | 2,16,615 |

b) Copy of the Authority letter dated 5th May, 2008 on taking note of Personal Protect policy offering term upto 5 years, filed by insurer under F&U guidelines.

c) Copy of the representations filed with the Authority on 30th September, 2013 informing the Authority that till further clarification from Authority, the company proposes to continue offering policies of term upto 5 years under these two products.

In addition to the above, insurer submitted that the polices were issued to fulfill the existing requirement of policyholders which is also subsequently allowed by the Authority. The company stated that it has issued policies in the best interest of the policyholders and to enable them to experience the seamless flow of insurance coverage without any break-in.

**9. Decision on charge no.1**

**a)** The product document filed with the Authority under F&U guidelines indicates that the 'Overseas Individual Student Insurance' policy can be given at inception for a coverage period of 365 days and a further extension of policy can be done up to 365 days on the request of the policyholder during the term of the policy and the total coverage period including the extension period shall not exceed 730 days. In the cases observed, insurer has issued policies for 730 days at inception itself thereby not complying with the terms of the product document filed with the Authority, based on which an approval has been given.

The insurer should have brought the issue to the notice of the Authority informing the need for the change in the terms of the existing product and should have sought Authority approval by filing a revision under the File and Use Guidelines.

However, taking note of the submission that the insurer has stopped the practice of issuing such policy w.e.f 1st October, 2017, the insurer is advised to ensure compliance to Regulation 4 under Chapter II of IRDAI (Health Insurance) Regulations, 2016 read with Point 'C' under Chapter III of Authority circular ref.no.IRDA/HLT/REG/Cir/150/07/2016 dated 29th July, 2016.

**b)** The Authority has notified the IRDA (Health Insurance) Regulations, 2013 on 16th February, 2013. As per Regulation 17(a-ii) of IRDA (Health Insurance) Regulations, 2013, "*Products not in compliance with this Regulation shall all stand withdrawn and shall not be sold:*

1. *In the case of Group products, from 1st July, 2013*
2. *In the case of individual products, from 1st October, 2013"*

Thus, the Authority has clearly mandated that all such non-compliant products "**shall not be sold"** after the date specified in the Regulation.

Further, as per Regulation 17(b-i) of IRDA (Health Insurance) Regulations, 2013, in case, insurers want to modify product feature after issuance of Health Insurance Regulations, 2013 and if such modifications render the product compliant in every aspect of the Regulation, then the insurer on the basis of a certificate to that effect duly signed by the Appointed Actuary and the CEO shall file the details with the Authority and the Authority shall record such change.

As per Regulation 3(c) and 3(d) of IRDA (Health Insurance) Regulations, 2013, the maximum allowable policy tenure for group and individual health products has been prescribed as below:

**IRDA (Health Insurance) Regulations, 2013** (notified on 16th February, 2013):

| | |
|---|---|
| Regulation 3(c) | *Non-life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and* ***maximum tenure of three years****.* |
| Regulation 3(d) | *Group Health insurance policies may be offered by any insurance company, provided that all such products* ***shall only be one year*** *renewable contracts.* |

In compliance to regulation 3(c) and 3(d) read with the Regulation 17 (b-i) of IRDA (Health Insurance) Regulations, 2013, the insurer sought approval on certificate basis from the Authority for Group PA product and for Personal Protect policy revising the policy term and other features in compliance to the IRDA (Health Insurance) Regulations, 2013. Both the applications were accompanied by certificates informing that the company filed products on certificate basis are compliant with Regulation 17 of IRDA (Health Insurance) Regulations, 2013.

Based on the certificate and the documents filed, the revised filing being in compliant with the maximum tenure allowable under group and individual health products as per IRDA (Health Insurance) Regulations, 2013, the filing was taken note by the Authority, as below:

| | Product name | Date of compliance certificate of CEO & Appointed Actuary submitted by insurer | Date of taking note of the certificate |
|---|---|---|---|
| 1 | Group Personal Accident policy | 19-07-2013 | 14-08-2013 |
| 2 | Individual Personal Protect policy | 11-06-2013 | 20-06-2013 |

However, on examining sample policy documents and based on insurer submissions to the charge, it is noted that insurer continued issuing Group Personal Accident policies with policy term of more than one year even after 1st July, 2013 and individual Personal Protect policies with policy term of more than 3 years even after 1st October, 2013, in spite of both the products not meeting the maximum policy term criteria as prescribed in the IRDA (Health Insurance) Regulations, 2013 and even after taking a certificate based approval from Authority on modifying the product term in accordance to the IRDA (Health Insurance) Regulations,2013.

Thus as per Regulation 17 (a-ii) of IRDA (Health Insurance) Regulations, 2013, product features not compliant with the IRDA (Health Insurance) Regulations, 2013 shall stand withdrawn and shall not be sold after the specific date. Further as the modified version of the product on the basis of certificate was filed and Authority noted the same, it is deemed that the older version of product was withdrawn. Thus the insurer by continuing to sell such older version health insurance products which should have been withdrawn and are not to have been sold, being not in compliant to the extant Health Insurance regulation, the insurer has effectively sold un-approved products.

On this matter, insurer has submitted a copy of the representation addressed to the Authority on 30th September, 2013 in regard to Group PA and Individual Personal Protect products stating that till further clarification from Authority, it proposes to continue offering policies of term upto 5 years under both the products.

Thus, from the above representation and the data provided by the insurer, it is evident that insurer continued selling Group Personal Accident product after 1st July, 2013 which was the cut-off date for group products and Individual Personal Protect policy after 1st October, 2013, which was the cut-off date for individual products.

The general insurer's representation was received after 3 months of the deadline stipulated by the IRDA (Health Insurance) Regulations,2013 for withdrawal of Group health products and after the last date stipulated for individual health products, mandating insurers to discontinue the products not meeting the criteria prescribed in the IRDA (Health Insurance) Regulations, 2013.

The general insurer should note that prior to issuance of the regulations, the Authority has hosted the draft regulations on its website on 1st June, 2012 and issued a press release inviting comments from the general public and also all the stakeholders of the industry. On examining the views of all the stakeholders, the Authority in consultation with the Insurance Advisory Committee has notified the Regulation.

As per the circular no.Gen/Cir/018/May-04 dated 24th May, 2004 of the Authority, the insurers were clearly informed as follows:

"*the approval of the Authority should not be taken as implicit with the intimation of a particular approach adopted by them. The Authority hereby clarifies that unless a formal approval is conveyed, the insurers shall not act on the issues raised for clarification.*"

In spite of clear communication through the above circular and also in the IRDA (Health Insurance) Regulations, 2013, insurer continued violating the provisions of the IRDA (Health Insurance) Regulations, 2013.

As per IRDAI (Health Insurance) Regulations, 2016, the Authority has relaxed the allowable maximum policy tenure **only** for credit linked group health products from one year to five years and has conveyed that no health product can be marketed without prior clearance of Authority.

Thus from all above, it is evident that:

a) Even after taking a certificate basis approval from Authority informing to be compliant with the Regulation 17 (b-i) of IRDA (Health Insurance) Regulations, 2013, the insurer continued selling products which were supposed to be withdrawn as per Regulation 17(a-ii) of IRDA (Health Insurance) Regulations, 2013.
b) The insurer submitted its representation after the stipulated date for withdrawal of group product and continued issuing both group and individual policies without waiting for Authority's approval.

c) The insurer has not sought any fresh approval under Regulation 4 (a & b) of IRDA (Health Insurance) Regulations, 2013 for selling a product which was no more in existence after the stipulated date for withdrawal.
d) The insurer has violated the Regulation 3 of the Health Insurance Regulations 2013 on the maximum allowable policy term for group and individual health products.

The facts as mentioned under (a) to (d) above lead to the following conclusions:

a) The violation with respect to issuing of Group Personal accident product with term more than one year continued from 1st July, 2013 till the notification of IRDAI (Health Insurance) Regulations, 2016 i.e. on 12th July, 2016.
b) The violation with respect to issuing of Individual Personal Protect policy with term more than 3 years continued from 1stOctober, 2013 till the notification of IRDAI (Health Insurance) Regulations, 2016 i.e. on 12th July, 2016.

As the violation by the insurer has continued for more than 100 days, in exercise of the powers vested in the Authority as per the provisions of Section 102(b) of the Insurance Act, 1938, the Authority hereby imposes a penalty of **Rs.1,00,00,000/- (Rupees ONE CRORE only)** for violation of Regulation 3(d), 3(c) and 4 (a & b) of IRDA (Health Insurance) Regulations, 2013.

10. **Charge no.2**

**Violation** of the Authority's circular no.IRDA/TPA/Misc/Cir/117/06/2015 dated 23/06/2015 wherein insurers were directed to pass on the benefit of any discount received from the network providers, by the insurers to the concerned policyholders.

11. **Inspection observation:**

The network hospitals were providing discounts to the insurer at the time of final settlement of bills under cashless health claims. However, in sample cases examined, it is noted that the insurer is passing this benefit to its customers in the form of enhanced sum insured but not refunding the discount received from hospital. This kind of arrangement may become harmful where –

a. There is no further claim by the policyholder in the same policy year and the remaining limit goes unutilized.
b. In cases, where claim amount exceeds the balance sum insured limit and no refund for the same is made to the insured.

c. In the following sample cases, the insurer was provided with discounts by network hospital at the time of final settlement of bill, under cashless health claims.

| Claim number | Gross amount | Discount allowed | Net amount | Claim payment less discount made to hospital on |
|---|---|---|---|---|
| 22020142276 | 31073 | 621 (2% on early payment) | 30452 | 03/07/2015 |
| 2201003156026 | 18000 | 900 (5% discount on tariff) | 17100 | 16/07/2015 |

12. **Summary of insurer submissions:**

It is submitted that the company negotiates with the network providers for providing quality health care infrastructure at reduced cost to the insured/claimants by agreeing on fixed tariffs. The discount so obtained are accommodated in the tariff itself and passed on to the insured/claimant at the time of billing.

In addition, the company also negotiates for additional discounts with all the network providers on the negotiated tariffs to further reduce the cost of care for the insured/claimants towards the services availed by them, however only some network providers accept to such further negotiations. The Company accordingly enters into arrangements with such network providers for availing further discounts towards early payments, volume discount, tariffs etc. at network reimbursement level.

Since the additional discount is provided on a periodic or on as and when basis, apportioning the same at the time of billing is not possible as these will come into effect at the network reimbursement stage. Under such circumstances, it was not possible to adjust these additional administrative discounts (over and above the agreed discounted rates) by network hospitals at the time of final settlement of bill by the insured/claimants. Further most of the network providers do not have such advanced system architecture to accommodate such complicated billing structure at the time of billing itself. Also the network providers may have to again approach the Company for revised computation and approval which would increase the customer discharge turnarounds and thereby inconvenience the insured/claimant.

Further, by the time the Company settles accounts with any network provider, the claim of the insured/claimants are settled and the insured/claimants are already discharged from the hospitals. Under such circumstances, it was not possible to show these allowable by network hospitals at the time of final settlement of bill by the insured/claimants. Owing to these difficulties, if any additional discount comes into effect at the network reimbursement stage, which may be after the discharge of the insured, the said discounts are also passed on to the customer by reinstating the sum insured of the policy.

However, the company having recorded the objection of the Authority, has discontinued the practice of negotiating or availing any administrative discount from hospitals which

cannot be apportioned in favour of the corresponding patients/beneficiaries/insured either at the time of discharge or otherwise. The company is negotiating with network hospitals to adjust the same in tariff which can be assessed at the time of discharge of the patient and passed to the customer at the time of discharge itself. In the interim, the company has started passing on the deduction received in monetary terms to customers for those claims where sum insured is exhausted post August 19, 2019 in lieu of enhancing the sum insured.

As sought by the Authority, the company hereby provides the details of retail policies, where the sum insured exhausted during a policy year (from 23rd June, 2015 to 12th November, 2019):

| FY wise | Count of claims where SI exhausted & Additional discount received | Deduction received | Claims settled post reinstatement of SI | Amount settled |
|---|---|---|---|---|
| 2015-16 | 72 | 15,59,162 | 3 | 48,870 |
| 2016-17 | 134 | 29,69,737 | 12 | 2,47,807 |
| 2017-18 | 151 | 40,67,290 | 7 | 1,11,91 |
| 2018-19 | 254 | 51,05,919 | 24 | 5,01,134 |
| 2019-20 | 200 | 49,13,729 | 25 | 4,95,014 |
| **GRAND TOTAL** | **811** | **1,86,15,837** | **71** | **14,04,816** |

13. **Decision on Charge no.2**

The Authority vide circular dated IRDA/TPA/Misc/Cir/117/06/2015 dated 23rd June, 2015 has advised the insurers to ensure that the discounts obtained from the hospitals, if any, are passed on to the policyholders or the claimants of underlying health insurance policy and advised as below:

"*Where by virtue of any agreement, discounts are agreed to be received on the aggregated bills raised by the hospitals; every insurer or TPA shall appropriately identify and apportion the eligible amount of the discount to the underlying health insurance policy in respect of which the claim is settled so as to pass-on the benefit of the discount to the concerned policyholder or the claimant, as the case may be.*"

Further at point 4 of the circular, it is again reiterated that *'the insurers and the TPAs shall ensure that* ***every discount*** *received or agreed to be received from the hospital is passed on to the policyholder or the claimant in respect of the underlying claim only in absolute monetary terms'.*

Thus, from the above circular, it is apparent that the Authority has clearly indicated its stand on the discounts received by the insurers from the network providers.

As per the practice followed by insurer, the enhancement of sum insured equivalent to the discount received from the network provider will be of help only to those customers who make a further claim during the remaining policy period.

As such, in the cases where the claim amount exceeded the sum insured and balance of hospital claim, if any, over and above the sum insured was being paid at the time of discharge by the claimant out of his own pocket, as such, any discount subsequently received by the insurer from the network provider should go back to the policyholder / claimant as it is the amount already paid by the claimant to the network hospital on sum insured being exhausted. Hence in cases of this nature, it is not rational for the insurer to say that they will pass on the discount to the insured/claimant by way of enhanced sum insured.

Thus, as per insurer response, after the issuance of the circular dated 23rd June,2015 and till 12th November,2019, in respect of 811 health claims settled by insurer, the policy sum insured got exhausted on claim settlement and subsequently the company has received discount from network hospitals amounting to Rs.1,86,15,837. On the discount amount being restored in the form of available sum insured, the company settled 71 claims amounting to Rs.14,04,816 out of the sum insured being restored in lieu of discount received from network hospitals.

From the submission, it is evident that, insurer still has a balance of Rs.1,72,11,021 out of the discount received from network hospitals in respect of customers whose sum insured got exhausted and have not made any further claim during the respective policy period.

Insurer submitted that it has stopped the practice with effect from 12th November, 2019 on enhancing the sum insured equivalent to discount received and is alternatively refunding the discount amount received from network providers where the sum insured got exhausted.

The insurer is directed to re-work in all such cases on the actual claim amount payable after reducing the received discount from the network providers, as if, what would have been the allowable claim if the discount was received at the time of claim settlement itself and to pay accordingly to the claimant. The insurer is advised to initiate the process of refunding the discount received from the network providers along with interest as per Regulation 9(6) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 or Regulation 16 of IRDAI (Protection of Policyholders' Interests) Regulations, 2017, as applicable, in respect of the claimants whose sum insured got exhausted. The insurer is directed to complete the entire process of refund within 3 months of the issue of the Order and to update the Authority on the progress of action immediately on completion of 3 months, and seek further direction of IRDAI on utilisation of unrefunded amount, if any.

The insurer is further directed to ensure the compliance of provisions of Regulation 20 (9) of IRDAI (Third Party Administrators – Health Services) Regulations, 2016, hereafter.

14. **Charge no.3**

**Violation** of

a) Cir IRDA/Hlth/Misc/cir/2016/09/2011 dated 20.09.2011
b) Regulation 27(v) of IRDAI (Health Insurance) Regulations, 2016 by repudiating claims on the reason of non receipt of documents.

15. **Inspection observation:**

From the claims register and the claims data provided by the insurer, it is noted that the insurer follows the practice of closing claims cases (reversal of liability) without clearly rejecting the claims. The insurer informed that it closes such claims, which are not settled for a long time due to want of documents or any other information and cannot be clearly rejected.

16. **Summary of insurer submissions:**

It is submitted that in order to assess or determine a claim, an insurer requires certain mandatory/critical documents and/or other material information without which the claims cannot be assessed. In cases where the insured/claimant fails to provide the said mandatory/critical document(s)/information, the Company closes the claim with a view to be able to reopen it as and when the claimant is able to supply necessary information, document(s). A closed claim is one that is held in the books of the company with necessary reserves maintained and which could be easily re-opened to facilitate payment at any point of time the policyholder is able to supply necessary documents and testimonials. In support of submission, the company submits a certificate 'Claim reserve confirmation on closed claims' along with sample copies of closure letters addressed to claimants. The company sends multiple reminders at regular intervals. It is submitted that once the necessary documents and/or information are submitted, the claims are accordingly reopened and assessed as reopened claims.

However, in due observance of the regulatory directive as embedded in the IRDAI (Health Insurance) Regulations 2016, it is submitted that the Company has now adopted the practice of repudiating the claims upon the claimant failing to provide necessary/critical and/or mandatory documents within a specified timeline.

17. **Decision on Charge no.3**

The Authority notes from the insurer submission that the claims were re-opened and settled on receipt of mandatory claim documents and also reminders were sent at periodic intervals for pending requirements.

On insurer submission that 'a closed claim is the one that is held in the books of the company with necessary reserves', a confirmation was sought in that regard. In the confirmation, the company moved from its previous submission and clarified that closed claims were considered for the purpose of reserving under incurred but not reported (IBNR) category. The claims under consideration were clearly reported and payment was outstanding due to necessary documentation. Hence by considering the same under IBNR category, was an attempt to lower the reserving requirement and to improve the solvency position.

Taking note of the above submissions, the Authority directs the insurer to ensure compliance of

- Regulation 15 (8 & 9) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by having proper internal control mechanism to ensure that the clear reasons/grounds of rejection are properly communicated to the claimants, so as to enable them to respond appropriately and to claim the amount.

- Regulation 13(3) and 15(1) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by keeping informed to the claimant of all the mandatory claim requirements at the time of receipt of claim form and to collect requisite contact details for follow-up.

- Regulation 15(4) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by following up with claimants through intermediary, e-mail, mobile SMS and any other channel on the pending requirements.

- Regulation 27(v) of IRDAI (Health Insurance) Regulations, 2016 by settling claims based on merits/available documents and as per the terms and conditions of the policy and non-receipt of a document shall not be the basis for rejection of a claim nor shall claims be closed.

- Regulation 27 of IRDAI (Health Insurance) Regulations, 2016 by calling for documents in one time and not in piece meal basis and by not calling for the information which is already collected at proposal stage.

18. **Summary of Decisions:**

| Charge No. | Violation of Provisions | Decision |
|---|---|---|
| 1.a | F&U guidelines dated 28.09.2006 | Advisory |
| 1.b | IRDA (Health Insurance) Regulations, 2013 | Penalty of Rs.1 crore |
| 2 | Authority circular no.IRDA/TPA/Misc/Cir/117/06/2015 dated 23/06/2015 | Direction |
| 3 | Regulation 27(v) of IRDAI (Health Insurance) Regulations, 2016 | Direction |

19. i. The penalty of Rs 1,00,00,000 shall be remitted by the insurer through NEFT / RTGS (bank account details will be communicated separately) within a period of 15 days from the date of receipt of this Order. An intimation of remittance of penalty shall be sent to Shri Prabhat Kumar Maiti, General Manager (Enforcement),IRDAI, Sy.no.115/1,Financial District, Nanakramguda, Hyderabad-500032.

The Order shall be placed before the Board of the general insurer in the upcoming Board Meeting and the general insurer shall provide a copy of the minutes of the discussion.

ii. The general insurer shall submit an Action Taken Report to the Authority on direction given within 90 days from the date of this Order.

20. If the general insurer feels aggrieved by this Order, an appeal may be preferred to the Securities Appellate Tribunal as per the provisions of Section 110 of the Insurance Act, 1938.

SCKhuntia 27/1/20.

Place: Hyderabad
Date: 27-01-2020

(Dr. Subhash C. Khuntia)
Chairman