LIFE INSURANCE CORPORATION OF INDIA

IC -38 Notes

CLH Pattern

Compiler : Mahesh Shinde

04/05/2023

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

SECTION COMMON CHAPTERS

C - 01 Introduction to Insurance

History of Insurance :

Insurance has existed in some form or other since 3000 BC. Many have practiced the concept of pooling and sharing among themselves, “all the losses suffered” by some members of the community.

Insurance through the ages :

Bottomry Loans - Traders of Babylon paid extra money to their lenders to write off their loans if any shipment was lost or stolen. Traders of Bharuch and Surat also had similar practices.

Benevolent/ Friendly Societies - Greeks of 7th Century A.D use to pay in advance to take care of the family of members who died.

Rhodes - Traders of Rhodes who were sending goods by sea, were sharing losses if any of them lost their goods.

Chinese Traders - They use to send their goods in different ships, so that even if some boats sank, their loss would be partial.

Modern concepts of insurance :

Lloyds - The origins of modern day commercial insurance started at Lloyd’s coffee house in London, where traders agreed to share losses they suffered due to various perils at sea.

Amicable Society for a Perpetual Assurance founded in 1706 in London is considered to be the 1st life insurance company in the world.

Life insurance history and evolution :

India: Modern insurance in India began in early 1800 or thereabouts, with agencies of foreign insurers starting marine insurance business.

The Oriental Life Insurance Co. Ltd	The first life insurance company to be set up in India was an English company
Triton Insurance Co. Ltd.	The first non-life insurer to be established in India
Bombay Mutual Assurance Society Ltd.	The first Indian insurance company. It was formed in 1870 in Mumbai

National Insurance Company Ltd. The oldest insurance company in India. It was founded in 1906

a) The **Insurance Act 1938** was the first legislation to regulate the conduct of insurance companies in India. This Act, as amended from time to time continues to be in force.

b) Life insurance business was nationalised on 1st September 1956 and the **Life Insurance Corporation of India (LIC)** was formed. From 1956 to 1999, the LIC held exclusive rights to do life insurance business in India.

c) In 1972, the non-life insurance business was also nationalized and the **General Insurance Corporation of India (GIC) and its four subsidiaries** were set up.

d) **The Malhotra Committee, in its report submitted in 1994, recommended** opening of the market for competition

e) The Insurance market was liberalized in 2000, with the passing of the Insurance Regulatory & Development Act, 1999 (IRDAI), which also established the Insurance Regulatory and Development Authority of India (IRDAI) in April 2000 as a statutory regulatory body for the insurance industry.

f) An amendment of the Insurance Act in 2021, has allowed Foreign investors, to hold up to 74% of the paid up equity capital in an Indian Insurance company. Foreign insurers can now establish branches in India to do reinsurance.

Insurance industry today (As on 30th September 2021)

a) There are 24 Life insurance companies operating in India. Of these, Life Insurance Corporation (LIC) of India is a public sector company (PSU) and the remaining 23 life insurance companies are in the private sector.

b) There are 34 General Insurance companies of which 4 – The National Insurance Co. Ltd, The New India Assurance Co. Ltd., The Oriental Insurance Co. Ltd and United India Insurance Co. Ltd. are PSU Companies dealing with all lines of general insurance. 26 Private Companies also deal with all lines of general insurance. 6 General Insurers deal only in Health insurance. 2 are specialized insurers - Agricultural Insurance Company [AIC] and Export Credit and Guarantees Corporation [ECGC], both set up as Public sector entities.

c) There is one Reinsurance Company – The General Insurance Corporation of India [GIC Re] and 11 foreign Reinsurers that operate through branch offices.

How Insurance Works : Modern commerce was founded on the principle of ownership of property. When an Asset losses value (by loss or destruction), it incurs an economic loss to owner. This loss can be compensated from a common fund made up of small contributions from many similar asset owners. This process of transferring the chance and consequence of a loss making event is insurance.

Definition - **Insurance is a process by which the losses of a few are shared amongst many of those exposed to similar uncertain events/ situations**.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

There must be an asset which has economic value (Car physical; Goodwill-nonphysical; Eye-personal). These assets may lose value due to uncertain event. This chance of loss/damage is known as risk. The cause of risk is known as peril. Persons having similar risks pool (contribute) money (premium) together.

There are 2 types of Risk Burdens–

i) **Primary burden of risk** – losses actually suffered. Eg. Factory getting fire.

ii) **Secondary burden of risk** – losses that might happen. Eg. Physical/mental Stress strain.

Principle of Risk Pooling :

Insurance is basically a contract between company and different entities – policyholders (Individuals/Corporates). The compensation for the losses by company to entities on the occurrence of event is contractual obligation. **This compensation structure arises from application of Mutuality or the pooling principle**. **Mutuality or pooling** is collection of funds through various individuals from many sources to one. Thus mutuality gives power and Uniqueness to insurance product by paying small contribution (the premium) creating a large quantity of funds (corpus) available in the event of loss. In short here premium Collected from various people is collected in same pool for same risk and used for same kind of risk-claim. Under no circumstances money collected under one risk pool is used for another pool. It also makes use of diversification, where funds flowing from one source is invested/kept at many destinations.

Risk Management techniques :

The various types of techniques that can be used to manage risk are risk avoidance; risk retention; risk reduction and control; risk financing.

Risk Avoidance - It is one of the negative way to handle risk by avoiding the situation.

Risk Retention - also termed as self-insurance.

Risk Reduction & control – more practical and relevant approach to lower the severity of loss.

Risk Financing – it means making provision of funds to face the losses that may take place. It could be through self-financing, retaining with bigger groups or transferring.

Insurance is one of the major forms of risk transfer. Instead of facing the uncertainty of many other forms people prefer insurance as it provides certainty and peace of mind.

Note: Insurance refers to protection against an event that **might happen** whereas **Assurance** refers to protection against an event that **will happen.**

Insurance as a tool for managing risk:

Don't risk a lot for a little. Eg. There is no need to insure a ball pen as its cost is not high.

Don't risk more than what we can afford to lose. Eg. We cannot afford to not insure our house as its cost is high.

Don't insure without considering the likely outcome. Eg. Can anyone insure a space satellite.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Risk – it refers not to a loss that has actually suffered but likely to occur, It is the expected loss. the cost of this loss depends on probability(happening) and severity(amount suffered).

Insurance market players :

Insurers - Insurance Companies

Intermediaries - Agent, Brokers, Banks (Bancassurance), IMFs, POSP

Regulator- IRDAI

Surveyors & **Loss Assessors/ Adjusters** for assessing claims, **TPA** for health claims

Duty - An insurer or its agent or other intermediaries shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be available in his or her interest.

Insurance and Social Security :

Soical Security is an obligation of the state. Providing Employees State Insurance Corporation (ESIC) through Employees state insurance act 1948 is one of the Compulsory & Voluntary provision. Insurers also provide Certain Government Schemes such as PMJJBY (Jivan Jyoti Bima Yojana) PMSBY (Suruksha Bima Yojna); PMFBY (Fasal Bima Yojana); PMJAY (Jan Arogya Yojana - Ayushman Bharat) Pmvvy (Vaya Vandana Yojana Pension Plan); APY - Atal Pension Yojana.

C - O2 Core Elements of Insurance

Elements of Insurance :

• **Asset** - Any physical or non-physical thing that confers same benefits and has an economic value to its owner. Economic value can arise through- Income generation / serving needs. Few things are valuable that cannot be Considered as assets in economic sense due to - abundant Supply & not Scarce - not owned by 1 individual or freely available (eg. Air & Sunlight). Insurance of Assets provide protection only against financial losses arising due to certain unexpected event. It cannot protect an asset from loss or damage.

• **Risk** - Risk can be defined as the chance of a loss. It refers to likely loss or damage that can arise on account of happening of an event. fire in the house, car accident resulting into limb loss.

• **Peril** - It is the cause of the loss. Eg. fire, earthquakes, floods, burglary, heart attack, Aciddent.

Note : Loss occurring due to natural wear & tear are not covered in Insurance.

Hazards and Perils :

The Condition or conditions which increases the probability of loss or its Severity & this impact(s) the risk is known as Hazards. Insurers make assessment of risk, generally with reference to the hazards to which asset is subjected

Asset	Peril	Hazard
Life	Cancer	Excessive Smoking
Factory	Fire	Explosive material left Unattended
Car	Accident	Careless driving by driver
Cargo/Ship	Storm	water seeping inside, Cargo not packaged in waterproof

Types of Hazards –

i. Physical - Defective wiring, water sport activities; Mountaineering, Sedentary lifestyle.

ii. Moral - refers dishonesty / character defects. Buying health insurance after onset of major disease

iii. Legal - prevalent in cases involving a liability to pay for damages.

Mathematical Principle of Insurance (Risk pooling) :

Large number of people	Paying Premium	Premium	Paying Claims to a few who suffered loss
Many people pay	Small amounts of money as Premiums	These small amounts are pooled together as a Common Pool, big enough to pay claims	Big amounts are paid to those who suffer a loss

Insurance work on a principle known as **"Law of Large numbers "**. It states that larger the size of the pool of risk, the actual average of losses wold be closer to the estimated or expected average loss. The system of risk pooling & insurance may fail if sufficient premium pools are not maintained to pay claims that are liable. In short, Insures need to keep Surplus money (solvency margin) to meet unforeseen situations. Solvency Ratio assesses the extent to which assets are available to cover the insurer's Commitment towards future payments. **IRDAI has mandated to maintain minimum solvency ratio of 1.5 in India.**

Conditions for Insuring a risk :

When does it make sense to insure a risk from the insurer's point of view?

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Six broad requirements for a risk to be considered insurable are given below.

i. A sufficiently large number of homogenously [similar] exposed units to make the losses reasonably predictable. This follows from the **law of large numbers**. Without this it would be difficult to make predictions.

ii. Loss produced by the risk must be definite and measurable. It is difficult to decide the compensation if one cannot say for sure that a loss has occurred and how much it is.

iii. Loss must be fortuitous or accidental. It must be the result of an event that may or may not happen. The event must be beyond the control of insured. No insurer would cover a loss that is intentionally caused by the insured.

iv. Sharing of losses of the few by many can work only if a small percentage of the insured group suffers loss at any given period of time.

v. Economic feasibility: The cost of insurance must not be high in relation to the possible loss; otherwise the insurance would be economically unviable.

vi. Public policy: Finally the contract should not be contrary to public policy and morality.

C - O3 Principles of Insurance

Uberima Fides it means that every party to contract must disclose all material facts related to the subject matter of insurance whether asked or not. The rule observed here is "Caveat Emptor" which means buyer beware.

Insurable Interest proposers family history; medical history; financial details; occupational details; illness if any; habits etc. are known as material facts.

Proximate cause it is the main reason behind the various activities taking place and there by resulting into any event.

Indemnity - It means that the policyholder, who suffers a loss, is compensated so as to put him or her in the same financial position. It guarantees that insured would be compensated off to the amount of loss and not more. The philosophy being, one should not make profit out of insurance. In some instances the extent of loss cannot be estimated accurately, especially in marine cases the principle of agreed value is adopted. Indemnity may be settled on following modes -Cash payment; repairs; Replacement &; Reinstatement.

Subrogation – it is corollary of Indemnity, it means transfer of all right and remedies with respect to insurance, from insured to insurer. It basically is a claim process involving third party.

Contribution - It is also a Corollary of Indemnity mostly found in general insurance policies. Where same material is insured through more than one insurer, the compensation to be paid in such

cases should not exceed actual loss and would be distributed proportionately amongst all the Companies involved. It does not arise in the case of life insurance policies.

C - 04 Features & Insurance Contracts

Insurance Contract - an insurance policy is a contract between 2 parties - Insurer (Insurance Company) and Insured (Policy holder) as per Indian Contract act 1872.

Elements of Valid Contract - For any contract to be a valid contract following elements should be there

Offer and Acceptance - out of the 2 parties' one should offer and other party should accept. Usually offer is made by proposer (policy holder) and acceptance is made by insurer.

Consideration - premium paid by policy holder and the promise to indemnify by insurer is known as consideration.

Agreement between parties - both parties should agree to the same thing.

Free consent - there should be no pressure on proposer while taking policy. Consent is free when the policy is taken under no-coercion; undue influence; fraud; misrepresentation; mistake.

Capacity of the parties - proposer should be legally competent. Ie. Sound mind, not disqualified by law, should not be minor.

Legality - the object of contract must be legal.

Paying Premium in Advance – Insurers are not allowed to assume risk unless they receive premium. Insurance protection cannot be sold on credit basis in India. Section 64VB of insurance act 1938 does not allow risk to be assumed unless premium is received in advance. Section 59 of insurance rules allows premium to be accepted in instalments. Eg. Sickness insurance, group personal accident, fidelity guarantee, workmen's compensation & cash in travel insurance.

Solicitation - Insurance is something to be purchased after a proper understanding of the product and not just bought/sold, that it is to be "asked for" by the Customer.

Grace period - the specified period of time, immediately following the premium due date during which submit can be made to renew or continue the policy without at any loss of benefit. For Life insurance, if there is no grace period a Single delay in payment can lead to policy lapse. Generally IRDAI allows a grace period of 15 days for monthly made payment & 30 days in other modes. For Health insurance policies monthly mode policies 15 days & other 30 days. For motor – Insurance have to be renewed before due date, in case of comprehensive policy for more than 90 days, No-claim bonus (NCB) wold b lost.

Free-Look Period - if any proposer after entering into a contract ie. After taking a policy if he wants to cancel or reject the policy then he or she can take this decision within 15 days from

receiving the policy document. 30 days in case of electronic policies and policies sourced through distance mode. Pro-rata premium - proportionate of premium corresponding to expenses for period of insurance cover is charged and refunded less.

C - 05 Underwriting & Rating

Basics of Underwriting

In the previous chapters, we have seen that the concept of insurance involves managing risk through pooling Insurers create a pool consisting of premiums that are made by several individuals/ commercial/ industrial firms/ organizations.

This process of understanding risks, classifying risks, identifying which category they fall into, deciding whether to accept the risk or not and if so, how much premium the insurer would require to accept the risk and whether any extra conditions are to be imposed on the risk –all this comprises the part of Underwriting. It is also important to know what rate is to be charged and how the rates are made. The purpose of underwriting is to classify risks so that depending on their characteristics and degree of risk bored, an appropriate rate of premium may be charged.

Underwriting Comprises - Assessment & evaluation of hazard and risk in terms of frequency and Severity of loss, formulation of policy Coverage along with terms & Conditions, fixing rates of premium.

Sources of information for underwriting

i) Proposal form ii) Risk Survey iii) Historical claims experience data.

Product filing with IRDAI:

Every insurance product needs to be approved by IRDAI before offered for sale. UIN (unique identification Number) for every insurance product is allotted. For withdrawal of products also there are guidelines.

Basics of Rate making

A process adopted for calculating a price to cover the future cost of insurance claims & expenses, including a margin for profit is known as Ratemaking. Rates are not same as premium.

Premium = Sum Insured * Rate. Rate is determined by 2 factor – i) The probability of loss due to a loss event; ii) Estimated amount of loss that may arise due to loss end. How can Insurer ensure that the pool is sufficient to compensate the losses actually incurred? By following / implementing "the Law of large numbers", that is insurance companies need to sell more policies to more & more people to make their expected/predicted Calculations work.

Determine the Rate premium - Rate premium or Burning Cost is the fund which will be sufficient only to pay for losses, but since insurance is commercial product hence pure premium is suitably loaded or increased by adding percentages to provide expenses, reserves and profits. The final rate

of premium will consist of - loss payments, loss expenses (eg. Survey), agency commission, management expenses, margin for profit, margin for reserves for unexpected heavy losses. (eg. earthquake, floods).

Deductibles: Deductible, or excess is a cost sharing provision between an Insurer and insured. It provides when the claims in excess of a partial or threshold is payable by the insurer. In short there is limit to the claims to be paid by insurer. For instance H.I policies there is limit/capping to various availabilities like rooms, instruments etc. For L.I policies there are no deductibles.

Franchise: A threshold set usually as a percentage of some Insured below which no claim is admissible. In event of a claim exceeding the franchise. The full amount of the loss will be paid.

Rating factors

The relevant elements that used to add up the rates and make the rating plan is termed as rating factors. They determine the risk & decide the price to be charged. A base rate is established on which discounts are applied in positive or superior features (loading is applied) in case L.I policies with adverse health, habits, hereditary or occupation factors.

C - 06 Claims Processing

Loss Assessment and Claim settlement

The Process of determining whether the loss suffered by the insured is covered by insurance policy Settlement of claim has to be based on considerations of former, expedition process, which is the benchmark of efficiency for its services and has intend guidelines about time taken is know an Turnaround time (TAT). For speedy processing of claims there are claims hub.

6 important aspect for non-life claims – i) within scope of the policy ii) Complied with his part of policy Condition iii) Compliance with warranties iv) Observance of utmost good faith take measures to minimise the loss v) Determination of the amount payable vi) amount payable depends on - insurable interest, Salvage value, underinsurance, Contribution & subrogation.

In case of life insurance policy claims - Condition of Policy not breached; Utmost good faith followed; No material facts have been concealed fraudulently.

Categories of claim

i) **Standard claim** - **clearly** within the terms & Conditions of the policy

ii) **Average Clause** - In this condition insured are penalized for ensuring his property at sum insured less than its actual value known as under insurance. In event of claim the amount is paid proportionately after reducing from the actual loss.

iii) **Act of God Perils** - Catastrophic losses, natural perils like cyclone, floods, earthquake one termed as "Act of GOD “perils. Surveyors help is taken to assess the nature and extent of loss taken place.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

iv) **Account payment** - Based on interim reports Submitted from time to time where repairs or replacements are made over a long period of the claim if found to be in order, payment is made. In some cases insured may not be the person to whom the money is to be paid.

v) **Discharge Vouchers** - Settlement of claim is made only after obtaining a discharge.

vi) **Post Settlement action** - Action taken after Settlement of the non-life claim in relation to underwriting eg. Personal accident Policy, policy terminates after payment of Capital Sum insured.

vii) **Salvage** - Refers to damaged property, on payment of loss, the salvage belongs to insurers.

viii) **Recoveries** - After settlement of claims, under Subrogation rights can recover the loss paid from a TPA due to his negligence.

ix) **Disputes related to claim** - delay in payment, non-payment (repudiation) etc. might lead to dissatisfaction & dispute. Other reasons been

• Non-disclosure of material facts • lack of coverage • loss due to excluded perils • lack of adequate sum insured • Breach warranty • Issues regarding quantum due to underinsurance, depreciation etc.

Arbitration

It is a method of settling disputes arising out of Contracts Arbitration & Act 1996. The Arbitration act allows the parties to submit disputes under Contracts to more informal, less costly & private process. Arbitration can be done by single party or more than one party , normally the arbitrator's decision is considered final & binding on both the parties. If the 2 Arbitrator's don't agree on a decision then matter is submitted before a Umpire, who makes the quad. Disputes relating to question of liability are to be settled through litigation.

Other dispute resolution Mechanisms

As per IRDAI regulations, all policies have to mention grievance redressed mechanism available to the insured. In case of dissatisfaction, insured can approach insurance ombudsman.

C 07 Documentation

Prospectus

Prospectus is a proposal stage document. The prospectus is a formal legal document used by insurance companies that provide details about the product. It can be a document issued by the insurer in physical, electronic or any other format to sell or promote insurance products. For this purpose, Insurance products would also include the add-on covers/ riders offered, if any. The prospectus is like an introductory document which helps the prospective policyholder to get familiar with the company's products.

As per IRDAI's (Protection of Policyholders' Interests) Regulations, 2017 the prospectus should contain all facts that are necessary for a prospective policyholder to make an informed decision regarding purchase of a policy.

It should contain the following for each plan of insurance:

•UIN • extent of Cover • Scope of benefits/ entitlements • Warranties, exclusions

/exceptions • Gears & conditions • Description of Contingencies to be covered classes of lives/property • Par n Non-participating.

Other important Inclusions

• Any difference - covers and premium • Renewal terms • terms of Cancellation • Discounts/loading • any revision / modification & terms • Any incentives • Copy of section 41

Section 41 - prohibits any direct/indirect inducement to any person for buying new insurance including rebate of the whole or part of the Commission on the policy.

Proposal form

Proposal form it is a form to be filled by the proposer for giving all material fact required by insurer inorder to decide catheter the risk of the proposer to be accepted or rejected.

Proposal form Details • Who he/she is • kind of insurance he/ she needs • Details of insurance • What time period • Details of risk • Details of monetary value proposed

Declaration in proposal from - insurer add declaration at the end of the proposal form to be signed by the proposer. such declaration Converts the Common law principle of utmost good faith to a contractual duty of Utmost good faith.

Know Your Customer (KYC) documents

Know Your Customer (KYC) – It is the process used to verify the identity of their clients. The objective is to prevent financial institutions from being used by criminal elements for money laundering activities. Hence in order to determine the true identity of their customers following documents are called for - **Photographs**; **Age proof** – passport, school certificate, birth certificate; **Address proof** – electricity bill, aadhar card, ration card; **Identity proof** – pancard, passport, driving license, voter id; and **income proof**. **Non standard age proof** – horoscope, ration card, affidavit by self declaration, certificate by village panchayat.

Anti-money laundering (AML) – the prevention of money laundering is the process of bringing illegal money into economy by hiding its origin. The act to curtail was paned in 2002 and person found guilty is perishable for 3-7 years imprisonment and fine upto 5lakhs.

The prevention of money laundering Act (PMLA) 2002 Came into effect from 2005 1st July.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

C - 08 Customer Service

Customer Service

Customers are the most important part of any industry and no enterprise can afford to treat them indifferently. The role of customer service and relationships is important in the service sector and more so for insurance.

Every enterprise has a goal to delight its customers. This can be explained by examining how buying insurance differs from buying a car.

A car can be seen, touched, test driven and experienced, whereas the Insurance of the car is just a promise to pay if there is loss or damage to the car due to an accident. This promise is intangible – it cannot be seen, touched or experienced.

While the customer of the car will be able to understand and experience the car easily, the customer of insurance can evaluate and experience the insurance protection that he buys only when a loss happens and the insurance company settles the claim. All customers do not get the chance to experience this. In insurance, when such a situation arises, if the service exceeds expectations, the customer would be delighted.

Quality of service It is necessary for insurance companies and their personnel, which includes their agents, to render high quality service and delight the customer.

SERVQUAL attributes - Reliability, Responsiveness, Assurance, Empathy and Tangibles.

Customer service & insurance

Getting in top and staying there is the patronage and support of a large number of existing clients with whose help the business gets built. These clients are a source of commissions from renewal of existing contracts. These can be a valuable source for acquiring new customers.

One great mantra of success in insurance selling is to be able to convert one's customers into one's clients. Customers are those who buy a product. Clients, on the other hand are people with whom an agent relates for life, who continue to buy from him/ her as also help and possibly, support him/ her in reaching out to and selling to other customers.

Clients are built by working with deep commitment to serving one's customers. To understand how keeping a customer happy benefits the agent and the company, one should understand the **concept of Customer's Lifetime Value**.

Customer Relationship & Service

What goes in to making of a good relationship is TRUST that you generate in your customers mind through – Attraction; Being Present; Communication.
Represent physical environmental factors like location, layout and cleanliness are also the sense of professionalism that a customer feels when contacting a service provider. First impressions last long.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Insurance Agents' role in providing customer service

i) **Point of sale** – the 1st point for service is the point of sale. The agent should be able to understand the needs and suggest products whose benefit features are best suitable. The role of an agent is like a personal financial planner and advisor.

ii) **Proposal stage** – the agent has to help customers in filling the proposal form. It is important that the agent explains and clarifies the proposers doubt while filling the form.

iii) **Acceptance stage** – the promptness of agent in handing over FPR to customer develops surety in customers mind. Delivery of policy bond is another major opportunity.

iv) **Premium payment** – agents can be in continuous touch with their customers through reminder calls for premium dues in order to avoid lapsation of policy.

v) **Claim settlement** – agents play crucial role during claim settlement by providing policy holder details required during investigation stage.

vi) **Other services** – another opportunity that agents have in order to give their best is during other services such as nomination change, assignment, duplicate policy etc..

vii) **Grievance redressal** – the time for high priority action is when the customer has a complaint, the issue of service failure can lead to 2 types of feeling/emotion – a) sense of unfairness, cheating; b) feeling of hurt - ego being made to look and feel small.

Comunication Skills

One of the most important set of skills that an agent needs to possess for effective performance is soft skills. Soft skills relate to one's ability to interact effectively with other workers, customers. What goes into making of a good relationship is TRUST that you generate in your customers mind through – Attraction; Being Present; Communication. Communication can take place in several forms – Oral; Written; Non-Verbal; Body Language. Lastly possessing good listening skills and being not judge -mental helps a lot. Elements of effective listening – paying attention, providing feedback, responding appropriately, empathetic listening and not being judgemental.

Nen Verbal Communication - 1st impression – on time, presenting appropriately, smile, open, confident, positive, body language – confident , trustworthy listening skills - paying attention, Removing filters- non-judgemental, Emphatic.

Ethical Behaviour –

Some characteristics of ethical behavior are:

a) Placing the best interests of the client above one's own direct or indirect benefits

b) Holding in strictest confidence and considering as privileged, all business and personal information pertaining to client's affairs

c) Making full and adequate disclosure of all facts to enable clients make informed decisions

There could be a likelihood of ethics being compromised in the following situations:

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

a) Having to choose between two plans, one giving much less premium or commission than the other

b) Temptation to recommend discontinuance of an existing policy and taking out a new one

c) Being aware of circumstances that, if known to the insurer, could adversely affect the interests of the client or the beneficiaries of the claim.

C-09. Grievance Redressal Mechanism

Grievance redressal mechanism –

IRDA has various regulations in order to render the consumers grievances/complaints which come under protection of policyholder's interests' regulation 2002.

Integrated grievance management system (IGMS) – IRDA has launched an integrated grievance management system (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievances in the industry. Policyholders can register on this system with their policy details. Complaints are then forwarded to the respective insurance company.

The consumer protection act 1986 – the act was passed to provide for better protection of the interest of consumers and to make provision for the establishment of consumer's disputes".

.**service** – any provision made available to potential users such as banking, financing, transport, insurance etc.

.**consumer** – any person who buys any goods for a consideration or hires or avails of any services for a consideration.

.**defec**t – it means any fault, imperfection, shortcoming, in adequacy in quality, nature, manner or performance for any service that is taken by the customer.

Complaint – it means any allegation given in writing regarding any unfair trade, defect in goods, deficiency in services hired or availed, excess pricing.

.**consumer dispute** – It means a dispute where the person against whom the complaint is made, denies and disputes the allegations made on him.

There are 3 consumer dispute redressal agencies to handle such complaints at each level –

District forum - They take complaints where value of goods is up to Rs.20 lacs. Established by each state govt. In each district.

State commission - They take complaints where value of goods is more than 20 lacs but less than 100 lacs. Established by state govt. In each state. They take cases which are not settled at district forum.

National commission - They take complaints where value of goods is exceeding Rs.100 lacs. Established by central govt. By notification. They take cases which are not settled at state level.

Procedure for filling a complaint – the complaint can be filled personally or by any authorised person. There is NO fee for filling complaint. No advocate is needed.

Nature of complaints – delay in settlement of claims, non-settlement of claims, repudiation of claims, policy term & conditions improper etc.

Consumer forum orders – if allegations made in the complaint is proved then the forum can issue an order to opposite party :

Return of goods price (premium in case of insurance)

To remove defects or deficiencies in the services in goods.

To discontinue unfair trade practice to provide adequate costs to the parties.

To award such amount as compensation to the consumers for any loss or injury.

Insurance Ombudsman **(Lokpal)** :- the objective to resolve all complaints relating to settlement of claim on the part of insurance companies in a cost effective, efficient and impartial manner. The ombudsman by mutual agreement of the insured and the insurer can act as a mediator and counsellor within the terms of reference. The decision of ombudsman– whether to accept or reject the complaint is final.

Complaints to ombudsman – any complaint should be made in writing, signed by the insured or his legal heirs. Complaints can be made if – complaint was initially made to insurer and was rejected or not received by insurer, no satisfactory reply given by insurer, complaint is made within 1yr from date of rejection from insurer, complaint is not pending in any court or consumer forum.
Recommendations by ombudsman – ombudsman has to give his recommendation within 1month of receipt of complaint. Copies of recommendation are sent to both complainant and insurer. Recommendations have to be accepted in writing by complainant within 15 days of receipt. A copy of acceptance letter by the insured should be sent to insurer and his written confirmation within 15 days of his receiving such acceptance letter.

Awards by ombudsman – the awards should not be more than Rs. 20lacs, the award should be made within a period of 3months from date of receipt of complaint, and the insurer shall abide by the award and send written intimation to the ombudsman within 15days. If the insured does not intimate in writing the acceptance of such award, the insurer may not implement the award.

Right To Information

RTI ACT 2005- IRDAI and insurers may have to reveal certain information to customers and others, also allow them to inspect the work, document records, extracts or certified copies as and when required.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

C-10 Regulatory Aspect for Insurance Agents

IRDAI (Appointment of Insurance Agents) Regulations, 2016 that came into force with effect from 1st April 2016, is discussed in this part.

Appointment letter – letter issued by an insurer to any person to act as an insurance agent.

Insurance agent – an individual appointed by an insurer for the purpose of soliciting or procuring insurance business including business related to continuance, renewal or revival of policies.

Designated official – an officer authorised by the insurer to make appointment of an individual as an insurance agent.

Appeal provision – appellate officer who are authorised by the insurer to consider and dispose representations and appeals received from an appointed insurance agent. Appeal to be done within 45 days of the order. Decision in writing to be given within 30 days of receipt of the appeal.

Insurance regulations and regulatory Framework :-

Importance of insurance regulations – some common concerns are: is insurance legal; are agents recognized by law; are insurers regulated or supervised; is document provided legally valid; will claim be paid if loss happens.

Requirement of insurance regulations – the prime purpose is policy holder's protection. As we have RBI in order to regulate all banks in India and SEBI (securities exchange board of India) to regulate all capital markets. Similarly we have IRDAI (Insurance Regulatory and Development Authority India) to keep check on all insurance companies in India.

Insurance regulatory framework – the insurance act 1938 is the basic insurance legislation of the country, which governs insurance business in India. The IRDA was established in 2000. The obligations prescribed by regulator to insurer are applicable – at the point of sale; towards policy servicing; claims servicing; control on expenses & investments; financial strength to meet the commitments to policyholder.

Regulatory Compliance for Agents:- As per the insurance act 1938 (section42), to work as an insurance agent, one must have a valid licence. IRDA deals with issuance of licences and other matters related to agents recruitment. Agents of life and non-life (general) insurance can do business for stand-alone health insurance companies as well. Agents who want to change their insurance companies need to submit NO-Objection certificate (NOC).

Rules governing licensing of insurance agents :- .Qualification, Practical training, Examination –Fees payable, Cancellation of license – in case of any disqualification mentioned – he is minor; he is of unsound mind; he is found guilty of criminal misappropriation or breach of trust/cheating or forgery; he is found committing fraud, dishonesty.

Agent's code of conduct:-

.disclose his license to the proposer on demand.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

.explain carefully all information regarding the product.

.indicate the premium to be charged

.obtain require documents from the proposer

.assist policyholder in filling up the form

.disclose commission to be received on the policy if policyholder demands for it.

.cannot solicit the business of insurance without holding valid license.

.cannot offer different rates, terms and conditions which are not mentioned in policy.

.cannot force any policyholder to close any policy

NOTE: - Insurance institute of india is the only examination body approved by irdai to conduct pre-recruitment tests for insurance agents.

SECTION LIFE INSURANCE

L-01 what life Insurance Involves

Asset – any physical or non-physical thing which has value ie. Can measured in terms of money is known as Asset. Every human being has a value which can be determined and is termed as Human Life Value (HLV).

HLV helps to determine how much insurance one should have for full protection.

Eg. Mr.Mahesh earns Rs.120000 per annum and spends Rs.24000 on himself. Therefore net earning for family in case of Mahesh's death is Rs.96000 per annum. Suppose rate of interest is 8% then

HLV = 96000/0.08 = 12,00,000 .

Risk Insurance – Risk there are various types of risk involved for a human being such as
Dying too early; Living too long; Living with Disability.

Difference between general n life insurance

General Insurance	Life Insurance
Indemnity: General insurance policies, with the exception of Personal Accident Insurance, are usually contracts of indemnity i.e. after an event like fire, the insurer assesses the exact amount of loss that has occurred and compensates only that amount of loss – no more, no less.	Assurance**:** Life insurance policies are contracts of assurance. The amount of benefit to be paid in the event of death is fixed at the beginning of the contract. An assured sum is paid to the nominees or beneficiaries of the insured when he dies.
Duration: The contract is generally short period or for one year renewable basis	The contract is generally long term though some one year renewable contracts are also prevalent

Name: Mahesh B Shinde
Branch: 90A Mumbai Div4
Contact: 9029106565 / 9322669032
Email: maheshshinde.lic@gmail.com

Uncertainty: In general insurance contracts, the concerned risk event is uncertain. No one can be certain about whether a house would catch fire or a car meet an accident.	There is no such question Death is certain once a person is born. What is uncertain is the time of death. Life insurance offers protection against the risk of premature death.
Increase in probability: In case of General insurance perils like fire or earthquake, the probability of happening of the event does not increase with time.	In life insurance the probability of death increases with age.

Nature of life insurance risk since probability of death increases with age, lower premiums are charged for those who are young and higher premiums for older people.

Indemnity – in the occurrence of an event, the procedure to assess the loss and pay

The compensation for this loss is known as Indemnity.

Level Premium – it is a premium fixed in such a manner that it does not increase

With age but remains constant throughout the contact period.

Principle of Risk Pooling – it works on the principle of mutuality. Here premium

Collected from various people is collected in same pool for same risk and used for

Same kind of risk-claim. Under no circumstances money collected under one risk

Pool is used for another pool. It also makes use of diversification, where funds

Flowing from one source is invested/kept at many destinations.

Contract – taking insurance involves getting into a contract. Here the contract is between the Insurer (Insurance company) and Insured (Policyholder).

• Nature of Life Insurance risk - Since probability of death increases with age, lower premium are charged for those who are young & higher premium for older people.

Advantage	Disadvantages
safe & Secure investment	Returns not beating inflation
Compulsory saving discipline	High marketing & other initial costs
Provides Liquidity	Yield low compare to other Financial
Income tax advantages Safe from creditors' claims	instant but guaranteed

L-02 Financial Planning

Financial planning is a process to identify his goals; assess networth; estimating future financial needs; and working towards meeting those needs.

Goals – Short term – buying LCD Television; family vacation. Medium term – buying house. Long term – Children's education/marriage; post – retirement provision.

A) **Economic Life Cycle** :–

. Student Phase – this is pre-job phase. One is getting ready for earning phase.

. Working Phase – this phase starts around 20-25yrs of age and lasts for 35-40yrs.

. Retirement Phase – this phase is where in one has stopped working.

B) **Individual life cycle** :–

. Learner [till age 25] – this is the learning phase of an individual.

. Earner [25 onwards] – this is the phase when one starts earning.

. Partner [28-30yrs] – this is the phase when one gets married.

. Parent [30-35yrs] – this is the phase when one move towards parenting.

. Provider [35-55yrs] – this is the phase when parents have to fulfil children's needs.

. Empty Nester [55-65yrs] – this is the phase when children get married.

. Retirement [60 onwards] – this is the phase when one gets retired and there's no regular source of income. Health also gets deteriorating.

C) **Individual Needs** :–

. Enabling future transactions – making provision for future transactions such as education marriage.

. Meeting contingencies – keeping money for unforeseen events like unemployment, hospitalization, death etc.

. Wealth accumulation – this is to be done for increasing your money value.

D) **Financial products** :– for above needs to be fulfilled following products can be used

. Transactional product – bank deposits can be used for cash requirements.

. Contingency product – Insurance can be used to protect against unforeseen events.

. Wealth accumulation product – shares; bonds can be used to invest for wealth creation.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Role of Financial Planning : –

It is a process in which clients current and future needs are considered and evaluated along with his risk profile and income assessment. Financial planning includes – Investing, Risk management, Estate planning, Retirement planning, Tax planning and financing daily and regular requirements.

Note – the right time to start financial planning is when one starts receiving his 1st salary.

Need for Financial Planning :– Disintegration of joint family; multiple investment choices; changing lifestyles; inflation; other contingency needs.

Financial planning types

(i) **Cash planning** - It is done to manage income and expenditures flow systematically to create and maintain a Surplus.

(ii) **Insurance planning** - It is done to manage untimely premature death or in case of emergency hospitalization for medical expenses.

(iii) **investment planning** - It is done based upon individuals risk taking appetite, financial goals & the time horizon to meet the goals. Investment parameters will depend on returns, liquidity, taxes, diversification marketability and risk tolerance along with proper products such as FD, SSC; Share debentures, MF, Ulips,

(iv) **Retirement Planning** - it is done to meet one's needs post retirement. It involves accumulation, Conservation & Distribution.

(v) **Estate Planning** - it is done in order to transfer ones estate after ones demise. It can be done through nomination, assignment, will.

(vi) **Tax planning** - It is done to gain maximum benefit on the income earned through proper planning under the Pertaining tax laws (80(C) & 10 10(D))

L-03 Life Insurance Products: Traditional

Overview of life insurance products :-

Product can be turmed as commodity, a goods bought and sold in market. Products can be tangible is – one which are physical objects (such as T.V) and intangible is – one which are just perceived (such as bank FD returns).

Life insurance is an intangible product where the customer is made to understand features and returns of it. Life insurance products offer protection against the loss of economic value of an individual's productive abilities it is not only used for protection against death and disease; it is also a financial product for long term investment.

A rider is a provision typically added to basic policy in order to increase the death cover or supplementary benefits such as accident cover rider, premium waiver, term rider, critical illness rider, and disability income benefit rider.

A) Traditional life insurance products :-

I) **Term insurance plan** :- it is the simplest form of insurance plan to offer only death cover risk – in the event of premature death of the policyholder it provides income to the family. A term insurance plan cover only death. It is the cheapest insurance plan available in market. Term insurance plan can be converted to whole life plan but the new premium will be higher. Term insurance plans death cover can be increased or decreased during the term of plan. Some term insurance plan has return of premium (ROP) option as well. Some term insurance plans are also marketed as mortgage redemption and credit life insurance plans.

Note :- Term insurance plan does not provide any amount on maturity.

II) **Whole life plan** :- whole life plan are permanent life insurance policy there is no fix term, here the policy holder receives money no matter when the death occurs. Premium of whole life plan is very high. Whole life insurance helps in developing savings and creating wealth for the next generation.

III) **Endowment assurance** :- it is a combination of 2 plans ; term assurance plan and a pure endowment. Thus this plan has both death and survival (maturity) benefit. Endowment plans are bought in order to meet Certain purpose such as Childs education marriage etc. Money back policy, children policy etc are some variations of endowment insurance policy.

B) Par and Non-Par Schemes :- participating policy are the ones where the profit earned by the insurer on investment done is distributed back in the form of bonus. They are also known as with-profits' plans. Money back, whole life etc. are par schemes. Non-participating policy are the ones where the policy holder are not entitled to participate in the profits of the insurance company. They are also known as "without-profits plan" term insurance plan is non-par scheme policy.

NOTE :- according to IRDA guidelines, new traditional product will have higher death cover.

I. For single premium policy it will be 125% of single premium for below 45years and 110% of single premium for above 45years.

II. For regular premium, it will be 10 times of annualized premium for below 45years and 7 times of annualized premium for above 45years.

Pension Plans & Annuities : A pension plan is one in which money is funded over a period during the person's employment years and then withdrawn after his retirement in periodic form. Pension plans guarantee life time money thus insuring against longevity. There can be occupational or employee pension else one can purchase pension plans from Insurance Companies. Pension plans can be on immediate basis or deferred for over a time period.

To provide uniformity across insurers, to reduce confusion, IRDAI introduced a Common/standard immediate annuity product - Saral pension in Jan 21. It offers only 2 options a) Life Annuity with 100% Return of purchase price b) Joint life Annuity with 100% annuity to 2nd annuitant and 100% return of purchase price on death of last survivor.

L-04 Life Insurance Products: Non Traditional

Non-traditional life insurance products :-

Insurance products are considered and compared with others financed products available in market. In order to achieve inter- temporal allocation of resources is allocation of funds across the time (life-span) ,insurer and other investment organisation started for searching various kind of product compared to traditional insurance products.

Cash valve compared :- it depends on assumptions such as mortality, interest rate, expenses.

Rate of return :- it is not certain what rate of return would be given on tradition

Surrender value :- it is also not certain what would be the exact surrender value on if depends on the actuarial reserve of the policy

Yield :- the yield on traditional policy may not be as high compared to others .due to above limitation in traditional policy people started drifting.

The various kinds of shifts that occurred in the products are as follows :-

Unbundling - separating the protection part and saving element of the policy. This led to discovery of new products like universal insurance, variable insurance, unit linked insurance.

Investment linkage - rather than giving only financial security, products with high yield and managed by fund managers were introduced.

Transparency - this brought in greater visibility in the rate of return and expenses incurred by insurer for their services were revealed.

Inflation beating returns - In order to fulfil the inflation beating return policy to policy holders investment linked insurance policy were introduced.

Flexibility - policy holders were given the choice to decide on investment in death benefit and cash values. It also provided mix of funds.

Non- traditional life insurance :- Universal life insurance plan - it was introduced in USA in 1979. As per IRDA all universal life products shall be known as variable insurance products .One major feature of such products was its flexible premium option. The flexibility in the product also allowed the policy holders for partial withdrawal.

In India as per IRDA norms there are only 2 kind of non- traditional savings life insurance products.

Variable insurance plans (VIPs) :- It is a kind of life policy where death benefit and cash value of the policy fluctuates according to investment performance of premium invested in it. The policy provides no guarantee with respect to interest rate or minimum cash value. This cash value is allotted in separate investment accounts and depending upon the performance of such separate investment account the cash value grows and earns interest. The main reason for purchase of VIPs is the policy holder must be able and willing to bear the investment risk on the policy.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Unit Linked Insurance Plan (ULIPs) :- ULIPs the investment of such policies is done in

. Equity fund ie. In equity or equity related instruments;

. Debt funds ie in government bonds, corporate bonds, fixed deposits;

. Balanced funds ie. Mix of equity and debt funds;

. Market funds ie. Treasury bills, certificates of deposits, commercial papers etc.

In ULIPs the investment is invested in the form of units. The value of units is given by net asset value (NAV). The insured decides on the amount of premium to be contributed at regular intervals. In case of death sum assured or fund value whichever is higher is payable.

L-05 Application of life Insurance

Key man insurance – it is used for business purpose. Keyman insurance does not indemnify the actual loss incurred but compensates with affixed monetary sum as specified in insurance policy. Thus keyman insurance can be described as an insurance policy taken out by a business to compensate that business for financial loss that would arise from death of an important member. Keyman insurance is a term insurance policy where the sum assured is linked profitability of company and not the key person's income. In case the keyman dies the benefit is received by the company.

Mortgage Redemption Insurance – it is an insurance policy that provides financial protection for home loan borrower. It is basically decreasing term life insurance policy taken by mortgagor to repay the balance mortgage in case of his/her premature death. It is also known as loan protector policy. The insurance cover decreases each year.

Married Women's Property Act (MWP) – section 6 of MWP act 1874 provides for security of benefits under a life insurance policy to the wife and children. Under MWP act the life insurance policy forms for a creation of trust. Features of policy under MWP act –

. each policy will be a separate trust. Either the wife or child can be trustee.

. policy will be beyond control of court attachments, creditors or even life assured.

. the claim money will be paid to trustees.

The policy cannot be surrendered, nomination and assignment is not allowed

L-06 Pricing & Valuation in life Insurance

Insurance pricing basic elements :-

Premium – the price that is paid by an insured for purchasing insurance policy.

Rebates – insurance companies may offer certain discount on the premium. There are basically 2 such rebates – rebate for high sum assured and for mode of payment.

Extra charges – in case of certain policies where extra benefits are to be given such as rider benefits (eg. Double accident benefit) or for a customer with high risk are charged extra amount in premium.

Determining the premium – mortality, interest, expenses of management, reserves and bonus loading are the elements which determine the premium. Mortality and interest are used to get net premium and other elements such as expenses of management, reserves and bonus are added to get gross premium.

Mortality and interest – mortality tables designed by actuarial and interest ie. Discount rates assumed to arrive at present value of future claim payments to be made are used to arrive at net premium. Higher the mortality rate, higher is the premium. Higher the interest rate assumed lower is the premium.

Expenses and reserves – life insurers incur various operating expenses – agents training and recruitment, commission of agents, staff salaries, office accommodation, stationery, electricity etc. Lapses and withdrawal of policy also add for increase in expenses of the company.

Bonus loading – it is the margin of profits earned within the premium paid in order to provide cushion against unforeseen activities and also to be paid for policy holder's share of surplus distributed as bonus.

Gross premium = net premium + loading (expenses & contingencies) + bonus loading.

Surplus and Bonus :-

Surplus is the excess of value of assets over value of liabilities. Ie. **Surplus = assets – liabilities.** The value of assets is determined using its book value (the price at which it was acquired); market value (the price of that asset in current market); discounted present value. The surplus earned is also to be allocated in proper manner in which is done using solvency requirement and free assets.

Bonus is an addition to the basic benefit paid to policyholder. The most common form of bonus is reversionary bonus. Bonus are payable even on surrender of policy. The various bonuses given on life insurance policies

. **simple reversionary bonus** – it is the percentage of the basic cash benefit under the contract. In India it is an amount per thousand sum assured.

. compound bonus – it is a percentage of basic benefit and already attached bonus. It is thus bonus on bonus.

. **terminal bonus –** it is given at the contractual termination (ie. Death or maturity). It depends upon the time duration of the contract.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

L-07 Life Insurance Documentation

Proposal stage documentation :-

Prospectus - it is a formal legal document by insurer that provides details about the product. It states the terms and conditions, scope of benefits- guaranteed non- guaranteed; entitlements; exceptions.

Proposal form - it is a form to be filled by the proposer for giving all material required by insurer in order to decide catheter the risk of the proposer to be accepted or rejected.

Age proof - age is a factor that insurer use to determine the risk of propose verification of correct age through appropriate document thus is important standard age proof- school certificate, birth certificate, passport, pan card, register, certificate baptism, I-card defence personnel, non-standard age proof- ration card, village- panchayat certificate, horoscope, self- declaration.

Agent report - agent is primary under writer. All material facts and particulars about the proposer such as health, habits, occupation, income, family etc.

Medical examiners report - the medical examiner's report is required typically when the proposal cannot be considered under normal condition ie. Sum proposed is high or age is high or there are certain characteristics which call for examination and report by medical examiner.

Moral hazard report - it is the likelihood that a client's behaviour might change as report of purchasing a life insurance policy and such a change would increase the chance of loss.

Policy Stage documentation

First Premium Receipt (FPR*)* - it is that document issued by insurer which gives the evidence that the policy contract has begun. The FPR contains – Name & address; policy number; premium amount; mode of payment; next due date; date of commencement; date of maturity; date of last premium; sum assured. The subsequent receipts given are known as renewal premium receipt (RPR).

Policy Document - it is the evidence of the contract between the assured and the insurer. Policy document is to be signed and stamped according to the Indian stamp act. In case of loss of policy document, duplicate policy document can be issued from insurer. Policy document has 3 parts –

Policy Schedule – it is found on the front/ face page of the policy. It normally contains – name of the company, ombudsman's address, signature & policy stamp, promise to pay (this forms heart of the contract), some of specific details – name & address of policy holder, date of birth, plan term sum assured, amount of premium, premium paying term, date of commencement, date of maturity, name of nominee, mode of premium, policy number.

Standard Provisions – standard policy provisions which are present in all insurance contracts, unless excluded such as term, single premium.

Specific Policy Provisions – specific provisions generally linked between insurer and insured are mentioned in it. Eg. A clause precluding death due to pregnancy for a lady who is expecting while taking policy.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Policy conditions and privileges :-

Grace period – the clause that grants the policy holder an additional period of time to pay the premium even after its due date is known as grace period. The standard length of grace period is 1 month or 30 days. The policy would be considered lapse if the premium is not paid after grace period is over. If the policy holder dies during grace period, the insurer would deduct the last premium and then give the benefits. In case of death after grace period insurer are not obliged for payment of claim.

Lapse and Reinstatement / Revival – the policy is considered to be lapse if the premium is not paid even after the grace period is over. Lapse policies can be revived. Revival / reinstatement of policy means to put back into force which have been stopped / terminated due to non payment of premiums or non-forfeiture. Revival of policies however is not unconditional right of insured. Insurer will do it if they think –there is no increase in risk for insurer, creation of reserve, payment of overdue premium with interest, satisfactory evidence of continued insurability, revival application within specific time period, payment of outstanding loan. Policy revival measures –

. **Ordinary revival** – one which involves payment of arrears of premium with interest. It is affected when surrender value is acquired.

. Special revival – one which policy has not completed 3yrs and has not acquired surrender value and time from first unpaid premium (**FUP**) is more.

. Loan cum revival – one in which simultaneous granting of loan and revival of policy is done. Arrears of premium and interest are calculated as pre ordinary revival.

. Instalment revival – sometimes policy holder is not in a position to pay arrears in lump sum. The arrears of premium are calculated and depending on mode of payment are asked to pay in future premiums as distributed.

Non – Forfeiture provisions - *o*ne of the important provisions that allow for accrual of certain benefits to policy holders even when they are unable to keep their policies in full force. If the policy has not been surrendered it shall subsist with reduced paid up value.

. **Surrender value** – it is a percentage of paid up value. It is different at different term of policy. It depends upon the type and plan of insurance, term of policy, premium paying term. Surrender value is arrived as a percentage of premiums paid is called as guaranteed surrender value.

. **Policy loan** – policy holder can take loan on their policy as each policy has accumulated certain cash value and loan is given against its security. Policy loan amount is generally 90% of surrender value. No legal obligation to repay the loan but if the loan is not repaid it can be recovered by deducting it from policy benefits. No credit check is required.

Special policy provisions and endorsements –

Nomination – it is the person who is entitled to receive the amount in case of the death of policy holder. Life assured can nominate one or more than one person. Nomination can be changed. In case of multiple nominees no specific share can be made for each nominee. Where the nominee is minor, the policy holder needs to appoint an appointee. The appointee needs to sign the

declaration. Appointee loses its status once the minor nominee attains 18yrs of age. In case of minor nominee death, money is paid to legal heirs. It comes under section 39.

Assignment – the term assignment refers to transfer of property by writing as distinguished from transfer by delivery. On assignment, nomination is cancelled, except when assignment is made to insurer for loan. The person who transfers the rights is called assignor and the person to whom it is transferred is called assignee. There are 2 types of assignment –

. **Absolute** – In such assignment all rights, title and interest are transferred to assignee without any reversion in policy.

. **Conditional** – In such assignment the policy shall revert back to assignor after the fulfilment of prescribed conditions in the policy. Conditions for valid assignment –

. First of the person who transfers ie. Assignor must have absolute right & title on policy.

. Assignment should be supported by value consideration, which may include love affection etc.

. It should not be opposed by any law in force.

. Assignee can do another assignment but cannot do nomination.

Duplicate policy – a duplicate policy is issued to policy holder on loss of policy. Standard procedures are to be followed in case of loss of policy document. Satisfactory proof may be required to produce in order to deal with such cases. If required advertisement may be placed in national paper and produce indemnity bond.

Alteration – the provision to make certain changes in policy document is known as alteration. Certain common alterations are change in name address, mode of payment, reduction in sum assured, change in term (if risk is not increased), change in date of commencement, splitting up of policies, removal of extra premium or certain clause, settlement option for payment of claim.

L-08 underwriting

Underwriting :- Basic Concepts

The process of insurers to decide whether the proposal to be accepted or rejected depending upon the proposal information and insurers requirements and procedure is known as underwriting.

Underwriting purpose - to prevent anti selection or selection or selection against the insurer. Anti selection can be termed as the degree of risk where in it is high or low and thereby resulting in high loss, gain from insurance.

To classify risks and ensure equity among risks. Equity among risks here refers to those applicants who are exposed to similar degree of risk and are to be grouped together and charged same premium.

Degree of risk (or) risk classification -

Standard lives – those applicants / proposers whose mortality rate is considered to be as per standard requirements.

Preferred lives – those applicants / proposers whose mortality rate is significantly low and hence can be charged lower premium.

Sub –standard lives – those applicants / proposers whose mortality rate is higher than standard lives but insurable. They are charged extra premium.

Declined lives – those applicants / proposers whose mortality rate is very significantly high and cannot be insured at affordable cost.

Selection process - underwriting or selection process takes place at 2 levels

Field level (or) primary level – it includes information gathering of proposer through agents. Hence agents are also termed as primary underwriters. He monitors if any information given by proposer is true or not as he is the person who is in direct contact with proposer. He sends his confidential report containing proposer's occupation, income, financial standing and reputation.

Department level – at office level a specialist person who is expert in judging the collected data and considering this relevant data decides whether to accept or not the proposal. Such experts are known as underwriters.

Underwriters may use two types of methods for the purpose :

Judgment Method	**Numerical Method**
Under this method subjective judgment is used, especially when deciding on a case that is complex.	Under this method underwriters assign positive rating points for all negative or adverse factors (negative points for any positive or favourable factors).
Example: Deciding whether life insurance can be given to a person staying in a disturbed country/ area.	**Example:** A person with history of cardiac ailments and/ or early deaths in the family may be assigned positive points. The total number of points so assigned will help an underwriter in deciding the extent of risk involved.
In such situations, the department may get the expert opinion of a medical doctor who is also called a medical referee.	The sum total of these positive/negative points, and/or is referred to as Extra Mortality Rating (EMR). Higher EMR indicates that the life is substandard. If the EMR is very high, underwriters may decline insurance.

Underwriting decisions - the various options available to underwriter besides accepting or rejecting the proposal are as follows.

Acceptance at ordinary rate (OR) – it is the most common decision where in the proposal is accepted at same premium as it would apply for standard lives.

Acceptance at extra rate (ER) – it involves charging extra premium for sub- standard lives.

Acceptance with lien – it is kind of hold on sum assured amount. It implies if a policy is accepted under lien and if the proposer dies within lien period then the nominee is entitled to receive decreased sum assured. Lien is applicable normally for 1/3rd period of the total period.

Acceptance with restrictive clause – for certain kind of hazards or restrictive clause is applied; if tomorrow claim arises due to such clause then full sum assured is not payable.

Decline or postpone – if the proposer does not fit in any of the above conditions ie. They are very adverse and there is little chance of improvement then such cases are declined or decision on them is postponed for certain time period.

Rating factors in underwriting : -

Female insurance – insurability of women depends upon various factors such as income source (own, heir); pregnancy problems; moral hazards- domestic violence.

Minors – insurability of minors look for capacity of parents; need for insurance; has properly developed physique; proper family history; parents adequately insured.

Large sum assured – insurability for large sum assured policies raise a doubt of concern. Generally S.A is to be 10-12 times of annual income.

Age – insurability for advanced age group is to be considered with utter care. As chances of moral hazard is very high. Some special reports may be called.

Moral hazard – it is termed as characteristics of an individual's financial situation, lifestyle, habits, reputation, mental health that indicate his / her intentions.

Occupational hazard – insurability for people with occupational hazard may arise due to accident – driver / circus artists / stuntmen's; health – chemical factory workers / nuclear plant / deep sea divers; moral – criminal mind / night club workers.

Lifestyle and habits – drinking and smoking.

Non-medical underwriting :- a large number of proposals get accepted without conducting medical examination. Such cases are termed as non- medical proposals. Depending upon the information given in proposal form such cases are underwritten under non-medical case. Conditions for non-medical underwriting -

. certain categories of female, like working women may be eligible.

. upper limit of sum assured for eg. Cases above 5lac may need to undergo medical.

. entry level of age. Proposers above 40-45 age may compulsory need medical.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

. term of the policy. Insurer might restrict term up to 20 yrs or maturity age till 60.

. class of lives. Depending upon work area insurer might call for medical.

Medical underwriting :- the medical factors that would influence an underwriter's decision. They may often call for a medical examiner's report. Factors involved are-

Family history – 3 factors are taken into consideration in order to understand family history of the proposer

. heredity – certain diseases can be transmitted from one generation to another.

. average longevity of family – if parents have died early due to cancer, heart trouble.

. family environment – the environment in which the family lives.

Personal history – it refers to past impairment of various systems of human body which the proposer might have suffered.

Personal characteristics –

. build – for a given age & height there is a standard weight, if the standard weight is too high or too low then such proposals need to be checked.

. blood pressure – another indicator to know personal characteristic. Average pulse rate should be 72 and varying between 50-90.

. urine-specific gravity – one's urine indicates the salts in the body. Its mal

-functioning can be indicated through its test.

L-09 Life Insurance Claims

Types of claims and claims procedure :-

Claim is a demand that the insurers has to fulfil the promise specified in the contract claims can be of 2 types

i) Survival claim - claims payable even when the life inured is alive.

ii) Death claim – claims payable on the death of the life assured.

A Claim event is said to have occurred when
. For survival claim the event has to be occurred as per stipulated conditions.
. Maturity claim & money back claims are given based on determined dates.
. Surrender value are claims to be given based on decision taken by insured.
. Critical illness claims are processed based on medical and other records provided.

Payments to be done during the policy term :-

Survival benefits payment – payments made at regular intervals by insurer at specified time during the policy term.

Surrender of policy – the voluntary decision taken by the policy holder to stop the policy contract. The amount payable to insured is surrender value.

Rider benefit – a payment done by insurer on occurrence of specified event according to terms and conditions. The policy continues even after the rider benefit payment is done.

Maturity claim – a payment done by insurer at the end of the policy term, if the insured survives the entire term of the policy. The insurance contract comes to an end after maturity claim is paid.

Death claim – if the insured expires during the term of the policy, accidentally or otherwise, then the insurer pays the sum assured, bonus, etc to nominee; assignee or legal heir. Such payments are known as death claim. Contract comes to an end. Death claim can be

. early death claim – claim that arises within 3yrs from start of policy.

. non-early death claim – claim that arises after 3yrs from start of policy.

Forms to be submitted by nominee; assignee or legal heir on death are claim form; certificate of burial or cremation; treating physicians certificate; hospitals certificate; employers certificate; certified court copies of police reports in case of accidental death; death certificate issued by municipal authority.

Repudiation of death claim – if it is detected by insurer that the proposer had made any incorrect statements or had suppressed material facts relevant to policy, the contract becomes void. All benefits under the policy are forfeited.

Indisputability clause – a policy which has been in force for 2yrs cannot be disputed on the ground of incorrect or false information. The insurer will have to prove in order to repudiate a policy after 2yr period.

Presumption of death – the Indian evidence act 1872 deals with presumption of death; under this act if an individual has not been heard off or seen for 7yrs then they are presumed to be dead. It is necessary that premiums should be paid till the court decrees presumption of death.

Claim procedure for life insurance policy -

. it is included in the IRDA(protection of policy holder's interests) regulation 2002.

. insurer will call upon the primary documents which are normally required.

. any query or requirement of **additional documents** are to be asked within **15days**.

. a **claim is to be paid** or be disputed giving all relevant reasons within **30days**.

. in case of any **dispute over the claim**, it shall initiate and complete within **6months** from the time lodging the claim.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

. claim is ready for payment but cannot be done due to **lack of proper identification**, the life insurer shall **hold such amount** and shall earn interest as per schedule banks saving accounts rate (effective from **30days** following the submission of all papers and information).

.on **delay of payment** of claim on its completion would earn an **interest of 2%** above the prevalent rate of interest.

Role of agent -

An agent shall render all possible service to the nominee, legal heir or the beneficiary in filling up the claim form accurately and assist in submission of these at insurer's office. Apart from discharging obligations, goodwill is generated from such a situation where by there exists ample opportunity for the agent to procure new business or referrals in future.

SECTION 3 HEALTH INSURANCE

H-01 INTRODUCTION TO HEALTH INSURANCE

What is healthcare :- Health is a state of complete physical, mental and social well being and not merely the absence of disease. Determinants of health

Lifestyle factors – those which are mostly in the control of the individual concerned eg. Exercising and eating within limits, avoiding worry and leading to good health; and bad lifestyles and habits such as smoking, drug abuse, unprotected sex and sedentary (no exercise) lifestyle.

Environmental factors – safe drinking water, sanitation and nutrition are crucial to health, lack of which leads to serious health issues as seen all over the world. Certain diseases are also caused due to environmental factors eg. People working in certain manufacturing industries are prone to diseases related to occupational hazards such as coal miners facing lung problems.

Genetic factors – diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends.

Levels of healthcare :- Healthcare is nothing but a set of services provided by various agencies and providers including the government, to promote, maintain, monitor or restore health of people. Health care to be effective one needs – appropriate catering to needs of people, comprehensive, adequate, easily available, affordable.

Health status varies from person to person. The health care facilities should be based upon the probability of the incidence of disease for the population. For example, a person may get fever, cold, cough, skin allergies etc, many a times but chances of him/her suffering from Hepatitis B, Asthma etc is less. Hence the need to set up the health care facilities in any area should be based upon various factors such as – size of population, death rate, sickness rate, disability rate, social n mental health of people, nutritional state of people, environmental factors such as industrial area, socio-economic factors such affordability.

Types of healthcare :- health care is broadly categorized as follows

Primary – it refers to the services offered by the doctors, nurses and other small clinics which are contacted first by patient for any sickness. For most of the primary care cases, the doctor acts like a ‘family doctor’. Primary health care centres are set up both by government and private players.

Secondary – it refers to services offered by medical specialists and other health professionals. It includes intensive care services, ambulance facilities, pathology, diagnostic and other relevant medical services.

Tertiary – it refers to specialized consultative healthcare. It includes providers who have advanced medical facilities and medical professionals, eg. Oncology (cancer treatment), organ transplant, high risk pregnancy etc. it is to be noted as the level of care increases, the expenses associated with care also increases.

Factors affecting the health systems in India :-

Demographic or population related – due to overpopulation people are exposed to various problems and the level of poverty has affected the ability to pay for medical care.

Social – due to urbanization ie. People moving from rural to urban areas, lifestyle has become more sedentary. Also lack of availability & accessibility of medical facilities has affected a lot.

Life expectancy – the average lifespan of people has increased resulting into old age diseases. So one has to cater issues related to longer lifespan.

Evolution of health insurance in India :-

Employees' state insurance scheme – it was introduced under ESI act 1948. ESIC is the implementing agency which runs its own hospitals and dispensaries. Workers earning up to Rs.15000 are covered under contributory scheme wherein employee n employer contribute 1.75% and 4.75% of pay roll. State government contributes 12.5% of medical expenses.

Central government health scheme – it was introduced in 1954 for central government employees including pensioners and their family members working in civil jobs. It is partly funded by the employees and largely by the employer. The contribution from employees is quite nominal though linked to salary scale – Rs.15 to Rs.150 per month.

Commercial health insurance – it was offered by some of the non-life insurers before as well as after nationalisation of insurance industry. In 1986, 1st standardised health insurance product for individuals and their families was launched in India. This product Mediclaim was introduced to provide coverage for hospitalization expenses up to a certain annual limit and certain exclusions such maternity, pre-existing diseases. Health insurance has grown tremendously but there is large untapped market even today.

Health insurance market :-

it is made up of many players some providing the infrastructure, services, intermediaries and also other regulatory, educational as well as legal entities.

Infrastructure –

. Public health sector – it operates at national, state n district level. These include anganwadi workers, trained birth attendants, ASHA (Accredited Social Health Activists). Sub centres have been established for every 5000 population, primary health centres which are referrals for 6 sub centres are established for every 30000 population, community health centres are referrals for 4 primary centres for every 1lac population. Rural hospitals, speciality and teaching hospitals include medical colleges, other agencies belonging to government, such as hospitals and dispensaries of railways, defence etc. however their services are restricted to their employees n dependants.

. Private sector providers – India has very large private health sector providers ranging from trusts, solo practitioners, diagnostic laboratories, pharmacy shops. Private health expenditure accounts more than 75%.

. Pharmaceutical industry – it is a large industry which has grown from Rs.10 cr in 1950 to Rs.55000 cr till now.

Insurance providers – general insurance sector provide the bulk of health insurance services. There are 5 standalone health insurance companies as on date.

Intermediaries :–

Insurance brokers – they are individuals or corporate and work independently of insurance companies. They represent people and are remunerated by insurers.

Insurance agents – they are individuals who work only for 1 life, 1 non- life n 1 standalone insurance company. They are also remunerated by insurers.

Third Party Administrators (TPA) – they provide administrative services to companies such as preparing data base, collecting bills, providing health cards etc.

Web aggregators – they are the newest type of service providers through web and telemarketing. They are remunerated based on the leads converted to business.

Insurance marketing firms – they have been permitted to sell insurance products of 2 life, 2 non-life and 2 stand alone health insurance companies. They are allowed to solicit or procure only retail business.

H-02 Health Insurance Documentation

A proposal form -

It incorporates a prospectus, which gives details of the cover, such as Coverage, exclusions, provisions etc. It forms part of the proposal form.

•Proposal form Collects information such as name, add, occupation, DOB, Sex, income, Pan, qualification.

•If also collect medical Condition of the prospect which forms underwriting details for risk calculation

• Insured person has to give full details of any other illness or disease suffered or accident sustained

• Additional facts, Past insurance & claim history has to be disclosed in the proposal form

• Special features of the declaration to be signed by proposer must be noted.

• The declaration includes, usual warranty regarding the truth of the Statement. Proposal form forms the basis of the Contract.

Medical questionnaire - In Case of adverse medical history, the insured person has to complete a detailed questionnaire relating to various diseases. This form is scrutinised by Companies panel doctor based on whose opinion, acceptance, exclusions etc all are decided.

Nature of questions

• Previous & present insurance : Proposer has to inform if any insurance was declined, imposed special conditions increased premium or refused.

• Claim experience : declare full details of all losses suffered by him/her whether or not insured.

Acceptance Proposal (Underwriting) - *The process of scrutinising the proposal and deciding about acceptance is known as underwriting. The insurer has to process the proposal form within 15days.*

Prospectus :- In health policies, a Prospectus is also provided to the insured and he has to declare in the proposal that he has read and understood it. It should clearly state the scope of benefits, extent of cover and other issues such as riders, warranties, exceptions and conditions. Section 64VB of the insurance ACT1938 stipulates that premiums have to be collected in advance.

Policy Document:- The policy is a formal document which provides an evidence of the contract of insurance. A certificate of insurance provides proof of insurance in cases where it may be required.

IRDAI Regulations for protecting policy holder's interest act 2017 specified that a Health Insurance Policy document should contain:

a) The name(s) and address(es) of the insured and any other person having insurable interest in the subject matter

b) Full description of the persons or interest insured

c) The sum insured under the policy person and/ or peril wise

d) UIN of the product, name, code number, contact details of the person involved in sales process;

e) Date of birth of the insured and corresponding age in completed years;

f) The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break

g) The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross reference to the concerned policy section;

h) Co-pay limits if any;

i) The pre-existing disease (PED) waiting period, if applicable;

j) Specific waiting periods as applicable;

k) Deductible as applicable – general and specific, if any Perils covered and exclusions

l) Premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium along with periodicity of instalments if any

m) Policy terms, conditions and warranties

n) Action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy

o) The obligations of the insured in relation to the subject-matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances

p) Any special conditions

q) Provision for cancellation of the policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation of the insured

r) The details of the Add-on covers, if any

s) Details of Grievance Redressal mechanism and address of Ombudsman

t) Details of Grievance Redressal mechanism of Insurer;

u) Free-look period facility and portability conditions;

v) Policy migration facility and conditions where applicable.

Conditions and Warranties :- A condition is a provision (eg. Claim must be filed within certain days from date of discharge) in an insurance contract which forms the basis of the agreement. A warranty is a condition expressly stated in the policy which has to be strictly & literally complied for validity of the contract.

Endorsements :- If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement. Eg. Change in sum insured, addition deletion of family members.

H-03 Health Insurance Products

Introduction to Health Insurance Products :- A health insurance policy provides financial protection to the insured person in the event of an unforeseen and sudden accident / illness leading to hospitalization. Life insurance companies may offer long term health products where as non-life and standalone health insurance companies may provide 1yr or maximum 3yr tenure products. Thus providing 2 major benefits providing financial assistance to pay for medical bills, preserving the savings of an individual.

Regulations for Health Insurance :- Some important changes have been brought in Health Regulations, 2016 regarding Health Products, some of which have been given below:

1. Life Insurance Companies can offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.

2. Non-Life and Standalone Health insurance companies can offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium will remain unchanged for the tenure.

3. Insurance companies may offer innovative ‘Pilot-Products’. General-Insurers and Health-Insurers, can offer these products for policy tenure of 1 Year, but not exceeding 5 Years. Group Health Policies can be offered by any insurer for a term of one year except credit linked products where the term can be extended up to the loan period not exceeding five years.

4. No Group Health Insurance Policy shall be issued where a Group is formed with the main purpose of availing itself of insurance. The Group shall have a size as determined by the Insurer which shall be applicable for all its group policies, subject to a minimum of 7.

5. General Insurers and Health Insurers may also offer Credit Linked Group Personal Accident policies for a term extended up to the loan period not exceeding five years.

6. Multiple policies –In case insured has taken health policies from more than one insurance company which provide fixed benefits, each insurer shall make the claim payment, on occurrence of an insured event, independent of payments received from other similar policies in accordance with the terms and conditions of the policies.

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to ask for a settlement of his/ her claim in terms of any of his/ her policies. The insurer on whom the claim is made shall make the claim payment and balance claim or claims disallowed under the earlier chosen policy/ policies may be made from the other policy/ policies even if the sum insured is not exhausted in the earlier chosen policy/ policies.

IRDA issued Guidelines on standardization in health insurance in 2016 which was further amended in 2020. These are applicable to all General and Health Insurers offering indemnity based Health insurance (excluding PA and Domestic/ Overseas Travel) products (both Individual and Group)

The guidelines now provide for standardization of:

1. Definitions of commonly used insurance terms

2. Definitions of critical illnesses

3. List of optional items of expenses in hospitalization indemnity policies

4. Claim forms and pre-authorization forms

5. Billing formats

6. Discharge summary of hospitals

7. Standard contracts between TPAs, insurers and hospitals

8. Standard File and Use format for getting IRDAI for new policies

9. Standardisation of exclusions

10. Exclusions not allowed

Broad Classification of Health insurance products:- Health insurance products can be classified on the basis of number of people covered under the policy: individual policy, family floater policy, group policy. They are also further classified in 2 categories

Indemnity cover – these products pay for actual medical expenses incurred due to hospitalization.

Fixed benefit cover – also known as "hospital cash" pay for a fixed sum per day for the period.

Classification based on customer segment a) Individual cover – retail customers and their family members b) Group cover – for corporates covering their employees c) Mass policies – for govt schemes such as PMJAY, State health insurance schemes.

Besides above products there are other products such as personal accident cover, Overseas health insurance or Travel insurance.

Life Insurance can offer long term health products, premium will remain unchanged for 3yrs after which it can be reviewed and modified.

Hospitalization Indemnity product:- It protects one from the expenditure incur in the event of hospitalization. In most of the cases they cover only a specific no. of days before and after hospitalization, but exclude other expenses done. In short the cover is provided on "Indemnity" basis. A regular **HIP** covers expenses only if the duration is more than 24hrs.

Inpatient Hospitalization expenses:- A hospitalization expenses policy or Mediclaim reimburses the cost of hospitalization expenses incurred on account of illness / accident.

Day Care Procedures:- some surgeries do not require or can be conducted at specialized hospitals eg. Eye surgery, dialysis these can be classified under day care surgeries.

OPD Cover:- coverage of outpatient expenses is still very limited in India. Very few products offer OPD cover.

Pre hospitalization expenses:- would be relevant medical expenses incurred during period up to the defined number of days (generally 30 days) prior to hospitalization and will be considered as part of claim.

Post hospitalization expenses:- would be relevant medical expenses incurred during period up to the defined number of days (generally 60 days) after hospitalization and will be considered as part of claim.

Domiciliary hospitalization:- the condition in which the patient cannot be taken to hospital and needs to be given cover at his place itself. This cover has an excess clause of 3-5 days wherein the initial treatment cost of given days is to be borne by the insured.

Common exclusions:- some of the exclusions in HI policies are Pre-existing diseases, covering the costs of treating existing medical conditions is not part of insurance. Diseases suffered within 48 months prior to commencement of the policy are regarded as pre existing. All non-medical items expenses, waiting period of 30days from start of policy.

Family floater:- In a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Coverage options available:- Individual coverage – can cover himself along with family members such as spouse, dependents. In such covers, each person insured under the policy can claim upto the maximum amount.

Renewability:- HI policies have a contract life of one year, fresh policies to be issued every year. at the same time lifelong renewability has been made compulsory by IRDAi.

Special Features of Hospitalization Indemnity Products (HIP):- number of changes can be done to existing coverage and value added features can be used as per one's convenience.

Sub limits and disease specific capping – one can put limit to per day room charges to 1% of sum insured and in case of ICU 2%.

Co-payment – a specified percentage of the admissible claim amount is bear by policyholder/insured.

Deductible – benefits given to insured before hospitalization and which are charged such deductibles are not payable by insurer.

New exclusions – genetic disorders, service charges, doctor's home visit all fall under exclusions.

Zone wise premium – cities such as Delhi, Mumbai fall under highest premium zone.

Coverage of pre-existing disease – pre-existing diseases which were excluded are included after a waiting period of 4yrs. In high end products it is 3-4yrs.

Renewability – lifelong renewal option is available now as per IRDAI in all policies.

Coverage for Day-care procedure – policies are including treatment of illnesses which are done in 1day. Earlier only 7procedures were included now the list has gone up to 150.

Cost of pre-policy check up – insurer reimburses the cost of medical examination provided the policy is accepted.

Duration of pre n post hospital covers – it is 60 and 90 days in most of the policies.

Add on covers – maternity, critical illness benefit policy with a provision to pay a lump sum amount on diagnosis of certain ailments which are life threatening, coverage of AYUSH up to certain percentage is included.

Value added covers – they provide other benefits such as Out-patient covers provide for medical expenses like dental treatments, vision care expenses routine medical examinations and tests etc. that do not require hospitalization., Hospital daily cash which provides a fixed sum to the insured person for each day of hospitalization, donor's expenses, reimbursement of ambulance, recovery benefit is paid if total period of stay is less than 10days.

High Deductible or Top-up Covers:- offer cover for higher sum insured over and above a specified chosen amount (called threshold or deductible). These covers are available on individual and family basis.

Senior Citizen policy:- entry age of such policy is 60yrs and lifelong renewable. Sum insured ranges from 50,000 to 5lac. **Standard health product** – Arogya Sanjeevani no variations in terms & conditions but premium may vary according to pricing of each company. **Critical Illness policy** – a basic HI policy may not be sufficient to cover all medical costs, in such cases a provision to pay a limp sum amount on diagnosis of certain diseases is done through critical illness policy. It is commonly sold by life insurers as riders. To avoid confusion , IRDAi has listed 22 common critical illnesses.

The fixed benefits cover:- provides adequate cover to the insured person and also helps the insurer to effectively price his policy. Some of the fixed benefit insurance plans are i. Hospital

daily cash insurance ii. Critical illness insurance plan (also known as dreaded disease cover or trauma cover). Both these plans can be sold as standalone cover or add-on cover. In all critical illness policies **waiting period of 90days** and **survival clause of 30days** after diagnosis of illness is carried out.

Disease specific product:- Corona kawach, corona rakshak are few to name. kawach is mandatory to be be provided by GI n HI whereas rakshak is optional. Waiting period of 15days for both the products.

Long term care insurance:- these products are yet to be developed in Indian market. There are 2 types of such plans pre-funded and immediate need.

Bhavisya arogya policy a pre funded insurance plan was designed long back in 1990 by general insurance companies. It was a deferred mediclaim policy with entry age of 25 to 55yrs and retirement age 55 to 60yrs with a condition of 4yrs gap between joining age n retirement age. In case of death or withdrawal before retirement age refund of premium is allowed. Grace period of 7days for renewal premium is given, this plan also provides assignment.

Government Schemes:- Rashtriya Swasthya Bima Yojana S.I-30,000. Pradhan Mantri Jan Arogya Yojana(PMJAY) with S.I of 5,00,000 also known as Ayushman Bharat. Pradhan Mantri Suraksha Bima Yojana(PMSBY) covers personal accident death & disability for 18-70yrs having savings bank account. Enrolment 1st June to 31st May.

Combi Products:- life insurance plans are combined with health insurance products. It is packaged through 2insurers. Marketing of combi products can be done through direct marketing, brokers, composite individuals and corporate agents common to both insurers. It cannot be marketed through bank referral arrangement.

A Personal Accident (PA) Cover:- provides compensation in the form of death and disability benefits due to unforeseen accidents. Types of disability covered are i) permanent total disability ii) permanent partial disability iii) temporary total disability. Sum insured of such policies is basically 60times of gross monthly income.

Overseas Mediclaim / Travel Policies:- provide cover to an individual against exposure to the risk of accident, injury and sickness during his stay overseas. Corporate Frequent Travellers Plan is an annual policy whereby a corporate takes individual policies for its executives who frequently make trips outside India.

Group Health cover:- is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals. In India regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking group policy. **Corporate Floater or Buffer** Cover amount helps meet excess expenses over and above the family sum insured.

Special products:- disease specific covers like cancer, diabetes have been introduced by insurer for long term cover of 5-20yrs.

Key Terms in Health policies:- health insurance terms have been standardized by IRDA by regulation to avoid confusion especially for the insured.

Network provider – they are hospitals or health care providers enlisted by TPA or insurer or both to provide medical services by cashless.

Preferred provider network (PPN)

Cashless service

Third party administrators (TPA) – any person who is licensed by IRDA and is engaged for a fee or remuneration by insurance company for the purpose of providing health services.

Hospital – any institution having in-patient or day-care treatment facility and has atleast 10 beds in city with population less than 10,00,000 and 15 beds in other places along with trained nurses n doctors round the clock. Fully equipped operation theatre and maintain daily records of patients and makes accessible to insurer.

Medical practitioner – a person who holds valid registration from medical council.

Qualified nurse - a person who holds valid registration from nursing council of any state/India.

Notice of claim – claim documents for reimbursement is to be submitted within 15days of discharge.

Free health check – for 4 claim-free policy year's reimbursement is given for health check done.

Cumulative bonus – for every claim-free year the sum insured gets increased on renewal by fixed percentage which is maximum allowed upto 50% for ten claim-free renewals.

Malus / Bonus – If the claims under policy are very high then malus or loading of premium is collected at renewal.

No-claim Discount - Discount in next year's premium if it is claim-free year instead of bonus on sum insured.

Co-payment – here insured bears some portion of the claim

Deductible / Excess – it is the fixed amount to be paid by insured before claim is paid by insurer.
Room rent restrictions

Renewability clause – Insurer can deny renewal on basis of fraud, misrepresentation or suppression or non-disclosure of material facts.

Cancellation clause – Insurer can at any time cancel the policy with a minimum of **15days** notice in writing to insured.

Free look in period – Insured can cancel if the terms n conditions of the policy are not what he expected within **15days** from receiving of policy document.

Grace period for renewal – **30days** grace period is allowed for renewal from date of expiry.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

H-O4 HEALTH INSURANCE UNDERWRITING

Health insurance is based on the concept of **morbidity** which is defined as the risk of a person falling ill or sick.

A) **Underwriting** is the process of assessing the risk appropriately and deciding the terms on which the insurance cover is to be given. Thus it is a process of risk selection and risk pricing.

Need of Underwriting is required to strike a proper balance between risk and business thereby maintaining the competitiveness and yet profitability for the organisation is the backbone of an insurance Company.

Factors affecting chance of illness Some of the factors which affect a person's morbidity are age, gender, habits, occupation, build, family history, past illness or surgery, current health status and place of residence. The deliberate intention of taking insurance just to collect a claim is moral Hazard is HI.

B) **Underwriting Purpose** The purpose of underwriting is to **i)** prevent adverse selection against the insurer and **ii)** ensure proper classification and equity among risks. Risks are further classified as

i) Standard risk - those people whose chance of falling ill is average.

ii) Preferred risk - those people whose chance of falling ill is significantly lower than average and can be charged lower premium.

iii) Substandard risk - those people whose chance of falling ill is higher than average but still considered for insurance subject to some restrictions or higher premium.

iv) Declined risk - those people whose chance of falling ill is very high and cannot be insured.

C) **Selection process** it takes places at 2levels. The agent is the first (primary) level underwriter as he is in the best position to know the prospective client to be insured. The second level is at the department (office) level. i) other HI regulation ii) Portability of HI iii) Migration of HI

D) **Portability** - the right to transfer from one insurer to another insurer intimidated The key tools for underwriting are: one plan to another plan of the same insurer Posting can be done at time renewal of rancese

E) **Migration**- to transfer with the same insurer, should be done atleast 30 days before renewal premium date.

F) Basic Principles of insurance and tools for underwriting The core principles of insurance are: utmost good faith, insurable interest, indemnity, contribution, subrogation and proximate cause.

The Key tools of underwriting are:

i) proposal form - it is the base of the contract where all the critical information pertaining to health and personal details is mentioned.

ii) age proof - premiums are based on the basis of the age of the insured. Valid age documents are divided in 2 categories i) standard age proofs - school certificate, passport, domicile certificate, pan

card etc. ii) non-standard age proofs - ration card, voter id, elder's declaration, gram panchayat certificate etc.

iii) financial documents - financial status of proposer is understood and reduces moral hazard.

iv) medical reports - medical reports are asked depending upon the age and sum insured opted.

v) Reports of salesperson - report given by sales people form an important information for policy acceptance.

Underwriting Process

i) Medical underwriting is a process which is used by the insurance companies to determine the health status of an individual applying for health insurance policy.

ii) Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.

iii) Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.

G) HI at Group level – standard underwriting process involves evaluating – typr of group, size, type of industry, eligible persons, entire group or option for members, level of coverage, composition of group on sex, age, single, married, location. Such policies have both on duty / off duty coverage.

H) Underwriting of PA Insurance – main factor in underwriting is occupation of the insured person. To fix premium rates, risk zones are classified Risk I- doctors, accountants, architects, admin jobs. Risk II – builders, contractors, engineers, supervisors. Risk III – underground mine workers, bike/car racing activities.

I) Underwriting of Overseas Travel Insurance – premium rate depends on age and duration of foreign travel, premium rates are higher.

The underwriting process is completed when the received information is carefully assessed and classified into appropriate risk categories.

Group health insurance is mainly underwritten based on the law of averages, implying that when all members of a standard group are covered under a group health insurance policy, the individuals constituting the group cannot anti select against the insurer. As a part of risk management process, the underwriter uses 2 methods of transferring his risks especially in case of large group policies

i) **Coinsurance** - it refers to acceptance of a risk by more than one insurer. Normally it is done by allocating certain percentage to each company.

ii) **Reinsurance** - the process of insurer to re insure his risk with other insurance company is known as reinsurance.

H-O5 HEALTH INSURANCE CLAIMS

Insurance is a "promise" and the policy is a "witness" to that promise. The occurrence of insured event leading to a claim under the policy is the true test of that promise. One of the key rating parameter in insurance is the claims paying ability of the insurance company.

Stakeholders in claim process

Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.

Owners have big stake as payers of claims, it is they who are liable to keep the promise.

Underwriters understand the claims in design the products, decide policy terms, conditions n pricing.

Regulator maintain order in insurance sector, protect policy holder's benefits

Third Party Administrators (TPA) process health insurance claims.

Agents/Brokers not only sell policies but also provide service in event of claim of policy

Providers/Hospitals they ensure for smooth claim experience during cashless hospitalization.

Reserving : In many cases, insurance companies may not be able to settle claims instantly and may have to wait for information or the results of disputes, litigation etc. So, they have to hold the claim amounts in reserve till the payments are due. Reserves are usually are actuarial estimates of the amounts that will be paid on outstanding claims.

Reserving refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims.

Claim process in health insurance

In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer/TPA and later submits the documents for settlement of the claim.

In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer/TPA for payment.

Documentation in health insurance claims requires a range of documents for processing.

Discharge summary - it gives the complete information about the condition of the patient and treatment

Investigation reports - it helps in comparing the diagnosis and the treatment

Consolidated and detailed reports - it decides what needs to be paid under the policy

Receipt for payment - to claim the amount one requires formal receipt of amount paid from the hospital

Claim form - it is the formal and legal request for processing the claim which is duly signed by customer

Identity proof - for verification of the person covered and treated to be same his ID proof is taken)

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Document Contingent to specific claims – require additional documents such as medico legal certificate, case indoor papers/ medical charts.

If a fraud is suspected by insurance company in case of insurance claim, it is sent for investigation. Investigation of a claim could be done in-house by an insurer/TPA or be entrusted to a professional investigation agency.

In case of a denial, the customer has the option, apart from the representation to the insurer, to approach the Insurance Ombudsman or the consumer forums or even the legal authorities.

Frauds occur mostly in hospitalization indemnity policies but Personal accident policies also are used to make fraud claims.

Cashless settlement processed by TPA.

Role of Third Party Administrators (TPA) provides many important services to the insurer and gets remunerated in the form of fees.

Providing networking services - in the form of hospitals with cashless claim payments.

Call centre services - in the form of toll free number available 24*7-365

Cashless access services

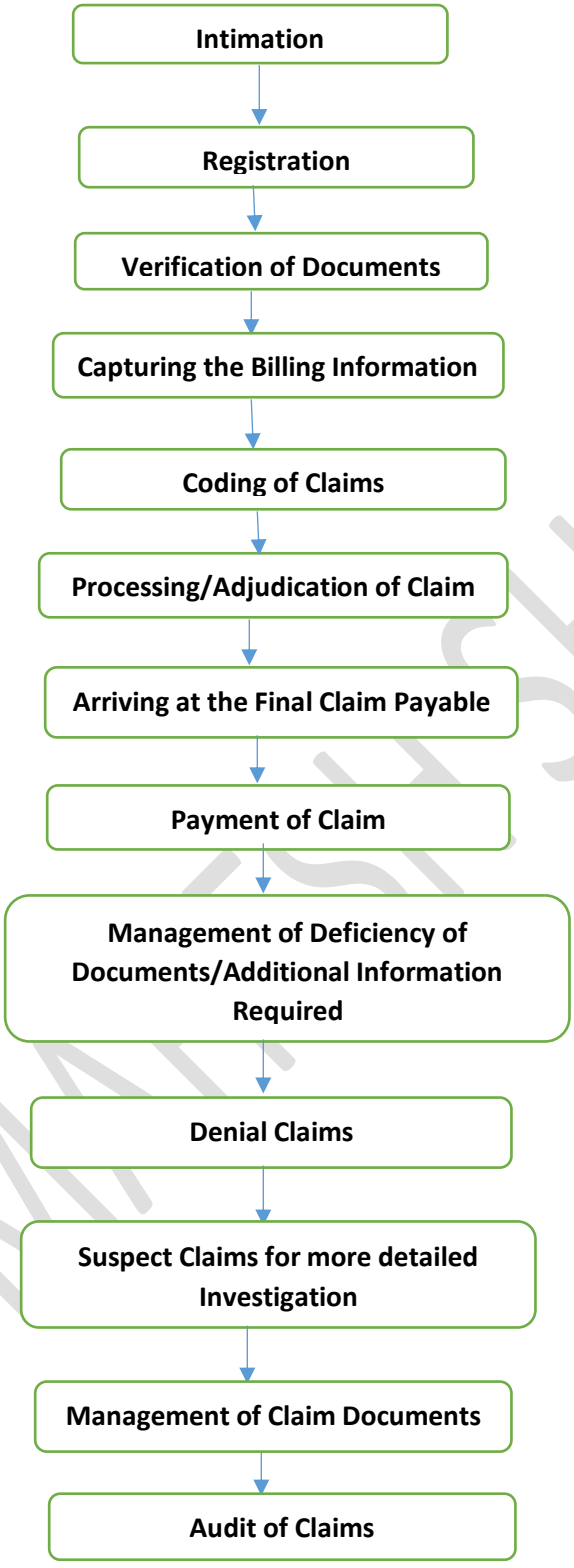
Customer relationship and contact management - to represent customer grievances

Billing services - in order to code, verify and standardize the billing data

Claim processing and payment services in order to make sure the money is accounted and provided to the claimant on approval

Management information services - to keep data of claims made and provided accurately time n when needed by insurance company.

Claim Process broadly comprises of following steps (not in exact order)



Name: Mahesh B Shinde
Branch: 90A Mumbai Div4
Contact: 9029106565 / 9322669032
Email: maheshshinde.lic@gmail.com

Claims Management – Personal Accident

On receipt of the notification of the claim the following aspects should be looked into:

a) Person in respect of whom the claim is made is covered under the policy

b) Policy is valid as on date of accident and premium has been received

c) Loss is within the policy period

d) Loss has arisen out of "Accident" and not sickness

e) Check for any fraud triggers and assign investigation if need be

f) Register the claim and create reserve for the same

g) Maintain the turnaround time (claim servicing time) and keep the customer informed of the development of the claim.

Claims Investigation

Claims Investigation is about determining the validity of the claim and finding out the real cause and extent of the loss. On receipt of the claim documents, if a claim appears suspicious, the claim may be assigned to an internal/ professional investigator for verification.

Claim documentation- Each company gives a list

a) Duly completed Personal Accident claim form signed by the claimant's nominee/ family member

b) Original or Attested copy of First Information Report.

c) Original or Attested copy of Death certificate.

d) Attested copy of Post Mortem Report if conducted.

e) Attested copy of AML documents (Anti-money laundering) - for name verification (passport/ PAN card/ Voter's ID/ Driving license) for address verification (Telephone bill/ Bank account statement, Electricity bill/ Ration card).

f) Legal heir certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized

g) Permanent disability certificate from a civil surgeon or any equivalent competent doctors certifying the disability of the insured.

h) Medical certificate from treating doctor mentioning the type of disability and disability period. Leave certificate from employer giving details of exact leave period, duly signed and sealed by the employer.

The above list is only indicative, further documents (including photographs of scar marks, site of accident etc.) may be required depending on particular facts of the case, especially the cases with suspected fraud angle to be investigated.

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

Claims Management- Overseas Travel Insurance

The coverage under this policy has already been discussed under the product chapter. This section tries to explain how the claims arising during overseas travel are handled.

Claims services essentially include:

a) Taking down the claim notification 24*7 basis;

b) Sending the claim form and procedure;

c) Guiding customer on what to do immediately after loss;

d) Extending cashless services for medical and sickness claims;

e) Arranging for repatriation and evacuation, emergency cash advance.

Assistance companies – Role in overseas claims

Assistance companies have their own offices and tie up arrangements with other similar service provider's world over. These companies offer assistance to the customers of insurance companies in case of contingencies covered under the policy.

These companies operate a 24*7 call centre including international toll free numbers for claim registration and information. They also offer the following services and charges for the services vary depending on agreement with the particular insurance company, benefits covered etc.

a) Medical assistance services:

i. Medical service provider referrals

ii. Arrangement of hospital admission

iii. Arrangement of Emergency Medical Evacuation

iv. Arrangement of Emergency Medical Repatriation

v. Mortal remains repatriation

vi. Compassionate visit arrangements

vii. Minor children assistance/ escort

b) Monitoring of Medical Condition during and after hospitalisation

c) Delivery of Essential Medicines

d) Guarantee of Medical Expenses Incurred during hospitalization subject to terms and condition of the policy and approval of insurance company.

e) Pre-trip information services and other services:

i. Visas and inoculation requirements

ii. Embassy referral services

iii. Lost passport and lost luggage assistance services

iv. Emergency message transmission services

v. Bail bond arrangement

vi. Financial Emergency Assistance

f) Interpreter Referral

g) Legal Referral

h) Appointment with lawyer

a) Hospitalization Procedures

i. Most hospitals accept Guarantee of Payments from all international insurance companies once the insured provides them with a valid health or overseas travel insurance policy.

ii. Hospitals start the treatment immediately. If there is insurance cover the insurance policy pays or the patient person has to pay. The hospitals tend to inflate charges since payments are delayed.

iii. Information regarding network hospitals and the procedures is available to the insured on the toll free numbers provided by the assistance companies.

iv. In event of the necessity of a hospitalization the insured needs to intimate the same at the call centre and proceed to a specified hospital with the valid travel insurance policy.

v. Hospitals usually contact the assistance companies/ insurers on the call centre numbers to check the validity of the policy and verify coverage.

vi. Once the policy is accepted by the hospital the insured would undergo treatment in the hospital on a cashless basis.

vii. Some basic information required by the insurer/ assistance provider to determine admissibility are:

1. Details of ailment

2. In case of any previous history, details of hospital, local medical officer in India:

. Past history, current treatment and further planned course in hospital and request for immediate sending of

. Claim form along with attending physician's statement

. Passport copy

. Release of medical information form

b) Reimbursement of medical expenses and other non-medical claims:

Reimbursement claims are normally filed by insured after they return to India. Upon receipt of the claim papers, claim is processed as per usual process. Payments for all admissible claims are made in Indian Rupee (INR), unlike in cashless claims where payment is made in foreign currency.

While processing the reimbursement claims, currency conversion rate is applied as on date of loss to arrive at quantum of liability in INR. Then the payment is made though cheque or electronic transfer.

c) Claim documentation for Medical Accident and Sickness Expenses

i. Claim form

ii. Doctor's report

iii. Original Admission/ discharge card

iv. Original Bills/ Receipts/ Prescription

v. Original X-ray reports/ Pathological/ Investigative reports

vi. Copy of passport/ Visa with Entry and exit stamp

The above list is only indicative. Additional information/ documents may be required depending on specific case details or depending upon claim settlement policy/ procedure followed by particular insurer.

---------- **The End** ----------

Name: Mahesh B Shinde **Contact: 9029106565 / 9322669032**
Branch: 90A Mumbai Div4 **Email: maheshshinde.lic@gmail.com**

How to prepare for IC38 Exam

DAY 1. Read all the chapters of Common Section it will take 1hr to read all the chapters and then go through all the textbook questions.

DAY 2. Read all the chapters of Life Insurance Section it will take 1hr to read all the chapters and then go through all the textbook questions.

DAY 3. Read all the chapters of Health Insurance Section it will take 1hr to read all the chapters and then go through all the textbook questions.

DAY 4. Solve Model papers (1/2) provided with these notes.

DAY 5. Download IC38 from google play store. Solve all those question sets one by one and check how much you are scoring.

DAY 6. Once again revise all the chapters given in the notes. Make sure you are aware of all the important topics of each chapter.

DAY 7. Exam day.

---------- **ALL THE BEST** ----------

Name: Mahesh B Shinde
Branch: 90A Mumbai Div4
Contact: 9029106565 / 9322669032
Email: maheshshinde.lic@gmail.com

MS Tips

How to solve the paper

1. There will be 50 questions in total. First go through all the questions. We have to score 18 questions to pass.

2. Now solve those questions which you are 100% sure. That is you know the answers of such questions very well. Questions which you have read or questions you have solved before also in practice test. It will take hardly 10 minutes to solve this questions.

Note - There will be 12-15 such questions which you can solve confidently. Now we have to work for 3-6 questions only.

3. Now you are left with 2 categories of questions i) **doubtful** and ii) **don't know anything**.

Note - There will be 30-35 such questions in this category.

4. First try to solve those questions which you are doubtful. In doubtful questions there will be 2 options which have no connection with question leave such options and try to figure out correct answer from remaining 2 options. Don't waste much time on such questions. Maximum 10-15 minutes only for doubtful questions.

Note - There will be 10-15 such questions in this category. After using above trick you can easily score 3-4 questions correct.

5. Now you will be left with only those questions which you don't know or have no idea about it. Don't think much about it simply mark option C to all such question. It will take hardly 5 minutes to do it.

Note - There will be 15-20 questions in such category. After using above trick you can easily score 3-4 questions correct. Your complete paper will finish in 35-40 minutes. Make use of remaining time for another checking.

6. In last 10 minutes of the exam check all questions and make sure you have attempted all questions.

NO QUESTION SHOULD BE LEFT BLANK - ATTEMPT ALL.

Name: Mahesh B Shinde
Branch: 90A Mumbai Div4
Contact: 9029106565 / 9322669032
Email: maheshshinde.lic@gmail.com