Bima Bemisaal

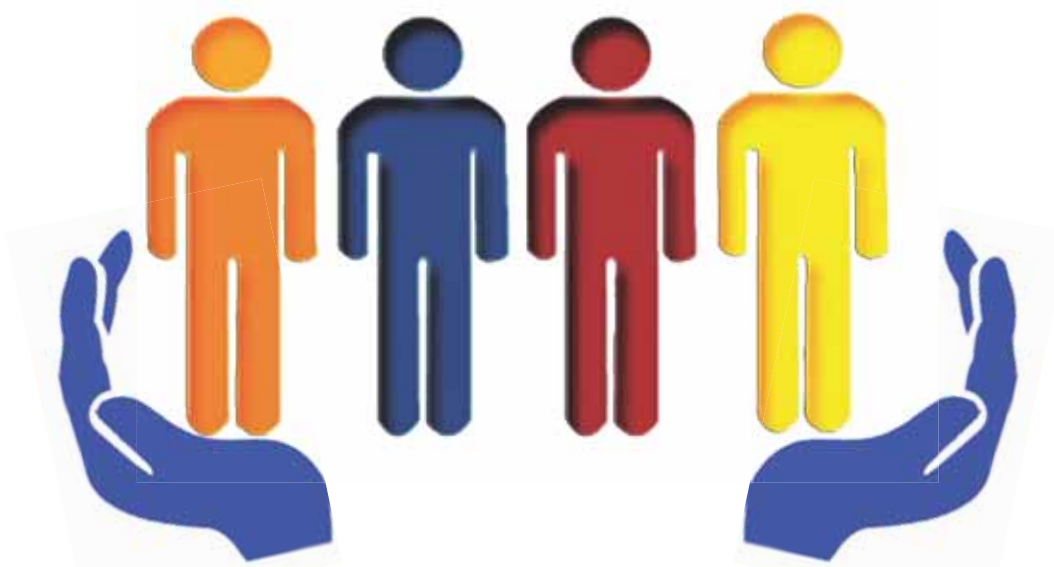
भारतीय बीमा विनियामक और विकास प्राधिकरण

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

Promoting insurance. Protecting insured.

www.irdai.gov.in www.policyholder.gov.in

CONSUMER AFFAIRS BOOKLET



CONTENTS

FOREWORD

(T.S. VIJAYAN)
Chairman

Protection of policyholders' interests is the prime focus of Insurance Regulatory and Development Authority of India (IRDAI) and almost all regulatory interventions are aimed towards this end. In this endeavour, the feedback that we receive from policyholders plays a crucial role. This feedback from policyholders is usually received in the form of grievances that they lodge with the Regulator. We at IRDAI have established systems which capture such grievances in a web-based portal and facilitate their resolution. The portal also enables us to analyse the grievances received and take necessary corrective steps at macro level.

In this background, the Consumer Affairs Department of IRDAI is publishing this E-booklet analysing the grievances lodged by policyholders during 2016-17 and 2015-16.

I am sure, the data and the analysis published in this E-booklet will be of use to all regulated entities such that they better their services. The booklet will also be useful for other interested segments for research and other analytical activities.

Hand book on Insurance Sector's Grievance Redressal System

Is your insurance company listening to you?

If your complaints have not been addressed by your insurance company, please contact

IRDAI Grievance Call Centre

Toll Free Nos : 155255 or 1800 4254732

to register your complaints and track their status or you may log on to www.igms.irda.gov.in

A public awareness initiative by

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INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

Bima Bemisaal

Handbook on Insurance Sector's Grievance Redressal System

Contents:

1. About IRDAI

Insurance Regulatory and Development Authority of India (IRDAI) was set up as an autonomous body under the IRDA Act, 1999 to protect the interests of policyholders and to regulate, promote and ensure orderly growth of the insurance industry. Redressal of grievences is one of the key components of IRDAI's efforts in protection of interests of proposers and policyholders.

2. Does IRDAI stipulate any turnaround time for services by insurance companies?

Yes. IRDAI's regulations stipulate the Turnaround Times (TAT) for various services that an insurance company has to render to the consumer. These are part of the IRDA Protection of Policyholders' Interests Regulations 2002. Insurance companies are also required to have an effective Grievance Redressal Mechanism and IRDAI has issued guidelines for that too. Here are the TATs for an insurance company to deal with various types of service requests including complaints:

Life Insurance Companies	
Service	**Maximum Turn Around Time**
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy/Cancellations	15 days
Obtaining copy of the proposal	30 days
Post Policy issue service requests concerning mistakes/ refund of proposal deposit and also Non-Claim related service requests	10 days
Life Insurance	
Surrender value/annuity/pension processing	10 days
Maturity claim/Survival benefit/penal interest not paid	15 days
Raising claim requirements after lodging the Claim	15 days
Death claim settlement without Investigation requirement	30 days
Death claim settlement/repudiation with Investigation requirement	6 months
Grievances	
Acknowledging a grievance	3 days
Resolving a grievance	15 days

General Insurance Companies	
Service	**Maximum Turn Around Time**
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy /Cancellations	15 days
Obtaining copy of the proposal	30 days
Post Policy issue service requests concerning mistakes/refund of proposal deposit and also Non-Claim related service requests	10 days
General Insurance	
Survey report submission	30 days
Insurer seeking addendum report	15 days
offer of Settlement/rejection of Claim after receiving first/addendum survey report	30 days
Grievances	
Acknowledging a grievance	3 days
Resolving a grievance	15 days

3. Proposer or Policyholder Grievances

Grievance / Complaint has been specifically defined in Para 1 of the Guidelines for Grievance Redressal by Insurance Companies dated 27 July 2010 issued by IRDAI which reads as follows:

"A 'Grievance or Complaint' is defined as any communication that expresses dissatisfaction about an action or lack of action about the standard of service / deficiency of service of an insurance company and/or any intermediary or asks for remedial action."

An insurance company is required to resolve a grievance within two weeks of its receipt.

If a customer is unhappy with an insurance company or an intermediary associated with the company, he should approach the Grievance Redressal Officer of the company first and give the complaint. It is preferable to give a complaint in writing along with the necessary support documents.

4. What is the course of action in case the complaint is not resolved within the prescribed time frame or there is no response from the insurance company?

In case the complaint is not resolved within two weeks of its receipt or it is unattended, the complainant can approach the Consumer Affairs Department of IRDAI for registering his complaint.

IRDAI plays a facilitating role by taking up the complaint with the insurance companies for their resolution and responding to the complaint. A complaint can be registered with IRDAI through any of the following modes

- Calling Toll Free Number 155255/1800 425 4732 (i.e. IRDAI Grievance Call Centre) or
- Sending an e-mail to complaints@irda.gov.in
- Registering a complaint on Integrated Grievance Management System at www.igms.irda.gov.in
- Sending the complaint through letter / courier to IRDAI at Consumer Affairs Department, Insurance Regulatory and Development Authority of India, 3-5-817/818, United India Towers, 9th Floor, Hyderguda, Basheerbagh, Hyderabad - 500 029

5. What is IRDAI Grievance Call Centre?

IRDAI Grievance Call Centre was launched on July 20, 2010 as a true alternative channel for prospects and policy holders with comprehensive telefunctionalities. The call centre serves as a toll free, 12 hours X 6 days service platform, from 8 AM to 8 PM, Monday to Saturday. The services are offered not only in Hindi and English but also in other major Indian languages. The toll free number

of the call centre is 155255/1800 425 4732 and is serving as an inexpensive, expeditious and simple method of registering complaints, ascertaining their status and escalating them to IRDAI.

6. What is Integrated Grievance Management System?

IRDAI launched the Integrated Grievance Management System (IGMS) in April 2011. IGMS is a comprehensive solution which not only has the ability to provide a centralized and online access to the proposer or policyholder but also provides for complete access and control to IRDAI for monitoring market conduct issues of which proposer or policyholder's grievances are the main indicators. IGMS has the ability to classify different complaint types based on pre-defined rules. The system has the ability to assign, store and track unique complaint IDs. It also sends intimations to various stakeholders as required, within the workflow. The system has defined target Turnaround Times (TATs) and measures the actual TATs on all complaints. IGMS sets up alerts for pending tasks nearing the laid down Turnaround Time. The system automatically triggers activities at the appropriate time through rule based workflows.

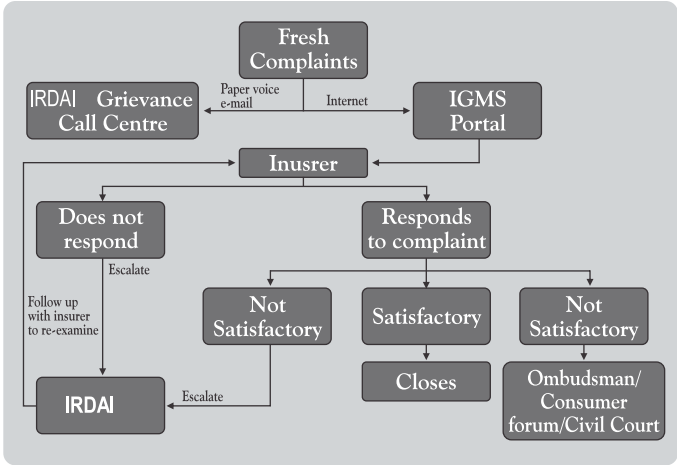
Proposers or Policyholders who have grievances should register their complaints with the Grievance Redress Channel of the Insurance Company first. If they are not able to access the insurance company directly for any reason, IGMS provides a gateway to register complaints with insurance companies and track their status. A complaint registered through IGMS will flow to the insurance company's system as well as the IRDAI repository. Thus, IGMS provides a standard platform to all insurance companies to resolve proposer or policyholder's grievances and provides IRDAI with a tool to monitor the effectiveness of the grievance redress system of insurance companies. Updating of status will be mirrored in the IRDAI system. Therefore, apart from creating a central repository of industry-wide insurance grievance data, IGMS is a grievance redress monitoring tool for IRDAI.

7. How are grievances handled at IRDAI ?

The complaint is registered with a unique token number. An acknowledgement of complaint with the complaint token number is sent to the complainant by email or if no email id is registered, by letter to his postal address. A brief description of the grievance is given on the IGMS. The documents relating to the complaint are captured and forwarded to the insurance company for

resolution. The insurance company is required to examine the complaint and attend to it within two weeks by responding to the complainant. The action taken on the complaint has to be updated by the insurance company in the IGMS. The status of the complaint and the description of action taken can be checked by the complainant from the IGMS or by calling up the IRDAI Grievance Call Centre by using the token number assigned to the complaint. In case the complainant does not come back within 8 weeks of the insurance company attending to the complaint and recording the action taken, the complaint will be closed by the insurance company. In case the company does not respond even after 15 days or if the complainant is not satisfied with the action taken, he can again escalate the complaint to IRDAI. IRDAI will then take up the complaint with the company for its resolution and responding to the complainant. In case the complainant is not satisfied with the resolution of the insurance company, he may approach the Insurance Ombudsman or the appropriate legal authority

8. What is the work flow relating to grievances handled by IRDAI?



9. Is there a Scheme of Ombudsman for Insurance Sector?

Yes. With an objective of providing a forum for resolving disputes and complaints from the aggrieved insured public or their legal heirs against insurance companies, the Government of India, in exercise of powers conferred on it under Section 114(1) of Insurance Act, 1938, framed "**Redressal of Public Grievances Rules, 1998**", which came into force with effect from 11 November 1998. These Rules aim at resolving complaints relating to settlement of disputes of proposers or policyholders with insurance companies on personal lines of

insurance, in a cost effective, efficient and impartial manner. These Rules apply to all the insurance companies operating in general Insurance business and life insurance business, in public and private sectors. To implement the above Rules, the Institution of Insurance Ombudsman has been established which has been functioning since 1999.

10. Who is an Insurance Ombudsman?

An Insurance Ombudsman is a person appointed by Government of India under the Redressal of Public Grievance Rules, 1998. There are at present 17 Insurance Ombudsman in different locations in India.

11. What are the grounds under which a complaint can be made to the Insurance Ombudsman?

- Any partial or total repudiation of claims by an insurance company
- Any dispute about premium paid or payable in terms of the policy
- Any dispute on the legal construction of the policies as far as it relates to claims
- Delay in settlement of claims
- Non-issue of any insurance document to after payment of premium

12. What are the requirements of lodging a complaint before the Insurance Ombudsman?

- A complaint in writing should have been made to the Insurance Company and the same should have been rejected or not satisfactorily replied to or not responded to within 30 days of its receipt.
- The complaint should be lodged within 1 year of rejection or receipt of reply or non-response after 30 days of making complaint.
- The complaint should be by an individual on 'Personal Lines' of insurance
- The complaint should be in writing duly signed by the complainant or through legal heirs and should state clearly the name and address of the complainant, the name of the branch or office of the insurance company against which the complaint is made, the fact giving rise to complaint supported by documents, if any, relied on by the complainant, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman
- The complaint should be made to the Ombudsman having jurisdiction over the location of office or branch of the insurance company against which the complaint is made.
- The complaint should be on one of the grounds of complaint that can be handled by the Insurance Ombudsman.

- The subject matter of the complaint is not currently before a Court/Consumer Forum/Arbitrator or disposed of earlier by a Court/Consumer Forum/Arbitrator.
- The total relief sought is not exceeding Rs.20 lakhs.

13. How does the Insurance Ombudsman deal with a complaint?

The Ombudsman takes up a complaint for settlement through mediation if both the complaint and insurance company, by mutual agreement, request for the same in writing. In such a case, the Ombudsman, within one month of receipt of complaint, will make a recommendation which he thinks fair based on the circumstances of the case. The recommendation is sent to complainant and insurance company. If the complainant accepts the recommendation in full and final settlement of his grievance within 15 days, the same is communicated to the insurance company. The insurance company should comply with the recommendation immediately or within 15 days and inform compliance to the Ombudsman.

Where the complaint is not settled by agreement, the Ombudsman will dispose the complaint by passing a speaking Award within 3 months from

receipt of complaint. The award, with reasons indicating the amount awarded and ex gratia, if any, will be communicated to complainant and insurance company. The complainant must convey his acceptance of the Award in full and final settlement of his grievance to the insurance company within one month. In case he does not do so, the insurance company may not implement the Award. If the award is accepted by the complainant, the insurance company should comply with the same within 15 days of receipt of letter of acceptance and submit compliance to the Ombudsman.

14. What are the important regulations relevant to proposers and policy holders?

- IRDA (Protection of Policyholders' Interest) Regulations, 2002
- Redress of Public Grievances Rules, 1998
- Guidelines for Grievance Redressal by Insurance Companies (Ref. 3/CA/GRV/ GrvRedrGuidelines/YPB/10-11 dated 27 July 2010)

15. For further information please visit

IRDAI's Consumer Education Website - www.policyholder.gov.in

IRDAI Site - www.irdai. gov.in

Disclaimer:

The Handbook is intended to provide you general information only and is not exhaustive. It is an education initiative and does not seek to give you any legal advice.

Circulars issued by Consumer Affairs Department, IRDAI.

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INSURANCE REGULATORY AND
DEVELOPMENT AUTHORITY OF INDIA

Ref: IRDAI/CAD/CIR/MISC/063/03/2016

Date: 31-03-2016

To

CEOs of All Insurers.

Re: Non-Compliance of Award of Insurance OMBUDSMAN.

IRDAI has been receiving communications from certain Ombudsman bringing to its notice the inordinate delay on the part of the Insurance Companies to implement the orders/awards of the Insurance Ombudsman. Similar complaints have also been received from the aggrieved Policy Holders on the above issue.

Considering the seriousness of the issue, IRDAI in consultation with Legal Department updated the earlier circular Ref: CAD/Insu.Omb/10-11 dated 23.11.2010 and issued a circular Ref: IRDAI/Cir/Misc/194/11/2015 dated 03-11-2015 advising the Insurers as follows:

1. Orders of Judicial/Quasi Judicial bodies should be complied by the Insurer within the time frame stipulated in the order or award and in cases where time frame is not specified in the order/award, the order/award should be complied within 60 days of the receipt of the order/award by the Insurer and
2. In cases where the Insurer prefers an appeal against the order of the Judicial/Quasi Judicial body, such appeal against the order should be preferred within the stipulated time limit as per the rules applicable.
3. The Complainant should be informed in the matter accordingly.

In view of the above and in order to monitor the above aspect, You are advised to submit the following data for review and to place before the competent authority:

1. The List of Ombudsman awards that are pending for compliance for the last 3 years ie., 2013-14,2014-15 and 2015-16 (Yly.) by 7h of April, 2016 in the attached format.
2. Monthly statement on the status of Ombudsman cases and compliance of its awards by the Insurers, as per the format enclosed, from April 2016 onwards to reach us before 10th of the subsequent month.
3. Monthly statement on the status of court cases as per the format attached to be submitted every month from April, 2016 onwards to reach us before 10th of the subsequent month.

This has the approval of the Competent Authority.

T. S. Naik,
Joint Director,
Consumer Affairs Department.

पारिश्रम 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

ANALYSIS OF OMBUDSMAN AWARDS

NAME OF THE INSURER

YEAR		Opening Balance as the beginning of the year		Received during the year		No. of cases for which Appeal preferred		Awards/Cases pending for compliance by Insurers		Duration wise data of pending Awards			
		A		B		C		D		E		F	
										More than 60 days		Less than 60 days	
		No.	Amount	No.	Amount	No.	Amount	No.	Amount	No.	Amount	No.	Amount
2013-14													
2014-15													
2015-16													

** Reasons for non compliance with regard to each of the awards mentioned at E & F to be provided separately

Name of the GRO

Remarks of the GRO

MLY-9

ANALYSIS OF OMBUDSMAN AWARDS

NAME OF THE INSURER

Month	Opening Balance as the beginning of the Month *		Received during the Month		No. of cases for which Appeal preferred		No. of Awards complied with by the Insurers		Awards/Cases pending for compliance by Insurers			Duration wise data of pending Awards#			
	A		B		C		D		F =A+B-(C+D)			G		H	
												More than 60 days		Less than 60 days	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount	No		Amount	No.	Amount	No.	Amount
2013-14															
2014-15															
2015-16															
2016-17															
Total															

*Total No. of Cases pending as at the end of previous month pertaining to the respective years.

** Columns D,F,G &H are to be ~~year~~ year wise.

 # Reasons for non compliance with regard to each of the awards mentioned at G & H to be provided separately

Name of the GRO

Remarks of the GRO

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INSURANCE REGULATORY AND
DEVELOPMENT AUTHORITY OF INDIA

Ref:IRDA/CAD/CIR/MISC./194/11/2015 Date:3.11.2015

To

All Insurers,

Re: Non compliance of award of Insurance Ombudsman or Order of MACT or Consumer Fora.

IRDAI has been receiving complaints from policyholders against the insurers regarding non-compliance of Orders/Awards passed by Judicial/Quasi-judicial bodies such as (a)Orders of Consumer Forums (b) Orders of the Motor Accident Claims Tribunals(MACT) and (c) Awards of the Insurance Ombudsmen.

2. Considering the fact that the complainant is already aggrieved, further delay in compliance of the Order/Award by the Insurer causes undue hardship to the complainant.

3. Therefore, IRDAI in exercise of its powers under Section 14(2)(b) of IRDA Act, 1999 hereby advises all the Insurers that

I. Orders of Judicial/Quasi-judicial bodies should be complied by the Insurer within the time frame stipulated in the order or award and in cases where time frame is not specified in the order/award the order/award should be complied within 60 days of the receipt of the order/award by the Insurer and

II. In cases where the Insurer prefers an appeal against the order of the judicial/quasi judicial body, such appeal against the order should be preferred within the stipulated time limit as per the rules applicable.

III. Complainant should be informed in the matter accordingly.

This has the approval of the Competent Authority.

T.S.Naik,
Joint Director,
Consumer Affairs Department.

परिश्रम भवन, तीसरा तल, बशीरबाग, हैदराबाद-500 004. भारत
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Parisharam Bhavan, 3rd Floor, Basheer Bagh, Hyderabad-500 004. India.
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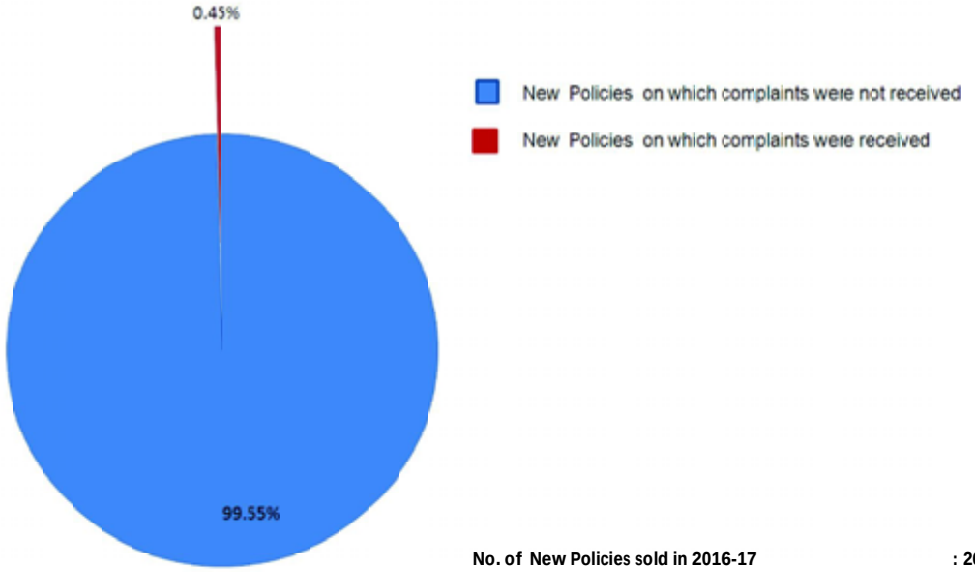
E-mail : irda@irda.gov.in Web.: www.irda.gov.in

Snapshot
Grievances Reported in 2015-16 & 2016-17

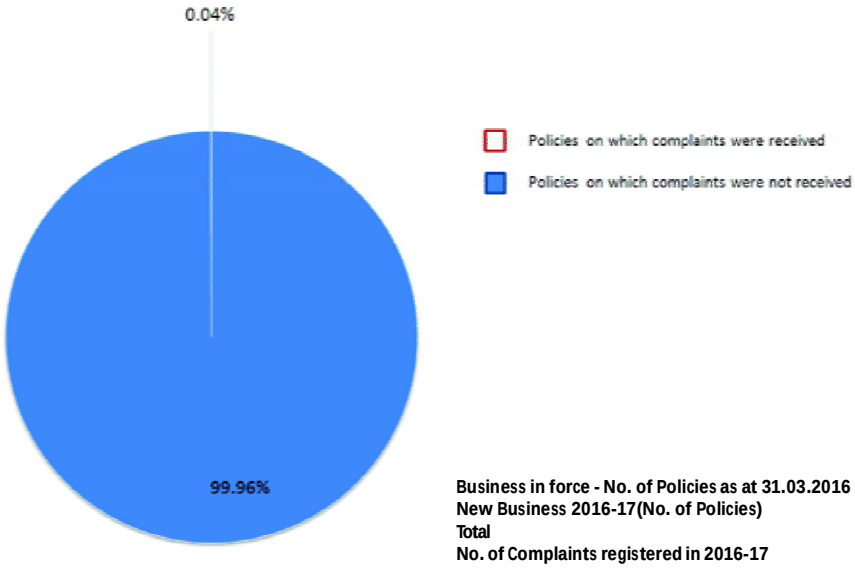
COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS NEW BUSINESS - NO. OF POLICIES SOLD (INDIVIDUAL BUSINESS WITHIN INDIA)



No. of New Policies sold in 2016-17	: 26456645*
No. of Complaints Registered in 2016-17	: 120847
Percentage of complaints registered to new polices issued	: 0.45%

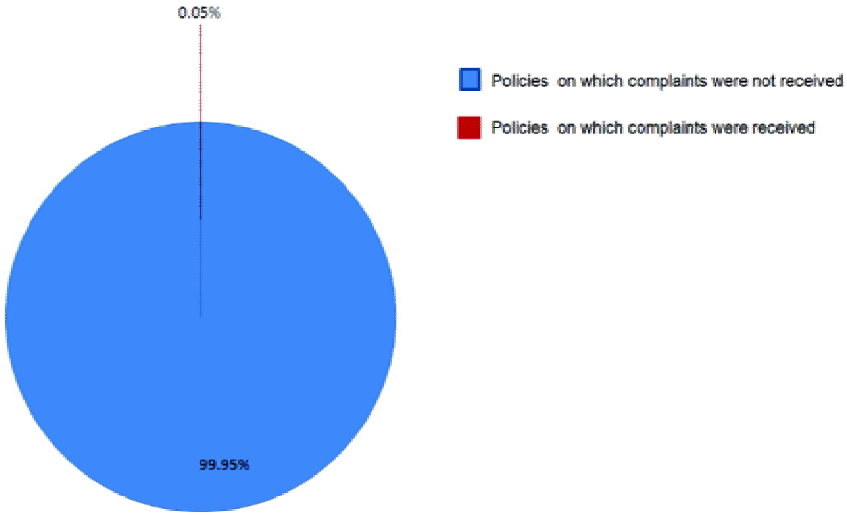
*Provisional Figures

COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS BUSINESS IN FORCE (INDIVIDUAL BUSINESS WITHIN INDIA)



Business in force - No. of Policies as at 31.03.2016	: 327265110
New Business 2016-17(No. of Policies)	: 26456645
Total	: 353721755
No. of Complaints registered in 2016-17	: 120847
Percentage of complaints registered in 2016-17 to Business in force as at 31.03.2017	: 0.04%

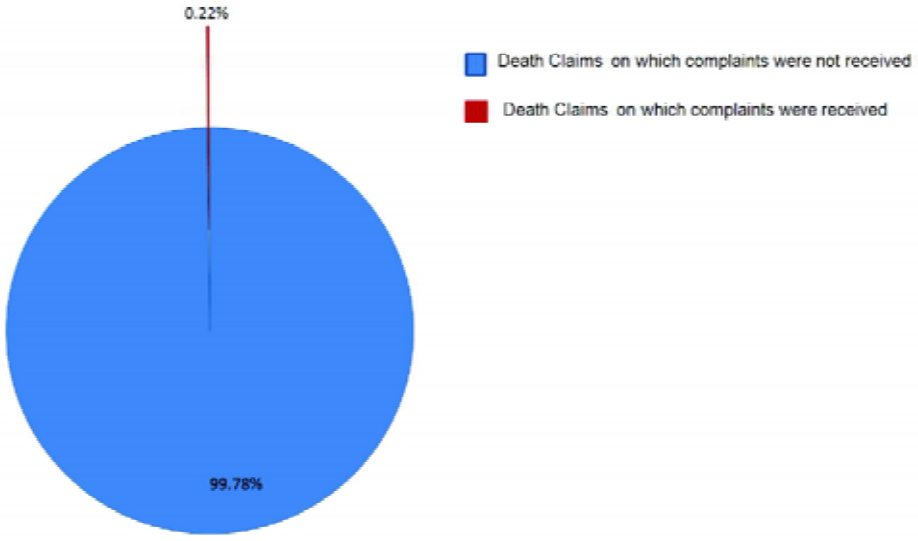
ANALYSIS OF NON-LIFE INSURANCE COMPLAINTS VIS-A-VIS NO. OF POLICIES SOLD



No. of Policies sold in 2015-16 : 126862946
No. of Complaints Registered in 2015-16 : 59083
Percentage of complaints registered to policies issued : 0.05%

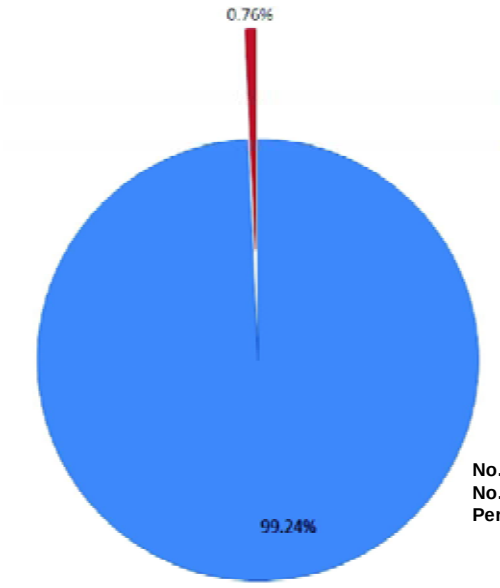
No. of Complaints Registered in the year 2016-17 : 52104
% of complaints registered in 2016-17 to the policies issued in 2015-16 : 0.04%

ANALYSIS OF LIFE INSURANCE COMPLAINTS VIS-A-VIS NO. OF DEATH CLAIMS



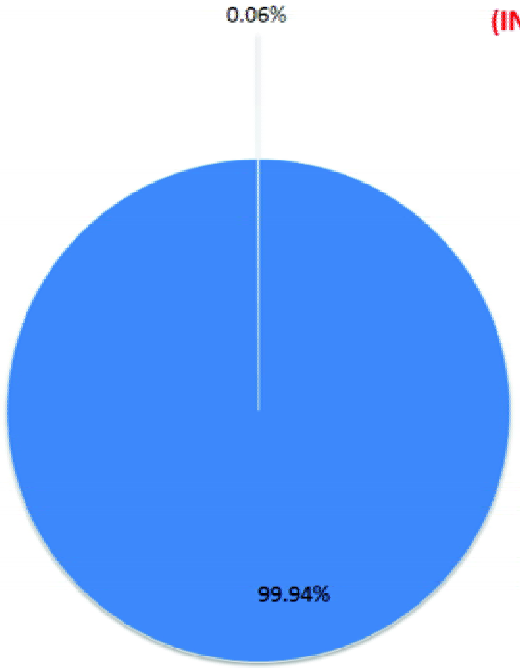
No. of Death claims intimated during the year 2015-16 : 1400568
No. of Complaints on Death Claims registered during the year 2016-17 : 3026
% of complaints on death claims to death claims intimated : 0.22%

COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS NEW BUSINESS - NO. OF POLICIES SOLD (INDIVIDUAL BUSINESS WITHIN INDIA)



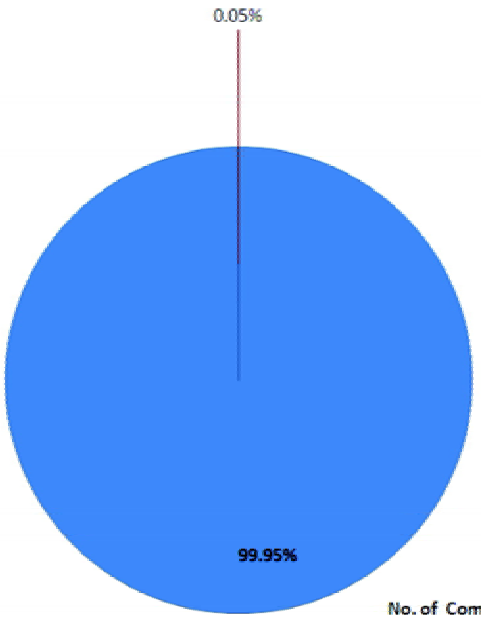
No. of New Policies sold in 2015-16 : 26704213
No. of Complaints Registered in 2015-16 : 204701
Percentage of complaints registered to new polices issued : 0.76%

COMPLAINTS REGISTERED AGAINST LIFE INSURERS VIS-A-VIS BUSINESS IN FORCE (INDIVIDUAL BUSINESS WITHIN INDIA)



Business in force - No. of Policies as at 31.03.2015: 326297000
New Business 2015-16(No. of Policies) : 26704213
Total : 353001213
No. of Complaints registered in 2015-16 : 204701
Percentage of complaints registered in 2015-16 to Business in force as at 31.03.2016 : 0.06%

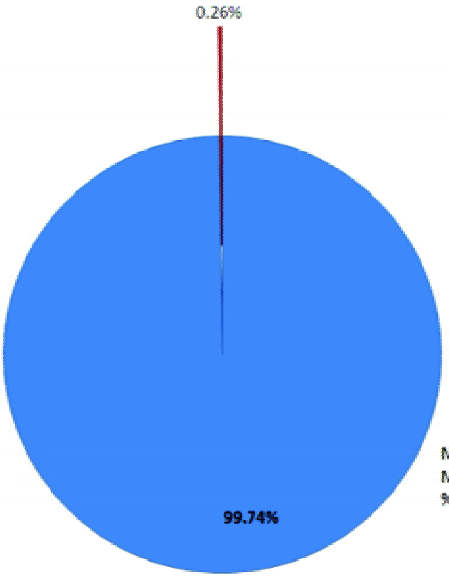
ANALYSIS OF NON-LIFE INSURANCE COMPLAINTS VIS-A-VIS NO. OF POLICIES SOLD



No. of Policies sold in 2014-15 : 118279000
No. of Complaints Registered in 2014-15 : 60688
Percentage of complaints registered to policies issued : 0.05%

No. of Complaints Registered in the year 2015-16 : 59083
% of complaints registered in 2015-16 to the policies issued in 2014-15 : 0.05%

ANALYSIS OF LIFE INSURANCE COMPLAINTS VIS-A-VIS NO. OF DEATH CLAIMS



No. of Death claims intimated during the year 2014-15 : 1321957
No. of Complaints on Death Claims registered during the year 2015-16: 3402
% of complaints on death claims to death claims intimated : 0.26%

STATUS OF GRIEVANCES

Integrated Grievance Management System(IGMS)

The IGMS put in place by IRDAI is the repository of the insurance industry complaints providing not only a platform to raise customer grievances with insurers but also to generate various analytical reports on Customer grievances registered against the Insurers.

Department of Administrative Reforms and Public Grievances (DARPG), Government of India (DARPG)

Apart from the complaints registered in the IGMS Portal of IRDAI, Complaints registered in DARPG Portal against insurers are also referred to IRDAI. IRDAI regularly accesses the portal of the DARPG and ensures that complaints relating to the insurance sector are downloaded and necessary action to get them examined by the insurers is taken.

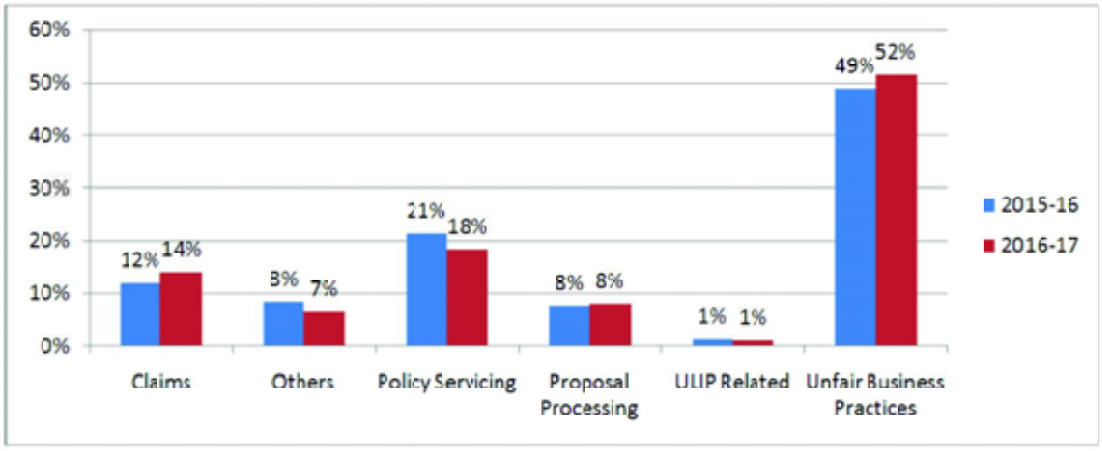
STATUS OF GRIEVANCES – AS PER IGMS

Life Insurers

STATUS OF GRIEVANCES - LIFE INSURERS DURING 2016-17				
Insurer	**Outstanding as on 1st April, 2016**	**Grievances Reported during 2016-17**	**Resolved during 2016-17**	**Outstanding as on 31st March, 2017**
LIC	0	30784	30784	0
PRIVATE	935	90063	90751	247
TOTAL	**935**	**120847**	**121535**	**247**

During 2016-17, the insurance companies resolved 99.79 per cent of the complaints handled. The private life insurers resolved 99.73 per cent of the complaints reported, while LIC resolved 100 per cent of the complaints as a result of which there were no pending complaints of LIC as at 31.3.2017.

CLASSIFICATION OF LIFE COMPLAINTS RECEIVED DURING THE LAST 2 YEARS



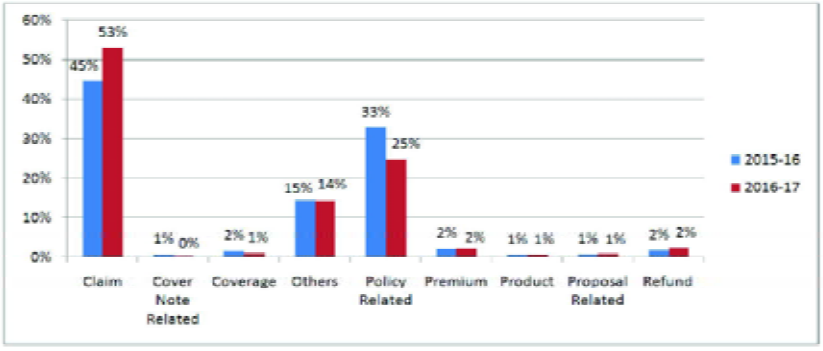
As can be seen from the above, the classification as per the IGMS in terms of grievance Redressal guidelines, indicates a marginal increase of 3% in the complaints under Unfair Business Practices during 2016-17 over 2015-16 and 2% increase in the complaints reported under Claims. The complaints under Others and Policy servicing have registered a marginal decrease of 1% and 3% respectively. The complaints under Proposal Processing and ULIP Related has maintained the same share to the total complaints during the last 2 years.

General Insurers

STATUS OF GRIEVANCES - GENERAL INSURERS DURING 2016-17				
Insurer	**Outstanding as on 1st April, 2016**	**Grievances Reported during 2016-17**	**Resolved during 2016-17**	**Outstanding as on 31st March, 2017**
PUBLIC	525	19053	19060	518
PRIVATE	446	33051	33229	268
TOTAL	**971**	**52104**	**52289**	**786**

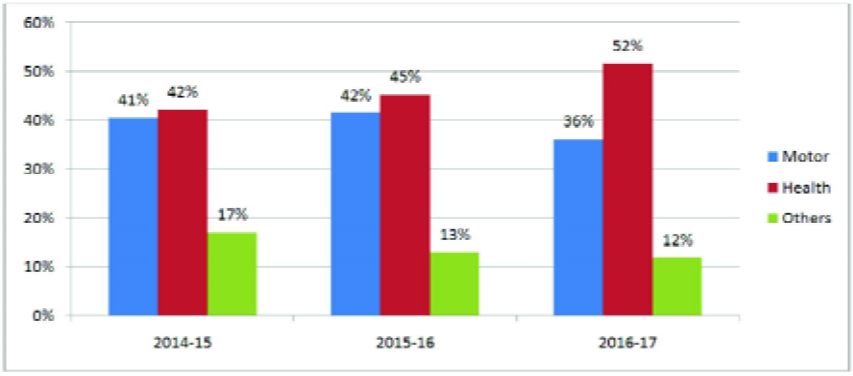
The General insurance companies resolved 98.52 per cent of the complaints handled during the year 2016-17. The private General insurance companies resolved 99.20 per cent and public General insurance companies resolved 97.35 per cent of the complaints handled by them. As at 31st March, 2017, a total of 786 complaints were pending for resolution, out of which 268 were belonging to private sector insurance companies and 518 were pertaining to public sector insurance companies.

COMPLAINT TYPE WISE CLASSIFICATION OF GENERAL INSURANCE COMPLAINTS REGISTERED DURING THE LAST 2 YEARS



It can be seen from the above that there is a 8% reduction of the complaints reported under policy related and 8% increase in the complaints reported under Claims during the year 2016-17 as compared to 2015-16. The complaints reported under Cover note related, Coverage and Others have shown a 1% reduction over the previous year. Complaints reported under all other categories have maintained the same share as that of the previous year.

POLICY TYPE WISE GENERAL INSURANCE COMPLAINTS DURING THE LAST 3 YEARS



The analysis of the complaints under policy type indicates that health insurance complaints are more during the last 3 years as compared to the complaints reported under motor insurance.

DATA ON INSURANCE OMBUDSMEN – 2016-17

DISPOSAL OF COMPLAINTS BY INSURANCE OMBUDSMEN DURING 2016-17

Insurer	Complaints O/S as on 1.4.16	Received during 2016-17	Total	Complaints disposed during 2016-17	No. of Complaints disposed by way of				Complaints O/S as on 31.3.2017
					(I)	(II)	(III)	(IV)	
Life	2009	16744	18753	17377	4599 [26.47]	1251 [7.20]	1412 [8.13]	10115 [58.21]	1376
General	684	10883	11567	10613	2921 [27.52]	712 [6.71]	1106 [10.42]	5874 [55.35]	954
Combined	**2693**	**27627**	**30320**	**27990**	**7520 [26.87]**	**1963 [7.01]**	**2518 [9.00]**	**15989 [57.12]**	**2330**

Note: O/S : Outstanding

(I) Recommendations / Awards (II) Withdrawal / Settlement (III) Dismissal (IV) Non-acceptance / Not-entertainable

During 2016-17, the Seventeen Ombudsmen centers spread across India have received a total of 27627 complaints. While 16744 complaints (about 60 per cent) pertain to life insurers, the remaining 10883 complaints (about 40 per cent) related to General insurers. This was in addition to 2693 complaints pending with various offices of Ombudsmen as at the end of March 2016.

During 2016-17, Ombudsmen disposed of 27990 complaints. Out of these complaints, Ombudsmen declared 57.12 per cent of the complaints as non-acceptable/not-entertainable. Awards/recommendations were issued for 26.87 per cent of total complaints. Other than this, 7.01 per cent of the complaints were withdrawn/settled, while nearly 9 per cent of the complaints were dismissed. 2330 complaints were pending as on 31st March, 2017.

Grievances - 2016-17 in comparison with 2015-16

Life & General

MOVEMENT OF COMPLAINTS - LIFE INSURERS

S.No	Insurer	2015-16			2016-17					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints Reported	Attended to during the year	Pending at the end of the year
(i)	*Public total:*	*64750*	*64750*	*0*	*0*	*30784*	*0*	*30784*	*30784*	*0*
(ii)	*Private Total:*	*139951*	*145125*	*935*	*935*	*91829*	*1766*	*90063*	*90751*	*247*
Grand total:		204701	209875	935	935	122613	1766	120847	121535	247

Life Insurance Industry – In **number of complaints reported**, there has been a **considerable reduction of about 40.00%** in the year 2016-17 (122613 in 2016-17 as against 204701 in 2015-16). As regards the pending complaints as at **31.3.2017**, it is observed that **247** complaints were pending as against **935** as at **31.3.2016**.

MOVEMENT OF COMPLAINTS – GENERAL INSURERS

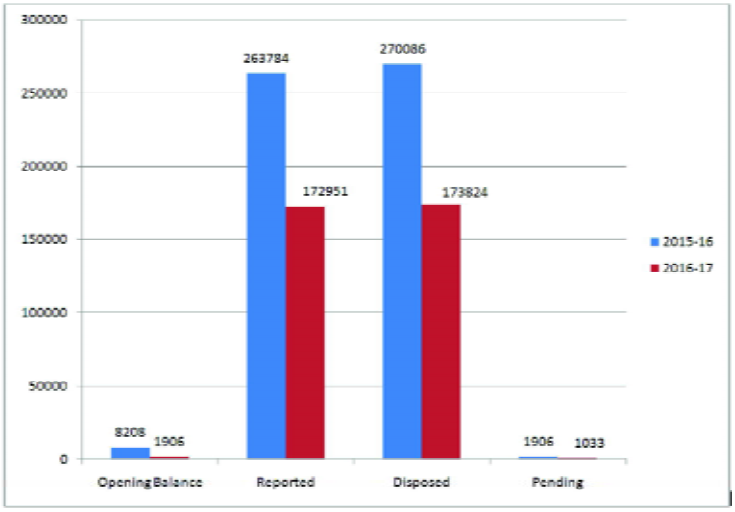
S.No	Insurer	2015-16			2016-17					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints Reported	Attended to during the year	Pending at the end of the year
(i)	*Public total:*	*17806*	*17718*	*525*	*525*	*19198*	*145*	*19053*	*19060*	*518*
(ii)	*Private Total:*	*41277*	*42493*	*446*	*446*	*33710*	*659*	*33051*	*33229*	*268*
Grand total:		59083	60211	971	971	52908	804	52104	52289	786

General Insurance Industry – In **number of complaints reported**, there has been a **reduction of 11%** in the year 2016-17 as compared to the number reported in 2015-16(52908 in 2016-17 as against 59083 in

2015-16). As regards the pending complaints, the no. as at **31.3.2017** reads **786** as against **971** pending as at **31.3.2016**.

MOVEMENT OF COMPLAINTS - INDUSTRY										
Insurer	2015-16				2016-17					
	Reported during the year	Attended to during the year	Pending at the end of the year		Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints Reported	Attended to during the year	Pending at the end of the year
Industry (Life + General)	263784	270086	1906		1906	175521	2570	172951	173824	1033

Industry – Industry has witnessed a considerable **reduction of 93833 complaints** in the year 2016-17. A total of 172951 complaints were reported in the year 2016-17 as against 263784 in the year 2015-16. The reduction in number of complaints expressed in terms of percentage is about **34.40%.**



With regard to the pending complaints as at 31.3.2017, **12 Life insurers** and **7 General Insurers** have shown **NIL pending.**

Insurers who have registered NIL pending in No.of complaints as at 31.3.2017

S. No	Insurer type	Name of the insurer	Pending complaints as at	
			31.3.2017	31.3.2016
1	Life Insurers	LIC	0	0
2		Aegon Life	0	144
3		Aviva Life	0	0
4		Bajaj Allianz Life	0	14
5		Canara HSBC	0	13
6		Edelweiss Tokio	0	6
7		Exide Life	0	41
8		IDBI Federal	0	0
9		Max Life	0	0
10		Reliance Nippon	0	169
11		Star Union Dai-ichi	0	88
12		TATA AIA Life	0	0
13	General Insurers	HDFC ERGO	0	16
14		L & T General	0	0
15		Max Bupa	0	0
16		Raheja QBE	0	0
17		Religare Health	0	6
18		Shriram General	0	0
19		Universal Sompo	0	0

Receipt and Disposal of Grievances registered in DARPG Portal and referred to IRDAI (During the period from 1.4.2016 to 31.3.2017)

Grievance Source	B/F Balance	Receipt During the Period	Total Receipts	Cases Disposed of During the Period	Closing Balance as on 31/03/2017
DARPG	26	299	325	312	13
DPG	3	168	171	165	6
Local/Internet	56	1104	1160	1102	58
Pension	1	1	2	1	1
PMO	149	1486	1635	1565	70
President Secretariat	2	29	31	31	0
Total	**237**	**3087**	**3324**	**3176**	**148**

During the Year 3087 grievances have been referred to IRDAI of the grievances registered in DARPG Portal. A total of 3176 grievances have been disposed of during the year. 148 grievances were pending as at 31.3.2017.

Grievances referred to IRDAI - Pending as at 31.3.2017

Name of Organisation	B/F as on 01/04/2016	Grievances Received	Grievances Disposed	Pending as on 31/03/2017	Pending 0 to 15 days	Pending 16 to 30 days	Pending 31 to 60 days	Pending more than 60 days
IRDAI	237	3087	3176	148	113	25	7	3

Out of 148 grievances pending as at 31.3.2017, 3 grievances were pending resolution beyond 60 days.

Summary of Grievances 2015-16

(Summary of Complaints, Disposal & Resolutions)

1. Industry (Life & General)
2. Life Insurance Industry
3. General Insurance Industry

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & General)

01-Apr-2015 TO 31-Mar-2016

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	8208	
Received during the period	270517	
Duplicate during the period	6733	
Actual during the period	263784	
Attended to during the period	270086	99.30%
Pending as at the end of the period	1906	0.70%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices (Life)	100257	38.01%
Policy Servicing (Life)	43928	16.65%
Claim (Non Life)	26480	10.04%
Survival Claims (Life)	21347	8.09%
Policy Related (Non Life)	19422	7.36%
Others (Life)	17360	6.58%
Proposal Processing (Life)	15599	5.91%
Others (Non Life)	8635	3.27%
Death Claims (Life)	3402	1.29%
ULIP Related (Life)	2808	1.06%
Premium (Non Life)	1271	0.48%
Refund (Non Life)	1072	0.41%
Coverage (Non Life)	998	0.38%
Proposal Related (Non Life)	445	0.17%
Cover Note Related (Non Life)	407	0.15%
Product (Non Life)	353	0.13%
TOTAL	**263784**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	8.73

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	31648	12.00%
o Registered by IRDAI	26214	9.94%
o Telephone	6493	
o Email	12291	
o Letter	7430	
o Fax	0	
o walk In	0	
o Registered by Policy Holder	5434	2.06%
Complaints Registered in Insurer's portal	232136	88.00%
TOTAL COMPLAINTS	**263784**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	1308	68.63%
16 – 30 days	105	5.51%
More than 30 days	493	25.87%
Total Pending	**1906**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices (Life)	Unfair Business Practices	50075	18.98%
Complaint raised with Insurer not addressed (Life)	Others	14597	5.53%
Insurer not disposed of the claim (Non Life)	Claim	10550	4.00%
Policy bond not received. (Life)	Proposal Processing	9250	3.51%
Spurious calls or Hoax Calls (Life)	Unfair Business Practices	9089	3.45%
Certificate of Insurance / Policy not received by the Insured (Non Life)	Policy Related	8997	3.41%
Payment of premium not acted upon or wrongly acted upon (Life)	Policy Servicing	8934	3.39%
Non-receipt of Premium receipt (Life)	Policy Servicing	8369	3.17%
Survival Benefit is not paid (Life)	Survival Claims	6839	2.59%
Tampering,Corrections, forgery of proposal or related papers (Life)	Unfair Business Practices	6804	2.58%

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy (Life)	133555	50.63%
Others (Life)	38991	14.78%
Health Insurance (Non Life)	26838	10.17%
Unit Linked Insurance Policy (Life)	25898	9.82%
Motor Insurance (Non Life)	24536	9.30%
Others (Non Life)	6326	2.40%
Pension Policy (other than Unit Linked) (Life)	3946	1.50%
Health Insurance Policy (Life)	2311	0.88%
Fire (Non Life)	969	0.37%
Marine Cargo (Non Life)	268	0.10%
Engineering (Non Life)	100	0.04%
Marine Hull (Non Life)	23	0.01%
Crop (Non Life)	13	0.00%
Credit (Non Life)	10	0.00%
TOTAL	**263784**	

RECEIPT OF COMPLAINTS		
Top 5 companies		**%**
Life Insurance Corporation of India	64750	24.55%
Bajaj Allianz Life Insurance Company Ltd	14295	5.42%
Max Life Insurance Company Limited	14157	5.37%
Reliance Life Insurance Company Limited	14024	5.32%
Birla SunLife Insurance CompanyLimited	12402	4.70%
TOTAL	**119628**	**45.35%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially In favour**	**Reject**
Policy Servicing (Life)	36137	2561	5135
Unfair Business Practices(Life)	30765	8603	60248
Policy Related (Non Life)	15611	2135	1488
Survival Claims (Life)	14586	1626	5082
Others (Life)	13783	974	2569
Proposal Processing (Life)	11346	1036	3183
Claim (Non Life)	10808	4255	10991
Others (Non Life)	5705	1138	1695
Death Claims (Life)	1672	398	1312
ULIP Related (Life)	1295	233	1271
Premium (Non Life)	931	98	236
Refund (Non Life)	819	102	140
Coverage (Non Life)	467	261	267
Cover Note Related (Non Life)	316	19	70
Proposal Related (Non Life)	206	23	215
Product (Non Life)	155	10	181
TOTAL	**144602**	**23472**	**94083**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	144602	55.16%
Partially in favour	23472	8.95%
Reject	94083	35.89%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer

01-Apr-2015 TO 31-Mar-2016

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	6109	
Received during the period	210907	
Duplicate during the period	6206	
Actual during the period	204701	
Attended to during the period	209875	99.56%
Pending as at the end of the period	935	0.44%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	775	82.89%
16 – 30 days	22	2.35%
More than 30 days	138	14.76%
Total Pending	**935**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	100257	48.98%
Policy Servicing	43928	21.46%
Survival Claims	21347	10.43%
Others	17360	8.48%
Proposal Processing	15599	7.62%
Death Claims	3402	1.66%
ULIP Related	2808	1.37%
TOTAL	**204701**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	Unfair Business Practices	50075	24.46%
Complaint raised with Insurer not addressed	Others	14597	7.13%
Policy bond not received.	Proposal Processing	9250	4.52%
Spurious calls or Hoax Calls	Unfair Business Practices	9089	4.44%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	8934	4.36%
Non-receipt of Premium receipt	Policy Servicing	8369	4.09%
Survival Benefit is not paid	Survival Claims	6839	3.34%
Tampering, Corrections,forgery of proposal or related papers	Unfair Business Practices	6804	3.32%
Intermediary did not provide material information concerning proposed cover	Unfair Business Practices	6352	3.10%
Single premium Policy issued as Annual premium policy	Unfair Business Practices	6248	3.05%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.26

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	18836	9.20%
o Registered by IRDAI	15859	7.75%
o Telephone	3936	
o Email	7178	
o Letter	4745	
o Fax	0	
o walk In	0	
o Registered by Policy Holder	2977	1.45%
Complaints Registered in Insurer's portal	185865	90.80%
TOTAL COMPLAINTS	204701	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	109584	53.77%
Partially in favour	15431	7.57%
Reject	78800	38.66%

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy	133555	65.24%
Others	38991	19.05%
Unit Linked Insurance Policy	25898	12.65%
Pension Policy (other than Unit Linked)	3946	1.93%
Health Insurance Policy	2311	1.13%
TOTAL	204701	

RECEIPT OF COMPLAINTS		
Top 5 companies		
Life Insurance Corporation of India	64750	31.63%
Bajaj Allianz Life Insurance Company Ltd	14295	6.98%
Max Life Insurance Company Limited	14157	6.92%
Reliance Life Insurance Company Ltd	14024	6.85%
Birla SunLife Insurance Company Ltd	12402	6.06%
TOTAL	**119628**	**58.44%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	1672	398	1312
Others	13783	974	2569
Policy Servicing	36137	2561	5135
Proposal Processing	11346	1036	3183
Survival Claims	14586	1626	5082
ULIP Related	1295	233	1271
Unfair Business Practices	30765	8603	60248
TOTAL	**109584**	**15431**	**78800**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - General Insurer

01-Apr-2015 TO 31-Mar-2016

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	2099	
Received during the period	59610	
Duplicate during the period	527	
Actual during the period	59083	
Attended to during the period	60211	98.41%
Pending as at the end of the period	971	1.59%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	26480	44.82%
Policy Related	19422	32.87%
Others	8635	14.62%
Premium	1271	2.15%
Refund	1072	1.81%
Coverage	998	1.69%
Proposal Related	445	0.75%
Cover Note Related	407	0.69%
Product	353	0.60%
TOTAL	**59083**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	13.87

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**12812**	**21.68%**
o Registered by IRDAI	10355	17.53%
o Telephone	2557	
o Email	5113	
o Letter	2685	
o Fax	0	
o walk In	0	
o Registered by Policy Holder	2457	4.16%
Complaints Registered in Insurer's portal	**46271**	**78.32%**
TOTAL COMPLAINTS	**59083**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		**%**
Less than 15 days	533	54.89%
16 – 30 days	83	8.55%
More than 30 days	355	36.56%
Total Pending	**971**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	10550	17.86%
Certificate of Insurance/ Policy not received by the Insured	Policy Related	8997	15.23%
Insurer failed to clarify the queries raised by Insured.	Others	2862	4.84%
Difference between assessed loss and amount settled by Insurer.	Claim	2754	4.66%
Details shown in policy or Add-on are incorrect.	Policy Related	2713	4.59%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	2211	3.74%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	1844	3.12%
TPA not sent ID card to Insured.	Others	1484	2.51%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	1319	2.23%
Delay on the part of TPA to arrange claim reimbursement.	Claim	1266	2.14%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	35018	60.02%
Partially in favour	8041	13.78%
Reject	15283	26.20%

POLICY TYPE CLASSIFICATION		
Policy Type	**No. of Complaints**	**%**
Health Insurance	26838	45.42%
Motor Insurance	24536	41.53%
Others	6326	10.71%
Fire	969	1.64%
Marine Cargo	268	0.45%
Engineering	100	0.17%
Marine Hull	23	0.04%
Crop	13	0.02%
Credit	10	0.02%
TOTAL	**59083**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
Star Health And Allied Insurance Company Limited	7093	12.01%
United India Insurance Company Limited	6221	10.53%
ICICI Lombard General Insurance Company Limited	4974	8.42%
National Insurance Company Limited	4933	8.35%
Future Generali India Insurance Company limited	4251	7.19%
TOTAL	27472	46.50%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED **DURING** THE YEAR * (Complaint Type wise)			
Complaints Type	In favour	Partially in favour	Reject
Claim	10808	4255	10991
Cover Note Related	316	19	70
Coverage	467	261	267
Others	5705	1138	1695
Policy Related	15611	2135	1488
Premium	931	98	236
Product	155	10	181
Proposal Related	206	23	215
Refund	819	102	140
TOTAL	**35018**	**8041**	**15283**

* Out of the total complaints registered during the year

Summary of Grievances 2016-17

(Summary of Complaints, Disposal & Resolutions)

1. Industry (Life & General)
2. Life Insurance Industry
3. General Insurance Industry

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Industry (Life & General)

01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1906	
Received during the period	175521	
Duplicate during the period	2570	
Actual during the period	172951	
Attended to during the period	173824	99.41%
Pending as at the end of the period	1033	0.59%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices (Life)	62286	36.01%
Claim (NonLife)	27637	15.98%
Policy Servicing (Life)	22261	12.87%
Survival Claims (Life)	14357	8.30%
Policy Related (NonLife)	12934	7.48%
Proposal Processing (Life)	9771	5.65%
Others (Life)	7889	4.56%
Others (NonLife)	7536	4.36%
Death Claims (Life)	3026	1.75%
ULIP Related (Life)	1257	0.73%
Refund (NonLife)	1249	0.72%
Premium (NonLife)	1193	0.69%
Coverage (NonLife)	562	0.32%
Proposal Related	513	0.30%
Product (NonLife)	299	0.17%
Cover Note Related (NonLife)	181	0.10%
TOTAL	**172951**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	9.12

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	32894	19.02%
o Registered by IRDAI	26885	15.54%
o Email	13176	
o Letter	6044	
o Telephone	7665	
o Registered by Policy Holder	6009	3.47%
Complaints Registered in Insurer's portal	**140057**	**80.98%**
TOTAL COMPLAINTS	**172951**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		**%**
Less than 15 days	576	55.76%
16 – 30 days	72	6.97%
More than 30 days	385	37.27%
Total Pending	**1033**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices (Life)	Unfair Business Practices	32600	18.85%
Insurer not disposed of the claim (Non Life)	Claim	12462	7.21%
Complaint raised with Insurer not addressed (Life)	Others	6945	4.02%
Certificate of Insurance / Policy not received by the Insured (Non Life)	Policy Related	6019	3.48%
Policy bond not received.	Proposal Processing	5716	3.30%
Tampering, Corrections, forgery of proposal or related papers (Life)	Unfair Business Practices	5037	2.91%
Payment of premium not acted upon or wrongly acted upon (Life)	Policy Servicing	4988	2.88%
Product differs from what was requested or disclosed (Life)	Unfair Business Practices	4233	2.45%
Survival Benefit is not paid (Life)	Survival Claims	4112	2.38%
Surrender Value not paid (Life)	Survival Claims	3770	2.18%

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy (Life)	85372	49.36%
Health Insurance (Non Life)	26937	15.57%
Motor Insurance (Non Life)	18904	10.93%
Unit Linked Insurance Policy (Life)	16493	9.54%
Others (Life)	15452	8.93%
Others (Non Life)	4893	2.83%
Pension Policy (other than Unit Linked) (Life)	2097	1.21%
Health Insurance Policy (Life)	1433	0.83%
Fire (Non Life)	913	0.53%
Marine Cargo (Non Life)	247	0.14%
Engineering (Non Life)	89	0.05%
Crop (Non Life)	68	0.04%
Credit (Non Life)	37	0.02%
Marine Hull (Non Life)	16	0.01%
TOTAL	**172951**	

RECEIPT OF COMPLAINTS		
Top 5 companies		**%**
Life Insurance Corporation of India	30784	17.80%
Max Life Insurance Company Limited	8791	5.08%
HDFC Standard Life Insurance Co. Ltd	8647	5.00%
SBI Life Insurance Co. Ltd.	8165	4.72%
United India Insurance Company Ltd	7484	4.33%
TOTAL	**63871**	**36.93%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially In favour**	**Reject**
Unfair Business Practices (Life)	17724	4555	39858
Policy Servicing (Life)	16904	1662	3667
Claim (Non Life)	10877	5004	11437
Policy Related (Non Life)	10522	1038	1303
Survival Claims (Life)	9487	1087	3770
Proposal Processing (Life)	7005	602	2134
Others (Life)	5221	555	2098
Others (Non Life)	4802	558	2126
Death Claims (Life)	1477	370	1173
Refund (Non Life)	898	154	186
Premium (Non Life)	809	80	296
ULIP Related (Life)	566	67	622
Proposal Related (Non Life)	239	21	250
Coverage (Non Life)	235	140	185
Product (Non Life)	140	25	127
Cover Note Related (Non Life)	136	6	39
TOTAL	**87042**	**15924**	**69271**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	87042	50.54%
Partially in favour	15924	9.25%
Reject	69271	40.22%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Life Insurer

01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	935	
Received during the period	122613	
Duplicate during the period	1766	
Actual during the period	120847	
Attended to during the period	121535	99.80%
Pending as at the end of the period	247	0.20%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		%
Less than 15 days	235	95.14%
16 – 30 days	5	2.02%
More than 30 days	7	2.83%
Total Pending	**247**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	62286	51.54%
Policy Servicing	22261	18.42%
Survival Claims	14357	11.88%
Proposal Processing	9771	8.09%
Others	7889	6.53%
Death Claims	3026	2.50%
ULIP Related	1257	1.04%
TOTAL	**120847**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	Complaint Type	No. of Complaints	%
Malpractices or unfair business practices	Unfair Practices Business	32600	26.98%
Complaint raised with Insurer not addressed	Others	6945	5.75%
Policy bond not received.	Proposal Processing	5716	4.73%
Tampering, Corrections, forgery of proposal or related papers	Unfair Business Practices	5037	4.17%
Payment of premium not acted upon or wrongly acted upon	Policy Servicing	4988	4.13%
Product differs from what was requested or disclosed.	Unfair Business Practices	4233	3.50%
Survival Benefit is not paid	Survival Claims	4112	3.40%
Surrender Value not paid	Survival Claims	3770	3.12%
Illegitimate inducements offered	Unfair Business Practices	3688	3.05%
Non-receipt of Premium receipt	Policy Servicing	3589	2.97%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.17

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**17247**	**14.27%**
o Registered by IRDAI	14411	11.92%
o Email	6848	
o Letter	3598	
o Telephone	3965	
o Registered by Policy Holder	2836	2.35%
Complaints Registered in Insurer's portal	**103600**	**85.73%**
TOTAL COMPLAINTS	**120847**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	58384	48.41%
Partially in favour	8898	7.38%
Reject	53322	44.21%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Conventional Life Insurance Policy	85372	70.64%
Unit Linked Insurance Policy	16493	13.65%
Others	15452	12.79%
Pension Policy (other than Unit Linked)	2097	1.74%
Health Insurance Policy	1433	1.19%
TOTAL	**120847**	

RECEIPT OF COMPLAINTS		
Top 5 companies		
Life Insurance Corporation of India	30784	25.47%
Max Life Insurance Company Limited	8791	7.27%
HDFC Standard Life Insurance Co. Ltd	8647	7.16%
SBI Life Insurance Co. Ltd.	8165	6.76%
ICICI Prudential Life Insurance Company Ltd	6680	5.53%
TOTAL	**63067**	**52.19%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Death Claims	1477	370	1173
Others	5221	555	2098
Policy Servicing	16904	1662	3667
Proposal Processing	7005	602	2134
Survival Claims	9487	1087	3770
ULIP Related	566	67	622
Unfair Business Practices	17724	4555	39858
TOTAL	**58384**	**8898**	**53322**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - General Insurer

01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	971	
Received during the period	52908	
Duplicate during the period	804	
Actual during the period	52104	
Attended to during the period	52289	98.52%
Pending as at the end of the period	786	1.48%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	27637	53.04%
Policy Related	12934	24.82%
Others	7536	14.46%
Refund	1249	2.40%
Premium	1193	2.29%
Coverage	562	1.08%
Proposal Related	513	0.98%
Product	299	0.57%
Cover Note Related	181	0.35%
TOTAL	**52104**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	13.68

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**15647**	**30.03%**
o Registered by IRDAI	12474	23.94%
o Email	6328	
o Letter	2446	
o Telephone	3700	
o Registered by Policy Holder	3173	6.09%
Complaints Registered in Insurer's portal	**36457**	**69.97%**
TOTAL COMPLAINTS	**52104**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		**%**
Less than 15 days	341	43.38%
16 – 30 days	67	8.52%
More than 30 days	378	48.09%
Total Pending	**786**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	12462	23.92%
Certificate of Insurance / Policy not received by the Insured	Policy Related	6019	11.55%
Insurer failed to clarify the queries raised by Insured.	Others	3082	5.92%
Difference between assessed loss and amount settled by Insurer.	Claim	2449	4.70%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	1880	3.61%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	1771	3.40%
Insured asked for cancellation of policy, Insurer failed to respond	Policy Related	1539	2.95%
Details shown in policy or Add-on are incorrect.	Policy Related	1488	2.86%
Claim repudiated without giving reasons	Claim	1228	2.36%
Delay on the part of TPA to arrange claim reimbursement.	Claim	1131	2.17%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	28658	55.50%
Partially in favour	7026	13.61%
Reject	15949	30.89%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy Type	No. of Complaints	%
Health Insurance	26937	51.70%
Motor Insurance	18904	36.28%
Others	4893	9.39%
Fire	913	1.75%
Marine Cargo	247	0.47%
Engineering	89	0.17%
Crop	68	0.13%
Credit	37	0.07%
Marine Hull	16	0.03%
TOTAL	**52104**	

RECEIPT OF COMPLAINTS		
Top 5 companies		%
United India Insurance Co. Limited	7484	14.36%
Star Health And Allied Insurance Co.Ltd.	6434	12.35%
National Insurance Company Limited	4680	8.98%
The New India Assurance Co. Ltd.	4208	8.08%
ICICI Lombard General Insurance Co.Ltd.	3587	6.88%
TOTAL	**26393**	**50.65%**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	10877	5004	11437
Policy Related	10522	1038	1303
Others	4802	558	2126
Refund	898	154	186
Premium	809	80	296
Coverage	235	140	185
Proposal Related	239	21	250
Product	140	25	127
Cover Note Related	136	6	39
TOTAL	**28658**	**7026**	**15949**

* Out of the total complaints registered during the year

Summary of Grievances 2016-17

(Summary of Complaints, Disposal & Resolution - Life Insurers)

1. AEGON Life Insurance Company Limited
2. Aviva Life Insurance Company India Limited
3. Bajaj Allianz Life Insurance Company Ltd
4. Bharti-Axa Life Insurance Company LTD
5. Birla SunLife Insurance Company Limited
6. Canara HSBC Oriental Bank of Commerce Life
7. DHFL Pramerica Life Insurance Company Limited
8. Edelweiss Tokio Life Insurance Company Limited
9. Exide Life Insurance Company Limited
10. Future Generali India Life Insurance Co Ltd
11. HDFC Standard Life Insurance Co. Ltd
12. ICICI Prudential Life Insurance Company Ltd
13. IDBI Federal Life Insurance Co Ltd
14. India First Life Insurance Company Limited
15. Kotak Mahindra Old Mutual Life Insurance Ltd.
16. Life Insurance Corporation of India
17. Max Life Insurance Company Limited
18. PNB MetLife India Insurance Company Ltd.
19. Reliance Nippon Life Insurance Company Limited
20. Sahara India Life Insurance Co. Ltd.
21. SBI Life Insurance Co. Ltd.
22. Shriram Life Insurance Company Ltd.
23. Star Union Dai-ichi Life Insurance Co Ltd
24. Tata AIA Life Insurance Company LTD

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Aegon Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	144	
Received during the period	4384	
Duplicate during the period	123	
Actual during the period	4261	
Attended to during the period	4405	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3410	80.03%
Policy Servicing	378	8.87%
Survival Claims	287	6.74%
Proposal Processing	104	2.44%
Others	69	1.62%
ULIP Related	8	0.19%
Death Claims	5	0.12%
TOTAL	**4261**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	16.77

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**363**	**8.52%**
o Registered by IRDAI	323	7.58%
o Email	142	
o Letter	112	
o Telephone	69	
o Registered by Policy Holder	40	0.94%
Complaints Registered in Insurer's portal	**3898**	**91.48%**
TOTAL COMPLAINTS	**4261**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED* (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	410	10	2990
Policy Servicing	211	1	166
Survival Claims	199	0	88
Proposal Processing	55	4	45
Others	5	0	64
ULIP Related	7	0	1
Death Claims	0	0	5
TOTAL	**887**	**15**	**3359**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2526	59.28%
Illegitimate inducements offered	UBP	231	5.42%
Spurious calls or Hoax Calls	UBP	226	5.30%
Surrender Value not paid	Sur Cla	203	4.76%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	193	4.53%
Tampering, Corrections, forgery of proposal or related papers	UBP	185	4.34%
DNC Registry	UBP	72	1.69%
Alteration in policy not effected.	Pol Ser	67	1.57%
Complaint raised with Insurer not addressed	Others	66	1.55%
Dispute concerning statement of account or premium position statement	Pol Ser	58	1.36%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	887	20.82%
Partially in favour	15	0.35%
Reject	3359	78.83%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Others	3585	84.14%
Conventional Life Insurance Policy	609	14.29%
Unit Linked Insurance Policy	53	1.24%
Health Insurance Policy	8	0.19%
Pension Policy (other than Unit Linked)	6	0.14%
TOTAL	**4261**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Aviva Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	2596	
Duplicate during the period	104	
Actual during the period	2492	
Attended to during the period	2492	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1392	55.86%
Policy Servicing	779	31.26%
Others	109	4.37%
Survival Claims	76	3.05%
Proposal Processing	73	2.93%
ULIP Related	47	1.89%
Death Claims	16	0.64%
TOTAL	**2492**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.68

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**201**	**8.07%**
o Registered by IRDAI	173	6.94%
o Email	85	
o Letter	52	
o Telephone	36	
o Registered by Policy Holder	28	1.12%
Complaints Registered in Insurer's portal	**2291**	**91.93%**
TOTAL COMPLAINTS	**2492**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED* (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	196	394	802
Policy Servicing	216	259	304
Others	10	15	84
Survival Claims	20	11	45
Proposal Processing	12	21	40
ULIP Related	4	11	32
Death Claims	0	1	15
TOTAL	**458**	**712**	**1322**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1122	45.02%
Policy Benefit option not effected	Pol Ser	578	23.19%
Complaint raised with Insurer not addressed	Others	85	3.41%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	67	2.69%
Tampering, Corrections, forgery of proposal or related papers	UBP	55	2.21%
Premium paying period projected is different from actual	UBP	49	1.97%
Product differs from what was requested or disclosed.	UBP	48	1.93%
Policy bond not received.	Prop Proc	44	1.77%
Single premium Policy issued as Annual premium policy	UBP	38	1.52%
Misappropriation of premiums	UBP	30	1.20%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	458	18.38%
Partially in favour	712	28.57%
Reject	1322	53.05%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2126	85.31%
Others	198	7.95%
Unit Linked Insurance Policy	133	5.34%
Pension Policy (other than Unit Linked)	20	0.80%
Health Insurance Policy	15	0.58%
TOTAL	**2492**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bajaj Allianz Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	14	
Received during the period	3993	
Duplicate during the period	0	
Actual during the period	3993	
Attended to during the period	4007	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3278	82.09%
Survival Claims	299	7.49%
Others	199	4.98%
Policy Servicing	90	2.25%
Death Claims	52	1.30%
Proposal Processing	45	1.13%
ULIP Related	30	0.75%
TOTAL	**3993**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.53

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**799**	**20.01%**
o Registered by IRDAI	662	16.58%
o Email	243	
o Letter	224	
o Telephone	195	
o Registered by Policy Holder	137	3.43%
Complaints Registered in Insurer's portal	**3194**	**79.99%**
TOTAL COMPLAINTS	**3993**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	2010	88	1180
Survival Claims	221	13	65
Others	110	10	79
Policy Servicing	58	2	30
Death Claims	30	2	20
Proposal Processing	31	3	11
ULIP Related	11	1	18
TOTAL	**2471**	**119**	**1403**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2413	60.43%
Intermediary did not provide material information concerning proposed cover	UBP	407	10.19%
Complaint raised with Insurer not addressed	Others	190	4.76%
Spurious calls or Hoax Calls	UBP	139	3.48%
Tampering, Corrections, orgery of proposal or related papers	UBP	123	3.08%
Maturity claim is not paid	Sur Cla	122	3.06%
Surrender Value not paid	Sur Cla	76	1.90%
Death claim not paid	Dea Cla	40	1.00%
Survival Benefit is not paid	Sur Cla	38	0.95%
Single premium Policy issued as Annual premium policy	UBP	38	0.95%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	2471	61.88%
Partially in favour	119	2.98%
Reject	1403	35.14%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Others	2203	55.17%
Conventional Life Insurance Policy	1456	36.46%
Unit Linked Insurance Policy	118	2.96%
Pension Policy (other than Unit Linked)	109	2.73%
Health Insurance Policy	107	2.68%
TOTAL	**3993**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bharati Axa Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	4556	
Duplicate during the period	0	
Actual during the period	4556	
Attended to during the period	4548	99.82%
Pending as at the end of the period	8	0.18%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	4035	88.56%
Others	159	3.49%
Policy Servicing	100	2.19%
Proposal Processing	85	1.87%
ULIP Related	83	1.82%
Survival Claims	62	1.36%
Death Claims	32	0.70%
TOTAL	**4556**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	10.91

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**824**	**18.09%**
o Registered by IRDAI	685	15.04%
o Email	292	
o Letter	206	
o Telephone	187	
o Registered by Policy Holder	139	3.05%
Complaints Registered in Insurer's portal	**3732**	**81.91%**
TOTAL COMPLAINTS	**4556**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1027	235	2769
Others	56	7	96
Policy Servicing	51	1	48
Proposal Processing	51	0	34
ULIP Related	32	2	48
Survival Claims	25	7	30
Death Claims	2	0	30
TOTAL	**1244**	**252**	**3055**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	4	50.00%
16 – 30 days	2	25.00%
More than 30 days	2	25.00%
Total Pending	**8**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2333	51.21%
Illegitimate inducements offered	UBP	552	12.12%
Tampering, Corrections, forgery of proposal or related papers	UBP	347	7.62%
Product differs from what was requested or disclosed	UBP	239	5.25%
Complaint raised with Insurer not addressed	Others	135	2.96%
Single premium Policy issued as Annual premium policy	UBP	131	2.88%
Definitions of eligibility misinterpreted	ULIP Rel	66	1.45%
Misappropriation of premiums	UBP	66	1.45%
Policy bond not received.	Prop Proc	58	1.27%
Free-look refund not paid	UBP	57	1.25%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	1244	27.33%
Partially in favour	252	5.54%
Reject	3055	67.13%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Unit Linked Insurance Policy	2747	60.29%
Conventional Life Insurance Policy	1674	36.74%
Others	126	2.77%
Health Insurance Policy	6	0.13%
Pension Policy (other than Unit Linked)	3	0.07%
TOTAL	**4556**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Birla Sun Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	6356	
Duplicate during the period	0	
Actual during the period	6356	
Attended to during the period	6347	99.84%
Pending as at the end of the period	10	0.16%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3736	58.78%
Policy Servicing	882	13.88%
Survival Claims	623	9.80%
Proposal Processing	593	9.33%
Others	314	4.94%
ULIP Related	115	1.81%
Death Claims	93	1.46%
TOTAL	**6356**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.53

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**647**	**10.18%**
o Registered by IRDAI	578	9.09%
o Email	251	
o Letter	199	
o Telephone	128	
o Registered by Policy Holder	69	1.09%
Complaints Registered in Insurer's portal	**5709**	**89.82%**
TOTAL COMPLAINTS	**6356**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED* (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	347	179	3204
Policy Servicing	167	182	532
Survival Claims	117	90	416
Proposal Processing	270	102	221
Others	46	45	222
ULIP Related	13	17	85
Death Claims	20	19	52
TOTAL	**980**	**634**	**4732**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	10	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**10**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1494	23.51%
Illegitimate inducements offered	UBP	454	7.14%
Intermediary did not provide material information concerning proposed cover	UBP	312	4.91%
Complaint raised with Insure not addressed	Others	299	4.70%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	284	4.47%
Tampering, Corrections, forgery of proposal or related papers	UBP	271	4.26%
Misappropriation of premiums	UBP	268	4.22%
Policy bond not received.	Prop Proc	229	3.60%
Spurious calls or Hoax Calls	UBP	206	3.24%
Surrender Value not paid	Sur Cla	187	2.94%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	980	15.44%
Partially in favour	634	9.99%
Reject	4732	74.57%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	3142	49.43%
Others	2085	32.80%
Unit Linked Insurance Policy	1050	16.52%
Health Insurance Policy	51	0.80%
Pension Policy (other than Unit Linked)	28	0.44%
TOTAL	**6356**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Canara HSBC
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	13	
Received during the period	974	
Duplicate during the period	0	
Actual during the period	974	
Attended to during the period	987	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	697	71.56%
Policy Servicing	124	12.73%
Survival Claims	71	7.29%
ULIP Related	29	2.98%
Proposal Processing	27	2.77%
Death Claims	16	1.64%
Others	10	1.03%
TOTAL	**974**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.43

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**40**	**4.11%**
o Registered by IRDAI	30	3.08%
o Email	10	
o Letter	8	
o Telephone	12	
o Registered by Policy Holder	10	1.03%
Complaints Registered in Insurer's portal	**934**	**95.89%**
TOTAL COMPLAINTS	**974**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED* (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	343	69	285
Policy Servicing	81	26	17
Survival Claims	38	13	20
ULIP Related	13	3	13
Proposal Processing	19	7	1
Death Claims	4	7	5
Others	5	2	3
TOTAL	**503**	**127**	**344**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	435	44.66%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	88	9.03%
Single premium Policy issued as Annual premium policy	UBP	64	6.57%
Tampering, Corrections, forgery of proposal or related papers	UBP	57	5.85%
Surrender Value not paid	Sur Cla	57	5.85%
Illegitimate inducements offered	UBP	37	3.80%
Premium paying period projected is different from actual	UBP	22	2.26%
Free-look refund not paid	UBP	20	2.05%
Product differs from what was requested or disclosed.	UBP	18	1.85%
Poor disclosures of various Charges	ULIP Rel	17	1.75%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	503	51.64%
Partially in favour	127	13.04%
Reject	344	35.32%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Unit Linked Insurance Policy	779	79.98%
Conventional Life Insurance Policy	169	17.35%
Others	26	2.67%
TOTAL	**974**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - DHFL Pramerica Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	7	
Received during the period	1481	
Duplicate during the period	6	
Actual during the period	1475	
Attended to during the period	1481	99.93%
Pending as at the end of the period	1	0.07%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1058	71.73%
Proposal Processing	238	16.14%
Others	69	4.68%
Survival Claims	54	3.66%
Policy Servicing	43	2.92%
Death Claims	8	0.54%
ULIP Related	5	0.34%
TOTAL	**1475**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	10.69

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**217**	**14.71%**
o Registered by IRDAI	203	13.76%
o Email	102	
o Letter	43	
o Telephone	58	
o Registered by Policy Holder	14	0.95%
Complaints Registered in Insurer's portal	**1258**	**85.29%**
TOTAL COMPLAINTS	**1475**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	226	111	720
Proposal Processing	165	27	46
Others	20	14	35
Survival Claims	10	9	35
Policy Servicing	10	16	17
Death Claims	1	2	5
ULIP Related	1	1	3
TOTAL	**433**	**180**	**861**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	1	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**1**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	294	19.93%
Illegitimate inducements offered	UBP	236	16.00%
Tampering, Corrections, forgery of proposal or related papers	UBP	160	10.85%
Mistakes in the name and address of the insured.	Prop Proc	98	6.64%
Policy bond not received.	Prop Proc	90	6.10%
Free-look refund not paid	UBP	83	5.63%
Complaint raised with Insurer not addressed	Others	66	4.47%
Single premium Policy issued as Annual premium policy	UBP	61	4.14%
Credit/Debit card debited without consent of Consumer	UBP	58	3.93%
Proposed Insurance not in the interest of proposer	UBP	35	2.37%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	433	29.38%
Partially in favour	180	12.21%
Reject	861	58.41%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	1357	92.00%
Unit Linked Insurance Policy	81	5.49%
Others	36	2.44%
Health Insurance Policy	1	0.07%
TOTAL	**1475**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Edelweiss Tokio Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	6	
Received during the period	1038	
Duplicate during the period	25	
Actual during the period	1013	
Attended to during the period	1019	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	724	71.47%
Proposal Processing	143	14.12%
Policy Servicing	92	9.08%
Others	26	2.57%
ULIP Related	16	1.58%
Death Claims	8	0.79%
Survival Claims	4	0.39%
TOTAL	**1013**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.91

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**52**	**5.13%**
o Registered by IRDAI	45	4.44%
o Email	22	
o Letter	15	
o Telephone	8	
o Registered by Policy Holder	7	0.69%
Complaints Registered in Insurer's portal	**961**	**94.87%**
TOTAL COMPLAINTS	**1013**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	191	15	518
Proposal Processing	98	1	44
Policy Servicing	78	2	12
Others	19	0	7
ULIP Related	12	0	4
Death Claims	0	1	7
Survival Claims	2	0	2
TOTAL	**400**	**19**	**594**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	546	52.60%
Premium paying period projected is different from actual	UBP	40	3.85%
Mistakes in the name and address of the insured.	Prop Proc	38	3.66%
Policy bond not received.	Prop Proc	32	3.08%
Illegitimate inducements offered	UBP	27	2.60%
Complaint raised with Insurer not addressed	Others	24	2.31%
Non-receipt of Premium receipt	Pol Ser	19	1.83%
Mode of premium payment differs from requested or disclosed	UBP	18	1.73%
After submission of all requirements, no comm-unication was received.	Prop Proc	17	1.64%
Product differs from what was requested or disclosed.	UBP	16	1.54%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	400	39.49%
Partially in favour	19	1.88%
Reject	594	58.64%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	984	97.14%
Unit Linked Insurance Policy	18	1.78%
Others	9	0.89%
Health Insurance Policy	1	0.10%
Pension Policy (other than Unit Linked)	1	0.10%
TOTAL	**1013**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Exide Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	41	
Received during the period	6718	
Duplicate during the period	312	
Actual during the period	6406	
Attended to during the period	6447	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	5186	80.96%
Policy Servicing	509	7.95%
Survival Claims	281	4.39%
Proposal Processing	259	4.04%
Others	108	1.69%
ULIP Related	37	0.58%
Death Claims	26	0.41%
TOTAL	**6406**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.78

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**845**	**13.19%**
o Registered by IRDAI	776	12.11%
o Email	316	
o Letter	190	
o Telephone	270	
o Registered by Policy Holder	69	1.08%
Complaints Registered in Insurer's portal	**5561**	**86.81%**
TOTAL COMPLAINTS	**6406**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1306	285	3595
Policy Servicing	282	75	152
Survival Claims	188	43	50
Proposal Processing	115	43	101
Others	39	12	57
ULIP Related	19	4	14
Death Claims	7	3	16
TOTAL	**1956**	**465**	**3985**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	3845	60.02%
Free-look refund not paid	UBP	393	6.13%
Tampering, Corrections, forgery of proposal or related papers	UBP	255	3.98%
Product differs from what was requested or disclosed.	UBP	230	3.59%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	167	2.61%
Surrender Value not paid	Sur Cla	145	2.26%
Illegitimate inducements offered	UBP	138	2.15%
Policy bond not received.	Prop Proc	133	2.08%
Complaint raised with Insurer not addressed	Others	106	1.65%
Policy Benefit option not effected	Pol Ser	93	1.45%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
in favour	1956	30.53%
Partially in favour	465	7.26%
Reject	3985	62.21%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	5559	86.78%
Others	650	10.15%
Unit Linked Insurance Policy	94	1.47%
Pension Policy (other than Unit Linked)	87	1.36%
Health Insurance Policy	16	0.24%
TOTAL	**6406**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Future Generali Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	52	
Received during the period	4998	
Duplicate during the period	0	
Actual during the period	4998	
Attended to during the period	5035	99.70%
Pending as at the end of the period	15	0.30%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	15	100.00%
16 – 30 days	0	0
More than 30 days	0	0
Total Pending	**15**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	4274	85.51%
Proposal Processing	212	4.24%
Survival Claims	178	3.56%
Policy Servicing	130	2.60%
Others	120	2.40%
Death Claims	61	1.22%
ULIP Related	23	0.46%
TOTAL	**4998**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	3539	70.81%
Tampering, Corrections, forgery of proposal or related papers	UBP	232	4.64%
Policy bond not received.	Prop Proc	194	3.88%
Illegitimate inducements offered	UBP	186	3.72%
Complaint raised with Insurer not addressed	Others	120	2.40%
Single premium Policy issued as Annual premium policy	UBP	74	1.48%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	54	1.08%
Spurious calls or Hoax Calls	UBP	52	1.04%
Surrender Value not paid	Sur Cla	51	1.02%
Proposed Insurance not in the interest of proposer	UBP	50	1.00%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	10.53

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**551**	**11.02%**
o Registered by IRDAI	497	9.94%
o Email	173	
o Letter	168	
o Telephone	156	
o Registered by Policy Holder	54	1.08%
Complaints Registered in Insurer's portal	**4447**	**88.98%**
TOTAL COMPLAINTS	**4998**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	956	19.19%
Partially in favour	1011	20.29%
Reject	3016	60.53%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	798	823	2640
Proposal Processing	64	66	82
Survival Claims	34	29	114
Policy Servicing	35	39	56
Others	18	26	75
Death Claims	4	24	33
ULIP Related	3	4	16
TOTAL	**956**	**1011**	**3016**

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	4460	89.24%
Unit Linked Insurance Policy	451	9.02%
Others	62	1.24%
Pension Policy (other than Unit Linked)	24	0.48%
Health Insurance Policy	1	0.02%
TOTAL	**4998**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - HDFC Standard Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	85	
Received during the period	8734	
Duplicate during the period	87	
Actual during the period	8647	
Attended to during the period	8722	99.89%
Pending as at the end of the period	10	0.11%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	6388	73.88%
Survival Claims	709	8.20%
Proposal Processing	622	7.19%
Policy Servicing	451	5.22%
Death Claims	217	2.51%
Others	193	2.23%
ULIP Related	67	0.77%
TOTAL	**8647**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.42

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**2555**	**29.55%**
o Registered by IRDAI	2241	25.92%
o Email	1241	
o Letter	472	
o Telephone	528	
o Registered by Policy Holder	314	3.63%
Complaints Registered in Insurer's portal	**6092**	**70.45%**
TOTAL COMPLAINTS	**8647**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1168	99	5113
Survival Claims	249	10	449
Proposal Processing	253	16	353
Policy Servicing	187	9	254
Death Claims	34	4	179
Others	34	13	146
ULIP Related	16	0	51
TOTAL	**1941**	**151**	**6545**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	10	100.00%
16 – 30 days	0	0
More than 30 days	0	0
Total Pending	**10**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Illegitimate inducements offered	UBP	1557	18.01%
Tampering, Corrections, forgery of proposal or related papers	UBP	1349	15.60%
Proposed Insurance not in the interest of proposer	UBP	1099	12.71%
Intermediary did not provide material information concerning proposed cover	UBP	630	7.29%
Free-look refund not paid	UBP	449	5.19%
Spurious calls or Hoax Calls	UBP	256	2.96%
Malpractices or unfair business practices	UBP	248	2.87%
Single premium Policy issued as Annual premium policy	UBP	241	2.79%
Complaint raised with Insurer not addressed	Others	189	2.19%
Policy bond not received.	Prop Proc	180	2.08%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1941	22.47%
Partially in favour	151	1.75%
Reject	6545	75.78%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	6596	76.28%
Unit Linked Insurance Policy	1069	12.36%
Others	506	5.85%
Health Insurance Policy	346	4.00%
Pension Policy (other than Unit Linked)	130	1.49%
TOTAL	**8647**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ICICI Prudential Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	12	
Received during the period	6723	
Duplicate during the period	43	
Actual during the period	6680	
Attended to during the period	6689	99.96%
Pending as at the end of the period	3	0.04%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	5352	80.12%
Others	521	7.80%
Survival Claims	271	4.06%
ULIP Related	221	3.31%
Proposal Processing	132	1.98%
Policy Servicing	111	1.66%
Death Claims	72	1.08%
TOTAL	**6680**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.56

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**1612**	**24.13%**
o Registered by IRDAI	1351	20.22%
o Email	825	
o Letter	259	
o Telephone	267	
o Registered by Policy Holder	261	3.91%
Complaints Registered in Insurer's portal	**5068**	**75.87%**
TOTAL COMPLAINTS	**6680**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1372	221	3756
Others	206	34	281
Survival Claims	123	12	136
ULIP Related	54	11	156
Proposal Processing	82	18	32
Policy Servicing	49	7	55
Death Claims	7	7	58
TOTAL	**1893**	**310**	**4474**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	3	100.00%
16 – 30 days	0	0
More than 30 days	0	0
Total Pending	**3**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2153	32.23%
Product differs from what was requested or disclosed.	UBP	1386	20.75%
Single premium Policy issued as Annual premium policy	UBP	740	11.08%
Complaint raised with Insurer not addressed	Others	509	7.62%
Tampering, Corrections, forgery of proposal or related papers	UBP	441	6.60%
Proposed Insurance not in the interest of proposer	UBP	421	6.30%
Poor disclosures of various Charges	ULIP Rel	201	3.01%
Surrender Value not paid	Sur Cla	111	1.66%
Free-look refund not paid	UBP	76	1.14%
Policy bond not received.	Prop Proc	66	0.99%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1893	28.35%
Partially in favour	310	4.64%
Reject	4474	67.01%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	4580	68.56%
Others	1167	17.47%
Unit Linked Insurance Policy	797	11.93%
Health Insurance Policy	76	1.14%
Pension Policy (other than Unit Linked)	60	0.89%
TOTAL	**6680**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - IDBI Federal Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	679	
Duplicate during the period	12	
Actual during the period	667	
Attended to during the period	667	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	545	81.71%
Proposal Processing	34	5.10%
Others	26	3.90%
Death Claims	26	3.90%
Policy Servicing	17	2.55%
Survival Claims	14	2.10%
ULIP Related	5	0.75%
TOTAL	**667**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.99

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**88**	**13.19%**
o Registered by IRDAI	75	11.24%
o Email	34	
o Letter	27	
o Telephone	14	
o Registered by Policy Holder	13	1.95%
Complaints Registered in Insurer's portal	**579**	**86.81%**
TOTAL COMPLAINTS	**667**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	95	59	391
Proposal Processing	24	0	10
Others	5	2	19
Death Claims	7	1	18
Policy Servicing	6	1	10
Survival Claims	2	0	12
ULIP Related	0	0	5
TOTAL	**139**	**63**	**465**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Single premium Policy issued as Annual premium policy	UBP	122	18.29%
Tampering, Corrections, forgery of proposal or related papers	UBP	105	15.74%
Intermediary did not provide material information concerning proposed cover	UBP	94	14.09%
Proposed Insurance not in the interest of proposer	UBP	49	7.35%
Premium paying period projected is different from actual	UBP	45	6.75%
Malpractices or unfair business practices	UBP	31	4.65%
Complaint raised with Insurer not addressed	Others	26	3.90%
Surrender value projected is different from actual	UBP	25	3.75%
Repudiation of Claim	Dea Cla	23	3.45%
Misappropriation of premiums	UBP	22	3.30%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	139	20.84%
Partially in favour	63	9.45%
Reject	465	69.72%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	567	85.01%
Unit Linked Insurance Policy	84	12.59%
Others	10	1.50%
Pension Policy (other than Unit Linked)	5	0.75%
Health Insurance Policy	1	0.15%
TOTAL	**667**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - India First Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	24	
Received during the period	2023	
Duplicate during the period	33	
Actual during the period	1990	
Attended to during the period	1995	99.06%
Pending as at the end of the period	19	0.94%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1459	73.32%
Policy Servicing	188	9.45%
Survival Claims	132	6.63%
Death Claims	115	5.78%
Proposal Processing	40	2.01%
ULIP Related	37	1.86%
Others	19	0.95%
TOTAL	**1990**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.01

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**50**	**2.51%**
o Registered by IRDAI	41	2.06%
o Email	18	
o Letter	7	
o Telephone	16	
o Registered by Policy Holder	9	0.45%
Complaints Registered in Insurer's portal	**1940**	**97.49%**
TOTAL COMPLAINTS	**1990**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	920	25	499
Policy Servicing	152	9	25
Survival Claims	71	5	55
Death Claims	32	5	77
Proposal Processing	31	1	8
ULIP Related	20	3	14
Others	17	0	2
TOTAL	**1243**	**48**	**680**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	19	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**19**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	813	40.85%
Product differs from what was requested or disclosed.	UBP	317	15.93%
Spurious calls or Hoax Calls	UBP	134	6.73%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	127	6.38%
Repudiation of Claim	Dea Cla	94	4.72%
Single premium Policy issued as Annual premium policy	UBP	54	2.71%
Disputes concerning correctness of surrender value	Sur Cla	46	2.31%
Misappropriation of premiums	UBP	42	2.11%
Surrender Value not paid	Sur Cla	37	1.86%
Tampering, Corrections, forgery of proposal or related papers	UBP	35	1.76%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1243	63.06%
Partially in favour	48	2.44%
Reject	680	34.50%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	919	46.18%
Others	855	42.96%
Unit Linked Insurance Policy	145	7.29%
Health Insurance Policy	41	2.06%
Pension Policy (other than Unit Linked)	30	1.51%
TOTAL	**1990**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Kotak Mahindra Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	246	
Received during the period	3764	
Duplicate during the period	23	
Actual during the period	3741	
Attended to during the period	3882	97.37%
Pending as at the end of the period	105	2.63%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	2235	59.74%
Policy Servicing	672	17.96%
Proposal Processing	312	8.34%
Others	250	6.68%
Survival Claims	156	4.17%
Death Claims	72	1.92%
ULIP Related	44	1.18%
TOTAL	**3741**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	20.96

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**433**	**11.57%**
o Registered by IRDAI	374	10.00%
o Email	169	
o Letter	112	
o Telephone	93	
o Registered by Policy Holder	59	1.58%
Complaints Registered in Insurer's portal	**3308**	**88.43%**
TOTAL COMPLAINTS	**3741**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	521	3	1661
Policy Servicing	343	3	304
Proposal Processing	154	0	145
Others	56	3	180
Survival Claims	59	0	90
Death Claims	4	0	65
ULIP Related	13	0	30
TOTAL	**1150**	**9**	**2475**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	105	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**105**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1575	42.10%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	254	6.79%
Complaint raised with Insurer not addressed	Others	220	5.88%
Alteration in policy not effected.	Pol Ser	156	4.17%
Product differs from what was requested or disclosed.	UBP	133	3.56%
Policy bond not received.	Prop Proc	126	3.37%
Tampering, Corrections, forgery of proposal or related papers	UBP	107	2.86%
Premium paying period projected is different from actual	UBP	80	2.14%
Surrender Value not paid	Sur Cla	76	2.03%
Excess proposal deposit not refunded	Prop Proc	67	1.79%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1150	31.65%
Partially in favour	9	0.25%
Reject	2475	68.11%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2529	67.60%
Unit Linked Insurance Policy	657	17.56%
Others	488	13.04%
Pension Policy (other than Unit Linked)	53	1.42%
Health Insurance Policy	14	0.37%
TOTAL	**3741**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - LIC of India
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	30784	
Duplicate during the period	0	
Actual during the period	30784	
Attended to during the period	30784	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Servicing	13855	45.01%
Survival Claims	7635	24.80%
Others	4667	15.16%
Death Claims	1587	5.16%
Proposal Processing	1575	5.12%
Unfair Business Practices	1215	3.95%
ULIP Related	250	0.81%
TOTAL	**30784**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	3.56

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**3865**	**12.56%**
o Registered by IRDAI	2790	9.06%
o Email	1290	
o Letter	578	
o Telephone	922	
o Registered by Policy Holder	1075	3.49%
Complaints Registered in Insurer's portal	**26919**	**87.44%**
TOTAL COMPLAINTS	**30784**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Servicing	12764	598	493
Survival Claims	6781	544	310
Others	4251	256	160
Death Claims	1216	267	104
Proposal Processing	1436	89	50
Unfair Business Practices	1062	106	47
ULIP Related	237	6	7
TOTAL	**27747**	**1866**	**1171**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Complaint raised with Insurer not addressed	Others	3921	12.74%
Non-receipt of Premium receipt	Pol Ser	3312	10.76%
Survival Benefit is not paid	Sur Cla	3161	10.27%
No Response for recording Change of address	Pol Ser	2561	8.32%
Maturity claim is not paid	Sur Cla	1798	5.84%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	1606	5.22%
Death claim not paid	Dea Cla	1297	4.21%
Surrender Value not paid	Sur Cla	1295	4.21%
Premium payment position statement not received	Pol Ser	1244	4.04%
Request for Servicing Branch transfer is not effected	Pol Ser	1047	3.40%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	27747	90.13%
Partially in favour	1866	6.06%
Reject	1171	3.80%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	27511	89.37%
Unit Linked Insurance Policy	1245	4.04%
Pension Policy (other than Unit Linked)	1192	3.87%
Health Insurance Policy	528	1.72%
Others	308	1.00%
TOTAL	**30784**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Max Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	8791	
Duplicate during the period	0	
Actual during the period	8791	
Attended to during the period	8791	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	6115	69.56%
Proposal Processing	909	10.34%
Policy Servicing	886	10.08%
Survival Claims	413	4.70%
Others	328	3.73%
Death Claims	131	1.49%
ULIP Related	9	0.10%
TOTAL	**8791**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.97

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**995**	**11.32%**
o Registered by IRDAI	881	10.02%
o Email	405	
o Letter	205	
o Telephone	271	
o Registered by Policy Holder	114	1.30%
Complaints Registered in Insurer's portal	**7796**	**88.68%**
TOTAL COMPLAINTS	**8791**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	2169	1387	2559
Proposal Processing	836	42	31
Policy Servicing	650	197	39
Survival Claims	286	49	78
Others	153	62	113
Death Claims	12	2	117
ULIP Related	7	1	1
TOTAL	**4113**	**1740**	**2938**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	2969	33.77%
Spurious calls or Hoax Calls	UBP	1256	14.29%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	530	6.03%
Product differs from what was requested or disclosed.	UBP	437	4.97%
Premium paying period projected is different from actual	UBP	419	4.77%
Tampering, Corrections, forgery of proposal or related papers	UBP	337	3.83%
Mistakes in any other policy schedule item.	Prop Proc	330	3.75%
Complaint raised with Insurer not addressed	Others	319	3.63%
Alteration in policy not effected.	Pol Ser	276	3.14%
Intermediary did not provide material information concerning proposed cover	UBP	248	2.82%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	4113	46.79%
Partially in favour	1740	19.79%
Reject	2938	33.42%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	5727	65.15%
Unit Linked Insurance Policy	1740	19.79%
Others	1295	14.73%
Health Insurance Policy	18	0.20%
Pension Policy (other than Unit Linked)	11	0.13%
TOTAL	**8791**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - PNB MetLife
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	20	
Received during the period	4461	
Duplicate during the period	78	
Actual during the period	4383	
Attended to during the period	4333	98.41%
Pending as at the end of the period	70	1.59%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	2866	65.39%
Policy Servicing	503	11.48%
Proposal Processing	494	11.27%
Survival Claims	350	7.99%
Death Claims	83	1.89%
ULIP Related	48	1.10%
Others	39	0.89%
TOTAL	**4383**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	9.1

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**719**	**16.40%**
o Registered by IRDAI	638	14.56%
o Email	310	
o Letter	157	
o Telephone	171	
o Registered by Policy Holder	81	1.85%
Complaints Registered in Insurer's portal	**3664**	**83.60%**
TOTAL COMPLAINTS	**4383**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	1085	12	1724
Policy Servicing	358	2	141
Proposal Processing	345	1	131
Survival Claims	280	1	68
Death Claims	29	0	54
ULIP Related	32	0	16
Others	13	0	24
TOTAL	**2142**	**16**	**2158**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	63	90.00%
16 – 30 days	2	2.86%
More than 30 days	5	7.14%
Total Pending	**70**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1867	42.60%
Product differs from what was requested or disclosed.	UBP	334	7.62%
Policy Benefit option not effected	Pol Ser	226	5.16%
Policy bond not received.	Prop Proc	213	4.86%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	192	4.38%
Tampering, Corrections, forgery of proposal or related papers	UBP	185	4.22%
Proposal papers submitted but misplaced by Insurer	Prop Proc	179	4.08%
Surrender Value not paid	Sur Cla	146	3.33%
Survival Benefit is not paid	Sur Cla	117	2.67%
Premium paying period projected is different from actual	UBP	92	2.10%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	2142	49.63%
Partially in favour	16	0.37%
Reject	2158	50.00%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	3281	74.86%
Unit Linked Insurance Policy	953	21.74%
Others	116	2.65%
Health Insurance Policy	25	0.57%
Pension Policy (other than Unit Linked)	8	0.18%
TOTAL	**4383**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Reliance Nippon Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	169	
Received during the period	5577	
Duplicate during the period	619	
Actual during the period	4958	
Attended to during the period	5127	100.00%
Pending as at the end of the period	0	0.00%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	2491	50.24%
Survival Claims	962	19.40%
Proposal Processing	738	14.89%
Policy Servicing	383	7.72%
Others	205	4.13%
Death Claims	127	2.56%
ULIP Related	52	1.05%
TOTAL	**4958**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	1825	36.81%
Policy bond not received.	Prop Proc	689	13.90%
Surrender Value not paid	Sur Cla	399	8.05%
Dispute concerning claim value	Sur Cla	205	4.13%
Complaint raised with Insurer not addressed	Others	190	3.83%
Misappropriation of premiums	UBP	186	3.75%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	175	3.53%
Survival Benefit is not paid	Sur Cla	159	3.21%
Maturity claim is not paid	Sur Cla	145	2.92%
Free-look refund not paid	UBP	114	2.30%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	8.64

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**990**	**19.97%**
o Registered by IRDAI	869	17.53%
o Email	403	
o Letter	243	
o Telephone	223	
o Registered by Policy Holder	121	2.44%
Complaints Registered in Insurer's portal	**3968**	**80.03%**
TOTAL COMPLAINTS	**4958**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	1792	36.15%
Partially in favour	205	4.14%
Reject	2960	59.71%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	478	123	1889
Survival Claims	291	58	613
Proposal Processing	695	2	41
Policy Servicing	259	6	118
Others	30	9	166
Death Claims	13	7	107
ULIP Related	26	0	26
TOTAL	**1792**	**205**	**2960**

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	3275	66.05%
Others	975	19.67%
Unit Linked Insurance Policy	544	10.97%
Health Insurance Policy	119	2.40%
Pension Policy (other than Unit Linked)	45	0.81%
TOTAL	**4958**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Sahara Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	32	
Duplicate during the period	0	
Actual during the period	32	
Attended to during the period	30	90.91%
Pending as at the end of the period	3	9.09%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	2	66.67%
16 – 30 days	1	33.33%
More than 30 days	0	0.00%
Total Pending	**3**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Survival Claims	15	46.88%
Policy Servicing	7	21.88%
Unfair Business Practices	3	9.38%
Others	3	9.38%
Death Claims	2	6.25%
ULIP Related	1	3.13%
Proposal Processing	1	3.13%
TOTAL	**32**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Maturity claim is not paid	Sur Cla	6	18.75%
Malpractices or unfair business practices	UBP	3	9.38%
Complaint raised with Insurer not addressed	Others	3	9.38%
Death claim not paid	Dea Cla	2	6.25%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	2	6.25%
Survival Benefit is not paid	Sur Cla	2	6.25%
Dispute concerning statement of account or premium position statement	Pol Ser	2	6.25%
Disputes concerning correctness of surrender value	Sur Cla	2	6.25%
Non-payment of penal interest	Sur Cla	2	6.25%
Dispute concerning claim value	Sur Cla	1	3.13%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	16.66

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**16**	**50.00%**
o Registered by IRDAI	15	46.88%
o Email	2	
o Letter	5	
o Telephone	8	
o Registered by Policy Holder	1	3.13%
Complaints Registered in Insurer's portal	**16**	**50.00%**
TOTAL COMPLAINTS	**32**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Survival Claims	5	0	8
Policy Servicing	2	0	5
Unfair Business Practices	1	0	1
Others	0	0	3
Death Claims	0	0	2
ULIP Related	0	0	1
Proposal Processing	0	0	1
TOTAL	**8**	**0**	**21**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	8	27.59%
Partially in favour	0	0.00%
Reject	21	72.41%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	23	71.88%
Unit Linked Insurance Policy	8	25.00%
Others	1	3.13%
TOTAL	**32**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - SBI Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	3	
Received during the period	8387	
Duplicate during the period	222	
Actual during the period	8165	
Attended to during the period	8166	99.98%
Pending as at the end of the period	2	0.02%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	3040	37.23%
Proposal Processing	2642	32.36%
Policy Servicing	1060	12.98%
Survival Claims	949	11.62%
Others	272	3.33%
Death Claims	161	1.97%
ULIP Related	41	0.50%
TOTAL	**8165**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.72

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**707**	**8.66%**
o Registered by IRDAI	607	7.43%
o Email	219	
o Letter	199	
o Telephone	189	
o Registered by Policy Holder	100	1.22%
Complaints Registered in Insurer's portal	**7458**	**91.34%**
TOTAL COMPLAINTS	**8165**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	616	246	2177
Proposal Processing	2021	139	482
Policy Servicing	401	170	489
Survival Claims	225	134	590
Others	68	39	165
Death Claims	34	13	114
ULIP Related	14	2	25
TOTAL	**3379**	**743**	**4042**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	2	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**2**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Policy bond not received.	Prop Proc	2352	28.81%
Malpractices or unfair business practices	UBP	1258	15.41%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	500	6.12%
Intermediary did not provide material information concerning proposed cover	UBP	445	5.45%
Dispute concerning claim value	Sur Cla	273	3.34%
Tampering, Corrections, forgery of proposal or related papers	UBP	272	3.33%
Product differs from what was requested or disclosed.	UBP	262	3.21%
Surrender Value not paid	Sur Cla	243	2.98%
Complaint raised with Insurer not addressed	Others	241	2.95%
Misappropriation of premiums	UBP	218	2.67%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	3379	41.39%
Partially in favour	743	9.10%
Reject	4042	49.51%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	5177	63.40%
Unit Linked Insurance Policy	2257	27.64%
Others	463	5.67%
Pension Policy (other than Unit Linked)	255	3.12%
Health Insurance Policy	13	0.16%
TOTAL	**8165**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ShriRam Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	9	
Received during the period	403	
Duplicate during the period	24	
Actual during the period	379	
Attended to during the period	387	99.74%
Pending as at the end of the period	1	0.26%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	238	62.80%
Others	45	11.87%
Survival Claims	35	9.23%
Death Claims	30	7.92%
Proposal Processing	21	5.54%
Policy Servicing	9	2.37%
ULIP Related	1	0.26%
TOTAL	**379**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	9.56

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**274**	**72.30%**
o Registered by IRDAI	205	54.09%
o Email	90	
o Letter	47	
o Telephone	68	
o Registered by Policy Holder	69	18.21%
Complaints Registered in Insurer's portal	**105**	**27.70%**
TOTAL COMPLAINTS	**379**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	73	0	164
Others	8	0	37
Survival Claims	3	1	31
Death Claims	2	0	28
Proposal Processing	5	0	16
Policy Servicing	1	0	8
ULIP Related	0	0	1
TOTAL	**92**	**1**	**285**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	1	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**1**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	143	37.73%
Complaint raised with Insurer not addressed	Others	44	11.61%
Free-look refund not paid	UBP	37	9.76%
Tampering, Corrections, forgery of proposal or related papers	UBP	37	9.76%
Death claim not paid	Dea Cla	24	6.33%
Policy bond not received.	Prop Proc	19	5.01%
Survival Benefit is not paid	Sur Cla	12	3.17%
Maturity claim is not paid	Sur Cla	11	2.90%
Surrender Value not paid	Sur Cla	8	2.11%
Repudiation of Claim	Dea Cla	5	1.32%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	92	24.34%
Partially in favour	1	0.26%
Reject	285	75.40%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	323	85.22%
Others	27	7.12%
Unit Linked Insurance Policy	25	6.60%
Health Insurance Policy	3	0.79%
Pension Policy (other than Unit Linked)	1	0.25%
TOTAL	**379**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Star Union Daichi Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	88	
Received during the period	1811	
Duplicate during the period	13	
Actual during the period	1798	
Attended to during the period	1886	100.00%
Pending as at the end of the period	0	0.00%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1099	61.12%
Policy Servicing	241	13.40%
Proposal Processing	202	11.23%
Survival Claims	158	8.79%
Others	58	3.23%
Death Claims	36	2.00%
ULIP Related	4	0.22%
TOTAL	**1798**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Product differs from what was requested or disclosed.	UBP	269	14.96%
Malpractices or unfair business practices	UBP	262	14.57%
Single premium Policy issued as Annual premium policy	UBP	184	10.23%
Policy bond not received.	Prop Proc	178	9.90%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	178	9.90%
Tampering, Corrections, forgery of proposal or related papers	UBP	111	6.17%
Free-look refund not paid	UBP	96	5.34%
Premium paying period projected is different from actual	UBP	59	3.28%
Complaint raised with Insurer not addressed	Others	53	2.95%
Misappropriation of premiums	UBP	50	2.78%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	12.4

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**104**	**5.78%**
o Registered by IRDAI	95	5.28%
o Email	55	
o Letter	19	
o Telephone	21	
o Registered by Policy Holder	9	0.50%
Complaints Registered in Insurer's portal	**1694**	**94.22%**
TOTAL COMPLAINTS	**1798**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	998	55.51%
Partially in favour	47	2.61%
Reject	753	41.88%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	578	19	502
Policy Servicing	177	15	49
Proposal Processing	118	5	79
Survival Claims	72	4	82
Others	38	0	20
Death Claims	14	4	18
ULIP Related	1	0	3
TOTAL	**998**	**47**	**753**

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	1289	71.69%
Unit Linked Insurance Policy	495	27.53%
Others	13	0.72%
Health Insurance Policy	1	0.06%
TOTAL	**1798**	

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Tata AIA Life
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	3350	
Duplicate during the period	42	
Actual during the period	3308	
Attended to during the period	3308	100.00%
Pending as at the end of the period	0	0.00%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Unfair Business Practices	1450	43.83%
Policy Servicing	751	22.70%
Survival Claims	623	18.83%
Proposal Processing	270	8.16%
ULIP Related	84	2.54%
Others	80	2.42%
Death Claims	50	1.51%
TOTAL	**3308**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Malpractices or unfair business practices	UBP	306	9.25%
Payment of premium not acted upon or wrongly acted upon	Pol Ser	303	9.16%
Tampering, Corrections, forgery of proposal or related papers	UBP	264	7.98%
Surrender Value not paid	Sur Cla	252	7.62%
Free-look refund not paid	UBP	241	7.29%
Spurious calls or Hoax Calls	UBP	232	7.01%
Product differs from what was requested or disclosed.	UBP	175	5.29%
Policy Benefit option not effected	Pol Ser	105	3.17%
Alteration in policy not effected.	Pol Ser	101	3.05%
Policy bond not received.	Prop Proc	100	3.02%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	3.7

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**300**	**9.07%**
o Registered by IRDAI	257	7.77%
o Email	151	
o Letter	51	
o Telephone	55	
o Registered by Policy Holder	43	1.30%
Complaints Registered in Insurer's portal	**3008**	**90.93%**
TOTAL COMPLAINTS	**3308**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	1459	44.11%
Partially in favour	165	4.99%
Reject	1684	50.91%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Unfair Business Practices	732	46	672
Policy Servicing	366	42	343
Survival Claims	186	54	383
Proposal Processing	125	15	130
ULIP Related	31	1	52
Others	14	6	60
Death Claims	5	1	44
TOTAL	**1459**	**165**	**1684**

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Conventional Life Insurance Policy	2039	61.64%
Unit Linked Insurance Policy	950	28.72%
Others	248	7.50%
Health Insurance Policy	42	1.27%
Pension Policy (other than Unit Linked)	29	0.87%
TOTAL	**3308**	

* Out of the total complaints registered during the year

Summary of Grievances 2016-17

(Summary of Complaints, Disposal & Resolution - General Insurers)

1. Aditya Birla Health Insurance Co. Limited
2. Apollo Munich Health Insurance Co Ltd
3. Bajaj Allianz General Insurance Company Ltd
4. Bharti AXA General Insurance Company Limited
5. Cholamandalam MS General Insurance Co. Ltd.
6. Cigna TTK Health Insurance Co. Ltd.
7. Export Credit Guarantee Corporation of India Ltd
8. Future Generali India Insurance Company limited
9. HDFC Ergo General Insurance Company Ltd.
10. ICICI Lombard General Insurance Company Ltd
11. IFFCO TOKIO General Insurance Co. Ltd.
12. Kotak Mahindra General Insurance Company Limited
13. L&T General Insurance Company Limited
14. Liberty Videocon General Insurance Co. Ltd
15. Magma HDI General Insurance Company Ltd.
16. Max Bupa Health Insurance Company Limited
17. National Insurance Company Limited
18. Reliance General Insurance Co Ltd
19. Religare Health Insurance Company Limited
20. Royal Sundaram Alliance Insurance Co. Ltd
21. SBI General Insurance Co. Ltd.
22. Shriram General Insurance Co. Ltd.
23. Star Health And Allied Insurance Company Ltd
24. TATA AIG General Insurance Company Ltd.
25. The New India Assurance Co. Ltd.
26. The Oriental Insurance Company Ltd.
27. United India Insurance Company Limited
28. Universal Sompo General Insurance Co Ltd
29.* Agriculture Insurance Company of India Limited
30.* Raheja QBE General Insurance Company Limited

*** As Nil complaints were pending at the beginning of the year and Nil complaints were reported during the year, summary sheets not kept for these insurers.**

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Aditya Birla Health
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	5	
Duplicate during the period	0	
Actual during the period	5	
Attended to during the period	4	80.00%
Pending as at the end of the period	1	20.00%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	1	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**1**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Product	4	80.00%
Others	1	20.00%
TOTAL	**5**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Product (policy) received by insured is not what it was negotiated at the time of sale.	Product	4	80.00%
Insurer failed to clarify the queries raised by Insured.	Others	1	20.00%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.25

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	2	50.00%
Partially in favour	2	50.00%
Reject	0	0.00%

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**0**	**0.00%**
o Registered by IRDAI	0	0.00%
o Email	0	
o Letter	0	
o Telephone	0	
o Registered by Policy Holder	0	0.00%
Complaints Registered in Insurer's portal	**5**	**100.00%**
TOTAL COMPLAINTS	**5**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Others	0	1	0
Product	2	1	0
TOTAL	**2**	**2**	**0**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Apollo Munich Health
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	4	
Received during the period	1110	
Duplicate during the period	13	
Actual during the period	1097	
Attended to during the period	1081	98.18%
Pending as at the end of the period	20	1.82%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	430	39.20%
Others	326	29.72%
Policy Related	228	20.78%
Premium	46	4.19%
Refund	33	3.01%
Proposal Related	17	1.55%
Coverage	10	0.91%
Product	7	0.64%
TOTAL	**1097**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	8.96

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**601**	**54.79%**
o Registered by IRDAI	492	44.85%
o Email	299	
o Letter	68	
o Telephone	125	
o Registered by Policy Holder	109	9.94%
Complaints Registered in Insurer's portal	**496**	**45.21%**
TOTAL COMPLAINTS	**1097**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	529	49.35%
Partially in favour	38	3.54%
Reject	505	47.11%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	20	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**20**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer failed to clarify the queries raised by Insured.	Others	283	25.80%
Insurer not disposed of the claim	Claim	247	22.52%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	86	7.84%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	51	4.65%
Insured asked for cancellation of policy, Insurer failed to respond	Pol Rel	35	3.19%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	34	3.10%
Insurer repudiated claim due to delay in submission of claim documents by the Insured.	Claim	28	2.55%
Premium paid through electronic modes/cheque not accepted	Premium	25	2.28%
Claim repudiated without giving reasons	Claim	25	2.28%
Refund of premium due under policy not received by Insured.	Refund	24	2.19%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	88	19	310
Others	192	10	121
Policy Related	173	8	38
Premium	33	1	12
Refund	26	0	7
Proposal Related	9	0	8
Coverage	4	0	6
Product	4	0	3
TOTAL	**529**	**38**	**505**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bajaj Allianz General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	49	
Received during the period	917	
Duplicate during the period	0	
Actual during the period	917	
Attended to during the period	959	99.28%
Pending as at the end of the period	7	0.72%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	458	49.95%
Policy Related	242	26.39%
Others	159	17.34%
Premium	21	2.29%
Refund	19	2.07%
Product	10	1.09%
Proposal Related	5	0.55%
Coverage	2	0.22%
Cover Note Related	1	0.11%
TOTAL	**917**	

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**756**	**82.44%**
o Registered by IRDAI	591	64.45%
o Email	317	
o Letter	82	
o Telephone	192	
o Registered by Policy Holder	165	17.99%
Complaints Registered in Insurer's portal	**161**	**17.56%**
TOTAL COMPLAINTS	**917**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	601	66.04%
Partially in favour	114	12.53%
Reject	195	21.43%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	564	61.50%
Others	185	20.17%
Health Insurance	129	14.07%
Fire	30	3.27%
Crop	5	0.55%
Marine Cargo	4	0.44%
TOTAL	**917**	

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	5	71.43%
16 – 30 days	1	14.29%
More than 30 days	1	14.29%
Total Pending	**7**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	317	34.57%
Insurer failed to clarify the queries raised by Insured.	Others	123	13.41%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	68	7.42%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	33	3.60%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	23	2.51%
Claim repudiated without giving reasons	Claim	22	2.40%
Insured asked for cancellation of policy, Insurer failed to respond	Pol Rel	22	2.40%
Refund of premium due under policy not received by Insured.	Refund	16	1.74%
Insurer not given no claim bonus	Others	14	1.53%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	14	1.53%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	26.86

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	219	82	156
Policy Related	222	7	10
Others	119	18	21
Premium	16	1	4
Refund	12	4	2
Product	7	1	1
Proposal Related	3	1	1
Coverage	2	0	0
Cover Note Related	1	0	0
TOTAL	**601**	**114**	**195**

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Bharati Axa General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	37	
Received during the period	3661	
Duplicate during the period	82	
Actual during the period	3579	
Attended to during the period	3609	99.81%
Pending as at the end of the period	7	0.19%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1767	49.37%
Policy Related	1456	40.68%
Others	163	4.55%
Refund	102	2.85%
Premium	34	0.95%
Coverage	19	0.53%
Proposal Related	15	0.42%
Product	15	0.42%
Cover Note Related	8	0.22%
TOTAL	**3579**	

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**341**	**9.53%**
o Registered by IRDAI	269	7.52%
o Email	142	
o Letter	32	
o Telephone	95	
o Registered by Policy Holder	72	2.01%
Complaints Registered in Insurer's portal	**3238**	**90.47%**
TOTAL COMPLAINTS	**3579**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1815	50.81%
Partially in favour	1483	41.52%
Reject	274	7.67%

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	3149	87.99%
Health Insurance	306	8.55%
Others	109	3.05%
Marine Cargo	8	0.22%
Fire	5	0.14%
Crop	1	0.03%
Marine Hull	1	0.03%
TOTAL	**3579**	

* Out of the total complaints registered during the year

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	7	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**7**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Pol Rel	643	17.97%
Insurer not disposed of the claim	Claim	365	10.20%
Difference between assessed loss and amount settled by Insurer.	Claim	318	8.89%
Surveyor delayed issue of his report.	Claim	233	6.51%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	204	5.70%
Details shown in policy or Add-on are incorrect.	Pol Rel	186	5.20%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	114	3.19%
In the renewal policy, Insurer changed the terms & conditions without informing the Insured	Pol Rel	94	2.63%
Insurer asking for irrelevant claim documents	Claim	81	2.26%
Survey report copy not issued to the Insured by the surveyor.	Claim	78	2.18%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.81

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	284	1241	242
Policy Related	1261	170	20
Others	110	43	8
Refund	91	9	2
Premium	28	5	1
Coverage	14	4	1
Proposal Related	12	3	0
Product	8	7	0
Cover Note Related	7	1	0
TOTAL	**1815**	**1483**	**274**

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Cholamandalam MS General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	10	
Received during the period	1673	
Duplicate during the period	3	
Actual during the period	1670	
Attended to during the period	1677	99.82%
Pending as at the end of the period	3	0.18%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	3	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**3**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	828	49.58%
Policy Related	698	41.80%
Others	109	6.53%
Refund	19	1.14%
Product	4	0.24%
Cover Note Related	4	0.24%
Premium	4	0.24%
Coverage	3	0.18%
Proposal Related	1	0.06%
TOTAL	**1670**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Pol Rel	591	35.39%
Insurer not disposed of the claim	Claim	460	27.54%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	254	15.21%
TPA not sent ID card to Insured.	Others	71	4.25%
Details shown in policy or Add-on are incorrect.	Pol Rel	49	2.93%
Delay on the part of TPA to arrange claim reimbursement.	Claim	42	2.51%
Insurer failed to clarify the queries raised by Insured.	Others	29	1.74%
Details shown in policy different from the Cover Note.	Pol Rel	26	1.56%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	15	0.90%
Dispute regarding quantum of premium refund.	Refund	12	0.72%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	1.78

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**162**	**9.70%**
o Registered by IRDAI	140	8.38%
o Email	64	
o Letter	33	
o Telephone	43	
o Registered by Policy Holder	22	1.32%
Complaints Registered in Insurer's portal	**1508**	**90.30%**
TOTAL COMPLAINTS	**1670**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	1344	80.62%
Partially in favour	199	11.94%
Reject	124	7.44%

* Out of the total complaints registered during the year

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	553	169	104
Policy Related	670	16	11
Others	91	12	6
Refund	18	0	1
Product	3	0	1
Cover Note Related	4	0	0
Premium	2	1	1
Coverage	2	1	0
Proposal Related	1	0	0
TOTAL	**1344**	**199**	**124**

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	1214	72.69%
Health Insurance	379	22.69%
Others	40	2.40%
Fire	33	1.98%
Engineering	3	0.18%
Marine Cargo	1	0.06%
TOTAL	**1670**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Cigna TTK Health
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	6	
Received during the period	1043	
Duplicate during the period	23	
Actual during the period	1020	
Attended to during the period	1018	99.22%
Pending as at the end of the period	8	0.78%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	8	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**8**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Others	665	65.20%
Claim	130	12.75%
Policy Related	90	8.82%
Refund	73	7.16%
Proposal Related	34	3.33%
Product	20	1.96%
Premium	7	0.69%
Coverage	1	0.10%
TOTAL	**1020**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Alleged misconduct of officials of Insurer.	Others	459	45.00%
Insurer failed to clarify the queries raised by Insured.	Others	176	17.25%
Refund of premium due under policy not received by Insured.	Refund	69	6.76%
Delay on the part of TPA to arrange claim reimbursement.	Claim	43	4.22%
Insurer not disposed of the claim	Claim	41	4.02%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	26	2.55%
Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	Product	18	1.76%
Insured asked for cancellation of policy, Insurer failed to respond	Pol Rel	18	1.76%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	16	1.57%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	16	1.57%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.77

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**233**	**22.84%**
o Registered by IRDAI	190	18.63%
o Email	107	
o Letter	19	
o Telephone	64	
o Registered by Policy Holder	43	4.22%
Complaints Registered in Insurer's portal	**787**	**77.16%**
TOTAL COMPLAINTS	**1020**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED*		
In favour	388	38.30%
Partially in favour	32	3.16%
Reject	593	58.54%

* Out of the total complaints registered during the

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Others	179	28	458
Claim	44	3	80
Policy Related	70	0	19
Refund	63	0	9
Proposal Related	24	1	9
Product	5	0	13
Premium	2	0	5
Coverage	1	0	0
TOTAL	**388**	**32**	**593**

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ECGC of India
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	55	
Received during the period	8	
Duplicate during the period	0	
Actual during the period	8	
Attended to during the period	11	17.46%
Pending as at the end of the period	52	82.54%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	5	62.50%
Proposal Related	2	25.00%
Others	1	12.50%
TOTAL	**8**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	191.17

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**8**	**100.00%**
o Registered by IRDAI	5	62.50%
o Email	1	
o Letter	3	
o Telephone	1	
o Registered by Policy Holder	3	37.50%
Complaints Registered in Insurer's portal	**0**	**0.00%**
TOTAL COMPLAINTS	**8**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	0	0	3
Proposal Related	0	0	2
Others	0	0	1
	0	0	0
TOTAL	**0**	**0**	**6**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	0.00%
16 – 30 days	1	1.92%
More than 30 days	51	98.08%
Total Pending	**52**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	3	37.50%
Insurer accepted premium and then rejected the proposal	Pro Rel	2	25.00%
Insurer failed to clarify the queries raised by Insured.	Others	1	12.50%
Claim repudiated without giving reasons	Claim	1	12.50%
Insurer asking for irrelevant claim documents	Claim	1	12.50%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	0	0.00%
Partially in favour	0	0.00%
Reject	6	100.00%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	
Others	4	50.00%
Credit	3	37.50%
Crop	1	12.50%
TOTAL	**8**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Future Generali India
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	2109	
Duplicate during the period	34	
Actual during the period	2075	
Attended to during the period	2073	99.86%
Pending as at the end of the period	3	0.14%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	816	39.33%
Claim	708	34.12%
Proposal Related	243	11.71%
Others	174	8.39%
Cover Note Related	57	2.75%
Product	41	1.98%
Premium	20	0.96%
Refund	14	0.67%
Coverage	2	0.10%
TOTAL	**2075**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	3.55

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**190**	**9.16%**
o Registered by IRDAI	154	7.42%
o Email	68	
o Letter	30	
o Telephone	56	
o Registered by Policy Holder	36	1.73%
Complaints Registered in Insurer's portal	**1885**	**90.84%**
TOTAL COMPLAINTS	**2075**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	697	9	109
Claim	224	25	458
Proposal Related	78	6	159
Others	50	0	124
Cover Note Related	25	0	32
Product	9	0	31
Premium	4	0	16
Refund	8	0	6
Coverage	1	0	1
TOTAL	**1096**	**40**	**936**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	3	100.00%
16 – 30 days	0	0.0%
More than 30 days	0	0.00%
Total Pending	**3**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer refused to renew the policy without giving any reasons.	Pol Rel	339	16.34%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	270	13.01%
Insurer not disposed of the claim	Claim	221	10.65%
Insured does not know the scope of coverage and other terms where Proposal form was filled up by Agent	Pro Rel	213	10.27%
Difference between assessed loss and amount settled by Insurer.	Claim	186	8.96%
Insured asked for cance-llation of policy, Insurer failed to respond	Pol Rel	65	3.13%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	62	2.99%
Claim repudiated without giving reasons	Claim	53	2.55%
Cover Note not received	C N R	51	2.46%
Insurer failed to clarify the queries raised by Insured.	Others	47	2.27%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	1096	52.90%
Partially in favour	40	1.93%
Reject	936	45.17%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	1779	85.73%
Others	142	6.84%
Health Insurance	94	4.53%
Fire	46	2.22%
Marine Cargo	14	0.67%
TOTAL	**2075**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - HDFC ERGO General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	16	
Received during the period	2922	
Duplicate during the period	22	
Actual during the period	2900	
Attended to during the period	2916	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1405	48.45%
Policy Related	1060	36.55%
Others	328	11.31%
Refund	49	1.69%
Proposal Related	18	0.62%
Premium	13	0.45%
Product	12	0.41%
Cover Note Related	12	0.41%
Coverage	3	0.10%
TOTAL	**2900**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.59

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**577**	**19.90%**
o Registered by IRDAI	459	15.83%
o Email	235	
o Letter	69	
o Telephone	155	
o Registered by Policy Holder	118	4.07%
Complaints Registered in Insurer's portal	**2323**	**80.10%**
TOTAL COMPLAINTS	**2900**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	336	60	1009
Policy Related	1003	18	39
Others	133	10	185
Refund	38	0	11
Proposal Related	13	0	5
Premium	6	0	7
Product	6	1	5
Cover Note Related	11	0	1
Coverage	1	1	1
TOTAL	**1547**	**90**	**1263**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	832	28.69%
Insurer not disposed of the claim	Claim	511	17.62%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	324	11.17%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	189	6.52%
Insurer asking for irrelevant claim documents	Claim	179	6.17%
Insured asked for cancell-ation of policy, Insurer failed to respond	Pol Rel	87	3.00%
TPA not sending pre-autho-rization to the Hospital	Others	79	2.72%
Complaint of Insured relating to pre-inspection / pre-acceptance survey	Others	66	2.28%
Insurer cancelled policy arbit-rarily without serving notice	Pol Rel	59	2.03%
Insurer failed to clarify the queries raised by Insured.	Others	48	1.66%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED*		
In favour	1547	53.34%
Partially in favour	90	3.10%
Reject	1263	43.55%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	%
Motor Insurance	1407	48.52%
Health Insurance	1130	38.97%
Others	308	10.62%
Fire	25	0.86%
Crop	15	0.52%
Engineering	10	0.34%
Marine Cargo	5	0.17%
TOTAL	**2900**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - ICICI Lombard General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	90	
Received during the period	3822	
Duplicate during the period	235	
Actual during the period	3587	
Attended to during the period	3589	97.61%
Pending as at the end of the period	88	2.39%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Policy Related	1319	36.77%
Claim	1054	29.38%
Others	941	26.23%
Premium	207	5.77%
Refund	31	0.86%
Proposal Related	17	0.47%
Product	15	0.42%
Coverage	3	0.08%
TOTAL	**3587**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	9.47

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**1157**	**32.26%**
o Registered by IRDAI	986	27.49%
o Email	536	
o Letter	147	
o Telephone	303	
o Registered by Policy Holder	171	4.77%
Complaints Registered in Insurer's portal	**2430**	**67.74%**
TOTAL COMPLAINTS	**3587**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Policy Related	1302	0	2
Claim	931	0	79
Others	918	0	9
Premium	200	0	1
Refund	31	0	0
Proposal Related	17	0	0
Product	13	1	0
Coverage	2	0	0
TOTAL	**3414**	**1**	**91**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	88	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**88**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insured asked for cancell-ation of policy, Insurer failed to respond	Pol Rel	1021	28.46%
Insurer not disposed of the claim	Claim	541	15.08%
Alleged misconduct of officials of Insurer.	Others	369	10.29%
Insurer failed to clarify the queries raised by Insured.	Others	204	5.69%
Insurer calculated premium wrongly and over charged the Insured.	Premium	165	4.60%
Alleged misconduct of surveyor / investigator.	Others	128	3.57%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	128	3.57%
Rebating resorted to by Agent.	Others	122	3.40%
Details incomplete in the policy.	Pol Rel	99	2.76%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	94	2.62%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	3414	97.38%
Partially in favour	1	0.03%
Reject	91	2.60%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	1235	34.43%
Health Insurance	1209	33.71%
Others	1122	31.28%
Crop	10	0.28%
Fire	7	0.20%
Marine Cargo	3	0.08%
Engineering	1	0.03%
TOTAL	**3587**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - IFFCO Tokio General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	1796	
Duplicate during the period	15	
Actual during the period	1781	
Attended to during the period	1781	99.94%
Pending as at the end of the period	1	0.06%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1263	70.92%
Policy Related	290	16.28%
Others	169	9.49%
Premium	24	1.35%
Refund	17	0.95%
Coverage	8	0.45%
Proposal Related	4	0.22%
Cover Note Related	4	0.22%
Product	2	0.11%
TOTAL	**1781**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	13.46

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**898**	**50.42%**
o Registered by IRDAI	721	40.48%
o Email	401	
o Letter	108	
o Telephone	212	
o Registered by Policy Holder	177	9.94%
Complaints Registered in Insurer's portal	**883**	**49.58%**
TOTAL COMPLAINTS	**1781**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	576	389	297
Policy Related	247	33	10
Others	103	43	23
Premium	18	5	1
Refund	13	3	1
Coverage	4	3	1
Proposal Related	3	0	1
Cover Note Related	4	0	0
Product	2	0	0
TOTAL	**970**	**476**	**334**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	1	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**1**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	915	51.38%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	197	11.06%
Insurer failed to clarify the queries raised by Insured.	Others	96	5.39%
Difference between assessed loss and amount settled by Insurer.	Claim	42	2.36%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	35	1.97%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	26	1.46%
Insurer closed the claim without advising the Insured any reasons.	Claim	19	1.07%
Delay on the part of TPA to arrange claim reimbursement.	Claim	19	1.07%
Claim repudiated without giving reasons	Claim	18	1.01%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	18	1.01%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	970	54.49%
Partially in favour	476	26.74%
Reject	334	18.76%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	1167	65.52%
Health Insurance	516	28.97%
Others	81	4.55%
Fire	9	0.51%
Marine Cargo	4	0.22%
Marine Hull	2	0.11%
Crop	2	0.11%
TOTAL	**1781**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Kotak General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	26	
Duplicate during the period	1	
Actual during the period	25	
Attended to during the period	23	92.00%
Pending as at the end of the period	2	8.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	17	68.00%
Policy Related	3	12.00%
Others	3	12.00%
Refund	2	8.00%
TOTAL	**25**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.63

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**14**	**56.00%**
o Registered by IRDAI	10	40.00%
o Email	2	
o Letter	0	
o Telephone	8	
o Registered by Policy Holder	4	16.00%
Complaints Registered in Insurer's portal	**11**	**44.00%**
TOTAL COMPLAINTS	**25**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1	2	14
Policy Related	2	0	0
Others	1	0	1
Refund	2	0	0
TOTAL	**6**	**2**	**15**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	2	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**2**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	6	24.00%
Insurer repudiated the claim due to alleged breach of policy condition/ warranty.	Claim	6	24.00%
Difference between assessed loss and amount settled by Insurer.	Claim	1	4.00%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	1	4.00%
Dispute regarding quantum of premium refund.	Refund	1	4.00%
Fraudulent behavior on the part of Agent in claim matter	Others	1	4.00%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	1	4.00%
Insured asked for cancell-ation of policy, Insurer failed to respond	Pol Rel	1	4.00%
Insurer not given no claim bonus	Others	1	4.00%
Insurer repudiated claim due to dispute on premium paid.	Claim	1	4.00%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	6	26.09%
Partially in favour	2	8.70%
Reject	15	65.22%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	22	88.00%
Health Insurance	3	12.00%
TOTAL	**25**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - L&T General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	409	
Duplicate during the period	0	
Actual during the period	409	
Attended to during the period	409	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	216	52.81%
Policy Related	110	26.89%
Others	44	10.76%
Refund	20	4.89%
Proposal Related	11	2.69%
Premium	5	1.22%
Product	2	0.49%
Cover Note Related	1	0.24%
TOTAL	**409**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.39

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**159**	**39.88%**
o Registered by IRDAI	118	28.85%
o Email	75	
o Letter	10	
o Telephone	33	
o Registered by Policy Holder	41	10.02%
Complaints Registered in Insurer's portal	**250**	**61.12%**
TOTAL COMPLAINTS	**409**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	78	5	133
Policy Related	87	0	23
Others	24	1	19
Refund	20	0	0
Proposal Related	1	1	9
Premium	2	0	3
Product	1	0	1
Cover Note Related	1	0	0
TOTAL	**214**	**7**	**188**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
IInsurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	56	13.69%
Insurer not disposed of the claim	Claim	55	13.45%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	47	11.49%
Insurer failed to clarify the queries raised by Insured.	Others	30	7.33%
Difference between assessed loss and amount settled by Insurer.	Claim	24	5.87%
Details shown in policy or Add-on are incorrect.	Pol Rel	19	4.65%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	18	4.40%
Refund of premium due under policy not received by Insured.	Refund	16	3.91%
Dispute on mode of claim settlement-Total loss /cash loss vis-à-vis repair basis.	Claim	10	2.44%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	9	2.20%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	214	52.32%
Partially in favour	7	1.71%
Reject	188	45.97%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	238	58.19%
Health Insurance	149	36.43%
Others	17	4.16%
Fire	4	0.98%
Engineering	1	0.24%
TOTAL	**409**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Liberty Videocon
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	3	
Received during the period	315	
Duplicate during the period	0	
Actual during the period	315	
Attended to during the period	315	99.06%
Pending as at the end of the period	3	0.94%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	161	51.11%
Policy Related	68	21.59%
Others	51	16.19%
Refund	23	7.30%
Product	6	1.90%
Proposal Related	5	1.59%
Coverage	1	0.32%
TOTAL	**315**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	4.95

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**59**	**18.73%**
o Registered by IRDAI	43	13.65%
o Email	15	
o Letter	8	
o Telephone	20	
o Registered by Policy Holder	16	5.08%
Complaints Registered in Insurer's portal	**256**	**81.27%**
TOTAL COMPLAINTS	**315**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	54	2	103
Policy Related	53	1	13
Others	5	0	46
Refund	20	0	3
Product	3	0	3
Proposal Related	3	0	2
Coverage	0	0	1
TOTAL	**138**	**3**	**171**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	3	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**3**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	77	24.44%
Alleged misconduct of surveyor / investigator.	Others	30	9.52%
Insurer repudiated the claim due to alleged breach of policy condition /warranty.	Claim	27	8.57%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	26	8.25%
Refund of premium due under policy not received by Insured.	Refund	19	6.03%
Details shown in policy or Add-on are incorrect.	Pol Rel	15	4.76%
Insurer paid claim to a wrong person.	Claim	12	3.81%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	11	3.49%
Dispute on obsolete factor.	Claim	9	2.86%
Insurer failed to clarify the queries raised by Insured.	Others	8	2.54%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *		
In favour	138	44.23%
Partially in favour	3	0.96%
Reject	171	54.81%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	244	77.46%
Health Insurance	71	22.54%
TOTAL	**315**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Magma HDI General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	113	
Duplicate during the period	0	
Actual during the period	113	
Attended to during the period	96	84.96%
Pending as at the end of the period	17	15.04%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	70	61.95%
Policy Related	20	17.70%
Others	15	13.27%
Premium	4	3.54%
Refund	2	1.77%
Product	2	1.77%
TOTAL	**113**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	14.72

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**31**	**27.43%**
o Registered by IRDAI	29	25.66%
o Email	15	
o Letter	6	
o Telephone	8	
o Registered by Policy Holder	2	1.77%
Complaints Registered in Insurer's portal	**82**	**72.57%**
TOTAL COMPLAINTS	**113**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	29	0	29
Policy Related	17	0	3
Others	13	0	1
Premium	4	0	0
Refund	1	0	1
Product	1	0	1
TOTAL	**65**	**0**	**35**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	2	11.76%
16 – 30 days	0	0.00%
More than 30 days	15	88.24%
Total Pending	**17**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	36	31.86%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	11	9.73%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	8	7.08%
Difference between assessed loss and amount settled by Insurer.	Claim	6	5.31%
Insurer failed to clarify the queries raised by Insured.	Others	6	5.31%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	4	3.54%
Unable to register Grievance due to faulty systems	Others	3	2.65%
Insurer refused to renew thepolicy without giving any reasons.	Pol Rel	3	2.65%
Details shown in policy or Add-on are incorrect.	Pol Rel	3	2.65%
Insurer repudiated the claim due to alleged breach of policy condition/ warranty.	Claim	2	1.77%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED*		
In favour	65	65.00%
Partially in favour	0	0.00%
Reject	35	35.00%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	103	91.15%
Others	9	7.96%
Health Insurance	1	0.88%
TOTAL	**113**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Max Bupa Health
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	814	
Duplicate during the period	12	
Actual during the period	802	
Attended to during the period	802	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	375	46.76%
Others	221	27.56%
Policy Related	51	6.36%
Premium	44	5.49%
Coverage	43	5.36%
Product	25	3.12%
Refund	22	2.74%
Proposal Related	21	2.62%
TOTAL	**802**	

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**340**	**42.39%**
o Registered by IRDAI	273	34.04%
o Email	133	
o Letter	39	
o Telephone	101	
o Registered by Policy Holder	67	8.35%
Complaints Registered in Insurer's portal	**462**	**57.61%**
TOTAL COMPLAINTS	**802**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	79	65	231
Others	95	49	77
Policy Related	25	9	17
Premium	6	8	30
Coverage	10	11	22
Product	9	2	14
Refund	12	2	8
Proposal Related	4	2	15
TOTAL	**240**	**148**	**414**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer failed to clarify the queries raised by Insured.	Others	193	24.06%
Insurer not disposed of the claim	Claim	188	23.44%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	47	5.86%
Insurer repudiated the claim due to alleged breach of policy condition/warranty.	Claim	46	5.74%
Dispute relating to Interp-retation of perils/exclusions /conditions/warranties	Coverage	40	4.99%
Insurer loaded premium arbitrarily	Premium	40	4.99%
TPA refuses to extendcashless facility to the Insured.	Claim	26	3.24%
Product (policy) received by insured is not what it was negotiated at the time of sale.	Product	22	2.74%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	21	2.62%
Insurer accepted premium and then rejected the proposal	Pro Rel	21	2.62%

AVERAGE RESOLUTION RATE	
Average Resolution Rate	5.48

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	240	29.93%
Partially in favour	148	18.45%
Reject	414	51.62%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - National Insurance
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	180	
Received during the period	4680	
Duplicate during the period	0	
Actual during the period	4680	
Attended to during the period	4671	96.11%
Pending as at the end of the period	189	3.89%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	2912	62.22%
Others	1183	25.28%
Policy Related	432	9.23%
Premium	59	1.26%
Refund	39	0.83%
Cover Note Related	23	0.49%
Coverage	15	0.32%
Proposal Related	9	0.19%
Product	8	0.17%
TOTAL	**4680**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	24.15

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**1941**	**41.47%**
o Registered by IRDAI	1491	31.86%
o Email	720	
o Letter	333	
o Telephone	438	
o Registered by Policy Holder	450	9.62%
Complaints Registered in Insurer's portal	**2739**	**58.53%**
TOTAL COMPLAINTS	**4680**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1352	143	1377
Others	836	102	239
Policy Related	326	29	72
Premium	44	4	11
Refund	28	4	6
Cover Note Related	18	3	2
Coverage	10		5
Proposal Related	6		3
Product	2	1	5
TOTAL	**2622**	**286**	**1720**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	14	7.41%
16 – 30 days	12	6.35%
More than 30 days	163	86.24%
Total Pending	**189**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	949	20.28%
Insurer failed to make offer of settlement to Insured after receipt of survey report.	Claim	686	14.66%
Insurer failed to clarify the queries raised by Insured.	Others	595	12.71%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	295	6.30%
Refusal to renew Insurance	Others	295	6.30%
Difference between assessed loss and amount settled by Insurer.	Claim	183	3.91%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	154	3.29%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	153	3.27%
Claim repudiated without giving reasons	Claim	128	2.74%
Delay on the part of TPA to arrange claim reimbursement.	Claim	121	2.59%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	2622	56.66%
Partially in favour	286	6.18%
Reject	1720	37.17%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Health Insurance	2971	63.48%
Motor Insurance	1104	23.59%
Others	435	9.29%
Fire	120	2.56%
Marine Cargo	39	0.83%
Engineering	7	0.15%
Crop	3	0.06%
Marine Hull	1	0.02%
TOTAL	**4680**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Reliance General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	46	
Received during the period	1287	
Duplicate during the period	0	
Actual during the period	1287	
Attended to during the period	1324	99.32%
Pending as at the end of the period	9	0.68%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	803	62.39%
Policy Related	241	18.73%
Others	131	10.18%
Product	60	4.66%
Premium	38	2.95%
Refund	6	0.47%
Coverage	5	0.39%
Proposal Related	3	0.23%
TOTAL	**1287**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	8.12

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**367**	**28.52%**
o Registered by IRDAI	267	20.75%
o Email	108	
o Letter	55	
o Telephone	104	
o Registered by Policy Holder	100	7.77%
Complaints Registered in Insurer's portal	**920**	**71.48%**
TOTAL COMPLAINTS	**1287**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	219	6	577
Policy Related	213	0	25
Others	70	5	56
Product	33	0	26
Premium	24	1	12
Refund	5	0	1
Coverage	2	0	3
Proposal Related	3	0	0
TOTAL	**569**	**12**	**700**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	5	55.56%
16 – 30 days	2	22.22%
More than 30 days	2	22.22%
Total Pending	**9**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Difference between assessed loss and amount settled by Insurer.	Claim	357	27.74%
Insurer not disposed of the claim	Claim	189	14.69%
Details shown in policy different from the Cover Note.	Pol Rel	156	12.12%
Claim repudiated without giving reasons	Claim	120	9.32%
Product (policy) received by insured is not what it was negotiated at the time of sale.	Product	56	4.35%
Delay in conducting survey.	Claim	44	3.42%
Alleged misconduct of officials of Insurer.	Others	43	3.34%
Insurer failed to clarify the queries raised by Insured.	Others	39	3.03%
Insurer calculated premium wrongly and over charged the Insured.	Premium	36	2.80%
Insurer refused to renew the policy without giving any reasons.	Pol Rel	33	2.56%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	569	44.42%
Partially in favour	12	0.94%
Reject	700	54.64%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	986	76.61%
Health Insurance	210	16.32%
Others	70	5.44%
Fire	9	0.70%
Crop	5	0.39%
Marine Cargo	4	0.31%
Marine Hull	2	0.16%
Engineering	1	0.08%
TOTAL	**1287**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Religare Health
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	6	
Received during the period	998	
Duplicate during the period	103	
Actual during the period	895	
Attended to during the period	901	100.00%
Pending as at the end of the period	0	0.00%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	592	66.15%
Policy Related	122	13.63%
Others	59	6.59%
Premium	58	6.48%
Refund	28	3.13%
Proposal Related	18	2.01%
Product	12	1.34%
Coverage	6	0.67%
TOTAL	**895**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	499	55.75%
Insurer failed to clarify the queries raised by Insured.	Others	58	6.48%
Insurer loaded premium arbitrarily	Premium	50	5.59%
Insured asked for cancell-ation of policy, Insurer failed to respond	Pol Rel	35	3.91%
Details shown in policy or Add-on are incorrect.	Pol Rel	30	3.35%
Difference between asse-ssed loss and amount settled by Insurer.	Claim	28	3.13%
Insurer repudiated claim due to “pre-existing disease exclusion”	Claim	22	2.46%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	20	2.23%
Dispute regarding quantum of premium refund.	Refund	19	2.12%
Insurer accepted premium and then rejected the proposal	Pro Rel	15	1.68%

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**345**	**38.55%**
o Registered by IRDAI	263	29.39%
o Email	127	
o Letter	19	
o Telephone	117	
o Registered by Policy Holder	82	9.16%
Complaints Registered in Insurer’s portal	**550**	**61.45%**
TOTAL COMPLAINTS	**895**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	8.52

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	78	6	507
Policy Related	68	1	53
Others	31		28
Premium	6	1	51
Refund	15	0	13
Proposal Related	7	0	11
Product	6	0	6
Coverage	1	0	5
TOTAL	**212**	**8**	**674**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	212	23.71%
Partially in favour	8	0.89%
Reject	674	75.39%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Royal Sundaram Alliance General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	22	
Received during the period	839	
Duplicate during the period	31	
Actual during the period	808	
Attended to during the period	824	99.28%
Pending as at the end of the period	6	0.72%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	402	49.75%
Others	210	25.99%
Policy Related	140	17.33%
Premium	27	3.34%
Refund	15	1.86%
Proposal Related	9	1.11%
Product	4	0.50%
Coverage	1	0.12%
TOTAL	**808**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	6.33

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	378	46.78%
o Registered by IRDAI	315	38.99%
o Email	180	
o Letter	48	
o Telephone	87	
o Registered by Policy Holder	63	7.80%
Complaints Registered in Insurer's portal	**430**	**53.22%**
TOTAL COMPLAINTS	**808**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	113	93	194
Others	113	23	72
Policy Related	97	10	32
Premium	10	3	14
Refund	11	0	4
Proposal Related	2	1	5
Product	1	0	3
Coverage	1	0	0
TOTAL	**348**	**130**	**324**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	6	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**6**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	234	28.96%
Insurer failed to clarify the queries raised by Insured.	Others	158	19.55%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	43	5.32%
Difference between assessed loss and amount settled by Insurer.	Claim	40	4.95%
Details shown in policy or Add-on are incorrect.	Pol Rel	34	4.21%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	24	2.97%
Insurer repudiated claim due to "pre-existing disease exclusion"	Claim	24	2.97%
Insurer loaded premium arbitrarily	Premium	23	2.85%
Refusal to renew Insurance	Others	22	2.72%
Claim repudiated without giving reasons	Claim	16	1.98%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	348	43.39%
Partially in favour	130	16.21%
Reject	324	40.40%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Health Insurance	418	51.73%
Motor Insurance	328	40.59%
Others	56	6.93%
Fire	5	0.62%
Crop	1	0.12%
TOTAL	**808**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - SBI General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	61	
Received during the period	1139	
Duplicate during the period	22	
Actual during the period	1117	
Attended to during the period	1123	95.33%
Pending as at the end of the period	55	4.67%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	560	50.13%
Others	350	31.33%
Policy Related	190	17.01%
Premium	5	0.45%
Proposal Related	4	0.36%
Product	4	0.36%
Refund	3	0.27%
Coverage	1	0.09%
TOTAL	**1117**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	27.9

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**367**	**32.86%**
o Registered by IRDAI	316	28.29%
o Email	126	
o Letter	75	
o Telephone	115	
o Registered by Policy Holder	51	4.57%
Complaints Registered in Insurer's portal	**750**	**67.14%**
TOTAL COMPLAINTS	**1117**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	156	1	362
Others	286	0	58
Policy Related	120	0	64
Premium	2	0	3
Proposal Related	2	0	1
Product	2	0	2
Refund	3	0	0
Coverage	1	0	0
TOTAL	**572**	**1**	**490**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	30	54.55%
16 – 30 days	8	14.55%
More than 30 days	17	30.91%
Total Pending	**55**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Failure of online transaction though premium was deducted through credit card.	Others	273	24.44%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	251	22.47%
Insurer not disposed of the claim	Claim	213	19.07%
Without the consent of Insured Insurer debited customer bank A/c / credit card and issued policy.	Pol Rel	103	9.22%
Insurer failed to clarify the queries raised by Insured.	Others	62	5.55%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	43	3.85%
Difference between assessed loss and amount settled by Insurer.	Claim	21	1.88%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	17	1.52%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	14	1.25%
Details shown in policy or Add-on are incorrect.	Pol Rel	12	1.07%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	572	53.81%
Partially in favour	1	0.09%
Reject	490	46.10%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	509	45.57%
Others	342	30.62%
Health Insurance	154	13.79%
Fire	112	10.03%
TOTAL	**1117**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Shriram General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	231	
Duplicate during the period	17	
Actual during the period	214	
Attended to during the period	214	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	178	83.18%
Policy Related	21	9.81%
Others	12	5.61%
Coverage	1	0.47%
Refund	1	0.47%
Proposal Related	1	0.47%
TOTAL	**214**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	3.23

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**134**	**62.62%**
o Registered by IRDAI	113	52.80%
o Email	30	
o Letter	38	
o Telephone	45	
o Registered by Policy Holder	21	9.81%
Complaints Registered in Insurer's portal	**80**	**37.38%**
TOTAL COMPLAINTS	**214**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	35	66	77
Policy Related	21	0	0
Others	4	4	4
Coverage	0	0	1
Refund	0	0	1
Proposal Related	0	1	0
TOTAL	**60**	**71**	**83**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	118	55.14%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	20	9.35%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	15	7.01%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	7	3.27%
Insurer failed to clarify the queries raised by Insured.	Others	7	3.27%
Difference between assessed loss and amount settled by Insurer.	Claim	6	2.80%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	3	1.40%
Claim repudiated without giving reasons	Claim	3	1.40%
Insurer closed the claim without advising the Insured any reasons.	Claim	3	1.40%
Details shown in policy or Add-on are incorrect.	Pol Rel	2	0.93%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED*		
In favour	60	28.04%
Partially in favour	71	33.18%
Reject	83	38.79%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	202	94.39%
Others	8	3.74%
Health Insurance	2	0.93%
Engineering	1	0.47%
Fire	1	0.47%
TOTAL	**214**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Star Health and Allied
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	93	
Received during the period	6447	
Duplicate during the period	13	
Actual during the period	6434	
Attended to during the period	6490	99.43%
Pending as at the end of the period	37	0.57%

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	37	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**37**	

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	3188	49.55%
Policy Related	2678	41.62%
Refund	369	5.74%
Others	154	2.39%
Premium	16	0.25%
Product	14	0.22%
Proposal Related	11	0.17%
Coverage	4	0.06%
TOTAL	**6434**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Certificate of Insurance / Policy not received by the Insured	Pol Rel	1647	25.60%
Insurer not disposed of the claim	Claim	1419	22.05%
Insurer repudiated the claim due to alleged breach of policy condition/ warranty.	Claim	625	9.71%
Details shown in policy or Add-on are incorrect.	Pol Rel	492	7.65%
Claim repudiated without giving reasons	Claim	414	6.43%
Refund of premium due under policy not received by Insured.	Refund	330	5.13%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	321	4.99%
Delay on the part of TPA to arrange claim reimbursement.	Claim	204	3.17%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	167	2.60%
Difference between assessed loss and amount settled by Insurer.	Claim	133	2.07%

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**784**	**12.19%**
o Registered by IRDAI	603	9.37%
o Email	314	
o Letter	119	
o Telephone	170	
o Registered by Policy Holder	181	2.81%
Complaints Registered in Insurer's portal	**5650**	**87.81%**
TOTAL COMPLAINTS	**6434**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	7.8

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	91	1816	1263
Policy Related	1706	544	416
Refund	228	109	28
Others	33	47	73
Premium	3	2	11
Product	2	8	4
Proposal Related	2	3	5
Coverage	0	0	4
TOTAL	**2065**	**2529**	**1804**

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	2065	32.28%
Partially in favour	2529	39.53%
Reject	1804	28.20%

* Out of the total complaints registered during the year

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Tata-AIG General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	1	
Received during the period	1502	
Duplicate during the period	29	
Actual during the period	1473	
Attended to during the period	1473	99.93%
Pending as at the end of the period	1	0.07%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	461	31.30%
Policy Related	338	22.95%
Coverage	315	21.38%
Others	233	15.82%
Refund	82	5.57%
Product	16	1.09%
Premium	16	1.09%
Proposal Related	11	0.75%
Cover Note Related	1	0.07%
TOTAL	**1473**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	3.49

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**244**	**16.56%**
o Registered by IRDAI	210	14.26%
o Email	101	
o Letter	33	
o Telephone	76	
o Registered by Policy Holder	34	2.31%
Complaints Registered in Insurer's portal	**1229**	**83.44%**
TOTAL COMPLAINTS	**1473**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	162	104	195
Policy Related	273	33	31
Coverage	105	113	97
Others	182	17	34
Refund	62	9	11
Product	11	1	4
Premium	12	3	1
Proposal Related	8	1	2
Cover Note Related	1	0	0
TOTAL	**816**	**281**	**375**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	1	100.00%
16 – 30 days	0	0.00%
More than 30 days	0	0.00%
Total Pending	**1**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Dispute relating to Interpr-etation of perils/exclusions/ conditions/warranties	Coverage	306	20.77%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	223	15.14%
Insurer not disposed of the claim	Claim	172	11.68%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	150	10.18%
Insurer failed to clarify the queries raised by Insured.	Others	92	6.25%
Difference between asses-sed loss and amount settled by Insurer.	Claim	80	5.43%
Failure of online transaction though premium was deducted through credit card.	Others	71	4.82%
Refund of premium due under policy not received by Insured.	Refund	59	4.01%
Endorsement for modification of policy/add on not issued by the Insurer	Pol Rel	39	2.65%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	29	1.97%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	816	55.43%
Partially in favour	281	19.09%
Reject	375	25.48%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Motor Insurance	711	48.27%
Health Insurance	489	33.20%
Others	183	12.42%
Fire	69	4.68%
Marine Cargo	12	0.81%
Crop	9	0.61%
TOTAL	**1473**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - The New India Assurance
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	139	
Received during the period	4301	
Duplicate during the period	93	
Actual during the period	4208	
Attended to during the period	4312	99.19%
Pending as at the end of the period	35	0.81%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	2911	69.18%
Policy Related	670	15.92%
Others	349	8.29%
Premium	115	2.73%
Refund	84	2.00%
Coverage	41	0.97%
Cover Note Related	26	0.62%
Product	8	0.19%
Proposal Related	4	0.10%
TOTAL	**4208**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	17.75

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**1516**	**36.03%**
o Registered by IRDAI	1138	27.04%
o Email	552	
o Letter	262	
o Telephone	324	
o Registered by Policy Holder	378	8.98%
Complaints Registered in Insurer's portal	**2692**	**63.97%**
TOTAL COMPLAINTS	**4208**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED * (Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	1236	201	1443
Policy Related	515	48	103
Others	181	32	131
Premium	82	7	26
Refund	55	3	24
Coverage	30	1	10
Cover Note Related	24	0	2
Product	5	1	2
Proposal Related	1	0	3
TOTAL	**2129**	**293**	**1744**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	19	54.29%
16 – 30 days	8	22.86%
More than 30 days	8	22.86%
Total Pending	**35**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	1378	32.75%
Difference between assessed loss and amount settled by Insurer.	Claim	442	10.50%
Insurer asking for irrelevant claim documents	Claim	312	7.41%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	199	4.73%
Insurer failed to clarify the queries raised by Insured.	Others	161	3.83%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	158	3.75%
Delay on the part of TPA to arrange claim reimbursement.	Claim	133	3.16%
Insurer refused to renew the policy without giving any reasons.	Pol Rel	121	2.88%
Details shown in policy or Add-on are incorrect.	Pol Rel	114	2.71%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	70	1.66%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED*		
In favour	2129	51.10%
Partially in favour	293	7.03%
Reject	1744	41.86%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	**%**
Health Insurance	2018	47.96%
Motor Insurance	1192	28.33%
Others	723	17.18%
Fire	171	4.06%
Engineering	36	0.86%
Marine Cargo	33	0.78%
Credit	30	0.71%
Marine Hull	3	0.07%
Crop	2	0.05%
TOTAL	**4208**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - The Oriental Insurance
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	129	
Received during the period	2725	
Duplicate during the period	52	
Actual during the period	2673	
Attended to during the period	2672	95.36%
Pending as at the end of the period	130	4.64%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	1606	60.08%
Policy Related	449	16.80%
Others	406	15.19%
Premium	169	6.32%
Refund	19	0.71%
Coverage	11	0.41%
Proposal Related	6	0.22%
Cover Note Related	5	0.19%
Product	2	0.07%
TOTAL	**2673**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	40.8

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**2108**	**78.86%**
o Registered by IRDAI	1688	63.15%
o Email	916	
o Letter	375	
o Telephone	397	
o Registered by Policy Holder	420	15.71%
Complaints Registered in Insurer's portal	**565**	**21.14%**
TOTAL COMPLAINTS	**2673**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	614	247	728
Policy Related	324	66	57
Others	201	71	131
Premium	99	25	44
Refund	10	5	4
Coverage	5	3	3
Proposal Related	3	0	3
Cover Note Related	4	0	1
Product	2	0	0
TOTAL	**1262**	**417**	**971**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	23	17.69%
16 – 30 days	11	8.46%
More than 30 days	96	73.85%
Total Pending	**130**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	949	35.50%
Insurer failed to clarify the queries raised by Insured.	Others	239	8.94%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	200	7.48%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	158	5.91%
Delay on the part of TPA to arrange claim reimbursement.	Claim	142	5.31%
Insurer loaded premium arbitrarily	Premium	66	2.47%
Details shown in policy or Add-on are incorrect.	Pol Rel	64	2.39%
Difference between assessed loss and amount settled by Insurer.	Claim	59	2.21%
TPA not sent ID card to Insured.	Others	54	2.02%
Claim repudiated without giving reasons	Claim	52	1.95%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	1262	47.62%
Partially in favour	417	15.74%
Reject	971	36.64%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	
Health Insurance	1933	72.32%
Motor Insurance	409	15.30%
Others	241	9.02%
Fire	69	2.58%
Marine Cargo	19	0.71%
Crop	2	0.07%
TOTAL	**2673**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - United India Insurance
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	22	
Received during the period	7484	
Duplicate during the period	0	
Actual during the period	7484	
Attended to during the period	7394	98.51%
Pending as at the end of the period	112	1.49%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	4667	62.36%
Policy Related	1178	15.74%
Others	1056	14.11%
Premium	259	3.46%
Refund	173	2.31%
Coverage	65	0.87%
Proposal Related	41	0.55%
Cover Note Related	39	0.52%
Product	6	0.08%
TOTAL	**7484**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	20.03

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**1766**	**23.60%**
o Registered by IRDAI	1463	19.55%
o Email	692	
o Letter	398	
o Telephone	373	
o Registered by Policy Holder	303	4.05%
Complaints Registered in Insurer's portal	**5718**	**76.40%**
TOTAL COMPLAINTS	**7484**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	2971	259	1350
Policy Related	1022	36	120
Others	826	42	183
Premium	206	13	40
Refund	125	6	40
Coverage	39	3	22
Proposal Related	37	1	3
Cover Note Related	36	2	1
Product	3	1	2
TOTAL	**5265**	**363**	**1761**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	63	56.25%
16 – 30 days	24	21.43%
More than 30 days	25	22.32%
Total Pending	**112**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	1948	26.03%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	560	7.48%
Delay on the part of TPA to arrange claim reimbursement.	Claim	400	5.34%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	371	4.96%
Difference between assessed loss and amount settled by Insurer.	Claim	351	4.69%
Insurer failed to clarify the queries raised by Insured.	Others	226	3.02%
No response from TPA / Insurer for queries raised / clarifications sought by Insured.	Others	212	2.83%
Details shown in policy or Add-on are incorrect.	Pol Rel	205	2.74%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	186	2.49%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	176	2.35%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	5265	71.25%
Partially in favour	363	4.91%
Reject	1761	23.83%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	
Health Insurance	4439	59.31%
Motor Insurance	1997	26.68%
Others	724	9.67%
Fire	174	2.32%
Marine Cargo	101	1.35%
Engineering	28	0.37%
Crop	10	0.13%
Marine Hull	7	0.09%
Credit	4	0.05%
TOTAL	**7484**	

SUMMARY OF COMPLAINTS, DISPOSAL & RESOLUTION - Unirversal Sompo General
01-Apr-2016 TO 31-Mar-2017

RECEIPT AND DISPOSAL OF COMPLAINTS		
Pending as at beginning	0	
Received during the period	532	
Duplicate during the period	4	
Actual during the period	528	
Attended to during the period	528	100.00%
Pending as at the end of the period	0	0.00%

COMPLAINT TYPE CLASSIFICATION		
Complaint Type	**No. of Complaints**	**%**
Claim	470	89.02%
Policy Related	24	4.55%
Others	23	4.36%
Refund	4	0.76%
Proposal Related	3	0.57%
Coverage	2	0.38%
Premium	2	0.38%
TOTAL	**528**	

AVERAGE RESOLUTION RATE	
Average Resolution Rate	0.33

REGISTRATION & MODE OF RECEIPT OF COMPLAINTS		
Complaints Registered in IGMS Portal	**172**	**32.58%**
o Registered by IRDAI	127	24.05%
o Email	52	
o Letter	37	
o Telephone	38	
o Registered by Policy Holder	45	8.52%
Complaints Registered in Insurer's portal	**356**	**67.42%**
TOTAL COMPLAINTS	**528**	

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED *(Complaint Type wise)			
Complaints Type	**In favour**	**Partially in favour**	**Reject**
Claim	354	0	116
Policy Related	8	0	16
Others	6	0	17
Refund	1	0	3
Proposal Related	0	0	3
Coverage	0	0	2
Premium	0	0	2
TOTAL	**369**	**0**	**159**

PERIOD OF PENDENCY		
Complaints pending as at the end of the period		
Less than 15 days	0	
16 – 30 days	0	
More than 30 days	0	
Total Pending	**0**	

COMPLAINT DESCRIPTION CLASSIFICATION (Top 10)			
Complaint Description Type	**Complaint Type**	**No. of Complaints**	**%**
Insurer not disposed of the claim	Claim	411	77.84%
Insurer failed to clarify the queries raised by Insured.	Others	21	3.98%
Insurer not issued claim cheque inspite of offer of settlement.	Claim	14	2.65%
Certificate of Insurance / Policy not received by the Insured	Pol Rel	11	2.08%
Difference between assessed loss and amount settled by Insurer.	Claim	8	1.52%
Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Claim	7	1.33%
Claim repudiated without giving reasons	Claim	6	1.14%
Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Claim	5	0.95%
Insurer refusing to register claim	Claim	3	0.57%
Refund of premium due under policy not received by Insured.	Refund	3	0.57%

RESOLUTION CLASSIFICATION OF COMPLAINTS DISPOSED DURING THE YEAR *		
In favour	369	69.89%
Partially in favour	0	0.00%
Reject	159	30.11%

* Out of the total complaints registered during the year

POLICY TYPE CLASSIFICATION		
Policy type	**No. of Complaints**	
Motor Insurance	344	65.15%
Health Insurance	110	20.83%
Others	47	8.90%
Fire	24	4.55%
Crop	2	0.38%
Engineering	1	0.19%
TOTAL	**528**	

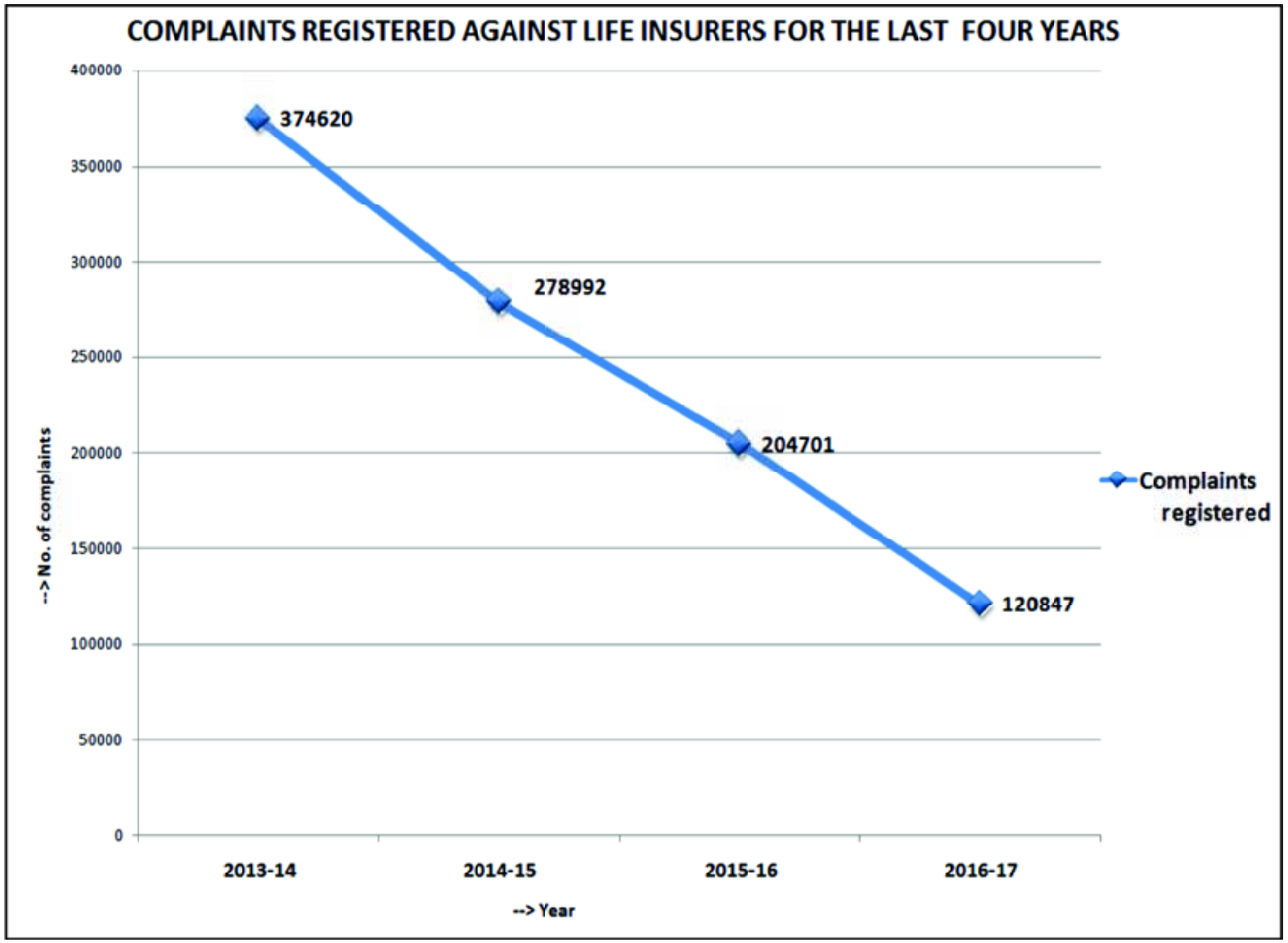
Analysis of the Grievances Reported against Life insurers

1. Cursory glance of complaints registered & 'attended to' by Life Insurers
2. Complaints registered against Life Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of registered Life Complaints – 2015-16
5. Analysis of registered Life Complaints – 2016-17
6. Classification of Life Complaints - Graphical Presentation
7. ULIP Complaints - Graphical Presentation
8. Analysis of Unfair Business Practice Complaints – Policy type wise
9. State-wise Distribution of Complaints - 2015-16
10. State-wise Distribution of Complaints - 2016-17

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY LIFE INSURERS

S. No.	Description	2013-14		2014-15		2015-16		2016-17	
		Registered	Attended to	Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly in IGMS	14472	14183	4903	4423	2977	2930	2836	2817
2	Complaints of the Policyholders registered by IRDAI in IGMS	17333	17113	16462	15359	15859	15698	14411	14356
3	Compliants of the Policyholders registered by Life Insurers	342815	342186	257627	253729	185865	185083	103600	103379
	Total:	**374620**	**373482**	**278992**	**273511**	**204701**	**203711**	**120847**	**120552**

* Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to , which relates to earlier year.


COMPLAINTS REGISTERED AGAINST LIFE INSURERS FOR THE LAST FOUR YEARS
400000
350000
300000
250000
200000
150000
100000
50000
0
--> No. of complaints
374620
278992
204701
120847
2013-14
2014-15
2015-16
2016-17
--> Year
Complaints registered

MOVEMENT OF COMPLAINTS - LIFE INSURERS

S.No	Insurer	2015-16			2016-17					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints	Attended to during the year	Pending at the end of the year
1	LIC	64750	64750	0	0	30784	0	30784	30784	0
(i)	***Public total:***	***64750***	***64750***	***0***	***0***	***30784***	***0***	***30784***	***30784***	***0***
1	Aegon Life	8595	8822	144	144	4384	123	4261	4405	0
2	Aviva	3259	3259	0	0	2596	104	2492	2492	0
3	Bajaj Allianz	14295	14556	14	14	3993	0	3993	4007	0
4	Bharti Axa	4728	5079	0	0	4556	0	4556	4548	8
5	Birla Sun Life	12402	12412	1	1	6356	0	6356	6347	10
6	Canara HSBC	3179	3225	13	13	974	0	974	987	0
7	DHFL Pramerica	1372	2018	7	7	1481	6	1475	1481	1
8	Edleweiss Tokio	627	654	6	6	1038	25	1013	1019	0
9	Exide Life	9375	9968	41	41	6718	312	6406	6447	0
10	Future Generali	7162	7491	52	52	4998	0	4998	5035	15
11	HDFC Standard	11513	13726	85	85	8734	87	8647	8722	10
12	ICICI Prudential	8865	8912	12	12	6723	43	6680	6689	3
13	IDBI Federal	853	853	0	0	679	12	667	667	0
14	India First	1912	2006	24	24	2023	33	1990	1995	19
15	Kotak Mahindra	3444	3326	246	246	3764	23	3741	3882	105
16	Max Life	14157	14161	0	0	8791	0	8791	8791	0
17	PNB MetLife	4411	4398	20	20	4461	78	4383	4333	70
18	Reliance	14024	14345	169	169	5577	619	4958	5127	0
19	Sahara	35	34	1	1	32	0	32	30	3
20	SBI Life	9391	9403	3	3	8387	222	8165	8166	2
21	Shri Ram	259	264	9	9	403	24	379	387	1
22	Star Union Daichi	1825	1832	88	88	1811	13	1798	1886	0
23	Tata AIA	4268	4381	0	0	3350	42	3308	3308	0
(ii)	***Private Total:***	***139951***	***145125***	***935***	***935***	***91829***	***1766***	***90063***	***90751***	***247***
Grand total: (i+ii)		**204701**	**209875**	**935**	**935**	**122613**	**1766**	**120847**	**121535**	**247**

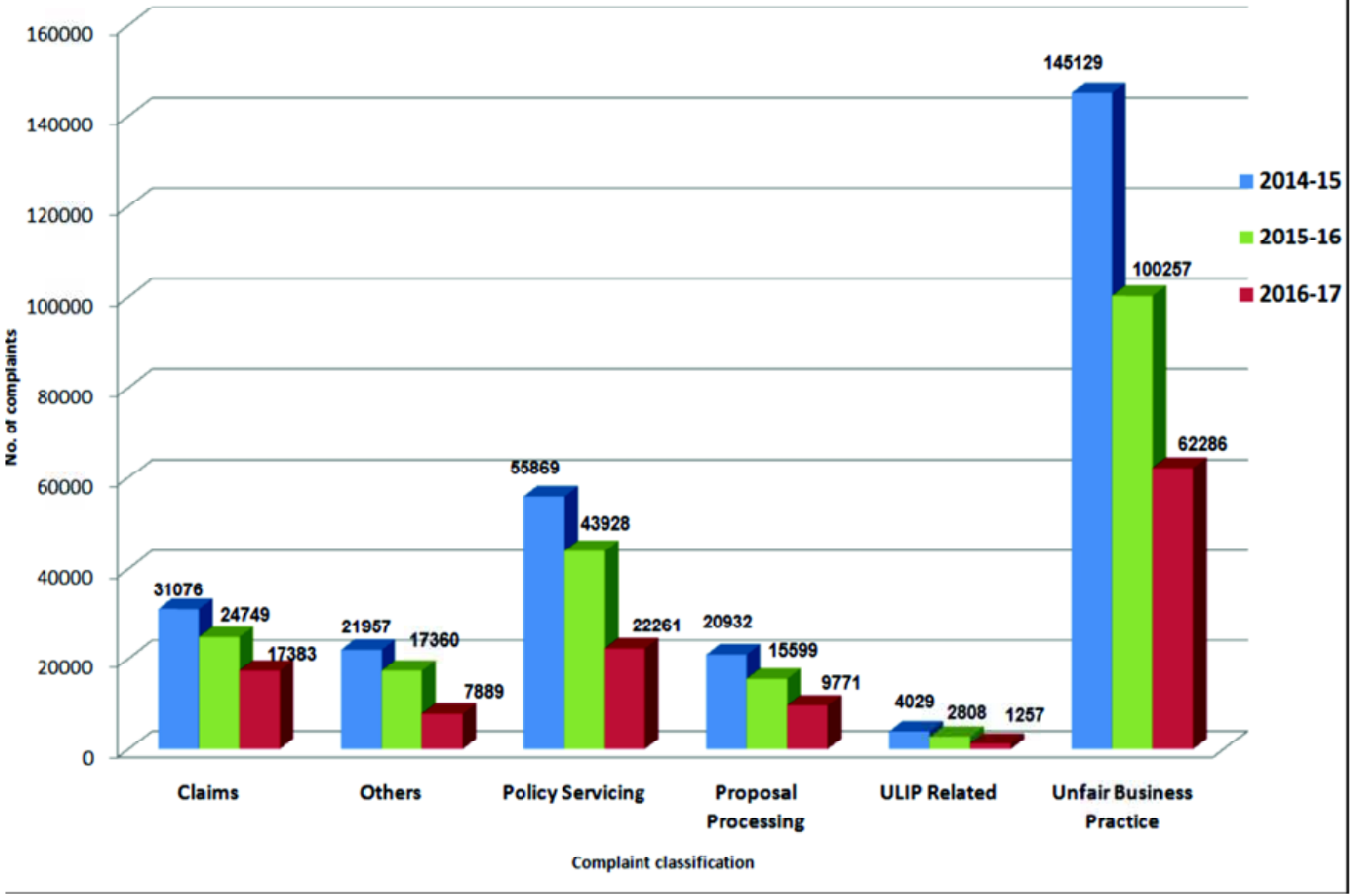
ANALYSIS OF REGISTERED LIFE COMPLAINTS (2015-16)

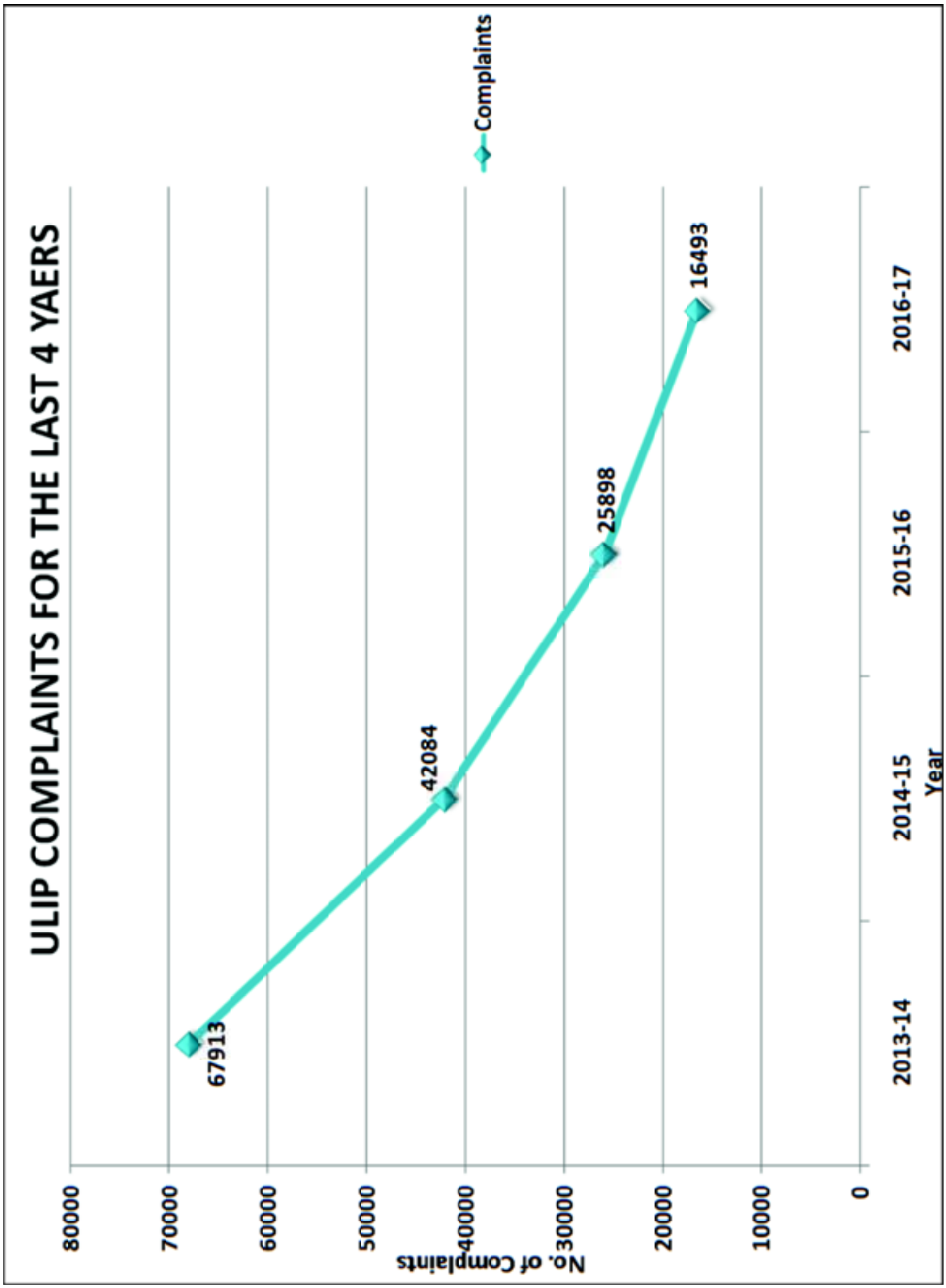
S.No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non-Linked (A)	ULIP (B)	Total (A+B)
1	LIC	1694	29	12963	584	31015	850	3128	104	11374	491	627	1851	40	62025	2725	64750
(i)	*Public total:*	1694	29	12963	584	31015	850	3128	104	11374	491	627	1851	40	62025	2725	64750
1	Aegon Religare	9	0	66	1	406	82	169	2	255	113	6	7401	85	8306	289	8595
2	Aviva	31	3	127	26	726	85	114	29	76	22	93	1921	6	2995	264	3259
3	Bajaj Allianz	128	1	170	19	352	21	157	10	736	58	461	12174	8	13717	578	14295
4	Bharti AXA	25	0	92	6	163	1	209	0	102	1	160	1373	2596	1964	2764	4728
5	Birla Sunlife	94	5	520	85	899	224	362	33	649	211	112	8880	328	11404	998	12402
6	Canara HSBC	2	16	0	0	211	440	284	392	3	406	213	379	833	879	2300	3179
7	DHFL Pramerica	7	2	49	3	63	12	101	13	27	12	0	1019	64	1266	106	1372
8	Edleweiss Tokio	2	0	10	0	47	0	175	0	1	0	4	387	1	622	5	627
9	Exide Life	53	1	282	23	799	65	674	38	881	133	165	6261	0	8950	425	9375
10	Future Generali	47	21	89	28	66	50	584	144	84	74	10	5620	345	6490	672	7162
11	HDFC Standard	101	13	266	29	315	60	792	60	475	72	47	8085	1198	10034	1479	11513
12	ICICI Prudential	109	21	368	16	90	21	90	2	244	49	296	6459	1100	7360	1505	8865
13	IDBI Federal	30	1	24	1	7	0	25	0	18	1	3	581	162	685	168	853
14	IndiaFirst	57	1	14	0	126	32	52	9	144	46	42	1389	0	1782	130	1912
15	Kotak Mahindra	47	3	244	31	196	70	179	21	95	10	62	1917	569	2678	766	3444
16	Max Life	139	10	396	101	1118	940	1763	635	606	280	38	7081	1050	11103	3054	14157
17	PNB MetLife	91	13	19	2	259	159	551	154	195	227	113	1813	815	2928	1483	4411
18	Reliance	233	39	322	28	1184	250	847	65	793	511	132	9175	445	12554	1470	14024
19	Sahara	4	0	3	0	3	1	0	0	19	3	0	2	0	31	4	35
20	SBI Life	159	19	175	46	696	313	2114	1032	683	255	58	2909	932	6736	2655	9391
21	Shri Ram	23	0	36	2	14	0	18	0	17	4	3	141	1	249	10	259
22	Star Union Daichi	19	4	14	8	262	193	103	54	125	162	9	563	309	1086	739	1825
23	Tata AIA	70	26	46	26	732	310	248	63	281	323	154	1582	407	2959	1309	4268
24	*Private Total:*	1480	199	3332	481	8734	3329	9611	2756	6509	2973	2181	87112	11254	116778	23173	139951
	Total [(i) + (ii)]	3174	228	16295	1065	39749	4179	12739	2860	17883	3464	2808	88963	11294	178803	25898	204701
Grand Total		3402		17360		43928		15599		21347		2808	100257		204701		

ANALYSIS OF REGISTERED LIFE COMPLAINTS (2016-17)

S.No	Name of the Insurer	Death Claims		Others		Policy Servicing		Proposal Processing		Survival Claims		ULIP Related	Unfair Business Practice		Total		
		Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP	Non-Linked	ULIP		Non-Linked	ULIP	Non- Linked (A)	ULIP (B)	Total (A+B)
1	LIC	1569	18	4467	200	13586	269	1503	72	7370	265	250	1044	171	29539	1245	30784
(i)	***Public total:***	**1569**	**18**	**4467**	**200**	**13586**	**269**	**1503**	**72**	**7370**	**265**	**250**	**1044**	**171**	**29539**	**1245**	**30784**
1	Aegon Life	5	0	66	3	363	15	104	0	278	9	8	3392	18	**4208**	**53**	**4261**
2	Aviva	15	1	85	24	746	33	58	15	72	4	47	1383	9	**2359**	**133**	**2492**
3	Bajaj Allianz	50	2	174	25	68	22	40	5	281	18	30	3262	16	**3875**	**118**	**3993**
4	Bharti AXA	32	0	138	21	92	8	85	0	61	1	83	1401	2634	**1809**	**2747**	**4556**
5	Birla Sunlife	71	22	265	49	674	208	500	93	377	246	115	3419	317	**5306**	**1050**	**6356**
6	Canara HSBC	2	14	9	1	19	105	6	21	3	68	29	156	541	**195**	**779**	**974**
7	DHFL Pramerica	8	0	68	1	35	8	228	10	45	9	5	1010	48	**1394**	**81**	**1475**
8	Edleweiss Tokio	8	0	26	0	92	0	143	0	4		16	722	2	**995**	**18**	**1013**
9	Exide Life	26	0	106	2	490	19	249	10	256	25	37	5185	1	**6312**	**94**	**6406**
10	Future Generali	42	19	89	31	92	38	195	17	104	74	23	4025	249	**4547**	**451**	**4998**
11	HDFC Standard	170	47	189	4	365	86	551	71	533	176	67	5770	618	**7578**	**1069**	**8647**
12	ICICI Prudential	66	6	487	34	86	25	127	5	213	58	221	4904	448	**5883**	**797**	**6680**
13	IDBI Federal	26	0	23	3	16	1	30	4	12	2	5	476	69	**583**	**84**	**667**
14	IndiaFirst	112	3	16	3	126	62	39	1	94	38	37	1458	1	**1845**	**145**	**1990**
15	Kotak Mahindra	70	2	226	24	507	165	262	50	113	43	44	1906	329	**3084**	**657**	**3741**
16	Max Life	117	14	286	42	523	363	715	194	297	116	9	5113	1002	**7051**	**1740**	**8791**
17	PNB MetLife	73	10	38	1	341	162	462	32	218	132	48	2298	568	**3430**	**953**	**4383**
18	Reliance	109	18	190	15	334	49	686	52	715	247	52	2380	111	**4414**	**544**	**4958**
19	Sahara	2	0	2	1	5	2	1	0	12	3	1	2	1	**24**	**8**	**32**
20	SBI Life	149	12	241	31	783	277	1680	962	721	228	41	2334	706	**5908**	**2257**	**8165**
21	Shri Ram	29	1	43	2	6	3	21	0	20	15	1	235	3	**354**	**25**	**379**
22	Star Union Daichi	32	4	47	11	143	98	167	35	80	78	4	834	265	**1303**	**495**	**1798**
23	Tata AIA	34	16	53	27	577	174	230	40	341	282	84	1123	327	**2358**	**950**	**3308**
24	***Private Total:***	**1248**	**191**	**2867**	**355**	**6483**	**1923**	**6579**	**1617**	**4850**	**1872**	**1007**	**52788**	**8283**	**74815**	**15248**	**90063**
	Total [(i) + (ii)]	**2817**	**209**	**7334**	**555**	**20069**	**2192**	**8082**	**1689**	**12220**	**2137**	**1257**	**53832**	**8454**	**104354**	**16493**	**120847**
Grand Total		**3026**		**7889**		**22261**		**9771**		**14357**		**1257**	**62286**		**120847**		

CLASSIFICATION OF LIFE COMPLAINTS FOR THE LAST THREE YEARS

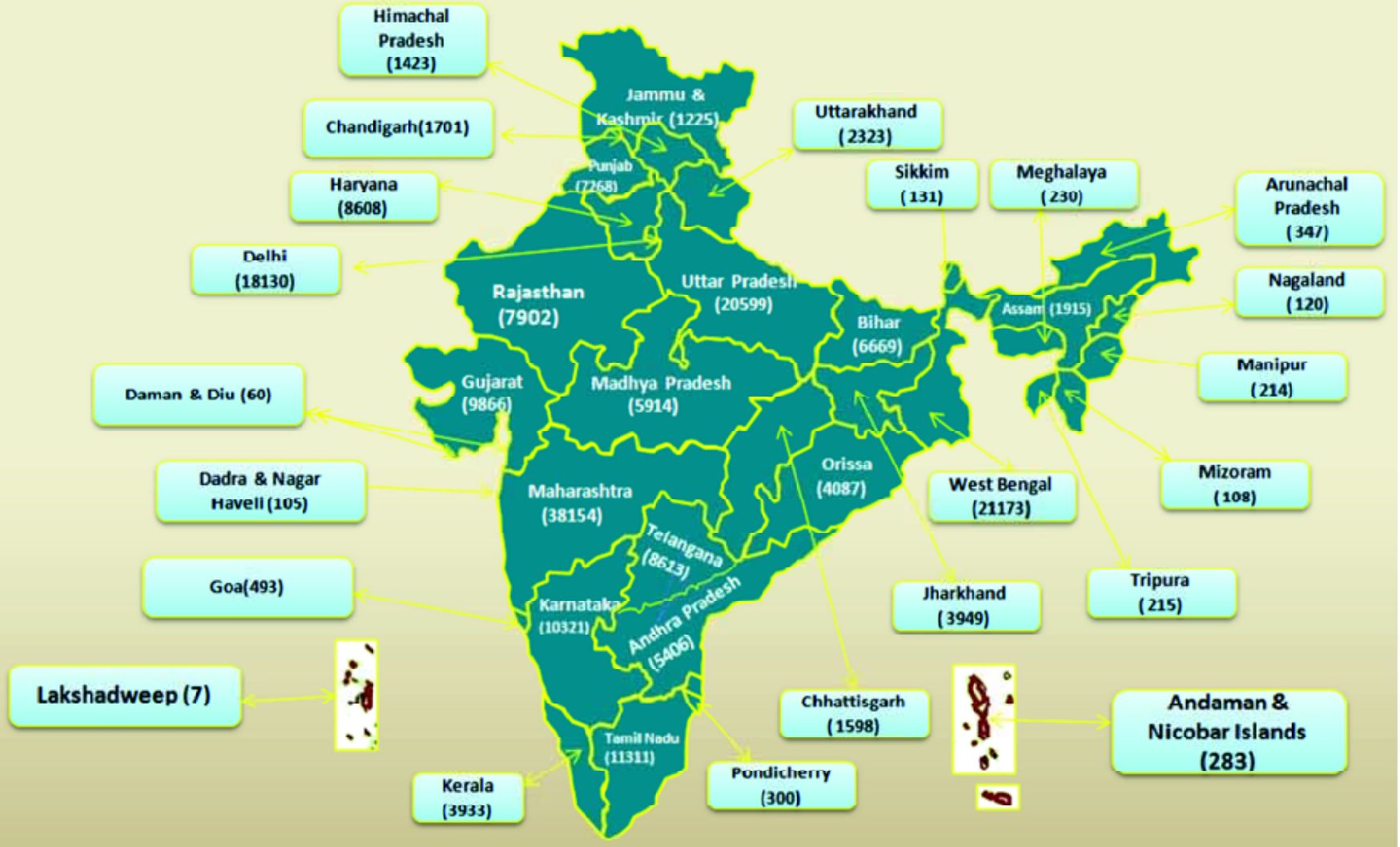



ULIP COMPLAINTS FOR THE LAST 4 YAERS
Complaints
No. of Complaints
80000
70000
60000
50000
40000
30000
20000
10000
0
67913
42084
25898
16493
2013-14
2014-15
2015-16
2016-17
Year

ANALYSIS OF 'UNFAIR BUSINESS PRACTICE' COMPLAINTS FOR THE LAST 3 YEARS - POLICY TYPE WISE

S. No.	Complaint Description	Conventional			Health			Pension			ULIP			Others			Total		
		2016-17	2015-16	2014-15	2016-17	2015-16	2014-15	2016-17	2015-16	2014-15	2016-17	2015-16	2014-15	2016-17	2015-16	2014-15	2016-17	2015-16	2014-15
1	Advice concerning Exclusions/ limitations of cover not communicated	90	60	101	5	2	4	0	3	4	48	38	36	17	21	24	**160**	**124**	**169**
2	Annuity/Commutation/Cash Option / Rider/other Options not included as requested	49	81	74	4	0	2	18	42	40	3	9	16	12	5	23	**86**	**137**	**155**
3	Credit/Debit card debited without consent of Consumer	292	332	321	38	20	8	3	13	4	38	20	45	36	10	19	**407**	**395**	**397**
4	Do Not Call Registry	28	44	93	0	0	0	1	3	3	48	37	117	83	24	65	**160**	**108**	**278**
5	Free-look refund not paid	1624	2745	4340	27	27	54	14	47	86	217	317	997	160	336	983	**2042**	**3472**	**6460**
6	Illegitimate inducements offered	2682	2259	5030	12	11	13	15	18	38	687	590	877	292	863	812	**3688**	**3741**	**6770**
7	Intermediary did not provide material information concerning proposed cover	1424	1734	2936	30	14	29	48	50	51	355	401	812	390	4153	2868	**2247**	**6352**	**6696**
8	Malpractices	20619	29358	35619	163	191	338	266	310	484	4682	6426	9001	6870	13790	17393	**32600**	**50075**	**62835**
9	Misappropriation of premiums	1127	1733	2929	11	22	28	16	23	40	456	602	1057	190	475	617	**1800**	**2855**	**4671**
10	Mode of premium payment differs from requested or disclosed	238	343	574	5	7	12	3	7	12	40	83	131	29	73	119	**315**	**513**	**848**
11	Premium paying period projected is different from actual	982	831	1224	7	4	6	11	17	13	213	300	668	73	195	278	**1286**	**1347**	**2189**
12	Product differs from what was requested or disclosed.	3409	4006	4373	20	49	62	53	60	78	413	615	1053	338	418	526	**4233**	**5148**	**6092**
13	Proposed Insurance not in the interest of proposer	1636	2290	5102	85	28	50	27	26	53	240	330	1263	58	80	153	**2046**	**2754**	**6621**
14	Single premium Policy issued as Annual premium policy	1904	2572	4564	6	4	11	27	27	58	350	610	1377	162	3035	10260	**2449**	**6248**	**16270**
15	Spurious Calls													2946	9089	9994	**2946**	**9089**	**9994**
16	Surrender value projected is different from actual	305	340	516	4	2	1	16	8	17	59	134	417	46	45	88	**430**	**529**	**1039**
17	Tampering, Corrections, forgery of proposal or related papers	4049	5185	9825	16	21	48	40	44	84	570	709	1550	362	845	862	**5037**	**6804**	**12369**
18	Term(Period) of the policy is different/altered without consent	271	431	843	7	2	4	5	12	13	35	73	304	36	48	112	**354**	**566**	**1276**
	Total	**40729**	**54344**	**78464**	**440**	**404**	**670**	**563**	**710**	**1078**	**8454**	**11294**	**19721**	**12100**	**33505**	**45196**	**62286**	**100257**	**145129**

STATE/UT WISE DISTRIBUTION OF COMPLAINTS - LIFE - 2015-16



STATE/UT WISE DISTRIBUTION OF COMPLAINTS - LIFE - 2016-17

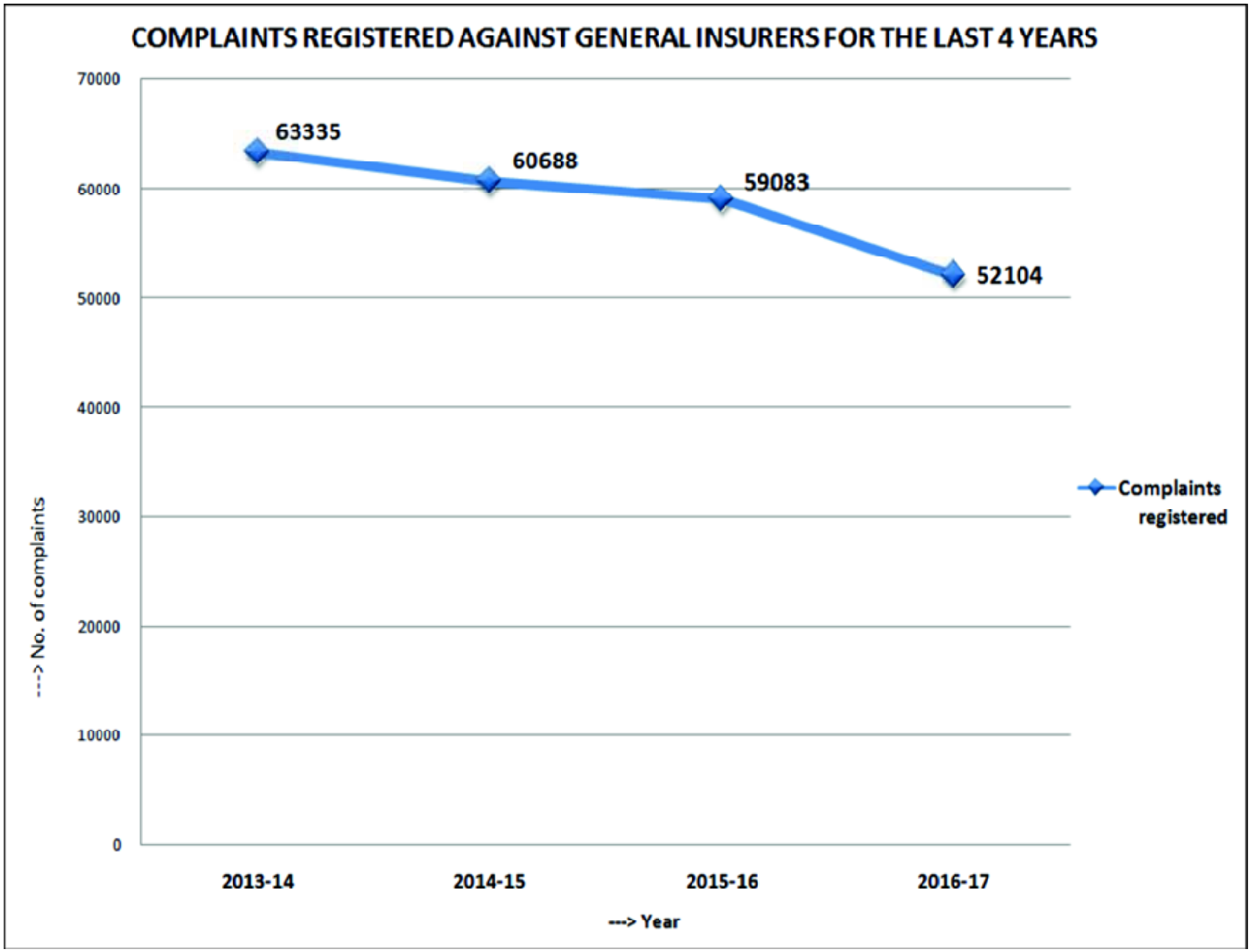
Analysis of the Grievances Reported against General Insurers

1. Cursory glance of complaints registered & 'attended to' by General Insurers
2. Complaints registered against General Insurers - Graphical Presentation
3. Movement of Complaints
4. Analysis of registered General Complaints
5. Classification of General Complaints - Graphical Presentation
6. Policy Type wise General Insurance Industry Complaints
7. Policy Type wise General Insurance Complaints - Graphical Presentation
8. Analysis of Health Insurance Complaints
9. Analysis of Motor Insurance Complaints
10. State-wise Distribution of Complaints – 2015-16
11. State-wise Distribution of Complaints – 2016-17

CURSORY GLANCE OF COMPLAINTS REGISTERED AND ATTENDED TO BY GENERAL INSURERS

S. No.	Description	2013-14		2014-15		2015-16		2016-17	
		Registered	Attended to	Registered	Attended to	Registered	Attended to	Registered	Attended to
1	Complaints registered by Policyholders directly in IGMS	4181	4031	2787	2612	2457	2337	3173	3008
2	Complaints of the Policyholders registered by IRDAI in IGMS	6697	6540	7260	6816	10355	10027	12474	12194
3	Compliants of the Policyholders registered by Life Insurers	52457	52096	50641	49352	46271	45862	36457	36225
	Total:	**63335**	**62667**	**60688**	**58780**	**59083**	**58226**	**52104**	**51427**

*** Complaints 'Attended to' refers to the cases registered during the year and does not include complaints that were attended to , which relates to earlier year.**


COMPLAINTS REGISTERED AGAINST GENERAL INSURERS FOR THE LAST 4 YEARS
70000
60000
50000
40000
30000
20000
10000
0
---> No. of complaints
63335
60688
59083
52104
2013-14
2014-15
2015-16
2016-17
---> Year
Complaints registered

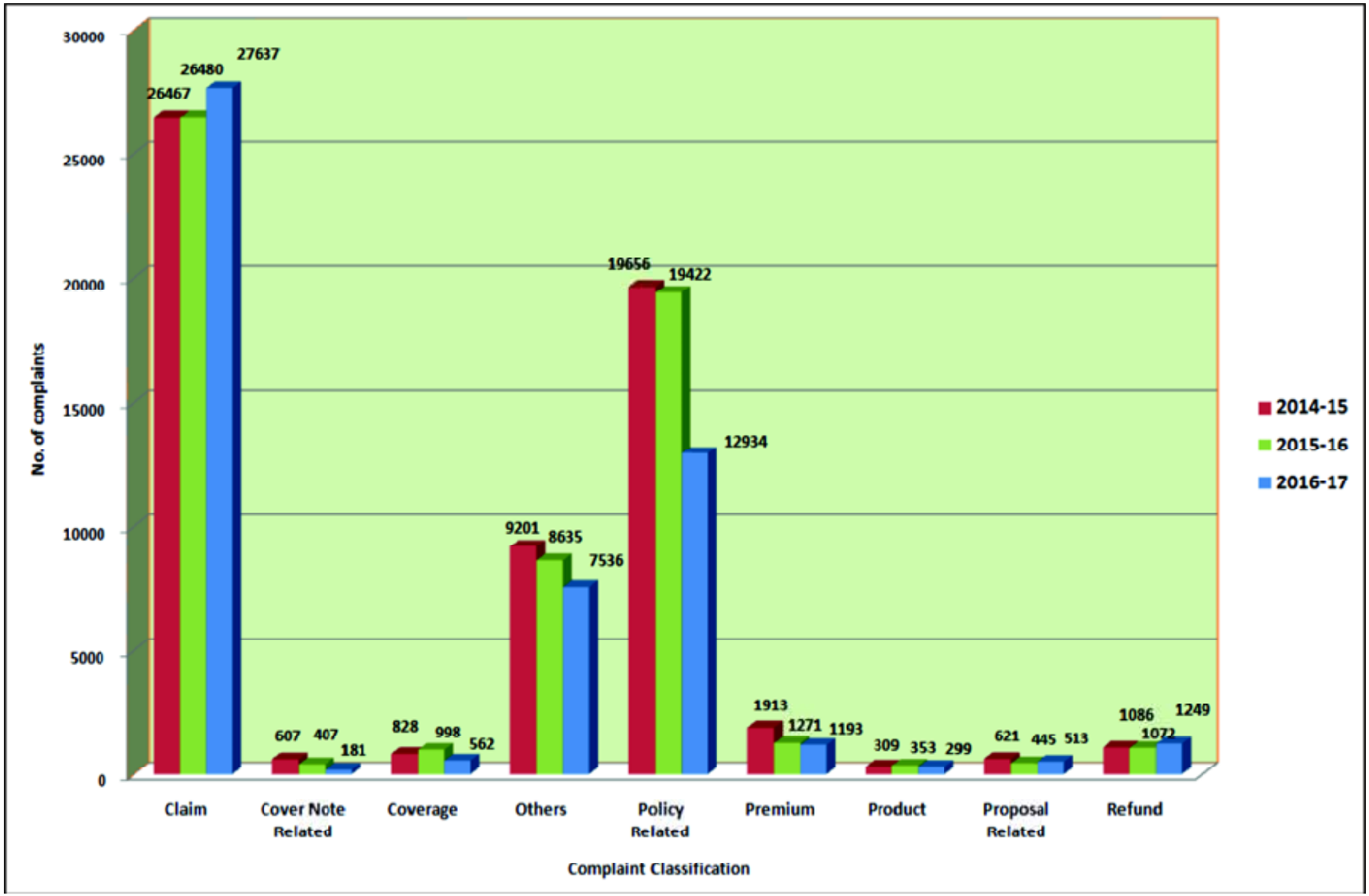
MOVEMENT OF COMPLAINTS - GENERAL INSURERS

S.No	Name of the Insurer	2015-16			2016-17					
		Reported during the year	Attended to during the year	Pending at the end of the year	Opening Balance	Reported during the year	Duplicate Complaints	Actual Complaints	Attended to during the year	Pending at the end of the year
1	Agriculture Insurance*	-	-	-	-	-	-	-	-	-
2	ECGC of India	10	1	55	55	8	0	8	11	**52**
3	National Insurance	4933	4928	180	180	4680	0	4680	4671	**189**
4	The New India Assurance	4087	4050	139	139	4301	93	4208	4312	**35**
5	The Oriental Insurance	2555	2485	129	129	2725	52	2673	2672	**130**
6	United India Insurance	6221	6254	22	22	7484	0	7484	7394	**112**
(i)	**Total - PSU insurers**	***17806***	***17718***	**525**	**525**	***19198***	***145***	***19053***	***19060***	***518***
1	Aditya Birla Health				0	5	0	5	4	**1**
2	Apollo MUNICH Health Insurace	978	987	4	4	1110	13	1097	1081	**20**
3	Bajaj Allianz General Insurance	1756	1911	49	49	917	0	917	959	**7**
4	Bharati Axa General Insurance	4198	4266	37	37	3661	82	3579	3609	**7**
5	Cholamandalam MS General Insurance	2163	2256	10	10	1673	3	1670	1677	**3**
6	CignaTTK Health Insurance	334	332	6	6	1043	23	1020	1018	**8**
7	Future Generali India Ins.	4251	4250	1	1	2109	34	2075	2073	**3**
8	HDFC ERGO General Insurance	2879	2886	16	16	2922	22	2900	2916	**0**
9	ICICI Lombard General Insurance	4974	5256	90	90	3822	235	3587	3589	**88**
10	IFFCO Tokio General Insurance	1355	1517	1	1	1796	15	1781	1781	**1**
11	Kotak General Insurance	0	0	0	0	26	1	25	23	**2**
12	L&T General. Insurance	335	340	0	0	409	0	409	409	**0**
13	Liberty Videocon Genral Insurance	524	527	3	3	315	0	315	315	**3**
14	Magma HDI General Insurance	151	160	0	0	113	0	113	96	**17**
15	Max Bupa Health Insurance	620	620	0	0	814	12	802	802	**0**
16	Raheja QBE	0	0	0	0	0	0	0	0	**0**
17	Reliance General Insurance	1500	1521	46	46	1287	0	1287	1324	**9**
18	Religare Health Insurance	564	560	6	6	998	103	895	901	**0**
19	Royal Sundaram Alliance General Insurance	2551	2595	22	22	839	31	808	824	**6**
20	SBI General Insurance	1136	1392	61	61	1139	22	1117	1123	**55**
21	Shriram General Insurance	120	120	0	0	231	17	214	214	**0**
22	Star Health and Allied Insurance	7093	7166	93	93	6447	13	6434	6490	**37**
23	Tata- AIG General Insurance	3422	3458	1	1	1502	29	1473	1473	**1**
24	Universal Sompo General Ins	373	373	0	0	532	4	528	528	**0**
(ii)	**Total Private Insurers**	***41277***	***42493***	**446**	**446**	***33710***	***659***	***33051***	***33229***	***268***
Grand Total [(i)+(ii)]		**59083**	**60211**	**971**	**971**	**52908**	**804**	**52104**	**52289**	**786**

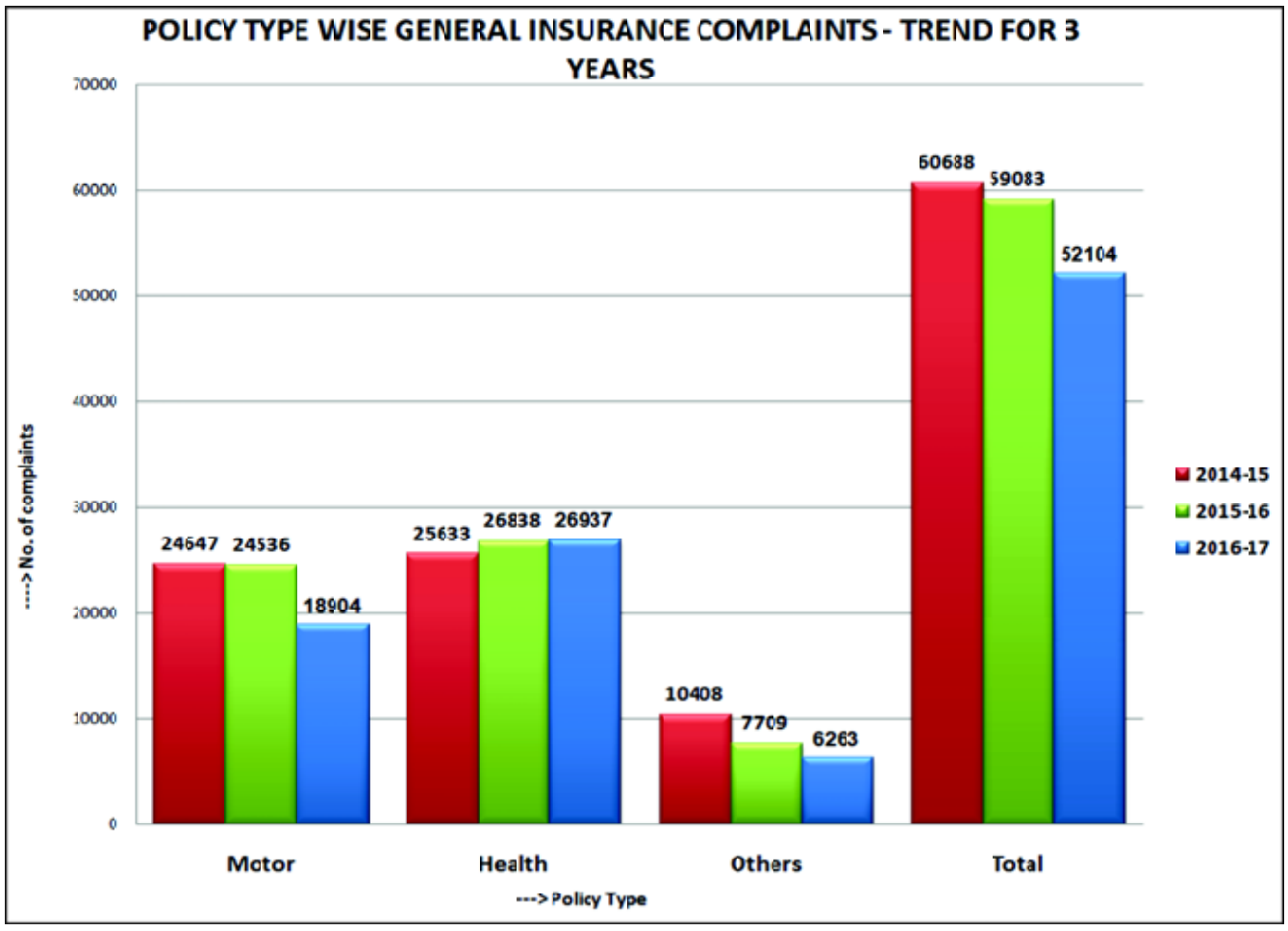
ANALYSIS OF THE REGISTERED GENERAL INSURANCE COMPLAINTS

S. No.	Name of the Insurer	Claim		Cover Note Related		Coverage		Others		Policy Related		Premium		Product		Proposal Related		Refund		Total	
		2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17
1	Agriculture Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2	ECGC of India	4	5	0	0	0		4	1	0		1		0		1	2	0		**10**	**8**
3	National Insurance	2876	2912	37	23	38	15	1376	1183	474	432	63	59	15	8	9	9	45	39	**4933**	**4680**
4	The New India Assurance	2747	2911	30	26	26	41	344	349	784	670	80	115	4	8	17	4	55	84	**4087**	**4208**
5	The Oriental Insurance	1514	1606	7	5	9	11	366	406	429	449	155	169	5	2	11	6	59	19	**2555**	**2673**
6	United India Insurance	3581	4667	59	39	64	65	804	1056	1262	1178	256	259	9	6	24	41	162	173	**6221**	**7484**
	(i) Total - PSU insurers	**10722**	**12101**	**133**	**93**	**137**	**132**	**2894**	**2995**	**2949**	**2729**	**555**	**602**	**33**	**24**	**62**	**62**	**321**	**315**	**17806**	**19053**
1	Aditya Birla Health		0		0		0		1		0		0		4		0		0		**5**
2	Apollo MUNICH Health Insurace	479	430	0		10	10	154	326	253	228	29	46	9	7	27	17	17	33	**978**	**1097**
3	Bajaj Allianz General Insurance	435	458	60	1	6	2	119	159	1049	242	34	21	9	10	35	5	9	19	**1756**	**917**
4	Bharati Axa General Insurance	2112	1767	15	8	35	19	136	163	1716	1456	43	34	8	15	22	15	111	102	**4198**	**3579**
5	Cholamandalam MS General	741	828	25	4	4	3	224	109	1087	698	5	4	8	4	1	1	68	19	**2163**	**1670**
6	CignaTTK Health	25	130	0		0	1	250	665	32	90	3	7	1	20	2	34	21	73	**334**	**1020**
7	Future Generali India Ins.	1980	708	115	57	1	2	319	174	1475	816	19	20	171	41	153	243	18	14	**4251**	**2075**
8	HDFC ERGO General Insurance	1592	1405	47	12	2	3	284	328	878	1060	7	13	10	12	9	18	50	49	**2879**	**2900**
9	ICICI Lombard General Insurance	1233	1054	2		10	3	1081	941	2262	1319	319	207	10	15	12	17	45	31	**4974**	**3587**
10	IFFCO Tokio General Insurance	759	1263	6	4	12	8	183	169	338	290	15	24	4	2	3	4	35	17	**1355**	**1781**
11	Kotak General Insurance		17		0		0		3		3		0		0		0		2		**25**
12	L&T General. Insurance	100	216	0	1	9		58	44	116	110	3	5	1	2	21	11	27	20	**335**	**409**
13	Liberty Videocon General	391	161	0		0	1	19	51	103	68	2		0	6	1	5	8	23	**524**	**315**
14	Magma HDI General Insurance	96	70	0		0		23	15	24	20	2	4	3	2	1		2	2	**151**	**113**
15	Max Bupa Health Insurance	330	375	0		3	43	217	221	25	51	21	44	7	25	11	21	6	22	**620**	**802**
16	Raheja QBE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
17	Reliance General Insurance	767	803	2		3	5	360	131	284	241	28	38	32	60	10	3	14	6	**1500**	**1287**
18	Religare Health Insurance	338	592	0		1	6	129	59	27	122	9	58	1	12	27	18	32	28	**564**	**895**
19	Royal Sundaram Alliance General Insurance	893	402	0		4	1	339	210	1220	140	48	27	23	4	4	9	20	15	**2551**	**808**
20	SBI General Insurance	465	560	0		0	1	307	350	325	190	9	5	3	4	4	4	23	3	**1136**	**1117**
21	Shriram General Insurance	85	178	1		0	1	7	12	24	21	0		1			1	2	1	**120**	**214**
22	Star Health and Allied Insurance	1634	3188	0		1	4	1151	154	4111	2678	68	16	2	14	25	11	101	369	**7093**	**6434**
23	Tata- AIG General Insurance	981	461	1	1	760	315	370	233	1093	338	45	16	15	16	15	11	142	82	**3422**	**1473**
24	Universal Sompo General Ins	322	470	0		0	2	11	23	31	24	7	2	2		0	3	0	4	**373**	**528**
	Total Private Insurers	***15758***	***15536***	***274***	***88***	***861***	***430***	***5741***	***4541***	***16473***	***10205***	***716***	***591***	***320***	***275***	***383***	***451***	***751***	***934***	***41277***	***33051***
	Grand Total [(i)+(ii)]	**26480**	**27637**	**407**	**181**	**998**	**562**	**8635**	**7536**	**19422**	**12934**	**1271**	**1193**	**353**	**299**	**445**	**513**	**1072**	**1249**	**59083**	**52104**

CLASSIFICATION OF GENERAL INSURANCE COMPLAINTS FOR THE LAST 3 YEARS



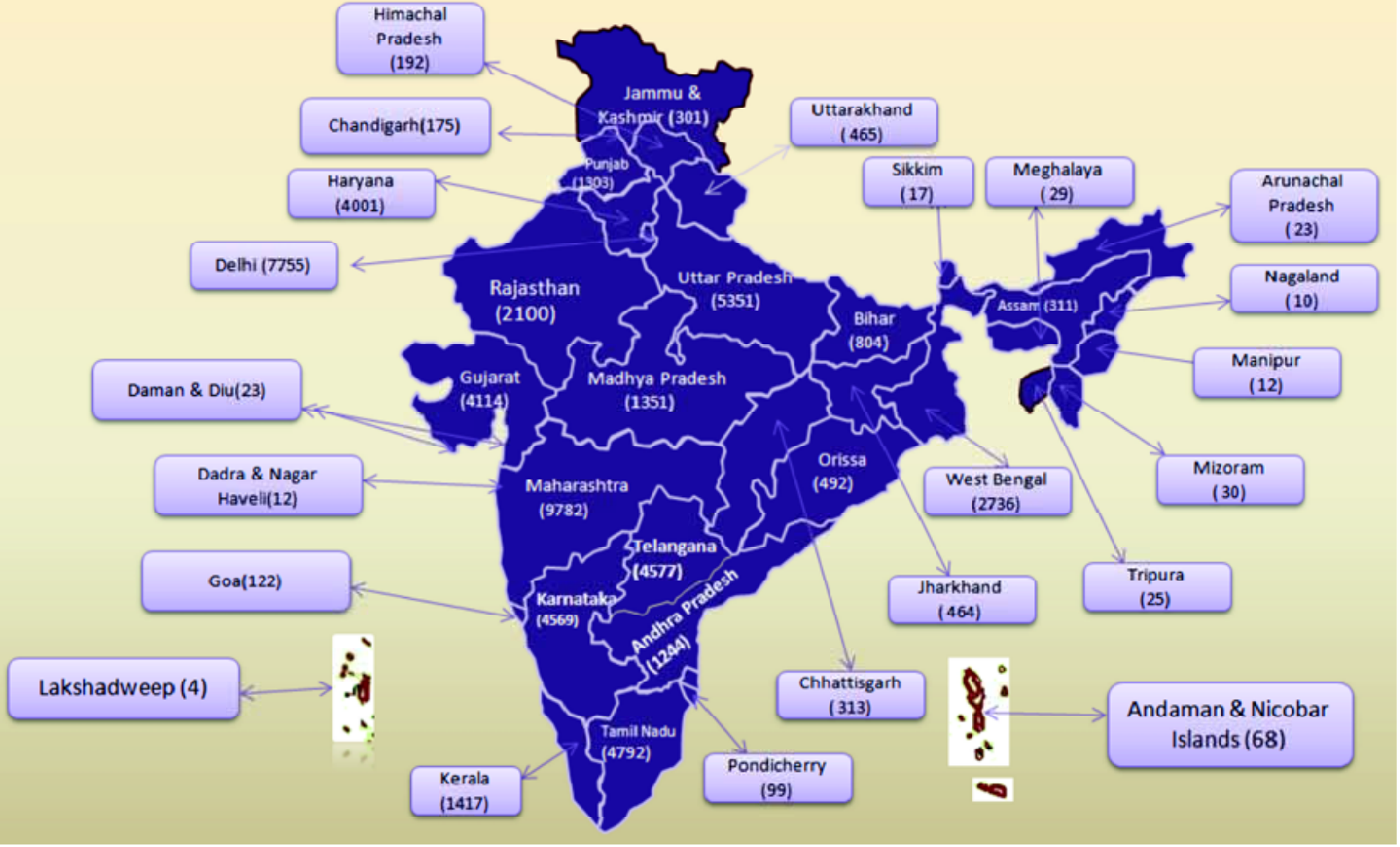
POLICY TYPE WISE GENERAL NSURANCE INDUSTRY COMPLAINTS FOR THE LAST THREE YEARS				
S.No.	**Sector of Insurance**	**2014-15**	**2015-16**	**2016-17**
1	**Motor**	24647	24536	18904
2	**Health**	25633	26838	26937
3	**Others**	10408	7709	6263
	Total:	**60688**	**59083**	**52104**



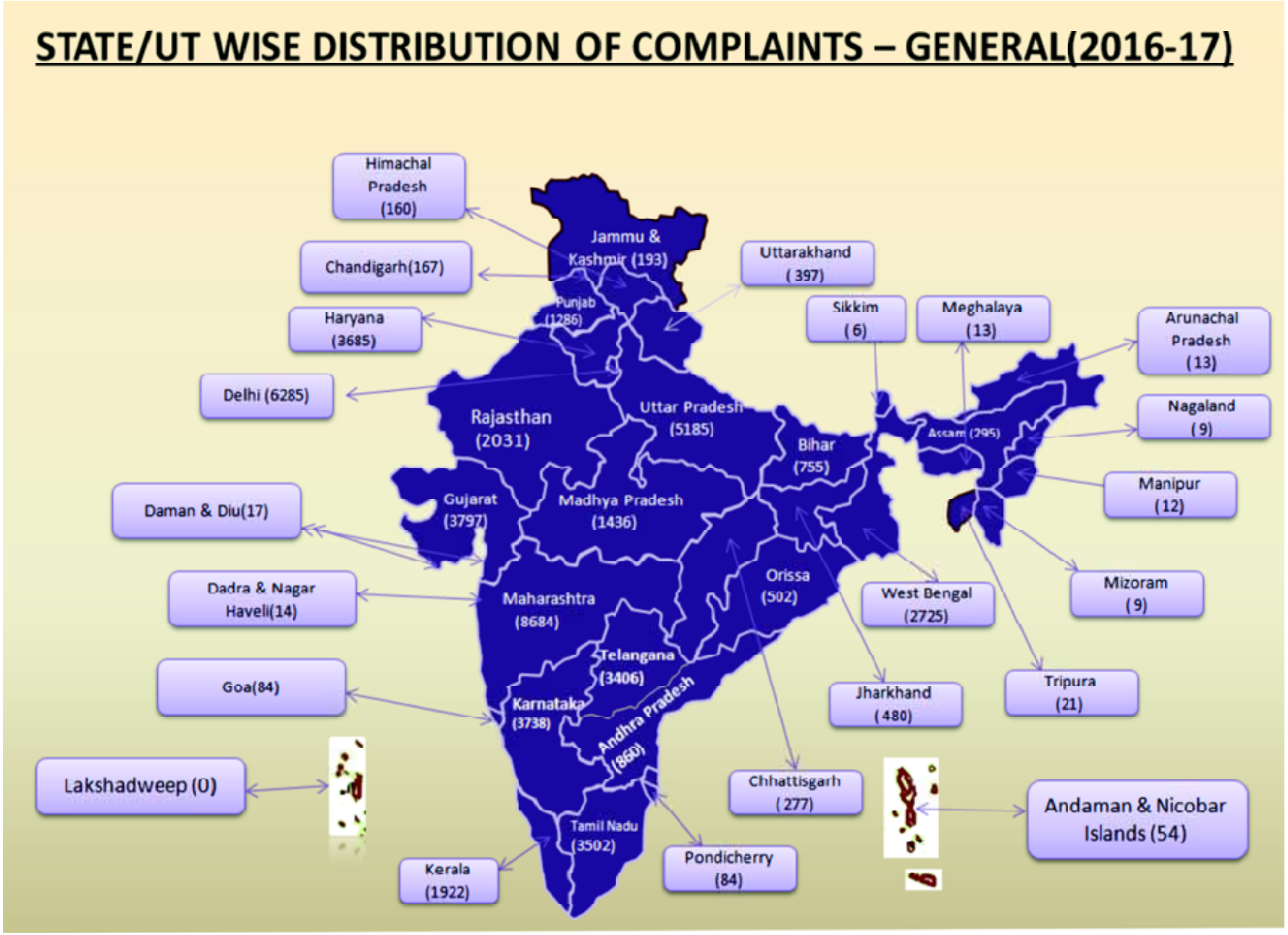
ANALYSIS OF HEALTH INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS				
S.No	**Complaint Type**	**2016-17**	**2015-16**	**2014-15**
1	Claim	14500	11881	11184
2	Coverage	386	672	152
3	Others	4274	4570	4877
4	Policy Related	6042	8379	7455
5	Premium	695	626	1071
6	Product	130	91	111
7	Proposal Related	182	162	362
8	Refund	728	457	421
	Total	**26937**	**26838**	**25633**

ANALYSIS OF MOTOR INSURANCE COMPLAINTS FOR THE LAST THREE FINANCIAL YEARS				
S.No	**Complaint Type**	**2016-17**	**2015-16**	**2014-15**
1	Claim	9800	11259	11641
2	Cover Note Related	159	360	553
3	Coverage	105	211	74
4	Others	2428	2840	3027
5	Policy Related	5343	8565	8177
6	Premium	364	460	525
7	Product	127	195	143
8	Proposal Related	269	245	193
9	Refund	309	401	314
	Total	**18904**	**24536**	**24647**

STATE/UT WISE DISTRIBUTION OF COMPLAINTS – GENERAL(2015-16)



STATE/UT WISE DISTRIBUTION OF COMPLAINTS – GENERAL(2016-17)

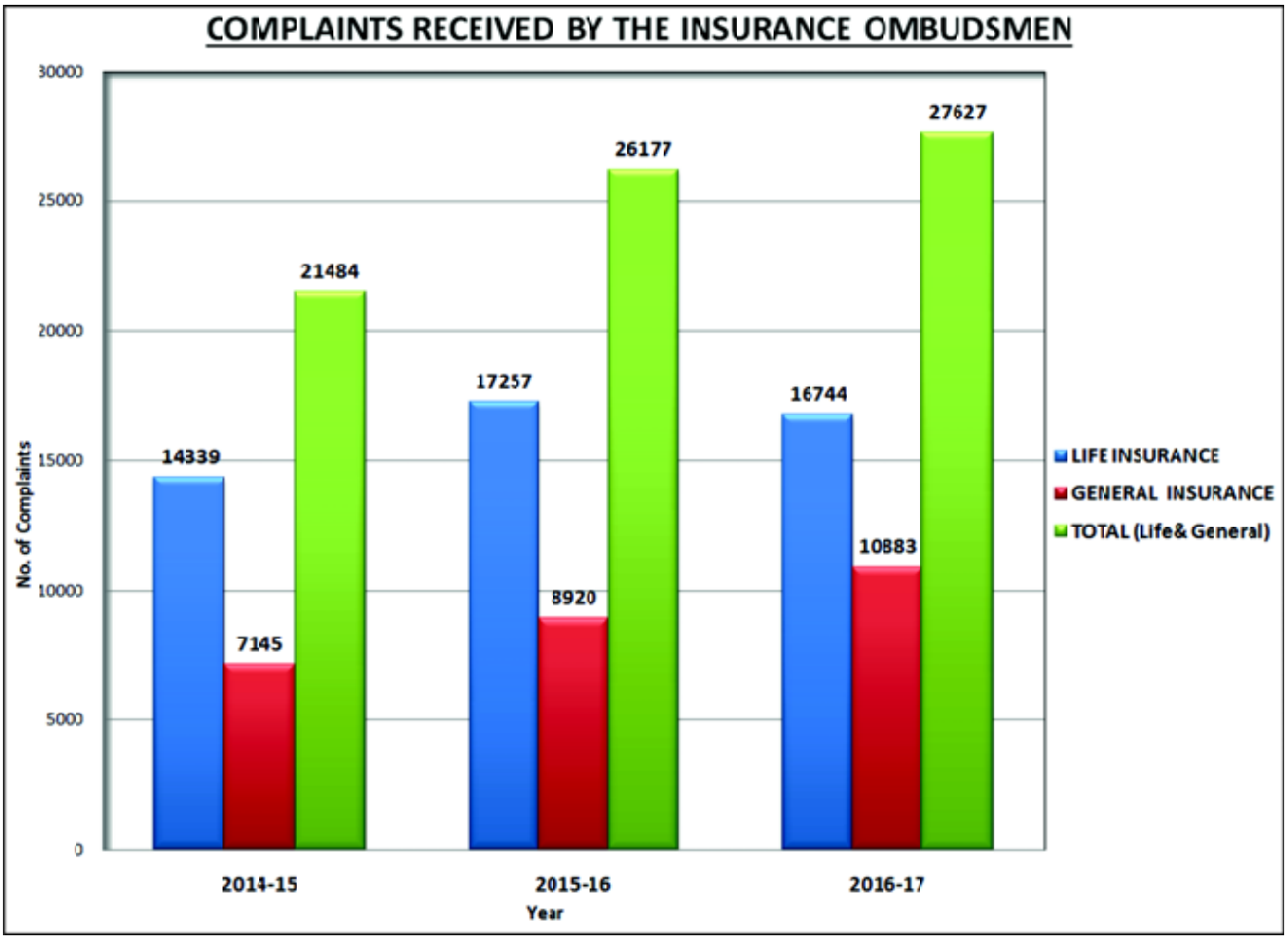


Analysis of the Grievances Reported to Insurance Ombudsmen

1. Cursory glance of Complaints received during the last 3 years
2. Complaints received during the last 3 years - Graphical Presentation
3. Disposal of Complaints during the last 2 years
4. Classification of Complaints received during the last 2 years
5. Performance of Ombudsmen at Different Centers (LIFE INSURANCE)
6. Performance of Ombudsmen at Different Centers (GENERAL INSURANCE)
7. Performance of Ombudsmen at Different Centers (INDUSTRY)

COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN - CURSORY GLANCE

Insurance Type	2014-15	2015-16	2016-17
LIFE INSURANCE	14339	17257	16744
GENERAL INSURANCE	7145	8920	10883
TOTAL (Life& General)	**21484**	**26177**	**27627**



DISPOSAL OF COMPLAINTS BY THE INSURANCE OMBUDSMEN

Sl. No	Particulars	2015-16				2016-17			
		O/S as on 01.04.2015	Received	Disposed	O/s as on 31.03.2016	O/S as on 01.04.2015	Received	Disposed	O/s as on 31.03.2016
1	Against Life Insurers	4397	17257	19645	2009	2009	16744	17377	1376
2	Against General Insurers	2385	8920	10621	684	684	10883	10613	954
3	**Against Life & General Insurers**	**6782**	**26177**	**30266**	**2693**	**2693**	**27627**	**27990**	**2330**

Source: GBIC

CLASSIFICATION OF COMPLAINTS RECEIVED BY THE INSURANCE OMBUDSMEN

(Life & General Insurers)

Year	Complaints which are not entertainable	Partial or total repudiation of claim	Dispute in regard to premiums paid or payable in terms of policy	Disupute on the legal construction of the policies so far as such dispute relates to claim	Delay in settlement of claims	Non issuance of document to customer after receipt of premium	Total
2015-16	15000	6312	4309	194	292	70	**26177**
2016-17	15989	6592	4454	161	362	69	**27627**

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (LIFE INSURANCE)

Name of Centre	Total No. of Complaints			No. of Complaints disposed by way of					Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2016	Received during 2016-17	Total	(I)	(II)	(III)	(IV)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	22	1083	1105	144	394	58	496	1092	859	233	0	1092	13	0	0	13
Bengaluru	0	985	985	123	57	70	688	938	905	33	0	938	47	0	0	47
Bhopal	9	609	618	124	23	57	390	594	548	46	0	594	22	2	0	24
Bubaneshwar	45	550	595	82	0	64	449	595	543	52	0	595	0	0	0	0
Chandigarh	610	1866	2476	707	9	190	596	1502	683	608	211	1502	279	695	0	974
Chennai	0	819	819	42	22	23	719	806	804	2	0	806	13	0	0	13
Delhi	24	966	990	460	35	5	490	990	985	5	0	990	0	0	0	0
Guwahati	17	287	304	81	12	58	151	302	293	9	0	302	2	0	0	2
Hyderabad	75	750	825	191	38	103	493	825	619	206	0	825	0	0	0	0
Jaipur	0	754	754	202	28	66	435	731	717	14	0	731	23	0	0	23
Kochi	0	654	654	159	11	69	415	654	635	19	0	654	0	0	0	0
Kolkata	923	2020	2943	1097	383	383	889	2752	998	1615	139	2752	191	0	0	191
Lucknow	128	1080	1208	407	8	71	645	1131	696	411	24	1131	53	24	0	77
Mumbai	21	2181	2202	158	62	23	1955	2198	2117	81	0	2198	1	3	0	4
Noida	121	743	864	312	85	0	467	864	603	258	3	864	0	0	0	0
Patna	1	629	630	80	64	87	399	630	521	109	0	630	0	0	0	0
Pune	13	768	781	230	20	85	438	773	758	15	0	773	8	0	0	8
Total	**2009**	**16744**	**18753**	**4599**	**1251**	**1412**	**10115**	**17377**	**13284**	**3716**	**377**	**17377**	**652**	**724**	**0**	**1376**

Note:

O/S : Outstanding

(I) Recommendations / Awards

(II) Withdrawal / Settlement

(III) Dismissal

(IV) Non-acceptance / Not-entertainable

(A) Within 3 months

(B) 3 months to 1 Year

(C) Above 1 Year

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (GENERAL INSURANCE)

Name of the Centre	Total No. of Complaints			No. of Complaints disposed by way of					Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2016	Received during 2016-17	Total	(I)	(II)	(III)	(IV)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	39	1609	1648	359	201	120	923	1603	1337	266	0	1603	45	0	0	45
Bengaluru	0	872	872	92	51	68	621	832	814	18	0	832	40	0	0	40
Bhopal	9	230	239	46	8	52	108	214	184	30	0	214	24	1	0	25
Bubaneshwar	19	199	218	41	0	23	154	218	199	19	0	218	0	0	0	0
Chandigarh	129	965	1094	257	1	98	544	900	621	279	0	900	74	120	0	194
Chennai	0	720	720	103	45	83	460	691	640	51	0	691	29	0	0	29
Delhi	19	808	827	383	45	0	399	827	808	19	0	827	0	0	0	0
Guwahati	10	79	89	41	6	9	29	85	72	13	0	85	4	0	0	4
Hyderabad	24	316	340	98	17	54	171	340	266	74	0	340	0	0	0	0
jaipur	0	313	313	62	22	56	157	297	293	4	0	297	16	0	0	16
Kochi	0	701	701	278	30	108	285	701	668	33	0	701	0	0	0	0
Kolkata	192	853	1045	248	82	200	411	941	461	479	1	941	104	0	0	104
Lucknow	12	258	270	82	5	30	149	266	243	23	0	266	4	0	0	4
Mumbai	164	1747	1911	425	110	128	767	1430	880	548	2	1430	279	202	0	481
Noida	60	370	430	188	53	0	189	430	263	167	0	430	0	0	0	0
Patna	1	201	202	52	12	0	138	202	188	14	0	202	0	0	0	0
Pune	6	642	648	166	24	77	369	636	632	4	0	636	12	0	0	12
Total	**684**	**10883**	**11567**	**2921**	**712**	**1106**	**5874**	**10613**	**8569**	**2041**	**3**	**10613**	**631**	**323**	**0**	**954**

Note:

O/S : Outstanding
(I) Recommendations / Awards
(II) Withdrawal / Settlement
(III) Dismissal
(IV) Non-acceptance / Not-entertainable
(A) Within 3 months
(B) 3 months to 1 Year
(C) Above 1 Year

PERFORMANCE OF OMBUDSMEN AT DIFFERENT CENTRES (LIFE & GENERAL COMBINED)

Name of the Centre	Total Number of Complaints			Number of Complaints disposed by way of					Duration-wise Disposal				Duration-wise Outstanding			
	O/S as on 31st March, 2016	Received during 2016-17	Total	(I)	(II)	(III)	(IV)	Total	A	B	C	Total	A	B	C	Total
Ahmedabad	61	2692	2753	503	595	178	1419	2695	2196	499	0	2695	58	0	0	58
Bengaluru	0	1857	1857	215	108	138	1309	1770	1719	51	0	1770	87	0	0	87
Bhopal	18	839	857	170	31	109	498	808	732	76	0	808	46	3	0	49
Bubaneshwar	64	749	813	123	0	87	603	813	742	71	0	813	0	0	0	0
Chandigarh	739	2831	3570	964	10	288	1140	2402	1304	887	211	2402	353	815	0	1168
Chennai	0	1539	1539	145	67	106	1179	1497	1444	53	0	1497	42	0	0	42
Delhi	43	1774	1817	843	80	5	889	1817	1793	24	0	1817	0	0	0	0
Guwahati	27	366	393	122	18	67	180	387	365	22	0	387	6	0	0	6
Hyderabad	99	1066	1165	289	55	157	664	1165	885	280	0	1165	0	0	0	0
Jaipur	0	1067	1067	264	50	122	592	1028	1010	18	0	1028	39	0	0	39
Kochi	0	1355	1355	437	41	177	700	1355	1303	52	0	1355	0	0	0	0
Kolkata	1115	2873	3988	1345	465	583	1300	3693	1459	2094	140	3693	295	0	0	295
Lucknow	140	1338	1478	489	13	101	794	1397	939	434	24	1397	57	24	0	81
Mumbai	185	3928	4113	583	172	151	2722	3628	2997	629	2	3628	280	205	0	485
Noida	181	1113	1294	500	138	0	656	1294	866	425	3	1294	0	0	0	0
Patna	2	830	832	132	76	87	537	832	709	123	0	832	0	0	0	0
Pune	19	1410	1429	396	44	162	807	1409	1390	19	0	1409	20	0	0	20
Total	**2693**	**27627**	**30320**	**7520**	**1963**	**2518**	**15989**	**27990**	**21853**	**5757**	**380**	**27990**	**1283**	**1047**	**0**	**2330**

Note:

O/S : Outstanding

(I) Recommendations / Awards

(II) Withdrawal / Settlement

(III) Dismissal

(IV) Non-acceptance / Not-entertainable

(A) Within 3 months

(B) 3 months to 1 Year

(C) Above 1 Year

CLAIMS
(A brief on Claim Handling by Insurance Companies)

I. INTRODUCTION

Claim is a moment of truth as far as an Insurance policy is concerned. It is the culmination of the insurance contract. The expectation of the policyholder is whenever the claim amount has fallen due, the insurer honours the claim and makes the payment of the insured amount at the earliest and with least possible inconvenience. The efficiency of claim handling is a test of the customer service orientation of an insurer.

II. IMPORTANCE OF EFFICIENT CLAIM HANDLING

Claim has a different impact on the policyholder/ claimant and the insurer. In case of a claimant, the claim amount is the benefit whereas for an insurer it is an expenditure. A claimant would expect the payment of the due amount in time without facing any hardship whereas the insurer would want to pay the claims only after due satisfactory compliance of all the requirements for making the payment in accordance with the policy terms and conditions. The information asymmetry in so far as the understanding of the insurer and the policyholder/ claimant and the interpretation of clauses of the insurance contract is one of the main reasons for disputes relating to claims.

Delay in settlement of claims creates undue hardship to the claimants who are already reeling under the impact of the loss caused to the subject matter of insurance. Repudiation of claims either fully or partially makes the claimant feel that the entire exercise of taking an insurance policy was futile and the premium paid was only an item of expenditure without any commensurate benefit. If the reasons for delay in settlement of claims and the reasons for partial or complete repudiation of claims are not informed to the claimant with clarity by the insurer, the claimant is left with no other option but to raise a dispute. Once a dispute is raised and the same is not resolved or explained with reasons, the policyholder/claimant loses trust in the insurer. Thus, there is little possibility that the claimant would take/ renew insurance with the insurer, thereby affecting new business or persistency. Further, the negative publicity about the unreasonable rejection of claims also can affect the potential of sourcing of new business or renewals by the insurer.

On the part of insurer, paying of all claims without proper examination can result in a situation where fraudulent claims also get entertained and paid. This would severely impact the financials of the company putting in jeopardy the very solvency of the insurance company.

Therefore, the claim handling is a critical function of an insurer which has to be carried out with diligence and prudence without adversely affecting the customer service.

III. INTERMEDIARIES IN HANDLING OF CLAIMS

Surveyors and loss assessors in non-life and third party administrators in health insurance are the most important intermediaries who have a significant role in claim handling. Ensuring that these intermediaries function properly is the most critical to the discharge of claim related functions by insurers.

Surveyors and loss assessors are appointed by the insurer for surveying and assessing the loss caused when a claim is reported. The report is required to be furnished to the insurer. The insurer would decide upon the claim and may use the report of the surveyors and loss assessors but are not bound by it. The timeliness in appointment and conduct of survey and furnishing a report, the professionalism displayed in their functioning and the quality of the report determines the speed and quality of settlement of claims by insurers.

In case of health insurance, Third Party Administrators are the most important intermediaries handling policyholder servicing issues. Providing of cashless facility and settlement of reimbursement claims is facilitated by TPAs. The professionalism in conducting both these functions determines the smoothness of claim handling by insurers.

IV. COMPLAINTS RELATED TO CLAIMS

Once a claim has been unduly delayed or repudiated by the insurer, there is a cause of complaint. The claimant takes up the matter first with the insurer. All the insurers have put in place internal mechanism to deal with such grievances and resolve them. The resolution of claim related complaints also generally includes review of the decision on claims by a

Committee. After review, the decision on the claim is conveyed to the complainant.

Once the complaint is not internally redressed, the claimant is forced to seek adjudication of the dispute. For this purpose, he may approach an insurance ombudsman, consumer forum or a civil court and later take it through the appellate channels if redress is not to his satisfaction.

The statistics on claim related grievances indicate that in the Non-Life Sector, claim related complaints constitute a major proportion to the total complaints as compared to the life insurance sector.

The data relating to claim related complaints as obtained from the Integrated Grievance Management System, is as follows:

Year	No. of Claim complaints	% increase / decrease compared to last year	Total complaints	% of Claim related complaints to total complaints
NON-LIFE COMPLAINTS				
2013-14	27409	(-) 8.77	63335	43.28
2014-15	26467	(-) 3.43	60688	43.61
2015-16	26480	0.05	59083	44.82
2016-17	27637	4.37	52104	53.04
LIFE COMPLAINTS				
2013-14	36685	(-) 15.04	374620	11.58
2014-15	31076	(-) 15.29	278992	11.14
2015-16	24749	(-) 20.36	204701	12.09
2016-17	17383	(-) 29.76	120847	14.38

(Source: Integrated Grievance Management System of IRDAI)

Claim related complaints constitute less than 15 % of life complaints whereas they constitute nearly 43-53 % of general Insurance complaints. This clearly shows that claim handling is a serious customer service issue in general insurance industry which needs immediate attention.

There has been a general reduction of claim related complaints in life with the rate of reduction being close to 30 % in life insurance claims and in respect of general Insurance there is an increase of about 4% compared to the previous year. While the volume of complaints in relation to total number of claims is very small, the problems faced by the complainants cannot be wished away given the inconvenience caused to them.

The major claim related complaints as per IGMS are as follows:

1. Insurer not disposing of the claim.
2. Difference between the amount claimed and the amount settled by the Insurer
3. Insurer reduced the quantum of claim without providing proper reasons.
4. Insurer failing to offer settlement of claim after receipt of survey report.
5. Delay on the part of TPA to arrange claim reimbursement

I. REGULATORY AND SUPERVISORY FRAMEWORK

The regulatory framework and institutional arrangement for processing claims expeditiously and resolving grievances relating to claims is discussed below in brief:

A. Regulations:

- IRDA (Protection of Policyholders' Interest) Regulations, 2002 constitutes the regulatory framework for the protection of policyholders' interests. In terms of Regulation 5, every insurer should have in place proper procedures and effective mechanism to address complaints and grievances of

policyholders efficiently and with speed. Regulation 8 and 9 deals with claims procedure in respect of life insurance and general insurance policy respectively.

The Turn Around Time (TAT) for claims related services as per the Regulations are as follows:

	CLAIM SERVICE	Turn Around Time
LIFE INSURANCE CLAIM		
1.	Surrender Value / Annuity / Pension processing	10 days
2.	Maturity claim / survival benefit / penal interest not paid	15 days
3.	Raising claim requirements after lodging the claim	15 days
4.	Death claim settlement (without investigation requirement)	30 days
5.	Death claim settlement / Repudiation (with investigation requirement)	6 months
NON-LIFE INSURANCE CLAIM		
1.	Surveyor appointment	72 hours
2.	Survey report submission	30 days
3.	Insurer seeking addendum report	15 days
4.	Additional report submission	3 weeks
5.	Offer of settlement / Rejection of claim after receiving 1st / addendum survey report	30 days
6.	Payment after acceptance of offer of settlement	7 days

- In terms of Regulation 8(5) and Regulation 9(6), where there is a delay on the part of the insurer in payment of life insurance claims or non-life insurance claims respectively, the insurer is required to pay interest @ bank rate plus two per cent for the delay.
- IRDA (Non-Linked Insurance Products) Regulations, 2013 and IRDA (Linked Insurance Products) Regulations, 2013 contain provisions relating to claim settlement in case of group life insurance policies.
- **IRDAI (Appointment of Insurance Agents) Regulations, 2016, IRDAI (Registration of Corporate Agents) Regulations, 2015, IRDA (Insurance brokers) Regulations, 2013,** IRDAI (Third Party Administrators – Health Services) Regulations, 2016 and IRDAI(Insurance Surveyors and Loss Assessors)Regulations, 2015 stipulate Code of conduct for insurance agents, corporate agents, brokers and TPAs respectively wherein aspects relating to claims are also specified.
- IRDAI has issued Circular No IRDA/HLTH/ MISC/CIR/216/09/2011 dated 20-9-2011 in respect of delay in claim intimation/document submission with respect to all life insurance contracts and non-life individual and group insurance contracts. IRDAI advised all companies not to repudiate delayed claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.

B. Grievance Redressal System

- To enable timely resolution of grievances, IRDAI has issued Guidelines for Grievance Redressal by insurance companies on 27 July

2010 according to which every insurance company is required to acknowledge grievances within 3 days and resolve complaints within two weeks.

- Grievance cell in the Consumer Affairs Department of IRDAI also receives complaints from policyholders which include those relating to claims. The complaints are registered and forwarded to the insurers for resolution under advice to the complainants. The insurers are required to examine the complaints and resolve the same within two weeks.
- Where the complaints are not resolved to the satisfaction of the complainant, the complainant can take up the matter with the Insurance Ombudsman or any other appropriate forum.

C. Insurance Ombudsmen in Mediation and Adjudication of Claim related grievances

- In order to provide an expeditious and inexpensive forum for adjudication of matters relating to claims in respect of personal lines of insurance upto a certain limit, Government introduced a system of Ombudsman in the Insurance Sector with effect from 11th November 1998. Currently there are 17 insurance ombudsmen in the country who are allotted to different geographical areas as their areas of jurisdiction
- The grounds relating to claims for which a complaint can be made to the Insurance Ombudsman are as follows:
  - Any partial or total repudiation of claims by an insurer.
  - Any dispute on the legal construction of the policies in so far as such disputes relate to claims.
  - Delay in settlement of claims.
- Each Ombudsman is empowered to redress customer grievances in respect of insurance contracts on personal lines where the compensation amount sought is less than Rs.20 lakhs. The Insurance Ombudsman adjudicates upon the complaint and issues an Award. The insurer shall comply with the award given by the Ombudsman within 15 days of the receipt of the acceptance letter from the complainant and it shall intimate the compliance to the Ombudsman.

IRDAI in order to monitor the non compliance of the award of Insurance Ombudsman has issued Circulars Ref: CAD/Insu.Omb/10-11 dated 23-11-2010 and Ref: IRDAI/Cir/Misc/194/11/2015 dated 03-11-2015 . In the recent circular dt.3.11.2015 issued by IRDAI Insurers have been advised as follows:

- Orders of Judicial/Quasi Judicial Bodies should be complied with by the Insurer within the time frame stipulated in the order or award and in cases where time frame is not specified in the order/award, the order/award should be complied within 60 days of the receipt of the order/award by the Insurer and
- In cases where the Insurer prefers an appeal against the order of the Judicial/Quasi Judicial body, such appeal against the order should be preferred with in the stipulated time limit as per the rules applicable.
- The Complainant should be informed in the matter accordingly.

D. Supervision and Regulatory action

- IRDAI constantly monitors the claims payment position of the insurance companies by collecting the claims payment data quarterly.
- IRDAI monitors the claim handling systems based on the complaints registered in the IGMS.
- IRDAI regularly inspects the books of the insurance companies as per Section 33 of the Insurance Act, 1938 which includes the examination of systems and procedures relating to handling of claims, practices of making payment as well as compliance with various regulatory requirements relating to claim handling. Whenever any deviations are noticed regulatory action is initiated.

VI INITIATIVES BY INSURERS

Insurers themselves also take several steps for better claims handling. The steps include giving the claim related documents and the list of documents to be submitted along with the policy document itself, having a claim review committee headed by independent persons of repute from the industry / judiciary. The monitoring, supervision and constant interaction with the intermediaries like surveyors/loss assessors, TPAs etc. also enables

these intermediaries to perform their responsibilities in accordance with regulations issued by IRDA and the Code of Conduct specified for them.

VII. THE INSURANCE LAWS (AMENDMENT) ACT, 2015 –

Amendment of Section 45 of the Insurance Act vis.a vis claim settlement

The amendment made to Section 45 removes much of the confusion by (i) extending the period for calling to question the facts stated in proposal from two years to three years (ii) dropping the provision for such action even after two years on the ground of fraudulent intentions on the part of the proposer (iii) clearly defining the date of reckoning for determining the period of three years and (iv) defining fraud as any misrepresentation or concealment of fact or omission by the proposer or the agent.

The amendment states that in case of fraud, the insurer must write to the claimant the basis of their considering the proposal or the claim as an attempt to defraud the company. Onus is now on the policyholders or the beneficiaries to prove that the misstatement or suppression of a fact was not done deliberately. The amendment eliminates chances of litigation after three years of the commencement of risk by clearly stating that a policy cannot be disputed after the expiry of three years 'on grounds whatsoever'.

The amendment has thus taken full care of the interest of the insurers as well as of the insured and it is likely to reduce litigation. Any policyholder can now be sure of payment of claims amount to his heir in case of his unfortunate demise if his life insurance policy has completed three years since inception or revival. The insurers, on the other hand, will have to upgrade their underwriting standards and skills to protect themselves against potential fraud.

VIII CLAIMS AND LITIGATION

The basic principle on which insurance operates is 'uberrima fides' i.e. principle of utmost good faith. The good faith is applicable equally to insured as well as the insurer. The insured gives all the information required in the proposal form and the insurer has to give the information about the products like terms, conditions, warranties and exclusions in documents of offer like prospectus, brochure, advertisement etc. and also make them part of the policy document. The fine print of insurance policy and the legalese in the wording of policy terms and conditions makes it an unequal bargain from the customer's point of view. Since the insurer knows only those things about the insured and the risk as is disclosed by him in the proposal, any failure to disclose renders the position of insurer difficult. The insured has chosen to buy the insurance product and is presumed to have satisfied himself about the product as the principle of 'caveat emptor' or 'buyer beware' applies to insurance as well. However, considering the several terms and conditions in the insurance contract which are presented in highly technical legal terms, literal application of the principle to largely financially illiterate insured persons would shift the balance heavily in the insurer's favour in case of any dispute in enforcing the obligations under the insurance contract. Protection to an extent is provided to the insured through the 'contra proferentem' rule. As the decision to underwrite a policy is supposed to be taken by the insurer after obtaining all information necessary for understanding the risk and the policy terms and conditions being standard forms drafted by the insurer, while interpreting the clauses of contract, any unclear term is interpreted in favour of the insured and against the insurer. The interplay of these principles, provides reason for disputes in insurance. So, over the years, insurance has grown to be not only a subject matter of solicitation but also a fertile ground for litigation.

Disputes in insurance are basically disputes in contract and have to be taken up with civil court. To provide scope for settling the disputes through alternate dispute resolution mechanisms, the institution of Insurance Ombudsmen has been created by Government of India under the Redressal of Public Grievances Rules, 1998. However, only disputes on personal lines of insurance on only 5 grounds of complaint and where compensation sought is less than Rs. 20 lakhs can be taken up with Insurance Ombudsman. Absence of mechanisms of appeal against Awards or for enforcement of Awards make the legal recourse the only alternative for persons or insurers aggrieved by unsatisfactory Awards.

In case of commercial lines of insurance, while resolution through Arbitration and Conciliation is provided for, the Arbitration Awards do not provide finality leaving room for litigation even after arbitration. Further arbitration clause is provided in

general for partial repudiation cases of claim and not in cases of denial of claim.

With the increasing publicity about the recourse to Consumer Fora under the Consumer Protection Act, 1986, the volume of cases before Consumer Fora on matters of insurance has also been increasing with more and more people taking recourse to Consumer Fora alleging deficiency of service. The delay in resolving a case before the District Forum and the several years taken in disposal of appeals by State Forum and National Forum because of the huge volume of cases pending before these Fora have rendered the recourse to Consumer Fora ineffective in the expeditious resolution of insurance related disputes.

In order to provide a separate forum for dealing with cases relating to third party claims in case of motor accidents, the Motor Accident Claims Tribunals have been set up under the Motor Vehicles Act. Several of these Tribunals are in operation across the country. The number of cases pending before these Tribunals is huge and the time taken for disposal owing to the involved processes, is also substantial. There is no finality to the decisions as cases where the claimants feel that the compensation ordered is too low, they go for Appeal to the High Court and where the insurer feels that the compensation ordered is too high, the insurer goes on an Appeal leading to increased number of appeals before High Court and if further appealed against, before the Supreme Court. The difficulty in resolving disputes about motor accidents arise of the onerous task of assessing the value of human life lost in the accident and there can always be divergence of views of either party leading to litigation and escalations in the form of appeals. A straight jacketed formula is difficult to implement. However, there is sufficient scope of settlement of disputes at the earliest to save the financial burden in the form of absence of any earning of the deceased, cost of filing a case and pursuing it and the consequent time value of the money ordered at some remote time after the loss occurred.

In addition to these, disputes regarding claims in other non-life insurance policies which are not on personal lines are taken up before Civil Courts, where long time is taken in deciding the matter, owing to the involved processes. Even after decision of the Court is received, there is the option of Appeal leading to delay in finality of the decision.

IX. VOLUME OF LITIGATION

The volume of cases pending before various Fora / courts as on 31-03-2016 is given below:

COURT / FORUM		LIFE	NON-LIFE
		No. of Cases	No. of Cases
Consumer Forum	District Level	15270	50723
	State Level	5088	19684
	National Level	299	2352
Civil Court		8874	6933
High Court		156	2770
Supreme Court		8	983
MACT Related	MACT	NA	889239
	State Level	NA	180400
	National Level	NA	557

(Source – Consolidation of Information furnished by the Insurers)

It is clear from the above that the number of cases relating to life insurance is much less when compared to non-life insurance. There are more than 10.7 lakh cases relating to motor accident third party claims pending at MACT itself or in appellate courts.

While delays in litigation and large pendency of cases are a common problem in India, the impact of the delay in decision in matters relating to insurance on the insurers and the insured is significant calling for a new approach for dealing with the problem. Since the liability to honour the decision of the Court which has ordered payment has to be maintained, the cost of engaging counsel and pursuing the matter across different fora is definitely

something which affects the financial strength of insurance companies. The occurrence of peril for which insurance was intended to provide cover for puts the claimants in a very difficult position where they have to not only battle the loss / tragedy caused as a consequence of the occurrence of the peril but also spend substantial amounts of money, time and effort to pursue the legal battle with an institution.

Therefore, there is an urgent need to deal with the problem of litigation in insurance by resorting to out-of-court settlements, taking up the cases through Lok Adalats, etc.

X. INSURANCE AWARENESS

Insurance awareness can help persons taking insurance to be more aware about the nuances of insurance, what to disclose and what to look for in an insurance product, how to understand the insurance product and comprehend the terms, conditions, exclusions and warranties in the insurance policy. When this meeting of minds of insurer and the policyholder/claimant about mutual rights and obligations is there, disputes warranting litigation would not arise. In non-life insurance, underwriting includes risk assessment. Therefore, suggesting the suitable insurance policy and also mechanisms of mitigating risks can be an important service provided by the insurer to the policyholder. Building insurance awareness and bringing in more transparency in policy terms and conditions through simplification of language can help in interpretational problems in claim handling, avoiding an important reason for a lot of litigation in claims.

XI. CONCLUSION

Insurers should have proper systems in place for quick and proper handling of claims. Providing a reasoned and timely decision about the claim can help mitigate the agony of the claimant in approaching various channels only to understand why there is a delay and what is the reason for repudiation of claim in full or in part. A suitable mechanism at insurer's level to ensure that this information would be provided promptly would reduce the number of complaints relating to claims.

CLAIMS

(Claim settlement and related information received from the Life Insurers)

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Aegon Life Insurance Company Limited.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	0	0	1	232	301	394	168	261	370	62	38	19	0	1	5
ULIP	0	0	0	147	149	130	135	142	129	14	6	1	0	0	0
Pension	0	0	0	21	10	9	21	10	9	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (pl.specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**400**	**460**	**533**	**324**	**413**	**508**	**76**	**44**	**20**	**0**	**1**	**5**

*Balances are re-casted

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	196	144	255	29	111	108	5	43	22	0	0	0	0	0	0
ULIP	122	128	120	23	18	10	4	3	4	0	0	0	0	0	0
Pension	20	9	9	1	1	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**338**	**281**	**384**	**53**	**130**	**118**	**9**	**46**	**26**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	0	1	1	0	0	4	0	0	0	0	0	0	0	0	0
ULIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**1**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	0	0	5	15,20,923
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**5**	**15,20,923**

5. Constraints which cause delay in settlement of claims

a. Non receipt of mandatory documents
b. Identification of correct nominee
c. Delay in receiving reverts for RTI
d. Delayed claim intimation
e. Non-cooperation from various hospitals in sharing medical records

6. Initiatives taken by the company to ensure expeditious settlement of claims

a. Dedicated claims Helpline number for Branches for prompt resolution of customer queries & documents to be submitted thereby helping in improving First Time Right & claim settlement.
b. Multiple options for claim intimation
c. Regular follow-up over phone/e-mail with claimants for submission of pending document.
d. Availability of claim form in 10 regional languages for ease of understanding, document submission & claim settlement.
e. Training of branch teams to ensure smoother & faster claim settlement

7. Institutional Framework for review of repudiated claims

a. All claims to be rejected are referred to an internal committee (CCM) comprising of Head-Legal & Compliance, Head-Customer Services & Head-Underwriting & Claims
b. The CCM reviews the case on merits before we reject the claim.
c. In case of representation we have a second level committee, Claims Review Committee (CRC).
d. CRC is a 3 member committee, includes 2 external members & Chief Operating Officer. The committee is headed by imminent external member who have more than 30 years of experience in the life insurance industry along with other external member who too is equally experienced in life insurance industry.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF
Consumer Courts	**PENDING CASES**
District Forum	95
State Commission	14
National Commission	0
Other Courts	
Civil Courts	2
High Courts @	0
Supreme Court	0
Total	**111**
@ of these, the number of appeals against orders of Insurance Ombudsman	**NA**

• Additionally, 9 cases open at Lok Adalat.

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Post intimation of Court / For a notice, cases are reviewed internally to see if it can be resolved at our end.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	0	NA
Camps	NIL	NIL	NIL	NIL	0	NA
Others (give details)	NIL	NIL	Ombudsman: 2	6,60,000	SCDRC: 01	50,00,000
TOTAL	**NIL**	**NIL**	**2**	**6,60,000**	**SCDRC: 01**	**50,00,000**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Aviva Life Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claimsrepudiated +rejected			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	8	2	7	986	897	902	717	672	689	284	220	212	2	7	8
ULIP	0	1	2	817	649	531	772	593	474	35	55	57	1	2	2
Pension	0	0	0	211	122	90	211	122	90	0	0	0	0	0	0
Health Insurance	0	0	0	11	12	8	8	11	8	3	1	0	0	0	0
Others (pls specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8**	**3**	**9**	**2025**	**1680**	**1531**	**1708**	**1398**	**1261**	**322**	**276**	**269**	**3**	**9**	**10**

***FY 2015-16** Figures are tentative.

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	442	458	461	221	179	187	54	35	41	0	0	0	0	0	0
ULIP	711	520	428	53	59	38	8	14	8	0	0	0	0	0	0
Pension	200	119	89	9	2	1	2	1	0	0	0	0	0	0	0
Health Insurance	4	10	7	3	1	0	1	0	1	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1357**	**1107**	**985**	**286**	**241**	**226**	**65**	**50**	**50**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	0	5	7	2	2	1	0	0	0	0	0	0	0	0	0
ULIP	0	2	2	1	0	0	0	0	0	0	0	0	0	0	
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**7**	**9**	**3**	**2**	**1**	**0**	**0**		**0**	**0**		**0**	**0**	

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	0	0	1	83
ULIP		0	0	1	1726	0 0
Pension	1	1872	0	0	1	3321
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**1**	**1872**	**1**	**1726**	**0**	**3404**

5. Constraints which cause delay in settlement of claims

As an organization, AVIVA is committed to provide hassle free and speedy claims settlement to the claimants and at the same time ensure that only valid claims are paid keeping the interest of both – Policy Holder and the Company in perspective. The primary concern that prevents fast settlement of claims is increasing trend of fraudulent claims from certain geographical pockets, which often necessitates multiple investigations at different locations and in this process, insurers have to liaise with hospitals, police authorities and various other organizations for fact verification, and insurer's end to end TAT is often affected in this process.

6. Initiatives taken by the company to ensure expeditious settlement of claims

The very first step that AVIVA undertook in this regard was to enhance training program for its advisors and sales force, reiterating the importance of need based selling and correct product being offered to the correct segment. Some of the important initiatives taken by company for speedier claim settlement are:

1. The claimant is involved and informed at every claim stage through letters, calls and SMS. (Giving sympathy call on intimation of claim, explaining requirements, following up, providing help in obtaining documents from hospitals, Dispatch of Claims cheques etc.)
2. Involvement of Branch personnel-Branch operations team is well versed with the documents that are required for processing a claim. Branch Ops do the initial screening of the claims at the time of submission by the claimant.
3. Pro active Document collection through Aviva personnel and Investigators- Claimant is guided for Documentation and in case claimant is unable to procure the same, Branch Ops / Investigators are roped in for the Document collection
5. Introduction of Net Promoter Score (NPS), a customer loyalty metric which is clear measure of an organization's performance through its customers' eyes. A sample of settled claims cases are picked monthly and feedback is taken from the claimants about the delivery process and their experience of claims settlement. The feedbacks received are analyzed and if required, the claims process is redesigned.
6. Claim Review Committee-To be more customers friendly and to provide claimant an opportunity to presenthis case, we have Claims Review Committee and in the communication of declining claim, we intimate claimant about the option of CRC

7. Institutional Framework for review of repudiated claims

The claim is denied only in cases of fraudulent suppression of material information. This ensures that claims are not paid to fraudulent persons at the cost of honest policyholders.Each decision of repudiation is reviewed by two senior claims assessors, including, but not limited to Head of claims. Any representation made against any decision is reviewed by an internal committee including senior members of legal, complaints, policy servicing, and underwriting, risk, audit and claims teams. Any further scope of re-evaluation or re-investigation is clearly envisaged so as to ensure that customer is given a fair chance to put forward facts in his favor.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	165
State Commission	55
National Commission	8
Other Courts	
Civil Courts	20
High Courts @	5
Supreme Court	1
Permanent Lok Adalat	11
Total	**265**

@ of these, the number of appeals against orders of Insurance Ombudsman

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The claim is denied only in cases of fraudulent suppression of material information. Thereafter, each decision of repudiation is reviewed by an internal committee including senior members of legal team, complaints, underwriting and others. Any further scope of re-evaluation or re-investigation is clearly envisaged so as to ensure that customer is given a fair chance to put forward facts in his favor.

However on receipt of the claims case from the court/ fora it is once again reviewed by the legal team and if found weak case then it is taken up for amicable settlement with the complainant.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others	0	0	0	0	0	0
District Forum	3	300000	8	4915253	2	1416550
State Commission	0	0	3	11013696	1	2800000
National Commission	0	0	1	146544	0	0
Civil Courts	1	76333	1	330000	0	0
Permanent Lok Adalat	0	0	1	2000000	0	0
TOTAL	**4**	**376333**	**14**	**18405493**	**0**	**4216550**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Bajaj Allianz Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	738	441	571	9731	9990	9741	8652	8815	8834	1376	1045	1076	441	571	402
ULIP	365	131	4	12813	10145	7691	12760	10118	7524	287	154	150	131	4	21
Pension	15	0	51	368	272	90	383	221	139	0	0	2	0	51	
Health Insurance	383	296	225	10268	6884	4658	8171	5697	4074	2184	1258	660	296	225	149
Others	0	0		0	0	0	0			0			0		
Total	**1501**	**868**	**851**	**33180**	**27291**	**22180**	**29966**	**24851**	**20571**	**3847**	**2457**	**1888**	**868**	**851**	**572**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	5562	5692	6163	3036	2989	2329	1430	1175	1415	0	4	3	0		
ULIP	11808	9464	7189	957	708	398	282	100	87	0			0		
Pension	359	198	122	20	23	15	4		4	0			0		
Health															
Insurance	10345	6949	4732	6	6		4		2	0			0		
Total	**28074**	**22303**	**18206**	**4019**	**3726**	**2742**	**1720**	**1275**	**1508**	**0**	**4**	**3**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	312	329	217	112	234	140	17	8	45						
ULIP	117	1	19	12	3	1	2		1						
Pension		40			11										
Health															
Insurance	296	225	146			3									
Others															
Total	**725**	**595**	**382**	**124**	**248**	**144**	**19**	**8**	**46**						

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount (in Rs.)	No. of claims	Amount (in Rs.)	No. of claims	Amount (in Rs.)
Conventional	6	51790	56	72904	104	150675
ULIP	18	829233	29	10276	53	43511
Pension	0	0	3	513	2	1773
Health Insurance	3	36074	1	523		
Others	0	0				
Total	**27**	**917097**	**89**	**84216**	**159**	**195959**

5. Constraints which cause delay in settlement of claims

1. Investigation of claims in the known fraud areas where some authorities/ Hospitals donot cooperate to provide the documents.
2. Delayed response from policy holders in providing additional documents called from them.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. We have tightened the TATs of Investigation and increased the number of investigators on board. Exchanging the information across the industry.
2. Sent letters in short intervals of 10-15 days;
3. Tele calling done to policy holders explaining the need for the documents called for

7. Institutional Framework for review of repudiated claims

1) Claims Review Committee is with 7 members.
2) Inducted one Retired Civil Judge in June 2014 with additional experience of representing Insurance related matters in Consumer disputes forum to have an independent/non-partisan view.
3) Customer calls/mails/enquiries received at our call centers/branches with regard to repudiated/rejected claims are automatically registered as Claim Review Committee requests for further processing.
4) Representations from policy holders on repudiation are reviewed by the Committee.
5) Claims Review Committee (CRC) works independent of claims processing team to review any referred claim and takes an independent view.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1603
State Commission	461
National Commission	25
Other Courts	
Civil Courts	259
High Courts @	29
Supreme Court	1
Total	**2378**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

It is always our endeavor to address, redress and reduce the number of grievances raised which have gone in litigation. The Company has reviewed various cases in the light of allegations and based on the evidence and fact of the matter including monetary impact and the additional evidences led by the customers in the Courts and wherever possible, we have tried to redress the issue by offering suitable settlement option. Accordingly the details of the cases settled may be considered in the below requirement. This is an additional option toward settlement besides the efforts taken by the company at the pre-litigation phase to review and address the grievance.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount (in Rs.)	No. of claims	Amount(in Rs.)	No. of claims	Amount(in Rs.)
Lok Adalat	3	3,45,500.00	2	7,23,000.00	19	11,51,969.00
Camps	0	0.00	0	0.00	0	0.00
Others	44	1,85,04,751.00	46	1,74,21,025.00	53	1,69,11,716.00
TOTAL	**47**	**1,88,50,251.00**	**48**	**1,81,44,025.00**	**72**	**1,80,63,685.00**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Bharti AXA Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	4	14	32	396	648	977	318	473	694	68	157	156	14	32	87
ULIP	5	9	0	505	332	272	464	318	256	37	23	0	9	0	1
Pension	0	0	0	168	107	52	168	107	52	0	0	0	0	0	
Health Insurance	3	4	2	69	93	127	53	75	110	14	20	13	4	2	6
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**12**	**27**	**34**	**1138**	**1180**	**1428**	**1004**	**973**	**1112**	**119**	**200**	**169**	**27**	**34**	**94**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	162	250	385	118	179	257	38	44	52	0	0	0	0	0	0
ULIP	394	286	248	53	21	5	17	11	3	0	0	0	0	0	0
Pension	168	107	52	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	54	75	100	0	0	9	0	0	1	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**778**	**718**	**785**	**171**	**200**	**271**	**55**	**55**	**56**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	6	24	28	4	7	41	4	1	18	0	0	0	0	0	0
ULIP	4	0	1	2	0	0	3	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	1	0	2	2	0	2	1	2	2	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**11**	**24**	**31**	**8**	**7**	**43**	**8**	**3**	**20**	**0**	**0**	**0**	**0**	**0**	**0**

4. **Statistics of instances and quantum of penal interest paid for delayed payment of claims:**

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	0	0	0	0	0	0
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. **Constraints which cause delay in settlement of claims**

- Delay/Incomplete submission of Mandatory documents from the Claimants
- Delay in receipt of Medical cause of Death, Hospital records, Treatment papers from the Claimant.

6. **Initiatives taken by the company to ensure expeditious settlement of claims**

- Company has dedicated claims handler, who speaks to the claimant, explains the process to assist the claimant for fulfilling the documentation. The dedicated claims handler also updates the status of the claim on various milestones.
- Company Pro-actively informs the claimants about the list of the documents required for speedy processing.

7. **Institutional Framework for review of repudiated claims**

The Company has a Claims committee and Claims review Committee which consist of members as various functional heads (Compliance, Legal, Actuarial, finance)

8. **Statistics of cases of policyholders / claimants before Consumer Fora /Courtsas on 31st December 2015**

NAME OF THE FORUM / COURT	NO. OF PENDING CASES (In number)
Consumer Courts	
District Forum	293
State Commission	18
National Commission	2
Other Courts	
Civil Courts (Including LokAdalat)	33
High Courts @	6
Supreme Court	0
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

The Company had formed an internal committee which consists of Chief Distribution Officer, Compliance Officer, Legal Head and Chief Operating Officer etc., wherein the cases pending before the Forums and Courts were discussed and recommended for settlement.

The recommendations were further discussed with the dealing Advocates and were taken ahead for settlement before the Forums and Courts by filing Memo of Settlement.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR (2013-14) No. of claims (matters)	Amount	YR(2014-15) No. of claims (matters)	Amount	YR(2015-16) No. of claims (matters)	Amount
LokAdalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (Litigation Matters placed before the committee)	23	565000	14	1144625	5	324000
TOTAL	**23**	**565000**	**14**	**1144625**	**5**	**324000**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Birla Sun Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	320	144	100	3849	4072	3430	3274	3798	2778	751	318	545	144	100	207
ULIP	109	93	39	3951	3602	3135	3824	3622	3054	143	34	63	93	39	57
Pension	6	7	3	356	343	307	351	347	308	4	0	0	7	3	2
Health Insurance	1	1		35	15	24	34	16	24	1	0	0	1	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**436**	**245**	**142**	**8191**	**8032**	**6896**	**7483**	**7783**	**6164**	**899**	**352**	**608**	**245**	**142**	**266**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1148	2875	1956	1055	762	490	1004	129	318	59	21	7	8	11	7
ULIP	2874	3265	2600	573	280	348	346	32	98	22	12	3	9	33	5
Pension	327	317	264	17	23	24	5	3	18	2	2	0	0	2	2
Health Insurance	21	14	20	6	1	2	7	1	2	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4370**	**6471**	**4840**	**1651**	**1066**	**864**	**1362**	**165**	**436**	**83**	**35**	**10**	**17**	**46**	**14**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	71	53	129	48	33	62	7	5	9	9	0	3	9	9	4
ULIP	21	9	22	12	3	12	4	1	1	18	2	1	38	24	21
Pension	2	0	0	0	0	0	0	0	0	1	0	1	4	3	1
Health Insurance	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**94**	**62**	**151**	**61**	**36**	**74**	**11**	**6**	**10**	**28**	**2**	**5**	**51**	**36**	**26**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	40	663802.60	107	463351.72	8	72593.15
ULIP	13	326593.02	1	2928.48	7	10366.91
Pension	0	0.00	0	0.00	0	0.00
Health Insurance	0	0.00	1	304.00	1	893.67
Others	0	0.00	0	0.00	0	0.00
Total	**53**	**990395.62**	**109**	**466584.20**	**16**	**83853.73**

5. Constraints which cause delay in settlement of claims

The endeavor of BSLI has always been to settle claims faster. However, there are quite number of constraints leading to delay in settlement of claims which are listed below:

- Claims from Identified Industry vide negative locations. Insurance frauds are seen in cartel operating in such locations who are insuring lives on already dead people, individuals who does not exist, terminally ill, uninsurable older lives using forged identity, age proofs & financial documents. Hence, most of these cases are investigated leading to delay in settlement of claims.
- A large chunk of fraudulent cases come to forefront only at claims stage rather than at the proposal stage, hence establishing fraudulent intent with concrete evidences is a challenge which leads to exhaustive investigation which leads in delay in claim settlement.
- Also, there is delay in claim settlement where the titles to Policy monies are not clear & we are unable to disburse the claim in view of want of legal requirements to establish the rightful beneficiary.
- Another factor attributing to delay in claim settlement is customer requirement wherein claim gets intimated however claimants are not traceable or uninterested in submitting claim requirements.

6. Initiatives taken by the company to ensure expeditious settlement of claims

At BSLI Claims we believe in enhancing the Customer experience at every possible touch point Settling Claims on time and speedily is one of our core deliverable Hence following best practices are carried out:

- Non-early claims, claims under non risk plans & Claims for inactive Policies as on date of event are treated as “Straight through Cases and are processed swiftly by a specific team.
- Early claims are handled separately by team with the aim of settling genuine valid claims by assigning the cases for investigation & effectively guiding them and mitigating the risk associated with fraud claims.
- Further we ensure that the claim requirements raised & received are first time right resulting in faster settlement of claims.
- Majority of the claim payouts are processed thru NEFT thereby resulting in faster payments and credit to theClaimant’s Bank account.
- Claims which require cursory checks or wherein claim requirement is pending are assigned to Third Parry agency as ‘Claims Assistance” ”Documentation Pickup’’ wherein they carryout basic verification and assists the claimants in arranging the pending claim requirements. This facility is only to assist the claimant and as a customer experience of BSLI being with them in their hour of grief.

- BSLI also has designated Claims Service Ambassadors within the organization, wherein the Ambassadors visit the claimant as an emotional support to them and assist in collecting pending claim requirements This again is a gesture of service to claimants in their need and facilitating swifter claim settlement which is the ultimate Moments of Truth

7. Institutional Framework for review of repudiated claims

- As a claims philosophy, Birla Sun Life Insurance Company Ltd repudiates claim only on the basis of strong documentary evidence establishing material suppression/ misstatement of facts which would have impacted the risk assessment at application stage.
- Further specific cases are also routed through Leal team for their consensus who represents the cases in litigation.
- Representation is tabled before Grievance Redressal Committee compromising Chief Operating Officer. Customer Service - Function Head, Legal & Risk Head & external chair person.

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	368
State Commission	180
National Commission	26
Other Courts	
Civil Courts	46
High Courts @	6
Supreme Court	0
Permanent Lok Adalat	20
Total	**646**
@ of these, the number of appeals against orders of Insurance Ombudsman	No appeal filed against orders of Insurance Ombudsman.

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The legal team based on the precedent and experience available at the various forums does a periodic review of cases and depending upon case to case basis appropriate methodology is adopted for settlement of cases.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-				
Camps	-	-				
Others (give details) *	16	4930500	30	27276752	51	46353823.57
TOTAL	**16**	**4930500**	**30**	**27276752**	**51**	**46353823.57**

* Others include the cases settled at various forums for Eg- District Consumer Forum, Permanent Lok Adalat etc, excluding the Ombudsman.

Note: Only individual death claims & Court order cases considered (Excluding Rural, Social, Health, and Group)

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1	1	5	506	557	702	471	530	679	36	23	26	1	5	1
ULIP	11	15	14	446	413	377	398	382	364	44	32	25	15	14	4
Pension	-	-		17	18	13	17	18	13	-		-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others (pl.specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**12**	**16**	**19**	**969**	**988**	**1092**	**886**	**930**	**1056**	**80**	**55**	**51**	**16**	**19**	**5**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	353	382	569	80	78	82	38	70	27	-	-	-	-	-	1
ULIP	251	214	287	88	91	51	57	73	24	1	-	-	1	4	2
Pension	17	18	12	-	-	1	-	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**621**	**614**	**868**	**168**	**169**	**134**	**95**	**143**	**51**	**1**	**-**	**-**	**1**	**4**	**3**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1	4	-	-	-	-	-	1	-	-	-		-	-	-
ULIP	2	5	-	2	3	-	1	3	-	7	1		3	2	-
Pension	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**3**	**9**	**-**	**2**	**3**	**-**	**1**	**4**	**-**	**7**	**1**	**-**	**3**	**2**	**-**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	3	28,789.48	1	1,209.06	2	16,130.06
ULIP	3	25,683.94	5	881,132.07	2	123,881.36
Pension	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-
Others	-	-	-	-	-	-
Total	**3**	**54,473.42**	**6**	**882,341.13**	**4**	**140,011.42**

5. Constraints which cause delay in settlement of claims

- Final Police Investigation report
- Viscera report
- Succession certificate in case of rival claims
- Dependency on external agencies to obtain medical records
- Verification of documents from authority / through RT
- Delay in response from claimants on claim related documents

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Claim registration form includes the list of documents required for claims processing.
- Channel partners have been informed on the list of documents to be collected from claimant and they assist claimant in the claims process·
- Sales Field force & Branch Operations are well informed on the list of documents to be collected from claimant and they assist claimant in the claims process
- Case Manager will call claimant and guide on claims processing·
- First communication / condolence letter includes the case manager contact details.·
- SMS is being sent to claimant on claims status / pending claims related documents·
- Investigation agency personnel will be deployed to collect documents from claimant's doorsteps (need based)·
- Investigation agency is deployed to collect medical / employer records on behalf of the claimant·
- Regular follow-up with claimant through letters and calls

7. Institutional Framework for review of repudiated claims

In case of repudiation, Claims Unit follows the mechanism as detailed below:

1. The claims unit would carry out a detailed evaluation / investigation on the case to ascertain the non-disclosure/misrepresentation of any material fact.
2. The documents and case details would be procured and recorded to support the material nature of the non disclosure / misrepresentation.
3. All claim repudiations would be recommended by the Claims Unit and approved basis the Repudiation Empowerment Grid.
4. A repudiation letter detailing the rationale and the reason behind the repudiation would be sent to the claimant and a copy will be marked to the respective LBS/ISM, RM and respective Hub.

5. The reason / rationale for repudiation may be explained to the LBS/ISM, Relation Manager (RM) or the respective Hub SPOC to enable them to explain the same to the claimant (if requested)
6. The repudiation letter may be backed up by a telecon with the claimant to communicate and discuss in detail the reason and rationale behind the repudiation (if requested)
7. In case the claimant is not satisfied or needs further clarification, the LBS/ISM or RM may be requested to meet the family of the life assured.
8. In the repudiation letters, the claimant would be given an option to write back to the claims unit or the complaints redressal unit for any clarifications required as the first option and the second option could be to approach the Ombudsman / consumer forums / other authorities.
9. In case of representation, a reply would be sent to the claimant after internal review, exploring all angles and if required, calling for Claims Review Group Meeting / Ex-Gratia payouts.
10. If the customer is not yet convinced with the rationale for repudiation, the customer may approach the Ombudsman for their region / respective court of law.
11. In case the Ombudsman decides the case in the company's favor, the claimant then has the option to approach the court of law.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts*

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	13
State Commission	6
National Commission	1
Other Courts	
Civil Courts	4**
High Courts @	NIL
Supreme Court	NIL
Total	**24**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL, We have not challenged any order passed by Ombudsman.

NOTE

* It includes death claim related pending cases as on March 31, 2016 (does not include pending Ombudsman cases)

** It includes 1 case before Debt Recovery Tribunal and 3 cases before Permanent Lok Adalat

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Claims are repudiated by the Company after a close scrutiny of available claim related documents and only after being satisfied that the repudiation was justified and within the ambit of applicable insurance laws. As a result, the Company has very low number of claims repudiation cases filed before various fora/courts. As of now, the Company has not initiated any settlement for claim cases by way of settlement camps as the Company takes proactive steps to settle the cases wherever merits permit.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : DHFL Pramerica Life Insurance Co Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	274	416	52	454	432	443	127	463	408	185	318	71	416	52	13
ULIP	49	46	3	69	51	48	54	74	48	17	20	3	46	3	-
Pension	2	1	-	10	7	4	9	8	4	2	-	-	1	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others (pl specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**325**	**463**	**55**	**533**	**490**	**495**	**190**	**545**	**460**	**204**	**338**	**74**	**463**	**55**	**13**

Note- Written-back cases are not included in above data against point no. 1

*. Repudiated claims also include Rejected claims

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	121	455	408	4	6	-	2	2	-	-	-	-	-	-	-
ULIP	51	72	48	2	1	-	1	-	-	-	-	-	-	-	-
Pension	9	8	4	-	-	-	-	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**181**	**535**	**460**	**6**	**7**	**-**	**3**	**2**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Note- Data against point no. 2 is for settled claims. The Settlement duration is from the date of receipt of last requirement.

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	51	10	11	58	19	2	82	10	-	115	7	-	110	6	-
ULIP	2	1	-	10		-	9	-	-	13	2	-	12	-	-
Pension	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**53**	**11**	**11**	**69**	**19**	**2**	**91**	**10**	**-**	**128**	**9**	**-**	**122**	**6**	**-**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	9	20,079	20	50,151	2	701
ULIP	6	15,016	6	89,770	-	-
Pension	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-
Others	-	-	-	-	-	-
Total	**15**	**35,095**	**26**	**139,921**	**2**	**701**

5. Constraints which cause delay in settlement of claims

- Delay in settlement of claims is usually caused due to non-submission of critical documents by the claimant which are critical to claims decision·
- Difficulty is faced in procuring medical records from both Government and Private Hospitals where customer has undergone treatment·
- Geographical constraints specially in remote and rural areas and unawareness about Insurance claim documentation·
- Non-availability of complete critical Police records such as Final Police Report, Chemical Analysis/ Viscera Report, etc which usually takes many months to be finalized by respective authorities·
- At times the deceased life assured's Employer does not support in sharing employment, leave and income details

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Strengthening New Business process through introduction of 'Pre-issuance verification call' and 'Face-to-Face' by Office Heads on select business segment for improved quality of business·
- Revamped the Claims communication suite where claimants are regularly communicated through letters, SMSs and outbound calls·
- Set-up Centralized Claims Helpdesk and dedicated Claims Processors to assist and guide Claimant throughout the Claims settlement process·
- Continuous knowledge sharing and Simplified Claims Settlement Process·
- Claims documentation and FAQs uploaded on Company's website for ready availability·
- Evaluation of medical diagnostic centers and dis-empanelment basis negative findings ·
- Regular internal review, weekly data published to all stakeholders to keep them updated with claim performance and monthly management review·
- Continuous evaluation and empanelment of external Investigation agencies with proven track record for faster document procurement and field investigation·
- Increased Company's footprints through new branches and Zonal level set-up for local level support to claimant·
- Disciplinary action against errant Sales person

7. **Institutional Framework for review of repudiated claims**

- Repudiated Claims review done by 'Claims Review Committee' comprising of Head-Operations, Appointed Actuary and Chief Financial Officer·
- Legal opinion is also taken on case specific basis·
- In case of fraud, the case is referred to internal Fraud Control Unit for appropriate action·
- Customized Repudiation letter containing detailed reason for declinature as well as steps for Grievance Redressal mechanism·
- Claims Reconsideration process is in place and referred to 'Claims Review Committee'

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	43
State Commission	22
National Commission	0
Other Courts	
Civil Courts	1
High Courts @	0
Supreme Court	0
Total	**66**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

We abide by the decision given by various For a and Courts

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil	Nil	1	8,00,000	1	42,230
Camps	Nil	Nil	Nil	Nil	Nil	Nil
Others (give details)	Nil	Nil	Nil	Nil	Nil	Nil
TOTAL	**Nil**	**Nil**	**1**	**8,00,000**	**1**	**42,230**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Edelweiss Tokio Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	4	20	14	258	719	1376	222	690	1367	20	35	18	20	14	5
ULIP	0	0	0	2	7	9	2	7	8	0	0	0	0	0	1
Pension	0	0	0	0	2	15	0	2	15	0	0	0	0	0	0
Health Insurance	0	2	0	17	13	18	14	14	15	1	1	1	2	0	2
Others(pl.specify)	0	0	0	2	4	6	2	4	3	0	0	3	0	0	0
Total	**4**	**22**	**14**	**279**	**745**	**1424**	**240**	**717**	**1408**	**21**	**36**	**22**	**22**	**14**	**8**

* Health Insurance is inclusive of Claim under the "Edelweiss Tokio Life - Hospital Cash Benefit Rider" (UIN No: 147C006V01) & (UIN No: 147B006V02), "Edelweiss Tokio Life - Critical Illness Rider" (UIN No: 147B005V02) & (UIN No: 147C005V01)

\# *Others included claims reported under Payor Waiver Benefit Rider and Waiver of Premium*

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	160	604	1298	61	45	54	21	73	32	0	3	2	0	0	0
ULIP	1	6	8	1	1	0	0	0	0	0	0	0	0	0	0
Pension	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	8	6	12	6	8	2	1	1	2	0	0	0	0	0	0
Others	0	2	4	2	2	1	0	0	1	0	0	0	0	0	0
Total	**169**	**620**	**1336**	**70**	**56**	**57**	**22**	**74**	**35**	**0**	**3**	**2**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	7	2	4	9	9	1	4	3	0	0	0	0	0	0	0
ULIP	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	2	0	0	0	0	2	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**9**	**2**	**5**	**9**	**9**	**3**	**4**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	2	561	3	22012.98	0	0
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	27	3090.5
Health Insurance	0	0	1	493	0	0
Others	0	0	0	0	0	0
Total	**2**	**561**	**4**	**22505.98**	**27**	**3090.5**

5. Constraints which cause delay in settlement of claims

Although we have an average TAT maintained at 39 days for the claims settled in FY 15-16 the foremost reason for delay in settlement is due to majority of death claim fall under the category of Early claims. As a part of risk mitigation, we investigate all such early claims to ensure unscrupulous claimants do not gain undue advantage.

6. Initiatives taken by the company to ensure expeditious settlement of claims

-]Proactive assistance to claimants to provide complete documentation (WhatsApp services, frequent calls, reminders in form of letters) ·
- Stringent monitoring of turnaround times for investigation·
- Process improvement and simplification

7. Institutional Framework for review of repudiated claims

- All claims proposed to be repudiated are reviewed by the Claims Committee (CC) consisting of senior management in consultation with chief of legal and compliance. Prior to placing the claim decision before the CC we seek advisory from the senior underwriter, medico legal doctor and external legal consultants.
- All repudiated claims that are received for reconsideration on behest of the claimant are reviewed by the claims reconsideration committee (CRC). The members of the CRC are independent of the claims committee which helps in garnering an unbiased decision.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	5
State Commission	3
National Commission	1
Other Courts	
Civil Courts	1*
High Courts @	0
Supreme Court	0
Total	**10**
@ of these, the number of appeals against orders of Insurance Ombudsman	0
*Filed by Claimant – Lok Adalat , Ganjam	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

N.A.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Exide Life Insurance Company

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	155	199	46	1974	2201	2424	1559	1961	2123	371	393	330	199	46	17
ULIP	22	4	2	617	578	441	628	578	442	7	2	1	4	2	0
Pension	2	2	0	449	436	325	451	438	325	0	0	0	0	0	0
Health Insurance	4	13	5	48	37	54	14	18	21	25	27	38	13	5	0
Others - ADDDB	2	4	1	15	10	9	3	7	4	10	6	6	4	1	0
Other – PH Death	0	2	2	64	47	50	62	48	52	0	1	0	2	0	0
Total	**185**	**224**	**56**	**3167**	**3309**	**3303**	**2717**	**3050**	**2967**	**413**	**429**	**375**	**222**	**54**	**17**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1134	1394	1588	389	556	485	306	348	337	80	56	43	21	0	0
ULIP	566	543	396	32	25	38	28	8	8	8	1	1	1	3	0
Pension	436	386	313	9	50	11	5	2	1	1	0	0	0	0	0
Health Insurance	15	9	36	13	12	17	9	14	5	6	8	1	0	0	0
Others-ADDDB	8	4	7	0	6	1	3	1	2	2	2	0	0	0	0
Others - PH	54	38	39	8	9	9	0	1	4	0	1	0	0	0	0
Total	**2209**	**2386**	**2303**	**451**	**627**	**543**	**354**	**374**	**349**	**97**	**68**	**44**	**22**	**4**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	67	0	9	92	31	8	40	15	0	0	0	0	0	0	0
ULIP	3	0	0	1	0	0	0	2	0	0	0	0	0	0	0
Pension	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	2	2	0	7	2	0	3	1	0	1	0	0	0	0	0
Others - ADDDB	2	0	0	1	0	0	1	0	0	0	0	0	0	1	0
Others - PH	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Total	**76**	**2**	**9**	**103**	**33**	**8**	**44**	**18**	**0**	**1**	**0**	**0**	**0**	**1**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	34	215740	1 9	136221	11	24122
ULIP	4	23342	4	48835	3	5958
Pension	0	0	1	128	1	80
Health Insurance	0	0	0	0	0	0
Others - ADDDB	0	0	0	0	0	0
Others - PH	0	0	0	0	0	0
Total	**38**	**239082**	**24**	**185184**	**15**	**30160**

5. Constraints which cause delay in settlement of claims

1. Fraudulent claims with involvement of nexus in specific pockets delays the claims settlement as documentary evidences are not available to take final decision
2. Unavailability of common repository to cross check suspicious claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. To ensure speedy claims processing, the checks are strengthened at underwriting stage before policy issuance
2. Separate claims committee has been formed comprising of claims, actuarial, underwriting, Anti-Fraud, Legal Team members to take faster decision on complex cases and mitigate the high risk.
3. Faster claims case closure by following various enhanced due diligence by way of industry check, investigator, intervention, online database verification etc.

7. Institutional Framework for review of repudiated claims

1. Repudiated claims review is done by the claims committee members with a different approach to check if there is a merit to reconsider the request
2. The review is also done by the head of customer servic equitable from view point 2. es department to check if the approach is fair and

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	79
State Commission	37
National Commission	1
Other Courts	
Civil Courts	NIL
High Courts @	NIL
Supreme Court	NIL
Total	117
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Company as a practice reviews the case before filing written statement and settles the case if party portrays his interest on settlement.
2. Cases pending before various courts are presented to PHPC and initiatives are taken to close the cases as early as possible.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat						
Camps						
Others (give details)	Nil	Nil	2	16,754	2	4,77,646
TOTAL	**Nil**	**Nil**	**2**	**16,754**	**2**	**4,77,646**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Future Generali India LIC Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	62	201	36	1612	1459	1222	1164	1328	1123	309	296	118	201	36	17
ULIP	8	30	2	456	397	309	92	73	298	20	18	13	30	2	
Pension	-	-	-	91	73	25	413	407	25	-	-	-	-	-	-
Health Insurance	-	-													
Others (pl specify)															
Total	**70**	**231**	**38**	**2159**	**1929**	**1556**	**1669**	**1808**	**1446**	**329**	**314**	**131**	**231**	**38**	**17**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1428	1596	935	2	2	249	10		47	13	3	10	20	23	
ULIP	419	419	274	3	1	27			9	8		1	3	5	
Pension	92	73	22			3									
Health Insurance															
Others															
Total	**1939**	**2088**	**1231**	**5**	**3**	**279**	**10**	**0**	**56**	**21**	**3**	**11**	**23**	**28**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	86	25	11	82	7	3	33	2	3						
ULIP	12			10	2		8				2				
Pension															
Health Insurance															
Others															
Total	**98**	**25**	**11**	**92**	**9**	**3**	**41**	**2**	**3**	**0**	**2**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	10	761,859.00	8	53,174.00	21	169,186.42
ULIP			8	126,945.00	15	19,622.15
Pension						
Health Insurance						
Others						
Total	**10**	**761,859.00**	**16**	**180,119.00**	**36**	**188,808.57**

5. Constraints which cause delay in settlement of claims

Some of the constraints which causes delay in claims settlement are·

- Identification of correct nominee due to legal heir·
- Pending FIR, post mortem&viscera requirement in unnatural death claim cases·
- Non receipt of mandatory documents to process claim·
- Non- cooperation from Government institutions/Hospitals for procurement and authentication of documents

6. Initiatives taken by the company to ensure expeditious settlement of claims

Initiatives taken by FG·

- Due diligence at UW, usage of social media and credit bureau to improve quality of UW decision which helps in taking faster claims decision·
- Calling to customer updating about pending requirement, assistance from branch network·
- A very active Claims Committee (comprising senior management) to review decision on all cases with claim amount greater than 10 lakhs (Meets once every month)·
- Investigation agencies are empanelled who have wide geographic reach resulting in speedy investigation closures. Investigations are assignments based on variousfactors like degree of suspicion, claim amount etc.

7. Institutional Framework for review of repudiated claims

- All claims which is received for re-consideration are reviewed by the company's Claims Review Committee (CRC). The CRC is headed by Ex- high court judge (independent chairman).

  The other members are Appointed Actuary, CFO, Head Legal & Compliance,Advisor-Actuary.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	104
State Commission	25
National Commission	01
Other Courts	
Civil Courts *	21
High Courts @	04
Supreme Court	00
Total	**155**
@ of these, the number of appeals against orders of Insurance Ombudsman *includes LokAdalats	**01**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

The company considers each Consumer Forum or Court matter on its merits before considering it for settlement out of court. We do not have any specific policy for initiation of settlement. We however, consider following points before a matter is taken up for settlement:

- Any specific instructions/requests that the Consumer Forums/Courts make during the course of hearing;
- Merits of the case based on facts and circumstances prevailing at the given point in time;
- Any specific customer related fact or issue that comes to light at the time of hearing
- Keeping the above facts in mind company settles matters on case to case basis.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	00	00	00	00	00	00
Camps	00	00	00	00	00	00
Others **	03	Rs.24,76,197/-	01	Rs. 1,93,000/-	02	Rs. 26,72,500/-
TOTAL	**03**	**Rs.24,76,197/-**	**01**	**Rs. 1,93,000/-**	**02**	**Rs. 26,72,500/-**

** District Consumer Disputes Redressal Forums and State Consumer Disputes Redressal Commissions

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : HDFC STANDARD LIFE INSURANCE COMPANY LTD

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014- 15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	60	83	236	3,141	7,230	7,352	2,918	6,557	6,971	200	520	516	83	236	70
ULIP	41	12	39	2 ,651	4,519	3,6 92	2,539	4,290	3,703	141	202	1	12	39	9
Pension	0	0	0	1,434	247	1,210	1,434	247	1,210	0	0	0	0	0	0
Health Insurance	0	0	0	8	0	10	7	0	7	1	0	0	0	0	0
Others (pl specify)															
Total	**101**	**95**	**275**	**7,234**	**11,996**	**12,264**	**6,898**	**11,094**	**11,891**	**342**	**722**	**517**	**95**	**275**	**79**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	2,312	5,723	6,117	607	774	547	199	579	823		1				
ULIP	2,127	3,712	2,922	458	514	503	95	266	279						
Pension	1,412	244	1,196	18	3	13	4	0	1						
Health Insurance															
Others															
Total	**5,858**	**9,679**	**10,242**	**1,084**	**1,291**	**1,063**	**298**	**845**	**1,103**		**1**				

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	62	115	33	17	77	30	4	44	7						
ULIP	9	13	8	2	13	1	1	13	0						
Pension	0	0	0	0	0	0	0	0	0						
Health Insurance															
Others															
Total	**71**	**128**	**41**	**19**	**90**	**31**	**5**	**57**	**7**						

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	5	63,200.2	3	49,962.25	26	1,97,545.47
ULIP	1	1,071	3	13,239.39	15	5,30,695.1
Pension	2	27,093	0	0	3	3,672.19
Health Insurance						
Others						
Total	**8**	**91,364.2**	**6**	**63,201.64**	**44**	**7,31,912.8**

5. Constraints which cause delay in settlement of claims

1. Delay in receipt of documentation from the claimant
2. Difficulties in extract of documentation through various authorities viz. hospitals, doctors, police authorities. Many a times these authorities refuse to co-operate with the insurer.
3. Lack of good investigators who consistently carry out satisfactory investigations

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Regularly keep the claimant updated on the pending documents through letters, emails and SMS
2. Letters are sent to intimate the claimant if the case is being investigated.
3. Personal follow-up with claimant through dedicated Branch operations team
4. Document procurement done through empanelled vendors

7. Institutional Framework for review of repudiated claims

Grievance mechanism via claims review committee through which we review the repudiated claims

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	**1152**
State Commission	83
National Commission	2
Other Courts	
Civil Courts *	225
High Courts @	2
Supreme Court	0
Total	
• @ of these, the number of appeals against orders of Insurance Ombudsman • Includes Writs filed by and against the Insurer. • This data excludes Ombudsman Cases.	6

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

All the complaints are settled in court of law and there is no complaint which has been settled in Lok Adalat and other settlement camps.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	NA	NA	NA	NA	NA	NA
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	NA	NA	NA	NA	NA	NA
TOTAL	NA	NA	NA	NA	NA	NA

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : ICICI Prudential Life Insurance Company Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	0	50	38	2,331	2,670	2,755	1,932	2,380	2,655	349	302	127	50	38	10
ULIP	8	31	30	5,113	4,832	4,871	4,832	4,569	4,708	258	264	177	31	30	15
Pension	1	0	0	4,955	3,889	2,533	4,953	3,889	2,532	3	0	0	0	0	2
Health Insurance	426	411	513	24,591	25,926	25,606	20,455	22,594	22,921	304	150	86	411	513	538
Others (Term)	3	40	27	928	694	683	834	608	622	57	99	82	40	27	6
Others(Annuity)	0	0	0	36	68	75	36	68	75	0	0	0	0	0	0
Total	**438**	**532**	**608**	**37,954**	**38,079**	**36,523**	**33,042**	**34,108**	**33,513**	**971**	**815**	**472**	**532**	**608**	**571**

Note: Claims closed due to other reasons is not included in Health insurance data

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1,514	2,018	2,460	186	171	119	229	189	75	3	2	1	0	0	0
ULIP	4,265	4,257	4,477	287	186	155	277	123	67	3	3	9	0	0	0
Pension	4,889	3,870	2,527	34	14	4	27	4	0	3	1	1	0	0	0
Health Insurance	20,198	22,208	22,720	131	181	108	125	204	93	1	1	0	0	0	0
Others (Term)	779	553	535	17	30	40	35	25	44	3	0	2	0	0	1
Others (Annuity)	34	68	74	2	0	1	0	0	0	0	0	0	0	0	0
Total	**31,679**	**32,974**	**32,793**	**657**	**582**	**427**	**693**	**545**	**279**	**13**	**7**	**13**	**0**	**0**	**1**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	6	6	7	27	16	3	17	16	0	0	0	0	0	0	0
ULIP	10	10	6	11	16	8	9	2	0	0	1	0	1	1	1
Pension	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0
Health Insurance	312	345	427	68	114	101	31	54	10	0	0	0	0	0	0
Others(Term)	4	8	4	26	8	2	9	11	0	1	0	0	0	0	0
Others (Annuity)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**332**	**369**	**445**	**132**	**154**	**115**	**66**	**83**	**10**	**1**	**1**	**0**	**1**	**1**	**1**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Conventional	3	72,488.50	0	0.00	2	169.20
ULIP	4	1,450.95	0	0.00	0	0.00
Pension	0	0.00	0	0.00	0	0.00
Health Insurance	11	2,172.61	24	3,088.11	0	0.00
Others	0	0.00	0	0.00	2	1,99,506.89
Total	**18**	**76,112.06**	**24**	**3,088.11**	**4**	**1,99,676.09**

5. Constraints which cause delay in settlement of claims

- Incorrect or incomplete contact details given by the claimant causes delay in processing of a claim as company faces difficulties in establishing contact with the claimant for any requirement or clarifications.·
- Delay in submission of additional documents like hospital/medical records, KYC documents or electronic pay out mandate details by the claimant·
- Sometimes certain claims needs viscera report and/or final police report to conclude on exact cause of death. Such reports usually takes long time to issue which is beyond the control of the claimant and the company
- In certain claims though the decision has been taken to pay the claim however payment is kept on hold as matter may be pending in the court to decide right beneficiary to whom payment is to be made. ·
- In certain cases procuring medical treatment records from hospitals/ health centers causes delay in decisioning the claim·
- Suspicious claims received by the Company are investigated which leads in delay of decisioning the claim

6. Initiatives taken by the company to ensure expeditious settlement of claims

- At ICICI Prudential life every claim is a fulfillment of a promise that we have made to our policyholder and we do our best to process the claim in the most transparent and quick manner. Company has taken various initiatives in order to facilitate faster claim settlement & to enhance overall customer satisfaction.·
- **Online claim intimation & documents upload facility:** Claimant can initiate a claim by using company's online claim intimation along with document upload facility. Thus claimant need not visit company branch and can initiate a claim from one's home/ office.·
- **Dedicated claims hotline:** Company has set up a dedicated "Claims hotline" which connects customer touch points like branch and call centre directly with claim expert. With this unique initiative, claimant can directly speak to claim experts through local branch or call centre and get the first hand resolution on claim related queries. This initiative has helped to get all case related requirements at one go.
- **Document procurement:** Wherever claimant is unable to collect the documents due to any constraints at his end, company deploys procurement agencies to collect the required documents on behalf of the claimant.
- **24x7 Call centre:** A dedicated 24x7 call centre has been set up to provide information related to claims procedure, documents required or status of a claim. Thus claimant can contact call centre any time to seek clarifications or to know the status of the claim.
- **Electronic pay outs for claim payments:** Company ensures that maximum claim payouts are processed through electronic mode which is safe, convenient and faster. Currently more than 95% of claim payouts are processed through electronic mode.

7. Institutional Framework for review of repudiated claims

- The Claim assessor reviews the documents received and refers the claim to be repudiated to a dedicated team. This team reviews each and every repudiation, referred to them. They examine the case facts and evidences while decisioning the claim.·
- To review all representations received on repudiated claims, Grievance Redressal Committee (GRC) has been constituted. The GRC comprises of two external members, who are eminent persons from the industry and four internal members from the senior management. This Committee independently reviews the case facts and provides its decision. The final decision given by the committee is communicated to the Claimant within 15 calendar days from the date of receipt of the representation. The GRC members also meet quarterly to review overall claims performance and the claim repudiations.·
- The Company has also established a Claim Committee which comprises of various functional heads from Actuary, Legal, Risk Control, Sales, Customer Service, etc. which reviews the overall Claims experience and repudiations.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1000
State Commission	223
National Commission	29
Other Courts	
Civil Courts	238
High Courts @	23
Supreme Court	2
Total	**1515**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

The Company proactively looks into the matters and initiate settlement with customers on regular basis.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : IDBI Federal Life Insurance Co Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	22	35	41	655	788	887	593	590	772	49	193	138	35	41	18
ULIP	4	4	4	229	174	191	227	169	183	2	5	10	4	4	2
Pension	0	0	0	22	30	15	22	30	15	0	0	0	0	0	0
Health Insurance	2	0	0	23	11	8	21	8	8	4	3	0	0	0	0
Riders	4	1	0	57	48	41	51	44	40	9	5	1	1	0	0
Total	**32**	**40**	**45**	**986**	**1051**	**1142**	**914**	**841**	**1018**	**64**	**206**	**149**	**40**	**45**	**20**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	242	309	442	336	279	324	15	2	6	0	0	0	0	0	0
ULIP	187	145	160	36	24	23	4	0	0	0	0	0	0	0	0
Pension	17	25	15	5	5	0	0	0	0	0	0	0	0	0	0
Health Insurance	12	6	8	9	2	0	0	0	0	0	0	0	0	0	0
Riders	24	29	34	27	14	6	0	1	0	0	0	0	0	0	0
Total	**482**	**514**	**659**	**413**	**324**	**353**	**19**	**3**	**6**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	26	41	18	9	0	0	0	0	0	0	0	0	0	0	0
ULIP	3	3	1	0	0	0	0	0	0	0	0	0	1	1	1
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Riders	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Total	**29**	**44**	**19**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1***	**1***	**1***

*This is a subjudice case

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	NA	NA	NA	NA	NA	NA
ULIP	NA	NA	NA	NA	NA	NA
Pension	NA	NA	NA	NA	NA	NA
Health Insurance	NA	NA	NA	NA	NA	NA
Others	NA	NA	NA	NA	NA	NA
Total	NA	NA	NA	NA	NA	NA

5. Constraints which cause delay in settlement of claims

- Non submission of basic claim requirements and additional requirements (called, if any) despite various follow ups. Many a times it is observed that the Claimants don't submit duly completed claim forms and all mandatory documents especially bank statement and KYC documents
- Non co-operation from the Hospital Authorities / Govt. Authorities in getting records related to LA which delays the investigation process·
- Since the past medical history in most of the cases are older records it gets difficult for the hospital authorities to retrieve·
- In case of certain areas where syndicates are operational, investigators find it difficult to procure documents leading to delay.·
- Also there is delay in the claim settlement for cases where the title to Policy monies are not clear & we are unable to disburse the claim in view of want of legal requirements to establish the rightful beneficiary.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- All claim payouts are processed thru NEFT thereby resulting in faster payments and credit to the Claimant's Bank account.
- In case of Non early claims where complete documentation is received & no further investigation are required; the company has put a claims settlement guarantee of 8 working days or payment of 8% interest.
- The TAT & Ageing of pending claims is monitored regularly by the Claims Head and COO and on monthly basis by Claims Review committee.
- The company has put in a process of having investigators to procure documents on behalf of claimants in some cases.
- There is a process to follow up with claimants at periodic intervals by letters, emails and tele-calling of the claimants for pending requirements.

7. Institutional Framework for review of repudiated claims

- Prior to repudiation of any claim, there is a process to seek the Re-underwriting opinion on the adversities noted to understand whether the non-disclosure/ misrepresentation would have any bearing on the underwriting decision at the proposal stage·
- Repudiated claims are presented before the Claims Review Committee with details including: reason for repudiation, channel details, client details, Sum assured, early or non-early.
- Any representation made against claim repudiation is reviewed by Chief Operating Officer in consultation with GRO.
- Action is initiated against Advisors, in accordance with guidelines for treatment of fraudulent claims.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	101
State Commission	9
National Commission	0
Other Courts	
Civil Courts	4
High Courts @	2
Supreme Court	0
Total	**116**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Facilitating settlement of cases & providing resolution to Customers has been included in the job description of the Legal Team of the Company. Accordingly, two main approaches were adopted to bring this into effect - (i) Holding settlement camps; and (ii) direct coordination with customers. Both the approaches have yielded good results during FY 2015-2016.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	21	Rs. 46,79,645.33
Others (give details)#	0	0	19	Rs. 80,86,934.31	77	Rs. 66,82,963.79
TOTAL	**0**	**0**	**19**	**Rs. 80,86,934.31**	**98**	**Rs.1,13,62,609.12**

* includes all monetary claims made by policyholders/claimants before various courts/Fora/ Ombudsman - such as death claims, rider claims, servicing & others.

by directly approaching the policyholders/claimants.

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: INDIAFIRST LIFE INSURANCE CO. LTD.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	24	90	88	3088	3707	4330	2550	3145	3583	472	564	251	90	88	584
ULIP	8	15	21	801	931	1009	666	705	820	128	220	151	15	21	59
Pension	0	0	1	75	98	49	75	95	48	0	0	0	0	1	1
Health Insurance	16	56	33	817	938	753	476	673	602	301	289	162	56	33	32
Others (pl.specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**48**	**161**	**143**	**4781**	**5674**	**6141**	**3767**	**4618**	**5053**	**901**	**1075**	**565**	**161**	**143**	**676**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	2498	2484	2945	163	483	605	38	155	30	12	23	2	0	0	1
ULIP	691	569	754	86	110	60	16	25	6	1	1	0	0	0	0
Pension	73	84	44	2	9	4	0	2	0	0	0	0	0	0	0
Health Insurance	506	570	463	188	272	251	80	115	50	3	5	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**3768**	**3707**	**4206**	**439**	**874**	**920**	**134**	**297**	**86**	**16**	**29**	**2**	**0**	**0**	**1**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	71	48	369	18	30	178	0	4	33	1	1	0	0	5	4
ULIP	12	12	43	2	9	12	0	0	3	1	0	1	0	0	0
Pension	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	28	21	27	23	12	5	5	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**111**	**82**	**440**	**43**	**51**	**195**	**5**	**4**	**36**	**2**	**1**	**1**	**0**	**5**	**4**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	3	133523	16	406189.8	3	220054.8
ULIP	0	0	0	0	0	0
Pension	0	0	0	0	0	0
Health Insurance	0	0	0	0	1	52.4
Others	0	0	0	0	0	0
Total	**3**	**133523**	**16**	**406189.8**	**4**	**220107.2**

5. Constraints which cause delay in settlement of claims

- Non-submission of basic claim requirements and additional requirements (called, if any) despite various follow ups
- Non-co-operation from the Hospital Authorities / Govt. Authorities in getting records related to LA which delays the investigation process
- Since the past medical history in most of the cases are older records it gets difficult for the hospital authorities to retrieve
- There has been a steep rise in fraudulent claims (like Death before issuance, policy deliberately taken on older aged lives by misrepresenting the actual age, impersonation, etc.) and as a result it becomes extremely difficult to get evidences in such types of cases.
- Many a times we come across cases where there is a Rival claimant approaching for the claim money / Nominee has predeceased the LA / Multiple nominations etc. These cases takes a legal route in which getting the legal documents is difficult

6. Initiatives taken by the company to ensure expeditious settlement of claims

- We are doing the telephonic follow up with the claimant and make them understand of the pending requirements
- We also ask the field investigator in assisting the claimants in arranging the pending claim requirements including legal documents
- For the rural area claims where the claimants are illiterate, we arrange our Sales support team to make the claimants aware of the pending requirements and help them in arranging those
- We share the soft copies of all the pending requirements to our sales support team, so that they personally follow up with the claimants in getting the requirements fulfilled

7. Institutional Framework for review of repudiated claims

- Prior to repudiation of any claim, we seek the Re-underwriting opinion on the adversities noted to understand whether the non-disclosure/misrepresentation would have any bearing on the underwriting decision at the proposal stage
- We also seek the opinion of the Claims Review Committee comprising of Director & CEO, Appointed Actuary, Head of Governance & Company Secretary, Head of Operations, & Chief Financial Officer who provide their views on sustainability of our decision
- For the cases where we get adversities related to LA's medical history, we seek Chief Medical Officer's opinion
- Reinsurer's opinion is sought for complex cases and the cases which falls under the treaty
- In case of Health Claims TPA has not been given authority to reject claims. All recommendations to reject claim is reviewed by IndiaFirst claims team.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	106
State Commission	30
National Commission	1
Other Courts	
Civil Courts	13
High Courts @	2
Supreme Court	-
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

1. Four cases were settled in the year 2015-2016 which were filed with the District consumer forum.
2. One case was settled in the year 2015-2016 which was filed with the High Court.
3. One case was settled in the year 2015-2016 which was filed with the Permanent LokAdalat.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	NA	NA	NA	NA	1	1,14,000
Camps	NA	NA	NA	NA	NA	NA
Others (give details)	2	219013.70	NA	NA	5	2318066.32
TOTAL	**2**	**219013.70**	**NA**	**NA**	**6**	**2432066.32**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: KOTAK MAHINDRA OLD MUTUAL LIFE INSURANCE LIMITED

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	46	49	82	14867	20490	36122	14563	20213	35694	301	239	407	49	82	102
ULIP	30	19	38	1519	1257	1162	1507	1234	1149	23	9	8	19	38	44
Pension	6	5	9	389	327	186	390	323	183	0	0	2	5	9	10
Health															
Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others -Annuity	0	0	2	4	7	5	4	5	4	0	0	0	0	2	3
Total	**82**	**73**	**131**	**16779**	**22081**	**37475**	**16464**	**21775**	**37030**	**324**	**248**	**417**	**73**	**131**	**159**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	14112	14875	33017	569	3752	2023	169	1717	608	8	94	26	6	14	20
ULIP	1392	1126	1060	88	81	63	33	30	17	3	3	3	14	3	6
Pension	361	294	175	11	20	4	5	8	1	12	1	0	1	0	3
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others-Annuity	4	5	2	0	0	1	0	0	1	0	0	0	0	0	0
Total	**15869**	**16300**	**34254**	**668**	**3853**	**2091**	**207**	**1755**	**627**	**23**	**98**	**29**	**21**	**17**	**29**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	6	9	8	11	18	19	3	6	13	12	8	29	17	41	33
ULIP	0	1	2	2	5	3	3	6	7	0	9	4	14	17	28
Pension	0	0	0	0	2	0	1	1	1	0	1	5	4	5	4
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others-Annuity	0	1	0	0	1	0	0	0	1	0	0	0	0	0	2
Total	**6**	**11**	**10**	**13**	**26**	**22**	**7**	**13**	**22**	**12**	**18**	**38**	**35**	**63**	**67**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	-	-	-	-	1	1,11,369.05/-
ULIP	-	-	-	-	-	-
Pension	-	-	-	-	-	-
Health Insurance	-	-	-	-	-	-
Others	-	-	-	-	-	-
Total	-	-	-	-	**1**	**1,11,369.05/-**

5. Constraints which cause delay in settlement of claims

- There are cases wherein the nominee expires and there is no clear title of the legal heir, thus procuring those documents takes time.
- There are cases in rural areas wherein the claimants do not have the required mandatory documents and hence assisting them to get the requisite documents takes time.
- Waiting for Viscera and Chemical analysis report which is essential in cases wherein there is a decision to rule out suicide.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Hand holding drive wherein our 3rd party vendors would assist the customer in procuring legal documents &mandatory documents as an additional service for hassle free and faster closure of Claims.
- Training front desk officials in branches to ensure all mandatory documents are informed to the customer and explanation and handholding for all required documents.

7. Institutional Framework for review of repudiated claims

- In cases of Frank Repudiations, the principle of Utmost Good faith and the provisions of section 45 of the Insurance Act are taken into consideration. In cases of Frank repudiations, the opinion of Legal team is mandatorily sought and as per the approval matrix or in case of discrepancy in opinion it may be referred to the Claims Review Committee for further opinion. On receipt of the Legal opinion the repudiation letters are sent to the Legal team for checking post which they are dispatched to the client.Review of Repudiated claims on receipt of complaints / GrievanceA 'Grievance' or 'Complaint' may be defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/ deficiency of service of an insurance company and/or any intermediary or asks for remedial action. The grievance and complaint management is based on the regulatory directions of the circular issued by IRDA. The complaints which qualify the categories as defined by the regulator are registered in the Kotak Grievance Management System either by the CSD/ Claims Team.

Step-wise process is as follows :

- The registration of the complaints is done in Kotak Grievance Management System as per the categories defined by IRDA and an acknowledgement with the stipulated time frame for the same is sent by CSD to the complainant.
- The facts of the case are analyzed and if the complaint cannot be reconsidered as per the opinion of the Claims teams of the grade L6 & above, then a communication to that effect is sent to the client.
- In case if the facts of the case and the information submitted by the claimant warrants a payment in any form then the opinion of the Internal Ombudsman or the Claims review Committee is taken as the case may be.
- When the final decision is taken a communication to that effect is given to the client with the time as stipulated by the regulator.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum*	157
State Commission	56
National Commission	6
Other Courts	
Civil Courts	23
High Courts @	6
Supreme Court	1
Total	**249**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

* Also includes cases pending before Permanent LokAdalat at District Level.

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

After receipt of customer-related litigations, the Legal Team assesses the grievance of the customers and the past communications, if any, between the customer and the Insurer, to find out the possibility of a settlement. At this very stage, many litigants are called up and possibility of settlement is explored. However, the experience so far is that most of the customers say that they need to speak to their lawyer. Ultimately, very few settlements actually materialize.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat						
Camps						
Others **(give details)**	1 (out of court settlement)	275,000/-	5 (out of court settlement)	1,191,796/-	6 (out of court settlement)	1,391,037.84/-
TOTAL	**1**	**275,000.00**	**5**	**1,191,796.00**	**6**	**1,391,037.84**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Life Insurance Corporation of India.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16 (Provisional)

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	99391	87276	53492	25306724	22869922	21048229	25310452	22895017	21040226	8387	8689	7386	87276	53492	54109
Pension	82484	43150	51175	95489	225012	363785	134823	216987	369199	0	0	0	43150	51175	45761
Health Insurance	93	0	79	18630	20105	22871	17177	18094	21030	1546	1932	1920	0	79	0
P&GS-Death	1095	928	885	266201	272866	239425	266367	272811	239393	1	98	98	928	885	819
P&GS-Maturity	295	339	875	509046	302070	443444	509002	301534	443728	0	0	0	339	875	591
MicroInsurance	36	34	9	12100	5103	9661	12050	5021	9563	52	74	93	34	42	14
Total	183394	131727	106515	26208190	23695078	22127415	26249871	23709464	22123139	9986	10793	9497	131727	106548	101294

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16 (Provisional)

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	21510817	20463617	17742883	2494434	1154987	1853919	683748	512199	727908	309548	383856	325680	311905	380358	389836
Health Insurance	18414	19848	23025	202	76	39	67	66	15	31	33	13	9	3	0
P&GS - Death	262290	272780	211738	3293	25	25886	782	3	376	0	2	6	2	1	0
P&GS - Maturity	*508961	*297876	*383971	0	0	62655	41	3658	395	0	0	83	0	0	0
Micro Insurance	12050	5021	9547	0	0	16	0	0	0	0	0	0	0	0	0
Total	22312532	21059142	18371164	2497929	1155088	1942515	684638	515926	728694	309579	383891	325782	311916	380362	389836

* Includes Claims settled on or before due date.

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16 (Provisional)

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	42864	28940	11005	30026	15392	7412	10124	6158	8078	2095	1480	7406	2167	1522	20208
Health Insurance	0	79	0	0	0	0	0	0	0	0	0	0	0	0	0
P&GS-Death	595	416	423	255	180	36	7	218	79	14	10	261	57	61	20
P&GS-Maturity	337	389	448	0	168	56	0	35	35	0	222	50	2	61	2
Micro Insurance	0	0	0	30	15	10	2	5	0	1	3	2	1	19	2
Total	43796	29824	11876	30311	15755	7514	10133	6416	8192	2110	1715	7719	2227	1663	20232

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	10532	87263118.82	10657	104428771.20	NA	NA
Pension	383	2001423.27	220	1751102.00	NA	NA
Health Insurance	NIL	NIL	NIL	NIL	NIL	NIL
P&GS	24	818033.00	49	1166223.00	76	616517.00
Micro Insurance	NIL	NIL	NIL	NIL	NIL	NIL
Total	**10939**	**90082575.09**	**10926**	**107346096.20**	**76**	**616517.00**

5. Constraints which cause delay in settlement of claims

- Non-receipt of NEFT Mandate Forms duly completed giving the Bank details of the policyholders wherever claim is due.
- Non-receipt of other requirements such as original policy bond, duly completed Discharge Form from the policyholders / claimants.
- Unable to establish contact with the policyholders wherever contact details such as address, telephone number, mobile number, email id have changed but the policyholders have not informed the Corporation to update the same in our records.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- On weekly basis, Information regarding pending Claims (of Health Insurance) for want of requirements is put on our website.
- Persistent and regular follow-up for requirements through registered post, telephone and through field force/marketing officials.
- Intimation of Survival Benefit claim is sent to the policyholder three months in advance from the due date of the claim along with Discharge Form, NEFT Mandate form through Speed Post / Registered Post. The policyholder is also informed through SMS and email (wherever details are available).
- Maturity Claim intimation for paid-up policies is sent to the policyholders 6 months in advance from the due date along with the Discharge Form and NEFT Mandate Form. For in-force policies, the Maturity Claim intimation is sent to the policyholders 3 months in advance from the due date. Such intimations are sent through Speed Post / Registered Post. The policyholder is also informed through SMS and email (wherever details are available).
- Review of responses from the policyholders to intimations is taken two months in advance.
- NEFT Mandate Forms are also sent to all the policyholders wherever Bank details is not available in our records.
- Constant monitoring is done to ensure that no Survival Benefit, Maturity Claim of in-force policies is pending beyond the due date and no Maturity Claim of paid-up policies is pending beyond one month from the due date.
- Death Claims are booked immediately on receipt of intimation letter from the nominee along with Death Certificate of the policyholder. All requirements are called for in one go through written communication or email / SMS (wherever details available).
- Follow-up is done to ensure that claim investigation wherever required is completed within 30 days from the date of entrusting the investigation to the official.
- Follow-up is done to obtain all requirements in case of Non-early death claims so that no claim is pending beyond one month from the date of intimation.

7. Institutional Framework for review of repudiated claims

LIC of India has adopted fair practices in the matter of settlement of claims by explicitly citing the grounds of repudiation in the letter conveying the decision to repudiate a death claim. A write up on why a death claim is repudiated with the copy of the proposal form is provided to the claimant with this letter.

Further, an opportunity of review of the repudiated clam within the organization is provided to the claimant and after having exhausted all avenues of review within the organization, the address of the Insurance Ombudsman is also provided in cases where the net claim amount is up to ` . 20 lacs.

For the purpose of review within the organization, when a claim is repudiated, the claimant is provided with the address of Zonal Office Claims Dispute Redressal Committee to prefer his / her appeal. ‘

Zonal Office Claims Dispute Redressal Committee [ZO CDRC] consists of senior officials of the Zonal Office and a retired District or High Court Judge who has been inducted to bring in transparency in the process of review vis-a-vis the claimant. Such Committees are functioning in all our 8 Zonal Offices at New Delhi, Kanpur, Bhopal, Kolkata, Hyderabad, Chennai, Mumbai and Patna.

On receipt of appeal from the claimant, ZO CDRC reviews the case. If the decision to repudiate the claim is upheld by the said Committee and if the net claim amount is less than the prescribed net claim amount for review by CO CDRC, the claimant is provided with the address of the Insurance Ombudsman. In respect of cases where net claim amount exceeds such stipulated amount, the claimant is provided with the address of the Central Office Claims Dispute Redressal Committee.

Central Office Claims Dispute Redressal Committee [CO CDRC] consists of senior officials of the Central Office and a retired High Court Judge. On receipt of appeal from the claimant, the case is reviewed by CO CDRC, which is again a fresh assessment. If the decision to repudiate the claim is upheld by CO CDRC, the claimant is informed of the decision and provided with the address of the Insurance Ombudsman for appeal.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	8056
State Commission	3268
National Commission	125
Other Courts	
Civil Courts	7709
High Courts @	
Supreme Court	
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	9

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Issued Circular Ref: Legal/Gen-96/dated 01.11.2002 to all zones in this regard.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil	Nil	Nil	Nil	Nil	Nil
Camps	Nil	Nil	Nil	Nil	Nil	Nil
Others (give details)	Nil	Nil	Nil	Nil	Nil	Nil
TOTAL	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF T HE INSURER: Max Life Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014- 15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated / rejected			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	8	4	7	6280	6316	6649	5740	6015	6345	544	298	306	4	7	5
ULIP	0	0	0	3046	2615	2427	2988	2554	2384	58	61	43	0	0	0
Pension	0	0	0	277	285	276	276	283	275	1	2	1	0	0	0
Health Insurance	0	0	0	236	182	170	214	177	157	22	5	13	0	0	0
Others (Pl. Specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**8**	**4**	**7**	**9839**	**9398**	**9522**	**9218**	**9029**	**9161**	**625**	**366**	**363**	**4**	**7**	**5**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	4804	4569	5290	837	1129	946	98	227	147	1	0	0	0	0	0
ULIP	2782	2249	2099	187	261	221	19	44	26	0	0	0	0	0	0
Pension	262	248	248	14	29	24	0	6	3	0	0	0	0	0	0
Health Insurance	191	135	120	19	41	34	1	3	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	8039	7291	7757	1057	1460	1225	121	278	179	1	0	0	0	0	0

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	4	6	5	0	0	0	0	1	0	0	0	0	0	0	0
ULIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	4	6	0	0	0	0	0	1	0	0	0	0	0	0	0

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	67	128,928	25	47381	68	108697
ULIP	8	141,558	1	1 25660	26	81956
Pension	1	12,679	2	52	3	111
Health Insurance	1	1,208	2	1868	3	2533
Others	0	-	0	-	0	-
Total	**77**	**284,374**	**40**	**74961**	**100**	**192031**

5. Constraints which cause delay in settlement of claims

1. Non-submission of requisite medical records from hospitals/clinics.
2. Non-availability/non-cooperation from Government authorities like Police, Hospitals, RTI response etc.
3. Non- cooperation by claimant/family in the claim documentation process.

6. Initiatives taken by the company to ensure expeditious settlement of claims

At Max Life Insurance Claims Unit, we follow the principle of Treating Customers Fairly. Our guiding philosophy is assessing claims in a fair, prompt and consistent manner.

Our processes are designed to provide a hassle-free claims experience and we are committed to providing the best in class service experience.

Some of the initiatives taken by us to expedite claim settlement are as below

1. Use of automated end to end workflow for faster claims processing. -
2. Electronic fund transfer of claim proceeds re sulting in faster claim settlement.
3. Extensive training of claims assessors. We train our assessors to approach every claim with 'Intent to Pay' unless fraud is established.
4. Enrolment of Investigation agencies with wide geographic reach resulting in fast tr ack investigation closures. Smart categorization of investigation assignments based on various factors like degree of suspicion, claim amount etc.
5. Continuous education & feed forward loops for Distributors and customers on claims process & documentation.

7. Institutional Framework for review of repudiated claims

At grievance/litigation stage, we continue to abide by the principle of Treating Customers Fairly. We have grievance redressal policy in place which is in compliance with the Regulation 5 of IRDA (Protection of Policyholders' Interest, 2002) and Guidelines For Grievance Redressal , 2010.

For repudiated claims we have a robust review mechanism in place :

1. We have an independent body- Claims Council in place that constitutes following members- Chief Operations Officer, Head of Customer Service & Operations, Appointed Actuary, Head of Legal, Regulatory & Compliance, Chief Underwriter and Head of Claims.
2. All grievances/litigation are thoroughly reviewed by the Head Claims and Chief Underwriter.
3. At litigation stage, inputs are taken from our in-house legal team & merits of the case are reviewed afresh.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	148
State Commission	55
National Commission	6
Other Courts	
Ombudsman/ PLA	22
Civil Courts	46
High Courts @	8
Supreme Court	1
Total	**286**
@ of these, the number of appeals against orders of Insurance Ombudsman	**1**

* Data is as on 29 Feb.,2016

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Reconsideration of cases basis change in laws by way of recent pronouncements and filing settlement application suo moto;
2. By paying requisite compensation, in certain cases;
3. By directly approaching the customer in cases where the opposite counsel representing the claimant is hindering the settlement process.

10. Statistics of cases settled out of court (specify other mechanisms)

Category		YR(2013-14)		YR(2014-15)		YR(2015-16)	
		No. of claims	Amount (in Lac)	No. of claims	Amount (in Lac)	No. of claims	Amount (in Lac)
Lok Adalat				5	10.13	5	20.93
Camps							
Others	District Consumer Forum	57	238.55	29	152.16	227.	54
	Ombudsman	5	22.38	8	30.72	10	35.95
	Civil Court	5	14.46	1	1.20	2	5.55
	Criminal Court	1	10.00				
	National Commission	2	3.05			1	7.30
	State Commission	8	24.46			5	31.27
	High Court			2	12.18		
TOTAL		**75**	**312.9**	**45**	**206.39**	**55**	**328.54**

INFOINFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: PNB MetLife India Insurance Co .Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014- 15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	42	5	28	1138	1310	1727	941	1152	1310	234	131	426	5	28	19
ULIP	25	3	9	1240	1110	1314	1260	1100	1316	2	0	0	3	9	7
Pension	0	0	0	63	38	15	63	38	15	-	0	0	0	0	0
Health Insurance	16	3	4	94	31	11	75	26	7	32	4	2	3	4	3
Others (pl.Specify)	7	1	-	1356	676	-	1358	665	-	4	1	-	1	-	-
Total	**90**	**12**	**41**	**3891**	**2489**	**3067**	**3697**	**1782**	**2648**	**272**	**78**	**428**	**12**	**42**	**29**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	941	1150	1270	0	2	37	0	0	3	0	0	0	0	0	0
ULIP	1253	1083	1294	7	13	19	0	4	3	0	0	0	0	0	0
Pension	63	38	15	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	74	12	2	1	12	3	0	2	2	0	0	0	0	0	0
Others	1353	-	-	5	-	-	0	-	-	0	0	0	0	0	0
Total	**3684**	**2283**	**2581**	**13**	**27**	**59**	**0**	**6**	**8**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	4	14	14	1	7	3	0	7	2	0	0	0	0	0	0
ULIP	1	2	5	2	6	1	0	1	1	0	0	0	0	0	0
Pension	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Insurance	3	2	0	0	2	2	0	0	1	0	0	0	0	0	0
Others	1	-	-	0	-	-	0	-	-	0	0	0	0	0	0
Total	**9**	**18**	**19**	**3**	**15**	**6**	**0**	**8**	**4**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	19	21259	0	0	6	33171.75
ULIP	30	450108	0	0	16	53834
Pension	1	824	0	0	0	0
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**50**	**472191**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Submission of incomplete documents at the time of claim intimation.
2. Fraudulent claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. MET Care Kit (simplified docket which contains details of required documents and forms for processing claims) is despatched to customers on receipt of claim intimation. Claim form is in regional language
2. Arranging for document pick-up from the claimants.
3. Focus on prompt investigation and report submission.

7. Institutional Framework for review of repudiated claims

All cases recommended for repudiation are reviewed by legal team independently and then decision is taken. In such cases where the claim is repudiated the communication sent to the claimant contains the details of The Chairman, Claims Committee and ombudsman to appeal in case customer is not satisfied with the decision. Customer may submit a written request for review of the claim decision, which would be independently reviewed by claims committee comprising various functional heads. The review decision is signed-off by two members other than those who were part original decision.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	186
State Commission	65
National Commission	12
Other Courts	
Civil Courts	37
High Courts @	2
Supreme Court	1
Total	**303**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

We, at PNB MetLife India Insurance Company Ltd, have a Board approved policy and a robust process in place for the settlement of litigations, out of the court. The company's motto in litigation management itself is to "Settle wherever we can and contest where ever we must". The company's philosophy is to extend the benefit of doubt to the customers. We actively participate in Lok Adalats and mediations wherever &whenever it is possible. The legal department evaluates every case on merits and in accordance with the philosophy and process of the company before deciding to contest it, as promoting settlement also saves substantial litigation costs of the compa

10. Statistics of cases settled out of court (specify other mechanisms)**

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	-	-
Camps	-	-	-	-	-	-
Others (give details)	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-

** We have settled claim cases with the claimants on frequent occasions by complying with the orders of courts/forums without taking recourse to the appellate mechanism, in line with our litigation management philosophy

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : RELIANCE NIPPON LIFE INSURANCE CO. LTD.

I. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	1,033	1,152	729	10,985	11,122	9981	8,849	9,827	9978	2,024	883	594	1,152	729	145
ULIP	302	390	299	7,825	5,056	3312	7,428	4,916	3438	318	118	127	390	299	37
Pension	21	35	22	845	435	268	830	446	291	3	-	-	35	22	1
Health Insurance	172	140	110	3461	2628	2027	1490	990	1000	2003	1668	1028	140	110	109
Others(Annuity)	-	-	-	-	12	7	-	10	7	-	-	-	-	-	-
Total	**1,528**	**1,717**	**1,160**	**23,116**	**19,253**	**15,595**	**18,597**	**16,189**	**14,714**	**4,348**	**2,669**	**1,749**	**1,717**	**1,160**	**292**

II. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	5,243	6,231	7517	2,813	3,042	1427	694	354	151	57	71	210	42	129	673
ULIP	6,658	4,268	2631	512	452	138	146	116	40	88	22	75	24	58	554
Pension	770	422	218	26	17	2	4	5	4	29	0	3	1	2	64
Health Insurance	3390	2652	2023	103	6	5	0	0	0	0	0	0	0	0	0
Others (Annuity)	0	9	5	0	1	0	0	0	0	0	0	1	0	0	1
Total	**16,061**	**13,582**	**12,394**	**3,454**	**3,518**	**1,572**	**844**	**475**	**195**	**174**	**93**	**289**	**67**	**189**	**1,292**

III. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	624	398	93	390	189	37	41	27	6	53	36	8	44	79	1
ULIP	205	110	21	60	34	11	20	16	1	36	33	1	69	106	3
Pension	20	2		0	0	1	4	0		1	8		10	12	
Health Insurance	139	109	109	1	1	0	0	0	0	0	0	0	0	0	0
Others	0	0		0	0		0	0		0	0		0	0	
Total	**988**	**619**	**223**	**451**	**224**	**49**	**65**	**43**	**7**	**90**	**77**	**9**	**123**	**197**	**4**

IV. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	292	9,90,972.42	152	36,76,854.56	620	1,09,24,627.87
ULIP	843	9,19,992.87	171	12,20,837.47	536	20,39,692.84
Pension	0	0	0	0	64	1,19,506.84
Health Insurance	NA	NA	NA	NA	NA	NA
Others	0	0	0	0	1	2,767.65
Total	**1,135**	**19,10,965.29**	**323**	**48,97,692.03**	**1,221**	**1,30,86,595.20**

V. Constraints which cause delay in settlement of claims

The challenges are with respect to authenticating the information through proper evidence regarding the circumstances and reason of death:

1) Death certificates and cremation records: Especially for non-urban areas in there is no central place where the death certificate can be authenticated. Further the cremation records are not available in non-urban areas
2) Non-cooperation of hospitals: Hospitals do not provide medical information to our investigators even when authorization letter from us as well as the nominee is available with our investigator
3) Fraudsters: There are fraudsters who make it difficult and at times threaten investigators from conducting proper investigations.

   Non-participation of banks in NEFT: We have nominees having bank accounts with branches in rural banks which do not necessarily participate in NEFT.

VI. Initiatives taken by the company to ensure expeditious settlement of claims

1) We have launched Service Guarantee for Ordinary Claims within 12 days it was launched in FY14-15
2) Claims settled through NEFT. We are also exploring Aadhar based payments specially for non-urban areas
3) Investigators are given specific and detailed guidelines to investigate the claims thereby mitigating the need for reinvestigation.
4) Claims experience is analysed and looped back to underwriting to enable enhancing underwriting rules to identify policies which are fraudulent in nature so that at underwriting of the proposal proper risk assessment can be done.

   We also do scientific and stratified data based sampling for post issuance risk verification within couple of months of issuance. This further helps us to identify risks early on and also to further enhance our underwriting assessment.

VII. Institutional Framework for review of repudiated claims

1) Early claims based on criteria are sent for investigations. The investigators are giving specific guidelines for investigation

2) Authority to repudiate the claims is with Head of the department (HOD), COO and Claims Review Committee (CRC). CRC comprises of CRO, COO, Appointed Actuary, Underwriting Head and CFO. Claims above certain criteria needs to go to COO or CRC for repudiation based on recommendation of the claims team.

3) Concurrence is taken from Legal team regarding the evidence collected and reason for repudiation prior to recommending the cases to COO or CRC for repudiation

Reconsideration policy is in place for evaluating the request from nominee for reconsideration of the repudiation decision.

VIII. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	620
State Commission	162
National Commission	10
Other Courts	
Civil Courts	10
High Courts @	5
Supreme Court	1
Total	**808**
@ of these, the number of appeals against orders of Insurance Ombudsman	1

IX. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Nil

X. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	Nil	Nil	Nil	Nil	Nil	Nil
Camps	Nil	Nil	Nil	Nil	Nil	Nil
Others (give details)	Nil	Nil	Nil	Nil	Nil	Nil
TOTAL	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : SAHARA INDIA LIFE INSURANCE CO. LTD.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	48	9	21	442	521	626	430	474	573	51	21	35	9	21	24
ULIP	21	7	6	325	240	138	324	225	141	15	11	1	7	7	1
Pension			1		1	2		1	3						
Health Insurance															
Others (pl specify)															
Total	**69**	**16**	**28**	**767**	**762**	**766**	**724**	**700**	**737**	**66**	**32**	**36**	**16**	**28**	**25**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	320	364	485	74	79	57	27	32	25	9	1	6			
ULIP	272	211	140	36	12	1	11	2		5					
Pension		1	3												
Health Insurance															
Others															
Total	**592**	**577**	**528**	**110**	**91**	**58**	**38**	**34**	**25**	**14**	**1**	**6**			

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	**5**	**8**	**16**	**2**	**8**	**7**	**2**	**5**	**1**						
ULIP	**7**	**1**	**1**		**1**			**5**							
Pension															
Health Insurance															
Others															
Total	**12**	**9**	**17**	**2**	**9**	**7**	**2**	**10**	**1**						

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Conventional	13	8469.39			16	5542.10
ULIP	5	8779.59	2	2658.34		
Pension						
Health Insurance						
Others						
Total	**18**	**17248.98**	**2**	**2658.34**	**16**	**5542.10**

5. Constraints which cause delay in settlement of claims

- Since most of our policyholder's reside in villages it is difficult to gather evidentiary documents w.r.t. pre existing illness. A primary health center which is the only accessible venue does not keep documents in many cases. Hospitalization before death proves that the life assured had pre existing illness but paucity of documentary evidence and its collection takes time. Medical cause of death is not clear in most cases.
- Secondly, since it is the uneducated class, the claimant too has difficulty in comprehending the requirements placed by us. There is considerable delay in sending bank details since claimants; usually ladies do not have bank accounts in their name.
- The proforma of death certificate at villages is not in consonance with the legal requirements.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Telephonic enquiries are made with the claimants where there is delay in reply from claimants. We take services of marketing executives in ensuring that the compliance from claimant is expedited and explain the requirement of medical documents. Claim form has been made bilingual for proper understanding.

7. Institutional Framework for review of repudiated claims

- We have a Claim Review Committee headed by Justice (Retd.) S.C.Verma, who is also ex lokayukt, Govt. of U.P. Our letter on repudiation of claim mentions the facility of representation to claim review committee.

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	16
State Commission	7
National Commission	1
Other Courts	
Civil Courts	1
High Courts @	
Supreme Court	
Total	**25**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Forum and Courts (like Lok Adalat, Settlement camps etc.)

- We have placed request to our legal counsels to request for dismissal of cases at District Forums which are pending for more than two year s and have not been attended by the complainants (claimants). Cases where there is continued absence of claimants.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	2	1060000	0		0	
Camps						
Others (give details)						
TOTAL	**2**	**1060000**				

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: SBI Life Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	157	441	420	17502	17105	20427	16460	16063	19834	758	1063	760	441	420	253
ULIP	121	172	180	6679	6055	6436	6420	5825	6329	208	222	162	172	180	125
Pension	38	41	47	2165	1546	1049	2156	1539	1064	6	1	1	41	47	31
Health Insurance	170	106	30	1471	603	210	518	279	135	1017	400	85	106	30	20
Others (pl specify)	3	2	2	45	117	7474	46	117	7432	0	0	19	2	2	25
Total	**424**	**634**	**500**	**15450**	**14951**	**15842**	**13478**	**13632**	**15245**	**1762**	**1453**	**766**	**634**	**500**	**331**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	15137	13936	17401	1967	2907	2830	94	269	336	17	14	24	3	0	3
ULIP	6137	5345	5712	436	666	709	36	35	68	6	1	1	13	0	1
Pension	2100	1506	1024	44	34	40	6	0	1	7	0	0	5	0	0
Health Insurance	864	345	99	319	186	60	255	118	30	86	28	20	11	2	11
Others	37	84	7028	8	30	412	1	1	10	0	2	1	0	0	0
Total	**13072**	**12158**	**13358**	**1652**	**2541**	**2330**	**374**	**339**	**290**	**113**	**45**	**21**	**29**	**2**	**12**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	**243**	**219**	**96**	**90**	**95**	**45**	**54**	**34**	**23**	**26**	**19**	**23**	**28**	**53**	**66**
ULIP	**86**	**80**	**27**	**21**	**21**	**8**	**15**	**17**	**11**	**15**	**14**	**22**	**35**	**48**	**57**
Pension	**13**	**22**	**2**	**5**	**2**	**2**	**4**	**4**	**1**	**4**	**4**	**7**	**15**	**15**	**19**
Health Insurance	**46**	**10**	**9**	**55**	**8**	**9**	**4**	**3**	**2**	**1**	**4**	**0**	**0**	**5**	**0**
Others	**1**	**1**	**14**	**0**	**1**	**7**	**1**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**1**
Total	**318**	**238**	**89**	**147**	**100**	**54**	**65**	**42**	**29**	**42**	**28**	**48**	**62**	**92**	**111**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	540	2178555	498	1228838	153	1785206
ULIP	230	1351335	70	366552	157	704878
Pension	100	81171	0	0	22	46220
Health Insurance	276	191232	0	0	27	118876
Others	7	13736	0	0	0	0
Total	1153	3816030	568	1595390	359	2655180

5. Constraints which cause delay in settlement of claims

1. Difficulty in procuring papers from Hospitals, Police authorities or any other agencies
2. Admitted claims where the title is not clear.
3. Increase in suspicious/fraudulent claims requiring extra efforts and time in investigation.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Involving our local branch offices in collection of requirements.
2. Entrusting procurement of documents in non-investigated cases to outside agencies.
3. Rigorous follow-up from Head Offic
4. Close monitoring of TAT for Non Early claims

7. Institutional Framework for review of repudiated claims

Whenever a Claim is Repudiated/Rejected, the claimant is communicated about the claim decision and an option is provided to appeal against the claim decision to the Claims Review Committee. The Claims Review Committee (CRC) of SBI Life meets once in a month. The CRC consists of the following members:

- Retired High Court Judge
- Deputy CEO
- ED –Actuarial & Risk
- ED – Operations & IT
- Chief Operating Officer
- Head –Legal
- Head- Underwriting

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES as on March 31, 2016
Consumer Courts	
District Forum	443
State Commission	164
National Commission	22
Other Courts	
Civil Courts	131
High Courts @	38
Supreme Court	0
Total	**798**
@ of these, the number of appeals against orders of Insurance Ombudsman	1

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

Wherever additional information or documents are produced by the claimants which are not on the records of the Company, the company is settling the claims by way of compromise during the pendency of any litigation and ensuring amicable settlement of the cases. The table given below gives the no of cases so settled.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	0	0	2	0.50	2	7.20
Camps	0	0	0	0	0	0
Others	4	3.25	3	0.95	4	12.70
TOTAL	**4**	**3.25**	**5**	**1.45**	**6**	**19.90**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: : Shriram Life Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	57	168	208	804	1346	1938	420	868	1188	271	414	696	168	208	261
ULIP	24	22	12	542	423	352	546	418	324	0	27	12	22	12	11
Pension	Nil	Nil	Nil	Nil	1	Nil	Nil	1	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Health Insurance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others (pl specify)	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Total	**81**	**190**	**220**	**1346**	**1770**	**2290**	**966**	**1287**	**1512**	**271**	**441**	**708**	**190**	**220**	**272**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	224	443	664	289	434	666	131	261	381	39	114	132	8	26	34
ULIP	405	334	277	100	72	46	18	23	11	11	6	4	12	14	5
Pension	Nil	1	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Health Insurance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Total	**629**	**778**	**941**	**389**	**506**	**712**	**149**	**284**	**392**	**50**	**120**	**136**	**20**	**40**	**39**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	29	80	128	65	103	97	52	13	26	17	4	4	5	7	6
ULIP	6	5	2	5	1	5	3	1	0	3	1	1	5	5	3
Pension	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Health Insurance	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Others	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Total	**35**	**85**	**130**	**70**	**104**	**102**	**55**	**14**	**26**	**20**	**5**	**5**	**10**	**12**	**9**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	11	255816	14	200556	20	496968
ULIP	23	1680460.06	8	346569	4	217293
Pension	Nil	Nil	Nil	Nil	Nil	Nil
Health Insurance	Nil	Nil	Nil	Nil	Nil	Nil
Others	Nil	Nil	Nil	Nil	Nil	Nil
Total	34	1936276.06	22	547125	24	714261

5. Constraints which cause delay in settlement of claims

Delayed submission of documentary requirements by Claimants. Fraud and very early claims consume more time in closure as syndicates obstruct investigations.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Have set up dedicated claims help desk for claims only.Company also uses its call centre to continuously remind customers for early submission of documents.

7. Institutional Framework for review of repudiated claims

ICRC, The Internal Claims Review Committee continuously works to decide on claims rejected by the company and represented by claimants.In some cases we pay expedite Ex Gratia settlements compassionately.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	136
State Commission	41
National Commission	4
Other Courts	
Civil Courts	0
High Courts @	5
Supreme Court	0
Total	**186**
@ of these, the number of appeals against orders of Insurance Ombudsman	05

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

NIL

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat						
Camps						
Others (give details)			01	2.5 Lakhs	01	2.5 Lakhs
TOTAL			**01**	**2.5 Lakhs**	**01**	**2.5 Lakhs**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Star Union Dai-ichi Life Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	15	7	2	321	540	606	294	496	409	35	49	58	7	2	141
ULIP	36	2	2	492	597	672	497	575	613	29	22	14	2	2	47
Pension	5	0	0	153	120	83	158	120	80	0	0	0	0	0	3
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (Group Death)	33	0	0	1531	907	5081	1555	901	4740	9	6	32	0	0	309
Total	**89**	**9**	**4**	**2497**	**2164**	**6442**	**2504**	**2092**	**5842**	**73**	**77**	**104**	**9**	**4**	**500**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	223	481	324	86	53	74	16	10	69	4	0	0	0	1	0
ULIP	370	558	547	122	36	43	22	2	37	11	0	0	1	1	0
Pension	144	117	75	13	2	5	1	1	0	0	0	0	0	0	0
Health Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others (Group Death)	1417	865	4423	70	35	312	77	7	36	0	0	1	0	0	0
Total	**2154**	**2021**	**5369**	**291**	**126**	**434**	**116**	**20**	**142**	**15**	**0**	**1**	**1**	**2**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	**5**	**0**	**42**	**1**	**0**	**53**	**0**	**2**	**40**	**1**	**0**	**5**	**0**	**0**	**1**
ULIP	**0**	**1**	**22**	**1**	**0**	**8**	**0**	**1**	**14**	**0**	**0**	**2**	**1**	**0**	**1**
Pension	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Health Insurance	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Others (Group Death)	**0**	**0**	**124**	**0**	**0**	**118**	**0**	**0**	**53**	**0**	**0**	**14**	**0**	**0**	**0**
Total	**5**	**1**	**190**	**2**	**0**	**180**	**0**	**3**	**107**	**1**	**0**	**21**	**1**	**0**	**2**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR(2012-13)		YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	7	1950.40	0	0.00	10	46837.00	8	26651.27
ULIP	22	165745.76	7	237042.72	57	380697.33	7	77011.17
Pension	39	58800.71	1	638.54	6	6386.51	1	177.61
Health Insurance	0	0.00	0	0.00	0	0.00	0	0.00
Others (Group Death)	7	35657.87	0	0.00	0	0.00	0	0.00
Total	**75**	**262154.74**	**8**	**237681.26**	**73**	**433920.85**	**16**	**103840.04**

5. Constraints which cause delay in settlement of claims

a. Non-receipt of claim documents (mandatory and medical documents) from the claimant

b. Open Title cases where nominee has pre-deceased the Life Assured. In such cases, procuring Joint Indemnity from Class I legal heirs / Succession Certificate from Class II legal heirs, causes delay in claim settlement

c. Fraudulent claims which warrant thorough end to end checks, right from Acquisition stage to Claims stage.

6. Initiatives taken by the company to ensure expeditious settlement of claims

a. Robust follow up mechanism is in place. Claimants are sent Requirement letter and the Reminder letters to submit pending claim documents

b. Claim Assistance is provided to illiterate / rural claimants. Through this Assistance, documents are procured from Hospitals / Doctors, etc, by the Agency, on behalf of the Claimant and submitted to SUD Life

c. Decentralized follow up done by Regional Offices & Branch Offices with the Claimant, to submit pending documents

7. Institutional Framework for review of repudiated claims

Claims Review Committee comprising of Senior Management and external member (Retired Justice of Mumbai High Court) is formed to review the representations of the claimants. Claimant's representation along with Case Facts is reviewed independently by the Committee. An unbiased decision is arrived at by the Committee, by taking the joint consensus of each and every member of the Committee. The decision taken by Claims Review Committee is communicated to the Claimant

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	31
State Commission	6
National Commission	1
Other Courts	
Civil Courts	3
High Courts @	1
Supreme Court	
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	**NIL**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The company has taken the initiative and settled 2 cases. Out of two vases one case is settled through Lok Adalat and one out of court.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	-	-	-	-	1	Rs. 15,000/-
Camps	-	-	-	-		
Others (give details)	-	-	-	-	1	Rs. 25,000/-
TOTAL	**-**	**-**	**-**	**-**	**2**	**Rs. 40,000/-**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : TATA AIA Life Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	230	164	57	3112	2795	3016	2886	2720	2942	292	182	131	164	57	0
ULIP	69	58	15	2353	1735	1236	2236	1733	1244	128	45	7	58	15	0
Pension	6	6	1	357	225	187	356	229	188	1	1	0	6	1	0
Health Insurance	12	3	0	522	348	274	491	340	274	40	11	0	3	0	0
Others (pl specify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**317**	**231**	**73**	**6344**	**5103**	**4713**	**5969**	**5022**	**4648**	**461**	**239**	**138**	**231**	**73**	**0**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	2031	1949	2595	673	588	377	408	281	79	56	46	10	10	38	12
ULIP	2047	1559	1201	236	150	33	71	41	3	7	10	2	3	18	12
Pension	342	209	182	12	11	5	1	6	0	0	1	0	2	3	1
Health Insurance	450	347	274	72	3	0	8	1	0	1	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4870**	**4064**	**4252**	**993**	**752**	**415**	**488**	**329**	**82**	**64**	**57**	**12**	**15**	**59**	**25**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Conventional	65	22	0	52	16	0	16	8	0	9	5	0	22	6	0
ULIP	26	4	0	8	0	0	8	0	0	1	2	0	15	9	0
Pension	1	0	0	1	0	0	1	0	0	0	0	0	3	1	0
Health Insurance	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**95**	**26**	**0**	**61**	**16**	**0**	**25**	**8**	**0**	**10**	**7**	**0**	**40**	**16**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Conventional	68	314763.3	17	60950.39	4	13904.62
ULIP	5	61881.5	4	31206.60	1	1869.86
Pension	0	0	3	47.32	1	4
Health Insurance	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	**73**	**376644.8**	**24**	**92204.31**	**6**	**15778.48**

5. Constraints which cause delay in settlement of claims

1. Sometimes claimants do not readily share the required documents despite sending pending letters and follow-up over phone.
2. Procuring medical treatment records from hospitals / health centers generally causes a lot of delay. In the absence of any law / guidelines, hospitals sometimes refuse to share information or provide the required information / documents only after a lot of follow up causing significant delays in claim settlement.
3. Verification of forged documents with Government authorities sometimes takes up a lot of time.
4. In cases where the cause of death is unnatural (suspected suicide within one year of risk commencement or accident caused under the influence of alcohol / drugs etc.) we await the Final Police report and the Chemical Viscera Report to ascertain the exact cause. These 2 documents hold up claims decision.
5. In Open Title cases where we are not able to establish the payee because of various reasons (no nomination/nominee dead/ appointee dead) we await the succession certificate/legal heir certificate/ legal guardianship certificate. The procurement of these documents delays the settlement of claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. We send SMS communication to the claimants at intimation, decision, payment & requirement stage informing them about the requirements pending for claim settlement. This is in addition to the letters sent by post / courier. For long pending claims, that is claims pending for more than a month, we call up the claimants to explain the reason for delay.
2. We have simplified claim process for non-early claims by reducing documentation.
3. We have an Online Claim Intimation Process whereby the claimant can lodge the claim intimation through TALIC website and can also upload the documents. Claimants can also track the status of their claim on our website.
4. We regularly engage with our advisors to train them and reiterate to them about the Claim process/requirements so that they can assist the claimants on the queries/ documentation.
5. We have a process of Condolence Calling whereby claims team calls up the customer within 2 days of claim intimation. During this call we offer condolence and acknowledge the claim lodged. We also convey the claim requirements to the claimant. We offer all support including in some cases in arranging to collect Claim documents through investigators/employees. This in turn speeds up the entire claim settlement process.
6. We emphasize on automation and regular improvements in processes for faster processing of claims. Our internal benchmarks for Turn Around Time (TAT) are regularly revised and monitored so that our response time to customers / claimants are the best that we can provide.
7. For open title cases, where the claim amount is not large, we determine the legal heirs and basis indemnity and affidavit, settle the claim in favour of legal heir(s), after proper due diligence.

7. Institutional Framework for review of repudiated claims

Tata AIA Life has a robust process for review of repudiated claims and any grievances or representations regarding the claims repudiation decisions. A claim cannot be repudiated unless it is reviewed by the Head of Claims (function head). The authority of repudiation of claims, irrespective of the amount involved, is with the Head of Claims. If an aggrieved or dissatisfied claimant represents against a repudiation decision, the case has to be necessarily put up to the Claims Review Committee. This Committee is made up of select heads of departments / functions including Legal or their representatives and an independent member with experience of the insurance industry as well as of arbitration / legal matters. The Committee reviews all the representation cases and communicates their decision to the Claims department. The Committee may agree with claims department decision, may advice the claims department to settle the claim or recommend that the claim may be paid as ex-gratia.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	350
State Commission	98
National Commission	15
Other Courts	
Civil Courts	47
High Courts @	12
Supreme Court	0
Total	**522**
@ of these, the number of appeals against orders of Insurance Ombudsman	9

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

In case of succession applications, the company has shown its willingness to the concerned to release amount of claim as per the direction of the court. Similar approach has been taken in case of rival claim cases, in order to settle the matters. Further, in cases where Forum or Lok Adalat has passed orders against the company, the company has not challenged said orders in higher courts, if the case does not have good merits.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NA	NIL	NA	NIL	NA
Camps	NIL	NA	NIL	NA	NIL	NA
Others (give details)	NIL	NA	NIL	NA	NIL	NA
TOTAL	**NIL**	**NA**	**NIL**	**NA**	**NIL**	**NA**

CLAIMS

(Claim settlement and related information received from the General Insurers)

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : AIC of INDIA

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health															
Misc.	9131408	9547634	8152146	15381717	10545322	14948249	9056170	11536919	10315578	7876	238	4722	15447468	8152146	12564361
Total	9131408	**9547634**	**8152146**	**15381717**	**10545322**	**14948249**	**9056170**	**11536919**	**10315578**	**7876**	**238**	**4722**	15447468	**8152146**	12564361

2. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health															
Misc.	0	2745636	410408	5228393	4049924	5177111	2443813	3173150	1967124	1129063	1256509	1713194	262776	311700	1047741
Total	0	**2745636**	**410408**	**5228393**	**4049924**	**5177111**	**2443813**	**3173150**	**1967124**	**1129063**	**1256509**	**1713194**	**262776**	**311700**	1047741

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health															
Misc.	0	2267080	3701106	11479130	3344033	5459281	1085305	854974	1146881	648273	32888	906478	2234759	1653171	1350615
Total	0	**2267080**	**3701106**	**11479130**	**3344033**	**5459281**	**1085305**	854974	**1146881**	**648273**	**32888**	906478	2234759	1653171	1350615

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health						
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	NIL	NIL	NIL	NIL	NIL	NIL

5. Constraints which cause delay in settlement of claims

- delay in receipt of yield data
- delay in receipt of share of Govt. towards their liability in premium subsidy and/or claims
- delay in receipt of area sown data from State Govt.
- delay in receipt of consent for application of area reduction factor
- inaccurate bank account details

6. Initiatives taken by the company to ensure expeditious settlement of claims

- follow up with Govts. for release of their share in liabilities
- follow up with State Govt. to provide upfront premium subsidy and make adequate budgetary provision

7. Institutional Framework for review of repudiated claims

- there is a committee formed by MOA, GOI to consider additional claims i.e. claims reported after settlement of claims under Govt. formulated schemes mainly due to bank's errors, which are not normally accepted as per scheme provisions.
- for other products, Technical committee considers such claims

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	2915
State Commission	1180
National Commission	90
Motor Claims related	
MACT	
Appeals with High Court	
Appeals before Supreme Court	
Other policyholder related cases	
Civil Courts	18
High Courts @	407
Supreme Court	668
Total	**5278**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

NIL

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	NIL	NIL	NIL	NIL	NIL	NIL
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others (give details)	NIL	NIL	NIL	NIL	NIL	NIL
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Apollo Munich Health Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	6,224	10,143	8,438	144,895	133,160	169,910	121,065	119,999	150,039	19,911	14,866	18,866	10,347	8,438	9,443
Misc.	177	204	263	1,295	1,346	1,910	744	762	1,200	524	525	609	204	263	364
Total	6401	**10347**	**8701**	**146190**	**134506**	171820	**121809**	**120761**	**151239**	**20435**	**15391**	**19475**	**10551**	**8701**	**9807**

2. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	104,462	119,999	150,039	13,834	-	-	2,076	-	-	549	-	-	144	-	-
Misc.	288	762	1,200	329	-	-	91	-	-	31	-	-	5	-	-
Total	104,750	120,761	151,239	14,163			2,167			580			149		

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	3,985	8,438	9,443	2689	-	-	3,008	-		409	-	-	256	-	-
Miscellaneous	50	263	364	26	-	-	92	-	-	11	-	-	25	-	-
Total	4,035	8,701	9,807	2715			3,100			420			281		

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health					14	4,700
Miscellaneous						
Total					14	4,700

5. Constraints which cause delay in settlement of claims

1. A fraud or suspected case requiring verification of the facts
2. Delay in completing pending requirements at customer's end

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Dedicated team for regular calling and reminder process for customer to submit pending documents
2. Fast-track verification to ensure timely processing

7. Institutional Framework for review of repudiated claims

1. Customer can request for redressal of claims rejection on communication of decision
   I. CRM/Customer Service team – reviewed by second doctor
   II. Grievance – reviewed by grievance handling doctor/medical team lead/ Head of claims
2. The rejected claim in never redressed by the initial reviewer who rejected the claim to avoid bias

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	351
State Commission*	32
National Commission	1
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	9
High Courts @*	3
Supreme Court	0
Total	**396**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

* **This report also contains such cases which have been filed by Apollo Munich Health Insurance Company Limited before the respective State Commissions / High Court.**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

Whenever we receive any case before various Court and Consumer Forum, we thoroughly review the merits of the case and also seek counsel opinion if required, considering the legal implication and intricacies. We also explore the possibility of out of court settlement with the customer or even before the Original Court with the help of Presiding Officer.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat*	3	72223	2	59625	5	290415
Camps	0	0	0	0	0	0
Others (give details)*	18	1561408	14	929597	29	2617138
TOTAL	**21**	**1633631**	**16**	**989222**	**34**	**2907553**

* **This report does not contain Ombudsman Cases. In case any such detail is required to be reported we may be instructed accordingly.**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Bajaj Allianz General Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	689	896	8585	2115	17507	5970	1575	18299	8218	333	344	830	896	8585	3301
Marine	963	911	1150	9372	9811	11160	9039	8882	8987	385	339	393	911	1150	1386
Motor	6201	7837	6194	399829	428198	479396	402091	438332	481930	26876	33179	27736	6199	7837	6194
Health	6171	26156	3207	331394	148006	241016	286090	164741	220863	25319	6214	18718	26156	3207	4642
Misc.															
Total	**14024**	**35800**	**12942**	**342881**	**175324**	**258146**	**296704**	**191922**	**719998**	**26037**	**6897**	**19941**	**34162**	**20779**	**9329**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	432	9610	1297	449	3746	1176	411	4566	3936	182	252	1529	101	125	280
Marine	5095	5399	4853	2541	2080	2463	893	855	1105	344	370	404	166	178	162
Motor	340947	359314	403452	48047	55828	61231	9660	11899	12802	2426	3221	3284	1011	8070	1161
Health	226207	165612	219337	51985	4597	17974	31349	176	1691	1754	189	291	114	381	288
Miscellaneous															
Total	231734	539935	225487	103022	66251	82844	42313	17496	19534	4706	4032	2224	1392	8754	1891

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	124	962	308	89	2049	314	141	4767	440	130	199	620	412	608	1619
Marine	292	298	331	155	202	211	105	122	164	63	155	161	296	373	519
Motor	2753	3199	3128	1309	1713	1755	429	798	1009	223	482	241	1487	1645	61
Health	5575	2554	4125	3061	364	269	10865	24	34	6009	18	53	646	247	161
Miscellaneous															
Total	5991	3814	4764	3305	4328	2549	11111	5711	638	6202	372	1075	2841	2873	2360

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor	5519	384,476,181	4504	409,843,624	5535	562,181,146
Health						
Miscellaneous						
Total	**5519**	**384,476,181**	**4504**	**409,843,624**	**5535**	**562,181,146**

5. Constraints which cause delay in settlement of claims

- Health: Deficiencies in claim documents
- Motor: Delay due to J&K and Chennai Floods.

6. Initiatives taken by the company to ensure expeditious settlement of claims

HEALTH

- Deficiency reminders are sent to the customer at an interval of 15 days from the date of intimation
- Proactive telephonic reminders are given to the customer & deficiency requirement is explained
- Awareness is created amongst the insured population through various modes of communications on claim documentations
- Whatsapp facility to submit documents, not required in original for settlement of claim
- Utility is provided on the website for "Claim Inquiry" where customers can log-in & view the status of the claim & act accordingly
- Senior Citizen Cell for priority treatment to our Senior Citizen customers
- Document Scanning Hubs at 10 strategic locations
- Image Based Claims processing
- SMS & email alerts to customers on each stage of the claim
- Dedicated email id to solve all customer queries

MOTOR·

- BADIC settlement for 4 wheelers up to 20000 /- and in Two wheeler up to 7500 /- claims
- E-Claims

7. Institutional Framework for review of repudiated claims

- Health: Six eye principle is followed for all Repudiated Claims, 3 levels of checks is done before dispatch of the letter.
- Motor: All claim which fits for repudiation to be reviewed by HO only.
- Formation of Claims Review Committee to review repudiated claims in case of a representation

8. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No.of claims	Amount
LokAdalat						
Camps						
Others						
(give details)						
TOTAL	**8239**	**1,872,421,047**	**8064**	**2,182,430,978**	**7310**	**2,278,119,738**

9. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	As on 31st March 2016
District Forum	3539
State Commission	1534
National Commission	83
Motor Claims related	
MACT	39,968
Appeals with High Court	9507
Appeals before Supreme Court	11
Other policyholder related cases	
WC Non-Motor	214
Civil Courts	144
High Courts @	39
Supreme Court	3
Total	**55,042**
@ of these, the number of appeals against orders of Insurance Ombudsman	5 writ against ombudsman other than above

10. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

No of cases compromised during FY-15-16	MACT	7310
No of cases compromised during FY-15-16	Consumer	72
No of cases compromised during FY-15-16	Ombudsman	11
No of cases compromised during FY-15-16	Civil	1
No of cases compromised during FY-15-16	Arbitration	0
No of cases compromised during FY-15-16	WC Non-Motor	14

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: BHARTI AXA GENERAL INSURANCE COMPANY LIMITED

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S				Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending	
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	169	291	438	496	996	808	345	726	685	13	32	93	291	438	420
Marine	290	461	672	1176	1614	1881	921	1257	1549	29	53	98	461	672	637
Motor	18861	22472	29017	179785	213866	223550	169082	198362	214704	1154	1376	2299	22472	29017	31266
Health	3762	3034	4106	55410	67930	27706	46450	54579	21257	7912	7106	1101	3034	4106	1620
Misc.	225	505	1033	1120	4868	1768	727	3883	1142	37	93	179	505	1033	710
Total	23307	26763	35266	237987	289274	255713	217525	258807	239337	9145	8660	3770	26763	35266	34653

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	46	31	57	79	211	107	67	210	223	94	154	133	59	120	107
Marine	75	63	13	195	303	293	283	378	399	303	404	416	65	109	232
Motor	97293	124890	154246	49906	52636	42341	13863	16445	18683	4470	4052	4111	3521	2994	1370
Health	46290	54579	21257	160	0	0	0	0	0	0	0	0	0	0	0
Misc	21	862	9	118	1656	174	285	754	1703	271	516	506	32	95	140
Total	143725	180425	175582	50458	54806	42915	14498	17787	21008	5138	5126	5166	3677	3318	1849

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	33	65	49	50	37	30	38	108	55	94	104	96	76	124	190
Marine	118	160	146	95	125	80	136	190	150	81	138	143	31	59	118
Motor	8073	9121	9088	3256	4678	4789	2475	3169	3167	2647	3799	3343	6021	8250	10879
Health	2100	2412	650	819	1200	700	39	158	95	56	178	84	20	158	91
Miscellaneous	124	301	204	120	300	123	131	192	197	103	184	123	27	56	63
Total	10448	12059	10137	4340	6340	5722	2819	3817	3664	2981	4403	3789	6175	8647	11341

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. Constraints which cause delay in settlement of claims

- ✓ Most common reason for delay in settlement of claims is due to delay in submission of required information / documentations from insured to arrive at admissibility of claim & for the purpose of assessment of loss.
- ✓ Non- submission of required documents in reimbursement cases.
- ✓ Poor response in completion of documents/RC cancellation for non-repair losses specifically where financier is involved.
- ✓ Theft claims; un-trace report and transferred RC are time consuming.
- ✓ Reaching and making correspondence with Insured/claimant at spoke location is an hindrance due to connectivity

6. Initiatives taken by the company to ensure expeditious settlement of claims

- ✓ There is monthly review of claims, wherein we monitor progress of claim and take necessary actions in expediting it.
- ✓ Fast track claim settlement for small partial repair losses.
- ✓ For speedy reimbursement, strive to achieve over 99% payment through NEFT.
- ✓ Simplification of claim processes to make an ease for policy holder.
- ✓ Increase in cashless garage listing Pan India.
- ✓ Enhance in-house survey to have better TAT and experience

7. Institutional Framework for review of repudiated claims

- ✓ Claim before repudiation is consulted with superior and further there is system of closed file review, which is done at least once in a year that covers samples of randomly selected claim files, which may include repudiated claims as well.
- ✓ There is layer of scrutiny by supervisor before approval of repudiation by Zonal Manager/ Head.
- ✓ Review of repudiation is being done at the time of CFR (Closed File Review).
- ✓ Claim before repudiation is consulted with superior and further there is system of closed file review, which is done at least once in a year that covers samples of randomly selected claim files, which may include repudiated claims as well.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	602
State Commission	97
National Commission	15
Motor Claims related	
MACT	14508
Appeals with High Court	826
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	19
High Courts @	8
Supreme Court	1
Total	**16076**
@ of these, the number of appeals against orders of Insurance Ombudsman	7

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1) Conducting Company arranged Lok Adalat at District Courts for Settling the Cases before Tribunals
2) Participating & Settling Cases in National Lok Adalat Conducted by National Legal Services Authority Regularly in Every State before HC & Tribunals
3) Participating & Settling Cases in State Level Lok Adalat Conducted by State Legal Services Authority in Every State before HC & Tribunals
4) Participating & Settling Cases in Every District Conducted by the District Legal Services Authority for Tribunals Coming under its Jurisdiction
5) Arranging and Conducting Separate Negotiation Talks with Assistance of Panel Advocates at their Office at Tribunal Level & HC also and Settling the Cases as Permanent Lok Adalat Constituted for this Purpose.

10. Statistics of cases settled out of court (other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	1,424	322,088,552	1,567	351,939,929	1,378	373,064,376
Camps	-	-	-	-	-	-
Others (give details)	-	-	1	200,000	2	350,000
Total	**1,424**	**322,088,552**	**1,568**	**352,139,929**	**1,380**	**373,414,376**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Cholamandalam MS General Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	837	304	312	1034	891	1831	573	616	1427	181	267	311	304	312	405
Marine	1250	1544	1391	18921	18895	18517	15684	17956	18135	791	1092	424	1544	1391	1349
Motor	26895	28508	31925	109310	89290	96302	93446	82043	89793	3929	3830	4735	28508	31925	33699
Health	21297	13743	10720	134526	57977	31265	133508	55423	22378	5606	5577	3718	13743	10720	15889
Miscellaneous	1226	1126	1045	5642	4788	4789	4037	4146	4430	520	723	353	1126	1045	1051
Total	51505	45225	45393	269433	171841	152704	247248	160184	136163	11027	11489	9541	45225	45393	52393

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1 - 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	102	71	628	132	179	426	149	183	222	139	136	116	51	47	35
Marine	9289	12971	12667	4068	3142	3818	1540	1214	1223	556	479	307	231	150	120
Motor	53016	49249	52168	20126	16407	20114	8142	5621	5891	4815	3863	3954	7347	6903	7666
Health	133489	55282	12994	19	82	9369	0	59	13	0	0	2	0	0	0
Miscellaneous	2890	1581	1451	645	1811	2240	272	507	475	156	183	172	74	64	92
Total	198786	119154	79908	24990	21621	35967	10103	7584	7824	5666	4661	4551	7703	7164	7913

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	58	72	85	55	50	95	66	54	113	62	78	45	63	58	67
Marine	553	436	519	369	387	334	277	268	229	238	170	115	107	130	152
Motor	3130	3365	4778	3605	3475	4032	3094	3086	3319	5261	5459	4690	13418	16540	16880
Health	9379	516	771	3000	8176	15086	207	9	15	640	140	5	517	1879	12
Misc.	240	198	281	245	235	211	168	156	142	164	184	81	309	272	305
Total	13360	4587	6434	7274	12323	19758	3812	3573	3818	6365	6031	4936	14414	18879	17416

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. Constraints which cause delay in settlement of claims:

- Non-availability of NEFT details on a timely basis.
- Geographical locations like North East, interior MP, Chattisgarh, Bihar, etc., where the process of survey & repair take a longer time.
- Time taken by customer for reinstatement (in commercial claims).

6. Initiatives taken by the company to ensure expeditious settlement of claims:

- Qualified surveyors employed by the company in motor claims, to assess smaller value claims (< Rs.50000).
- Health claims are processed in-house for 90% of all cases.

7. Institutional framework for review of repudiated claims:

- The company's delegation of authority provides for 'skip-level review' of all cases recommended for repudiation.
- The recent decisions of National Consumer Forum / Supreme Court are circulated to all others in the company to keep the local teams abreast of latest judicial pronouncements.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	2015-16
Consumer Courts	
District Forum	1231
State Commission	169
National Commission	22
Motor Claims related	
MACT	24984
Appeals with High Court	1153
Appeals before Supreme Court	5
Other policyholder related cases	
Civil Courts	13
High Courts @	1
Ombudsmen	13
Supreme Court	0
Total	**27591**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora & Courts (like Lok Adalat, Settlement camps, etc.):

- In motor TP, 12723 cases were settled on the basis of negotiated settlements during the year.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	10625	2033752557	8237	1972114600	9234	2678701590
Camps						
Others (give details)						
TOTAL						

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : CignaTTK Health Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	0	0	32	0	928	19199	0	697	17876	0	199	1021	0	32	67
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**32**	**0**	**928**	**19199**	**0**	**697**	**17876**	**0**	**199**	**1021**	**0**	**32**	**67**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Health	0	697	17868	0	0	8	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**697**	**17868**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	0	32	49	0	0	18	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**32**	**49**	**0**	**0**	**18**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	8	3225
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**8**	

5. Constraints which cause delay in settlement of claims

- Partial and inadequate documents submitted by customer leading to additional document requirements.
- NEFT details given by customers in claim form are not supported by cancelled cheque leading to additional document requirement.
- Investigation of suspicious and fraudulent claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Our approach is to process all claims in a time bound manner from the point of receipt of claim intimation to conclusion.
- Claims process Info graphic is included in the welcome kit.
- Reiteration of cashless process in welcome call to help the customer understand cashless process.
- Contact touch points are highlighted in all communication.
- Aggressive TAT's for cashless processing and reimbursement claim settlement.
- Proactive communication- Emails, SMS and outbound calling to explain computation of settled claim and deduction reason through customer service managers.
- Telephonic and request based onsite claims assistance is provided to customers through customer service managers.
- Empowerment of Branch operations and Customer service team through technology.

7. Institutional Framework for review of repudiated claims

Claim Repudiation Process:-

- Preliminary assessment of cashless and reimbursement claims is done by TPA.
- TPA recommends decision of rejection to CignaTTK claims team.
- Final assessment and rejection of claim is done by CignaTTK.
- Review of claims referred to claims committee is done as per the internal claims committee and authority matrix.

Scope of CignaTTK Claims Committee

- Decide on cases which have been referred by the individual approving authority.
- Review Representation & Grievance received against claims which have been primarily adjudicated by the individual authorities other than the Claims Committee. This review is irrespective of the sum assured under the policy.
- Post review of the cases following decision to be made
- Stand by the original decision
- Revoke the original decision
- Suggest additional actionable

Composition of Claims Committee-

Claims Committee	Department
Head – Products & Underwriting	Marketing
Head- Service Delivery	Operations
Head – Legal & Compliance	Legal & Compliance
Chief Executive Officer	NA
Chief Financial Officer	Finance
Head - Claims	Operations
Chief Risk Officer	Actuary

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	NA
District Forum	1
State Commission	0
National Commission	0
Motor Claims related	NA
MACT	
Appeals with High Court	
Appeals before Supreme Court	
Other policyholder related cases	NA
Civil Courts	
High Courts @	
Supreme Court	
Total	**1**
@ of these, the number of appeals against orders of Insurance Ombudsman	NA

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

NIL

10. Statistics of cases settled out of court (specify other mechanisms)-NA

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : ECGC LTD (Formerly Export Credit Guarantee Corporation of India Ltd)

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Miscellaneous	184	180	158	1005	879	939	381	373	439	628	528	434	180	158	224
Total	**184**	**180**	**158**	**1005**	**879**	**939**	**381**	**373**	**439**	**628**	**528**	**434**	**180**	**158**	**224**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Health	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Misc.	—	—	—	34.89 days	34.39 days	31.79 days	—	—	—	—	—	—	—	—	—
Total															

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Motor NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Health	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Miscellaneous	80	73	90	73	50	65	21	26	40	06	09	28	—	—	01
Total	**80**	**73**	**90**	**73**	**50**	**65**	**21**	**26**	**40**	**06**	**09**	**28**	**—**	**—**	**01**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NA	NA	NA	NA	NA	NA
Marine	NA	NA	NA	NA	NA	NA
Motor	NA	NA	NA	NA	NA	NA
Health	NA	NA	NA	NA	NA	NA
Misc.	Nil	NIL	Nil	NIL	Nil	NIL
Total	Nil	NIL	Nil	NIL	Nil	NIL

5. Constraints which cause delay in settlement of claims

Delay / Non submission of required documents.

Delay / non submission of additional documents & clarifications, during processing of the claims.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Conducting exporter's meets regularly, by each branch, to create awareness about claim procedures and documentations required for filing of the claim.Proposed claim hub at Regional Office level to process claims for speedy disposal.Regular follow up, including visits by Branch Officials to clients premises, to clarify, and obtain relevant documents, supporting evidences etc.

7. Institutional Framework for review of repudiated claims

Grievance Redressal Mechanism is already in place to review the repudiated claims.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	31
State Commission	48
National Commission	24
Motor Claims related	
MACT	0
Appeals with High Court	0
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	27
High Courts @	71
Supreme Court	3
Total	**204**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

-

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	0	0	0	0	0	0
Camps	0	0	0	0	0	0
Others (give details)	0	0	1	7,26,140	0	0
TOTAL	**0**	**0**	**1**	**7,26,140**	**0**	**0**

* (settled amicably between ECGC and the Policyholder)

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Future Generali India Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			ClaimsPending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire/Eng	335	485	1020	2561	2529	2435	1965	1527	1206	446	467	585	485	1020	1664
Marine	495	1269	1247	7840	9000	4510	5605	6313	3326	1461	2709	1544	1269	1247	887
Motor	11180	10853	12046	101890	125315	149636	94491	115961	136013	7726	8161	8757	10853	12046	16912
Health	2185	1992	2696	50815	46934	62906	45891	41612	55448	5117	4618	4807	1992	2696	5347
Miscellaneous	530	1111	1246	3671	3739	5158	2181	2307	3988	909	1297	1024	1111	1246	1392
Total	14725	15710	**18255**	166777	187517	224645	150133	167720	199981	15659	17252	16717	15710	18255	**26202**

Note: Fire is taken along with Engineering

Repudiation claims includes claim closed without payments, duplicate claims and wrong registration

Reported and settled claims also include any reopened claims during the financial year

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire/Eng	1380	581	417	343	484	456	374	408	348	212	354	350	102	167	220
Marine	3822	3939	2041	1772	1914	1201	830	1442	764	496	1541	539	146	186	325
Motor	76465	92955	104813	15687	20721	28936	4463	5246	6225	2622	2470	2459	2980	2730	2337
Health	36246	32612	46427	10643	9807	9750	3018	2580	2454	863	848	985	238	383	639
Miscellaneous	1312	1002	1784	645	974	1515	631	584	947	392	816	505	110	228	261
Total	119225	131089	155482	29090	33900	41858	9316	10260	10738	4585	6029	4838	3576	3694	3782

Note: Fire is taken along with Engineering

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire/Eng	104	160	232	94	130	206	126	194	244	101	418	465	60	118	517
Marine	254	360	228	703	285	166	173	195	182	92	267	121	47	140	190
Motor	2105	2872	5237	1561	1706	3087	1029	1242	1955	1500	1287	1480	4658	4939	5153
Health	1191	1507	3417	419	627	424	172	188	1144	73	154	93	137	220	269
Miscellaneous	171	229	207	251	493	312	492	180	531	114	163	175	83	181	167
Total	3825	5128	9321	3028	3241	4195	1992	1999	4056	1880	2289	2334	4985	5598	6296

Note: Fire is taken along with Engineering

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	
Motor	-	-	-	-	-	-
Health	-	-	-	-	-	-
Miscellaneous	-	-	-	-	-	-
Total	-	-	-	-	-	-

5. Constraints which cause delay in settlement of claims

In motor claims the key issues which constrain us from timely settlement pertain to pending requirements from the customer, delay in repairs, issues related with quantum/mode of settlement where customer confirmation on the acceptance is pending and requirements pending from third parties (for e.g. RTO, untrace report etc.)In marine claims we face issues likedeclarations not received, non submission of documents, and non-submission of recovery documents.In property claims issues relate to reinstatement of the property, submissions of bills of payments, disputes in assessment of the loss.

6. Initiatives taken by the company to ensure expeditious settlement of claims

A mobile based claim processing application (i-MOS) has been launched in 2015 for the use of claim officials which helps real-time update of the claim even while the officials are in the field, which aids faster processing of the claim.

Some of the key features are; automated surveyor deputation, real-time assessment, payment processing from the spot.

To ensure timely fulfillment of documents required for settlement of claims,so that claims are not pending on this count the requirementsare educated to customers at the time of claim intimation at contact center and the list of documents required is alsomade available on our website andthe reverse side of the claim form, in easy to understand language.

Wherever the claim intimation is not made by the customers themselves, outbound calls are made to the customer posts claim registration to confirm address and contact details, so that no gaps occur in communication during the claim settlement process.

SMS updatesare shared with the customers at every stage of claim progress.

Express modes of claims settlement like Future Xpress & Future Xpress+ are offered by the company where features like spot finalization of Insured liabilities and settlement in advance of the repairs (customer can carry out repairs later) are offered.

In case of non-motor claims we follow with the insured as well as with the intermediary and our marketing team to expedite the compliance.

We also try and visit the client and the intermediary to find out the constraints faced by them. In major clients where there is large numbers of claims we have a monthly or quarterly meeting to discuss the pending issues and ensure that these are resolved.

7. Institutional Framework for review of repudiated claims

A claims review committee is being constituted comprising of Senior members which are not a part of the claim settlement team and who can review any claim repudiation, wherever insured requests for the same.

Before closing or rejecting any Health Claim, a review of the claims documents is carried out by a team in order to assure that claim is being closed / repudiated at valid grounds.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	527
State Commission	144
National Commission	8
Motor Claims related	
MACT	6152
Appeals with High Court	692
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	7
High Courts @	10
Supreme Court	0
Total	**7540**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

We actively participate in the Lok-Adalats to aid the speedy settlement of such cases.We have received appreciation from various courts for assisting the expeditious settlement of cases under litigation.

10. Statistics of cases settled out of court

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	1385	324302126	1178	374613481	1307	398835870
Camps	0	0	0	0	0	0
Others (Compromise and conciliations)	2039	463042715	1676	458417626	1539	399040486
TOTAL	**3424**	**787344841**	**2854**	**833031107**	**2846**	**797876356**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : HDFC ERGO General Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	199	189	238	1,309	1,617	2,089	1,017	1,522	1,957	302	46	62	189	238	308
Marine	1,776	1,444	1,240	22,852	28,151	26,658	22,553	27,714	26,534	631	641	133	1,444	1,240	1,231
Motor	20,524	21,820	24,358	1,27,008	1,43,394	1,48,345	1,22,768	1,37,697	1,43,894	2,944	3,159	1,392	21,820	24,358	27,417
Health	4,744	7,472	4,221	2,19,314	1,20,633	79,434	2,06,765	1,15,441	75,957	9,821	8,443	3,767	7,472	4,221	3,931
Miscellaneous	2,857	2,928	3,305	35,721	33,203	66,808	33,359	32,158	65,984	2,291	668	528	2,928	3,305	3,601
Total	30,100	33,853	33,362	4,06,204	3,26,998	3,23,334	3,86,462	3,14,532	3,14,326	15,989	12,957	5,882	33,853	33,362	36,488

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	59	368	680	162	218	281	156	123	126	98	62	80	66	22	34
Marine	7,351	12,568	12,053	5,775	7,535	3,028	2,709	791	1,037	1,527	118	1,736	137	12	408
Motor	88279	98305	99968	13189	15306	14796	4022	4028	3094	2349	2111	2030	3512	2998	2932
Health	1,44,572	76,569	49,650	26,128	23,870	11,395	4,326	1,929	1,191	892	318	72	270	-	26
Miscellaneous	16,653	17,235	46,805	4,062	2,986	2,568	1,438	390	853	546	182	217	165	128	152
Total	2,56,914	2,05,045	2,09,156	49,316	49,915	32,068	12,651	7,261	6,301	5,412	2,791	4,135	4,150	3,160	3,552

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	60	64	65	39	36	62	30	55	105	43	57	50	17	26	26
Marine	991	848	800	333	183	169	63	129	141	41	65	86	16	15	35
Motor	4446	4828	5100	2854	3150	3109	1956	2399	2447	2823	3437	3887	9741	10544	12874
Health	6299	2973	2414	1013	1049	1087	120	174	394	40	25	34	0	0	2
Miscellaneous	1124	1611	1566	645	485	778	138	198	214	325	410	260	696	601	783
Total	12920	10324	9945	4884	4903	5205	2307	2955	3301	3272	3994	4317	10470	11186	13720

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

Delay in claim settlement is mainly due to delay in receiving of related documents from the insured.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Mail and SMS are sent to the customers requesting them to submit the documents at the earliest.

7. Institutional Framework for review of repudiated claims

Claim repudiation authority is given to very few senior managers in all line of business. All repudiations are reviewed by National managers of respective line of business. A quarterly report on repudiation claim is sent to the management for review.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1120
State Commission	276
National Commission	19
Motor Claims related	
MACT	18848
Appeals with High Court	1923
Appeals before Supreme Court	2
Other policyholder related cases	
Civil Courts	44 (District Court)
High Courts @	7 (1 appeal against Orders of Ombudsman)
Supreme Court	1
Total	**22240**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	Nil	Nil	Nil	Nil	Nil	Nil
Camps	Nil	Nil	Nil	Nil	Nil	Nil
District Forum, State Commiss & Ombudsman	21	1765067	31	10077708.76	16	1787271.98
TOTAL	**21**	**1765067**	**31**	**10077708.76**	**16**	**1787271.98**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : ICICI Lombard General Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14 and 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
Fire	2,332	2,230	2,417	2,485	3,374	3,152	2,499	3,070	3,370	88	117	129	2,230	2,417	2,070
Marine	2,403	3,570	3,140	27,495	26,587	32,382	25,844	25,794	30,791	484	1,223	1,059	3,570	3,140	3,672
Motor	91,858	96,177	103,562	687,351	792,343	951,653	673,328	774,847	923,867	9,704	10,111	13,915	96,177	103,562	117,433
Health	729,686	512,584	66,552	5,481,221	2,137,983	593,067	5,610,410	2,525,962	579,025	87,913	58,053	32,041	512,584	66,552	48,553
Miscellaneous	9,474	10,410	9,638	31,238	34,712	34,333	28,605	32,759	30,363	2,146	2,329	2,409	9,953	9,638	11,199
Total	835,753	624,971	185,309	6,229,790	2,994,999	1,614,587	6,340,686	3,362,432	1,567,416	100,335	71,833	49,553	624,514	185,309	182,927

Note: Settled includes Paid and Closed, Miscellaneous includes Engineering/Aviation/Credit/Liability/Weather/Other Misc

2. Statistics of time taken for disposal of claims for 2013-14 and 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	615	1,552	2,279	472	260	146	204	94	69	203	94	78	142	112	32
Marine	15,628	10,848	21,428	5,088	7,666	3,592	1,368	2,503	1,049	506	950	331	271	264	172
Motor	567,740	653,987	778,136	37,482	41,533	49,029	12,663	16,140	20,839	5,862	5,437	5,760	12,557	10,955	13,339
Health	5,446,653	2,426,776	523,525	78,050	39,104	4,391	2,122	4,041	369	184	148	18	15	11	2
Miscellaneous	15,417	17,405	17,643	2,908	4,403	1,800	984	651	466	495	352	215	276	510	2,632
Total	6,046,053	3,110,568	1,343,011	124,000	92,966	58,958	17,341	23,429	22,792	7,250	6,981	6,402	13,261	11,852	16,177

Note: Disposal considered paid claims only

3. Statistics of age-wise pendency of claims for 2013-14 and 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	227	445	538	219	72	83	98	230	120	297	532	224	1,389	1,138	1,105
Marine1,515	1,154	1,123	952	947	898	325	465	639	242	236	589	536	338	423	
Motor	27,083	31,968	44,326	9,294	9,359	11,966	6,574	7,453	8,816	7,324	7,600	7,826	45,902	47,182	44,499
Health	504,168	60,818	45,606	6,294	2,974	1,653	1,607	1,249	261	149	1,100	389	366	411	644
Miscellaneous	3,420	4,009	1,934	2,236	1,817	6,163	1,245	966	1,101	1,317	794	445	1,797	2,052	1,556
Total	536,413	98,394	93,527	18,995	15,169	20,763	9,849	10,363	10,937	9,329	10,262	9,473	49,990	51,121	48,227

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Incomplete details provided by insured at the time of claim intimation
2. Incomplete/wrong documents submission
3. Non-submission/delay in submission of required documents
4. Verification of pre-existing conditions and/or ailments in case of health claims
5. Verification of genuineness of claim through investigation getting delayed due to non cooperation of insured
6. Delay in reporting of Vehicle by insured for survey in case of own damage cases
7. Delay in repair of vehicle due to un-availability of parts own damage cases

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Frequent email & SMS are sent to insured explaining claim process
2. Intimation of claim by calling at call centre, through SMS and email
3. Communication for deficient documents through email, SMS and letters
4. Separate calling is done to insured explain a complicated query (if any) raised in the claim
5. The list of documents required is mentioned in the claim form to make it easy for insured to submit all documents at once
6. Trained Customer care executives at the very first level of customer touch point to guide the insured properly
7. In-house team of Claims surveyor is built for expeditious survey of claims
8. Empanelled Surveyors are assigned for locations/situations where inhouse team is not available
9. Mobile application provided to both Internal and external Surveyors with integrated Claims module for immediate upload of survey photographs and other inputs of survey
10. Access to Claims module provided to Investigators for seamless submission of reports
11. Extensive network of Cashless service providers all across India
12. Special arrangements are made for Catastrophic claims
13. System triggered SMS to insured at various stages of the claim, like – surveyor assignment (with surveyor details), post survey completion, post payment, etc
14. Payment of claim amount through electronic mode, ensuring quick and hassle free settlement
15. Launched Mobile app to enable customers to access all services over the phone

7. Institutional Framework for review of repudiated claims

1. A senior level claims team is there to review any repudiated claim represented by the insured
2. Grievance redressal details available on Website/policy documents

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	4555
State Commission	1422
National Commission	73
Motor Claims related	
MACT	50837
Appeals with High Court	10106
Appeals before Supreme Court	31
Other policyholder related cases	
Civil Courts	99
High Courts @	130
Supreme Court	1
Total	**67254**

* Cases filed in other forum = 683

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Review of cases on the basis of new documents/information if any produced by the customer before court of law
2. Review of cases earlier closed for want of documents if customer agrees to submit pending documents before court of law
3. Review of TP cases as per evidence produced by the claimant and offer for settlement as per M V Act

10. Statistics of cases settled out of court (specify other mechanisms)

Category -Consumer Forum Cases	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No.of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	16	2,366,218	30	4,378,424	33	3,892,976
Camps	0	0	0	0	0	0
Others (Consumer Forum, WC Commissioner)	600	139,390,696	515	97,376,540	1143	366253593
TOTAL	**616**	**141,756,914**	**545**	**101,754,964**	**1,176**	**370,146,569**

Category- MACT	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No.of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	3,556	767,880,406	3,978	1,079,368,094	6,336	1,684,686,239
Camps	0	0	0	0	0	0
Others (MACT)	5,266	970,726,490	4,459	989,195,575	5,197	1,180,101,845
TOTAL	**8,822**	**1,738,606,896**	**8,437**	**2,068,563,669**	**11,533**	**2,864,788,084**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: IFFCO TOKIO General Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	936	1163	1266	1149	905	1177	980	827	1216	0	0	0	1163	1266	1277
Marine	964	958	1152	15128	17323	21350	16122	17916	21494	0	0	0	958	1152	1450
Motor	52928	49774	48913	320455	365137	365756	327648	371723	374953	1202	898	297	49774	48913	46253
Health	2954	2585	7543	30108	90000	246521	31050	86453	223197	0	4	0	1682	7543	32405
Miscellaneous	3417	4204	4268	10977	11505	14359	10739	12194	15193	2	0	0	5107	4268	4168
Total	**61199**	**58684**	**63142**	**377817**	**484870**	**649163**	**386539**	**489113**	**636053**	**1204**	**902**	**297**	**58684**	**63142**	**85553**

*Health includes Overseas Travel

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	289	229	222	161	119	205	178	160	199	168	161	262	169	158	328
Marine	9639	11495	14047	3375	3509	4136	1368	1676	1781	752	748	1155	709	488	375
Motor	190406	235826	241382	85739	83663	84802	22780	24148	22210	12955	13716	12692	15541	14370	13867
Health	11783	28626	85141	15565	41797	100576	1699	11087	25008	977	3953	8455	743	990	4017
Miscellaneous	2496	3465	4633	2955	3016	3880	1939	2200	2979	1989	1904	2176	1214	1609	1525
Total	214613	279641	345425	107795	132104	193599	27964	39271	52177	16841	20482	24740	18376	17615	20112

*Health includes Overseas Travel

3 Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	72	33	30	70	59	57	105	121	143	191	126	165	725	927	882
Marine	289	263	236	209	328	309	122	187	299	128	153	321	210	221	285
Motor	8584	7926	7450	6160	6207	5576	4443	4782	4584	6528	6678	6178	24059	23320	22465
Health	438	2883	9414	174	2158	13932	348	1022	7184	391	783	1194	331	697	681
Miscellaneous	1946	462	477	638	697	733	457	603	552	866	694	593	1200	1812	1813
Total	11329	11567	17607	7251	9449	20607	5475	6715	12762	8104	8434	8451	26525	26977	26126

*Health includes Overseas Travel

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor			NIL			
Health						
Miscellaneous						
Total						

*No penal interest on account of delay in payment of claim amount, as stipulated under clause 9(6) of IRDA (Protection of policyholder's Interest) Regulations, 2002, was made during the reported period.

5. Constraints which cause delay in settlement of claims

Normally, following factors cause delay in settlement of claims:·

- Delay in Quantification of Salvage
- Delay in Non submission of necessary claim documents/clarifications/information from Insured especially in commercial vehicles. Ex. copy of FIR, Repair Bills, Permit, Fitness.
- Delay in Police Final Report
- Wrong address of Insured resulting into lack of communication, delay in registration of FIR, Financier NOC, Final report, transferred Registration Certificate in case of Theft Claims,
- Delay in reinstatement of damaged property

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Periodic review of outstanding claims.
- Releasing of interim payment wherever possible so that insured can expedite the reinstatement.
- Salvage Disposal assistance by arranging e- auction etc.
- Robust review system of follow-up with surveyor/insured, time bound claim processing/payment after getting the survey report/ documents

7. Institutional Framework for review of repudiated claims

- Standardized guidelines for claim settlement to ensure better understanding amongst claim officers & transparency in claim settlement.
- Before repudiation, legal opinion is sought from the legal department.
- Regular training on nuances of Motor & Non Motor Insurance to fresher & experienced claim officers.
- Authority to Repudiate claims is given one step higher than the delegated financial authority for approval of claims, thus obviating the need for review.
- Post repudiation representations made either directly to the company or through the Grievance Redressal mechanism of IRDA is given due consideration and decided on merits.
- We have Grievance Redressal System (Online) in place and customer can lodge their grievance on that system. In case of repudiation of claim, we close the claim immediately in our system as liability has been denied. Wherein, customer goes for litigation, then we follow same process as above for review/monitoring the claim progress.

8. Statistics of cases of policyholders / claimants before Consumer Forum /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES AS ON 31.03.2016
Consumer Courts	
District Forum	1829
State Commission	238
National Commission	31
Motor Claims related	
MACT	31209
Appeals with High Court	1297
Appeals before Supreme Court	3
Other policyholder related cases	
Civil Courts	20
High Courts @	8
Supreme Court	4
Total	**34639**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Settlement through alternative disputes resolution mechanism like conciliation, mediation etc.· Settlement of cases before permanent Lok Adalats exists at various State levels.
- Participation in Lok Adalat organized under Legal Services Act, 1987.
- Settlement of cases before Ombudsman.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	2030	334293377	2547	627426963	3329	969664916
Camps	0	0	0	0	0	0
Others (give details)	5374	918851409	5835	1199407221	6096	1429460770
TOTAL	**7404**	**1253144786**	**8382**	**1826834184**	**9425**	**2399125686**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : L & T GENERAL INSURNACE CO LTD

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	133	240	303	371	461	803	215	292	554	54	96	161	240	303	392
Marine	155	280	295	812	488	513	455	343	246	178	138	263	280	295	299
Engineering	120	168	186	370	292	222	244	168	164	127	105	104	168	186	140
Miscellaneous	92	159	98	264	263	242	121	231	188	72	48	52	159	98	99
Liability	47	58	80	111	151	172	47	82	117	57	95	82	58	80	53
Motor	705	838	1138	12240	20412	36258	11840	19892	34758	267	220	275	838	1138	2363
Health	320	646	587	11579	8130	8676	9682	6373	7023	1571	1816	1692	646	587	548
Total	**1572**	**2389**	**2687**	**25747**	**30197**	**46886**	**22604**	**27381**	**43050**	**2326**	**2518**	**2629**	**2389**	**2687**	**3894**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	48	63	162	54	109	256	68	97	149	60	85	115	39	34	33
Marine	220	115	105	111	86	161	195	108	117	100	140	106	7	32	20
Engineering	31	22	22	97	46	47	101	54	66	104	91	88	38	60	45
Miscellaneous	42	77	79	50	55	82	40	65	37	54	50	32	7	32	10
Liability	14	19	7	14	28	53	18	46	80	41	57	46	17	27	13
Motor	8481	13970	25403	2503	4418	7129	704	1103	1773	338	532	626	81	89	102
Health	11095	7978	8653	158	211	62	0	0	0	0	0	0	0	0	0
Total	**19931**	**22244**	**34431**	**2987**	**4953**	**7790**	**1126**	**1473**	**2222**	**697**	**955**	**1013**	**189**	**274**	**223**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	27	36	64	59	49	35	36	40	85	57	68	69	59	110	139
Marine	24	55	27	81	37	29	97	30	63	45	76	30	35	97	150
Engineering	30	32	14	45	31	12	40	35	35	37	48	39	15	40	40
Misc.	23	12	33	38	15	13	29	13	3	29	10	6	40	48	44
Liability	9	16	16	17	13	22	13	16	6	13	23	1	7	12	8
Motor	459	647	964	204	245	767	98	113	445	56	97	139	21	36	48
Health	415	496	406	231	74	126	0	0	16	0	11	0	0	6	0
Total	987	1294	1524	675	464	1004	313	247	653	237	333	284	177	349	429

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. Constraints which cause delay in settlement of claims

- The delayed submission of documents
- Time taken to repair and reinstate the property.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Rigorous Follow up with insured and his intermediary (if applicable)
- Proactive discussion with insured in case of complicated cases.

7. Institutional Framework for review of repudiated claims

- All repudiated claims on the basis of policy term are monitored and approved by corporate office.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	96
State Commission	16
National Commission	0
Motor Claims related	
MACT	2131
Appeals with High Court	125
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts 2	
High Courts @	0
Supreme Court	0
Total	**2370**
@ of these, the number of appeals against orders of Insurance Ombudsman	1

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

On regularbasis we are compromising the claims through our advocates both before Forum and LokAdalat.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	106	20488347	98	14608315	122	34987882
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
TOTAL	**106**	**20488347**	**98**	**14608315**	**122**	**34987882**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Liberty Videocon General Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	11	90	204	27	204	422	6	83	268	8	42	44	11	90	204
Marine	14	73	303	31	322	604	15	199	321	1	64	55	14	73	303
Motor	612	790	2188	6160	23009	39597	5063	21223	35292	494	1608	2939	612	790	2188
Health	67	6370	1452	179	17207	48157	80	9996	50004	34	908	4020	67	6370	1452
Miscellaneous	164	177	539	433	725	2167	209	572	1591	50	140	214	164	177	539
Total	**868**	**7500**	**4686**	**6830**	**41467**	**90947**	**5373**	**32073**	**87476**	**587**	**2762**	**7272**	**868**	**7500**	**4686**

2. Statistics of time taken for disposal# of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	39	176	6	6	25	0	22	15	0	16	35	0	0	17
Marine	5	150	230	10	32	52	0	16	29		1	6	0	0	4
Motor	1688	18761	31102	3216	2134	3683	158	276	376	1	48	103	0	4	28
Health	29	7480	46276	36	2080	2685	10	113	918	5	321	96	0	2	29
Miscellaneous	26	187	1163	160	131	271	23	154	102	0	90	40	0	10	15
Total	**1748**	**26617**	**78947**	**3428**	**4383**	**6716**	**191**	**581**	**1440**	**6**	**476**	**280**	**0**	**16**	**93**

Data shown here is for paid claims

3. Statistics of age-wise pendency of claimsfor 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	4	0	51	2	5	10	4	36	71	1	48	36	0	1	36
Marine	4	7	4	4	28	159	6	6	73	0	28	41	0	4	26
Motor	437	487	1244	136	161	402	28	56	240	11	67	157	0	19	145
Health	54	4313	592	0	1267	448	12	370	281	1	416	75	0	4	56
Miscellaneous	61	20	55	47	47	84	41	45	261	15	50	72	0	15	67
Total	**560**	**4827**	**1946**	**189**	**1508**	**1103**	**91**	**513**	**926**	**28**	**609**	**381**	**0**	**43**	**330**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

·

- Long settlement duration for court cases in general
- Unavailability of documents and/or key persons/witnesses·
- Delayed intimation of claims, sometimes in months, leading to complicating the evidence gathering process and uncertainity·
- Unlimited liability clause, generates greed that leads to court cases even when amount being offered to the recipient is fair and transparent
- Unavailability of parts or skilled labour (e.g. if part is not available with dealer, the time to repair the vehicle is more, increasing the overall claim settlement duration)
- Environment not ready for Catastrophic event – Example: In Chennai Floods, due to large no of vehicles needing repair, and limited workshops, time to repair is very high. Similarly, in case of Jammu – Kashmir floods, accessibility of the area to do claim processing became a constraint leading to increased time of settlement.
- In Case of Vehicel Theft claims – the non-traceability report from Police takes time, impacting the time to settle the claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Ensure surveys/assessments/pre-authorizations are done ASAP.·
- Handhold the customer and inform him/her of the documents needed and process to be followed, and guide him/her during the whole process·
- Regular follow-ups with customers to ensure that documents are submitted·
- Automating claims processing – to ensure manual interventions are minimized, and settlement time is reduced
- Focus on First Time Resolutions of customer queries at call center – to reduce claim settlement time.· When claim liability is known, offering the customer a fair and transparent amount for Third Party claims to settle out of court, amicably, thus saving time, energy and money of the customer·
- For small value and simple motor claims, providing FastTrack processing
- Participation in various lok-adalats for settlements

7. Institutional Framework for review of repudiated claims

- Every repudiated claim is reviewed (before repudiation) by senior management. Reasons of repudiation are verified and needed documentation/proof is checked·
- Systemic control that the claim manager processing the claim can not repudiate claim at his/ her end. Doing repudiation approval in system needs someone else to check the case details and then approve in the system.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	96
State Commission	10
National Commission	2
Motor Claims related	
MACT	502
Appeals with High Court	4
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	3
High Courts @	3
Supreme Court	0
Total	**620**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

- Proactively investigated the claims through external investigators to speed up liability assessment process
- Approached to claimants / their lawyers for amicable settlement
- Participation in various lokadalats for settlements

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	0	0	0	0	40	8124025
Camps						
Others (Conciliation)	2	28000	10	1992000	5	487000
TOTAL	**2**	**28000**	**10**	**1992000**	**45**	**8611025**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Magma HDI General Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	1	4	27	18	51	138	15	28	116	7	8	19	4	27	49
Marine	0	24	97	67	1036	1088	43	963	1081	8	79	74	24	97	104
Motor	262	1279	1524	11049	24965	30943	10031	24720	30710	948	1566	1298	1279	1524	1761
Health	0	0	0	0	0	72	0	209	71	0	0	0	0	0	1
Miscellaneous	0	11	137	27	555	629	16	220	635	5	37	84	11	137	131
Total	**263**	**1318**	**1785**	**11161**	**26607**	**32870**	**10105**	**26140**	**32613**	**968**	**1690**	**1475**	**1318**	**1785**	**2046**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	5	5	41	4	7	23	4	11	22	2	5	26	0	0	6
Marine	24	626	744	13	169	143	6	83	103	0	83	50	0	2	42
Motor	6450	17500	21394	2284	5010	6366	587	1612	2114	706	583	795	4	15	41
Health	0	209	35	0	0	31		0	4		0	0		0	0
Miscellaneous	3	82	187	9	65	214	4	60	135	0	10	70	0	3	28
Total	**6482**	**18422**	**22401**	**2310**	**5251**	**6777**	**601**	**1766**	**2358**	**708**	**681**	**941**	**4**	**20**	**117**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	2	3	17	1	4	6	1	10	6	0	10	17	0	0	3
Marine	17	10	17	5	27	31	1	22	27	0	37	16	1	1	13
Motor	689	776	681	403	481	463	166	194	285	21	73	237	0	0	95
Health	0	1	0	0	0		0	0	0	0	0		0	0	
Miscellaneous	4	33	46	3	45	26	4	33	28	0	26	20	0	0	11
Total	**712**	**822**	**762**	**412**	**557**	**526**	**172**	**259**	**346**	**21**	**146**	**290**	**1**	**1**	**122**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

5. Constraints which cause delay in settlement of claims

1. Delayed submission/ completion of documents required for assessing liability under respective policies.
2. Incorrect, incomplete and change in customer/insured correspondence address
3. Explanation of policy terms and conditions to insured/customer in order that they understand working of compensation as computed for the loss sustained
4. Delays in obtaining certified documents for public authorities

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Elaborating/ detailing documentation requirements required for assessing liability arising from the loss sustained under the policy terms and conditions
2. Educating insured/customer on the applicable terms and conditions affecting liability computation
3. Facilitating insured/customer access to MHDI network of Branches for document submission
4. Periodic review of outstanding claims

7. Institutional Framework for review of repudiated claims

1. In case a break of policy terms and conditions are observed which would result in repudiation of insurers liability – claims dealing executive explains the same to the insured/customer.
2. Wherever a claim made by the insured is not payable on account of the same not falling within the purview of policy terms and conditions due to breach of policy terms and conditions – insured/customers are provided an opportunity to represent their point of view and state additional facts in support of their claims which subject to the policy terms and conditions are verified before a final decision on repudiation of the claim is communicated
3. Repudiation of claims are approved only post review by senior and experience claims professionals after providing the customer/insured due to time to represent against the same.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	246
State Commission	19
National Commission	0
Motor Claims related	
MACT	3707
Appeals with High Court	46
Appeals before Supreme Court	
Other policyholder related cases	
Civil Courts	0
High Courts @	0
Supreme Court	0
Total	**4018**
@ of these, the number of appeals against orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

Proactive approach in Lok-adalat and approaching each and every advocate & claimant for Compromise Settlement.Attending the Lok-Adalat wherever the case of the Company is listed.De-centralized team to deal the cases individually and ensure early disposal.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	153	369.78 Lacs	742	2435.20 Lacs	1374	4788.74 Lacs
Camps -	-	-	-	-	-	
Others (give details)	-	-	-	-	-	-
TOTAL	**153**	**369.78 Lacs**	**742**	**2435.20 Lacs**	**1374**	**4788.74 Lacs**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Max Bupa Health Insurance Co Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	1761	3560	2929	49747	62425	60275	39390	50731	52850	8558	12325	8222	3560	2929	2132
Miscellaneous															
Total															

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	35488	49542	52619	3592	1063	226	270	101	3	40	25	2	0	0	0
Misc.															
Total															

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	3477	2927	1843	83	2	229	0	0	55	0	0	4	0	0	1
Misc.															
Total															

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health	0	0	855	254972	158	12281
Miscellaneous						
Total						

5. Constraints which cause delay in settlement of claims

Our settlement turnaround time is 30 days from the LDR(Last document received date). Though, we have achieved 99.5% settlement within 30 days in FY 2015-16, following constraints may cause delay in processing the claim requests

- Incomplete documents received at the claim stage.
- Incomplete response provided by the hospital/customer on a query raised by the Insurance Company.
- Delay in providing KYC/NEFT/RTGS details by the customer.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Proactive outbound calling for pending queries/clarification from hospital/customers.
- Payments being made through NEFT/RTGS.
- 97% of claims in 2015-16 have been paid within 15 days and 99.5% within 30 days in FY 2015-16.
- Decisioning of pre-authorization request from the last document received is being targeted at 30 minutes.

7. Institutional Framework for review of repudiated claims

- We have a robust grievance redressal mechanism to address customer issues related to claims.
- We also have a Medical Advisory Team(MAT) to review repudiated/contested cases.
- We have also institutionalized Claims Council comprising of Senior Management Officials and independent members including specialist doctors to review selected claims cases.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	396
State Commission	19
National Commission	-
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	5
High Courts @	2
Supreme Court	-
Total	**422**
@ of these, the number of appeals against orders of Insurance Ombudsman	Nil

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Communicating with the complainants along with their counsels for settling the cases at the earliest
- Revisiting the claims if a new or additional fact/document has been produced by the complainant.
- Focusing on settlements has been an important initiative on the part of the company.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat					1	75,139
Camps						
Others			4*	1,74,452	20**	20,31,380
TOTAL	**NIL**	**NIL**	**4**	**1,74,452**	**21**	**21,06,519**

*Consumer Forum cases ; ** 19 cases pertain to Consumer forum and 1 case pertains to Civil Court.

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: National Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire 2634	3222	2857	5362	7669	7126	2912	5421	4118	1862	2613	2442	3222	2857	3423	
Marine	2772	2722	2760	12424	14506	12728	10680	12083	10825	1794	2385	2381	2722	2760	2282
Motor	290980	240101	228608	643810	608091	706447	659635	608692	665224	35054	10892	37552	240101	228608	232279
Health32220	31551	34746	467861	524581	534741	392373	428687	453664	76157	92699	82124	31551	34746	33699	
Miscellaneous	23691	22616	18002	63495	89269	69183	49548	52017	50139	15022	41866	19877	22616	18002	17169
Total	352297	300212	286973	1192952	1244116	1330225	1115148	1106900	1183970	129889	150455	144376	300212	286973	288852

2. Statistics of time taken for disposal* of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	145	800	245	145	323	221	637	1152	736	1011	1990	1727	974	1156	1189
Marine	1814	1719	2771	831	621	1236	3039	4182	2732	3262	3428	2584	1734	2133	1502
Motor	240412	117719	166387	109757	117719	137605	216331	173088	223186	37878	33143	33159	55262	48996	47420
Health	136334	152400	165301	121768	28199	38215	165178	190086	189254	49616	46758	53538	7165	6992	7356
Miscellaneous	20719	11442	11856	15916	4573	5072	16100	16443	16077	12021	10695	10798	7760	8861	6336
Total	399424	284080	346560	248417	151435	182349	401285	384951	431985	103788	96014	101806	72895	68138	63803

* Disposal = Payment

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	515	403	815	622	327	923	863	1007	742	1222	1120	943
Marine	573	464	497	497	601	414	773	896	644	1652	799	727
Motor	38935	49590	49995	28286	26196	39882	26034	18627	20102	146846	134195	122300
Health	17049	22529	23217	5719	4919	4710	3895	3404	3489	4888	3894	2283
Miscellaneous	3660	3562	4681	3099	2804	3153	4369	3539	3956	10715	8097	5379
Total	**60732**	**76548**	**79205**	**38223**	**34847**	**49082**	**35934**	**27473**	**28933**	**165323**	**148105**	**131632**

*Miscellaneous includes all insurance data in Miscellaneous class except Health and Motor.

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	NIL	NIL	NIL	NIL	NIL	NIL

5. Constraints which cause delay in settlement of claims

- Non Submission of requisite documents in time for assessment of losses.
- Delay in Submission of Survey reports
- Delay in final judgment/ Court award·
- Non Compliance of post approval documentation requirements by Claimants
- Processing delays in some cases·
- IT related problems related to Direct Payment.
- TPA ID cards not issued.
- Claims under investigation by the TPA.
- Medical documents/bills not received from the hospital.
- Delay due to independent doctor's opinion sought.
- Delay in OMP claims due to late delivery of documents from the overseas treating hospital to the respective TPA's office.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Creation of dedicated Claim Hubs whenever feasible.
- Enhancement of financial authority to approving officials
- Rationalization of Claim documents.
- Framework put in place for dealing with small motor claims upto specified limits within 2-3 days
- Constitution of special claim disposal teams to deal with specified and catastrophic AOG claims.
- Direct payment system launched by our company.
- TPA monitoring- so that they strictly adhere to the TAT regarding claim settlement.
- Insured can directly approach us via portal.support@nic.co.in in case of any delay in claim settlement.
- In PPN (Preferred Provider Network) cities, "all-inclusive" PPN packages are charged which ensures speedy settlement.

7. Institutional Framework for review of repudiated claims

- Provision for review of small claims repudiated by TPA.
- Fully fledged CRM Department to deal with claim related grievance in a time bound manner with appropriate escalation mechanism.
- Online grievance reporting and monitoring system integrated with IRDAI's grievance monitoring system.
- Insured can directly approach us for review regarding repudiation via portal.support@nic.co.in ;the matter reaches us and is reviewed within the day.
- Insured can directly contact the CRM/grievance dept in HO for review.
- Insured can approach the respective DO/RO for repudiation cases.
- Insured can even directly approach the CMD of our company via mail customer.relations@nic.co.in
- Walk-in customers and postal letters are received by us on a daily basis regd such cases and we review such cases.
- Doctors in the ROs/HO regularly review claims that require medical opinion.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES (as on 31.03.2016)
Consumer Courts	
District Forum	5265
State Commission	2955
National Commission	167
Motor Claims related	
MACT	137850
Appeals with High Court	39525
Appeals before Supreme Court	32
Other policyholder related cases	
Civil Courts	115
High Courts @	83
Supreme Court	68
Total	
@ of these, the number of appeals against orders of Insurance Ombudsman	9

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Active participation in monthly Lok Adalat organized at various courts.
- Large number of cases being settled in the National/Mega Lok Adalats organized under the aegis of NALSA.
- Time to time special drive is organized to settle small injury cases.
- List of fit cases is produced before the regular Courts/Tribunals for early disposal of the same through conciliation where the liability of the company is established.
- Apart from settlement before Lok Adalat, the cases are also settled through DICC/RICC/ CMCSTPC and Alternative Dispute resolutions, which ensures early disposal of cases.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	17013	23717.55	20280	30753.65	18264	34388.9
Camps						
DICC/RICC	321	949.2	186	916.83	134	886.35
CMCSTPC	612	1361.54	219	523.45	275	1786.45
TOTAL	**17946**	**26028.28**	**20685**	**32193.93**	**18673**	**37061.7**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Raheja QBE General Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	2	3	0	4	6	1	1	3	0	0	0	0	3	0	2
Marine	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	3	6	7	10	4	2	5	2	7	0	0	0	3	7	4
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miscellaneous	42	85	41	105	110	118	24	57	72	2	0	0	86	41	66
Total	**48**	**94**	**48**	**119**	**120**	**121**	**30**	**62**	**79**	**2**	**0**	**0**	**92**	**48**	**72**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	1	0	1	1	0	0	1	1	0	2	1
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	1	0	0	0	3	2	1	2	0	3
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Misce.	0	0	0	4	15	37	8	14	13	11	21	19	1	5	4
Total	**0**	**0**	**0**	**4**	**16**	**38**	**9**	**15**	**13**	**14**	**24**	**20**	**3**	**7**	**8**

3. Statistics of age-wise penedncy of claims for 2013-14, 2014-15 and 2015-16

Category	**1 month**			**1- 3 months**			**3-6 months**			**6 months-1 year**			**>1 year**		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	2	0	1	1	0	1
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	2	0	1	1	1	0	2	1	0	1	5	0
Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miscellaneous	0	0	0	24	11	11	12	12	9	20	13	32	27	5	17
Total	**0**	**0**	**0**	**26**	**11**	**12**	**13**	**13**	**9**	**24**	**14**	**33**	**29**	**10**	**18**

4. Statistics of instances and qantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. Constraints which cause delay in settlement of claims

1. Delay in submission of documents by claimants

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Regular remiders to intermediaries and Insured.2. Visit to Insured's office to collect documents

7. Institutional Framework for review of repudiated claims

1. Each repudiated claims are discussed internally with the Distribution and Underwriting team and once a concurrence is arrived, the claim is repudiated. The reasons for repudiation is explained to the Intermediary / policholder before a repudiation letter is issued.
2. There is a quarter review that checks repudiated claims to determine that the correct action was taken.

8. Statistics of cases of policyholders / claimants before Consumer Fora / Courts

Name of the Forum / Court	**No. of Pending Cases**
Consumer Courts	
District Forum	0
State Commission	0
National Commission	0
Motor Claim related	
MACT	2
Appeals with High Court	1
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	0
High Courts	0
Supreme Court	0
Total	**3**
Of these, the number of appeals against	
orders of Insurance Ombudsman	0

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps, etc.)

The pending MACT cases are being settled on a compromise basis (out of court settlement).

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	4	2.25 lakhs	2	3.41 lakhs	7	27.60 lakhs
Camps	0	0	0	0	0	0
Others (give details)	0	0	0	0	0	0
Total	4	2.25 lakhs	2	3.41 lakhs	7	27.60 lakhs

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : RELIANCE GENERAL INSURANCE COMPANY LIMITED

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

LOB	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	358	457	522	1161	1304	1597	694	853	844	367	387	603	457	522	673
Marine	367	463	408	1808	1737	3259	1099	1135	2358	614	656	747	463	408	562
Motor	82859	84347	84695	174453	183355	216011	148567	156918	177882	24146	26122	33679	84347	84695	89042
Health	295291	67058	37244	1078231	684092	686446	1194885	649906	545448	111677	63987	59666	67058	37244	118606
Miscellaneous	4081	4992	5452	6077	6573	8157	3624	3926	4103	1697	2163	4114	4992	5452	5464
Total	382956	157317	128321	1261730	877061	915470	1348869	812738	730635	138501	93315	98809	157317	128321	214347

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
LOB	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	263	303	332	170	227	206	123	143	116	88	103	96	50	77	94
Marine	588	561	1475	296	359	462	140	121	234	55	67	103	20	27	84
Motor	100783	108961	125050	25033	24450	26960	8103	7563	8609	3697	3488	3919	10951	12456	13344
Health	193960	147554	534165	465525	419714	9632	288719	69823	1118	218554	5162	294	28127	7653	239
Miscellaneous	1086	1151	1369	1009	1238	1102	652	729	735	368	398	460	509	410	437
Total	296680	258530	662391	492033	445988	38362	297737	78379	10812	222762	9218	4872	39657	20623	14198

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

LOB	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	89	51	62	75	47	94	79	84	137	76	134	179	138	206	201
Marine	117	58	82	68	59	149	51	51	140	54	64	110	173	176	81
Motor	6542	6876	8162	6615	6190	7526	5326	5608	6135	8878	7506	8887	56986	58515	58332
Health	42061	11432	116932	12001	8231	825	3346	1281	162	8223	2244	127	1427	14056	560
Miscellaneous	416	382	396	583	444	641	605	540	517	805	860	1280	2583	3226	2630
Total	49225	18799	125634	19342	14971	9235	9407	7564	7091	18036	10808	10583	61307	76179	61804

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	426	246871	232	51556
Health	-	-	1664	177548	14	6398
Miscellaneous	-	-	-	-	-	-
Total	**-**	**-**	**2090**	**424419**	**246**	**57954**

5. Constraints which cause delay in settlement of claims

Non receipt of claim documents on time/Delay in submission
Non receipt of final repair bills
Delay in completing repairs by garages
Delay in receipt of "Non Traceable Certificate" for theft claims
Delay in getting "No Objection Certificate" from financiers to make payment to insured
Delay in original documents verification with relevant government authority e.g. RTA , Police Station
Extended time take for Reinstatement of damaged property
Lead time taken by OEM/Manufacturer for supply of parts/replacement machinery
Delay on insured in arranging for detailed inspection by surveyor/OEM
Delay in receipt in documents from authorities, Police, Fire brigade
Time taken by insured in segregating the salvage and confirming their intrest in retention of salvage or otherwise
Delay in receipt of documents from Transported

6. Initiatives taken by the company to ensure expeditious settlement of claims

100% Contact to claim customers and explain about claim process and documentation
Stage wise update to claimants to get documents / bills on time
Spot / immediate online work order approvals to garages
Complete workflow based claim processing system - to avoid any physical file movement and approval/ Settlement will be done online / system to meet TAT
Claim system access to garages to upload / download documents - this will help to speed up the claim finalization and delivery & settlement
Multiple modes of Communication to the customer by means of Call, E-mail, SMS for timely submission of documents/deficiencies
Timely reminders to the insured for sending document
Involvement of intermediaries for assistance in document submission
Communication of Claim status through various modes viz., call centre SMS, e-mail, web based status,
Regular reminders and followup
In consultation with the insured exploring alternative methods of finalizing the claims including the negotiated settlement
Initiating meeting of Surveyor with OEM in presence of insured to speedup the supply lead time
Release of On-account payment to help insured financially

7. Institutional Framework for review of repudiated claims

A three member team comprising of Licensed Surveyor & Legal person is formed at Corporate office, this team reviews each and every claim before repudiation. All the claims recommended for repudiation have to be validated by this team prior to repudiation.

Repudiation of Health claims are being reviewed by Qualified Medical Professionals

Multi-Level QC before repudiation

Legal and Under writer opinions on Complex cases

If the customer approaches RGICL grievances cell after repudiation then the grievance committee reviews the same again with all merits.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	3094
State Commission	933
National Commission	70
Motor Claims related	
MACT	56587
Appeals with High Court	11088
Appeals before Supreme Court	44
Other policyholder related cases	
Civil Courts	73
High Courts @	
Supreme Court	
Total	**71889**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The company is participating in the Lok Adalats, apart is also settling claims in usual course as and when an agreement is arrived with the claimants. The company is taking due care of all requirements in the claims and accordingly proceeding for the settlements. The company has been also proactively involved in the adjudication of claims through Court process as well by avoiding unnecessary adjournments and there has been a substantial disposal of cases through court proceedings as well. Recently Mega Lok Adalat was scheduled in December 2015 and the company has participated in the same and settled cases in agreement with claimants.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	**YR(2013-14)**		**YR(2014-15)**		**YR(2015-16)**	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	1395	1,81,557,669	2158	3,24,245,085	2969	6,19,030,301
Camps -	-	-	-	-	-	
Others (give details) -	-	-	-	-	-	
TOTAL	**1395**	**1,81,557,669**	**2158**	**3,24,245,085**	**2969**	**6,19,030,301**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Religare Health Insurance Co. Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	637	15630	14661	69858	92663	136367	49243	81643	110338	5622	11989	17724	15630	14661	22966
Miscellaneous															
Total	**637**	**15630**	**14661**	**69858**	**92663**	**136367**	**49243**	**81643**	**110338**	**5622**	**11989**	**17724**	**15630**	**14661**	**22966**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Motor															
Health	45396	78547	110338	3282	2802	0	565	276	0	0	18	0	0	0	0
Miscellaneous															
Total	**45396**	**78547**	**110338**	**3282**	**2802**	**0**	**565**	**276**	**0**	**0**	**18**	**0**	**0**	**0**	**0**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire															
Marine															
Motor															
Health	15147	14149	21700	381	313	661	102	192	567	0	7	38	0	0	0
Miscellaneous															
Total	**15147**	**14149**	**21700**	**381**	**313**	**661**	**102**	**192**	**567**	**0**	**7**	**38**	**0**	**0**	**0**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health	Nil	Nil	Nil	Nil	Nil	Nil
Miscellaneous						
Total						

5. Constraints which cause delay in settlement of claims

i) Incomplete document submission by leading to deficiency.

ii) Delay in submission of deficiency documents.

iii) Claim verification

6. Initiatives taken by the company to ensure expeditious settlement of claims

i) Corporate Training.

ii) Broker / Agent Training.

iii) Detailed Claim procedure in company website.

iv) Proactive Customer calling for claim deficiency resolution.

v) Campaign to reduce deficiency through Email/Camps at Corporates

7. Institutional Framework for review of repudiated claims

i) Client can approach for review of claims through Call centre/Email

ii) Claims reviewed by Claims Head/Customer Service Head independently of decision taken earlier

iii) Expert Medical opinion sought if requirement seen

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	114
State Commission	5
National Commission	0
Motor Claims related	
MACT	NA
Appeals with High Court	NA
Appeals before Supreme Court	NA
Other policyholder related cases	
Civil Courts	Nil
High Courts @	Nil
Supreme Court	Nil
Total	**119**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

None of the cases settled in LokAdalat or at a Pre-Litigative state.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	**YR(2013-14)**		**YR(2014-15)**		**YR(2015-16)**	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat						
Camps						
Others (give details)						
TOTAL	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Royal Sundaram General Insurance Co. Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	393	51	484	472	1,401	10,048	624	800	9,067	98	166	274	51	484	660
Marine	1,270	756	1,094	4,713	5,832	5,851	4,162	4,719	4,679	319	516	405	756	1,094	1,253
Motor	24,865	26,904	26,024	231,563	218,581	258,054	226,883	223,287	248,862	1,799	1,160	1,324	26,904	26,024	26,121
Health	7,521	17,523	24,459	145,724	135,836	53,071	129,550	111,051	67,383	7,925	7,705	4,767	17,523	24,459	2,709
Miscellaneous	904	1,111	639	2,822	2,697	2,643	2,231	1,867	1,567	405	401	337	1,111	639	834
Total	**34,953**	**46,345**	**52,700**	**385,294**	**364,347**	**329,667**	**363,450**	**341,724**	**331,558**	**10,546**	**9,948**	**7,107**	**46,345**	**52,700**	**31,577**

Note: The count provided for FY 2015-2016 is based on provisional unaudited figures.

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	103	355	8,215	199	172	486	164	110	183	119	113	139	40	50	44
Marine	1,790	1,581	1,884	1,957	2533	2,139	309	385	496	92	191	189	14	29	-29
Motor	171,309	182,199	203,966	28,431	14,648	33,483	9,755	7,269	5,547	6,309	6,111	1,753	11,079	13,060	4,113
Health	75,414	37,075	35,564	49,404	71,954	27,068	3,673	1,168	0	844	703	4,751	215	151	0
Miscellaneous	642	1,141	1,173	871	388	256	429	195	42	204	89	59	84	54	37
Total	**249,258**	**222,351**	**250,802**	**80,862**	**89,695**	**63,432**	**14,330**	**9,127**	**6,268**	**7,568**	**7,207**	**6,891**	**11,432**	**13,344**	**4,165**

Note: Count provided for disposal of claims pertains to Paid claims.

· The count provided for FY 2015-2016 is based on provisional unaudited figures.

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	20	137	99	3	112	112	10	90	210	9	78	142	9	67	97
Marine	205	336	361	30	201	197	67	109	207	98	166	219	357	282	269
Motor	6,562	3465	3497	951	2197	2645	2,276	2,125	2102	3,348	3,119	2860	13,767	15,118	15017
Health	10,785	24,028	1948	1564	150	478	2,344	26	89	1,256	34	31	1,574	221	163
Miscellaneous	375	106	158	54	116	205	192	65	139	152	102	107	337	250	225
Total	**17,947**	**28,072**	**6,063**	**2,602**	**2,776**	**3,637**	**4,889**	**2,415**	**2,747**	**4,863**	**3,499**	**3,359**	**16,044**	**15,938**	**15,771**

Note:

- The count provided for FY 2015-2016 is based on provisional unaudited figures.
- The pending claims count is inclusive of various claims that are pending with the Consumer courts, Civil Courts, MACT, High Courts etc and claims where requisite document submission is pending.

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL					
Marine						
Motor						
Health						
Miscellaneous						
Total						

5. Constraints which cause delay in settlement of claims

Motor OD Claims:

1. Receipt of documents such as RC, DL, Estimate, Claim Form and Bills.
2. Repair lead time and non-availability of spare parts.
3. Lieu of online verification of documents
4. Receipt of survey report from Independent Surveyors.

Commercial Claims:

5. Commercial claims have long shelf life because clients take time in reinstating the loss and providing payment proofs.
6. There is no single person to handle claims at the insured's place and frequent change of people handling the claims.
7. Delay may arise due to getting the spares/machinery imported from the OEM abroad
8. Marine - GA claims take long years for adjudication and settlement
9. Liability claims take long years for settlement if it goes to the court.

Accident & Health Claims:

1. In instances of claims which are investigated to ascertain genuineness, we appoint our service providers for facilitating the investigation process. The appointed service providers are dependent on extraneous factors such as co-operation by the hospital in providing records, availability of treating doctor etc. Completion of the investigation process in such claims causes delay in claim settlement.
2. Non-submission of certain vital claim documents like discharge summary, advance and final receipts, KYC documents etc by the customer despite repeated and periodic follow-up causes delay in claim settlement.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Motor OD Claims:

1. Vahan ID from the government.
2. Simplified documentations and process.
3. More In house surveyors.
4. Decentralised process
5. Exclusive systems for Motor OD claims Process.
6. SMS facility to customer for Document requirement.

Commercial Claims:

1. Taken proactive steps to speed up the recent Chennai flood claims by seeking effective documentations only
2. Suggesting market value settlement where the insured are having difficulty of reinstating the loss
3. Regular monitoring of the case development with the insured and surveyor

Accident & Health Claims:

1. Where the admissibility of the claim is otherwise established, we waive the requirement of submission of medical information (in Part B of the claim form) to expedite claim settlement.
2. Where submission of mandatory documents is not forthcoming from the customer, we explain the requirements to the customer telephonically for better understanding of the requirement and facilitate early submission of the same.

7. Institutional Framework for review of repudiated claims

Motor OD Claims:

1. Centralized repudiation process / Authority.
2. Our denial based on the material evidences on case to case basis.
3. Case Analysis of Repudiated claims.

Commercial Claims:

1. All claims repudiated are approved by authority who is one step higher than the licensed authority.
2. Similarly reopening of repudiated claims are done by one step higher than the authority who had repudiated the claim.

Accident & Health Claims:

1. Claim Review Committee:We have a review committee comprising of senior level representatives for a fair review of repudiated claims which have been represented for reconsideration.
2. Grievance Redressal Mechanism: Grievance Redressal mechanism in place as per the IGMS norms of IRDA

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	681
State Commission	195
National Commission	23
Motor Claims related	
MACT	17101
Appeals with High Court	2231
Appeals before Supreme Court	12
Other policyholder related cases	
Civil Courts	11
High Courts @	5
Supreme Court	
Total	**20259**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like LokAdalat, Settlement camps etc.)

We have been participating in all the lokadalats and try to compromise all the cases where we do not have any defence. We do have a separate target for compromise settlements and periodical reviews are being conducted.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
LokAdalat	6177	1208967326	5051	1251207458	4419	1215627594
Camps						
Others (give details)						
TOTAL	**6177**	**1208967326**	**5051**	**1251207458**	**4419**	**1215627594**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: SBI General Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	141	284	461	2173	2890	3304	1517	2181	2932	513	532	327	284	461	506
Marine	15	61	138	280	749	1210	177	570	1080	57	102	89	61	138	179
Motor	1446	5500	9476	34554	46098	72657	29898	41317	68341	602	805	731	5500	9476	13061
Health	114	264	1427	1710	8944	24811	1003	3992	13353	557	3789	10293	264	1427	2592
Miscellaneous	67	129	197	520	775	1449	368	565	1225	90	142	135	129	197	286
Total	**1783**	**6238**	**11699**	**39237**	**59456**	**103431**	**32963**	**48625**	**86931**	**1819**	**5370**	**11575**	**6238**	**11699**	**16624**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	478	741	906	780	782	977	546	743	746	212	365	475	14	82	155
Marine	59	162	241	86	258	442	66	169	283	23	73	176	0	10	27
Motor	17959	22090	30298	8695	11859	24587	2953	4900	8163	849	2533	3804	44	740	2220
Health	1285	6211	18541	246	1336	4751	21	207	312	8	25	40	0	2	2
Misc	137	162	252	134	225	530	124	193	356	58	94	157	5	33	65
Total	**19918**	**29366**	**50238**	**9941**	**14460**	**31287**	**3710**	**6212**	**9860**	**1150**	**3090**	**4652**	**63**	**867**	**2469**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	103	104	87	58	83	92	69	142	151	52	92	72	2	40	104
Marine	21	32	65	24	44	55	10	36	30	6	19	20	0	7	9
Motor	1826	2219	3415	1658	2002	2278	1143	1771	1975	717	2080	2214	156	1404	3179
Health	184	1068	1859	64	304	660	13	40	62	2	2	11	1	13	0
Miscellaneous	42	56	115	42	65	83	33	32	31	11	25	31	1	19	26
Total	**2176**	**3479**	**5541**	**1846**	**2498**	**3168**	**1268**	**2021**	**2249**	**788**	**2218**	**2348**	**160**	**1483**	**3318**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health						
Miscellaneous						
Total	NIL		NIL		NIL	

5. Constraints which cause delay in settlement of claims

There were no delays in settlement of claims and for last 3 years we have paid "Nil" penalty towards delayed payments/settlements

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. First contact with Customer and survey appointment is done within 24 hours of the claim intimation.
2. On account payments are released to give immediate financial relief to Customer, where ever applicable
3. Regular follow-up is done with customer to ensure that documents are submitted quickly and survey report is released at earliest.
4. Small Value claims are focused for settlement in less than 90 days
5. Relaxation of survey norms for claims less than Rs. 50,000, especially in Marine Insurance.
6. In event of catastrophic losses,
   i. Relaxed norms for On a/c payments / Settlements
   ii. Relaxations in documents for small value claims

7. Institutional Framework for review of repudiated claims

1. All the claims which are repudiated with due explanation to Insured on reasons for repudiation.
2. The repudiation letter provides an opportunity to Insured to present any additional facts to represent the case.
3. Claims for repudiation are approved by senior official only i.e. Regional Claims Head and above.
4. 4. All the claims which are repudiated, are given an opportunity to refer the matter to "Grievance Redressal Committee", This is an Independent forum available to Insured for addressing the complaints against repudiation of claim.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	393
State Commission	46
National Commission	8
Motor Claims related	
MACT	6702
Appeals with High Court	130
Appeals before Supreme Court	-
Other policyholder related cases	
Civil Courts	
High Courts @	
Supreme Court	
Total	**7279**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Maximum Participation before all the National Lok adalats·
- Active participations for settlement before ADRs(alternate disputes redressal forums) & Conciliations·
- Prompt settlement of the TP claims in all DAR (Detailed Accident report)
- Settlement thru Pre-litigations before legal aid committees

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	**226**	5,54,33,394	**700**	19,06,78,799	**1107**	35,08,44,718
Camps						
Others (give details)						
TOTAL	**226**	**5,54,33,394**	**700**	**19,06,78,799**	**1107**	**35,08,44,718**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Shriram General Insurance Company Limited

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	26	21	32	65	101	204	65	72	115	5	18	86	21	32	35
Marine	9	4	4	10	10	22	13	8	5	2	2	10	4	4	11
Motor	16519	27632	36806	79118	78563	130998	62213	63419	79131	5792	6240	19700	27632	36806	68973
Health	17	21	31	78	114	130	51	81	94	23	23	48	21	31	19
Miscellaneous	65	86	63	172	176	272	120	140	89	31	59	176	86	63	70
Total	**16636**	**27764**	**36936**	**79443**	**78964**	**131626**	**62462**	**63720**	**79434**	**5853**	**6342**	**20020**	**27764**	**36936**	**69108**

*The data relating to FY 2015-16 is on provisional basis.

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	6	10	77	13	10	17	22	27	2	18	21	17	6	4	2
Marine	4	2	1	3	2	2	3	3	0	3	0	1	0	1	1
Motor	14797	21050	33632	29643	27545	18340	10122	8013	1834	5227	2443	6092	2424	4098	19233
Health	18	12	29	17	37	21	6	15	17	9	16	22	1	1	5
Misce.	15	27	17	32	25	22	32	25	6	29	31	34	12	32	10
Total	**14840**	**21101**	**33756**	**29708**	**27619**	**18402**	**10185**	**8083**	**1859**	**5286**	**2511**	**6166**	**2443**	**4136**	**19251**

*The data relating to FY 2015-16 is on provisional basis.

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	5	3	32	5	7	3	3	8	0	6	7	0	2	7	0
Marine	0	1	11	0	0	0	0	2	0	1	0	0	3	1	0
Motor	7305	6913	6899	3131	2963	3617	4030	3533	4789	5982	6280	8215	7184	17117	45453
Health	4	8	19	7	12	0	4	2	0	1	2	0	5	7	0
Miscellaneous	13	13	67	17	10	2	13	15	1	20	5	0	23	20	0
Total	**7327**	**6938**	**7028**	**3160**	**2992**	**3622**	**4050**	**3560**	**4790**	**6010**	**6294**	**8215**	**7217**	**17152**	**45453**

*The data relating to FY 2015-16 is on provisional basis.

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	-	-	-	-	-	-
Marine	-	-	-	-	-	-
Motor	-	-	-	-	-	-
Health	-	-	-	-	-	-
Miscellaneous	-	-	-	-	-	-
Total						

5. Constraints which cause delay in settlement of claims

- Non-submission of documents by insured.
- Delayed intimation by insured.
- Communication gap due to non-intimation of changed contact number and address by insured.

6. Initiatives taken by the company to ensure expeditious settlement of claims

- A service analyst team named “SATHI” is constituted to educate the customers about required claim documents during claim process and to remove the bottleneck that is being faced by insured at the time of claims.
- An IT software Motoveys is introduced for real time updation by the Surveyor.
- Emphasis on OD Claim payment through NEFT so that insured can get the payment of claim instantly.
- Monthly Surveyors meeting at branch level to interact with Surveyors to sort out pending claim related issues.
- SMS is sent to insured about surveyor details for easy approach.

7. Institutional Framework for review of repudiated claims

A team of Senior Officials regularly review repudiated claims.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1582
State Commission	322
National Commission	12
Motor Claims related	
MACT	53464
Appeals with High Court	7106
Appeals before Supreme Court	16
Other policyholder related cases	
Civil Courts	3
High Courts @	-
Supreme Court	-
Total	**62505**
@ of these, the number of appeals against orders of Insurance Ombudsman	

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Initiating compromises on regular & continuous basis. And also participating actively in lok-adalat in various states as & when organized.
- Initiating & settling TP/WCC Cases "Out Of Court" which explored at the time of intimation of OD claims.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	2867	Rs. 49.96 Cr.	3934	Rs. 104.61 Cr.	8469	Rs. 264.76 Cr.
Camps						
Others (give details)	5	Rs. 0.04 Cr.	28	Rs. 0.26 Cr.	562	Rs. 3.16 Cr.
TOTAL	**2872**	**Rs. 50.00 Cr.**	**3962**	**Rs. 104.87 Cr.**	**9031**	**Rs. 267.92 Cr.**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: Star Health & Allied Insurance Company Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	27448	30507	33405	321400	358850	395125	248363	257722	317605	69978	98230	86186	30507	33405	24739
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**27448**	**30507**	**33405**	**321400**	**358850**	**395125**	**248363**	**257722**	**317605**	**69978**	**98230**	**86186**	**30507**	**33405**	**24739**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	228095	250864	314318	19077	6383	3007	937	373	195	169	79	60	85	23	25
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**228095**	**250864**	**314318**	**19077**	**6383**	**3007**	**937**	**373**	**195**	**169**	**79**	**60**	**85**	**23**	**25**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Marine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Motor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health	19809	22068	18570	7696	9022	4751	1965	1557	908	754	478	377	283	280	133
Miscellaneous	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**19809**	**22068**	**18570**	**7696**	**9022**	**4751**	**1965**	**1557**	**908**	**754**	**478**	**377**	**283**	**280**	**133**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	986	647184	2010	458696
Miscellaneous	0	0	0	0	0	0
Total	**0**	**0**	**986**	**647184**	**2010**	**458696**

5. Constraints which cause delay in settlement of claims

We have not encountered any constraints with respect to Retail and Market business.

With respect to Overseas Travel Policies:

1. Delay in receipt of the medical records and bills by the overseas hospital in case of cashless claims.
2. Delay in receipt of the claim documents by the customer in case of reimbursement claims since the customer waits to complete his trip and the documents are submitted upon arrival to India.
3. Improper claim documents.

6. Initiatives taken by the company to ensure expeditious settlement of claims

1) 24*7 customer care centre to address the need of customers.
2) Cashless handling through Medical personnel within two hours.
3) 6640 Network Hospitals to render cashless settlement.
4) Network hospitals with agreed package rates.
5) Team of Field Visit personnel to visit patients at hospitals which help the patients to get better attention by network hospitals.
6) Payment of claims through NEFT mode.
7) Addressing the grievance of customers on real time basis.
8) Providing claim procedure sheet along with the policy documents, the list of documents to be submitted.
9) Regular follow up with the overseas hospital for medical records and bills.

7. Institutional Framework for review of repudiated claims

- We have a dedicated team consisting of Insurance Medical Legal professionals to review repudiated claims and to take appropriate decision.
- After repudiation, if the customer represents then Grievance Department will review the claim

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts '

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1099
State Commission	30
National Commission	2
Motor Claims related	
MACT	0
Appeals with High Court	0
Appeals before Supreme Court	0
Other policyholder related cases	
Civil Courts	4
High Courts @	2
Supreme Court	0
Total	**1137**
@ of these, the number of appeals against orders of Insurance Ombudsman	6

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The cases pending before the Consumer Fora are further reviewed by the Company in consultation with the Doctors and wherever it is feasible within the terms and conditions of the Policy, we are taking all the steps to negotiate, compromise and settle the cases amicably.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	**YR(2013-14)**		**YR(2014-15)**		**YR(2015-16)**	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	125	6158977	130	11530152	107	11112718
Camps	0	0	0	0	0	0
TOTAL	**125**	**6158977**	**130**	**11530152**	**107**	**11112718**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: TATA AIG GENERAL INSURANCE CO LTD

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14 and 2014-15 & 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Closed			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	2154	2523	1316	25784	10207	2743	16208	8379	1401	1617	835	423	7590	2200	852	2523	1316	1383
Marine	3321	2965	6514	16119	37989	92854	10565	24787	46123	2108	2909	5289	3802	6744	25755	2965	6514	22201
Motor	11240	9647	10169	243356	241026	292270	220444	218276	269654	2456	2396	1540	22049	19832	20897	9647	10169	10348
Health	389	3044	1494	83244	60525	65512	72310	52036	51160	2775	3762	3900	5504	6277	8645	3044	1494	3301
Miscellaneous	7023	4773	4201	54697	48706	44247	45486	39025	33781	435	464	675	11026	9789	9498	4773	4201	4494
Total	24127	22952	23694	423200	398453	497626	365013	342503	402119	9391	4925	11827	49971	44842	65647	22952	23694	41727

2. Statistics of time taken for disposal of claims for 2013-14 and 2014-15 & 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year			Total		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	9230	3850	118	4880	2762	333	1149	954	353	632	502	329	317	311	268	16208	8379	1401
Marine	3283	11766	18936	4037	9045	20258	1983	2614	5123	940	972	1427	322	390	379	10565	24787	46123
Motor	135785	145871	96380	72261	63531	159707	8995	6515	11166	2785	1839	1936	618	520	465	220444	218276	269654
Health	67063	45572	37170	4157	4633	10857	836	1376	2275	221	395	701	33	60	157	72310	52036	51160
Miscellaneous	13378	13988	13676	25453	20962	17066	4842	2664	2036	1505	1010	734	304	401	269	45486	39025	33781
Total	228739	221047	166280	110788	100933	208221	17805	14123	20953	6083	4718	5127	1598	1682	1538	365013	342503	402119

3. Statistics of age-wise pendency of claims for 2013-14 and 2014-15 & 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year			Total		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	1059	155	95	239	172	161	503	248	337	403	356	345	319	385	445	2523	1316	1383
Marine	1006	2802	6747	312	2024	9331	593	712	4628	540	595	1002	514	381	493	2965	6514	22201
Motor	6563	3967	5821	799	4446	2374	1042	646	1063	686	445	365	557	665	725	9647	10169	10348
Health	2263	739	2168	371	154	699	244	405	303	120	82	46	46	114	85	3044	1494	3301
Miscellaneous	2639	1969	1805	310	607	1222	585	476	709	450	370	327	789	779	431	4773	4201	4494
Total	13530	9632	16636	2031	7403	13787	2967	2487	7040	2199	1848	2085	2225	2324	2179	22952	23694	41727

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	0	0	0	0	0	0
Marine	0	0	0	0	0	0
Motor	0	0	0	0	0	0
Health	0	0	0	0	0	0
Miscellaneous	0	0	0	0	0	0
Total	0	0	0	0	0	0

5. Constraints which cause delay in settlement of claims

- Delay in reporting Claims
- Non submission / Delayed submission of requested documents/reports by insured
- Repair/reinstatement happens over a period of time

6. Initiatives taken by the company to ensure expeditious settlement of claims

- Robust monitoring system in place for speedy settlement of claims
  - o Weekly report
  - o LOB wise monthly report
  - o Monthly Benchmark report
  - o Claim handler wise monthly No activity report ·
- Quarterly review of all claims pending over 90 days is mandatory·
- Frequent follow up mails/letter sent to insured for documents submission·
- Frequent follow up with surveyor for survey report submission·
- Service level agreement with corporate clients / affinity partners on claim process protocol and documentation

Proactive release of on account payment where repair / reinstatement is taking time

7. Institutional Framework for review of repudiated claims

- All claim repudiations are done at the level of Line head in Corporate Office.
- All customer grievances / litigations including Consumer Fora & Ombudsman cases, pertaining to repudiation of claim, are reviewed by the Line Head and Claims Legal Head.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	1064
State Commission	141
National Commission	34
Motor Claims related	
MACT	10621
Appeals with High Court	703
Appeals before Supreme Court	3
Other policyholder related cases	
Civil Courts	17
High Courts @	11
Supreme Court	1
Total	**12595**
@ of these, the number of appeals against orders of Insurance Ombudsman	**No appeals from order of Ombudsman**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

- Cases are being pro-actively investigated /reviewed and all the cases, where liability is established, are being settled promptly.·
- Where the claim is pending for documentation, a specific stand is taken in the written statement stating the requirement of the documents. ·
- Our Advocates are specifically instructed to report the evidence before the Consumer Foras and inform us where they feel the need to review our decision.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat/ consent Award	2,514	40,60,89,046	3274	96,76,94,932	3317	96,64,76,057
Camps						
Others (give details) JRY	64	83,53,893	33	46,87,754	17	24,48,584
TOTAL	**3152**	**64,35,13,135**	**3307**	**9,72,38,26,86**	**3334**	**96,89,24,641**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : THE NEW INDIA ASSURANCE CO. LTD.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S beginning of year			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending the end of year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	850	883	935	287	306	252	201	208	213	53	46	55	883	935	919
Marine	321	354	379	133	155	86	86	112	63	14	18	20	354	379	382
Motor	206148	185898	174735	66803	68129	69032	72462	69037	66777	14591	10255	12847	185898	174735	164143
Health	896	1210	1254	811	823	732	371	556	486	126	223	139	1210	1254	1361
Misc.	5007	5350	5513	1838	1949	1336	1145	1164	1358	350	622	485	5350	5513	5006
Total	213222	193695	182816	69872	71362	71438	74265	71077	68897	15134	11164	13546	2E+05	182816	171811

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16 *

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	15	15	13	17	8	12	19	22	9	35	36	36	257	254	320
Marine	7	8	13	13	7	1	16	8	2	11	4	2	83	132	88
Motor	12936	13827	13531	7603	7300	7653	8338	8843	9729	14257	12611	14166	67433	58415	56224
Health	64	60	35	42	41	23	26	47	31	64	75	99	255	372	375
Misc.	99	134	85	83	84	48	124	109	73	225	167	165	894	1080	1479
Total	**13121**	**14044**	**13677**	**7758**	**7440**	**7737**	**8523**	**9029**	**9844**	**14592**	**12893**	**14468**	**68922**	**60253**	**58486**

* Includes both partially / Fully paid

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	12	8	5	15	18	7	11	20	11	40	39	40	805	850	856
Marine	8	3	4	7	8	7	4	4	15	22	20	5	313	344	351
Motor	4746	5155	5034	6240	6009	6871	7057	7213	7889	13593	14865	15586	154262	141493	128763
Health	92	35	51	50	52	68	53	109	101	142	168	175	873	890	966
Misc.	106	70	27	137	79	52	179	147	91	321	333	176	4607	4884	4660
Total	**4964**	**5271**	**5121**	**6449**	**6166**	**7005**	**7304**	**7493**	**8107**	**14118**	**15425**	**15982**	**2E+05**	**148461**	**135596**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Misc.	NIL	NIL	NIL	NIL	NIL	NIL
Total	NIL	NIL	NIL	NIL	NIL	NIL

5. Constraints which cause delay in settlement of claims

Legal Issues and sometimes Claimants Insists at a Particular Amount of Settlements.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Various forums available to the claimants for redressal of their cases like Lok Adalats, Compromise Settlemets and Inhouse Claim Committees at Divisional, Regional and Head Office levels.

7. Institutional Framework for review of repudiated claims

New India Assurance Company Ltd. Has its Grievance Redressal Policy Adopted by the Board.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	4595
State Commission	1149
National Commission	526
Motor Claims related	
MACT	132843
Appeals with High Court	28707
Appeals before Supreme Court	106
Other policyholder related cases	
Civil Courts	384
High Courts	345
Supreme Court	86
Total	**168741**

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

The pending Consumer Fora cases are reviewed regularly at Operating Offices. Those cases which are found to be not sustainable, efforts are made to review and resolve through out of Court settlement. Such cases are also placed in Lok Adalat being held at different places for settlement.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	**YR(2013-14)**		**YR(2014-15)**		**YR(2015-16)**	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	24245		24722		25419	
Camps						
Others (give details)	151		223		191	
TOTAL	**24396**		**24945**		**25610**	

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : The Oriental Insurance Company Ltd.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	3,715	3,608	3,622	5,869	5,447	6,040	5,232	5,175	4,787	1,640	1,128	1,187	3,608	3,622	3,688
Marine	3,817	4,009	4,273	15,354	14,395	12,880	12,643	12,075	10,897	3,883	3,679	2,488	4,009	4,273	3,768
Motor	2,10,851	1,97,342	1,89,524	2,69,660	2,81,731	3,50,688	2,74,712	2,80,016	3,30,754	36,609	37,043	24,069	1,97,342	1,89,524	1,85,413
Health	36,168	37,636	42,336	5,92,585	6,35,755	7,72,482	4,94,585	6,21,971	6,62,970	97,716	9,276	93,402	37,636	42,336	58,575
Miscellaneous	23,200	22,835	24,302	66,046	57,212	63,587	51,590	49,037	49,210	20,773	11,794	12,828	22,835	24,302	25,851
Total	2,77,751	2,65,430	2,64,057	9,49,514	9,94,540	12,05,677	8,38,762	9,68,274	10,58,618	1,60,621	62,920	1,33,974	2,65,430	2,64,057	2,77,295

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	338	487	269	601	559	588	1,305	1,260	1,187	1,642	1,636	1,578	1,346	1,233	1,165
Marine	3,672	2,549	2,065	3,559	3,677	2,902	2,413	2,647	2,838	1,714	1,903	1,928	1,285	1,299	1,164
Motor	78,022	86,163	1,06,633	90,565	1,00,292	1,24,383	38,233	36,845	42,908	24,451	21,095	22,535	43,441	35,621	34,295
Health	78,028	2,57,688	3,55,589	2,87,078	2,53,666	2,60,833	1,10,946	41,442	35,284	14,104	55,004	8,376	4,429	14,171	2,888
Miscellaneous	9,336	8,396	9,109	15,405	14,985	14,910	13,025	12,354	12,303	7,882	8,029	7,318	5,942	5,273	5,570
Total	1,69,396	3,55,283	4,73,665	3,97,208	3,73,179	4,03,616	1,65,922	94,548	94,520	49,793	87,667	41,735	56,443	57,597	45,082

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	367	365	250	612	515	393	548	629	866	811	930	946	1,270	1,183	1,233
Marine	821	981	570	662	751	662	670	736	709	858	974	893	998	831	934
Motor	11,935	13,336	13,559	14,984	14,554	15,907	13,282	13,984	15,392	20,044	19,953	19,873	1,37,097	1,27,697	1,20,682
Health	21,296	24,681	33,948	5,983	10,686	16,757	6,745	2,891	4,170	1,991	2,048	2,137	1,621	2,030	1,563
Miscellaneous	3,194	2,894	3,639	4,106	3,971	4,500	3,268	3,757	4,274	3,901	4,878	4,584	8,366	8,802	8,854
Total	**37,613**	**42,257**	**51,966**	**26,347**	**30,477**	**38,219**	**24,513**	**21,997**	**25,411**	**27,605**	**28,783**	**28,433**	**1,49,352**	**1,40,543**	**1,33,266**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health						
Miscellaneous						
Total	NIL		NIL		NIL	

5. Constraints which cause delay in settlement of claims

Delay in submission of documents by the insured and compliance of requisite formalities.

6. Initiatives taken by the company to ensure expeditious settlement of claims

Claim clearance drive with regular follow up with the customers and other agencies involved.

7. Institutional Framework for review of repudiated claims

Company has a four tier grievance redressal mechanism which deals with the complaints of the policy holders. Grievance nodal officers are appointed in the Regional offices. In addition Grievance Redressal Committee also function in RO / HO.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES		
Consumer Courts	Motor	Non Motor	Total
District Forum	3152	3076	6228
State Commission	1397	3673	5070
National Commission	153	487	640
Motor Claims related			
MACT	114443		114443
Appeals with High Court	24791		24791
Appeals before Supreme Court	89		89
Other policyholder related cases			
Civil Courts	120	177	297
High Courts @	42	123	165
Supreme Court	10	74	84
Total	**144197**	**7610**	**151807**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL		

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (Like LokAdalat, Settlement camps etc)

Separate legal cell is created at Head Office to monitor suit claims other than Motor. This cell monitors Ombudsman cases also.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount (in Lakh)	No. of claims	Amount (in Lakh)	No. of claims	Amount (in Lakh)
LokAdalat	15741	28491.21	12308	22154.40	6179	11086.02
Camps	NIL	NIL	NIL	NIL	NIL	NIL
Others	NIL	NIL	NIL	NIL	NIL	NIL
	15741	**28491.21**	**12308**	**22154.40**	**6179**	**11086.02**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER: UNITED INDIA INSURANCE CO. LTD.

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	2780	3175	4905	6627	10346	10574	3970	6071	6252	535	440	759	3175	4905	4931
Marine	5184	4804	4895	16453	16815	14996	13439	13662	12066	1246	1296	874	4804	4895	5131
Motor	253372	234724	232673	349968	407636	436618	338581	359410	342239	3320	6262	3204	234724	232673	256416
Health	122538	74064	180304	963586	1694925	2404893	969730	1452938	2066726	19619	79244	169592	74064	180304	268163
Miscellaneous	23678	25332	28111	131715	133459	131711	111128	113870	115650	7225	7038	6895	25332	28111	25917
Total	407552	342099	450888	1468349	2263181	2998792	1436848	1945951	2542933	31945	94280	181324	342099	450888	560558

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	160	878	1139	266	1133	1578	982	1649	972	1234	1217	1051	1328	1194	1512
Marine	1010	1028	1616	1698	1837	3520	4022	4587	1877	3645	3734	2216	3064	2476	2837
Motor	117370	63864	72921	88501	152891	178230	38080	44036	25054	22175	26735	18338	72455	71884	47696
Health	227149	147852	1197509	79869	570297	810543	465930	296622	49055	169260	200519	8768	27522	9350	851
Miscellaneous	23731	9166	8766	12759	24298	23358	34506	37472	65282	25995	21005	9873	14137	10492	8371
Total	**369420**	**222788**	**1281951**	**183093**	**750456**	**1017229**	**543520**	**384366**	**142240**	**222309**	**253210**	**40246**	**118506**	**95396**	**61267**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1- 3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire & Engg	1157	886	693	782	982	1037	1120	2823	2179	1734	3466	2410	2224	3514	3360
Marine	677	742	344	593	590	502	789	761	927	1058	1176	1587	1760	1898	1730
Motor OD	6392	8080	10350	8391	10144	11895	7262	8664	9354	9176	9424	9422	29440	24428	7373
Health	7711	11974	3838	1608	1662	2527	1367	1446	2381	1353	3383	1724	59864	4684	3748
Miscellaneous	3308	2772	1376	2776	2499	1703	2902	3573	2423	3789	4424	3328	8434	10644	8373
Total	**19245**	**24454**	**16601**	**14150**	**15877**	**17664**	**13440**	**17267**	**17264**	**17110**	**21873**	**18471**	**101722**	**45168**	**24584**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire						
Marine						
Motor						
Health						
Miscellaneous						
Total	NIL		NIL		NIL	

5. Constraints which cause delay in settlement of claims

1. The claimants do not submit the documents completely. The documents are submitted piecemeal, even though the requirements are provided to them along with the claim form at the time of intimation of claim by the policyholder.
2. Intimation of claim itself is delayed.
3. The policyholders do not understand the policy terms and conditions but make a claim which is not covered under the policy .

6. Initiatives taken by the company to ensure expeditious settlement of claims

1. Company has in place a Citizen's Charter which is displayed in all Operating Offices. The Citizen's Charter contains the timelines for every activity including claim settlement.
2. The internal Audit machinery reviews delay in handling claim files vis-à-vis the benchmark timelines.
3. Health Department reviews the adherence of TAT by the TPA
4. On-account payments are also considered in deserving cases
5. Formation of Motor OD and TP Service Hubs in various centres
6. Tie up with garages for extending cashless settlement
7. Company maintains Surveyor Allotment Register in the Computer system and survey jobs are assigned to empanelled surveyors at the earliest

7. Institutional Framework for review of repudiated claims

Grievance Review Committee is formed at RO level to review the grievances on repudiated claims. At HO Level also, we have a Head Office Grievance Review Committee for reviewing grievances on repudiated claims over and above RO GRC powers.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	No. of Pending cases
Consumer Courts	
District Forum	8656
State Commission	3549
National Commission	499
Motor Claims related	
MACT	161497
Appeals with High Court	40171
Appeals before Supreme Court	203
Other policyholder related cases	
Civil Courts	5364
High Courts @	1459
Supreme Court	63
Total	**221461**
@ of these, the number of appeals against orders of Insurance Ombudsman	NIL

9. Initiatives taken by the company for settlement of cases penfore various Fora and Courts (like Lok Adalat, Settlement camps etc.)

1. Every office is instructed to identify TP Claims fit for compromise so that miximum number of claims can be settled in Lok Adalat as and when held.
2. The officers are also given higher financial Authority for the purpose of settling higher cases during National Mega Lok Adalats.
3. In DAR cases reasonsed offer is made for facilitating settlement through reconciliatory procedure.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	**Amount**	**No. of claims**	**Amount**	**No. of claims**	**Amount**
Lok Adalat	21093	3263516589	21163	3861453668	20254	3465454805
Camps				1962	390212708	
Others (give details)	0	0	0	0	0	0
TOTAL	**21093**	**3263516589**	**21163**	**3861453668**	**22216**	**3855667513**

INFORMATION ABOUT CLAIMS AND CLAIM RELATED COURT CASES

NAME OF THE INSURER : Universal Sompo General Insurance Co Ltd

1. Statistics of Number of Claims received, disposed, pending for the category wise for 2013-14, 2014-15 and 2015-16

Category	Claims O/S			Claims Reported during the period			Claims Settled			Claims repudiated			Claims Pending		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	193	191	174	1069	1085	1629	922	916	1231	149	186	196	191	174	376
Marine	140	113	84	2486	3089	3111	2477	3087	2996	36	31	25	113	84	174
Motor	6515	7152	7666	33942	39426	52750	32816	38080	51856	489	832	793	7152	7666	7767
Health	1707	2117	2891	28082	42227	48146	25242	37558	47108	2430	3895	1589	2117	2891	2340
Misc.	805	795	847	6551	6124	5976	6012	4837	5337	549	1235	657	795	847	829
Total	**9360**	**10368**	**11662**	**72130**	**91951**	**111612**	**67469**	**84478**	**108528**	**3653**	**6179**	**3260**	**10368**	**11662**	**11486**

2. Statistics of time taken for disposal of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	197	372	475	304	240	418	336	316	320	207	146	184	27	28	30
Marine	1909	2487	2400	266	375	408	224	189	167	108	59	45	6	8	1
Motor	16479	23401	33839	10389	10646	13502	3837	2737	3049	1887	727	670	713	1401	1589
Health	16908	25864	27496	9024	12753	16660	1533	2706	4184	207	130	357	0	0	0
Misc.	3144	2545	2181	2117	2302	2547	737	910	916	468	216	260	95	99	90
Total	**38637**	**54669**	**66391**	**22100**	**26316**	**33535**	**6667**	**6858**	**8636**	**2877**	**1278**	**1516**	**841**	**1536**	**1710**

3. Statistics of age-wise pendency of claims for 2013-14, 2014-15 and 2015-16

Category	1 month			1-3 months			3-6 months			6 months-1 year			>1 year		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Fire	37	39	40	49	48	78	56	47	213	28	13	23	21	27	22
Marine	51	55	79	33	20	44	22	6	44	5	1	5	2	2	2
Motor	1230	1414	1643	998	983	1038	929	564	667	1595	1311	698	2400	3394	3721
Health	1532	2449	1521	486	431	721	98	11	98	1					
Misc.	246	313	299	210	254	247	113	72	114	85	55	26	141	153	143
Total	**3096**	**4270**	**3582**	**1776**	**1736**	**2128**	**1218**	**700**	**1136**	**1714**	**1380**	**752**	**2564**	**3576**	**3888**

4. Statistics of instances and quantum of penal interest paid for delayed payment of claims:

Category	YR (2013-14)		YR (2014-15)		YR (2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Fire	NIL	NIL	NIL	NIL	NIL	NIL
Marine	NIL	NIL	NIL	NIL	NIL	NIL
Motor	NIL	NIL	NIL	NIL	NIL	NIL
Health	NIL	NIL	NIL	NIL	NIL	NIL
Miscellaneous	NIL	NIL	NIL	NIL	NIL	NIL
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

5. Constraints which cause delay in settlement of claims

The main constraints which cause delay in settlement of claims are

a) Delay in reinstatement / repairs of vehicles / property

b) Delay in carrying out repairs associated with unavailability of spares.

c) Delay in issuance of Final Police report.

d) Non Compliance of documentation to establish liability and assessment by insured

e) Insured not reporting /late reporting to garage for Repairs.

f) Long time taken in courts for MACT TP/legal claims

6. Initiatives taken by the company to ensure expeditious settlement of claims

Proactive initiatives have been taken towards expeditious settlement of claims

a) Decentralization of claims settlement at Zonal Offices. This has resulted in settlement of more than 90 % claims at local level.

b) Online motor surveyor assessment module implemented for quicker submission of reports and monitoring

c) Online processing and approval of claims, thus reducing TAT as physical movement of claim files is reduced.

d) Strict monitoring of health claims through TPA for quicker settlement.

e) Regular proactive follow up is done and reminders by way of letter, mails and phones calls are made to insured keeping the concerned marketing personnel in loop for better coordination and communication. Wherever required meetings are arranged with insured to explain and clarify the requirements. In case of difficulty in compliance alternative means are suggested for adoption in consultation with the surveyor to take the claim forward. Insured is also persuade to complete repairs quickly in cases where policy is on reinstatement / replacement basis.

7. Institutional Framework for review of repudiated claims

a) All repudiations go through rigorous process of thorough scrutiny at the Zonal and Corporate Office levels involving Claims Department, Underwriting and Marketing Department. No Claim would be declined without Corporate Office Approval

b) The Zonal Claims team based on survey / investigation / relevant papers thoroughly scrutinize claims considered for declinature. The Zonal Underwriter and Branch Manager is also informed for their opinion.

c) In case of agreement on declinature at Zonal level the complete file is dispatched to Corporate Claims Office recommending repudiation where the file is again thoroughly scrutinized to check if grounds of declinature are in order.

d) Thereafter the matter is referred to respective Underwriting and Marketing Heads for their opinion.

In case grounds of declinature are not found sound the same is referred back to Zone for taking the claim forward for settlement on merits.

e) In case of concurrence on the grounds of declinature being justified, the declinature of the claim is approved at Corporate Office which is conveyed to insured in writing detailing the grounds of declinature.

f) Insured is also given an opportunity to represent their case against declinature which if received is again scrutinized in detail on points raised and reverted depending on the outcome.

8. Statistics of cases of policyholders / claimants before Consumer Fora /Courts

NAME OF THE FORUM / COURT	NO. OF PENDING CASES
Consumer Courts	
District Forum	417
State Commission	85
National Commission	3
Motor Claims related	
MACT	5283
Appeals with High Court	268
Appeals before Supreme Court	
Other policyholder related cases	
Civil Courts	Before Debts Recovery Tribunal - 02 Before Labour Court - 01 Before Permanent Lok Adalat - 38 **Total - 41**
High Courts @	11
Supreme Court	0
Total	**6108**
@ of these, the number of appeals against orders of Insurance Ombudsman	1 (Filed by the Insured).

9. Initiatives taken by the company for settlement of cases pending before various Fora and Courts (like Lok Adalat, Settlement camps etc.)

A) On receipt of a claim, its genuinity is established, and where found in order ,the advocate is instructed to Initiate steps for settlement.

B) Claims which are pending for want of documents from the insured are settled as and when the documents are provided by the insured before the court.

C) Depending on the volume in the States ;Monthly Camps are initiated to settle and conclude the fit claims.

D) The Company is actively involved in the participation in the Mega Lok Adalats and Lok Adalats initiated by the respective State Legal Authorities.

10. Statistics of cases settled out of court (specify other mechanisms)

Category	YR(2013-14)		YR(2014-15)		YR(2015-16)	
	No. of claims	Amount	No. of claims	Amount	No. of claims	Amount
Lok Adalat	215	3,60,23,444/-	596	14,49,09,829/-	622	17,64,18,455/-
Camps	261	4,95,27,443/-	354	8,07,00,628/-	413	9,04,66,424/-
Others						
TOTAL	476	8,55,50,887	950	22,56,10,457	1035	26,68,84,879

MIS-SELLING & SPURIOUS CALLS

A brief on Mis-Selling and Spurious calls in the Life Insurance Sector

MIS-SELLING IN LIFE INSURANCE SECTOR

I. INTRODUCTION

Mis-selling in common parlance refers to unfair or fraudulent practices adopted at the time of soliciting and selling insurance and generally includes selling policies which have not been sought by the customer or which are different from what the customer wanted or was promised or where the product offered for sale is not suitable to the needs of the customer. Therefore misselling in insurance could be described as selling a product/service to a customer in a manner which is detrimental to his/her interest -.

Some of the common examples of mis-selling are

- Selling annual premium life insurance plans as single premium plan
- Premiums payable under the policy are beyond the financial capacity of the proposer/disproportionate to the actual sources of income
- Sale of life insurance plans which are unsuitable based on the profile / requirements of the customer.
- Sale of insurance policies without explaining the product features and without providing accurate and adequate information about the plan offered for sale.
- Sales of insurance plans by indulging in forgery, tampering of proposal or related papers
- Sale of insurance policies in the name of fixed deposits, term deposits, mutual fund schemes, shares etc. Sale of insurance policies by using coercive techniques such as imposing a precondition to obtain insurance cover from particular insurer for sanction of housing loan or any other benefit in respect of principal business carried out by corporate agents, banks/FI's, either formally or informally.
- Sale of insurance policies by making fictitious offers such as huge bonus on poorly performing policies, sanction of a loan, opening ATM, putting up a telecom tower etc.
- Sale of insurance policies by resorting to spurious calling in the name of officials of IRDAI,RBI,SEBI,Insurers and other government agencies such as Ministry of Finance, Income Tax Department etc.

The above list is only an illustrative - and not an exhaustive one.

Misselling is mostly in life insurance sector and is also prevalent to an extent in health insurance segment where misrepresentations about benefits or coverage or both are made to solicit and sell health cover. In non-life policies, there is not much of mis-selling. The focus therefore is on mis-selling in the sale of life insurance products..

II. IMPACT OF MIS-SELLING

Complaints on unfair business practices affect the sentiment about the insurance sector in general and life insurance sector in particular. This would significantly impact the initiatives aimed at enhancing the level of insurance inclusion as measured by indicators such as insurance penetration (measured as ratio of premium to GDP) and insurance density (measured as ratio of premium in USD to population). Increased incidence of mis-selling can adversely impact growth in the insurance industry which in turn would impact the availability of long term funds for economic development from the insurance sector. Hence, while there is need to assess and eradicate mis-selling from insurance industry, there is also a need to reassure general public that the regulatory framework of life insurance business is sound enough to protect policyholders' interests and grievances, if any, are capable of being resolved by insurers or settled / adjudicated by insurance ombudsmen or consumer fora.

III. COMPLAINTS OF MIS-SELLING

Integrated Grievance Management System (IGMS) introduced by IRDAI in 2011 is a computerized industry-wide grievance repository for the insurance sector. In IGMS, the complaints relating to misselling are included under the broad category of "Unfair Business Practices".

The complaints relating to broad head of 'unfair business practices' consist of complaints falling within the following complaint descriptions:

1. Product differs from what was requested or disclosed.
2. Term(Period) of the policy is different/ altered without consent
3. Mode of premium payment differs from requested or disclosed
4. Annuity/Commutation/Cash Option / Rider/other Options not included as requested
5. Proposed Insurance not in the interest of proposer
6. Intermediary did not provide material information concerning proposed cover
7. Single premium Policy issued as Annual premium policy
8. Tampering, Corrections, forgery of proposal or related papers
9. Credit/Debit card debited without consent of Consumer
10. Premium paying period projected is different from actual
11. Surrender value projected is different from Actual
12. Free-look refund not paid
13. Spurious calls or Hoax calls
14. Advice concerning Exclusions/ limitations of cover not communicated
15. Illegitimate inducements offered
16. Misappropriation of premiums
17. Malpractices or unfair business practices

The number of complaints relating to unfair business practices in life insurance business has come down, while the percentage of unfair business practices complaints to total

complaints remain more or less close to 50%. The details are provided in the table below:

Year	No. of UFBP complaints	% increase/ decrease compared to last year	Total life complaints	% of UFBP complaints	No. of new policies	% of UFBP complaints to new policies
2012-13	163482	(+) 63. 22	341012	49.41	441,55,298	0.38
2013-14	211622	(+) 25. 60	374620	56.49	441,85,973	0.47
2014-15	145129	(-) 31.22	278992	52.02	25869356	0.56
2015-16	100257	(-) 30.92	204701	48.98	26704213	0.37
2016-17	62286	(-) 37.87	120847	51.54	26456645	0.23

Source: Integrated Grievance Management System and Business Figures-Life of IRDAI

The number of complaints on unfair business practices increased by 63 % in 2012-13 and by about 26 % in 2013-14 over previous year's number and thereafter during the last three years the number of complaints on UFBP have shown reduction every year ranging from 31% to 38%. In the current year also, there has been 37.87% drop in the number of Unfair business practices complaints over previous year which can be attributed largely to the review made by IRDAI of the grievance redressal machineries of all life insurers and to the subsequent follow up measures taken up by IRDAI. This apart, based on the inputs provided during the review meetings with the GROs effective monitoring mechanism has been put in place by the Life Insurers towards arresting misselling. On the other hand the multi-pronged insurance awareness campaign by IRDAI towards educating the general public has also resulted into creating awareness on the misselling and consequent reduction in such instances.

The proportion of complaints relating to unfair business practices to total life complaints has increased from 49.41 % in 2012-13 to 56.49 % in 2013-14. However this proportion has shown reduction during the subsequent years and hovers around 50%.

The proportion of the complaints on mis-selling to new policies issued rose to 0.56 % in 2014-15 and has declined to 0.23% in the current year.

IV. REGULATORY FRAMEWORK

The regulatory framework for preventing mis-selling and to ensure right selling is discussed in brief. The basic framework for regulation of insurance business is contained in the Insurance Act, 1938. The IRDA Act, 1999 established IRDAI as the regulatory authority to enforce the provisions of the Insurance Act. Regulations are made there under, Circulars and Guidelines are issued from time to time. The following regulations made by the Authority are aimed at ensuring that mis-selling do not take place.

a. IRDA (Protection of Policyholders' Interests) Regulations, 2002

The basic framework for policyholder protection is contained in these regulations. Procedure to be followed at the 'point of sale', requirements to be complied with at the proposal stage and disclosures to be made in the life insurance policy are clearly stated in these Regulations.

These Regulations contain a **provision for free-look cancellation within 15 days of receipt of policy.** Every life insurer, while forwarding the policy to the insured, should inform by the letter forwarding the policy that he has a **period of 15 days from the date of receipt of the policy document to review the terms and conditions** of the policy and where the insured disagrees to any of those terms or conditions, he has the **option to return the policy stating the reasons for his objection.** On availing of the free-look cancellation, the insured would be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period of cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In case of ULIPs, the insured would also be entitled to repurchase the units at the price of the units on the date of cancellation.

The Regulations clearly indicate that the requirements of **disclosure of "material information" regarding a proposal or policy apply both to the insurer and the insured**. Further, every insurer is required to have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed.

Therefore, the regulations ensure that the prospective policyholder is given a thorough understanding of the specific requirements and details required for taking an insurance policy. The insurer, agent or intermediary should enable the prospect to take the best cover that would be in his or her interest.

b. The IRDAI (Insurance Advertisements and Disclosure) Regulations, 2000

These regulations require the insurers, agents or intermediaries not to issue "unfair or misleading advertisements" and follow the procedures laid down therein with respect to advertisements (including those on the internet) so that any communication directly or indirectly related to a policy and intended to result in the eventual sale or solicitation of a policy is not misleading or unfair. **The Master Circular Ref:IRDAI/ LIFE/CIR/MISC/ 147/08/2015 dated 19-08-2015 issued on Insurance Advertisements, clearly prescribes the details to be made available in the advertisements, and also indicates the do's and don'ts amongst other requirements."**

c. IRDAI (Appointment of Insurance Agents) Regulations, 2016

d. IRDAI (Registration of Corporate Agents) Regulations, 2015

e. IRDA (Insurance brokers) Regulations, 2013

f. IRDA (Web Aggregators) Regulations, 2013

g. IRDAI (Registration of Insurance Marketing Firm) Regulations, 2015

These regulations mandate compliance of the agents, corporate agents, brokers and web-aggregators with the code of conduct prescribed therein to ensure that the persons soliciting insurance business should be eligible persons and they disseminate the requisite information in respect of insurance products offered for sale, understand the policy being sold and should be capable of making suitable advice based on the customer needs so that the policy offered / sold meets the

requirements of the prospect. Responsibilities are cast upon the agents and other intermediaries in terms of code of conduct, which are mainly aimed at curbing the mis-selling and to promote best practices during solicitation of the business.

The training curriculum of these intermediaries is also updated to ensure that the sales force is up to date with all the changes and is capable of providing necessary advice at the time of sale to the prospects.

h. Guidelines on Distance Marketing of Insurance Products, 2011

With the increasing recourse taken by insurers, corporate agents and brokers to solicit policies including lead generation through telecalling, SMS, email, internet, DTH, postal mail and other modes which do not involve communication in person as well as requests from clients seeking information and sale of insurance products in distance mode, IRDAI issued Distance Marketing Guidelines. These guidelines cover not only measures for policyholder protection at the time of offer, negotiation and conclusion of sale but also about preparation of standardized script, training of telecallers, monitoring of calls, preservation of call recordings etc.

i. IRDA (Non-Linked Insurance Products) Regulations, 2013

j. IRDA (Linked Insurance Products) Regulations, 2013

IRDAI had a detailed review of the existing features of the insurance and pension products offered by the life insurers. Based on this review and also taking into account the persistency levels observed in the dynamic changing environment, IRDAI brought out these regulations for protecting the interests of the policyholders, improving the persistency levels and also bringing in value addition to both the insurer and the policyholder.

These regulations ensure that the commission rates are consistent across the industry and have been smoothened with the payments depending on the premium payment term. The benefit illustration requirements have been made applicable not only to linked products but also to all the non-linked products also. The Regulations prohibit certain type of products like highest NAV guarantee, splitting of policies, accepting advance premium for long periods in case of linked products, prohibit mis-leading names so that there is clarity on savings and protection products in case of non-linked products. The regulations also bring in transparency in terms of benefit payouts and enable the customers to choose the right policy.

In case of linked products the regulations for linked products make it mandatory for separate training to all the insurance agents/intermediaries before they are authorized to sell linked insurance products, recommending a suitable product and collecting sufficient information about the potential policyholder as a proof thereof, inform the upfront charges and indicate how premium paid is appropriated towards various charges from the unit fund and the balance of the fund at the end of the first year and subsequent years. An agent/ intermediary should obtain a statement of

consent (to be furnished along with the documents under File& Use Procedure) signed by the policyholder and countersigned by the person (agent, intermediary etc) himself/herself, along with the proposal form, that he has understood the inbuilt features of the policy and the applicable charges and that he is fully aware of investment risks under the policy to be issued.

k. Grievance Redressal Guidelines for Insurance Sector 2010

In addition to the above regulations, IRDAI has also issued Grievance Redressal Guidelines for insurance sector specifying the timelines for acknowledging, resolving and closure of grievances reported by the prospect and policyholders.. IRDAI has also provided channels for customers to raise grievances with insurers in the form of Integrated Grievance Management System, IRDA Grievance Call Centre and postal, fax and email channels, wherein IRDAI facilitates resolution of grievances by insurers.

Complainants who are not satisfied with the resolution provided by the insurer can take up with the Insurance Ombudsman or approach Consumer Fora or Courts.

l. Corporate Governance Guidelines – Policyholder Protection Committee

With a view to addressing the various compliance issues relating to protection of the interests of policyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint-handling procedures, each insurer has been directed to set up a Policyholder Protection Committee which shall directly report to the Board. The responsibilities of the Policyholder Protection Committee include putting in place proper procedures and effective mechanism to address complaints and grievances of policyholders including mis-selling by intermediaries and reviewing the mechanism as well as status of complaints at periodic intervals. The Committee is also responsible for ensuring compliance with the statutory requirements as laid down in the regulatory framework and adequacy of disclosure of “material information” to the policyholders.

From the foregoing it can be seen that elaborate regulatory framework has been put in place to ensure that insurers, agents or intermediaries do not resort to mis-selling.

V. MONITORING COMPLIANCE AND REGULATORY ACTION

The compliance with the regulatory framework can be ascertained by way of On-site inspection or off-site monitoring through tools such as complaints, press reports, etc. IRDAI conducts on-site inspection of insurance companies, agents and intermediaries periodically to inspect the books of accounts, examine the systems and procedures, compliance to the regulatory framework, etc. IRDAI also monitors the market conduct of the insurers, agents and intermediaries through complaints, their frequency and severity, press reports etc. Wherever it is found that the entities have not complied with the regulatory framework, IRDAI takes up regulatory action.

VI. CONSUMER EDUCATION

The definitive way of reducing mis-selling is to make the members of public aware of the concept of insurance, kinds of insurance policies, risks covered, benefits offered, exclusions, and conditions etc. This is sought to be achieved through various efforts of financial education to improve financial literacy

- Bima Bemisal campaign through print and electronic media,
- Cautioning public against fictitious offers and spurious calls
- Consumer education website www.policyholder.gov.in
- Devising various films, comics, games, handbooks and FAQs relating to insurance and initiatives of IRDAI and publicizing them
- Conducting regular seminars involving customer groups addressing policyholder concerns and policyholder education.

Considering the fact that several complaints were received from members of public relating to spurious calls and fictitious offers involving insurance products, IRDAI launched a multi-pronged campaign to caution members of public through print, electronic and mass media including Internet and by way of specific directions to insurers to incorporate the caution in their publicity material in policy related advertisements as well as advertisements in print, electronic media and TV.

VII. ACTION BY INSURERS

Insurers have also been taking the issue of mis-selling seriously by doing a root cause analysis of mis-selling complaints to identify the major causes and have taken steps to prevent or reduce mis-selling through steps to ascertain suitability of product, place controls on the various channels, tuning it based on the vulnerability of the channel and have a strategy on dealing with complaints of mis-selling. Insurers are now conducting sales audit of the proposals that satisfy certain vulnerability criteria like First time ulip customers, Proposals from Senior Citizens , Premia payable not commensurate to the declared sources of income etc. to ensure right selling.

Further, every insurer has a Board approved insurance awareness policy containing the strategy and efforts to build awareness among customers. This apart every life insurer has their company specific policy drawn on handling misselling and spurious call complaints

In addition to the action taken by IRDAI based on the examination of complaints by the insurers, Insurers also take up action against the agents or intermediaries in the form of issuing warning letters, terminating employees, filing police complaints and most commonly resorting to claw-back of commission wherever the policies have been cancelled as a consequence of proven mis-selling.

VIII. INSURANCE LAWS (AMENDMENT) ACT, 2015

The amendments to the Insurance Act, 1938 have been made through the enactment of Insurance Laws (Amendment) Act, 2015. In terms of section 42 (A)(2) of the insurance act

1938, no person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance policy through multilevel marketing scheme. Further, section 42 (A)(3) of the insurance act 1938 prescribes that the Authority may through an officer authorised in this behalf, make a complaint to the appropriate police authorities against the entity or persons involved in the multilevel marketing scheme. This Amendment Act vide section 42(5) of the insurance act 1938 also prescribes that the insurers shall be responsible for all the acts and omissions of its agents including violation of code of conduct and liable to a penalty which may extend to one crore rupees. These changes will enable the interests of consumers to be better served through provisions like those enabling penalties on intermediaries / insurance companies for misconduct and disallowing multilevel marketing of insurance products in order to curtail the practice of mis-selling.

IX. CONCLUSION

To summarize, the problem of misselling of life insurance is a major cause of concern in expansion of life insurance business. The regulatory framework is adequate to prevent misselling. However, greater compliance with the relevant regulations, increased insurance awareness, simpler policy terms and conditions, greater adherence to code of conduct by agents and intermediaries, and self-discipline among insurance intermediaries & insurance companies can significantly reduce the mis-selling complaints without affecting the volume of new business. Since mis-selling impacts the trust and confidence on insurance companies, it is time the insurance companies wake up to the challenge and not only take initiatives in educating and empowering consumers leaving them the freedom to exercise an informed choice but also to rein in unscrupulous agents and intermediaries who are bringing business by resorting to cheating through false promises. Putting in place systems to examine complaints from the underwriting perspective and expeditiously redressing them where the policy appears inappropriate can help build trust in the public. The enhanced levels of penalties would also help in deterring insurers and the agents and intermediaries from resorting to mis-selling. However, penalty imposed would in no way compensate for the inconvenience caused to hapless customers subject to mis-selling or rectify the damage caused to the image of the life insurance sector which serves a very important social purpose of providing social security to the insured and mobilise long term funds for investment for economic growth and development of the country.

SPURIOUS CALLS – PROBLEM, IMPACT AND EFFORTS OF IRDAI TO CAUTION PUBLIC

I. INTRODUCTION

Spurious calls in the name of regulatory organizations and government or quasi government authorities has been a problem which has been in prevalence for quite sometime now. The calls contain offers of benefits of huge amounts to be released by authorities. As a pre-requisite for such payment, the callers insist upon fulfillment of formalities which include furnishing documents of identity proof and address proof, details of bank account, banking username, password, PIN etc. and finally insisting upon payment of money for fulfilling certain regulatory requirements. The payments are made mostly in cash or sometimes through cheque or net banking. The gullible persons who respond to such calls and who are lured by such offers lose their money and trust in the financial system.

II. INSURANCE RELATED SPURIOUS CALLS

In 2010-11, it was observed that members of general public were receiving calls from individuals who claim to be representatives of IRDAI and offering insurance policies of different insurance companies with various benefits. However, the problem was not very serious in nature. However, to caution members of public IRDAI first issued a public notice on November 1, 2010 informing the general public that Insurance Regulatory and Development Authority is a regulatory body which does not involve directly or through any representative in sale of any kind of insurance or financial products. Any person making any kind of transaction with such individuals/agents will be doing the same at one's own risk. It was also advised that if any member of the public notices such instances he/she may lodge a police complaint in the local police station. This was followed by issuing public caution in newspapers for greater reach. With the introduction of Do Not Call Registry and the coming into force of the "The Telecom Commercial Communication Customer Preference Regulations, 2010" with effect from 27th September, 2011 provided protection to telecom customers from unsolicited commercial calls.

III. RISE IN SPURIOUS CALLS AND MODUS OPERANDI

However, the problem of spurious calls has been on the rise in recent times. More importantly, the calls in the name of IRDAI or its officials rose significantly in 2013-14. In addition to such calls, there have been complaints of spurious calls made in the name of RBI, Income tax department, Finance Ministry etc and other insurance related agencies like Governing Body of Insurance Council, Life Insurance Council, insurance companies, grievance management department of Central Government etc. The spurious callers are approaching customers either with fictitious offers of bonus on policies, returns, transfer of commission payable to agents etc. or on the threat that their money is transferred to someone else. In either case, the callers insist upon fulfilling certain formalities which include submitting KYC documents, giving their details

of bank account, cheques, card etc. and seeking payment of money for reasons like taking a dummy policy, payment of income tax, service tax etc. or for subscribing to some non-financial offers. The consequence of such calls are that members of public fall for such offers or threats and make payment to the spurious callers through various modes like transfer of funds, sharing card and pin, issuing cheque etc. While in certain cases fresh policies are issued to these customers, in certain other cases money is being collected for non-financial purposes without any issue of policy. Sometimes, there is no proof of payment, more so in cases where payments are reportedly made in cash.

IV. OFFERS MADE BY SPURIOUS CALLERS

The general nature of fictitious offers made through such spurious calls, as discerned from the complaints received by IRDAI, are as follows:

- Claiming to be representatives of IRDAI/IGMS and offering insurance policies of different insurance companies with various benefits.
- Claiming that IRDAI is distributing bonus to insurance policy holders out of the funds invested by insurance companies with IRDAI.
- Claiming that the policyholder would receive bonuses being distributed by IRDAI if they purchase an insurance policy and wait for a few months after which the bonus would be released by IRDAI.
- Advising existing policyholders that money in respect of their policy has been fraudulently transferred to someone else and for receiving that money back from IRDA, they have to fulfil certain formalities including payment of money
- Claiming that they are from the Grievance Cell or IGMS Department of IRDAI making a call in continuation with a complaint made against an insurer and for resolving the grievance and release of benefit, they have to fulfill certain formalities including payment of money.
- Advising customers to subscribe to a fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns / benefits.
- Informing that 'Survival Benefit or Maturity Proceeds or Bonus' is due under their existing policy and investing in a new insurance policy is mandatory to receive the amounts which are due.
- Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.

V. IMPACT OF SPURIOUS CALLS

Spurious calls of the nature indicated above cause loss of reputation to IRDAI and other agencies and also financial loss to the gullible public who pay money based on such calls in lure of the offers made. Considering the fact that the mission of Government as well as IRDAI is in promoting financial inclusion by improving access to insurance related services in both life and non-life segments, such spurious calls would adversely affect the general sentiment

of general public in relation to insurance. Given the fact that insurance is a complex financial product and is a subject matter of solicitation, the trust deficit caused due to such spurious calls can dissuade those who are apprehensive but interested in buying insurance because of the benefits of insurance. Since insurance is a product of risk protection, this can impact the general risk coverage of members of public rendering them more vulnerable to risks to their life and property. The premiums received from insured public forms the corpus for insurance companies to make long term investments in instruments such as Government securities and other securities. The money so invested serves as the investment for nation building. As a result, spurious calls are also indirectly hindering not only growth in the insurance sector but also development of the country through the premium funds available for development.

VI. IRDA'S CAUTION TO PUBLIC

Considering the extent of the problem and the impact of such calls on IRDAI's efforts in protecting the interests of policy holders and ensuring the orderly growth of the insurance sector, IRDAI has taken up a campaign to caution members of public. The emphasis is more on dissuading people from believing such spurious calls and acting upon them so that the problem does not manifest into a financial loss to members of public who make payment believing in the veracity of the calls and offers.

Through the caution, IRDAI has been informing the members of public that:

- IRDAI does not involve directly or through any representative in sale of any kind of insurance or financial products.
- IRDAI does not invest the premium received by insurance companies.
- IRDAI does not announce any bonus for policyholders or insurers.
- IRDAI has put in place Grievance Redressal Cell in Consumer Affairs Department, Integrated Grievance Management System and IRDAI Grievance Call Centre to provide an alternate platform for registering grievances against insurers thereby facilitating resolution of customer grievances by insurers.
- IRDAI or its officials dealing with Grievance Management do not make calls in relation to complaints lodged with IRDAI as IRDAI plays a facilitative role and does not adjudicate upon or investigate into such complaints
- Any person making any kind of transaction with such individuals/agents will be doing the same at their own risk.

VII. EFFORTS TAKEN BY IRDAI TO CAUTION PUBLIC

IRDAI has taken various initiatives to spread awareness among the members of the general Publicparticularly against the spurious calls through a multi-pronged strategy. The modes of campaign used by IRDAI directly for cautioning public about such offers are public notices, press releases, advertisements in newspapers, radio spots, television advertisements, caution on the Internet websites of IRDAI and its consumer education website etc.

IRDAI has already issued directions to all the life insurers to incorporate caution against such

spurious calls in their publicity material – print, internet and electronic – as well as through SMS to their policy holders. Insurers themselves have also been independently taking up steps for cautioning public through print, electronic and internet media.

The following are the various efforts taken in the direction of cautioning public from spurious calls and fictitious offers

- A massive campaign **cautioning general public against spurious callers and fictitious offers**, was carried out through **television** in 12 regional languages including Hindi.
- IRDAI has been spreading the awareness against the spurious calls by placing the relevant material i.e. radio jingles, TV Advertisements, press release etc. on IRDAI's Consumer Education Website (www.policyholder.gov.in), which is available both in Hindi as well as in English.
- The information sought by the visitors of IRDAI's Consumer Education Website as part of feedback w.r.t. spurious calls, IRDAI guidesthem to deal with it during the monthly review of the feedback.
- IRDAI has launched an **Insurance Awareness Campaign** for a period of six months starting from 20th February, 2017 through broadcast of radio jingles in five languages (Hindi, Tamil, Telugu, Malayalam and Kannada) on All India Radio and Private FM radio channels on the following insurance related topics:

S.No.	Subject of Radio Jingles	S.No.	Subject of Radio Jingles
1	Life Insurance	4	Motor Insurance
2	Home Insurance	5	Renewal of Policy
3	Health Insurance	6	Mis-selling of Insurance Policies

- IRDAI would continue with the initiatives for protecting policyholders' interests and for promoting insurance awareness.

VIII. RECOURSE FOR PERSONS WHO PAID MONEY BASED ON SPURIOUS CALLS

In spite of the best efforts in cautioning public there are several persons who complain about making payment to spurious callers. The various categories in cases where payment is made based on spurious calls and the recourse available are briefly indicated below:

i. The amount is paid to an individual

Being a fraud by an individual, the only recourse available is to take up the matter with police for necessary action.

ii. The amount is paid to a non-insurance related service provider or agency

In such cases, depending on whether the services promised by the agency have been provided or not, the individual has to take up the matter with such agency or the police for necessary

action. IRDAI would not be in a position to intervene as the institution does not fall within its regulatory purview.

iii. The amount is paid to an insurance company and a policy is issued

Being a case of fraud, a complaint can be filed with police for necessary action against the telecallers as well as the insurance company whom they represent. However, as an insurance policy is issued by an insurance company, the person may make a complaint of mis-selling with the insurance company bringing to the notice unfair business practice adopted by the telecaller/agent/intermediary in selling the policy and seek changes in the policy or cancellation of the policy. The other channels of making a complaint offered by IRDAI can also be used for registering a complaint against the insurer such as writing to Consumer Affairs Department of IRDAI, sending an email to complaints@irda.gov.in, making a call to toll free numbers (155255 or 1800 425 4732) of the IRDAI Grievance call centre or online on the Integrated Grievance Management System (IGMS) (www.igms.irda.gov.in).

IX. COMPLAINTS ON SPURIOUS CALLS

The complaints relating to spurious calls are included under the broader complaint category of unfair business practices in the Integrated Grievance Management System of IRDAI which is the industry-wide repository of insurance grievance related information. The number of complaints of this nature as per IGMS are as follows:

Sl. No.	Year	Number of complaints	% - variation over previous year	% of complaints on spurious calls to the total complaints under UFBP
1	2013-14	7356	15.82	3.47%
2	2014-15	9940	35.13	6.85%
3	2015-16	9089	(-) 8.56	9.07%
4	2016-17	2946	(-) 67.59	4.73%

It can be seen that the year 2016-17 has witnessed a reduction of about 68% over the previous year in terms of number of complaints and in terms of % share to the total UFBP complaints it has shown reduction of about 4.34%. This indicates that the extensive campaign for building awareness amongst public and cautioning them from falling prey to spurious calls taken up by both IRDAI as well by the Insurers have shown positive results

X. ACTION BY IRDAI ON COMPLAINTS

On receipt of complaints under spurious calls made in the name of Insurance Companies, IRDAI forwards the complaint to the named insurer to investigate the complaint vis-à-vis the telephone numbers/Mobile numbers/Names of persons mentioned in the complaint for taking appropriate action under intimation to IRDAI.

Wherever the spurious calling has resulted into issuance of an insurance policy IRDAI takes up

the complaint with the insurer concerned for resolution, which is updated by the insurer in IGMS. In case the complainant is not satisfied with the resolution provided by the insurer, he may take up the matter with insurance ombudsmen (for details visit www.gbic.co.in) for amicable resolution or adjudication under the Redressal of Public Grievance Rules, 1998 - Alternately, the complainant can file a complaint with Consumer Forum for deficiency of service; or take up before a criminal court for cheating or fraud; or file a suit in a civil court for breach of trust. -

However, through the volume of complaints, IRDAI monitors the market conduct of insurers, agents and intermediaries. Further, during the course of on-site inspection and off-site monitoring of regulated entities like insurance companies, insurance agents, corporate agents and insurance intermediaries (brokers) for examining the compliance of these entities with the extant regulatory framework, IRDAI focuses on the process of soliciting, offering and selling insurance. Based on the findings, IRDAI initiates regulatory action against the insurers or intermediaries as per the provisions of the Insurance Act and Regulations.

XI. FILING POLICE COMPLAINTS

IRDAI has filed police complaints against spurious callers and has advised all insurers to take up the matter with the police authorities concerned to take action against spurious callers. Insurance companies concerned have filed FIRs against spurious callers and have taken up the matter with the police authorities given the loss of reputation caused by such spurious calls.

CONCLUSION

As the popular usage in financial circles goes, there can be regulation for need but there cannot be any regulation for greed. The realization of the fact that insurance is for risk protection and not for windfall gains can bring about caution in the members of public. So, there is a need for greater insurance awareness apart from the specific efforts taken by IRDAI in cautioning public against spurious calls. IRDAI on its part has been proactive in devising and implementing a multi-pronged strategy for spreading caution so that people do not fall prey to offers made by spurious callers.

MIS-SELLING & SPURIOUS CALLS

Information received from life insurers – Complaints received and action taken

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER: Aegon Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	62	13	444	129	16	530	53	9	363	244	38	1,337
Bancassurance	29	9	241	0	0	0	0	0	0	29	9	241
Other Corporate Agents	107	100	1,941	65	9	455	21	1	277	193	110	2,673
Brokers	182	85	1,057	547	71	2,430	491	13	4,007	1,220	169	7,494
Direct selling	16	5	81	247	22	1,070	281	0	1,405	544	27	2,556
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	6	3	206	2	1	153	8	4	359
TOTAL	396	212	3,764	994	121	4,691	848	24	6,205	2,238	357	14,660

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	16,042	17,987	16,019	50,048
Bancassurance	30	0	0	30
Other Corporate Agents	3,323	-2,847	1,528	2,004
Brokers	4,336	15,030	7,020	26,386
Direct selling	40,445	35,087	32,274	1,07,806
Others (to be specified)	0	0	0	0
TOTAL	64,176	65,257	56,841	1,86,274

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	139	430	365	934
Bancassurance	0	0	0	0
Other Corporate Agents	230	291	79	600
Brokers	372	1771	2185	4328
Direct selling	164	789	1032	1985
Others (to be specified)	0	0	0	0
TOTAL	905	3281	3661	7847

4. Root Cause (s) for complaints relating to mis-selling

Customer comes back post expiry of the freelook period stating policy was sold to him:

- As a single premium plan
- He will receive high bonus/returns after the policy is purchased.
- Product terms and conditions explained to him differ from the terms and conditions given in the policy document.
- Promise of loan.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Product training is imparted to the sales force. The intermediaries are trained to use the premium calculator at the point of sales. The premium calculator facilitates the need-based assessment of insurance for the customer.
- In the Agent Confidential Report, the agent/intermediary/sales person has to provide information relating to customer's annual income, assets, liabilities, etc and give confirmation of his financial condition.
- Underwriter does financial validation while underwriting the policy.

6. Channel-wise controls placed to prevent mis-selling

- Company has put in place stringent quality norms like:
    a. Premium income ratio
    b. Restrictions on replacement and splitting of policies.
    c. Limits related to age and income of the individuals
- Detailed quality reports are shared with the channel partners on monthly basis and senior management team is regularly interacting with the broker's team.
- Quality parameters have been set at the time of on-boarding a new channel partner.
- Welcome calling has been started from the month of July 2015. Calling is done between 15th and 30th day post issuance of the policy.
- Company has exited most part of tele calling business model.
- Each sales person has been mandated to complete the annual online training course wherein company's commitment to quality business is re-inforced.
- Internal campaigns in the form of screen saver, etc. are also done in relation to correct selling.
- Training is imparted to the sales force on the importance of right selling and disciplinary actions in case of proven mis-selling.
- Persistency criteria is made part of Sales Force goal sheet.

7. Other Measures taken for addressing mis-selling

- Welcome calling has been started from the month of July 2015. Calling is done between 15th and 30th day post issuance of the policy.
- Company had reviewed sales related complaints on certain parameters for last 2 financial years and the findings were reviewed by Grievance Review Committee.
- Company has been taking counter measures like awareness campaign with existing customers, engagement with the industry bodies, meeting customers in person, etc to deal with such complaints.
- Escalation matrix is clearly mentioned on website which states:
  a. Customer can write to coo.desk@aegonlife.com if customer fails to get a favorable response after writing to customer.care@aegonlife.com.
  b. Further if the customer is still dissatisfied with the resolution he receives from COO's desk, he may write to gro@aegonlife.com.

8. Procedure adopted for dealing with complaints of mis-selling

- Welcome calling has been started from the month of July 2015. Calling is done between 15th and 30th day post issuance of the policy.
- Respective sales person are informed about the complaints which are received. Sales person is required to touch base with the customer and clarify his doubts as mentioned in the complaint and submit the report. In case of intermediary, the complaint resolution report is taken from them.
- There is a Grievance Review Committee comprising of Chief Distribution Officer, Chief- Risk, Audit & Compliance and Chief Financial Officer to review and decision the escalated complaints.
- GRO based on the facts of the complaint does an independent detailed verification of the complaint and based on the revised findings decides to either refund or decline the complaint. Basis the investigation findings, warning letter, termination, commission claw back is initiated.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	44	0	0	74	0	0	59	3	0	177
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	13	0	93	0	0	88	0	0	42	13	0	223
Brokers	19	0	117	4	0	220	4	0	241	27	0	578
Direct selling	1	0	152	1	0	196	2	0	156	4	0	504
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**36**	**0**	**406**	**5**	**0**	**578**	**6**	**0**	**498**	**47**	**0**	**1482**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Customer are informed to:

- Ignore such calls
- Register on DNC (Do not call)
- To lodge the police complaint along with the details of phone call number, etc.

11. Steps taken by the insurer to caution members of public about spurious calls

- On Aegon Life website, customer awareness is created under the head – IRDAI Public Notice on Spurious Phone Calls and Fictitious/Fraudulent Offers.
- All advertisements issued by Ageon Life Insurance Company Ltd. have spurious call disclaimer.
- SMS/Emails are sent to the customers to create awareness on spurious calls.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs*		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	34	2	2	42	27	11	0	2	0	123	93	59
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	6	0	0	17	8	6	0	2	0	230	84	39
Brokers	0	0	0	12	14	18	0	1	0	368	676	1095
Employees of Insurer	27	0	0	10	195	129	0	2	1	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	2(#)	0	0	0	0	0
Total	**67**	**2**	**2**	**81**	**244**	**164**	**2**	**7**	**1**	**721**	**853**	**1193**

Note:

1. # FIR logged for complaints received against non ALIC customer.
2. * In relation to “Number of commission claw backs”, commission reversal date s considered for financial year reporting and not the policy issued date.

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER: Aviva Life Insurance Company Ltd.

1. **Complaints relating to Mis-selling (**Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	153	100	827	134	77	511	52	60	437	339	237	1775
Bancassurance	200	57	686	340	103	1030	179	80	806	719	240	2522
Other Corporate Agents	1	0	6	0	0	6	4	13	148	5	13	160
Brokers	5	24	148	4	11	69	2	6	63	11	41	280
Direct selling	33	42	128	4	4	32	5	7	51	42	53	211
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	71	92	984	23	26	25	7	9	22	101	127	1031
TOTAL	**463**	**315**	**2779**	**505**	**221**	**1673**	**249**	**175**	**1527**	**1217**	**711**	**5979**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. **New Business sourced from different intermediaries (Individual policies)**

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	28181	25013	20968	74162
Bancassurance	45412	42281	22185	109878
Other Corporate Agents	1718	0	0	1718
Brokers	658	105	78	841
Direct selling	29481	15180	5458	50119
Others (to be specified)	499	2170	781	3453
TOTAL	**105949**	**84749**	**49473**	**240171**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	1183	315	225	1723
Bancassurance	2566	424	0	2990
Other Corporate Agents	926	773	1028	2727
Brokers	83	0	0	83
Direct selling	378	185	90	653
Others (to be specified)	0	0	0	0
TOTAL	**5136**	**1697**	**1343**	**8176**

4. Root Cause (s) for complaints relating to mis-selling

- Poor Product and Insurance awareness amongst customers
- Unrealistic projection of product details by agent
- High attrition rate amongst Sales team
- Incorrect assurance of product features and benefits by Sales person sourcing the business
- Insurance sold mandatorily to obtain loan/locker facility at bank
- Bank deposits converted into insurance premium without consent of customer
- Insurance sold to clients who were not present in India at the time of sourcing along with premium being funded without customer consent through bank accounts held with the bank.
- Tampering of documents
- Instigation by employees, advisor, channel partners who are no longer in the system
- Unrealistic expectation of fund performance in short term by customers
- Non availability of conclusive proof of delivery

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Need & Suitability based selling with checks inbuilt at login stage
- Special sales Induction training on ''Good Customer Outcomes'', impact of mis-selling on customer, company and agent
- Telephone helpline for sales team with the objective of providing real time query resolution to sales representatives in the field

6. Channel-wise controls placed to prevent mis-selling

- Proposal Stage verification is done at proposal stage to ensure right sale. The calling script is reviewed on at least half year basis complaint experience
- 3 Tier Most Important Document specifying key features part of the policy document and mandatory for customer to sign along with the proposal form
- Drive on sensitization to agents on importance of Original Seen and Verified and Premium Quotation Illustration
- Sales KPI with various parameters on business quality & persistency of business
- Ongoing trainings on need based selling, product details and risk matrix to minimize instances of mis-selling
- Sales Information Report (SIR) is submitted by Sales person confirming personal meeting with the policy holder and having explained all the features of the product
- Premium payment certificate watermarked to mitigate risk and fraud
- Product Churning policy in place

The above controls are in place for agents, corporate agents, Bancassurance channel, brokers , direct selling and all other intermediaries.

7. Other Measures taken for addressing mis-selling

- Enhanced communication related to policy delivery & all financial transactions
- Ensuring enhanced scrutiny at Login stage in the identified branches and channels basis complaints and claims experience
- Bank account details along with proof mandatory at login stage for Urban and Rural portfolio
- Customer Signature change request process made robust at Login stage
- Frequent class room training at login stage on fraud detection across and embedded in performance score cards
- New business proposal login with existing premium due is questioned to ensure non diversion of renewal premium
- Welcome call to policy holders seeking policy delivery confirmation with 100% call recording
- Investigation of customer profile through social sites, credit bureaus, NSDL, external agencies to ensure that information on proposal form is valid and not misrepresentated by the sourcing sale
- Formation of special committee comprising of Sales Regional Directors and Complaints Head for root cause analysis and implementation of action plans to reduce complaints on new business sourced policies
- Monthly Dashboard to Management highlighting customer complaints trend, channel wise and action plan to mitigate and reduce complaints

8. Procedure adopted for dealing with complaints of mis-selling

- Detailed discussion with the customer to understand the grievance
- Cases are reported Sales as per pre-defined grid for their inputs
- Sales Action Report and Action Taken Report is prepared against each mis-selling case
- Along with strong objection handling at complaints desk, Sales force (Agent / Channel Partner) is required mandatorily to touch base with customer and resolve the issues
- Basis the investigation findings, Warning letter, Termination, commission claw back is initiated against agents (Agent, Channel Partner)
- Legal notice for recovery of the loss amount for ex-employees and ex-agents pre-defined penal action grid
- The Company works on the principle of treating customers fairly at the time of complaint, investigation is carried to ensure that all policy related facts including documentation is reviewed thoroughly before arriving at a decision

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	12	14	1	35	24	0	36	10	1	83	48
Bancassurance	0	0	1	0	41	29	0	43	9	0	84	39
Other Corporate Agents	0	0	0	0	0	0	0	5	2	0	5	2
Brokers	0	3	2	0	11	11	0	12	1	0	26	14
Direct selling	0	2	0	0	2	1	0	3	1	0	7	2
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	12	9	0	12	3	0	8	2	0	32	14
TOTAL	**0**	**29**	**26**	**1**	**101**	**68**	**0**	**107**	**25**	**1**	**237**	**119**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Customer is informed to ignore and not share confidential information or hand over any documents and details related to the Policy or cheque or cash to individual offering attractive reward for surrendering /discontinuing your policy as company shall not be responsible for any loss or damage arising out of any such spurious calls or mails.Registering spurious / fictitious call complaints with TRAI (Telecom Regulatory Authority of India) for necessary action so as to minimize financial loss to the citizens who fall prey to the illegitimate offers made by such spurious callers All incidents of policy after the spurious call are reported to the Aviva's Complaint team by the customer. The customer complaints team carries out a basic due diligence and if the complaint is accepted the details are shared with Internal Audit team for a detailed investigation. As per of the investigation, the following procedures are carried out by Internal Audit:

1. Ascertain whether the call was made by Aviva sales employee or agent with the help of employee or agent database maintained by our company.
2. In case the contact details are different from the old proposal with the details entered in new proposal, contact details are verified through the application named “True Caller” or with the help of external empanelled vendor on a case to case basis.
3. If step b results into a finding that the call was made by an Specified person of the Corporate Agent / Broker, the case is then escalated to the Corporate Agent / Broker for further investigations and action
4. Verify with the Aviva Business Protection team to ascertain whether any policy related information including the contact details of the policyholder were sent outside the Aviva domain. If yes, the email communication is retrieved and analyzed for review of the sender, content and recipient of the email.
5. Since new policy has been sourced after spurious calls, the following steps are also carried out
    a. Matching of customer signature in proposal form with the signatures on PQIS and other supporting documents is carried out to ascertain forgeries if any
    b. Proposal stage calling (PSC calls) is also verified to ascertain whether the verification was done by customer or not.
    c. Verification of the mode of payment though which the premium has been received on a new policy is also conducted to analyze the trends if any.
    d. The option of contacting customer to get further details is also evaluated on a case to case basis

Basis the Investigation and evidences, a show cause notice is issued to the active sales employee / agent of Aviva. Appropriate action is taken basis the facts of the case and revert to the show cause notice

11. Steps taken by the insurer to caution members of public about spurious calls

1. The Company runs awareness Email & SMS campaigns
2. Relevant information on Company website informing dos’ and don’ts
3. The spurious call message is part of all Company advertisements – Print/ TV/ BTL
4. Mystery shopping done on various occasions to nab the culprits
5. Request customers who have been impacted to lodge an FIR with local police and share a copy of the same with the Company. The Company is committed to extend all support to the investigating agency and address Customer’s grievance

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	2	4	3	37	47	40	0	0	0	58	37	30
Bank Assurance Agents/Employees	0	0	0	1	1	0	0	0	0	45	50	133
Other Corporate Agents	0	0	0	0	0	0	0	0	0	1	0	0
Brokers	0	0	0	0	0	0	0	0	0	3	1	0
Employees of Insurer	4	9	9	12	11	2	1	1	3	0	0	0
Others (Spurious Tele-callers)	0	0	0	1	1	0	0	0	1	0	0	0
Others (Referral)	-	-	0	-	-	0	-	1	0	85	23	0
Total	**6**	13	12	**51**	60	42	1	0	4	192	111	163

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER: Bajaj Allianz Life Insurance Company Limited

1. **Complaints relating to Mis-selling (**Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	32950	1810	3730	11966	780	2516	787	5317	3785	45703	7907	10031
Bancassurance	75	41	26	11	7	14	2	2	27	88	50	67
Other Corporate Agents	1243	638	1132	324	193	570	226	40	831	1793	871	2533
Brokers	440	227	391	124	71	308	171	30	944	735	328	1643
Direct selling	4	4		1		2	8		13	13	4	15
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	1351	265	275	318	70	228	53	93	206	1722	428	709
TOTAL	**36063**	**2985**	**5554**	**12744**	**1121**	**3638**	**1247**	**5482**	**5806**	**50054**	**9588**	**14998**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	367,973	276,432	183,230	827,635
Bancassurance	9,450	2,414	2,429	14,293
Other Corporate Agents	65,595	6,034	3,323	74,952
Brokers	3,458	4,197	5,446	13,101
Direct selling	8,244	6,279	5,345	19,868
Others (to be specified)	-	-	4,970	4,970
TOTAL	**454,720**	**295,356**	**204,743**	**954,819**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	3801	2269	1717	7787
Bancassurance	119	47	23	189
Other Corporate Agents	631	84	59	774
Brokers	375	232	451	1058
Direct selling	170	10	98	278
Others (Micro Insurance & CSC)	0	0	2	2
TOTAL	**5096**	**2642**	**2350**	**10088**

4. Root Cause (s) for complaints relating to mis-selling

All the customer grievances alleging mis-selling cases are referredto our Sales Team with the help of Sales Admin Team. Proper precautions are taken towards the resolution of complaint and root cause analysis is done for each and every individual case in order to reduce the complaints of similar nature and with a view to address the grievances of customer in the best possible way.

We have also identified the following as major reasons for customer litigation:

1. Mis-selling of Regular Premium Policy in place of Single Premium,
2. Dis-satisfaction with policy as terms and conditions were not properly explained,
3. Non delivery of policy document and rejection of Free Look Cancellation,
4. Disputes relating to Policy Account e.g. disputes relating to surrender/maturity amount and Fund Value,
5. Non receipt/delay in receipt of premium amount and benefits under policy including FLC amount.

5. Steps taken for ascertaining suitability of insurance product at point of sale

BALIC conducts training programs for all intermediaries & employees wherein Specific training modules are created for different channels to address and provide training to the specified sales force as per its requirement wherein points relating to suitability of insurance products at point of sale are covered.

1) Human Life Value (HLV) calculator to ascertain the gap
2) A module called Symphoniais introduced with select channel partners for need analysis of the customer
3) Calculators required for analyzing life insurance needs are also available on BALIC Website.
4) Awareness created through marketing collaterals.

6. Channel-wise controls placed to prevent mis-selling

1) BALIC has started with verification calling for specified cases. Alleged mis-selling cases are referred to the sales team for their inputs. Based on the investigation the final decision for Cancellation / FLC is taken. The commission paid to the Insurance Agent is recovered for such cases.
2) Strict monitoring of Fraud / Forgery cases is done and in identified cases, the Company has also terminated the sales personnelwherein the mis-selling ratio was higher and sensitized the Channel Partners by issuing various communications including Warning letters.
3) The pre deceased login cases are categorized as high risk cases and the insurance agents' code is immediately terminated in BALIC records.The management reserves the right to forfeit/ recover competition benefits in such cases. The insurance agent is given an opportunity to explain the circumstances in which the insurance business of a pre-deceased person was solicited. Complaints are also lodged with the Police in appropriate cases.
4) We are also issuing QIM (Quality Index Meter) to the Intermediaries on monthly basis.QIM clearly indicates the Business done, the persistency ratio along with list of complaints and number of cancellation. Early death claims are treated as negative indicator in QIM.

a) **Individual Agency:** Calling at branch level is performed by BALIC employees before logging of proposal form. Post confirmation of the customer the policy is logged in.

b) **Corporate agents/ Bancassurance:**In case of identified mis-selling, BALIC is sharing the investigation findings with the intermediary and is seeking an action taken report against their SPs.

c) **Brokers:** Some of the brokers have their own PLVC(Pre Login Verification process) too.

d) **Direct selling:**Verification calls are being done to the customers as per process.

e) **Others:**Verification calls are being done to the customers as per process.

7. Other Measures taken for addressing mis-selling

1. To enhance customer education and prevent mis-selling, the Company has taken the following measures:
   a) The Welcome letter, forming part of the Policy document is a bilingual document. The Customer has an option to choose his preferred language out of 11 options provided by the Company in addition to English. The welcome letter of the Policy Document highlights whether a policy is a regular/single/limited premium along withinforming the Customer upfront about the number of years for which the premium needs to be paid. Further, this bilingual welcome letter specifies the document type provided by the customer towards age proof, identity proof and address proof along with the corresponding identification number of each document (for e.g. PAN no. is given under the heading of the identification number wherein the document provided is PAN card).
   b) The welcome letter also provides information in bold font about the common grounds of mis-selling and recommends the policyholder to go through the policy document with special reference to certain clauses addressing such grounds. For e.g., regular premium, termination, etc.
   c) Additionally, the welcome letter draws reference to the copy of proposal form and documents provided by the customer which are annexed as part of the Policy document.
   d) The Policy document specifically requests customers to go through the scanned copy of the benefit illustration counter signed by them which will help the customer in understanding the cash flow for each year of the term of the Policy.
2. Additional infographic information on key features of the policy (for e.g. Type of the plan, premium payment, maturity/survival benefit, death benefit, surrender) is being provided along with the Policy document. This page is also bilingual depending on the customer's preferred language.
3. Furthermore there is a renewal page which is also part of the Policy document which provides information on renewal premium payment instructions, guidelines on premium payment and once again clearly indicates nature of the policy whether regular/single/limited. A schedule is provided along with renewal dates for the entire term of the policy, taken into account the periodicity of premium payment chosen by the Customer viz. monthly/quarterly/half yearly/ annually. The renewal information is also provided in both English as well as customer's preferred language.
4. For ease of customers, the Company has started providing photo id card to the customer containing his/her photo, name and signature along with the Policy document.

5. In addition to the aforementioned initiatives taken by the Company having direct impact on the Customer, we have also set up a cross functional team comprising of Customer Experience Unit & Sales Admin for proactively monitoring the mis-selling complaints with support of the Legal Team. Mis-selling cases are closely monitored by Head Office.
6. Customer complaints escalated to our Customer Experience Unit are shared with the respective Regional Heads who discuss the issue with the customer & try to resolve the issue to retain the customer.
7. Insurance Consultants, Sales Managers & Office Heads with proven cases of misselling are not eligible to participate in monthly competitions.
8. Misselling & Persistency are part of the criteria for evaluation of Sales Managers & Office Heads who are eligible for promotions.
9. For all cases where violation of regulations pertaining to Code of Conduct or Duties and Responsibilities is noticed, financial disciplinary action as per the laid down procedure of the organization, is taken, where the alleged complaint is proved.

8. Procedure adopted for dealing with complaints of mis-selling

1) After receipt of the complaint, grievance teamsends an acknowledgement call and mail/ letter to the customer/complainant indicating the TAT required to address and resolve the complaint. This renders the complaint status as “acknowledged”.
2) Once the case is acknowledged, IRDAI token ID is generated for each case.
3) Further investigation, processing depending on the nature of the complaint is initiated and the complaint status is thereafter indicated as ‘pending” in the CRM module (e.g. pending from Finance or pending from Sales Administration or pending from Policy Servicing, etc.).
4) Once the complaint is resolved, the grievance team makes a confirmation call to the customer conveying the resolution and follows it up by a written communication either by mail or by letter. The complaint status hereafter changes to “Closed”
5) The written response to the customer/complainant duly carries the details of escalation matrix.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	101	27	12	56	16	71	9	2	84	166	45	167
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	76	25	12	53	11	69	6	0	62	135	36	143
Brokers	6	1	7	10	2	8	3	0	22	19	3	37
Direct selling	1	1	0	0	0	0	0	0	1	1	1	1
Others (to be specified)	55	23	8	24	5	23	5	0	21	84	28	52
Micro insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**239**	**77**	**39**	**143**	**34**	**171**	**23**	**2**	**190**	405	113	400

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1) A complaint shall be registered with TRAI' on behalf of the complainant enclosing a copy of the complaint received from the complainant with a copy marked to the customer/complainant.
2) After getting the relevant details/response from TRAI, the case shall be registered against the individual/entity allegedly indulging in spurious call under intimation to the complainant.
3) In case the individual/agent pertains to the insurer, an enquiry is undertaken and action is taken as per the laid down procedure.

11. Steps taken by the insurer to caution members of public about spurious calls

1. The company is conducting insurance awareness program to educate the customers and general public on the safeguards against spurious call. The other media through which awareness message is conveyed is advertisement in electronic media, radio, newspaper and hoardings in branches, besides sending SMS/ e-mails to the customers
2. Further, the Spurious Calls disclaimer (mentioned herein below) has been included as mandated, in font Times New Roman – 7, in all promotional and advertising communication material dealt through official channels of Bajaj Allianz Life Insurance Co. Ltd. These are namely product and non-product ranging from sales literature, leaflet, banner, one-pager, dangler, poster, standee, audio-visual communication, OOH mediums and emailers.

Disclaimer in use: BEWARE OF SPURIOUS PHONE CALLS AND FICTITIOUS/FRAUDULENT OFFERS- IRDAI clarifies to public that -

- IRDAI or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums.
- IRDAI does not announce any bonus. Public receiving such phone calls are requested to lodge a police complaint along with details of phone call, number.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013 -14	2014 -15	2015 -16	2013 -14	2014 -15	2015 -16	2013 -14	2014 -15	2015 -16	2013 -14	2014 -15	2015-16
Individual Agents	141	599	508	104	158	181	-	1*	44*	1835	717	628
Bank Assurance Agents/Employees	0	4	0	0	0	0				4598	7530	35128
Other Corporate Agents	2	2	0	1	0	1				990	134	134
Brokers	0	0	0	0	0	0				552	374	1085
Employees of Insurer	6	0	0	0	0	0				0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	-		1	0	0	0
Total	**149**	**605**	**508**	**105**	**158**	**182**	**-**	**1**	**45**	**7975**	**8755**	**36975**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

INSURER NAME: Bharti AXA Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	369	0	350	184	0	238	118	0	244	671	0	832
Bancassurance	3	0	21	0	0	3	1	0	0	4	0	24
Corporate Agents	69	0	107	65	0	156	68	0	142	202	0	405
Brokers	1176	1	1032	788	0	1351	657	0	1267	2621	1	3650
Direct selling	306	0	338	127	0	219	124	0	251	557	0	808
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	64	0	17	30	0	23	26	0	25	120	0	65
TOTAL	**1987**	**1**	**1865**	**1194**	**0**	**1990**	**994**	**0**	**1929**	**4175**	**1**	**5784**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	37,429	32,645	36,892	106,966
Bancassurance	-	-	-	-
Other Corporate Agents	1,153	1,365	966	3,484
Brokers	38,005	35,644	35,988	109,637
Direct selling	28,046	24,480	22,909	75,435
Others (to be specified)				-
TOTAL	**104,633**	**94,134**	**96,755**	**295,522**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	920	807	935	2662
Bancassurance	1	0	0	1
Other Corporate Agents	148	143	223	514
Brokers	2434	2225	3349	8008
Direct selling	403	325	531	1259
Others (to be specified)	0	51	45	96
TOTAL	**3906**	**3551**	**5083**	**12540**

4. Root Cause (s) for complaints relating to mis-selling

Root-causes for mis-selling complaints would be as under:

a) Deliberate intention of the seller

b) Inadequate product knowledge at the time of sale

c) Lack of insurance knowledge on the customer's part

d) Customer's blind faith on the insurance agent, and thus they fail to cross-check detailse) Improper financial need analysis by the seller

f) Attempt to meet Sales targets

g) Instigation by attrited agents

5. Steps taken for ascertaining suitability of insurance product at point of sale

We have launched **Need Analysis Tool** for **Proprietary channel** which ascertains the need and priority of the prospect customer. This tool enables customer and seller to ascertain the need and suitability of the product and premium

6. Channel-wise controls placed to prevent mis-selling

Agents

- Pre Issuance verification call to validate that customer has been given the correct information about the features & benefits of the product
- Mandatory supervisor/Area head declaration after meeting/speaking to the customer on product feature, term and benefit of the product

Corporate agents/ Brokers

- Pre-issuance verification calls are being done to all customers to ascertain product suitability
- Physical verification of customers basis a pre-defined matrix prior to issuance
- Mandating all tele partners to reduce/ stop selling multiple policies to one customer
- Allowing tele partners to source only policies with maximum NBI of Rs 50,000/-

Bancassurance – Presently, we do not have any Banca Channel for business sourcing

Direct selling

- Pre Issuance verification call to validate that customer has been given the correct information about the features& benefits of the product
- Mandatory supervisor/BSM declaration after meeting/speaking to the customer on product feature, term and benefit of the product.

7. Other Measures taken for addressing mis-selling

Below are the additional measures taken by Bharti AXA Life:·

- Case Studies are published to all internal employees on sales practices and disciplinary action, incase of malpractices
- Discussion with Sales Head on driving quality business with high risk partners
- Area Head/ Sales Manager declaration is taken prior to fresh application login, wherein the respective Area Head/ Sales Manager outcalls the customer to confirm on the product offered

- Pre-Verification calling script is reviewed incase of any new trends in complaints
- Education Series are published to existing customers vide Email/ SMS

8. Procedure adopted for dealing with complaints of mis-selling

The centralized Grievance Cell has dedicated individuals to handle policyholder complaints.

While the team outcalls the complainants to address their concerns and also provides best options to them to continue the policy, below mandatory checks are conducted to provide a fair decision:

- Details of the Plan opted versus policyholder's profile
- Outcome of the Pre login Verification call (as applicable)
- Any relevant interactions of the customer recorded with the Company
- Renewal Payment history, alongwith status of the policy
- Policy Bond dispatch/ delivery records
- Vintage of Policy i.e. date of policy issuance versus the first complaint date

Inputs from our Sales representatives are taken to understand the pitch done at the sourcing stage

Based on our investigation and Sales inputs, a final decision is taken in the matter,

Customer is communicated of our decision in writing, and steps for further redressal are shared in case of disputes.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	2	0	1	0	0	3	0	0	1	2	0	5
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	3	0	5	0	0	1	0	0	0	3	0	6
Brokers	11	0	21	0	0	7	0	0	2	11	0	30
Direct selling	1	0	1	0	0	4	1	0	1	2	0	6
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	8	0	4	2	0	2	2	0	1	12	0	7
TOTAL	**25**	**0**	**32**	**2**	**0**	**17**	**2**	**0**	**5**	**29**	**0**	**54**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

The centralized Grievance Cell has dedicated individuals to handle policyholder complaints.

While the team outcalls the complainant to address their concerns, details of the caller is taken to be further traced.

If it is identified that the policy was sold basis Spurious call, disciplinary action as per our internal matrix is taken; and decision considering customer's expectation is taken.

11. Steps taken by the insurer to caution members of public about spurious calls

a. Emailers and SMS are sent to the customer base every alternate month to caution them about spurious calls.

b. A PDF of the mailer has been uploaded on the website and the link to that page is included in the SMS that will be sent to the customers.

c. The TV advertisement Campaigns which were broadcasted in November-December and February- March had the mandatory Spurious calls slate which was displayed for 5 seconds during each spot.

d. The footer of all pages on the website carries the persistent Spurious Calls message.

e. All product brochures, leaflets, posters and a variety of other collaterals carry the Spurious calls disclaimer

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	10	27	9	14	17	3	1	0	0	21	306	102
Bank Assurance Agents/Employees	0	0	0	0	0	0	2	2	0	0	0	0
Other Corporate Agents	0	0	0	0	0	0	0	0	0	1	82	64
Brokers	0	0	0	0	0	0	1	0	0	102	1106	652
Employees of Insurer	21	27	4	8	9	6	0	0	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	2	0	0	0	0	0
Total	**31**	**54**	**13**	**22**	**26**	**9**	**6**	**2**	**0**	**124**	**1495**	**818**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

INSURER NAME: Birla Sun Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	484	128	4805	614	174	4911	231	59	3005	1329	361	12721
Bancassurance	48	18	679	37	11	529	16	9	310	101	38	1518
Other Corporate Agents	625	211	5349	436	85	2545	90	36	1007	1151	332	8901
Brokers	891	218	9527	899	256	7056	424	142	3688	2214	616	20271
Direct selling	13	6	107	31	10	163	12	9	92	56	25	362
Micro insurance agents	2	0	35	6	1	15	0	0	0	8	1	50
Distance Marketing	0	0	0	49	3	373	3	0	15	52	3	388
Policy number not provided	0	0	190	2	0	168	2	1	58	4	1	416
TOTAL	**2063**	**581**	**20692**	**2074**	**540**	**15760**	**778**	**256**	**8175***	**4915**	**1377**	**44627**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

*** excluding 1 pending complaint**

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015-16	
Individual Agents	253631	180894	182801	617326
Bancassurance	15769	13294	10176	39239
Other Corporate Agents	112524	11161	5665	656565
Brokers	24564	14704	10176	49444
Direct selling	7905	4678	11248	23831
Others (to be specified) – MI Agents for FY15 & FY16	1377	64370	71386	73275
TOTAL	415770	289101	291452	996323

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015-16	
Individual Agents	5909	3712	2865	12486
Bancassurance	239	177	170	586
Other Corporate Agents	1718	331	213	2262
Brokers	2559	1655	859	5073
Direct selling	163	118	268	549
Others (to be specified)	154	58	6	218
TOTAL	10742	6051	4381	21174

4. Root Cause (s) for complaints relating to mis-selling

- Unfair Business Practices
- Product not as per customer's requirement
- Single term policy issued as multiple term
- Freelook opted due to Mis-selling
- Misappropriation of premiums

5. Steps taken for ascertaining suitability of insurance product at point of sale

Birla Sun Life has taken several measures to ensure that the Customer is made aware of the product purchased as well as is suitable.

1. Field underwriting takes into account the suitability of the product at point of sale by considering the financial objectives, age, education, income and profession of the policy owner

2. Financial underwriting initiated for Elderly lives to ensure suitable product is sold as per their profile

3. For policies sourced by broker business, a Joint Declaration Form (JDF) was introduced to ensure that sales person has explained the product features and policy owner signs the form confirming the same

4. PIVC(Pre Issuance Verification Call) implemented to explain product features and obtain policy owner consent before issuance

5. SMS is sent to the policy owner's registered mobile number intimating that the policy has been issued

6. Channel-wise controls placed to prevent mis-selling

Brokers

- It was noted that incidence of mis-selling from some telesales business partners was very high.
- Established ground rules for tele sales business. To discontinue working with partners who are non compliant.
- The Company has exited all tele channel partner business effective 1st October 2014 where quality of sourcing was found to be concern
- Strict action against the channel partners as defined in the governance framework where misselling is proven
- Cases where complaints are settled favorably, commission claw back is effected
- Pre Issuance Verification Call / Pre Login Verification call

Agents

- Cases where complaints are settled favorably, commission claw back is effected

- Warning letters / termination of the agents for instances where mis-selling has been proven
- Pre Issuance Verification Call

Corporate agents :

- Pre Issuance Verification Call / Pre Login Verification call

7. Other Measures taken for addressing mis-selling

- We have made amendments in the underwriting guidelines for Senior citizens.
- PIVC has been introduced for Fund Transfer cases to ensure genuinely.
- Investigating all complaints and reaching out the customer to find out root cause and take preventive action to curb mis-selling.
- To collect premium cheques with application number or policy number
- Viral movie on complaints case circulated to all sales team educating them on Zero tolerance by BSLI

8. Procedure adopted for dealing with complaints of mis-selling

The company has a Board approved grievance redressal policy that provides the framework for a robust grievance redressal mechanism. The policy is reviewed periodically to ensure protection of policy holder's interests and was last reviewed in January 2016.

BSLI grievance team follows the below Investigation points for resolving mis-selling complaints:

1. Complaint review:

- All documents viz. application form, illustration, KYC , Joint Declaration form (JDF) submitted at the time of sale are verified to check customer information is correct and consent is provided by the policy owner
- Signatures are verified from external agency for signature forgery cases
- Pre Issuance Verification call (PIVC) referred to check customer's consent on policy issuance
- Sales team inputs taken on the complaints raised against adviser/channel partner
- Policy owner interaction history with BSLI is checked for tracing any similar concerns/query raised in past
- Policy owner/insured profile is checked for appropriateness of product sold viz. age/education/ profession/income/insurance solution offered/earlier policies opted from BSLI

2. BSLI grievance team takes the decision based on the investigation outcome

3. Outbound call made to the policy owner to intimate the complaint decision and written communication is subsequently sent vides e-mail/letter. The policy owner is given the option to approach the next level of escalation as defined in the grievance redressal mechanism, if he/she is not satisfied with the resolution provided

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1	5	554	11	2	1110	14	5	994	26	12	2658
Bancassurance	1	0	44	3	0	42	1	0	42	5	0	128
Other Corporate Agents	4	1	93	4	0	119	1	1	107	9	2	319
Brokers	20	10	377	32	5	406	11	4	261	63	19	1044
Direct selling	0	0	1	1	0	8	0	0	3	1	0	12
Micro insurance agents	0	0	3	0	0	2	0	0	0	0	0	5
Distance Marketing	0	0	0	0	1	10	0	0	2	0	1	12
Policy number not provided	0	0	42	1	0	41	0	0	5	1	0	88
TOTAL	**26**	**16**	**1114**	**52**	**8**	**1738**	**27**	**10**	**1414**	**105**	**34**	**4266**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. The complaints are validated based on the information provided by the complainant
2. BSLI compliance team visits the client's locations and also does mystery shopping on many occasions to nab the culprits
3. Written communication is sent to the complainant educating them of the hoax calls menace. The complainants are also advised to observe caution with regards to any financial transactions viz. no payment/documents to be handed over to any person on the basis of such hoax calls, register their contact nos. under DNC registry
4. The spurious call details are also shared with TRAI/DOT for initiating appropriate corrective action at their end

11. Steps taken by the insurer to caution members of public about spurious calls

Marketing and customer Service Initiative :

- The customers have been informed through various channels like newspaper advertisements, SMS, e mails and individual letters.
- Marketing has taken an aggressive campaign at Pan India level using all such channels.
- Various cases studies, communication to Sales personnel through online portal and mailers.

Industry Level:

- At an Insurance industry level FIR has been filed at EOW, Delhi to investigate on the errant telemarketers and was also flashed in the newspapers at Delhi.
- Regular meeting with the life council and IRDA to address this concern

Company Level:

- Many complaints had been filed before the Legal Authorities at various locations, at Delhi and Mumbai;
- Raids had been conducted by Police Authorities basis their investigations and due arrests have been made.
- Investigating all complaints and reaching to the customer to find out root cause and take preventive action
- Mystery shopping done on various occasions to nab the culprits.
- Registering spurious complaints with DOT and TRAI

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

As per Action Matrix action due action taken against the erring person.

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER: Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	0	0	0	0	0	0	0	0	0	0	0
Bancassurance	993	37	770	765	91	627	638	70	444	2396	198	1841
Other Corporate Agents	2	0	1	1	0	1	1	0	0	4	0	2
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**995**	**37**	**771**	**766**	**91**	**628**	**639**	**70**	**444**	**2400**	**198**	**1843**

I – In favor of Complainant; P – Partially in favour of complainant; R – Rejected *21 cases are open as of March 31, 2016

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents				
Bancassurance	51262	60006	75480	186748
Other Corporate Agents	-2			-2
Brokers				
Direct selling	112	566	502	1180
Others (to be specified)				
TOTAL	**51372**	**60572**	**75982**	**187926**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents				
Bancassurance	1110	832	733	2675
Other Corporate Agents	2			2
Brokers				0
Direct selling		2	1	3
Others (to be specified)				
TOTAL	**1112**	**834**	**734**	**2680**

4. Root Cause (s) for complaints relating to mis-selling

There appears an expectation gap between the actual product offered and the understanding of the policyholder. Largely this problem seems to arise as the policyholder does not read the complete proposal form or the product brochure before applying for an insurance policy and many times even after receipt of the policy document they fail to exercise the free look benefit. As a process, the Company makes a validation / welcome call to all the customers subject to contactability to ascertain if they have any concerns with regards to the policy. In all these cases the customers have signed the proposal form, benefit illustration and therefore, it is difficult to establish and identify the correctness of the complaint or if it was only an afterthought to cancel the policy.

5. Steps taken for ascertaining suitability of insurance product at point of sale

Assessment of need of the customer is a pre requisite for any insurance sales at CHOICe. A standard need assessment tool is used to understand customer needs and only after successful completion of need assessment process, a suitable product is offered. The need assessment tool considers various parameters like customer income, expenses, time to retire, current asset / liabilities, risk profile etc before arriving at a suitable product which is affordable for the customer.To ensure that need assessment is done for all customers, proposal are checked at login stage and ones with appropriate need assessment only are allowed to login for further processing.

6. Channel-wise controls placed to prevent mis-selling

Agents - NA

Corporate agents / Bancassurance : The following measures have been taken to address misselling concerns:-

1) **Validation call** – Post login of proposal form (and pre issuance of the same), call outs are made to customer to reiterate key product features, benefits etc. This helps in clarifying customer issues/concerns / queries (if any) prior to issuance of policy

2) **Key Information Document** (KID) – A KID has been introduced which provides key disclosures about the product in simple language to the customer e.g lock in period, premium paying term, policy term, etc. A copy of KID is handed over to the customer also sent along with the policy bond

3) **Churning Policy** – All new proposals sourced are de duped against existing policies and if there are any matches with existing policies which are in 'discontinued' status, then only upon fulfillment of certain conditions besides other which include a call out to the customer to confirm if he has understood the risks associated and new proposal is processed only post receipt of customer confirmation on the same

Brokers - NA

Direct selling - NA

Others - NA

7. Other Measures taken for addressing mis-selling

Transparent sales with all disclosures made to customer are intrinsic to the sales practices followed at CHOICe. This is achieved by various process / policies as noted below:-

1) Need assessment process - A robust need assessment process is in place to understand customers needs and requirements and suggest a suitable product accordingly

2) Key information document - A document comprising all the key features & disclosures is provided to the customer at point of sale and is acknowledged by the customer with his signature. A copy of the KID is sent along with the policy bond.

3) Validation call (VC) - Attempt is made to contact the customer prior to issuance of policy wherein he is taken through all the important features of the policy (e.g SA, PPT, PT, Premium amount etc), medical disclosure (if any) etc during the call. Any concern/query raised by the during the VC is 1st resolved and then only the policy is issued

4) Policy for Potentially vulnerable customers - This policy has been designed to safeguard the interests of vulnerable section of customer's e.g customers with low income, Aged customers, and customers with low education/occupation. The policy rules help in suitable sourcing for such vulnerable customers e.g Only Traditional plan can be sourced from customer with lower education and occupation

5) Policy for suspected Churning controls-This policy has been designed to ensure that if customers existing policy is in discontinued status, any new policy from same customer can be processed post adequate due diligence including customer consent. The control has been well embedded in the sales process.

8. Procedure adopted for dealing with complaints of mis-selling

As part of the company's initiatives to mitigate misspelling, the company has introduced PVC policy (potentially vulnerable customers) to do a suitability analysis and ensure that the product being sold is suitable for the customer based on certain parameters. This policy is based on considering the appropriateness of the product for the target customer, and ensuring that the product has been presented in a manner which increases transparency and helps the customer understand the products. Since, "potential vulnerability" involves a degree of subjectivity, the below key criteria is being used to identify PVC customers;

- Age based criteria: Customers aged 55 and over at the time of taking the policy
- Customers with an annual income of Rs 100,000 or below
- Customers who have lower educational qualification (Class X or below) and who are employed in certain professional activities to earn their living.

Appended are the various modifications which have been implemented in the current procedures as per the PVC policy.

1. In situations where the customer has limited understanding of English language, the sales person speaks and understands the language spoken by the customer. Additionally, the sales literature and brochures used during the sale is in the language that is understood by the customer.
2. While it is the responsibility of the SP to ensure the sale was made in a transparent manner, the Company will be responsible to ensure that suitability was assessed at the time of sale and the right product was offered/ sold to the customer in line with internal procedures. Assessment of suitability will typically involve consideration of customers need for contingency funds, their appetite to risk and their need behind the investment (savings, protection, building a retirement corpus, etc).
3. The Underwriting procedures and new business login procedures have been enhanced to ensure that the requirements under the policy and rules laid out for respective category of PVC customers are complied with.4. During the validation call to such customers, the company will among other features reiterate the following key terms to enable the customer to understand the product
   (i) customers are aware of the premium payment term,
   (ii) product sold to them is suitable,
   (iii) Charges structure including implications for mortality charges (especially for aged customers) is clearly explained.

Inaddition to above, the Company works on the principle of TCF (Treating customers fairly) at the time of complaint investigation to ensure that all policy related facts, documentation & communication is reviewed before taking a final decision on the complaint and benefit of doubt is given to the customer.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Brokers	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Direct selling	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Micro insurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

The Company looks into all such complaints received at its end. The Customer is requested to share all relevant details including details of caller, number from which calls were received and details of conversation. Additionally, the Company carries out its own investigation and suitable action as deemed necessary is taken basis the outcome of the investigation.The Company is committed to extend all support to address Customer's grievance

11. Steps taken by the insurer to caution members of public about spurious calls

- Customers receiving spurious calls are counseled by Company's staff to stay alert from fake offers being made on such calls and are reassured that Company takes all such complaints and feedback seriously. In order to ensure that Customers do not fall prey to offers made through such spurious calls, the Company has put up relevant information about spurious calls on its website. The information is considered to be useful & handy for customers and informs them about what they should do when they receive such calls including some relevant FAQ's.
- In line with the circular issued by the authority, all marketing campaigns undertaken by the Company have necessary guidance on spurious calls to enhance Customer awareness & subsequent action to be taken
- The Company has run periodic awareness campaigns through customer touch points like Investment newsletter, E-Mail & SMS, print media, etc.
- The Company requests its Customers, who have been impacted as a result of such fake offers, to lodge an FIR with local police and share a copy of the same with the Company. The Company is committed to extend all support to the investigating agency and address Customer's grievance
- The Company continues to work with the industry and regulator to address the issue.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc.

Intermediary/ Employee	Number of warning letters Issued			Num ber of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	189	448	98
Other Corporate Agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Brokers	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Employees of Insurer	0	0	0	0	0	0	0	0	0	0	0	0
Spurious Tele-callers	0	1	0	0	0	0	0	1	0	0	0	0
Total	0	1	0	0	0	0	0	1	0	189	448	98

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : DHFL Pramerica Life Insurance Co Ltd

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	171	17	347	75	34	382	84	42	273	1425	171	17
Bancassurance												
Other Corporate Agents	86	3	51	68	19	127	64	33	190	641	86	3
Brokers	119	15	281	71	21	408	59	52	351	1377	119	15
Direct selling	8		9	14	3	26	19	10	29	118	8	
Microinsurance agents												
Others (to be specified)	14	3	8	2	9	7	4	12	8	67	14	3
TOTAL	**398**	**38**	**696**	**230**	**86**	**950**	**230**	**149**	**851**	**3628**	**398**	**38**

I – In favor of Complainant; P – Partially in favor of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

New Business sourced from different intermediaries (Individual policies)				
Source	Years			TOTAL
	2013-14	2014-15	2015 -16*	
Brokers	**2,321**	**7,009**	**6,198**	**15,528**
Bancassurance	**665**	**349**	**7**	**1,021**
Direct selling	**30,001**	**20,691**	**25,399**	**76,091**
Individual Agents	**17,730**	**11,917**	**14,776**	**44,423**
Other Corporate Agents	**11,903**	**14,085**	**9,641**	**35,629**
Others (to be specified)	**-**	**-**	**-**	**-**
TOTAL	**62,620**	**54,051**	**56,021**	**172,692**
*** 2015 -16 New business count can be changed after Audit**				

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	609	497	643	1749
Bancassurance				
Other Corporate Agents	39	266	350	655
Brokers	161	261	353	775
Direct selling	294	506	885	1685
Others (to be specified)				
TOTAL	**1103**	**1530**	**2231**	**4864**

4. Root Cause (s) for complaints relating to mis-selling

Single premium Policy issued as Annual premium policy -

- Majority cases were related to allegation around term of the policy altered to regular premium paying term instead of single premium. However, it was difficult to establish in cases where there was no overwriting in the proposal form and / or salespersons/agents were no more associated with the company and/or no such grievance was indicated in pre and post issuance verification calls made to the policyholder.

Malpractices and Unfair Business practices -

- Some business complaints pertained to senior citizens who were unable to pay premium for long period of time.
- Some business complaints were due to false/wrong commitments made by business partners/ channel/salespersons.

Tampering, Corrections, Forgery of proposal related papers -

- In some cases above allegations had been proven and grievance redressed through refund of premium as applicable, even though the salespersons/agents were no more associated with the company. However, in many cases such allegations could not be established.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- The Company has initiated face to face meeting between the Customer and Senior Company officials prior to proposal login.
- The Company has put in place Pre-Issuance Verification calls to customers to verify proposal information and to detect malpractices/forgery/tampering/miss-selling instance for Brokers and Corporate Agents· In case of senior citizens as policy holders –
  - Face to face meeting has been formalized with Proposer/Life Insured and with Parent (in case insured is minor)
  - For proposer, Age & Premium paying term has been capped.
- The company makes Welcome Call to customer post policy issuance within free look period to confirm that customer is aware of key policy features and benefits of the policy and is satisfied with sales person.

6. Channel-wise controls placed to prevent miss-selling

Agents

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person confirming personal meeting with the policy holder and having explained all the features of the product.

Corporate Agents

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >1 Lakh confirming personal meeting with the policy holder and having explained all the features of the product.Banc assurance
- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >1 lakh confirming personal meeting with the policy holder and having explained all the features of the product.

Brokers

- Pre-issuance verification call is made to the policy holder on recorded line at the time of receipt of the application form and KYC. This call helps in confirming documents submitted by the policy holder, contact details and key features of the policy.
- Welcome call done within 1 month of policy dispatch with 100% call recording to policy holders.· PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Mobile/Landline phone bill is taken as a mandatory proof at the time of application solicitation.

Direct selling – NAOthers

- Welcome call to policyholders done within 1 month of policy dispatch, with 100% call recording.
- PAN , voter ID card verification is done from government websites in all the cases to reduce document forgery complaints.(wherever applicable)
- Face to Face report (FTF) is submitted by Sales person for premium >1 Lakh confirming personal meeting with the policy holder and having explained all the features of the product.

7. Other Measures taken for addressing mis-selling

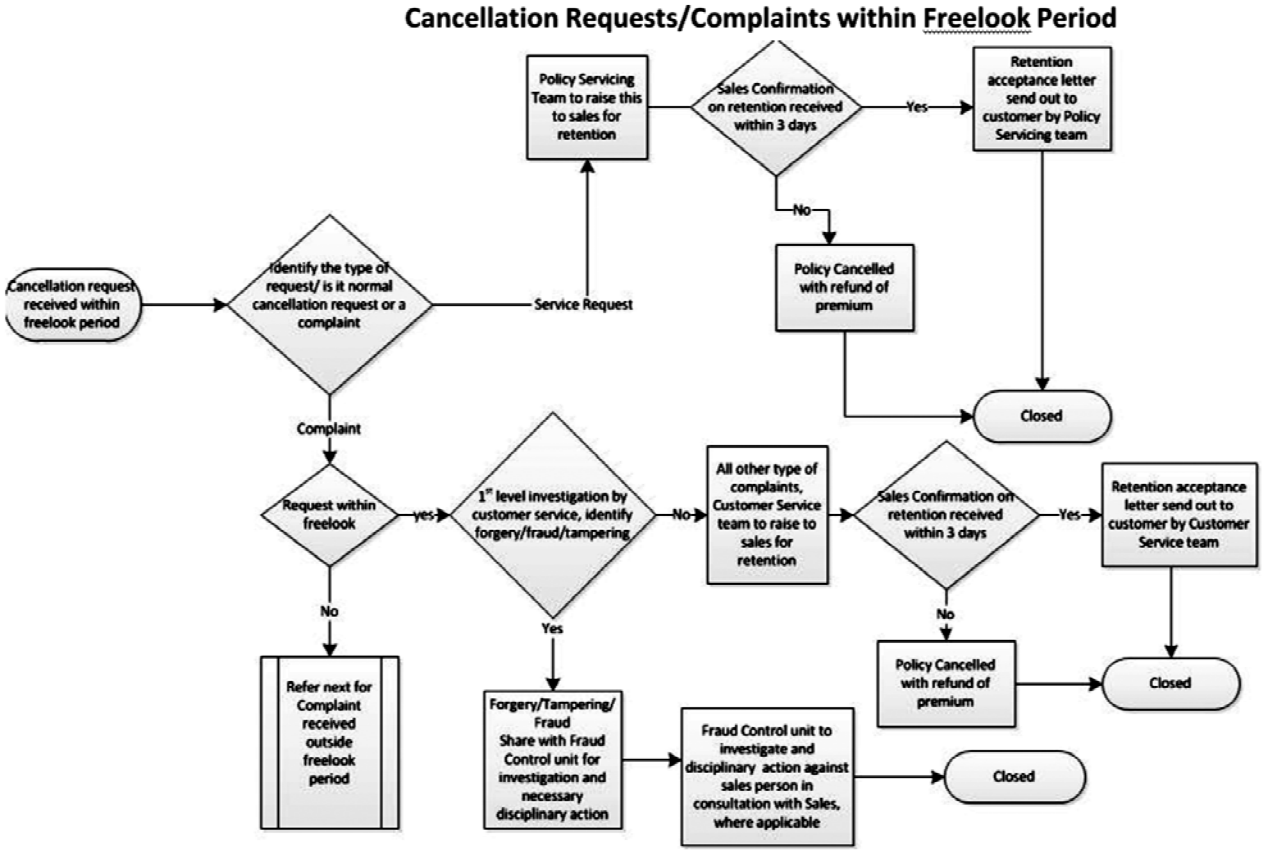
Frequent training sessions organized by Compliance Unit for all employees to sensitize them about the code of conduct and selling ethics

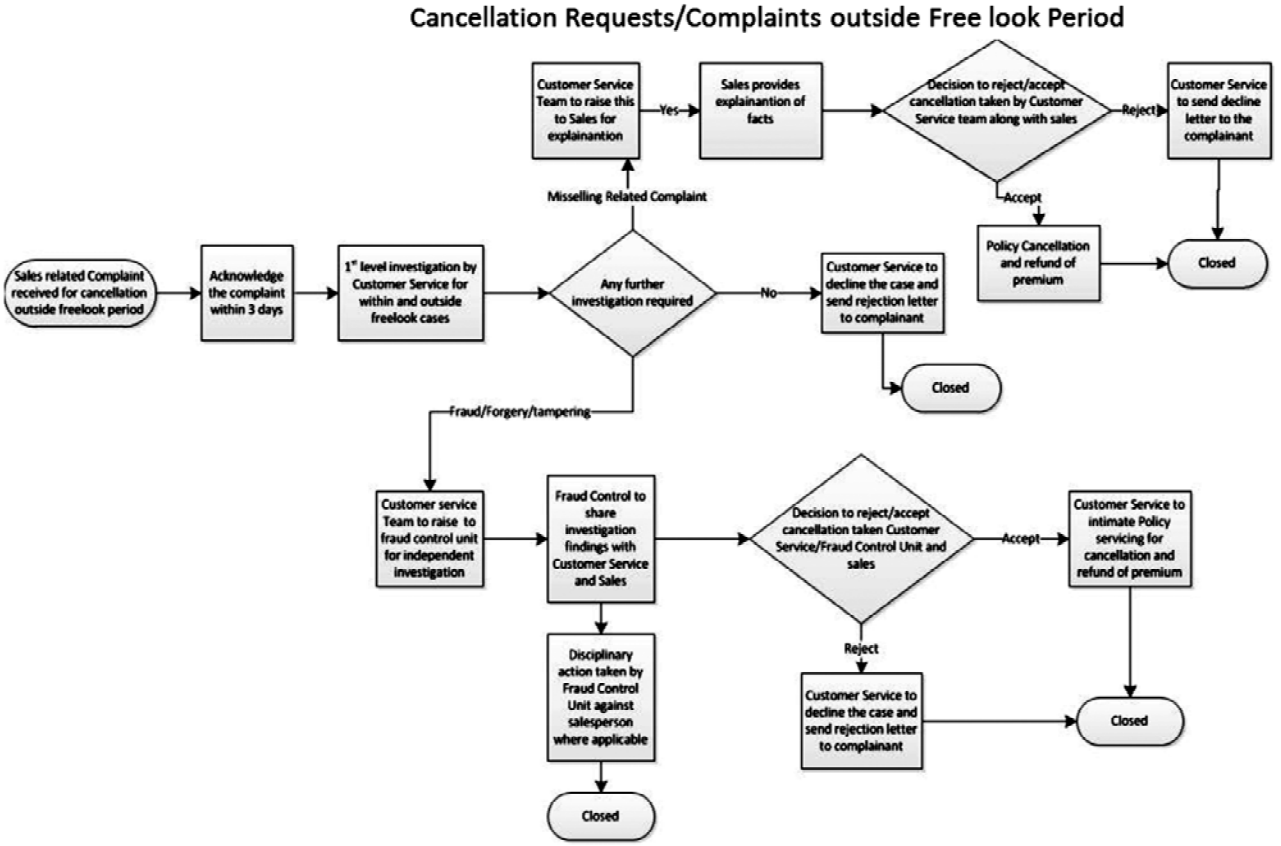
For malpractices/malpractices/forgery/tampering/miss -selling where the Company substantiated misselling by the company sales employees/agents, necessary disciplinary action has been taken by the Company.

Business relationship ended with some channels where complaints were high. In case of senior citizens as policy holders –

- Face to face meeting has been formalized with Proposer/Life Insured and with Parent (in case insured is minor)
- For proposer Age & Premium paying term has been capped.

8. Procedure adopted for dealing with complaints of mis-selling





9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	14	2	2	16	1	1	8	47	3	0
Bancassurance												
Other Corporate Agents	0	0	2	0	0	7	0	1	6	16	0	0
Brokers	3	1	19	3	2	30	3	1	20	82	3	1
Direct selling	0	0	1	0	0	0	0	0	0	1	0	0
Micro insurance agents												
Others (to be specified)	4	3	2	0	2	1	0	0	1	13	4	3
TOTAL	**10**	**4**	**38**	**5**	**6**	**54**	**4**	**3**	**35**	**159**	**10**	**4**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1. Collection of all the customer complaint letters with mentioned phone numbers along with other contact details
2. Updating Spread Sheet with the necessary information about the customer, policy number if any, spurious tele caller name and other contact details.
3. The phone numbers are scrubbed against the existing data base of spurious call, employee/ agents details to validate whether the number belong to any of our employees/ agents
4. The phone numbers are reported to the Economic Offense Wing , Mandir Marg on a monthly basis
5. Mystery shopping is done on the phone numbers
6. Phone numbers have been reported to SP Crime Noida wherein Investigation orders have been done and an Investigating Officer has been appointed.

11. Steps taken by the insurer to caution members of public about spurious calls

(1) IRDA circular no IRDA/CAD/PNTC/MISC/046/01/2014 Dated 29-01-2014, displayed on company website regarding spurious calls to spread awareness and caution to general public and customers.

(2) Customer awareness SMS are sent from time to time to all customers educating them about spurious calls.

(3) Customer awareness E-Mails are sent from time to time to all customers educating them about spurious calls.

(4) All advertisements have warning regarding spurious calls and fictitious/fraudulent offers.

(5) The application form contains advertisements have warning regarding spurious calls and fictitious/fraudulent offers.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers

Intermediary/ Employee	Number of warning letters issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	14	7	3	12	18	3	1	102	41	65	79	2
Bank Assurance Agents/Employees			-			-			-			0
Other Corporate Agents			1			-			14	3	23	0
Brokers			41	2	8	1	1	12	140	65	78	34
Employees of Insurer	13	14	2	9	11	15	1	51	-			0
Others (Spurious Tele-callers)			-			-			39			0
Total	**27**	**21**	**47**	**23**	**37**	**16**	**3**	**165**	**240**	**133**	**180**	**36**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Edelweiss Tokio Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	43	0	46	66	0	123	47	2	96	156	2	265
Bancassurance	1	0	0	1	0	1	2	0	5	4	0	6
Other Corporate Agents	24	0	10	30	0	56	11	0	33	65	0	99
Brokers	21	0	17	26	0	31	63	2	80	110	2	128
Direct selling	6	0	3	16	0	11	4	0	5	26	0	19
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**95**	**0**	**76**	**139**	**0**	**222**	**127**	**4**	**219**	**361**	**4**	**517**

I – In favor of Complainant; P – Partially in favor of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	24072	19244	23746	67062
Bancassurance	1081	2388	3716	7185
Other Corporate Agents	1662	1996	1452	5110
Brokers	1236	1480	3032	5748
Direct selling	4800	3593	5126	13519
Others (Micro Insurance Agents)	Nil	450	710	1160
TOTAL	**32851**	**29151**	**37782**	**99784**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	24072	19244	23746	67062
Bancassurance	1081	2388	3716	7185
Other Corporate Agents	1662	1996	1452	5110
Brokers	1236	1480	3032	5748
Direct selling	4800	3593	5126	13519
Others (Micro Insurance Agents)	Nil	450	710	1160
TOTAL	**32851**	**29151**	**37782**	**99784**

4. Root Cause (s) for complaints relating to mis-selling

The root cause(s) analysis of misselling complaints are -

- Miscommunication of products terms and condition by the intermediaries

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Customers' profiles are evaluated to assess the need before the actual selling.
- 100% Welcome Call to confirm the receipt of policy document after issuance and any issues with reference to product terms and condition
- Pre Issuance Verification process is initiated for high risk and ultra-high risk cases followed by underwriting evaluation.

6. Channel-wise controls placed to prevent mis-selling

We have put in place a Need BasedSelling and Verification process for all channels of Distribution i.e. Agents, Corporate Agents, and Direct Sales.

Pre issuance verification calls are undertaken for Broker Channel cases.

7. Other Measures taken for addressing mis-selling

- 100% Welcome Call to confirm the receipt of policy document and any issues with policy terms and conditions.

8. Procedure adopted for dealing with complaints of mis-selling

- Customer complaints on Misselling are shared with Sales for their feedback and evaluation of selling process.
- In case of tampering, forgery and fraud, the complaints get forwarded to Risk for investigation.
- Review of cases is done in consideration with Sales feedback and risk investigation report.
- Retention effort is initiated for cases where customers insist on cancellation.
- If misselling is proven disciplinary action initiated against agents, sales persons and intermediaries

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	2	0	2	0	0	4	1	0	0	3	0	6
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	0	1	0	7	0	0	0	1	0	7
Brokers	8	0	3	4	0	3	6	0	6	18	0	12
Direct selling	1	0	0	0	0	0	0	0	0	1	0	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**11**	0	**5**	**5**	0	**14**	**7**	0	**6**	23	0	25

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- The complaints with Spurious Calls are forwarded for investigation.
- Field Verification is carried out to ascertain the reason.
- If proven fake and illegal activity:
  - o Reported to Economics offence wing
  - o Reported to DOT for spurious number
- Awareness Campaign amongst the existing customers on nature of spurious call through SMS and Emails

11. Steps taken by the insurer to caution members of public about spurious calls

The Insurer carries out the following activities to caution its policyholders, customers and member of public about Spurious Calls:

- Issuance of emailers
- Issuance of SMS
- Posting a Caution Notice against Spurious Calls on its Website

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	4	8	6	4	3	13	-	-	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	7	-	1	-	-	-	-	-	-	-
Employees of Insurer	6	8	16	6	3	7	1	-	1	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	10	16	29	10	7	20	1	0	1	0	0	0

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER **: Exide Life Insurance Company**

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	320	235	163	376	297	179	453	551	733	1149	1083	1075
Bancassurance	136	108	98	179	154	116	64	150	216	379	412	430
Other Corporate Agents	22	17	15	24	34	20	85	68	265	131	119	300
Brokers	145	190	194	374	502	371	863	1190	1991	1382	1882	2556
Direct selling	46	44	30	108	111	56	35	93	139	189	248	225
Micro insurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (Referral)	21	20	13	35	16	13	11	22	18	67	58	44
TOTAL	**690**	**614**	**513**	**1096**	**1114**	**755**	**1511**	**2074**	**3362**	**3297**	**3802**	**4630**

2. New Business sourced from di? erent intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	124329	114013	126744	365086
Bancassurance	37773	15161	3294	56228
Other Corporate Agents	2113	1940	4097	8150
Brokers	20231	19634	46696	86561
Direct selling	4860	5692	2283	12835
Others (to be speci?ed)	8074	5269	8805	22148
TOTAL	**1,97,380**	**1,61,709**	**1,91,919**	**5,51,008**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	2447	1957	2832	7236
Bancassurance	1353	979	268	2600
Other Corporate Agents	153	168	458	779
Brokers	1224	2092	6177	9493
Direct selling	-	-	39	39
Others - Referral	204	195	209	608
TOTAL	**5381**	**5391**	**9983**	**20755**

4. Root Cause (s) for complaints relating to mis-selling

Majority of the mis-selling complaints pertain to Broker channel wherein customers are promised bonus, multiple policies sourced on the assurance of loan, policy sourced with assurance of cancellation of old policy from other insurance company.

Cases where mis-selling is proved we have cancelled the case or given an option to change the product.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- For broker cases we insist in having pre verification call to be made before login the proposal
- For the identified partners who have high mis-selling complaints we have changed the process of accepting proposal by allowing maximum of INR. 1lac in his/her capacity as policyholder or as a Payer.

6. Channel-wise controls placed to prevent mis-selling

Agents

- Extra Due diligence is done for identified agents who have high history of complaints.
- Physical verification is done for cases sourced by agents who have high mis-selling record
- Termination/Warning letter are issued to agent who have high mis-selling complaints

Bancassurance - We don't have any history of mis-selling complaints

Brokers/Corporate Agent Channel - Channel partner has been intimated on the rising trend in complaints. Misselling tactics have been highlighted where the partner has ensured that individuals who are involved in mis-selling are issued warning letters or terminated

Direct selling – We have not yet seen a trend of mis-selling for this channel

Others – N/A

7. Other Measures taken for addressing mis-selling

- We have instituted a monthly review of complaints with the Sales leadership to review trends and initiate suitable corrective actions
- Quality dashboard is shared with the sales leadership with complaints being integral part of the metric
- Monthly review of complaints has been initiated for identified partner/agent

8. Procedure adopted for dealing with complaints of mis-selling

Process of handling Misselling related grievances :

- Complaint received from the customer is registered as per the Grievance Redressal Policy
- Customer allegation is investigated and resolution provided within the regulatory guidelines
- Where the complaint is duly established as mis-sold basis the facts of case (mentioned below), the same will be admitted and policy cancelled :

- o Documented proof of assurance of loan or any other inducement offered
- o Multiple policies issued with us or various other insurance companies, which is above the premium paying capacity of the customer
- o Deficiency in Disclosure of key information

- Instances of mis-selling are viewed seriously and trends emerging, basis detailed analysis, is tabled before the Policy Holder Protection Committee for action to be taken against erring employee/agent or intermediary

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	10	5	-	21	5	-	6	11	6	37	21	6
Bancassurance	-	1	-	4	2	-	-	-	1	4	3	1
Other Corporate Agents	-	-	-	-	-	-	-	-	2	-	-	2
Brokers	3	2		8	5	1	7	9	8	18	16	9
Direct selling	2	2		6			1	2	4	9	4	4
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	1	2	-	-	-	-	-	-	-	1	2	-
TOTAL	**16**	**12**	-	**39**	**12**	**1**	**14**	**22**	**21**	**69**	**46**	**22**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Process of handling Spurious calls related grievances :

- Complaint received from the customer is registered as per the Grievance Redressal Policy and customer allegation on spurious call is investigated and resolution is provided within the regulatory guidelines
- The telephone number provided by customers are screened against our existing list of employee/ agent or intermediaries. If found matching, a detailed internal investigation is conducted and suitable action is initiated against the persons involved
- If telephone number is not found matching, we update our internal data base of such numbers. Our internal investigation team attempts to conduct a detailed investigation of external parties involved.
- Customers are also advised to raise a police complaint locally.
- For complaint received from non-policy holders, the Grievance Redressal team guides the customer to register a complaint with TRAI and also add the number to their 'DND' list.

11. Steps taken by the insurer to caution members of public about spurious calls

Process for creating awareness about Spurious calls

- Quarterly SMS are sent to policy holders
- All our promotional email / information emails contains awareness message about spurious calls
- Our policy document carries the information about spurious calls
- Creating awareness to the public through Website

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	-	-	-	439	435	447	2	-	-	610	366	1180
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	339	448	428
Other Corporate Agents	-	-	1	1	1	2	2	-	-	54	76	417
Brokers	-	-	4	17	17	15	-	-	-	386	1177	3990
Employees of Insurer	15	-	-	14	15	12	1	-	-	105	256	244
Others (Referral)	-	-	-	8	9	4	-	-	-	54	56	47
Total	**15**	**0**	**5**	**479**	**477**	**480**	**5**	**0**	**0**	**1548**	**2379**	**6306**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Future Generali India LIC LTD

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected
Individual Agents	46	2	2723	481	160	665	380	231	823	907	393	4211
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	7	0	45	4	1	13	2	1	13	13	2	71
Brokers	129	31	457	447	276	768	1130	701	2641	1706	1008	3866
Direct selling	176	2	110	293	115	379	303	86	611	772	203	1100
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	358	35	3335	1225	552	1825	1815	1019	4088	3398	1606	9248

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	37679	21301	18210	77190
Bancassurance	0	0	0	0
Other Corporate Agents	15534	4071	2908	22513
Brokers	24103	10965	5158	40226
Direct selling	3938	2288	3200	9426
Others (to be specified)	125	8	0	125
TOTAL	81379	38633	29476	**149480**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	830	1717	1145	3692
Bancassurance	0	0	0	0
Other Corporate Agents	104	18	18	140
Brokers	24	199	214	437
Direct selling	153	244	155	552
Others (to be specified)	0	0	0	0
TOTAL	**1111**	**2178**	**1532**	**4821**

4. Root Cause (s) for complaints relating to mis-selling

a) Lack of awareness to public at large with respect to being cautioned on such unscrupulous market practices

b) In many incidences, customers have been called (spurious calls) and have been found that these cases have been logged in through certain broking partners

c) Public at large has been falling prey to inducements being offered in the name of Govt institutions,Insurance companies,such incidences have been observed with a higher degree from certain broking partners

5. Steps taken for ascertaining suitability of insurance product at point of sale

a) Sales illustration is mandatory in every case which has to be signed by the customer

b) Online verification is being done for ITRs submitted, Pan-card & voter id cards

c) For every single proposal, a verification call is made by the company from recorded telephone line to confirm customer's understanding of the product, premium paying term and that there are no inducements made to the customer in order to apply for a policy.

d) Copy of Sales illustration, Proposal form are also provided along with the policy document

e) Age restriction up-to 50 years in most products so as to meet savings needs during working age

f) Restriction sale of combination of term and ages which are no tax efficient under 80C or 10(10D)

g) Sales illustration made simple to understand and the key features re clearly mentioned in illustration

6. Channel-wise controls placed to prevent mis-selling

Agents

- A report is completed by our sales employee after physical meeting with the proposer for every single new proposal where the agent has a vintage of less than 3 years with the company
- Sales illustration mandatory for all cases.
- A governance grid is in place which is signed by all company employees which clearly mentions the sanctions that would be applicable in cases of wrong practices adopted during sale
- Sales Compliance unit investigates instances of alleged malpractices and presents to the Governance committee for actions to be taken as per company governance grid.

Corporate agents/Brokers

- Effective July 2015, for every new proposal from broking partners, the sales employee of the company physically meets the proposer to verify customer's understanding of the product, its features and premium paying terms and other conditions prior to logging in the sale. Post the face to face meeting, a form is filled and signed by the proposer. This has now been made a mandatory form to accept logins of new proposals from brokers.

7. Other Measures taken for addressing mis-selling

- Pre Issuance Verification call (PIVC) mandatory to be cleared by the customer before issuance of policy.Calls done in regional language too through recorded line.
- Data scrubbing at proposal stage to check if the same contact number is being re-used.
- De-dupe of clients details to ensure single client id for customers opting for multiple policies. This ensures check on insurability / calling for medicals.
- Restriction on new policy issuance if the existing policies are in lapsed mode.
- Post-dispatch of policy bond a confirmation call(recorded line) is made to customers to check the receipt of policy documents· Strict Internal compliance guidelines to address mis-selling
- Mystery shopping done at branches / channel partners office / medical center
- Mandatory PAN number verification on NSDL website
- Field verification through investigation agencies to reconfirm the customer profile in selected sample proposals
- Signature verification training conducted for underwriting staff to detect potential signature forgery cases
- Usage of bureau data from Experian to verify customer credentials in select cases
- Delivery Calling – Pre and Post- dispatch of policy document, customers are called through a recorded line to verify address and confirm receipt of policy document

8. Procedure adopted for dealing with complaints of mis-selling

a) Written acknowledgement to the complainant is sent within 3 working days of the receipt of the grievance via e-mail or letter

b) Details of the grievance lodged against policy sourced by Individual Advisors, is shared with the concerned sales manager and the branch manager covering the points mentioned by the complainant and explanation is sought with respect to the grievance.

c) Details of the grievance lodged against policy sourced by employees, is shared with the concerned employee and the supervisor covering the points mentioned by the complainant and explanation is sought with respect to the grievance.

d) Details of the grievance lodged against policy sourced by third party intermediaries,is shared with the third party intermediary and relationship managers covering the points mentioned by the complainant and explanation is sought with respect to the grievance.

e) Post receipt of explanation as above, the grievance officer analyze the reply and prepare a brief summary of the case, along with verification of

   i) Proposal form and supporting documents provided

   ii) Any other document provided during the policy issuance.

iii) Listening to the recorded call made prior to issuance of the policy

iv) Studying previous Interactions of customers at any touch point

f) All grievances are investigated comprehensively, diligently and impartially and if required, by obtaining additional information

g) The grievance is examined fairly, promptly & the decision taken with reasons is conveyed to the customer (in writing) within 15 days from date of receipt of grievance along with the escalation procedure in case the customer is dissatisfied with the resolution provided.

h) Where agents or employees are found to have indulged in mis-selling practices, suitable action in accordance with the organization's governance policy is initiated

i) Mis-selling grievances received against third party intermediaries is formally communicated to the principle officers of the third party intermediaries by the organization's Chief Compliance Officer seeking explanation and actions taken against the wrong doers and measures taken to avoid such occurrences.

j) Mystery shopping of branch / channel partners & enhanced checks on the financial sales literature is ensured thereby enabling company is compliant to the rules and regulations set.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected	In Favour	Partially In Favour	Rejected
Individual Agents	1	0	5	8	4	24	7	2	4	16	6	33
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	1	0	11	0	0	0	0	0	2	1	0	13
Brokers	0	0	2	14	8	25	14	23	73	28	31	100
Direct selling	0	0	2	7	1	9	3	2	11	10	3	22
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	1	6	0	0	0	0	3	6	0	4
TOTAL	2	0	21	35	13	58	24	27	93	61	40	172

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

a) The companysends written acknowledgement to the complainant within 3 working days of the receipt of the grievance via e-mail or letter. The acknowledgement contains the details of the grievance raised such as

- Date of grievance registered with the Insurer.
- IRDA registered grievance number.
- Name and contact number of the officer handling the grievance

- Issue raised by the complainant
- Insurer's grievance redressal procedure
- The details provided by complainant from where he/she received the call soliciting business claiming to represent IRDAI, GOI etc.

b) The time within which the grievance would be addressed, and also the escalation touch point in the event the customer do not receive any reply is mentioned in the said acknowledgement.The complainant is informed the procedure to lodge the grievance with TRAI.

c) The acknowledgement contains a section for the complainant through which the customer is made aware about the facility offered by TRAI for registering his/her grievance about Spurious Calls:

- By dialing toll free number 1909.
- By sending an SMS to 1909.
- By dialing toll free number and registering via IVR.

d) The grievance is investigated comprehensively, diligently and impartially and if felt necessary, by obtaining additional information.

e) Customers who have lodged grievance are spoken to as part of investigation process.

f) The grievance are examined fairly, promptly & the decision taken with reasons are conveyed to the customer (in writing) within 15 days from the date of receipt of grievance along with the escalation procedure in case the customer is dissatisfied with the resolution provided.

g) A separate database is maintained for all such names and numbers provided by the complainant for record purpose.

h) We also send a communication to TRAI on behalf of the customer providing the following details (Duly copied to the complainant).

- Mobile number /landline number.
- Date of call as provided by the complainant.
- Place of call.
- Person identified himself/herself as.

i) The grievance lodged by customer directly in IGMS portal or through IRDAI, the redressal details provided to the client along with the copy of letter addressed to TRAI, is correspondingly addressed to the IRDAI too.

11. Steps taken by the insurer to caution members of public about spurious calls

- Once in 2 months SMS communication sent to all the existing customers cautioning them to be, aware of spurious and un-solicited calls and report to the company.
- Our Corporate Website highlights for general public and our customers, the steps to be taken in case they receive spurious and un-solicited calls

- All calls made by us to the customer followed with an SMS confirming the name of the representative, phone number through which the call was done along with the landline number of corporate office/call center number
- Instances where the identity of the spurious tele-caller is established the same are taken up by the Legal & Compliance department of the company and appropriate measures are taken including approaching law enforcement agencies, if necessary.
- E-Mailers and SMS to customers detailing out the steps to be followed for registering a spurious call grievance with TRAI in cases where customers have received any unsolicited communication post seven days after registering telephone number in NCPR.
- We also advice customers to lodge FIR at the nearest police station.
- Where agents or employees are found to have indulged in making spurious calls, suitable actions in accordance with the organization's governance policy are initiated
- Spurious calls grievances received against third party intermediaries are formally communicated to the principal officers of the third party intermediaries by the organization's Chief Compliance Officer seeking explanation and actions taken against the wrong doers and measures taken to avoid such occurrences.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	0	0	0	0	31	4	0	0	0	0	0	0
Bank Assurance Agents/Employees	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Employees of Insurer	186	56	23	3	34	6	0	0	0	0	0	0
Others (Spurious Tele-callers)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	186	56	23	3	65	10	0	0	0	0	0	0

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : HDFC STANDARD LIFE INSURANCE COMPANY LTD.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	886	0	4,226	239	0	2,311	61	0	794	1,186	0	7,331
Bancassurance	2,765	0	13,812	1,772	0	7,852	592	0	3,308	5,129	0	24,972
Other Corporate Agents	81	0	398	20	0	260	8	0	71	109	0	729
Brokers	2,233	0	11,261	1,169	0	9,129	315	0	3,827	3,717	0	24,217
Direct selling	195	0	1,124	39	0	293	40	0	367	274	0	1,784
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	81	0	432	239	0	1,766	35	0	366	355	0	2,564
TOTAL	6,241	**0**	31,253	3,478	**0**	21,611	1,051	**0**	8,733	10,770	0	61,597

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	3,44,166	3,14,878	4,11,900	1,07,0944
Bancassurance	4,00,455	4,11,252	5,12,820	13,24,527
Other Corporate Agents	1,261	18,769	22,076	42,106
Brokers	55,274	39,082	34,148	1,28,504
Direct selling	82,014	92,151	1,68,822	3,42,987
Others (to be specified)	379	12	524	915
TOTAL	**8,83,549**	**8,76,144**	**11,50,290**	**29,09,983**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	2,741	1,753	1,262	5,756
Bancassurance	12,990	9,406	9,480	31,876
Other Corporate Agents	707	341	326	1,374
Brokers	5,129	3,445	2,898	11,472
Direct selling	3,402	1,501	1,208	6,111
Others (Referrals)	2	0	0	2
TOTAL	**24,971**	**16,446**	**15,174**	**56,591**

4. Root Cause (s) for complaints relating to mis-selling

Broker

- Business sourced through open market rather through relationships or personal network leading to a low customer association and accountability with the sourcing broker.
- High attrition at the Broker shop resulting in frequent churning of existing customers. This leads to ex Broker employees reaching out to customers and misguiding/ instigating them after they join a new Broker.
- Broker (Telesales) channel are more prone to missale

Corporate Agent

Below mentioned are the common modus operandi for Bancassurance sourced polices.

- Insurance policy sold as Fixed deposit
- Insurance policy sold against Loan/ Credit card/ Bank overdraft
- Regular premium sold as single premium

Agency

- High value cases non involvement of line and clarity on premium paying terms (servicing issue)
- Regular premium sold as a single premium

5. Steps taken for ascertaining suitability of insurance product at point of sale

Product and Sales training of Partner and HDFC Life sales staff

Online/Tab based solutions have been extended to sales team, so that the details of the product are transparently explained to the customer at point of sales

The Company has institutionalized a process Pre-Conversion Verification Calling (PCVC) by which the product features and benefits are explained to the customer. The call also alerts the customer to any fraudulent offer (no benefits on another plan can be made against this policy, foreign trip, gold coin, not a special offer made on behalf of any entity – IRDAI, RBI, other Govt agencies). The call urges the customer to raise a concern if any offer or benefit other than what is offered by the product has been promised. The policy is only converted after the customer gives consent to issue the policy after full understanding of the product.

A Suitability Profiler has been introduced for HDFC Bank customers. The profiler takes customer details from bank CRM along with his age, income, etc and identifies appropriate products that are suitable to the customer. This ensures suitable product pitch at point of sale. Any product that is pitched/sold beyond the suggested one- has to be given justification in the profiler and signed off by both HDFC Bank and HDFC Life employees. This is a mandatory requirement for log in

The PCVC conducted for policies sourced by HDFC Bank is made stronger with introduction of specific lines to address to common mis sale points:

This is an insurance product and NOT a bank FD or related to any banking product. In case of regular premiums - categorical mention that premiums have to be paid every year/ every six month etc. This is to mitigate sale of regular premium paying policy as a single premium policy.

Malpractice Matrix

The Malpractice Matrix is an integral part of HDFC Life's Code of Conduct. As an ethics - driven organisation, we realize the importance to have a proactive deterrent in place to ensure that any kind of Malpractice is dealt with, at the right time and with the right action, to ensure minimum adverse impact. The Matrix includes a comprehensive list of malpractices, which we might come across during the course of the Company's operations. Thus, it has been designed to achieve the following objectives:

- To provide a comprehensive framework for monitoring of operational activities
- To take action against the erring parties
- To ensure transparency in dealing with internal and external risks

Fraud awareness initiatives

HDFC Life recognizes that training and awareness is key to any organization as it helps all entities understand their obligations, roles and responsibilities concerning fraud and misconduct management practices within the organization.

The following programs are undertaken to create awareness and create an anti fraud culture in the organization:

1. Mandatory online training for all employees
2. Code of Conduct training
3. Values training
4. Classroom training during surprise branch visits
5. SMS blast to employees and financial consultants

Surprise branch visits

The Risk Monitoring and Control Unit conduct Surprise Branch visits across selected branches of HDFC Life. The branches are selected through a structured mechanism of branch risk rating where various parameters of quality of business logged in a branch are taken into consideration. The primary purposes of this activity are:

1. Maintain a grass-root level oversight of fraud risks
2. Identify actual cases of malpractice as well as unhealthy fraud indicators
3. Spread awareness of Values, policies, and processes of the organization

Data leakage

Data leakage is one of the most severe risks faced across industries today. HDFC Life too realizes the high risk in this area and has taken several measures to protect customer confidential and Company data. Some of the key measures are listed below:

1. Information Security Management System
2. Data Leakage Prevention program

Concurrent audit

A special Concurrent Audit unit has been set up which scrutinizes high risk new business policies and the documents submitted. The objective here is to identify cases of mis-selling and forgery of primarily AML/ KYC documents and other cases of fraud and forgery. Suspected cases of forgery and document tampering are then investigated by the RMCU department in detail and disciplinary action is taken as per Malpractice Matrix. In Concurrent audit process, transactions are audited on T+2 basis (T being transaction date) at pre conversion, post conversion and Claims & payouts stages.

While performing the audits, adherence to process and regulatory compliances are also ensured.

Disciplinary panel for Mal practices:-

A separate panel called "Disciplinary Panel for Malpractices" will decide action to be taken on select malpractice cases. Cases can be referred to the Panel either by RMCU department or the Head of Department of the employees involved in a malpractice case. The Panel will also decide action on such other cases that require clarifications and cannot be closed by RMCU and/or HR basis regular investigation process. Disciplinary Panel would also decide on the actions to be initiated on supervisors, depending upon the number of direct reporters actioned upon and the severity of the cases observed under the supervisor. The Panel comprises of Sr. EVP, Chief Values Officer & Chief Human Resource Officer (Chairperson), Chief Distribution Officer, Chief Values Officer & EVP – Bancassurance, EVP – Audit & Risk Management and Company Secretary & Head – Compliance & Legal. The list of cases for submission to the Panel shall be compiled by RMCU.

Value Ambassadors

Key initiatives are run in the organisation to ensure organisation values (Customer centricity, Integrity, Collaboration, etc) are imbibed across all employees, across locations. The Branch locations across the country are split across multiple senior employees. These 'Value Ambassadors' must own each branch location allotted to him and ensure that a value based culture is imbibed in each branch location. Several initiatives are run locally to support this initiative.

6. Channel-wise controls placed to prevent mis-selling

Broker

- Pre-conversion calling is done to reiterate product features and other relevant details to the customer beforehand
- Analytics is used to understand patterns in mis-selling, regarding particular partner, teams, geography etc. and corrective measures are taken and tracked
- Market intelligence is used to avoid functioning with certain partners/teams
- Strict action like caution, suspending business etc. are taken against partners to set an example
- We have already terminated business with AB insurance broker and RDB insurance broker.
- Partners are pushed to take the above disciplinary actions against defaulters at their end

Awareness is conducted amongst the sales teams regarding consequences of mis selling to deal with the menace at the root itself

Agency

- PCVC and Insta Verify - PCVC inbound calling and Insta Verify app is used for client confirmation on his understanding about the product features like SA , Premium payable , Term of policy and premium paying term , type of product (ULIP / Traditional / Pure risk) , returns / benefit that he can expect from policy etc along with the additional agent / sales person validation with photo-graph in Insta Verify. Without success in PCVC call or Insta Verify app update the proposal do not get converted,
- High due diligence (HDD) by Regional Managers - All high value cases of Rs 10 lac and above , RM is supposed to either meet the client personally or give a phone call and tell client about the product , premium term and emphasize on the premium paying term by explaining the benefit , regional manager signs this declaration and it is kept for the record.
- Thirteen month persistency is linked to KPI at leadership level - All leadership level managers have 13 month persistency as part of their KPI, this is done to ensure the good quality business and 13 month renewal comes to the company. In case of lapse the Circle head / Regional man-agers are supposed to speak to clients / FC s and ensure that the renewal comes to the com-pany. And that there is ownership at leadership level to allow only quality business in the system

Bancassurance

- Suitability Profiler introduced- that pulls customer details from bank CRM along with his age and suitability and throws up product suggestions automatically, This ensure suitable product pitch-ing at POS any product that is pitched/sold beyond the suggested one- has to be given justifica-tion in the profiler and signed off by both bank and our employees. This is to ensure that right product is pitched to right customer. This is a mandatory requirement for log in

2. PCVC made stronger with introduction of specific lines to address to common mis-sale points:

a. This is an insurance product and NOT a bank FD or related to any banking product- (common mis sale modus operendi of selling insurance as bank FD) b. In case of regular premiums - category mention that premiums have to be paid every year/ every six month etc (common mis sale modus operendi of selling RP as SP)

Random calling by banks on high value cases of customers who are of 60 years plus: And in case of any disconnect address the same immediately.

Auditing of 60+ yrs customers by HDFC Bank support team self lead generation (SLG) cases.

60 yrs plus customers with 2 lacs+ premium are separately audited by bank third party product team and obtain supervisory explanation as to why it was sold to such customer and record the same

7 Other Measures taken for addressing mis-selling

- Regular updates to all channels on Business Quality and weak areas (looking at complaints, free look, etc). Action plans to improve the quality of business made and reviewed regularly
- Stringent checks institutionalized at business on-boarding to minimize incidence of missale and fraud
- Several channel-specific initiatives introduced to maintain a check on missale and fraud. For instance, restrictions introduced at Broker channel on sourcing of policies beyond a certain customer age, scrutiny of documents and validation of business sourced conducted by Sales in discussion with the customer.
- Channel Heads involved in end-to-end closure of complaints to ensure sensitization and corrective/ preventive action taken
- Complainant is offered all possible solutions like product change, mode change, refund of few policies out of many, etc. to address his concern to satisfaction
- Misselling is a part of Mal practice matrix of RMCU and there is a regular communication on the actions taken and consequences.
- Most important document form (MID) which contains details of product features and charges is duly signed by the customer giving authorization for issuing of the policy in the proposal stage

8 Procedure adopted for dealing with complaints of mis-selling

- Complaint is acknowledged through letter/email within 3 days of the complaint registered.
- Sales explanation on the concern raised is obtained and analyzed.
- Sales meeting with the customer is also arranged if required during the investigation of a complaint.
- Customer profile like age, education, income and need based product sold is verified while arriving at a conclusion.
- Signatures on the proposal form and documents provided are validated to authenticate probability of mis-sale in the complaint registered.
- Pre-conversion verification call is also heard as part of the missale complaint investigation.
- Complainant is offered all possible solutions like product change, mode change, refund of few policies out of many, etc. to address his concern to satisfaction.
- Final decision concluded in the complaint is conveyed to the customer and also a communication is sent to the customer through letter/email.
- Missale accepted complaints are reported to RMCU department for taking necessary action as per the Malpractice Matrix

9 Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	8	0	57		0	47	2	0	8	10	0	112
Bancassurance	12	0	67	2	0	65	1	0	40	15	0	172
Other Corporate Agents	1	0	2		0	2		0		1	0	4
Brokers	13	0	76	1	0	50	1	0	11	15	0	137
Direct selling	3	0	9		0	6		0	1	3	0	16
Microinsurance agents	0	0	0		0			0		0	0	0
Others (to be specified)	21	0	88	3	0	81		0	15	24	0	184
TOTAL	58	**0**	299	6	**0**	251	4	**0**	75	68	**0**	625

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- HDFC life in its ongoing process for creating awareness amongst its policy holders on dealing with spurious calls have been proactively sending regular Mailers, SMS and have placed instruction on the company website as well.
- We have also updated the Notice Corner link on the Customer Service section of our website www.hdfclife.com to

For complaint received, we follow the below procedure :

1) Contact numbers provided by the customer is investigated
2) If it belongs to HDFC life employees, the number is shared with RMCU unit for necessary action as per Malpractices matrix.
3) Incase the contact numbers does not belong to HDFC life employee, we urge the customer not to act on any such information received in the name of HDFC Life, IRDAI and/ or anyone else as HDFC Life will not indulge in such unethical practices to solicit business. We have also updated the Notice Corner link on the Customer Service section of our website www.hdfclife.com to create awareness of this issue faced by the insurance industry, as a whole.

11. Steps taken by the insurer to caution members of public about spurious calls

- Awareness created among the customer through brochures about spurious call.
- Awareness through advertisements online
- Awareness created by mentioning about spurious call in policy documents
- Mailers sent to the customers
- Awareness about spurious calls are mentioned in the website
- SMS sent to the customer.

12 Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	13-14	14-15	15-16	13-14	14-15	15-16	13-14	14-15	15-16	13-14	14-15	15-16
Individual Agents	208	135	290	38	110	296				3,11,20,789	41,59,463.47	6,27,085.8
Bank Assurance Agents/Employees								3	3	9,73,55,452	6,40,92,614	1,13,18,740
Other Corporate Agents										0	0	0
Brokers							2		2	57,637.58	4,62,252.28	32,99,373
Employees of Insurer	784	649	701	132	170	204			1			
Others							182	96	87	1,23,53,552	201391.49	3,53,069.3
Total	992	784	991	170	280	500	184	99	93	14,08,87,431	6,89,15,721.2	1,55,98,269

Notes: Below mentioned criterion were considered while preparing the report

- Action taken on proven fraud cases identified, investigated and, closed in the financial years, as stated, are included
- Cases where customers or policies have been affected due to proven malpractice have been included in the report
- Other cases where customers have not been affected like cases violation of internal Company procedures have not been considered for the purpose of this reporting
- Action taken by Company on its employees and individual agents have been included in this report
- Action taken by Channel Partners (for channels like Bancassurance, Broker, etc.) has not been included in this report as the Company does not have a mechanism to validate such information.

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : ICICI Prudential Life Insurance Co. Ltd

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	530	128	1096	205	101	885	168	49	521	903	278	2502
Bancassurance	727	120	1585	472	110	1798	797	147	2192	1996	377	5575
Other Corporate Agents	127	45	424	51	34	420	65	36	337	243	115	1181
Brokers	1039	290	3321	109	62	948	55	20	340	1203	372	4609
Direct selling	501	83	1014	198	30	526	171	29	403	870	142	1943
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	7	5	6	2	13	6	0	8	10	9	26	22
TOTAL	2931	671	7446	1037	350	4583	1256	289	3803	5224	1310	15832

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	202,298	149,382	149,435	501,115
Bancassurance	213,448	255,226	290,634	759,308
Other Corporate Agents	204,884	130,786	29,865	365,535
Brokers	53,925	27,265	35,461	116,651
Direct selling	104,093	63,772	74,901	242,766
Others (to be specified)	0	12,369	0	12,369
TOTAL	778,648	638,800	580,296	1,997,744

FY2015- Microinsurance Agents included in Others. No Business sourced through Microinsurance Agents Channel in FY2016

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	5,751	2,829	1,980	10,560
Bancassurance	11,655	9,539	7,319	28,513
Other Corporate Agents	1,160	912	734	2,806
Brokers	4,881	1,306	778	6,965
Direct selling	2,300	1,295	1,381	4,976
Others (to be specified)	0	0	0	0
TOTAL	25,747	15,881	12,192	53,820

4. Root Cause (s) for complaints relating to mis-selling

The broad reasons relating to mis-selling are listed below.

1. Communication and understanding gaps between the sales person and the policyholder
2. Product differs from what was requested or disclosed
3. Proposed insurance not in the interest of proposer
4. Regular premium policy sold as single premium policy
5. Misappropriation of premium
6. Illegitimate inducements offered
7. Malpractices or unfair business practices
8. Intermediary did not provide material information concerning proposed cover
9. Advice concerning exclusions/limitations of cover not communicated
10. Poor disclosures of various Charges

5. Steps taken for ascertaining suitability of insurance product at point of sale

We believe that it is extremely important to guide a customer in selecting a product that suits his/ her needs and requirements of life stage. We have various systems and processes to ensure that the customers are well informed about the product that they chose to buy.

Following are some of the measures to ensure that suitable product is offered to the customer:

a. We have a tool called 'What's good for me – Financial planning in 3 easy steps' which asks the customer 3 simple questions pertaining to his life stage, financial goals and risk appetite. Based on his/ her responses, the tool suggests one or more suitable product(s). This tool is available directly to customers on our website, as well as to our sales teams, who effectively use as a pre-sales tool to aid customers. Further, we have embarked on a journey of digitisation where the Sales persons are increasingly using tablets or similar online platforms for sale of policies. The work flow has the above mentioned tool built in, and the customer has the visibility and option of the suitability analysis tool prior to filling up the online application form.

b. The Company has a robust induction training module through which our frontline sales force and partners get trained on need analysis and gap analysis, in order to advise and meet the customer needs and suggest suitable products. Also, most of our product training modules identify the target customer segment for each product in order to help the sales teams sell the suitable products to customers.

6. Channel-wise controls placed to prevent mis-selling

The Company has put in place the following controls in the process of issuance of a policy.

Agents:

The Company is focused at driving the importance of right selling and has also made persistency as one of the key factors in determining the performance of the agent.

Corporate agents and Bancassurance:

I. **ICICI Bank:** Pre–login verification calling is done/accepted from the prospect/policyholder's registered mobile number before logging the case to verify the details of the product opted by the customers and explain the policy features. Wherever pre-login calling is not possible, calling is done by the Company at the pre issuance stage.There is an inbuilt control mechanism which ascertain the risk preference and to enables the customer to choose a suitable investment product.

II. **ICICI Securities:** In-house calling is done before login for all the policies sourced by them**Brokers:** Pre-login verification calling is done by brokers(selective) for verifying the factual information mentioned in the proposal form and explaining the features of the product

Direct selling: No cash payment accepted at proprietary sales business effective December 1, 2014. The Company doesn't accept cash premium payment in any of its branches effective August 01, 2015.

Others:

Pre-issuance controls:

a. We update the policy status to policyholders through SMS at all the relevant milestones - on receipt of the proposal form, intimation on issuance of policy and dispatch of the policy document.

b. On issuance of policy, we send SMS mentioning key policy details so as to reinforce key aspects of the policy purchased

Post – issuance controls:

a. The Company practices profile based calling that is done to policyholders, based on certain criteria (age etc) to educate on key aspects of the policy purchased, e.g., premium term, lock-in period, etc.

b. Electronic policy documents sent along with product feature videos (selected products) are sent to the policyholders on their registered email ids.

c. We send SMS and emails to all our policyholders, to exercise caution on fake and spurious calls claimed to be made on behalf of the Company, Regulator and other Government agencies.

Policy document:·

- The cover of the policy document clearly mentions the policy term and maturity term for certain segments of products.
- Know your policy features (policy highlights) is sent long with the policy document. It is a document which explains the key features of the policy in a simple language.
- The covering letter to policy document mentions the contact details (call centre number, email id) of the Company. It also mentions the freelook option and its time lines.

7. Other Measures taken for addressing mis-selling

The Company consistently works to promote education about benefits of life insurance and buying right. With the right education, consumers will be aware about key policy features and other important facts while buying and incidents of mis-selling are reduced. Various initiatives are being conducted amongst rural and urban consumers. On-ground programs like workshops, street plays and school programs have helped reach rural consumers. Special corporate events were carried out for women, factory workers and employees in leading companies. Other mediums used were news articles by senior management, product collaterals (brochures, leaflets) and customer e-mailers. Digital channels like website, social media posts, Whatsapp messages and simplified content on the internal sales channel (iNeo+) also helped drive awareness about life insurance. The key messages that were covered:

- Key features and benefits of ULIPs
- Importance of knowing premium paying term, charges on your policy, life cover and maturity benefit
- Benefits of staying invested and paying premiums regularly
- Being cautious about fake/spurious calls
- Why adequate protection through life cover is important
- How one can achieve life goals through life insurance.

8. Procedure adopted for dealing with complaints of mis-selling

We approach every mis-selling complaint with high sensitivity and strict actions are taken for all proven cases.

The Company does complete investigations on the complaint by reviewing the facts available and seeking views from the distribution channels. The resolution is conveyed to policyholders through letter/email.

The Company has initiated actions on the intermediaries on the basis of investigation of mis-selling complaints. The Company continues to engage and sensitise brokers and corporate agents regarding mis-selling instances reported from their end. We accordingly engage with the top management of certain distribution partners having high incidence of mis-selling complaints and sensitize them regarding the matter.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	23	0	2	1	0	3	0	0	0	24	0	5
Bancassurance	4	0	0	0	0	0	4	0	0	8	0	0
Other Corporate Agents	3	0	1	0	0	2	0	0	0	3	0	3
Brokers	126	6	22	7	2	29	0	0	0	133	8	51
Direct selling	20	0	2	2	0	0	0	0	0	22	0	2
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	176	6	27	10	2	34	4	0	0	190	8	61

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

"Spurious call complaints are also handled with high sensitivity and actions are taken for all proven cases. The Company does complete investigations on the complaint and resolution is conveyed to policyholders through letter/email.

We have disassociated with tele-calling partners involved in spurious calling. The Company has filed police complaints against entities indulged in doing spurious calling. Further, the company has also filed complaints with Economic Offences Wing against certain entities.

The Company has been using offices of Telecom Enforcement and Resource Monitoring Cell (TERM)-Department of Telecommunication highlighting cases where the calling lines were issued basis fraudulent KYC. It has also highlighted cases to TRAI where 140 series numbers are doing fake calls. The authorities have been penal actions against such erring entities"

11. Steps taken by the insurer to caution members of public about spurious calls

The Industry has been facing the menace of spurious calls to misguide policyholders in name of Regulator or advising them to surrender the existing policies and buy new policies under pretext of bonus.The Company has taken below initiatives to proactively educate our policyholders and safeguard them from such malpractices.

a) Regular policyholder awareness done on spurious calling through periodic emails and SMS, educating them to safeguard their policy information

b) We have a page on the Company website mentioning fraud prevention tips for general public which also educates on spurious calls

c) We have also updated the Authority's public notice in the Company's website

"Stay Alert" messages are updated in most letter communications sent to policyholders, such as renewal premium notices, unit statements etc, Company insurance advertisements carry disclaimer on the spurious calling issue as per the circular issued by the Authority.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	283	191	91	353	310	165	2	17	24	438	359	211
Bank Assurance Agents/Employees	3	6	6	9	23	5	0	0	0	623	596	935
Other Corporate Agents	0	0	0	0	0	0	0	1	0	94	78	77
Brokers	291	9	0	22	21	0	5	0	0	998	246	92
Employees of Insurer	132	67	73	66	111	43	10	7	5	0	195	122
Others (Spurious Tele-callers)	0	0	0	0	0	0	56	61	74	0	0	0
Total	709	273	170	450	465	213	73	86	103	2153	1474	1437

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : IDBI Federal Life Insurance Co Ltd

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	51	-	215	26	-	107	37	-	97	114	-	419
Bancassurance(Includes IDBI Bank, Federal Bank and CSF)	65	-	208	174	-	58	77	-	189	316	-	455
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	
Brokers	-	-	-	-	-	-	1	-	2	1	-	2
Direct selling(DSF)	15	-	79	79	-	34	32	-	64	126	-	177
Microinsurance agents	-	-	-	-	-		-	-		-	-	
Includes Invalid Complaints	-	-	-	-	-	1	-	-	-	-	-	1
TOTAL	**131**	**-**	**502**	**118**		**361**	**147**	**-**	**352**	**557**	**-**	**1054**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	25198	20082	18022	63302
Bancassurance	80273	63452	85188	228913
Other Corporate Agents	67	9	0	76
Brokers	17	507	3023	3547
Direct selling	4751	4498	2693	11942
Others (to be specified)	0	0	0	0
TOTAL	**110306**	**88548**	**108926**	**307780**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	546	339	245	1130
Bancassurance	955	778	1053	2786
Other Corporate Agents	-	-	-	-
Brokers			18	18
Direct selling	166	144	77	387
Others (to be specified)	-	-	-	-
TOTAL	**1667**	**1261**	**1393**	**4321**

4. Root Cause (s) for complaints relating to mis-selling

- The customer complaints are beyond the freelook period.
- Ignorance of pre-issuance calling/welcome calling confirmation of policy terms.
- Financial Problems/incapacity to pay future premiums·
- Change in mind set.
- Misunderstood the product features
- Ex-Employee/Advisors instigating the customers to allege misselling.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Need Assessment form is mandatory at the time of sale
- Pre-issuance/ Post- issuance calling is done to the customers to verify the details
- Continuous training is imparted to sales person of the product and right technique of the selling
- Penal action is taken on the sales persons, who are identified to be involved in mal practices

7. Channel-wise controls placed to prevent mis-selling (same as point no. 5)

Agents : Corporate agents **Bancassurance:**

Brokers : Direct sellingOthers

8. Other Measures taken for addressing mis-selling

- Every complaint that is received is treated based on its merit.
- Every case is properly scrutinized, investigated and the finding is documented by our concerned team based on which decisions pertaining to the complaint are taken by the management.
- In cases where misselling is established appropriate actions is taken against the concerned individuals and resolutions are provided to the customers.
- In cases where misselling allegation is not established the customer request is rejected and the closure letter is sent to the customer and Ombudsman list is also sent to the customers so that they can approach ombudsman in case they are not satisfied with the company resolution.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	1	-	-	1
Bancassurance(includes CSF channel too)	-	-	-	-	-	-	-	-	5	-	-	5
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	4	-	-	4
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-	-	-	10	-	-	10

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

As per the IRDAI circular dated 31st Jan 2016 the company has initiated the below process for spurious call cases :

- We are registering a complaint with TRAI on behalf of the complainant enclosing a copy of the complaint received from the complainant
- We are also sending a copy of the complaint lodged with TRAI to the complainant and advising him to follow up the matter further with the concerned authorities.
- Incases where there is a financial transaction done with the third party we are referring the complaint to RBI with the request to track the financial transaction and also sending a copy of the complaint lodged with RBI to the complainant and advising him to allow up the matter further with the concerned authorities.

11. Steps taken by the insurer to caution members of public about spurious calls

1. Details are updated on IFLI general public site.
2. SMS and Email cautioning the customers on spurious calls are sent on a regular basis to all policy holders.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	5	3	4	0	1	7	0	0	2	0	0	0
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	1	0	0	0
Other Corporate Agents	0	0	0	0	0	1	0	0	0	0	0	0
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Employees of Insurer	5	5	8	0	0	9	0	0	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	0	1	0	0	0
Total	10	8	12	0	1	16	0	0	4	0	0	0

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : INDIAFIRST LIFE INSURANCE CO. LTD.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	38	0	71	24	10	43	34	11	24	96	21	138
Bancassurance	168	12	283	216	36	264	324	50	223	708	98	770
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	0	4	0	2	1	1	4	5	1	6
Direct selling	9	0	6	0	0	0	3	0	0	12	0	6
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	0	1	1	0	1	1
TOTAL	**215**	**12**	**360**	**244**	**46**	**309**	**362**	**63**	**252**	**821**	**121**	**921**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	11116	7781	6605	25502
Bancassurance	71645	74352	80882	226879
Other Corporate Agents	0	0	1	1
Brokers	2055	3783	1803	7641
Direct selling	5200	4857	4015	14072
CSC	0	2029	1696	3725
TOTAL	**90016**	**92802**	**95002**	**277820**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	105	80	90	275
Bancassurance	457	384	695	1536
Other Corporate Agents	0	38	0	38
Brokers	17	33	21	71
Direct selling	3	0	6	9
CSC	0	0	3	3
TOTAL	**582**	**535**	**815**	**1932**

4. Root Cause (s) for complaints relating to mis-selling

- Lack of product knowledge and benefits in sales executives
- Customer Need Analysis not done to ascertain the requirement of the customer.
- Non-Disclosure of the terms and conditions by the sales executives

5. Steps taken for ascertaining suitability of insurance product at point of sale

- As a part of the on-boarding process we have included the Customer Need Analysis process in our application processing system. This module analyze the customer profile, assets, liabilities and other investment portfolios and recommends an insurance plan suitable to the customer.
- Product Audio Visual presentation is shown to the customer in regional language as a part of the onboarding process.
- Product Leaflets have been made available in regional languages.
- Our Sales Executives have also been trained on financial management to identify the need of the customer.
- Introduced an interactive e-learning and onboarding module where sales executivesare trained and certified on all our products on regular basis.
- Conduct regular Test/Quiz and Games around the products to disseminate the product related benefits and its features.

6. Channel-wise controls placed to prevent mis-selling

Agents/Corporate agents– Meetings and trainings conducted for agents by IndiaFirst representative on regular intervals.

Bancassurance– Product training given to Bank Staff on regular intervals.

Brokers - Regular reiteration on products features and benefits and regular visits of Business Managers to every agency for assistance.

Direct Selling – Extensive training and Certification done to each personnel as an onboarding process.

7. Other Measures taken for addressing mis-selling

- As a common process we have made Verification/Welcome Calling mandatory for all policies sourced, where the customer is explained about the all the features and benefits of the policy in the customers preferred language.

8. Procedure adopted for dealing with complaints of mis-selling

- Welcome / Verification call details are considered.
- All other customer interaction including renewal calling remarks are thoroughly investigated.
- Sales feedback is taken on case-to-case basis.
- Policy Documentdelivery status is verified
- Customer’s over all profile like Education/ Qualifications, Income, Occupation etc. is analyzed
- Any previous complaint pertaining is also checked.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise

Source	2013-14			2014-15			2015-16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	3	0	0	3	0	0	6	1	0	12	1	0
Bancassurance	82	0	3	171	1	2	543	1	6	796	2	11
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	0	0	0	0	1	0	0	1	0	0
Direct selling	0	0	0	0	0	0	2	1	0	2	1	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	0	0	0	1	0	0	1	0	0
TOTAL	**85**	**0**	**3**	**174**	**1**	**2**	**553**	**3**	**6**	**812**	**4**	**11**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- Call the customer to educate and understand the concern.
- All the required details such as Hoax caller name, phone number and location is obtained from the customer.
- Details of the same shared with compliance team for further action, if required.
- Reiterate the plan features and company background to build credibility and confidence in the customer.
- We also communicate the procedure for logging a complaint with TRAI in case of future instances or lodge a FIR if necessary.
- If the customer has remitted any money to the third party (hoax callers), we register a complaint with TRAI and RBI on behalf of the customer.

11. Steps taken by the insurer to caution members of public about spurious calls

To create awareness following steps are taken:

- Hoax awareness message is mentioned in Anniversary Statements, Renewal Premium Receipts in English as well as Hindi
- SMS and Email communication Hoax awareness is being sent to the customer on regular intervals.
- Voice message is being broadcasted to customers in multiple languages e.g. Hindi, English,Gujarati,Tamil,Telugu, Kannada and Malayalam as per the geographical location.
- Hoax awareness is also mentioned in all our promotional communications.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	-	-	9	-	-	11	-	1	-	61	7	-
Bank Assurance Agents/Employees	2	1	-	3	1	-	1	-	-	104	73	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	3	-
Employees of Insurer	-	-	1	-	-	1	-	-	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	1	-	-	-
Total	**2**	**1**	**10**	**3**	**1**	**12**	**1**	**1**	**1**	**165**	**83**	**0**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Kotak Mahindra Old Mutual Life Insurance limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	253	-	980	181	-	925	236	-	529	670	-	2434
Bancassurance	135	-	423	112	-	378	205	-	390	452	-	1191
Other Corporate Agents	211	-	955	74	-	553	67	-	270	356	-	1774
Brokers	304	-	1256	131	-	756	100	-	319	537	-	2329
Direct selling	128	-	639	105	-	398	60	-	195	294	-	1231
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others-No policy number	1	-	35	0	-	17	3	-	6	4	-	58
TOTAL	**1032**	-	**4288**	**603**	-	**3027**	**671**	-	**1709**	**2306**	-	**9024**

***105 complaints are pending to be closed within TAT as on 31st March 2016. Therefore the decision on these complaints is not included in the above table.*

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	67054	83349	111493	261896
Bancassurance	38703	51810	90075	180588
Other Corporate Agents	7439	2812	3413	13664
Brokers	15259	13517	8700	37476
Direct selling	31505	34763	46191	112459
Others (to be specified)				
TOTAL	**159960**	**186251**	**259872**	**606083**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	2092	1981	2896	6969
Bancassurance	1225	1535	3080	5840
Other Corporate Agents	639	327	305	1271
Brokers	1406	1026	626	3058
Direct selling	607	493	477	1577
Others (to be specified)	0	0	0	0
TOTAL	**5969**	**5362**	**7384**	**18715**

4. Root Cause (s) for complaints relating to mis-selling

- Low level of understanding of financial products by customers
- Greed of customers coupled with inducements by Agents to increase Sales which results into such grievances when the promised benefits are not received
- Customers treat insurance as short term investments and expect early returns and exits
- Movement of Agents and employees to other companies leading to instigation of clients

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Documented Sales Process for need identification.
- Product Suitability Check for all products.
- Pre-issuance calling and welcome calling post issuance to the customers.
- Deploying Technology for sale by launching end to end solutions which includes clients need analysis, clients profiling and product suitability including final recommendation of product and eventually sales fulfillment.
- Regular training to agents on sales process and products.

6. Channel-wise controls placed to prevent mis-selling

Agents

- Compulsory training for agents
- Defined selection and recruitment process for all LA.
- Mandatory predefined training on Products and processes given to sales force.
- Implementation of Malpractice Matrix for all channels
- Monthly review by Sr. Management on Mis-selling case & action plan to mitigate it.

Corporate Agents

Bancassurance

Brokers

Direct selling

Others

7. Other Measures taken for addressing mis-selling

Proactive / Preventive Measures

- Continuous training of employees
- As a process control any overwriting on proposal forms is not accepted unless the full signature of the client is obtained· All policy documents are directly sent to clients registered address
- Email alerts and SMS alerts are triggered on every action on proposal/policy
- Customer awareness program has been initiated through emailers and sms alerts in general interest of customers.
- In-house welcome call is done for certain channels and business criterion where incidents of malpractices are high. Various important details in the policy are confirmed to ensure understanding of policy terms

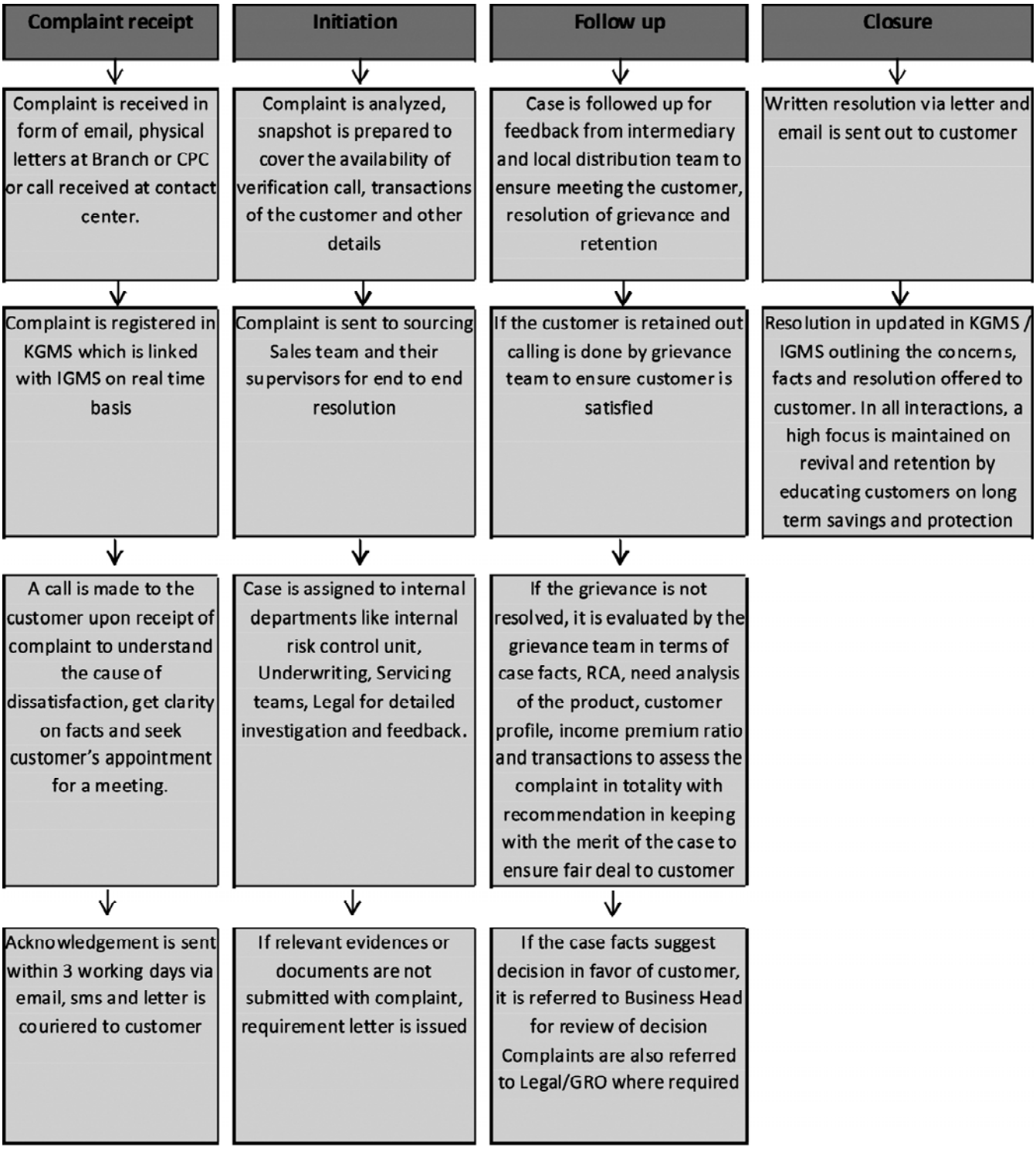
- Pre Conversion Verification Call to clients post login and pre-conversion to verify policy details for certain channels and business criterion to clarify policy details before the proposal is converted.
- High emphasis is given to persistency in rewards for Sales team, this will ensure that the policies are sold on proper and long term advice. A dedicated unit called the Business Retention and Excellence has been set up for improvement in business quality by way of increasing persistency and client retention thereby emphasizing Protection and Long Term Savings for clients.
- Public Notice released in Hindi in National Daily - Dainik Jagran PAN India for awareness on spurious calls and renewal cash remittance only at KLIFE branches.
- We have restricted specific mobile numbers enquiring on multiple policies of unrelated customers and blocked them on IVR at the contact center so that confidential information of customer is not available to such customers and customer's interest is safeguarded.
- We have been continuously alarming customers to beware of such callers recommending premature withdrawals (full/partial) on their policies ·
- We propose to make signature proof mandatory with application form for verification

Remedial measures (Implemented)

- Policy holders protection committee actively monitors channel wise, region wise complaints and top 5 defaulting areas are taken into discussion and action plan
- Internal Committee has been formed in April'12 with stakeholders from Sales, Operations, Customer Care and Compliance to monitor the Sales quality and drive reduction of complaints in terms of miss-selling and forgery. The steering committee brain storms solutions basis root cause analysis of complaints, monitors the action plan, measures progress of implementation and thereby enables reduction in complaints
- Formation of special committee comprising of Sales Head and Ops Head for root cause analysis and implementation of action plans which ensure correct sales and thereby reduction in complaints for new business sourced
- Regular sharing of MIS with Sales Teams to monitor their performance – Daily/Fortnightly
- Accountability brought in for complaints at every level
    - Target to Sales teams to reduce complaints for their channel/partners
    - Complaints included as a parameter for Sales Scorecards
    - Review of complaints as a standing matter at Sales review meetings - Weekly/ Monthly/ Quarterly meeting
    - High emphasis is given to persistency in rewards for Sales team
- Customer Care team being empowered to discharge cases in favour of the customer basis merit of the case (post approval from Sales/Ops Head)
- Complaints management team strengthened to discharge cases promptly and aim is to reduce TAT from 15 days to 12 days.
- Stern action against agents/Sales team where miss-selling is proved as per the approved Matrix
    - We have stopped sourcing new business from few top agencies in terms of malpractices
    - Termination of erring agents, corporate channels and brokers
    - Employees involved in such unethical practices are dealt with severely

- Action taken includes the following• Counselling by Branch Manager and above
  - Warning letters
  - Stern action including Resignation or Termination
  - Punitive action is decided by the fair play committee and depends on case to case basis
- It may also include filing of criminal complaints wherever appropriate

8. Procedure adopted for dealing with complaints of mis-selling



9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-	-	-	-	-	-	-

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Upon receipt of a complaint case, the contact numbers of callers shared by the customer is traced We try to trace address of the caller and check if the caller is from Insurance back ground. Further we match the number with our data base of employees/agents and if found, we take action as per the malpractice matrix.

We explain to the customer about the importance of filing the complaint against the number with TRAI.

Further we also assist the client to file an FIR against the caller.

11. Steps taken by the insurer to caution members of public about spurious calls

Kotak Life Insurance is continuously making attempts to reach out to its customers through different modes of communication like SMS, Emails and the Print Media to prevent customers from falling prey to spurious calls, fictitious offers and cash defalcation.

1. SMS are sent to all customers periodically on their registered mobile numbers
2. As a part of the customer education series, various emails have been sent to customers on their registered email ids, the content of which is available on our website http://insurance.kotak.com/policy_holder/pdf/beware_of_malicious_emails_and_unsolicited_calls.pdf
3. Notices in both English and Hindi have been affixed in each of our branch offices on the customer notice board
4. Public Notice released in June 2015, in a publication called Daily Thanthi & Dinakaran & Dinamani (Tamil News Paper), article which was published in newspaper alerting customers about a fake life insurance agency office who called unsuspecting customers with promises of travel to Goa and bonuses on investment in name of Kotak and also had opened a fraud office in name of company in Thiruvarur region. Police arrested the suspect and seized the office and seized Rs 3 lakhs rupees.

5. Public Notice released in June 2015, in a publication called Daily Sakal, Pudhari & Lokmat (Kolhapur Edition). An article was published in newspaper with the help of the investigating agency alerting customers in Kolhapur region on life insurance policies which was sold to people who were deceased before the risk commencement date of policy. A police complaint was filed with the help of our investigation agency in this case and Police has arrested Agent, Doctors and Sales officials of A Leading Life Insurance company who were instrumental in issuing Policy in the name of a person who died 12 years back. And also the suspected policies of Kotak Life were added to the complaint so that customers in touch with accused who fronted as agents were made aware of the dangers fraught with such insurance.
6. Formation of special committee comprising of Sales Head and Ops Head for root cause analysis and implementation of action plans which ensure correct sales and thereby reduction in complaints for new business sourced
7. A disclaimer alerting customers regarding spurious calls is incorporated on marketing communication
8. Awareness spread among existing customers via emailers & the Hello Life magazine in the form of 'Customer Education'.For prospects we have used social media to spread awareness via Facebook

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	99	186	142	9	100	82	1	2	0	1755	354	232
Bank Assurance Agents/Employees	0	42	39	0	0	0	0	0	2	0	175	201
Other Corporate Agents	118	89	62	5	0	0	0	0	0	14	133	63
Brokers	214	185	141	0	0	0	1	0	0	4	357	119
Employees of Insurer	95	164	177	7	37	51	1	3	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	9	5	3	1*	1*	0
Total	526	666	561	21	137	133	12	10	5	1774	1020	615

*Pertains to Referral commission

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Life Insurance Corporation of India.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	287	22	11	244	12	15	169	6	9	700	40	35
Bancassurance	4	2		1	1		2	1		7	4	
Other Corporate Agents	4			1	2		3			8	2	
Brokers	1			9			1			11		
Direct selling	3			5			4			12		
Micro Insurance Agents	1			1						2		
Others (Where policy no. not given of wrongly given)	42		2	19	1	1	32	2	3	93	3	6
TOTAL	**342**	**24**	**13**	**280**	**16**	**16**	**211**	**9**	**12**	**833**	**49**	**41**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16 (Provisional)	
Individual Agents	33872757	19305747	19712599	72891103
Bancassurance	427144	313173	250659	990976
Other Corporate Agents	57605	38988	40443	137036
Brokers	1822	810	699	3331
Direct selling	121102	78832	59832	259766
Micro Insurance Agents	2205820	400341	452291	3058452
TOTAL	**36686250**	**20137891**	**20516523**	77340664

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 - 16(Provisional)	
Individual Agents	63950	41501	27997	133448
Bancassurance	1362	1279	619	3260
Other Corporate Agents	186	137	71	394
Brokers	13	6	5	24
Direct selling	658	606	216	1480
Others (Micro Agents)	1496	728	1100	3324
TOTAL	67665	44257	30008	141930

4. Root Cause (s) for complaints relating to mis-selling

Under Unfair Business Practices category, the following sub categories are considered as mis-selling.

- Product differs from what was requested or disclosed.
- Proposed insurance not in the interest of proposer
- Premium paying period projected is different from actual
- Term of the policy is different / altered without consent
- Single Premium policy is issued as Annual premium policy
- Intermediary did not provide material information concerning proposed cover.

During our analysis, we observed that the complaints not falling under the above category / sub-categories are also registered by the policyholder / complainant..

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Sales literature on various products is published by the Corporation to provide the salient product features to help the customers to understand and select the appropriate product.
- Benefit illustrations are provided as per IRDAI guidelines to the prospects/policyholders.
- Training is imparted by the Corporation to its market intermediaries regularly with a purpose to sensitize the intermediaries to the needs and financial goals of the prospects. This can ensure that the prospective customers are fully informed about the unique selling proposition (USPs) of various plans in general and ULIP plans in particular.
- Besides, the web-site of the Corporation provides exhaustive information on the products offered for sale for the benefit of the prospective customer.

6. Channel-wise controls placed to prevent mis-selling

Agents: Training & Information sharing to the Agents/market intermediaries through in-house training centres, seminars, meetings etc.

Corporate agents: Training classes are conducted.

Bancassurance: Training classes are conducted.

Brokers: Training classes are conducted.

Direct selling: Training classes are conducted.

Customer : Cooling off option is provided in case of dissatisfaction regarding the plan.

7. Other Measures taken for addressing mis-selling

- Issue of instructions / circulars related to the procedures/guidelines/rules laid down by the IRDAI for creating awareness amongst the agents and for necessary implementation
- Information sharing by conducting meetings, seminars, conventions and any other informal forum.

- The functions and code of conduct to be followed by all the agents of the Corporation are specified in the newly formulated appointment letter based on the IRDAI guidelines.
- Disciplinary action is also initiated as per the rules governing the agents for violation of the prescribed functions.
- LIC has issued a comprehensive circular Ref. CC/Advt-reg/2014 dated 09.10.2014 regarding norms to be adhered to in regards to our advertisements as per IRDA guidelines.

8. Procedure adopted for dealing with complaints of mis-selling

On receipt of complaints about misselling, following broad steps are taken:

- To resolve the matter over discussion or correspondence to the satisfaction of both, viz., the complainant and the intermediary by the Competent Authority at the branch level.
- A cooling-off option provided to the customer in case of dissatisfaction regarding issuance of the plan.
- If the complaint is severe in nature and cannot be resolved to the satisfaction of the complainant, an enquiry is initiated to evaluate the facts about the case.
- On the basis of the report and the fact finding of the Reporting/Reviewing Officer/s, the further course of action is decided.
- If the intermediary/s is found involved, suitable action is initiated as per the governing rules.
- The final decision is conveyed to the complainant in a suitable manner

Our offices are verifying the complaints registered in Unfair Business Practices under mis-selling category to ascertain whether the complaint is actually related to mis-selling. In all such identified cases, an investigation is instituted to know whether it is case of mis-selling. Based on the outcome of the investigation report, a suitable action is initiated against the concerned Agent / Development officer. Otherwise informed the complainant accordingly.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents												
Bancassurance												
Other Corporate Agents												
Brokers												
Direct selling												
Microinsurance agents												
Others (to be specified)												
TOTAL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Though complaints are reported to our various offices on spurious calls, there are no cases of policy issued after receipt of spurious call.

In case, policy is issued after receipt of the spurious call complaint, a proper investigation is to be done by our Marketing Deptt. and suitable action to be initiated against the erring agent / Development officer.

11. Steps taken by the insurer to caution members of public about spurious calls

We have been educating our customers/general public cautioning them not to fall prey to apparently lucrative benefits through various means as below:-

- Our website www.licindia.in contains a display on Dos and Don'ts on Spurious Calls.
- We have published Newspaper Advertisements on 31.12.2012, 9.04.2013, 7.11.2013 and 29.03.2015.
- In all our advertisements, we have put a note cautioning general public for spurious phone calls/e-mails and fictitious/fraudulent offers.
- We have sent 1.06 Crore SMSs during the month of December, 2015 to all our existing customers whose details are available with us. Similarly 42.42 lac SMS' had been sent in March, 2014 and 61.75 lac bulk e-mails were sent in March, 2015 to our customers.
- Advertisement on Internet Sites had been made during March, 2015 -IBM LIVE, First Post, IRCTC, Rediff.
- An all India awareness campaign through FM Radio cautioning members of public against falling prey to spurious calls has been made in March, 2016.

As instructed by IRDAI a 'Policy on handling Spurious call complaints' has been framed with an objective to set a uniform procedure to be followed at all levels in the Corporation for dealing with such complaints.

- On receipt of such complaint, the respective office after acknowledging the complaint sends a reply to the complainant and cautions him against entertaining calls from unverified sources or part with any information about his/her policy number as well as any personal information like PAN Number, Aadhar Card Number, Address etc.
- Complainant is advised to lodge Police Complaint and register a complaint with TRAI.
- The intimation about spurious calls is also sent to TRAI by our Customer Relationship Management Department.
- There is a Committee at Central Office for analyzing such spurious call complaints and as per the recommendations of the Committee, necessary action has been taken.
- After investigation, if it is found that the source belongs to some other Insurance Company; complaints providing full details are sent to IRDAI. We have sent letters to IRDAI on 27.10.2015 and 24.02.2016 enclosing complaints.

- On investigation, it is observed that in most of the complaints, fake callers were from Delhi, Letters to Police Commissioner, Delhi were sent on 07.09.2015, 27.10.2015, 06.01.2016 and on 24.02.2016 enclosing the mobile number/landline number and other relevant details of spurious calls.
- Pursuant to our Complaint to Police Commissioner Delhi, a number of fraudsters have been arrested and have been appeared in prominent dalies as below:-
  a) Times of India (Delhi Edition) on 19.09.2015 & 20.09.2015.
  b) Times of India and Nav Bharat Times (Delhi Edition) on 22.12.2015 – Arrest of two fraudsters by Delhi Police.
  c) Times of India and Nav Bharat Times (Delhi Edition) on 13.01.2016- Arrest of 3 fraudsters by Delhi Police.

Amar Ujala (Bareilly Edition) on 06.02.2016 – Arrest of 40 fraudsters by U.P. Special Task Force.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	36	36	17	80[1]	59[1]	48[1]	-	1	1		2	1
Bank Assurance Agents/Employees												
Other Corporate Agents												
Brokers												
Employees of Insurer												
Others (Spurious Tele-callers)									4[2]			
Total	36	36	17	8	7	7	-	1	4	-	2	1

1. *The above includes cases where action has been taken against Agents in respect of Repudiated Claims, Suppression of Material Facts, Fraud, Black Listed and other reasons.*
2. *Four Police complaints against spurious callers comprising 353 complaints*

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Max Life Insurance Company Ltd.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	2021	146	1522	527	171	1046	350	236	776	2898	553	3344
Bancassurance	1210	59	1101	851	139	1348	556	316	1342	2617	514	3791
Other Corporate Agents	712	59	681	81	33	198	64	62	131	857	154	1010
Brokers	235	31	236	208	108	567	78	73	203	521	212	1006
Direct selling	194	12	170	61	11	120	40	26	83	295	49	373
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	63	2	40	25	2	63	35	11	56	123	15	159
TOTAL	**4435**	**309**	**3750**	**1753**	**464**	**3342**	**1123**	**724**	**2591**	**7311**	**1497**	**9683**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	193347	164553	160357	518257
Bancassurance	238666	255359	249099	743124
Other Corporate Agents	73997	37824	17366	129187
Brokers	1035	137	-90	1082
Direct selling	18919	32096	33336	84351
Others (to be specified)	121	0	0	121
TOTAL	**526085**	**489969**	**460068**	

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	1311	1111	1317	3739
Bancassurance	3324	4765	5392	13481
Other Corporate Agents	368	347	163	878
Brokers	46	3	24	73
Direct selling(including Internet Sales)	92	129	63	284
Others (to be specified)	0	0	0	0
TOTAL	**5141**	**6355**	**6959**	**18455**

4. Root Cause (s) for complaints relating to mis-selling

- At an attribute level, top 3 mis-selling complaints comprise of- incorrect premium payment tenure, Incorrect policy benefits and incorrect policy information (charges, mode, premium etc.)
- Agent attrition seems to be causing complaints. For e.g. many complaints are received on business where sourcing agent has already left Max Life Insurance.
- More than half of the policy (ones sourced by third party distributors) complaints were received from policies source by inactive distributors.
- For individual agents, majority of complaints were received from the policies which were source by them within their 12 months of joining.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- We have changed benefit illustration wherein key terms (premium payment term, guaranteed / non guaranteed returns) have been highlighted in bold font as well as increased font size (sample attached herewith as Annexure 1) just above the customer signature. This is to make the critical details eye catchy, lest it should be missed by the customer.
- Fact finder process has been mandated in all distribution channels in order to identify customer's financial in order to identify customer financial needs, goals and to recommend most suitable matrix. Risk profiler has been mandated in all ULIP policies so that funds opted should be in line with their risk appetite.
- Agents are not allowed to collect premium in cash from the customers.
- Electronic need analysis has been introduced which sets boundary conditions so that unsuitable products cannot be pitched.
- Display of critical policy information (payment term, AFYP, mode, policy maturity date, guaranteed maturity sum assured) in policy pack window implemented across all distribution channels for the ease of customer.
- Bilingual schedule page launched in English and one of the 10 local languages implemented for all distribution channels.

6. Channel-wise controls placed to prevent mis-selling

Agents:

- Stringent consequence management grid has been designed for mis-selling cases including appointment cancellation of the agents.
- We have launched a compliance guide containing code of conduct for agents in 9 regional languages for ease of comprehension of Agents.
- Customer confirmation is taken over SMS (English & Hindi) on key details of the policy. Pilot project has been initiated in 6 offices of Agency.
- Sachchi Advice form (new fact finder form) rolled out. This form is more comprehensive and customer can take infirmed decision on the product which he should purchase Product Suitability Matrix is integral part of this form.

- Agent facing “Sachchi Advice week” was conducted re-iterating right market conduct and TCF values. This included sharing of right sales practices in the voice of our best agents in addition to voice of management.
- Strong awareness campaign has been run over emails, articles and SMS to all agents & employees
- Code of Conduct included in trainings to agent and employees.
- Snap audits conducted in field w.r.t the Regulatory guidelines on Code of Conduct.
- Welcome calling to customer conducted on risk based sample.

Corporate agents / Bancassurance/ Direct Selling/ Brokers:

- 100% welcome calling introduced in bancassurance channel
- Management reviews trends of customer complaints on monthly basis and driving focused projects for controlling mis-selling customer complaints.
- We have launched the compliance guide containing code of conduct for specified persons for all corporate agents.
- The relationship with channel partner sourcing low quality of business sourced has been terminated.
- Enforcement of consequence management grid with third party distributors.
- Channel specific workshop for driving focused action planning & preventive steps.
- Customer complaints as a quality parameter in regular discussion with supervisors.
- Employee new orientation trainings include module on ethical sales.

7. Other Measures taken for addressing mis-selling

- Mis-selling continues to be an integral part of quarterly review agenda at board level (Policyholders Protection Committee).
- Treat Customer Fairly is in place and getting maintained on regular basis to improve drive towards need based selling.
- Introduced a simplified Key Feature Document (KFD) for most of the products as a part of the policy pack. It has been prominently visualized in the policy pack and promoted on the policy envelop in Hindi and English. The KFD is a summary of the most important features of the policy and provides information on coverage, benefits, policy details and associated risks. It also highlights the 'freelook' provision.
- We have also introduced the schedule page in vernacular. This contains the most important policy details.
- The window of the policy pack has been modified to showcase the premium payment term

8. Procedure adopted for dealing with complaints of mis-selling

- On receipt of a complaint from the policy holder alleging missale, the same is highlighted to the seller and to our internal investigation team for their necessary investigation and inputs along with the Sales Audit Questionnaire.

- There is an independent investigation unit in Max life named as 'Compliance Investigation Unit' which then investigates the allegation by getting in touch with the customer and the seller, wherever applicable.
- At the time of investigation, all documentation present with Max Life which were submitted at the time of proposing the policy and later are efficiently reviewed.
- Basis the above investigation either the missale gets substantiated or it doesn't.
- In case miselling gets substantiated, the complaint is resolved in favor of the customer i.e. the policy is cancelled and the amount is refunded to the customer.
- In Parallel, necessary action is taken against the seller (as per the company's guidelines) who had sold the policy

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)*

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents												
Bancassurance												
Other Corporate Agents												
Brokers												
Direct selling												
Microinsurance agents												
Others (to be specified)												
TOTAL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

**- In FY 16 there was no complaint received where policy was sourced through a spurious call. While in FY 14 & 15 there was no separate tracking of such cases and the same were registered as missale grievance against the distributor*.

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Any complaint which is received where customer claims that the policy is sold vide a spurious call is dealt in the following manner :

- The number from which the call is received from the customer is investigated to find out in whose name is it registered
- Sales audit Questionnaire is filled with customer and distributor inputs
- Complete investigation is conducted by an independent unit post receipt of feedback from customer and distributor which includes listening to welcome call , meeting with the customer and other policy related document being studied.
- Post the above investigation baiss the facts appropriate decision is taken for the customer followed by the consequence management on the distributor if any.

11. Steps taken by the insurer to caution members of public about spurious calls

Max Life has taken initiatives to keep our policy holders updated and aware of the spurious / hoax calls. Details of the initiatives taken by us are as follows :

- We have sent e-mailers to all our customers making them aware of spurious calling.
- We include a message on Spurious calling in all our promotional emailers sent to our customers. Over 20 mailers per customer through the year.
- There is an exclusive page on our corporate website 'www.maxlifeinsurance.com' which educates the policy holders about spurious calls.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	72	33	34	73	26	32	16	12	1	516	323	249
Bank Assurance Agents/Employees	9	8	82	3	28	6	0	0	0	707	807	597
Other Corporate Agents	15	1	5	10	6	1	0	0	0	292	68	27
Brokers	24	0	2	7	0	22	0	0	0	120	175	94
Employees of Insurer	162	76	7	147	151	19	1	3	0	0	0	0
Others (Spurious Tele-callers)	0	0	0	0	0	0	7	7	45	0	0	0
Total	**282**	**118**	**130**	**240**	**211**	**80**	**24**	**22**	**46**	**1635**	**1373**	**967**

NAME OF THE INSURER : Max Anaxure 1

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Max Life Super Term Plan

UIN No:104N086V02

Traditional Non Participating Regular Pay Term Insurance Plan

Policy/Proposal No: [103861829]

Date of Illustration : Feb 29, 2016 7:26:04 PM

Personal Details		Product Features	
Name of Policyholder	*KUMAR NAVANDEEP*	Policy Term (Years)	35
Age of Policyholder at Policy Inception	33 Years	Premium Paying Term (Years)	35
Gender of Policyholder	Male	Premium Paying Mode	Semi-Annual
Name of Life Insured	*KUMAR NAVANDEEP*	Option	Level Sum Assured
Age of Life Insured at Policy Inception	33 Years	Sum Assured	₹ 50,00,000
Gender of Life Insured	Male	State	Other
Risk Class	Non-Smoker		

Premium Summary

Base Modal Premium	₹ 4,756.00
Service Tax including cess on Base and Rider Modal Premium, if opted	₹ 689.91
Total Premium payable on Due Date along with Service Tax & Cess	₹ 5,445.91
Total Premium payable for the policy year	₹ 9,516.00
Total Premium payable for the policy year along with Service Tax & Cess	₹ 10,895.82

Max Life Insurance Company Limited having its corporate office at 11th Floor, DLF Square, Jacaranda Marg, DLF City, Phase II, Gurgaon 122 002

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YEARLY ILLUSTRATIVE DETAILS

(This shall form a part of the policy document)

(All amounts are in ₹)

General Details			Benefits*	
Policy Year	Age of Life Insured (BOY)	Premium (BOY)	Guaranteed Death Benefit** for the year	Reduced Insurance Cover*** for the year
1	33	9,516	50,00,000	0
2	34	9,516	50,00,000	0
3	35	9,516	50,00,000	0
4	36	9,516	50,00,000	0
5	37	9,516	50,00,000	0
6	38	9,516	50,00,000	0
7	39	9,516	50,00,000	0
8	40	9,516	50,00,000	0
9	41	9,516	50,00,000	0
10	42	9,516	50,00,000	0
11	43	9,516	50,00,000	0
12	44	9,516	50,00,000	0
13	45	9,516	50,00,000	0
14	46	9,516	50,00,000	0
15	47	9,516	50,00,000	0
16	48	9,516	50,00,000	8,92,857
17	49	9,516	50,00,000	10,35,714
18	50	9,516	50,00,000	11,78,571
19	51	9,516	50,00,000	13,21,429
20	52	9,516	50,00,000	14,64,286
21	53	9,516	50,00,000	16,07,143
22	54	9,516	50,00,000	17,50,000
23	55	9,516	50,00,000	18,92,857
24	56	9,516	50,00,000	20,35,714
25	57	9,516	50,00,000	21,78,571

YEARLY ILLUSTRATIVE DETAILS

(This shall form a part of the policy document)

General Details			Benefits*	
Policy Year	Age of Life Insured (BOY)	Premium (BOY)	Guaranteed Death Benefit** for the year	Reduced Insurance Cover*** for the year
26	58	9,516	50,00,000	23,21,429
27	59	9,516	50,00,000	24,64,286
28	60	9,516	50,00,000	26,07,143
29	61	9,516	50,00,000	27,50,000
30	62	9,516	50,00,000	28,92,857
31	63	9,516	50,00,000	30,35,714
32	64	9,516	50,00,000	31,78,571
33	65	9,516	50,00,000	33,21,429
34	66	9,516	50,00,000	34,64,286
35	67	9,516	50,00,000	36,07,143

* There is no surrender or maturity value available under this plan.

** On death of the Life Insured the Policyholder/nominee will have an option to take either 100% of Guaranteed Death Benefit as lump sum or 50% of Guaranteed Death Benefit as lump sum and 8.42% of Guaranteed Death Benefit as monthly income for 10 years (settlement period) increasing at 8.5% p.a. (simple) every year starting from policy anniversary following the date of death. The same needs to be informed in writing through a standard letter at the time of filing the death claim form.

*** The policy offers "Reduced Insurance Cover" from policy year 16 onwards in case Policyholder discontinues premium payment after paying premiums for first 15 years. This feature is only available for policy terms of more than 15 years. For eligible policies, the "Reduced Insurance Cover" increases with the number of premiums paid before the policyholder discontinues paying the premiums.

Important Notes:

– This is only an illustrative document. It does not purport to be a contract of insurance and does not in any way create any rights and/or obligations.
– All the benefits shown above are guaranteed and payable on approval of the death claim of the Life Insured.
– Death Benefit: On the death of the Life Insured anytime during the term of the policy, the Company will pay the Guaranteed Death Benefit under the plan.
Guaranteed Death Benefit is defined as the higher of:
i. 10 times the Annualised Premium
ii. 105% of all premiums paid as on the date of death,
iii. Sum Assured effective on the policy anniversary previous or coinciding with the date of death.
Annualised Premium includes extra premium (if any) but excludes service tax, education cess and any loadings for modal premiums and remains same irrespective of the premium payment mode.
– Please refer to the product brochures, for the understanding the product features and explanation of the terms used in this illustration.
–Service tax, education cess and other applicable taxes would be levied as per applicable laws and would be borne by the Policyholder. Tax laws and the benefits arising under the Policy are subject to change.
–You may be entitled to certain tax benefits on your premiums and benefits. Please note all the tax benefits are subject to tax laws prevailing at the time of payment of premium or receipt of benefits by you/your nominee.

I [redacted] (Name), have explained the terms and conditions and the benefits of the policy to the prospect/Policyholder in _____ language and he/she has understood the same.

Signature of Agent/Specified Person:
Name and ID:
Place:
Date:
Company Seal:

I [redacted] (Name), having received the information with respect to the above, have understand the above statement before entering into the contract. *I understand and intend to continue paying the above said premium amount for the complete Premium Payment Term of* 35 Years *and as per the opted frequency. I also understand that the death benefit under the plan is* guaranteed.

Policyholders Signature:
Policyholders Name:
Date:

Max Life Insurance Company Limited having its corporate office at 11th Floor, DLF Square, Jacaranda Marg, DLF City, Phase II, Gurgaon 122 002

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INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : PNB MetLife India Insurance Co Ltd

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	329	0	677	62	0	81	37	0	137	428	0	895
Bancassurance	371	0	582	294	0	140	353	0	511	1018	0	1233
Other Corporate Agents	43	0	109	2	0	0	6	0	30	51	0	139
Brokers	0	0	0	34	0	20	0	0	0	0	0	20
Direct selling	9	0	3	296	0	298	259	0	610	564	0	911
Micro Insurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	12	0	13	142	0	105	17	0	129	171	0	247
TOTAL	**764**	**0**	**1384**	**830**	**0**	**644**	**672**	**0**	**1417**	**2258**	**0**	**3436**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	38565	28764	28206	95535
Bancassurance	119523	129808	142856	392187
Other Corporate Agents	3014	3619	10922	17555
Brokers	-14	-10	-5	-29
Direct selling	22462	37053	58613	118128
Others (to be specified)	473	-43	-10	420
TOTAL	**184023**	**199191**	**240582**	**623796**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	1507	926	742	3175
Bancassurance	1842	2100	2930	6872
Other Corporate Agents	25	35	47	107
Brokers	11	0	1	12
Direct selling	1036	876	1464	3376
Others (to be specified)	0	0	0	0
TOTAL	**4421**	**3937**	**5184**	**13542**

4. Root Cause (s) for complaints relating to mis-selling

1) Lack of awareness among the prospects on Insurance product.
2) Customers trust on intermediaries /financial consultant who manage their portfolio.
3) Instigation by Ex-Financial Advisor /Ex-Sales Manager who sourced the products or plan to customers.
4) Inadequate knowledge on product features and benefits in financial advisor and new joinee.

5. Steps taken for ascertaining suitability of insurance product at point of sale

1) Certification by Agency sales confirming personal meeting and explaining key policy features for high value cases to avoid misselling or later customer disputes.
2) Regular refresher training for sales /intermediaries.
3) Sales Manager to speak with customer before login and confirm the details.
4) Need Analysis to ascertain customer requirement.
5) Financial assessment to judge the premium paying capacity.
6) Welcome call to customer post Issuance of the policy to gauge the overall experience and reemphasis the product details to customers.
7) Fresh New Business Application not to be accepted for login without Full Premium Payment.

6. Channel-wise controls placed to prevent mis-selling

Control specific to all channels(Including Agents & Bancassurance):

1) Mandatory certification by Sales person confirming personal meeting and explaining key policy features for high value cases implemented in Agency Channel
2) Disciplinary action against sales as per Malpractice Grid
3) Mandatory training on product, ethics & compliance
4) Welcome Call on all cases to ascertain customer understanding.

Specific for Agents

Mandatory customer contact by Sales Manager before business is logged to avoid any misselling.

Specific for Bancassurance :

1) Mandatory customer declaration confirming understanding on product features & benefits.
2) Control checklist for Specified Person to ensure all necessary validation during business solicitation to avoid complaints at later stage.

7. Other Measures taken for addressing mis-selling

1) Welcome Calling process to ascertain customer understanding on the product.
2) Dedicated specialized complaint cell to monitor & address Misselling complaints.

3) Key feature section in policy document highlighting critical policy details.

4) Risk investigation for suspicious business before issuance of Policy.

5) Specified Person conversation starter for need based analysis.

6) Simplified product literature in brochure, website and customer documents.

8. Procedure adopted for dealing with complaints of mis-selling

1) Request complaint letter from the customer mentioning details of the matter.

2) Acknowledgement of complaint by Grievance Officer

3) Review of complaint based on:

   a. Available documentary facts and evidence provided by customers.

   b. Feedback in Pre-verification call recording (for cases issued prior to June 2014)

   c. Feedback from Welcome call recording to ascertain the facts and feedback given by customers.

   d. KYC, supporting documents ,application details available with company

4) Case referred to respective sales /intermediaries for their inputs and face to face meeting with complainant.

5) Based on sales inputs and available details decision is taken by Central Grievance Officer.

6) In case of decision in favour of Customer, a. full refund is made & b. Recommendation made to compliance for action against the intermediaries/employee found guilty as per malpractice grid.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	10	0	10	44	0	74	1	0	54	55	0	138
Bancassurance	12	0	5	23	0	44	2	0	39	37	0	88
Other Corporate Agents	3	0	6	25	0	41	0	0	11	28	0	58
Brokers	0	0	0	0	0	0	0	0	0	0	0	0
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (to be specified)	0	0	0	143	0	131	4	0	52	147	0	183
TOTAL	**25**	**0**	**21**	**235**	**0**	**290**	**7**	**0**	**156**	**267**	**0**	**467**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

1) We request for written complaint letter with details of caller from along with the number from where the call/calls were received.

2) Acknowledgement of complaint by Grievance Officer

   a. Review of complaint based on available documentary facts and evidence provided by customers.

   b. KYC, supporting documents, application details available with company.

3) Case referred to respective sales /intermediaries for their inputs and face to face meeting with complainant.

4) Based on sales inputs and investigation available details decision is taken by Central Grievance Officer.

5) Post investigation if the decision is in favour of Customer,

   a. Initially attempt made to retain the client or else full refund is made,

   b. Recommendation made to compliance for action against the intermediaries/employee found guilty as per malpractice grid.

   c. Also the complaints get register with TRAI for action against the service provider post investigation.

11. Steps taken by the insurer to caution members of public about spurious calls

1) Slide/Voice over incorporated in advertisement and commercials in electronic media.

2) Educating existing customers to avoid such calls through SMS, Letter & Emails

3) Public notice flashed on home page of Website.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	103	116	190	67	53	70	0	0	0	628	265	185
Bank Assurance Agents/Employees	28	35	146	19	0	0	0	0	0	8	274	156
Other Corporate Agents	0	0	0	0	0	0	0	0	0	4	0	0
Brokers	0	0	0	0	0	1	0	0	0	0	4	2
Employees of Insurer	54	34	181	27	0	0	0	0	8	0	0	0
Others (Spurious Tele-callers)	13	159	0	0	0	0	0	45	61	5	43	0
Total	198	344	517	113	53	71	0	45	69	645	586	343

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : RELIANCE NIPPON LIFE INSURANCE CO. LTD.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1,424	120	3,161	850	188	1,956	343	89	1,053	2,617	397	6,169
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	2,853	220	6,374	402	128	2,261	223	64	711	3,478	412	9,346
Brokers	2,852	251	6,609	2,493	552	8,192	1,062	284	4,184	6,407	1,087	18,985
Direct selling	1	-	-	8	-	2	29	2	4	38	2	6
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others * (to be specified)	278	43	725	381	97	763	568	117	595	1,227	257	2,083
TOTAL	**7,408**	**634**	**16,869**	**4,134**	**965**	**13,174**	**2,225**	**556**	**6,546**	**13,767**	**2,155**	**36,589**

** Others refers to complaints registered through IGMS by non-policyholders / incorrect policy number*

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	396,204	309,219	247,937	953,360
Bancassurance	-	-	-	-
Other Corporate Agents	75,911	37,400	20,293	133,604
Brokers	58,246	60,411	40,605	159,262
Direct selling	56,985	71,635	55,670	184,290
Others (to be specified)	-	-	-	-
TOTAL	**587,346**	**478,665**	**364,505**	**1,430,516**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	3,452	2,869	1,983	8,304
Bancassurance	-	-	-	-
Other Corporate Agents	1,818	274	595	2,687
Brokers	4,406	4,128	2,463	10,997
Direct selling	2	16	7	25
Others (to be specified)	829	1,027	1,064	2,920
TOTAL	**10,507**	**8,314**	**6,112**	**24,933**

4. Root Cause (s) for complaints relating to mis-selling

a. Policies are often sold with offerings of unrealistic returns / gifts / bonus instead of the actual policy benefits and focus on the life cover. This may be attributed to some unscrupulous elements within sourcing intermediaries who prey on gullible customers misleading them with non-existent offers. Policy buyers do not take the time to understand the product purchased or go through the policy terms and conditions.

b. Even educated customers tend to overlook the fact that life insurance is a long term product. The expectation of short-term gains seems appealing to customers, but they fail to realise that the charges in insurance products are higher initially and usually taper down as the term progresses. Thus an early exit is never beneficial.

5. Steps taken for ascertaining suitability of insurance product at point of sale

a. We have recently launched a mobile application 'RlifeAssist' - our digital tool designed to help sales managers to perform the customer needs analysis. On-boarding of new customers is conducted via this application which makes the sales transaction completely transparent as the details are filled out in front of the customer. The tool leads the customer to customised array of suitable products recommended based on the customer's personal information.

b. Our product brochures are the primary tool used to explain the policy benefits to potential customers by our sales force. The brochure lists the benefits available under the policy and is used exhaustively for the sales pitch.

c. Benefit Illustration - The electronically generated benefit illustration signed by customer is a mandatory accompaniment to all proposal forms submitted to us for issuance. These explain the returns foreseen under the policy offered to the customer.

6. Channel-wise controls placed to prevent mis-selling

Pre Issuance Verification Calling (PIVC) is conducted for all insurance proposals received for issuance across channels. The objective of the Any failure in this verification does not move forward for issuance. The premiums of policies which do not pass our pre-issuance verification are offered a refund.

Agents -

Our branches conduct a verification call to the sourcing agent and recheck that the agent is contactable and the policy is indeed sourced by them. Issuance is held back for policies where agents are found non-contactable.We perform a OSV of all licensed Agents for individuals and of all "Specified Persons" for Corporate Agents – the signatures of these individuals are captured in our systems

Corporate Agents and Brokers -

We have placed a restriction on multiple policies sold to customer within 6 months across the broking channel. This restriction applies even if the sourcing brokers are different and want to sell a policy to the same client within 6 months of previous issuance with us. This is in addition to reduction in tele-calling business sourced through brokers.

We perform a OSV of all licensed Agents for individuals and of all "Specified Persons" for Corporate Agents – the signatures of these individuals are captured in our systems

Direct selling - NA

Bancassurance - NA

Others - NA

These restrictive controls were placed by identifying the specific type of business which resulted in a mis-selling complaint and have led to a significant decline in our complaint numbers.

7. Other Measures taken for addressing mis-selling

Our proposal form has a prominently placed field to be signed by the customer, indicating consent to regular premium policies. This was placed after identifying that we received numerous complaints where the customer requested a single premium policy and regular premium plan was sold to them instead.

8. Procedure adopted for dealing with complaints of mis-selling

The customer may approach our service desk at the Call Center, through the branch or directly write-in.Once received, the complaint is tagged in our CRM which is directly integrated with the IGMS. An empowered and tenured team investigates the complaint and arrives at a decision based on the facts of the individual complaint. The decision is communicated to the customer over the phone as well as in writing.

A root cause analysis conducted on sample cases is reviewed with the senior management team periodically to initiate any suitable process re-engineering and avoid recurrent instances of the same variety.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	23	2	22	159	4	26	19	-	5	201	6	53
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	38	-	48	32	2	18	9	2	4	79	4	70
Brokers	51	5	46	79	1	90	28	3	40	158	9	176
Direct selling	-	-	-	-	-	2	-	-	-	2	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	337	28	107	437	12	43	299	4	21	1,073	44	171
TOTAL	**449**	**35**	**223**	**707**	**19**	**177**	**357**	**9**	**70**	**1,513**	**63**	**470**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

The customer may approach our service desk at the Call Center, through the branch or directly write-in.Once received, the complaint is tagged in our CRM which is directly integrated with the IGMS.If the

spurious calling has resulted in the customer investing with us, the complaint is resolved as per the Mis-Selling process flow. Even in the event of the call not resulting in a sale, the spurious calling number is highlighted to TRAI and a copy is shared with the customer along with the process of directly registering the complaint with TRAI in future.

11. Steps taken by the insurer to caution members of public about spurious calls

a. Media advertisement campaign to spread awareness against the spurious calling menace.

b. Periodic communication sent to existing customers warning against spurious callers via SMS at each stage of the policy - from login and policy dispatch and post -issuance highlighting the terms of the policy.

c. Specific script in the pre-issuance verification call to educate customer and understand that he is aware of the terms and no bogus promises have been committed.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	652	820	619	650	273	279	43	48	41	3,805	2,220	1,358
Bank Assurance Agents/Employees	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Other Corporate Agents	6	23	39	0	17	33	Nil	Nil	Nil	4,625	1,164	926
Brokers	39	148	148	2	5	20	18	34	57	5,656	5,287	3,970
Employees of Insurer	76	282	310	58	168	160	3	5	7	Nil	Nil	Nil
Others (Spurious Tele-callers)	Nil	Nil	Nil	Nil	Nil	Nil	Nil	93	157	312	698	751
Total	**773**	**1273**	**1116**	**710**	**463**	**492**	**64**	**180**	**262**	**14,398**	**9,369**	**7,005**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : SAHARA INDIA LIFE INSURANCE CO. LTD.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	01	-	-	-	-	-	-	-	-	01
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**-**	**-**	**01**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**01**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	40152	21126	19442	80720
Bancassurance	-	-	-	-
Other Corporate Agents	824	39	98	961
Brokers	-	-	-	-
Direct selling	-	-	-	-
Others (to be specified)	-	-	-	-
TOTAL	40976	21165	19540	81681

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	09	10	11	30
Bancassurance	NA	NA	NA	NA
Other Corporate Agents	NA	NA	NA	NA
Brokers	NA	NA	NA	NA
Direct selling	NA	NA	NA	NA
Others (to be specified)	NA	NA	NA	NA
TOTAL	**09**	**10**	**11**	**30**

4. Root Cause (s) for complaints relating to mis-selling

- Selling product not having features as promised and making false promise of unreasonable high return.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- **Product training** –Post licensing of agents product related training is imparted to the agents under the strict supervision of the company sales staff.
- **Need based selling** – A Specially designed module on need based selling , which aims at identifying the needs of the customers at different stages of life is imparted to the agents with strict instructions to abide by it.
- **Financial Need Analysis** – A module on financial need analysis is given to the agents, the contents of which help the agents in assessing the financial stability and the requirement of funds at various stages of life like education , higher studies, marriage and other contingencies of life.
- **Refresher** courses at regular intervals for agents are conducted.The above measures contribute in pitching the right and suitable product to the customer by the agents at the point of sale.

6. Channel-wise controls placed to prevent mis-selling

Agents-

I. Agents Checks are imposed to prevent mis-selling by agents wherein the agents are mandatorily required to fill up an agent confidential report the contents of which furnish all client related details along with the product details. This report is verified by the marketing executive and further ratified by the LCO Heads.

II. AGENTS are under instruction to maintain transparency while pitching any company product and adhere to the facts mentioned in the company brochures.

III. Only prescribed benefit illustrations as per the company norms and brochures are circulated by the front liners to the customers.

IV. Agents and front liners are under strict instructions that their license shall be revoked with immediate effect if caught in any mis-selling activities.

V. Random calls made to customers to check the authenticity of the plan sold to them and whether their understanding of the product sold to them is in line with the actual terms as per the plan.

Corporate agents- In the case of corporate agents besides the above mentioned points an annual inspection of the corporate agents is being conducted by the senior company staff to ensure that all company norms are being adhered to while selling the products to the customers.

- **Bancassurance-**
- **Brokers-**
- **Direct selling-**
- **Others-**

7. Other Measures taken for addressing mis-selling

- **CALLING THROUGH CALL CENTRES** - We have an established call centre through which random calls are made to the new customers specially the ones who have bought ULIPs to ensure that they are aware of the product sold to them and the terms and conditions mentioned to them are in line with the specifications mentioned therein.
- Calls are made from the local corporate offices to large ticket size customers to ensure that fair and true statement of facts are furnished to the customer before selling the policy to them.· Regular product counseling to the marketing staff is conducted to update them of all company plans and products.
- Reports like agent confidential report and Marketing executive confidential reports are ratified by the LCO Heads in order to authenticate all information relating to the plan and customer.

8. Procedure adopted for dealing with complaints of mis-selling

If the complaint is found to be genuine then the company may provide reliefs to the complainant which may include but not limited to:

- Refund of money with interest;· Issuance of fresh policy;
- Compensation, if deemed appropriate.If allegation is proved then the Company may take actions against agent at fault which may include but not limited to:
- Issuing warning letter to the agent;
- Termination of agency/employment of the agent;
- Recovery of money from the agent.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bancassurance	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Direct selling	-	-	-	-	-	-	-	-	-	-	-	-
Micro insurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Others (to be specified)	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

If the complaint is found to be genuine and any employee/agent of the Company is found at fault then the company may provide reliefs to the complainant which may include but not limited to:

- Refund of money with interest
- Issuance of fresh policy
- Compensation, if deemed appropriate

If allegation is proved then the Company may take actions against agent/employee at fault which may include but not limited to:

- Issuing warning letter to the agent/employee at fault
- Suspension of employment of the employee at fault
- Termination of agency/employment of the agent/employee at fault
- Recovery of money from the agent/employee at fault

11. Steps taken by the insurer to caution members of public about spurious calls

- The Company follows the 'Zero-Tolerance Policy' for any kind of complaints against spurious calls i.e. the Company will not tolerate any form of spurious calls and is committed to take all necessary steps to ensure that its policyholders are not subjected to any form of fraud. If there is commission of any act of fraudulent calls with the objective of duping policyholder, it shall result in strict disciplinary action against Company staff / agents involved in such fraudulent or spurious call.
- Sahara India Life shall communicate to the policyholders that before taking any action on any call received on their number which is related to their policy, they must confirm by calling at customer care number of the Company.
- Sahara India Life ensures that all complaints shall be dealt in the manner prescribed in the Insurance Act, 1938 and rules made hereunder.

12. **Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (**Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	-	-	-	-	-	-	-	-	-	-	-	-
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	-	-	-
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	-	-	-	-	-	-	-	-	-
Employees of Insurer	-		-	-	-	-	-	-	-	-	-	-
Total	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**	**NIL**

Note: As, there was no such case of Spurious Calls reported to the Company. While in case of Mis-Selling it was disposed as rejected.

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : SBI LIFE INSURANCE COMPANY LIMITED.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	675	401	3169	487	299	1965	273	194	1093	1435	894	6227
Bancassurance	199	78	913	198	70	707	244	95	660	641	243	2280
Other Corporate Agents	162	66	814	174	61	590	55	50	352	391	177	1756
Brokers	127	62	942	39	31	433	26	36	456	192	129	1831
Direct selling	0	0	0	6	0	7	0	0	9	6	0	16
Microinsurance agents	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Others (to be specified)	77	32	328	79	27	266	21	13	152	177	72	746
TOTAL	**1240**	**639**	**6166**	**983**	**488**	**3968**	**619**	**388**	**2722**	**2842**	**1515**	**12856**

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	564399	**464758**	462278	1491435
Bancassurance	452200	**629962**	788207	1870369
Other Corporate Agents	10429	**9607**	7209	27245
Brokers	2551	**2257**	1106	5914
Direct selling	11543	**19293**	14145	44981
Others (Micro Insurance Agent)	0	**17**	65	82
TOTAL	**1041122**	**1125894**	**1273010**	**3440026**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	5743	3786	2514	12043
Bancassurance	3715	4011	5073	12799
Other Corporate Agents	910	572	250	1732
Brokers	379	58	67	504
Direct selling	48	86	133	267
Others (to be specified)	0	0	0	0
TOTAL	**10795**	**8513**	**8037**	**2735**

4. Root Cause (s) for complaints relating to mis-selling

- Intermediaries offering unrealistic returns.
- Non disclosure of complete product features and conditions.
- Products not sold as per the need of the customer.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Various training interventions have been initiated like Product trainings, need based selling and training on ethical selling for agents / intermediaries.
- We have provided the Need Analysis Calculator, Retirement Calculator, Child Education Calculator and such tools that can be used by agents, intermediaries and customers to assess the need and suitability.
- The pre-sales materials / sales collaterals for the products adhere to the advertisement guidelines, prominently disclosing the life cover element and conditions related to the features mentioned therein.

6. Channel-wise controls placed to prevent mis-selling

AgentsCorporate agentsBancassuranceBrokersDirect selling Others**Training and instruction given to all channels to offer products after analyzing customer need and risk appetite**

7. Other Measures taken for addressing mis-selling

- Continuance of Pre-issuance welcome calling to ascertain the authenticity of need based selling. It also provides accurate information to the customer on the product purchased.
- Connect life: A tablet based service which gives the power of choice to the customer while purchasing a policy. It involves digitization of the entire process beginning with built in need analysis calculator for choosing the right products, filling the proposal form, payment of premium and uploading necessary documents.
- Sales Quality Score policy to address misconduct by sales intermediary leading to penal action, including termination.

8. Procedure adopted for dealing with complaints of mis-selling

- On receipt of the complaint, we call the complainant to understand the grievance in detail.
- We also call for clarification from the sales intermediary, based on the grievance received.
- On receipt of the clarification and on the basis of the merit of the complaint, further necessary action is taken.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	1	1	4	3	0	12	0	1	10	4	2	26
Bancassurance	0	0	2	2	1	7	0	0	0	2	1	9
Other Corporate Agents	0	0	4	0	0	4	0	0	0	0	0	8
Brokers	0	0	2	0	0	18	0	1	2	0	1	22
Direct selling	0	0	0	0	0	0	0	0	0	0	0	0
Microinsurance agents	NA	NA	NA	0	0	0	NA	NA	NA	NA	NA	NA
Others (to be specified)	12	13	127	4	6	105	8	6	65	24	25	297
TOTAL	**13**	**14**	**139**	**9**	**7**	**146**	**8**	**8**	**77**	**30**	**29**	**362**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

The Company has put in place a comprehensive Policy detailing the procedure for that needs to follow for complaints relating to spurious calls. It is very difficult to trace the policies which have been sourced after receiving spurious calls. However whenever we received any specific customer complains about spurious calls, irrespective of, whether the customer is a policyholder or not we follow the following process.

- If the customer's mobile number is registered under DNC, we obtain details of the caller from TRAI and on receipt of the details from TRAI, we file a FIR against the caller.
- As per the details if the call was made by our intermediary, action is initiated against the intermediary as per the Sales Quality Score policy·
- If the customer's mobile number is not registered under DNC, we advise customer to register their number under DNC and to complain to their service provider about receipt of unsolicited calls.

However, as per the recent circular dated 31.01.2016 from the authority, the spurious call complaints received are categorized in one of the three categories as mentioned in the circular and the spurious call policy/ process is in place.All our sales collaterals, publicity material, etc. also contains necessary messages informing customer to "**Beware of Spurious Calls and fictitious/fraudulent offers** " in the manner prescribed by IRDAI.

11. Steps taken by the insurer to caution members of public about spurious calls

An alert message is displayed in the website to beware of spurious callsA leaflet is sent along with the Original Policy document.All our advertisements contain caution for spurious calls

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers) *

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	179	204	95	100	186	109	-	-	-	-	-	-
Bank Assurance Agents/Employees	11	16	21	0	1	1	-	-	-	-	-	-
Other Corporate Agents	33	36	5	0	2	8	-	-	-	-	-	-
Brokers	14	5	5	1	0	0	-	-	-	-	-	-
Employees of Insurer	97	138	99	0	0	0	-	-	-	-	-	-
Others (Spurious Tele-callers)	0	0	0	0	0	0	-	-	201	-	-	-
Total	**334**	**399**	**225**	**101**	**189**	**118**	**-**	**-**	**201**	**-**	**-**	**-**

Annexure

NAME OF THE INSURER: SBI Life Insurance Company Limited

Other kind of penalty imposed on erring employees and intermediaries

Intermediary/ Employee	Number of Censure letters issued			Number of Counsel letters issued			Number of Caution letters issued		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	0	0	118	102	70	3	0	1	9
Bank Assurance Agents/Employees	0	0	0	19	20	3	0	0	0
Other Corporate Agents	0	0	1	16	5	3	0	0	0
Brokers	0	0	7	3	3	2	0	1	0
Employees of Insurer	0	0	47	98	96	12	0	1	3
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**173**	**238**	**194**	**23**	**0**	**3**	**12**

Intermediary/ Employee	Number of Information letters Issued			Number of Exoneration letters Issued			Number of Quarantine letters Issued			Financial Penalty		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	162	117	9	0	0	2	33	38	2	0	0	15
Bank Assurance Agents/Employees	33	27	2	0	0	0	2	0	0	0	0	0
Other Corporate Agents	2	3	2	0	0	3	0	0	0	0	0	3
Brokers	8	8	0	0	0	1	0	0	0	0	0	2
Employees of Insurer	22	23	4	0	0	16	1	1	0	0	0	11
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	0	0	0	0	0
Total	**227**	**178**	**17**	**0**	**0**	**22**	**36**	**39**	**2**	**0**	**0**	**31**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Shriram Life Insurance Co. Ltd.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	0	13	0	0	16	3	0	13	3	0	42
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	15	0	0	17	8	0	13 (1)	8	0	45(1)
Brokers	0	0	82	0	0	30	0	0	18	0	0	130
Direct selling	1	0	42	4	0	62	23	0	59(1)	28	0	163(1)
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (Invalid and No Policy Nuber)	0	0	10	0	0	9	0	0	5	0	0	24
TOTAL	**1**	**0**	**162**	**4**	**0**	**134**	**34**	**0**	**108(2)**	**39**	**0**	**404(2)**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	20528	19081	14930	54539
Bancassurance	88	22	0	110
Other Corporate Agents	48669	71260	136519	256448
Brokers	1122	18	1614	2754
Direct selling	67203	100561	113768	281532
Others (to be specified)	0	0	0	0
TOTAL	**137610**	**190942**	**266831**	**595383**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	443	386	366	1195
Bancassurance	0	0	0	0
Other Corporate Agents	301	767	1052	2120
Brokers	56	0	7	63
Direct selling	554	813	1067	2434
Others (to be specified)	0	0	0	0
TOTAL	**1354**	**1966**	**2492**	**5812**

4. Root Cause (s) for complaints relating to mis-selling

Major area of Mis-selling is due to Miscommunication of the product features and benefits to the customer.

Incorrect product information given to customer.

Swapping of policies information and selling the policies.

Getting influenced with the relationship of the intermediary taking policy and later complaining about mis-selling

Intermediary advising customers to subscribe for fresh policy after surrender of the existing policy and wait for a few months after which the fresh policy would be entitled for additional enhanced returns /benefits.

5. Steps taken for ascertaining suitability of insurance product at point of sale

We have informed channels to be more apparent while explaining about the product and their features.Not to link other products with insurance and cross sell policy.

We have been circulating brochures which enable the customer to have better understanding of the product.

We also appraise employees / agents on the negative impacts of mis-selling on the customers, organization and the industry as a whole.

If required calling customer to ascertain is the customer aware of the policy features and benefits.

6. Channel-wise controls placed to prevent mis-selling

Agents

Corporate agentsBancassurance

Brokers

Direct selling

Others

For above all channels we are conducting sessions/ proper training to agents / internal sales person-nel / intermediaries on ‘right selling’ practices. we have very strong mechanism for induction and trainings for our sales groups.

We have a quality measurement team who will be monitoring all the channels to ensure transparency and quality is maintained.

7. Other Measures taken for addressing mis-selling

Pre- verification calls to customer to ensure that customer is aware of policy and identify such cases where the policy has been mis-sold to them.

Strict action is initiated on employees / agents / intermediaries for involvement in mis-selling and fraudulent activities

Upon receipt of complaints from various sources we are verifying the facts and thereon providing the resolution to the complaint by paying the refund.

Our News letter edition is continuously educating our customers to be aware of these Fraudulent activities prevailing in the market and if any instances found they may approach us for any clarifications needed.

8. Procedure adopted for dealing with complaints of mis-selling

- Verifying the signature from the proposal form and other documents
- Policy docs delivery details- Pre verification or welcome call recording
- Any service request received before raising mis-sale complaint
- Subsequent premiums are received
- Renewal or revival letters dispatched and received by customers (with response if there is one)
- We will call to customer if required for further assistance.
- Take the concern area sales feedback.

Post verification of all the facts we will take the appropriate action and close the complaint.

9. Complaints relating to sale of policies after spurious calls(Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	0	0	0	0	0	0	0	0	0	0	0	0
Bancassurance	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	0	0	0	0	0	0	0	0	0	0
Brokers	0	0	14	0	0	10	0	0	0	0	0	24
Direct selling	0	0	2	0	0	6	0	0	1	0	0	9
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others (Invalid Policy Number and No Policy numbers	0	0	4	0	0	3	0	0	0	0	0	7
TOTAL	**0**	**0**	**20**	**0**	**0**	**19**	**0**	**0**	**1**	**0**	**0**	**40**

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Upon receipt of call/email from customer with regard to Spurious call (Advising public to invest in insurance policies to avail gifts, promotional offers, interest free loans, or setting up of Telecom towers or other such offers.). We will inform customer not to act on that calls if they have any concerns with regard to that kind of calls they can approach our toll free number or alternatively inform us through email/letter. Further with all faith on that call they take policy and later they came to

know that this policy sold with fake promises. We will investigate the case with all facts available and if it found to be policy sold out of spurious call we will cancel the policy and refund back.

Year on year we were successful in reducing the complaints in respect of spurious calls.

11. Steps taken by the insurer to caution members of public about spurious calls

Besides running customer education campaigns, we also take 'case to case specific actions on reported incidents of spurious calls. Sending SMS to customers

Beware of Spurious phone calls and Fictitious / Fraudulent Offers. IRDA clarifies to public that:

1. IRDA or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums.
2. IRDA does not announce any Bonus Public receiving such phone calls are requested to lodge a police complaint along with details of phone call number.

Updates on the website There are updates on the website about spurious calls clearly indicating that customers should not fall prey to the fictitious / fraudulent offers.

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	0	0	3	0	0	0	0	0	0	0	0	0
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	0	0	0	0
Other Corporate Agents	0	0	5	0	0	0	0	0	0	0	0	0
Brokers	3	0	0	0	1	0	0	0	0	0	0	0
Employees of Insurer	1	10	15	0	5	12	0	0	0	1	3	22
Others (Spurious Tele-callers)	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4**	**10**	**23**	**0**	**6**	**12**	**0**	**0**	**0**	**1**	**3**	**22**

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Star Union Dai-ichi Life Insurance Co. Ltd.

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	35	-	4	75	1	21	42	2	34	139	3	60
Bancassurance	388	4	113	539	20	201	383	47	355	1145	75	636
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	-	-	-	68	1	12	12	1	7	123	2	26
Direct selling	-	-	-	-	-	-	-	-	-	1	-	-
Microinsurance agents	-	-	-	-	-	-	-	-	-	-	-	-
Incorrect Information * Unregistered	13	1	3	8		2	16	5	7	-	-	4
TOTAL	**436**	**5**	**120**	**690**	**22**	**236**	**499**	**55**	**403**	**1625**	**82**	**759**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	9467	7647	7073	24187
Bancassurance	116251	92087	82970	291308
Other Corporate Agents	-	-	-	-
Brokers	1720	117	1	1838
Direct selling	114	165	272	551
Others (to be specified)	-	-	-	-
TOTAL	**127552**	**100016**	**90316**	**317884**

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	109	161	101	371
Bancassurance	749	835	987	2571
Other Corporate Agents	-	-	-	-
Brokers	101	29	12	142
Direct selling	-	-	-	-
Others (to be specified)	-	-	-	-
TOTAL	**959**	**1025**	**1100**	**3084**

4. Root Cause (s) for complaints relating to mis-selling

- Customer is informed about false returns on investments and incorrect information of the products.
- Payment terms are not clearly explained to the customer.
- Elevated growth on investments promised against insurance products.
- Need based analysis was not done or discussed with the customers.

5. Steps taken for ascertaining suitability of insurance product at point of sale

- Product literature is given to the customer at the point of sales by the sales representatives.
- Increase in awareness training of the sales force.
- Key information document – A single pager is attached as a part of the policy document which explains the important details and benefits of the policy availed by the customer.
- Pre-Issuance calling is done for each new proposal at the time of processing of proposal to ascertain suitability of sale.
- Revised welcome calling explains all the key product features to the customer once again to avoid mis-selling.
- Customer awareness modules prepared and uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy.

6. Channel-wise controls placed to prevent mis-selling

Systems in place to address mis-selling especially for policies sourced from brokers / bancassurance

Channel	Systems in Place to address Mis-selling
Broker	• Pre issuance login verification call (PLVC) is made to customers for checking amongst other things, whether there was any mis-selling during the sales process. • Brokers themselves carry out Pre issuance login verification call (PLVC) to check whether there was any mis-selling done by their sales person. • Welcome calling is done to all customers post issuance of policies, in which, customers have an opportunity to complain. • Claw back of commission is done in case of mis selling by brokers. Also, the same is incorporated as a clause in the agreements with Brokers to deter them from mis-selling. • Customer awareness modules prepared and uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy. • In customer policy documents, Grievance Redressal procedures and escalation matrix are mentioned.· Grievance cell is in place to receive the customer complaints and suitably resolve and provide the resolution to customers. • Trainings on mis-selling practices are conducted for sensitising brokers. • Investigation is carried out for any reported mis-selling case of brokers • Action is also taken by the broker on proven mis-selling cases.

Bancassurance & Individual

- Pre issuance login verification call (PLVC) is made to customers for checking amongst other things, whether there was any mis-selling during the sales process.
- Welcome calling is done to all customers post issuance of policies, in which, customers have an opportunity to complain.
- Trainings are imparted to all employees managing banc assurance business of the company for sensitising them on mis-selling practices and action against it.
- Customer awareness modules prepared and uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy.
- In customer policy documents Grievance Redressal procedures and escalation matrix are mentioned.
- Grievance cell is in place to receive the customer complaints and provide suitable esolution to the customers.
- Penal Matrix implemented for actioning of mis-selling cases if any employee is found involved in mis-selling.
- Detailed investigation is done on any reported mis-selling case.
- Wherever mis-selling is proved and employee's involvement is found, action is taken as per the penal matrix.
- Broadcasting of MIS on action taken against employees involved in malpractice. This acts as a deterrent amongst employees against malpractices.

7. Other Measures taken for addressing mis-selling

1. Pre issuance login verification call (PLVC) is made to customers for checking amongst other things, whether there was any mis-selling during the sales process.
2. Welcome calling is done to all customers post issuance of policies, in which, customers have an opportunity to complain.
3. Customer awareness modules have been uploaded on company websites covering precautions during the purchase and servicing aspects of insurance policy.
4. In customer policy documents, Grievance Redressal procedures and escalation matrix are mentioned.
5. A copy of proposal form is provided along with the policy documents to customer so that he can check the details of plan and if there is any mismatch he can complain to company.
6. Product training is imparted to all sales personals.
7. Training is imparted to sales personal on do and don'ts and penal matrix.
8. Awareness through screen savers are given to sales personals.
9. Grievance cell is in place to receive the customer complaints and suitably resolve and provide the resolution to customers.
10. Sampling & Mystery shopping is done to check any unauthorized selling practice.
11. Penal Matrix is implemented for actioning of mis-selling cases if any employee is found involved in mis-selling.

8. Procedure adopted for dealing with complaints of mis-selling

Procedure adopted for dealing with mis-selling complaints:

1. The company has a process in place where the complaints received from the customers in the category of unfair practices are investigated.
2. Customer allegations made in the complaint are analyzed in detail.
3. Explanations are sought from the sales person involved in selling of the plans.
4. Proposal form is checked and customer data available in the system is checked to study the customer profile.
5. Product details and type of product sold to customer is studied.
6. Details obtained from customer complaint, proposal form, sales person clarification, customer profile and plan details are analyzed in detail to prepare the investigation findings.
7. Detail investigation findings are forwarded to Grievance Department for providing resolution to the customer complaint.
8. If mis-selling is proved after investigation then action is taken against the sale person involved in mis-selling as per the malpractice matrix of the company.
9. The action taken against employees involved in malpractice is broadcasted monthly to all employees.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents												
Bancassurance	20			27						47		
Other Corporate Agents												
Brokers												
Direct selling												
Microinsurance agents												
Others (to be specified)												
TOTAL	**20**			**27**						**47**		

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

Procedure adopted for dealing with complaints of spurious calls:

1. Once a complaint about spurious call is received, we ascertain whether the call has been made by any employee/sales intermediary of the company.
2. Contact number of the person from which the spurious call is made is obtained.
3. Investigation is conducted to find the details of the spurious caller.

4. During investigation of such cases, every effort is made to obtain the details such as address, name etc of the spurious caller.
5. Once the address, name, etc are obtained then the same is verified with the employee database/ sales intermediary data base to ascertain whether any person associated with the insurance company tried to make such spurious calls to our customers.
6. If the number belongs to any other person than the above, investigation is conducted to find out the person from whom the spurious call number belongs to.
7. Efforts are made to report the matter to police with the investigation details obtained after the receipt of customer complaint.
8. It has been our experience that police does not entertaining such complaints
9. Details obtained of such spurious callers are maintained and discussed with other companies at Insurance Industry meets and with Life Council.
10. Complaint is made to TRAI about spurious calls.

11. Steps taken by the insurer to caution members of public about spurious calls

1. SMS are sent to customers regularly to caution them about the spurious calls.
2. Key note regarding the spurious calling added to all the customer communications (letters, receipts, notices, emails).

12. Action taken against intermediaries found engaged in mis-selling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	2	-	1	1	-	-	-	-	-	4	11	8
Bank Assurance Agents/Employees	-	-	-	-	-	-	-	-	-	197	217	247
Other Corporate Agents	-	-	-	-	-	-	-	-	-	-	-	-
Brokers	2	4	-	-	1	-	-	-	-	62	18	6
Employees of Insurer	3	5	3	1	4	4	-	1	-	-	-	-
Others (Spurious Tele-callers)	-	-	-	-	-	-	-	-	-	-	-	-
Total	7	9	4	2	5	4	-	1	-	263	246	261

INFORMATION ABOUT MIS-SELLING AND SPURIOUS CALLS

NAME OF THE INSURER : Tata AIA Life Insurance Company Limited

1. Complaints relating to Mis-selling (Channel-wise, resolution status-wise number of complaints relating to mis-selling)

Source	2013-14			2014-15			2015 -16			Total		
	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	461	13	1137	435	13	838	643	9	374	1539	35	2349
Bancassurance	233	4	517	153	3	244	147	2	114	533	9	875
Other Corporate Agents	134	6	329	81	1	125	70	2	57	285	9	511
Brokers	598	16	1000	204	2	465	211	12	169	1013	30	1634
Direct selling	44	1	134	39	0	59	55	1	36	138	2	229
Micro insurance agents	3	2	0	0	0	0	1	1	2	4	3	2
Others (WSM, No Policies)	27	0	39	13	0	27	13	0	7	53	0	73
TOTAL	**1500**	**42**	**3156**	**925**	**19**	**1758**	**1140**	**27**	**759**	**3565**	**88**	**5673**

I – In favour of Complainant; P – Partially in favour of complainant; R – Rejected

2. New Business sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16 *	
Individual Agents	211.53	186.56	284.19	**682.28**
Bancassurance	20.78	33.10	294.01	**347.89**
Other Corporate Agents	-0.14	0.17	1.23	**1.26**
Brokers	16.77	1.24	18.37	**36.38**
Direct selling	19.76	13.55	16.48	**49.79**
Others (to be specified)	0.43	0.08	-	**0.51**
TOTAL	**269.13**	**234.70**	**614.28**	**1118.11**

***** *New Business figures for 2015-16 are on a provisional basis and is subject to changes*

3. Free-look cancellations of policies sourced from different intermediaries (Individual policies)

Source	Years			TOTAL
	2013-14	2014-15	2015 -16	
Individual Agents	1301	878	822	3001
Bancassurance	545	87	359	991
Other Corporate Agents	163	0	0	163
Brokers	741	8	24	773
Direct selling	115	18	56	189
Others (to be specified)				
TOTAL	**2865**	**991**	**1261**	**5117**

4. Root Cause (s) for complaints relating to misselling

- Customer understanding – for e.g. not clear about the various policy charges, other policy features.
- Product differs from what was requested by the customer or disclosed to him / her.
- Tampering / Corrections / Forgery of proposal or related papers by intermediaries
- Other malpractices or unfair business practices like misappropriation, renewal cheques being used for new business
- Policies sourced from customers through the mechanism of spurious / hoax calls with lure of bonus etc.

5. Steps taken for ascertaining suitability of insurance product at point of sale

The sales process which occurs over one or several meetings includes the following steps which are used to ascertain insurance product suitability.

- **Applicant expectation** – The sales person tries to achieve a common understanding with the applicant about the services that would be provided. The nature of the services the applicant expects is made clear e.g. does the client want to purchase predetermined products or does the client want professional advice and/or product recommendations. As a best practice, product literature and illustration are shared with the applicant for reference.
- **Fact finding** – Where product recommendations or professional advice are sought by the applicant, the sales person obtains information about life stage, investment goals and fund availability. If the applicant has identified his or her needs and has already identified a specific (pre-determined) product, a detailed fact-finding process is not followed.
- **Needs assessment** – Based on the facts and information obtained from the applicant, sales person conducts a Financial Need Analysis to ascertain the need & basis the risk appetite of the applicant & specific requirement, a suitable product is offered to the applicant. The extent of the assessment varies according to product-needs and circumstances.
- **Recommendations and advice** – Basis the fact-finding, needs assessment and advice the client is informed about suitable products and is provided regulatory approved marketing materials and brochures for the client to understand.
    - Signature taken on the Sales illustration of the product being purchased customer
    - Due diligence in disclosure of material facts and information and duly recording in the application/allied forms
    - Welcome Calling is done to all proposers before issuance of policy to check the understanding of the customerWe have designed different sales tools to identify the insurance GAP of an individual
    - These tools also assist sale channel to identify the suitable product for the individual.

6. Channel-wise controls placed to prevent misselling

Agenc

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Focus given on quality of agents recruitment
- Training to agents regarding Sales process and need based selling
- SMS for pending requirements
- Third Party verification (Window Shopping)
- Policy bond dispatch information shared
- Action taken against agents by Market Conduct Committee

Corporate Agents, Bancassurance Partners, Brokers

The following multi-stage process is deployed to control mis-selling and is practiced with Corporate Agents, Bancassurance Partners, Brokers

- **Sales Manager's Report (SMR)** is an assessment of the information shared by the applicant in the application form through a face-to-face or tele-call by Tata AIA Life RM. The objective is to ascertain applicant's understanding of the proposal and also to ascertain product suitability
- **Pre-Submission Calling (PSC)** is an assessment of the applicants understanding of the recommended product and proposal terms and conditions. The call is completed by a Tata AIA Life appointed tele-calling unit which calls every applicant before the application is underwritten and issued.
- **Welcome calling** is a confirmation call to the customer once the policy issued conveying the policy has been issued and the policy contract has been dispatched. It is also to confirm the policyholder has understood the policy terms and conditions.

Direct selling· Policy details verified with customer through pre submission calling before accepting new business

- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Action taken against employees by Market Conduct Committee.

7. Other Measures taken for addressing misselling

- Policy details verified with customer through pre submission calling before accepting new business
- Welcome call post issuance of policy to verify receipt of policy and address queries and explain product features and self service options
- Action taken against agents & employee by Market Conduct Committee
- Premium payment certificate is watermark to mitigate risk & fraud
- Face to Face Customer Service Camps are conducted every month wherein customers are invited to visit Company's Branches & are explained the policy features in detail & customer queries are answered

- Inserts added to PIP kit which briefs customers to:
  1. Read policy contract thoroughly
  2. Check if Product features, Charges, Sum Assured, Payment Term, etc are same as explained during sales
  3. How to register Online to Customer Portal
  4. Provides all touch points to contact company
- Periodic SMS and Email communication sent to customers informing them to beware of spurious & hoax communications. Published in local newspapers to customers to beware of such unsolicited calls.

8. Procedure adopted for dealing with complaints of misselling

- Grievance Redressal policy is periodically reviewed & shared with customers
- All complaints are recorded , processed and documented in CRM
- Our grievance Redressal process is a ISO (10002:2004) certified process
- Customer feedback is sought on complaint handling process through outcall post complaint closure for RCA
- Dedicated team conducts RCA on complaints received and implements solutions to minimize complaints
- Market Conduct Committee periodically reviews agent related complaints & action is taken as per Code of Conduct

An elaborate process of seeking and recording voice of customers (those who have complained and those who do transactions through other touch points) is implemented and monitored.

9. Complaints relating to sale of policies after spurious calls (Channel-wise, resolution status-wise number of complaints relating to spurious calls)

	2013-14			2014-15			2015 -16			Total		
Source	I	P	R	I	P	R	I	P	R	I	P	R
Individual Agents	11	0	49	120	0	211	476	4	11	607	4	271
Bancassurance	3	0	14	48	0	51	53	1	2	104	1	67
Other Corporate Agents	2	0	8	14	0	25	40	2	1	56	2	34
Brokers	1	0	59	29	0	122	123	3	5	153	3	186
Direct selling	0	0	3	10	0	5	21	1	2	31	1	10
Microinsurance agents	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	6	2	0	7	1	0	0	3	0	13
TOTAL	**17**	**0**	**139**	**223**	**0**	**421**	**714**	**11**	**21**	954	11	581

10. Procedure adopted for dealing with complaints of sale of policies after receiving spurious calls

- On receipt of information, a detailed investigation is carried out to ascertain the facts and to verify the telephone number through internet or Truecaller.
- A detailed investigation is carried out to ascertain the facts and to verify the telephone number through internet or Truecaller.
- We co-relate if any such instances has taken place in the past with any other customer.
- On completing preliminary check, a criminal complaint is filed in the police station against the spurious callers and their units.
- In the past, we have registered a FIR in the police station and have taken criminal action against such callers through police.
- Cancellation of policy where allegation gets established

11. Steps taken by the insurer to caution members of public about spurious calls

- SMS is being sent to the customers to be alert on such calls and to inform us.
- E-mail is sent to the customer on the same.
- We have created an alert in our website which informs the customers to verify the credentials of the agent, and callers and report any unsolicited calls/emails to us.
- We also alert our customers through a message in all our communications to them.

12. Action taken against intermediaries found engaged in misselling, misrepresentation, forgery, tampering, spurious calls, etc. (Please indicate any other kind of penalty imposed on erring employees, intermediaries or callers)

Intermediary/ Employee	Number of warning letters Issued			Number of Terminations			Number of police complaints/FIR			Number of cases of commission claw backs		
	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16	2013-14	2014-15	2015-16
Individual Agents	175	65	74	83	32	27	7	4	15	7	1	288
Bank Assurance Agents/Employees	0	0	0	0	0	0	0	0	7	1	0	0
Other Corporate Agents	1	0	0	0	0	0	28	20	2	5	2	2
Brokers	30	14	13	0	0	0	1	0	9	20	8	56
Employees of Insurer	12	9	0	8	2	0	1	0	0	0	3	0
Others (Spurious Tele-callers)	0	0	0	0	0	0			576	0	0	0
Total	**218**	**88**	**87**	**91**	**34**	**27**	**37**	**24**	**609**	**33**	**14**	346

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