CHAPTER-III

UNDERWRITING OF RISK AND SETTLEMENT OF CLAIMS

“Life is inherently risky. There is only one risk that you should avoid at all costs, and that is the risk of doing nothing.”

Denis Waitley
A. GENERAL

Insurance is an arrangement by which losses suffered by a small number of insured are spread over many, exposed to similar risk. Thus, the primary function of insurance, be it life, or non-life or reinsurance, is providing protection by assessing the risk and sharing the same with many by the process of risk sharing and, thus, minimizing individual risk and its impact. This basic function is followed by subsidiary responsibilities like efforts for preventing losses and adding the development through the investment of funds.

In the today’s complex and busy life risk is at every step. So, these days insurance has become essential for managing risk. The insurance company collects the premium from insuring public and act as a trustee to the amount so collected. In case of any unexpected incident the loss is paid out of the premium so collected.¹ Today, it is only the insurance company which prays for the longer life of insured.

B. UNDERWRITING OF RISK

The most complicated aspect of the insurance business is the underwriting of policies. Using a wide assortment of data, insurers predict the likelihood that a claim will be made against their policies or not and price the products accordingly. To this end, insurers use actuarial science to quantify the risks they are willing to assume and the premium they will charge to assume them. Data is analyzed to fairly and accurately project the rate of future claims based on a given risk. Upon termination of a given policy, the amount of premium collected and the investment gains thereon minus the amount paid out in claims is the insurer’s underwriting profit on that policy. From the insurer’s perspective, some policies are “winners” and some are “losers”, the insurance companies essentially use actuarial science to attempt to underwrite enough “winning” policies to pay out on the “losers” while still

maintaining the profitability. Thus, underwriting is the process of deciding to reject or accept an insurance proposal depending upon the risk factor.3

1. **Meaning and Definition of Risk**

   There is no definite or commonly accepted definition of term ‘risk’. However for the purpose of insurance, this term refers to the future risk of loss. A few definitions of the term ‘risk’ as given by well known authorities on the subject are as follows:

   Risk is the name of uncertainty and uncertainty is one of the basic realities of life. “In this world, nothing can be said to be certain except death and taxes”. Therefore, uncertainty and risk remain in every part of life.

   - Benjamin Franklin
   
   “Risk is the chance of loss or injury”

   - Boon and Kurtz
   
   “Risk is a measurable uncertainty”

   - Frank H. Knight
   
   “Risk is the variation in the possible outcome that exists in nature in a given situation”.

   - Williams and Heins

   Thus risk is the uncertainty or chance of loss or injury, which is one of the realities of life.

2. **Risk Covered in Life Insurance Policy**

   Human life has many probable uncertainties and risks such as untimely death, disability, fatal illness as well as a very long life. These risks can be successfully countered with the help of life insurance.4

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The ultimate objective of life insurance contract is to save the insured from economic loss caused by the loss of life or any other unfortunate event. Thus, the scheme of life insurance policy basically covers the risk of death. In case of death, insurance company pays full sum assured, which is several times larger than the total of the premium paid and thereby saves the family from the financial strain due to unforeseen and premature death.\(^5\)

3. Circumstances affecting Insurable Risk

Risk in life insurance is the risk of death at an early date due to disease as distinguished from accident. In *Thomson v. Weems*\(^6\) it was observed that those insurers whose business is to insure lives calculated on the average rate of mortality and charge a premium which on that average will prevent losses.

Hence, in life insurance, facts which tend to shorten the span of the life assured would amount to the circumstances affecting the risk and these facts are regarded as material facts for purposes of the duty of disclosure.\(^7\)

(a) Age

The age of the life who is assured is the most important factor to affect mortality. The insurance company asks for the age nearer to birth days. A person of 22 years 7 months and another person of 23 years 5 months are treated of the age of 23 years. The age proof is very essential for calculating premium rate. The maximum and minimum limit of age is fixed to avoid risk of mortality.\(^8\)

(b) Build Up

It includes- height, weight, and the distribution of weight and chest expansion of the person to be insured. Overweight is the indication of certain hidden diseases, underweight is


\(^6\) (1884) 9 AC 671, 681.

\(^7\) *Supra* n.4, p.79.

\(^8\) *Ibid.*
also not very desirable. If the assured life is not within the standard the proposal may not be accepted.\textsuperscript{9}

\textbf{(c) Physical Conditions}

Physical condition of a person has a direct bearing on the mortality of the life. Conditions of sight, hearing, heart, arteries, lungs, tonsils, teeth, nervous system are properly examined by the doctors before making his report.\textsuperscript{10}

\textbf{(d) Personal History}

The personal history of the proposer would reveal the possibility of death to him. The history may be connected with the health record, past habits, previous occupation and insurance history.\textsuperscript{11}

\textbf{(e) Family history}

Family history requires information of habit, health, occupation and insurance of other family members particularly of the parents, brothers, and sisters. Longevity of the parents is a relevant factor for determining the degree of risk of the proposed life to be insured. It is significant to know the transmission of characteristics by heredity. Heart, lungs, build etc. follow family characteristics.\textsuperscript{12}

\textbf{(f) Occupation}

The nature of his/her occupation and the factors in occupation that contribute to enhancing the risk are taken into consideration. If the nature of work is hazardous it will surely increase the degree of insurance risk. Factory workers employed in chemical factories, match factories run the risk of contacting poison. The dirty and unhealthy environment deteriorates the health of the workers.

\begin{flushright}
\\textsuperscript{9} Ibid.
\textsuperscript{10} Ibid.
\textsuperscript{11} Ibid.
\textsuperscript{12} Supra n.3, p.135.
\end{flushright}
(g) Residence

The insurance risk will be lesser in a good climate area and more in a bad climate. The geographical location, atmosphere, political stability, climate, travel, etc. greatly affect the degree of risk. Therefore, all these factors are given due consideration while assessing risk and the amount of premium.¹³

(h) Present Habits

Living standard and personal habits of a person like smoking, drinking, yoga, cycling, walking etc. also have an impact on the risk factor involved. Non temperate habits cause increase in mortality and temperate habits tend to increase longevity of a person.

(i) Morals

Departure from accepted standards of ethical and moral conduct involves extra mortality. Unethical conduct is considered to be a moral hazard. So, insurance is not given to bankrupt and reputed dishonest persons.

(j) Race and Nationality

Mortality rate differs from race to race and nation to nation, in tropical countries the span of life is shorter than that of persons living in temperate climate.¹⁴

(k) Gender

Mortality among female sex is higher than that of male sex, because of the physical hazard of maternity in the former case.¹⁵ Other factors which are also given due consideration in selection of risk are economic status of the person to be insured, nature of his occupation and the plan under which insurance is sought.¹⁶

Based on these risk inducing factors, the underwriter assess the premium, if the life falls within any substandard class, extra premium is levied. Besides these factors, the

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¹³ Supra n.4.
¹⁴ Ibid.
¹⁵ Ibid.
¹⁶ Ibid.
underwriter also takes into account the type of cover required by the proponent, the sum assured and the possibility of any moral hazard.

4. Meaning and Definition of Underwriting

An insurer receives insurance proposals having different kinds of hazards. It is not, however, practical to accept all these proposals. Only the proposals which are favorable and advantageous to the insurer are accepted and others are rejected. This process of accepting or rejecting a proposal in view of the risks involved in each is called underwriting.

Underwriting basically means investigating and verifying the economic, physical and social conditions of a person while accepting the risk for his life.\(^{17}\)

A few definitions given by important authorities on this subject are as under:

1. “Underwriting involves a determination of whether a given application for insurance will be accepted or declined”.

   - Frank Joseph Angell

2. “Underwriting is selection of risks for the insurers and determination of what amounts and what terms acceptable risks will be insured”.

   - Mowbray and Blanchard

3. “Underwriting is the process of accepting or rejecting risks”.

   - Mehr and Cammack

In light of above definitions, we may conclude that underwriting is the process of deciding whether to accept or reject an insurance proposal based on the risk factors.\(^{18}\)

5. Need and Importance of Underwriting

The process of underwriting is an important one in all insurances office but it is the backbone for life insurance. It is true that every individual has unlimited insurable interest in

\(^{17}\) Supra n.2, p.57.

\(^{18}\) Supra n.4, p.57.
his or her own life. But this dictum cannot be put into practice for many reasons.\textsuperscript{19} Underwriting offers a process of evaluating the monetary value of life, for which the life assured can be offered life insurance cover after taking into account the health, economic and social environments of the proponents.

So, it primarily involves assessment and evaluation of risk involved in a life insurance proposal. If the risk is wrongly assessed, the premium charged would not be appropriate. A lower premium affects the solvency of the fund. The cost of the additional risk, not recovered from the proposer would have to be borne by the rest of the policy holders. That is not fair to them. A decision to charge a premium higher than necessary would not be fair to the proposer, because of the principle of utmost good faith. ‘Underwriting’ has implications of fairness to the insurer and to policyholders, individually and collectively. The need and importance of underwriting has been discussed under following heads:

(a) \textbf{Classification of Risks}

Under the process, the proposals are analyzed and the risks are classified. On the basis of this analysis, risks are categorized as standard risks and sub-standard risks. Sub-standard risks are rejected.\textsuperscript{20}

(b) \textbf{Determination of Premium}

Under the process, the nature or risks can be identified. On basis of the gravity of risks, premium rates are fixed, either at increasing rate or decreasing.\textsuperscript{21}

(c) \textbf{Selection of Profitable Business}

Underwriting is a method to check whether the company accepts profitable business or not. The insurer accepts only those proposals which are beneficial to him.\textsuperscript{22}

(d) \textbf{Stability against Competition}

By determining premium in the light of risks involved, a larger number of insurance proposals can be accepted, by fixing competitive premiums.

\begin{itemize}
\item \textsuperscript{21} \textit{Ibid.} at 87.
\item \textsuperscript{22} \textit{Ibid.}
\end{itemize}
(e) **Balancing the Risks**

It is also one of the objectives of underwriting to bring uniformity in risks. Risks may differ in view of physical and moral hazards. These difference can be removed and bring uniformity of risks.

(f) **Removal of Doubts**

The acceptance of rejection of proposals is made on the basis of scientific analysis. As such, no doubts may remain in the mind of insurer about his decision.

(g) **Decision to Accept or Reject the Proposal/Risk**

Underwriting is helpful in taking a wise decision to accept or reject a proposal/risk.

(h) **To do Justice with Insured**

It is a process of classifying the risks according to their gravity and determining premium rates accordingly. This way the underwriter does justice to those involved with less risks by fixing low rate of premium.\(^{23}\)

6. **Underwriting Process**

The underwriting is a process by which a decision is taken either to accept or reject an insurance proposal. Therefore, this process involves various steps before and after the selection of risks. Various authorities on the subject have laid down various steps in the underwriting process.\(^ {24}\) A good underwriting process comes across various techniques of decision making such as:

(a) **Collection of Information**

The following types of information are collected at the beginning:

(i) Name, address and residence of proposed insured.

(ii) Physical and moral hazards that affect the prospective risks.

(iii) Previous experience of proposers’ losses.

(iv) Economic conditions of the proposer.

\(^{23}\) Supra n.3, p.113.

\(^{24}\) Supra n. 20, p.89.
(v) Life styles and habits of the proposer.

(vi) Physical and environmental conditions of proposer.

(vii) The character of the proposer and his business, etc.

Such kinds of information can be obtained from the agents, reports of inspectors, proposal forms, staff underwriters, banks, neighbors, employers, etc.

(b) Classification of Information

The next step is to classify the collected information qualitatively and quantitatively. The reliability of the collected information is also to be considered.

(c) Analysis of Information

When the collected information is classified, the next step should be to analyze the information with the help of statistical methods. In order to analyze the individual based information, the underwriter should use his own rationality and experience, so that accurate analysis would be possible.25

(d) Developing Alternatives

In case the report of the analysis reveals that a proposal is unsuitable for acceptance, the underwriter should consider the following alternatives:

i. At what levels the proposal can be accepted?

ii. Is it proper to change the conditions of policy and accept the proposal?

iii. Is it beneficial to change the premium rate and accept the proposal?

iv. Is it possible to get re-insurance in case the proposal is accepted?

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25 Id. at p.116.
(e) **Selection of Best Alternative**

After developing different alternatives, the underwriter selects the best alternative. While selecting the best alternative, attention should be paid on uniformity and comprehensiveness of risks, danger factors, physical hazards etc.\(^\text{26}\)

(f) **Execution or Implementation of Decision**

When it is decided to accept the proposal, the proposal is sent for the final approval by the person authorized for it. In case the proposal is accepted, the intimation is sent to the proposer, otherwise a letter of regret is sent.\(^\text{27}\)

(g) **Feedback and Taking Corrective Action**

Once the decision is taken to accept or reject a proposal, the process does not come to an end here. The underwriter has to take such decisions in future also. The underwriters should think over how he can improve the underwriting function in future. This is done by identifying the mistakes that he has committed in the earlier decision making process.\(^\text{28}\)

The method of underwriting commonly used in India is called the Numerical Rating Method.\(^\text{29}\) This method takes into account the principle of Hypothesis of unchanging Extra Mortality and Addition of Specific Rates of Extra Mortality underwriters prefer the numerical rating system because:

- (i) The subjective element in underwriting is near zero.
- (ii) It allows the underwriter to use his own sense of judgment in assessing the risk.
- (iii) It enables the underwriter to look into all the decision influencing factors.
- (iv) It helps the underwriters in exchanging experiences and moving towards standardization.
- (v) It offers enough scope to review the decision before declining a death claim.

\(^{26}\) Supra n.20, p.90.

\(^{27}\) Ibid.

\(^{28}\) Ibid.

\(^{29}\) Supra n.12, p.208.
(vi) It helps in expeditious underwriting and decision making.

7. Doctrine of Utmost Good Faith

Insurance contracts are a special class of contracts, one of the distinctive features of which is that they are based on the rocky foundation of utmost good faith. Such good faith is not a matter of art, but has to be really and sincerely appreciated by the insured. Therefore, a higher duty is expected from the parties to an insurance contract in order to ensure the disclosure of all material facts so that the contract may accurately reflect the actual risk being undertaken.

(a) Evolution

The doctrine of uberima fides owes its origin to British Maritime Insurance Law. The principles underlying this rule were stated for the first time by lord Mansfield in Carter v. Boehm 31 “Insurance is a contract of speculation, the special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the insured only; the underwriter trust his representations and proceed upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstances does not exist. Good faith forbids either party from concealing what he privately knows, to draw other into a bargain from his ignorance of that fact, and his believing the contrary”. This principle was confirmed by Lord Blackburn in Brownlie v. Campbell 32 over a hundred years later. Soon after Lord Blackburn’s statements, the common law of marine insurance was codified in the Marine Insurance Act, 1906.

(b) Meaning

Uberima fides is a Latin phrase which means utmost good faith. It is a legal doctrine which governs insurance contracts. This legal doctrine lays down a minimum standard that requires both the buyer and seller in a transaction to act honestly towards each other not to

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30 Srinivasa Pillai v. L.I.C. 1977 Mad 381.
31 (1766) 97ER 1162, 1164.
32 (1880) 5 App Cas 925.
mislead or withheld critical information from one another.\textsuperscript{33} In insurance market the doctrine of utmost good faith requires that each party to a proposed insurance contract must disclose to the other all information which would influence his decision to enter into the contract, whether such information is requested or not.\textsuperscript{34} For example, if you are taking a life insurance policy, you are required to disclose any previous health problem you may have had likewise, the insurance agent selling you the coverage must disclose the critical information you need to know about you contract and its terms.\textsuperscript{35}

\textbf{(c) Life Insurance Contract and the Doctrine}

In a life insurance contract the nature of subject matter of insurance is an intangible one and the circumstances surrounding the subject matter are known by one of the parties, namely, the proposer. Only the proposer knows or should know, all the relevant facts about the risk being proposed for insurance.\textsuperscript{36} This natural imbalance between the insurer and the insured in terms of knowledge can be fatal. To redress this possible fatal imbalance, a duty of utmost good faith is imposed on the insured, under which, he is obliged to disclose to the insurer, before contract is made, all matters that are material to the decision the insurer takes, whether to offer to insured any insurance at all and, if so, on what terms.\textsuperscript{37} A brief summary of the doctrine of utmost good faith was given in the case of \textit{Rozanes v. Bowes}\textsuperscript{38} as follows:-

“As the underwriter knows nothing and the man who comes to him to ask him to insure knows everything, it is the duty of the assured...... to make a full disclosure to the underwriter without being asked of all material circumstances.

Thus, a contract of life insurance survives essentially on principle of utmost good faith.

\footnotesize{http://www.investopedia.com/terms/d/doctrine-of-utmost-good-faith.asp. Accessed on 14/7/13 at 7:45 A.M.}


\footnotesize{Supra n.3.}

\footnotesize{http://en.wikipedia.org/wiki/uberima-fides. Accessed on 3/7/13 at 3:00 P.M.}

\footnotesize{Supra n.3.}

\footnotesize{(1928) 32 L.I.L.R. 98.}
(d) Full Disclosure

The general principles of full disclosure as enunciated by Lord Mansfield in *Carter v. Boehm* are equally applicable to all clauses of insurance. In this respect there is no difference between life and other classes of insurance. However, in life insurance contract, the law imposes a greater duty of disclosure. The reason for the necessity of full disclosure is that one of the parties is presumed to know or has means of knowledge which is not accessible to the other and so such a person is bound to disclose all the facts which may be supposed to affect such other person’s judgment.

In *Looker and another v. Law Union & Rock Insurance Co. Ltd.* it was held that since the insured knows or is expected to know more about the subject matter of insurance i.e. life; he is more liable to disclose all material facts about the subject matter.

(e) Duty of Good Faith is on Both Parties

The duty to make full and complete disclosure rests on both the parties i.e. the insurer as well as the insured. In *Lakshmi Insurance Company v. Bibi Padmavati*, it was held that the contracting parties are placed under a special duty towards each other, not merely to refrain from active misrepresentation but also to make full disclosure of all material facts within their knowledge.

(f) Extent of Duty

In a life insurance contract if the proposer has answered all the questions of proposal form fully and correctly to the best of his knowledge and belief he has done his duty unless he has knowledge of some other facts which are material to the contract. In defense of a non-disclosure the proposer cannot say that he had omitted to disclose it by carelessness or mistake or that he did not regard the matter as material. The facts on which no questions are

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39 In ordinary commercial transactions, the principle of caveat emptor i.e. “buyer beware” applies
40 (1928) 1 KB 554.
41 AIR 1961 PunjHar 253.
asked are assumed to be considered immaterial or waived off by the insurer.\textsuperscript{42} However, in the case of \textit{Asima Sarkar v. Western India Life Insurance Co. Ltd.}\textsuperscript{43} the Calcutta appellate Court held that the fact that the previous declined card (with information that earlier on insurer had considered this person as uninsurable) was available with the insurer, would not by itself suffice to draw the inference of waiver of this information. ‘Waiver’ would operate if the office had actually taken such facts into consideration.\textsuperscript{44}

\textbf{(g) Time for Disclosure}

The insured's duty to make full and complete disclosure continues during the period of negotiations for the formation of the contract of insurance and up to the moment when a binding contract is finally concluded and covers any material alteration in the character of risk which may take place between the proposal and acceptance of risk by payment of first premium.\textsuperscript{45} Thus, the duty of disclosure operates till the risk commences. Circumstances which may have arisen after the risk has commenced do not affect the validity of the contract, unless the conditions of the contract make relevant stipulations to that effect. For example, any change in occupation does not affect the contract unless the policy is issued with a condition that any change in occupation must be notified to the insurer. However, if the terms of policy are altered, or for any reason the continuance of the contract is subject to approval by the insurer, there would be a duty to disclose all material facts at that time.\textsuperscript{46}

Thus, there is no duty to inform the insurer about changes in the nature of risk taking place after the risk has commenced.

\textbf{(h) Material Fact}

A material fact is one which would affect the judgment of a prudent insurer in fixing the premium or in considering whether and upon what terms the insurer would accept the

\textsuperscript{43} AIR 1942 Cal 412.
\textsuperscript{45} \textit{Allis Chalmer v. Fidelity Deposit}, (1916) 32 T.L.R.263.
\textsuperscript{46} Insurance Institute of India, “\textit{Life Insurance}”, p.23, Shri Mahalakshmi Calender Co. Mumbai.
risk. It means that the duty of disclosure extends not only to facts which the insured knows, but also to those which he, as a reasonable person, ought to have known and which are in fact material whether he thinks them to be so or not. According to Evamy, the duty of disclosure is confined to such facts which he ought in the ordinary course of business to have known and he cannot escape the consequences of not disclosing them on the ground that he did not know them.

In Banarsi Devi v. New India Assurance Co. it was laid down that material fact has a direct bearing on the degree of risk in relation to the subject matter of insurance. For example, in life insurance contracts, material facts are age, income, type of occupation, habits, health, family history, earlier policies and loss, if any, suffered in past. As the material facts are determined not on the basis of opinion, the proposer should disclose not only those matters which the proposer may feel are material but all the facts which are material. The burden of proving that a fact not disclosed or misrepresented is material, lies upon the insurer. When the insured proves his policy and proves his loss, that puts the insurance company on their defense and if they fail to make out their defense their case would fail. If they fail to prove that there was a misrepresentation or concealment of material facts, they would be liable. Thus, every circumstance that would have a bearing on the judgment of a prudent insurer in fixing the premium or determining the acceptability of the proposal for insurance is a material fact.

(i) Facts which must be Disclosed

Facts which must be disclosed are circumstances which would influence the insurer in accepting or declining a risk or in fixing the premium or terms and conditions of the contract.

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48 Joel v. Law Union and Crown Insurance Company, (1908) 2 KB 863CA.
49 AIR 1959 Patna 540.
50 Supra n.1, p.45.
51 It is an application of the ordinary principle relating to burden of proof that burden of proof lies on the party whose case would fail if no evidence were given to either side.
In *Economides v. Commercial Union Assurance Co.*, it was held that the duty of the assured to disclose all material facts is limited only to facts known to him. There is no obligation on the assured to give details as to the factual basis of his belief. The fact must be material at the date at which it should be communicated to the insurer. A fact which was immaterial when the contract was made, but becomes material later on, need not be disclosed. There is one exception to the rule and it occurs when there is a policy condition requiring continuous disclosure, otherwise, the facts which must be disclosed are:-

i. Facts, which show that the particular risk represents a greater exposure than, would be expected from its nature or class;

ii. External factors which make the risk greater then would normally be expected;

iii. Previous losses and claims under other policies;

iv. Any special term imposed on previous proposals by other insurers;

v. The existence of other non-indemnity policies such as life and accident; and

vi. Full facts relating to the description of the subject matter of insurance.

(j) **Facts need not be Disclosed by the Insured**

The following facts, however, are not required to be disclosed by the insured:-

i. Facts which tend to lessen the risk;

ii. Facts of public knowledge;

iii. Facts which could be inferred from information, disclosed;

iv. Facts waived by the Insurer;

v. Facts governed by conditions of the policy;

vi. Facts of law;

vii. Facts which are superfluous to disclose by reason of a condition or warranty.

In *Bhagwani Bai v. LIC of India*, it was held that insurer cannot avoid or repudiate an insurance policy on the ground of non-disclosure of lapsed policies by the

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53 (1997) 3 All ER 636.
54 AIR 1984 M.P. 126 (130).
assured which had no bearing on the risk taken by the insurer.

(k) Legal Consequences

It is worth-mentioning here that in absence of utmost good faith the contract would be voidable at the option of the person who suffered loss due to non-disclosure or misrepresentation. The inadvertent concealment will be treated as fraud and the contract will be void ab-initio. But misrepresentation or even silence amounting to fraud will not entitle a party to avoid the contract if he had the means of discovering the truth with ordinary diligence and did not do so. However, as and when the voidable contract has been validated by the party not at fault, the contract cannot be avoided by his later on.

The burden of proof to show non-disclosure or misrepresentation is on the insurance company and the onus is a heavy one. The duty of good faith is of a continuing nature as such no material alteration can be made to the terms of the contract without the mutual consent of parties.

(l) Principle of Moral Hazard

Good faith and malicious intention cannot go hand in hand. A life insurance contract being a contract of good faith cannot accommodate a term which might inherently incorporate moral hazards and a self-inflicting harm to one by obliging the insurance company to pay the dependents. For example, the holder of a life insurance policy may kill himself. Moral hazard is a situation where an insured deliberately brings about the loss insured against. Moral and Morale hazards are controversial issues of uberima fides in a life insurance contract. In life insurance, suicide or any wrongful act by the assured leading to his death should ordinarily vitiate the liability of the insurance from the liability under insurance contract. But keeping in mind the psychological stress the person undergoes to commit suicide, will it be alright to absolve, the insurance company from liability to pay the agreed
amount, by far fetching and far stretching interpretation of the principle of moral hazard in life?\textsuperscript{55}

The principle of Uberimma Fides is an integral part of insurance law. It gives a fair chance of risk assessment to the insurer and also ensures that the ensured fully understands all the terms and conditions of the contract. Developments in law and technological advancement have further made it possible for both the parties to see to it that their interest is taken care of. But still, there are several grey areas to this doctrine as well.\textsuperscript{56} All these issues need to be taken care of and an effective solution must be provided considering that the principle of utmost good faith is one of the most fundamental principles associated with Insurance Law.

C. SETTLEMENT OF LIFE INSURANCE CLAIMS

Life insurance is an emotional business unlike in general insurance, there are sentiments involved since it is the question of a human being.\textsuperscript{57} Whether he is dead or has a critical illness or a severe disability, if the insurer delays the claim, insured and his family is unnerved and frustrated because a person is suffering and an insurer has not kept up his commitment. If insurers pay, then there is a feeling of gratitude. If the insurer rejects the claim, then the family members feel dejected because there is a feeling of being cheated. So either way, there is always very emotional outcome.\textsuperscript{58}

\textsuperscript{55} A life insurance contract is a civilian transaction is has to be looked just as a contract and the terms of contract should prevail to fix the liability of insurer to fulfill the purpose and objective of life insurance contract that is to help the dependents to absorb the shock of sudden death of the insured, either by natural or suicidal death, in sane or insane conditions.

\textsuperscript{56} There is no clear cut distinction between as to what is material or immaterial and the same is largely dependent on or the whims of the insurers and the terms of the contract. It is still very easy for an insurer to repudiate the contract on the slightest period of non-disclosure by treating them as warranties, thereby, putting the assured in an even more difficult position.

\textsuperscript{57} www.irdaonline.org/irdacontent/journals/irda-may06.pdf. Accessed on 21/12/13 at 5:00 P.M.

\textsuperscript{58} www.actuariesindia.org/LI\%20CLAIMS_JIM\%20\%20IYER. Accessed on 4/1/14 at 2:00 P.M.
Claim settlement is one of the key factors to judge the efficiency of a life insurance policy. It is a very important aspect of service to the policyholders because the performance of a life insurance company is evaluated on the basis of claim settlement operation.\(^{59}\)

In life insurance, all the policies are to be paid sooner or later, either by maturity of policy or on death of the assured.\(^{60}\)

Thus, claim settlement is the last obligation of the insurer under the contract of life insurance which it has to perform. It is called the discharge of contract by performance.\(^{61}\)

1. **Meaning and Definition of Claim**

In the field of insurance, claim is the right exercised by the assured from a contract of insurance. It is the return promise against the premiums paid the insurer. The claim may be made either on maturity of the policy or in case of death of assured or on voluntary surrender of policy.\(^{62}\)

In other words, a claim on the policy is the demand for performance of the promise made by the insurer at the time of making the contract.\(^{63}\)

2. **Pre-Requisite of Claims**

There are certain pre-requisite conditions which need to be fulfilled before an insured presents his claim before the insurer.

(a) **Insured Discharged his Obligations**

Before a claim is made on the insurer, the assured must ensure that he has discharged his obligations under the contract, viz., full payment of premiums, presentation of proof of age etc.\(^{64}\)


\(^{62}\) Supra n.3, p.272.

\(^{63}\) Federation of Insurance Institute of India, Mumbai.

\(^{64}\) Supra n. 20, p.307.
(b) Insurer is Liable to Pay

It is also necessary to ascertain before the claim is made, whether the risk has been covered by the insurer and he is bound to pay the claim.\(^65\)

(c) Determination of Liability

Under the conditions of different policies, the claim is payable with or without profits or in some cases by installments. So, it is necessary to ascertain the nature and liability limits before the claim is presented.\(^66\)

(d) Event Insured against has Occurred

The claim is eligible to be presented only after the event has occurred, viz., after the maturity of the policy or on death, or accident, etc.\(^67\)

(e) Claimant has Authority to Present the Claim

The claim should be presented by a person who has the authority to do so. Only a legally authorized person can present the claim.\(^68\)

3. Types of Claims

The life insurance claims may arise either on:

(a) Maturity of the policy (Maturity Claim)
(b) Survival upto a specified period during the term (Survival Benefits)
(c) Death of the policy holder (Death Claim)\(^69\)

(a) Maturity claim

If the life insured survives to the full term then the amount payable is called maturity claim. Maturity claim includes the sum assured and any other specified sum plus vested bonuses. Any debt or charge under the policy, like loans, outstanding premium (due but not paid), etc. will be deducted.\(^70\)

\(^{65}\) Ibid.
\(^{66}\) Ibid.
\(^{67}\) Ibid.
\(^{68}\) Ibid.
\(^{69}\) Supra n.1, p.396.
\(^{70}\) Id. at p.409.
Maturity claim required following documents:

(i) Original insurance policy
(ii) Discharge voucher
(iii) Declaration form with witnesses

If all the formalities are completed two months before the end of term, the insurance company issues claim cheque on the date of maturity. When maturity claim is paid the insurance contract is revoked and then there is no insurance cover with policyholders.  

(b) Survival Benefit Claims

In case of money back policy or policy promising periodical payment of partial sum assured, the survival benefit claim is paid. The policyholder surviving on a specified pre-determined period is paid percentage of sum assured as survival benefit claim.

For example, in the money back plans of LIC say of 15 years term, $\frac{1}{4}^{\text{th}}$ of the sum assured becomes payable on the life assured surviving 5 years, further $\frac{1}{4}$ of the sum assured becomes payable on his surviving 10 years and the balance $\frac{1}{2}$ of the sum assured became payable on his surviving to the end of the term of the policy viz. 15 years.

Survival claim required following documents:

(i) Original policy document
(ii) Discharge voucher
(iii) Request for survival benefits

(c) Death Claims

The payment of assured sum by the insurance company in case of death of policyholder is called death claim. An insurance contract revokes and comes to an end after paying insurance claim.

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71 Supra n.3, p.134.
72 Ibid.
73 Supra n.1, p.411.
Death claim requires following documents:

(i) Original policy document
(ii) Original death certificate
(iii) Age proof
(iv) Claim form duly filled
(v) Discharge voucher

In case of accidental death claim additional documents mentioned below are required: 74

(i) F.I.R.
(ii) Police Panchnama
(iii) Post Mortem Report
(iv) Certificate of Coroner

After assessing all documents and scrutinizing them insurance companies pays the claim amount. If death is due to air crash or by drowning in the sea, the certificate by concerned authority is accepted as death certificate.

(d) Pension Claim

Policyholder is required to inform insurance company at least six months in advance about the type of annuity payment he chooses for. There are five alternatives to receive annuity payment by the policyholder: 75

(i) Annuity for Life
Annuity is paid till the annuitant is alive.

(ii) Annuity for Life and Certain for 5, 10, 15, 20 years

74 In the settlement of claims by death, the proximate cause of death is significant in deciding the claim, particularly in case of accident claim.

75 Supra n.3, p.135.
In this option, the annuity is paid for fixed years though annuitant died e.g. If annuity certain is for 15 years and annuitant died on 10th day, annuity will be paid till 15th year to the heirs of annuitant. If annuitant outlived the term, annuity will be paid till he is alive.

(iii) Composite Annuity for Life

Annuitant receives annuity till he is alive. After his death, his spouse receives half of the annuity till she is alive.

(iv) Return of Annuity Fund

In this option, the annuity fund at the time of commencement of annuity is returned to the heirs of the annuity holder on the death of the annuity holder. Annuity is paid till the annuitant is alive and annuity fund is returned in this option on death of annuity holder.

(v) Increase Annuity for Life

In this option, considering the affect of inflation the annuity is increased by some fixed percentage normally 3 per cent per year till the annuitant is alive.

Annuity can be received in various options like monthly, quarterly, half yearly and annually. After the selection of annuity option and mode of receipt of annuity, original annuity policy document, letter of selection, detailed information about bank account is required to be submitted to the insurance company. One photograph with wife is to be submitted. After completion of all these formalities, the annuity payment gets commenced. It can be directly deposited into the account of annuitant as per instructions.

(e) Accident Disability Benefit Claim

This is also called as extended disability benefit claim. If there is permanent disability due to accident, the claim is applicable. On intimation, the claim form is provided. Claim form, is to be submitted duly along with information of accident, FIR, evidences like newspaper cutting, declaration by witness, medical report, disability report, percentage of

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disability, etc. The claim is paid after submission of claim form, policyholder’s statement, and a report by district surgeon along with above mentioned documents.\textsuperscript{77}

(f) **Premium Waiver Benefit Claim**

As per the original policy document, in case of permanent total disability or death of parent in children insurance, the premium waiver benefit is applicable.

Original policy document along with application for premium waiver benefit, documents about accident (like FIR, medical report, surgeon report, evidence of accident or death, etc.) are required to be submitted. On receipt of this, future premiums are waived and endorsement is made on original policy document.\textsuperscript{78}

(g) **Claim under Critical Illness Riders**

As per the attachment of the list of critical illness covered under rider, if any, diagnosed and policyholder is alive for the next 28 days, a written intimation should be given to the insurance company. The date of diagnosis is important as the limit of 28 days commencing from that date. After intimation, claim form will be given. Claim form with original policy document, diagnosis report, medical report, other laboratory and testing reports, personal statement are required to be submitted to the insurance company. Then the claim is paid and such endorsement will be made on policy document.\textsuperscript{79}

4. **Claims in Certain Special Circumstances**

Such special circumstances may be any one of the following:\textsuperscript{80}

(a) **Natural or Accidental Death of the Insured**

Nominee can claim the death benefit from the insurer when the insured dies naturally or by an accident. Proper documents have to be submitted as early as possible to the insurer for claiming the death benefit.

\textsuperscript{77} Supra n.3, p.136.
\textsuperscript{78} Ibid.
\textsuperscript{79} Supra n.42, p.107.
\textsuperscript{80} Supra n.44, p.261.
(b) Insured’s Life Status is Unknown

If the body of insured is not traceable for a period of seven years, under the provisions of Indian Witness Act, he shall be deemed to be died and the claim can be paid to his legal representative on after the completion of seven years.\textsuperscript{81}

(c) Suicide Claims

If the insured commits suicide within one year from the date of commencement of policy contract, then the claim will be rejected by the insurer. If all the essential documents are submitted properly, then the claim settlement by the insurer will be made within 15-20 days.\textsuperscript{82}

(d) Lapse of Policy

If after buying the policy and paying premium for a few years, the insured for any reason failed to pay premium within 15 days after the due date, the policy is said to have lapsed. This simply means the terms and conditions of the life insurance contract between the insured and the insurer has become void. In case of occurrence of any risk, the insurer is not liable to honor the claim on lapsed policy.\textsuperscript{83}

(e) Passing of Attachment Orders

When an attachment order has been issued under the law, such a person (Debtor) has no right on his asset. The right to claim the policy money also comes under the attachment order. In such case insurance company cannot make payment to policyholder.\textsuperscript{84}

\textsuperscript{82} Ibid.
\textsuperscript{83} Supra n.81, p.286.
\textsuperscript{84} There are three exceptions to this rule: (i) No attachment order can be obtained against insurance on self’s life, (ii) In case the debtor is a nominee in a life insurance policy and at the same time he is the legal representative of a deceased policyholder,(iii) In case a minor on whose life the policy was taken, but he died before the maturity of the policy, the premium money is payable to the guardian.
5. **Persons Entitled to Claim**

After the maturity of the policy either by death or by the happening of the event insured against, the contract in the policy is discharged by payment of the insurance money. It must be paid to the following persons:

(a) **Payees**

The person whose name is entered in the benefit schedule of this policy, is generally entitled to receive the amount due under the policy after its maturity. He is a person who by his own name on the face of the policy is entitled to the proceeds of the policy and he is called the payee.\(^{85}\)

(b) **Assured Himself**

In the case of insurance on one’s own life, the assured himself can get the payment if he is living at the time of it maturity. In the case of insurance on the life of third parties also, the assured will be entitled to get the amount. For example, if a creditor takes a policy on the life of the debtor, the creditor will be entitled to get the payment.

(c) **Executors and Administrators**

In the case of his death before the event, his legal representative can get the payment. It is generally provided in the policy that the sum assured is payable to the assured or his executors, administrators, assignees or other legal representatives.

(d) **Joint Family Members**

Insurance on the life of a joint family member gives rise to some difficulty. Having regard to modern social conditions the general presumption is that the policy amount is

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separate property and does not become joint family property unless there is clear contrary intention.\textsuperscript{86}

A different rule was laid down in \textit{Oriental Life Insurance Co. v. Ammiraju}.\textsuperscript{87} If the premiums are paid from the joint family funds then the proceeds of insurance policy belong to the joint family.

(e) Voluntary Assignees

Just as other properties, the claim under a life insurance policy is also alienable and heritable. It is an actionable claim. If a life insurance policy is transferred by sale, gift or mortgage, the assignee will be entitled to receive the payment, if it is a valid assignment as per the conditions laid down in the Insurance Act. Therefore, if a policyholder assigns the policy the assigner gets the rights in the policy.

(f) Nominees

When a person is named in proposal form, as the person for whose benefit the insurance is effected, such person whose name is mentioned, is called the nominee. The insurer agrees with the assured that he would pay the assured amount to the nominee in case of the death of the assured. The nominee is a third party to the contract and he is neither a party to the contract nor has privity with it and so in case of breach of payment by the insurer, he cannot recover the amount by suit.\textsuperscript{88}

The Insurance Act, 1938 empowered the nominee to give a valid discharge to the insurer and clothes him with the right to sue.\textsuperscript{89}

6. Evidence of Title

The payment of claims is made only after the presentation of evidence of title. The evidence of title can be proved on the basis of any of these documents.

\begin{flushright}
\textsuperscript{86} Mathupalli Venkata Subbarao v. Lakshminarasamma.
\textsuperscript{87} (1935) 35 Mad 162.
\textsuperscript{88} Sabita Devi v. Usha Devi AIR 1984 SC 346.
\textsuperscript{89} See Insurance Act 1938; Section 39.
\end{flushright}
(a) Nomination

The insurance proposal contains name of nominee. Either nominee’s name is included at the time of proposal or name of a person can be endorsed at the back of the policy for receiving the claim payment. 

(b) Assignment

Assignment is also an important document for the evidence of title. Assignment can be made either in the policy itself where the place is provided for it, or it may be made separately.

(c) Trust Deed

According to Trust Act, by executing trust deed, trust can be formed Trust deed can also be treated as evidence of title.

(d) Probate

Probate is the copy of a will certified under the seal of court of competent jurisdiction with a grant of administration to the estate of the estator. Probate can also serve as evidence of title.

(e) Letter of Administration

A letter of administration is issued when the insured has not written a ‘will’. The person who holds the letter of administration, will have the right on the entire property of deceased.

(f) Succession Certificate

This certificate is also issued under the provision of Succession Act. Bearer of Succession certificate is the owner of the property subject to limit of his debt.

90 Supra n.20, p.318.
91 Ibid.
92 Ibid.
93 Ibid.
94 See the Indian Succession Act, 1925; Section 227 and 273.
95 Supra n.3, p.265.
7. **Amounts Recoverable**

Under a life insurance policy the following amounts are recoverable namely:-

(a) **Amount Insured**

The amount insured on the happening of the event insured or after the completion of the period.

(b) **Bonus**

Bonus is also recoverable with the insurance amount. But Bonus is recoverable only if declared by the company.

(c) **Share of the Profits**

In the case of a participation policy, a share in the profits may be recovered in addition to the sum assured. This will not make the assured a member or a contributory of the company. But he has a right only after the profits have been declared by the Board of Directors of the company.

(d) **Surrender Value**

In case where the policy lapses due to non-payment of premium or where the assured surrenders the policy the insurance company may pay a percentage of premium paid according to the rules of the company.

The surrender value is the amount agreed to be paid by the insurer to the policy holder whose policy lapses due to default of payment of premium.\(^{96}\) In India, after the advent of Life Insurance Corporation a policy acquires surrender value after payment of premium for two years or \(\frac{1}{10}\)th the total number of premiums stipulated in the policy contract, whichever is less, provided the premium paid exceeds at least one full year’s premium.

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\(^{96}\) Life assurance is mainly based on a cooperative principle. If one of the policyholders withdraws from such a cooperative enterprise, the remaining policyholders suffer a setback and it is the duty of the seeding policy holder to make good not only the administrative expenses, etc. incurred, but something more must be deducted; but that amount must also be fair and equitable.
8. Disputes in Claim Settlement

Claim settlement is the most important service that an insurance company can provide to its customers. But claim settlement is very tricky and most of the times various disputes arise between the policy holder and the insurance company.\(^{97}\) Some of these disputes are enumerated as under:

(a) Any Partial or Total Repudiation of Claim

At the time of payment of claim the insurance companies sometimes repudiate the genuine claim of insured either partially or totally on small technical parameters. This practice needs to be checked as it shakes the very foundation of the trust based relationship of insurer and insured.

(b) Dispute relating to Legal Construction of Policy

Life insurance policy is a legally binding contract between the policyholder and the insurance company.\(^{98}\) It is designed and drafted as a standard form of contact by the insuring company, who gives primacy to its own financial interests. Beyond the knowledge of the insured certain terms are inserted to protect the company from financial liability when the claim arises. These terms frustrate the very object of life insurance policy. At such times, the insured as well as the insurer interpret the contract of life insurance in their own ways.

(c) Delay in Settlement of Claim

The real test of claim settlement procedure is speed. In most of the cases, it is observed that the sum assured is finally paid, but only after causing acrimony. Only a hassle free process can make the market believe in life insurance as an essential financial instrument. So, even if it is decided to repudiate the claim, the action must be completed promptly and courteously.\(^{99}\)

\(^{97}\) [www.lifeinscouncil.org/consumers/claims-process](http://www.lifeinscouncil.org/consumers/claims-process). Accessed on 17/12/13 at 10:00 P.M.

\(^{98}\) [www.phillipslawfl.com/insurance-disputes.html](http://www.phillipslawfl.com/insurance-disputes.html). Accessed on 12/12/13 at 2:30 P.M.

(d) Failure to Pay the Claim to Nominee/Assignee

The procedure of claim settlement is not just data processing, but an activity that culminates in wiping tears from the eyes of those who have just lost their most loved ones by making timely payment to the nominees. Life insurance is bought to serve the financial needs of the bereaved family after the death of the earning member so disputes are bound to arise if the insurer fails to pay the claim. Proper nomination is therefore essential to ensure that your loved ones get the benefit of the policy without any hassle and to speed up the claim processing in the hour of need.100

(e) Failure to Identify the Insured

In old insurance policies, it sometimes becomes difficult to establish the identity of insured. While in some cases people fraudulently obtain the insurance claim from Insurer Company by personating the policy holder and fabricating false death records. To guard against such mischief’s both the insurer and insured needs to be diligent and alert.

(f) Scaling Down of Insurance Claim

Sometimes while processing the final claim the insurer company scale down the claim made by the policyholder or his nominees on some petty technical parameters. In such circumstances the insured feels cheated. So, there is a need to set a procedure to determine the amount of claim to rule out any misdemeanor on part of mighty insurer.

9. Defenses Taken By Insurers to Escape Liability

In India, the post-contractual duty of good faith is very strict. The duty of good faith is of continuing nature in as much that no material alteration can be made to the terms of contract without mutual consent of parties. The insurer cannot subsequently demand additional premium nor can he escape liability by contending that the situation does not warrant the insurance cover.

100 www.businesstoday.intoday.in/story/how-to-choose-nominee-for-insurance-policy-to-help-claims/1/18850.html. Accessed on 25/12/13 at 6:00 P.M.
(a) Misrepresentation in Application Form

One of the most litigated issues in life and health insurance continues to be whether there was a misrepresentation in the application for insurance entitling the insurer to avoid paying the contracted benefits. A combination of case law and statutory law has developed around the question of whether misrepresentation will allow an insurer to avoid its policy obligations. These rules have typically been formulated in terms of whether the misrepresentation was “material”. The insurance company’s right to defend or rescind is further limited by an additional requirement that the matter misrepresented actually contributed to the loss, contingency, event or hazard for which the claim is made. In other words, in a limited number of cases, the insurance company may not deny a claim or seek rescission unless a “casual relation” exists between the misrepresentation and the actual loss. Under such statutes or case law, when there is an applicant who falsely claims to be a non-smoker, the insurance company can escape liability if the then insured dies of lung cancer due to smoking, but not if the insured later dies of AIDS. Finally, in some cases, the insurance company cannot avoid liability even when the policy has been procured through outright fraud.101

(b) Fraudulent Suppression of Material Information

In determining whether there has been suppression of a material fact it is necessary to examine whether suppression relates to a fact which is in the exclusive knowledge of the person intending to take the policy and also that it could be ascertained by reasonable inquiry of a prudent person.102 The Insurance act lays down three conditions to establish that the suppression was fraudulent and willful:

(i) The statement must be on a material matter which was bound to be disclosed.
(ii) The suppression must be fraudulently made by the policy holders.

101 http://www.the federation.org/documents/Sentell-WO2.htm. Accessed on 4/1/14 at 8:00 P.M.
(iii) The policy holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

The burden of proof of establishing that the insured had in fact suppressed material facts in obtaining insurance is on the insurer and all the aforesaid conditions are required to be proved cumulatively.\(^{103}\)

(c) Lapse of Policy for Non-Payment of Premium

A life insurance contract is a conditional contract where in order to keep the contract in force, the policyholders has to pay premiums as and when due. Premium is the monetary consideration, paid by the insured to the insurer in lieu of assurance of safety, benefits, facilities, interest’s protection and other financial aids. The net premium is payable in lump-sum or in installments, by intervals of fixed period. These intervals of time may be monthly, quarterly, half yearly or yearly. Non-payment of premium results in lapse of policy and the insurer is not under any obligation to continue her promise.\(^{104}\)

(d) Limitation Period

A policy of life insurance cannot be called in question on the grant of misrepresentation after a period of two years from the commencement of policy. This has been done to obviate the hardships of the insured when the insurance company tried to avoid a policy which has been in force for a long time, on the ground of misrepresentation. However, this provision is not applicable when the statement was made fraudulently.

10. Delay in Claim Settlement

Claim Settlement, which dates as far back as the history of insurance, is the only reason the consumer (insured) buys an insurance product.\(^{105}\) Traditionally, claim settlement has been regarded as one of the most painful areas of insurance contract. Though, it is one of

\(^{103}\) Life Insurance Corporation v. Smt. B. Kusuma T.Rao; (1991) 70 Comp Cas 86.

\(^{104}\) Supra n.5, p.48.

\(^{105}\) www.dspace.knust.edu.gh:8080/xmlui/bitstream/handle123456789/4425/Harry%20Ernest%20B. Accessed on 30/3/14 at 6:00 P.M.
the most important services that an insurance company can provide to its customers but, life insurance claims are not paid automatically. If you are beneficiary of a life insurance policy, you must file a claim in order to receive money. It sounds as simple as contacting your insurance agent and filling out some paper work but in reality the insurance companies make the bereaved family/beneficiary run from pillar to post.\textsuperscript{106}

Life insurance companies have an obligation to settle claims promptly, and the customer/policyholder also needs to submit all the relevant documents at the earliest as it is the cooperation of both the parties, the insurer and insured which facilitates speedy claim settlement.

On the happening of risk, the claimant must submit the written intimation as soon as possible to enable insurance companies to initiate the claim processing. It is important to mention here that for faster claim processing, it is essential that the claimant submits complete documentation as early as possible, as the insurer will not be able to take a decision until all the requirements are complete. Once all relevant documents, records and forms have been submitted, the life insurer can take a decision about the claim. As per the regulation 8 of IRDA (Protection of Policyholder’s Interest) Regulation 2002, the insurer is required to settle a claim within 30 days of receipt of all documents including the clarification sought by the insurer.\textsuperscript{107} However, if the claim requires further investigation, the insurer has to complete its procedure within six months from receiving the intimation of claim.

The process of claim settlement involves a series of steps like:

a. Scrutiny of the paper submitted

b. Calling for further requirements from beneficiary where necessary

c. Investigation in the case of death claims wherever required

d. Decision of the claims and final settlement of amount

\textsuperscript{106} www.financialliteracy.org/Topics/Insurance/Life-Insurance/Claiming-Life-Insurance-Benefits. Accessed on 30/3/14 at 6:00 P.M.

\textsuperscript{107} www.lifeinscouncil.org/consumers/claims-process. Accessed on 17/3/14 at 5:00 P.M.
In some cases, the process goes on for months. The obstacles in the claim settlement process, though conveyed to the beneficiary are not understood in the proper context. The entire process being manual, the client has no idea as to what stage of the claim settlement process his or her policy is in. This leads to consumer complaints, and claims manager have often no way to know where the problem lies, without a manual scrutiny of the policy file and documents.108

(a) IRDA Reports

The insurance regulator IRDAs annual reports for 2012-13 reveal that of the total 23 private life insurers, only five have a claim settlement ratio of over 90% (in terms of number of policies). Despite many of them having completed 10 years of operations, this figure tells you that many insurers are tight-fisted when it comes to passing on the benefits to nominee.

IRDAs data reveals LIC had the best claim settlement ratio of 97.73% among life insurers in the country. Private life insurers average settlement record was at 88.65% of the 23 private life insurers, only five ICICI prudential life, SBI life, HDFC Life, MAX Life, Kotak Life, have a claim settlement record of over 90%. Shree Ram Life, Aegon Religare Life, Edelweiss Tokio and DLF Pramerica Life are at the bottom of the list.109

(b) Effect of Delays

The fast administration of claims is not only a legal obligation of an insurance firm, but also a strong public relations and marketing strategy. Delay in claim settlement not only earn bad name for the company but also increases claim cost making it more expensive for the company.

When it comes to life insurance claims, the insurance companies do not enjoy a favorable public image. Insurance men and women are regarded in some areas as mere

Accessed on 21/3/14 at 4:00 P.M.

parasites, who exploit society without giving much in return except for the occasional claims which they pay out of fear of being taken to court and discredited or exposed, or out of fear of losing their customer to another company. The claim departments are seen as the “shop windows” of the insurance companies. Thus, the very nature of insurance makes the creation of good image a difficult task. The reputation of every insurance company depends to a large extent on the sort of claim service rounded by the company. It does not matter how cheap an insurance company’s premiums are, or how efficiently they conduct their underwriting administration if a claim is not properly and fairly dealt with, this is where an insurer will be judged. An unreliable and inefficient claims department could ruin the reputation of a company as once the customer discover that the company is reluctant to pay or delays payment of their genuine claims without good reason, they start drifting away.

Thus, it is the handling and settlement of claims, which can make or mar the image of Insurance Company.

(e) Recent Trends

Over recent years there have been many changes to the way in which claims are handed, viewed and managed. These changes are incremental and accumulative, rather than sudden and dramatic and this has created an ever changing and evolving claims environment.

i. Corporate reputation has emerged as an effective means to promote customer retention and to strengthen competitive advantages when confronting rivals in a dynamic and competitive global market. It has been considered to be the most sustainable drivers of business success.

ii. Customer orientation on the other hand is the cornerstone of a process that would influence a firm’s decisions in improving the quality of its products and services.
ultimately leading to a high corporate reputation. But, it is not the conception of customer orientation per se that drives a company’s performance in the eyes of its customers rather, it is the day to day, week to week and month to month processes, activities and services which actually make it or break it. Today, there is a great need to uphold the customer in high esteem and attend to their requirements with speed and efficiency because in this age of globalization, customer is hailed as “The King”. Thus satisfying their requirements means an organization will continue to stay in business and vice versa.

iii. Technological up gradation and utilization of new and better technology, better business process and off sharing has all been contributing factors in the evaluation of claims. For example, online claims tracking and rapid communication through standardized formats for requesting for information enables insurers to differentiate their brand from their completion and to provide a better service to their customers. Apart from this, reducing documents required to process a claim and minimize correspondence and claims communication and reporting could do this.

iv. Greater claim presence in this competitive era is not surprising. It is agreed that claims are much closer to heart of the industry than ever before and in many cases, it is believed to be the biggest trigger to an organizations’ profits and loss.

These measures directed at running efficient and effective claims administration would go a long way in addressing the image problem of the industry and the equitable and prompt settlement of claims will help earn the life insurance companies the confidence of customers and to retain their loyalty.

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114 Customer Orientation includes all the activities involved in acquiring information about customers, communicating that information through an organization and using that information for strategic planning and specific quality improvements.

115 Supra n.1.
11. Claim Management

Claim Management is one of the most challenging business processes of insurance industry. It is critical to an insurer’s success. Done right, it solidifies customer relationships, aids in regulatory compliance and prevents fraud.\(^{116}\)

Life insurance firms continue to struggle with manual and time intensive claim processing functions. Claim process suffers from large amounts of unstructured data collected from multiple sources and insufficient quantifiable performance metrics. It is largely paper based, manual and dependent on old technologies.

Overall, life insurers are looking for such a claim management strategy that reduces cost, improves customer satisfaction and enhance fraud detention.\(^{117}\)

1. Objective Claim Settlement

Customers are satisfaction maximisers. Claim process quality must begin with customer needs end with customer perceptions. Every insurer should ask themselves today whether claim is quantitative tort assessment or customer perception of loss. If the purpose of existence of an insurance company is to indemnify losses sufficiently then the later view seems valid.\(^{118}\)

2. Optimal Solution Systems

A claim settlement system should be transparent and efficient but never at the cost of laid down process. A claim settlement process is composed of various sub-processes wherein every sub-process consists of coming at a justifiable, quantitative, loss indemnity. If the sub-processes are compromised then whole system is compromised. Thus rather than creating swift expedite claim settlement system the objective of customer oriented insurer should be to create an optimal solution claim settlement process.\(^{119}\)


\(^{118}\) Ibid.

\(^{119}\) Ibid.
3. The Contract Benchmark

The basis of an insurance policy is the contract between a insurer and the insured. It has to be honored. An insurer should never try to rewrite the contract or revert to reverse underwriting. Therefore as the insured must obey the principle of utmost good faith at all times especially at the time of policy inception; the insured must do the same especially at the time of claim settlement.  

4. Process Turn Around Time Standardization

A claim settlement system is a set of sub-processes each unique in nature yet sequential. A good claim settlement system should identify these sub-processes and lay down standardization norms for them. The norms should be clear to the insurer and the insured.

5. Information Dissemination

At the time of policy inception the insured should have a brief idea of how the dynamics work at the time of claim. This can be through dissemination of information through literature (brochure, pamphlet etc.) or can become part of the policy schedule. An awareness of claim process makes the insured fulfill the requirements expeditiously.

6. Informed Intermediaries

The above process should be repeated with various intermediaries so that the process of claim requirements is much faster and efficient.

7. Fraud Detection Process

Traditionally, the fraud detection process was manual leading to poor detection rates and high occurrence of false positive cases. Today, the life insurers are expected to increasingly implement advanced fraud detection technologies to reduce fraud related costs.

\[120 \text{ Ibid.} \]
\[121 \text{ Ibid.} \]
\[122 \text{ Ibid.} \]
Advanced fraud detection techniques help the insurer to reduce fraud related expenses, which lead to lower premium rates for customers.\textsuperscript{123}

It is important and imperative for any insurer to understand that a successful claim management process is one of the sure steps to retain and maintain customers and in turn maintain a healthy top and bottom line. In this era of intense competition and market share this aspect gets doubly highlighted. A successful claim settlement shall strive to achieve:\textsuperscript{124}

(i) High Customer Satisfaction  
(ii) Sufficient Premium Income Growth  
(iii) Low Incurred Claim Ratio  
(iv) Profitable Underwriting

D. REVIEW

The purpose of taking a life insurance policy is predominantly to provide for protection against financial problems that may be faced in case the life assured dies too young or lives too long. Every insurance company has two gateways- the underwriting Gateway where the insurer under certain terms selects a proposal for life insurance, and the claims Gateway, through which the policy benefits are passed on to the life assured/policyholder or a beneficiary in the event of death or survival of the term. Needless to add, claims performance is the litmus test of life insurer’s credibility. If he repudiates or delays payment of a claim, a customer is going to be very unhappy and many more customers and prospects would have cause to doubt the promise made by the insurer. At the same time, if claims are paid blindly, overlooking fraudulent claims that can arise, it can seriously erode the financial soundness of the insurer and put its other customer’s interest in jeopardy.\textsuperscript{125} Insurance companies have standard proposal forms, which are to be filled giving the details of insurance required and presented to insurance companies. Depending upon the answers given in proposal form insurance companies assess the risk and quote the premium. On payment of premium and acceptance thereof by insurance company the insurance is affected.

\textsuperscript{123} Ibid.  
\textsuperscript{124} Jacob Thomas, “Claim Management as Strategic Management Tool”, The Insurance Times, March 2012, p.35.  
\textsuperscript{125} Supra n.32.
However, unless premium is paid there is no insurance cover. In case of unexpected event the insurance company gives the claim.

Details of the contingencies under which benefits are payable, are specified in the policy. When these contingencies occur, the benefits have to be claimed by the policy holder or the beneficiaries, as determined under various provisions of the policy and law. Claims may arise because of survival up to the end of the policy term, which is the date of maturity (Maturity Claims), survival up to a specified period during the term (Survival Benefits), death of the life assured during the term (Death Claims).

While settling the claim insurer desires certain documents like proof of death, cause of death, proof of title, the certificate of disability and any other document to pay the sum assured along with bonus after deducting the unpaid premium if any to the legal heirs. The Insurer will also verify that there is no attachment of policies from the Court or Income Tax Department. Most claims are settled by issuing a cheque within 7 days from the time they receive the documents. However, if the insurer is unable to deal with the claim or any part thereof he notifies the same to the insured in writing. However, settlement of claim does not always mean paying all the claims promptly but rather to pay the genuine claims and reject the in genuine ones. The life insurance industry is suffering from inefficiencies in the claim management process and life insurers across the globe are looking to reduce cost and improve customer retention.

Here, technological advancement, sensitization of staff and other measures directed at running efficient and effective claims administration would go a long way in addressing the problems faced by the industry.

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