INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

The IRD Act has established the Insurance Regulatory and Development Authority (“IRDA” or “Authority”) as a statutory regulator to regulate and promote the insurance industry in India and also to protect the interests of holders of insurance policies. Since its enactment has undergone a series of amendments to the Act of 1938 and conferred the powers of the Controller of Insurance on the IRDA.

The members of the IRDA are appointed by the Central Government from amongst persons of ability, integrity and standing who have knowledge or experience in life insurance, general insurance, actuarial science, finance, economics, law, accountancy, administration etc. The Authority consists of a Chairperson, not more than five whole-time members and not more than four part-time members.

Powers, Duties and Functions of the Authority

The Authority has been entrusted with the duty to regulate,

---

promote and ensure the orderly growth of the insurance and re-insurance business in India. In furtherance of this responsibility, it has been conferred with numerous powers and functions which include prescribing regulations on the investments of funds by insurance companies\(^2\), regulating maintenance of the margin of solvency, adjudication of disputes between insurers and intermediaries, supervising the functioning of the Tariff Advisory Committee, specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations and specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector.

The Indian Parliament passed the Insurance Regulatory and Development Act, 1999 ("IRDA Act") on December 2, 1999 with the aim “to provide for the establishment of an Authority, to protect the interests of the policy holders, to regulate, promote and ensure orderly growth of the insurance industry and to amend the Insurance Act, 1938, the Life Insurance Corporation Act, 1956 and the General Insurance Business (Nationalization) Act, 1972”.

---

MISSION STATEMENT OF IRDA

- To protect the interest of and secure fair treatment to policyholders;
- To bring about speedy and orderly growth of the insurance industry (including annuity and superannuation payments), for the benefit of the common man, and to provide long term funds for accelerating growth of the economy;
- To set, promote, monitor and enforce high standards of integrity, financial soundness, fair dealing and competence of those it regulates;
- To ensure speedy settlement of genuine claims, to prevent insurance frauds and other malpractices and put in place effective grievance redressal machinery;
- To promote fairness, transparency and orderly conduct in financial markets dealing with insurance and build a reliable management information system to enforce high standards of financial soundness amongst market players;
- To take action where such standards are inadequate or ineffectively enforced;
- To bring about optimum amount of self-regulation in day-to-day working of the industry consistent with the requirements of prudential regulation.


ESTABLISHMENT AND INCORPORATION OF AUTHORITY

(1) With effect from such date as the Central Government may, by notification, appoint, there shall be established, for the purposes of this Act, an Authority to be called "the Insurance Regulatory and Development Authority". The Authority shall be a body corporate by the name aforesaid having perpetual succession and a common seal with power, subject to the provisions of this Act, to acquire, hold and dispose of property, both movable and immovable, and to contract and shall, by the said name, sue or be sued.

COMPOSITION OF AUTHORITY\(^3\) – The Authority shall consist of the following members, namely:-

\(^3\) Section 4, Insurance Regulatory And Development Authority Act, 1999. 2.
(a) a Chairperson;
(b) not more than five whole-time members; and
(c) not more than four part-time members,

to be appointed by the Central Government from amongst persons of ability, integrity and standing who have knowledge or experience in life insurance, general insurance, actuarial science, finance, economics, law, accountancy, administration or any other discipline which would, in the opinion of the Central Government, be useful to the Authority:

Provided that the Central Government shall, while appointing the Chairperson and the whole-time members, ensure that at least one person each is a person having knowledge or experience in life insurance, general insurance or actuarial science, respectively.

BAR ON FUTURE EMPLOYMENT OF MEMBERS

The Chairperson and the whole-time members shall not, for a period of two years from the date on which they cease to hold office as such, except with the previous approval of the Central Government, accept:

(a) any employment either under the Central Government or under any State Government; or
(b) any appointment in any company in the insurance sector.

---

CONSTITUTION OF FUND

There shall be constituted a fund to be called "the Insurance Regulatory and Development Authority Fund" and there shall be credited thereto-

(a) all Government grants, fees and charges received by the Authority;

(b) all sums received by the Authority from such other source as may be decided upon by the Central Government;

(c) the percentage of prescribed premium income received from the insurer.

The Fund shall be applied for meeting -

(a) the salaries, allowances and other remuneration of the members, officers and other employees of the Authority;

(b) the other expenses of the Authority in connection with the discharge of its functions and for the purposes of this Act.

FURNISHING OF RETURNS, ETC., TO CENTRAL GOVERNMENT

The Authority shall furnish to the Central Government at such time and in such form and manner as may be prescribed, or as the Central Government may direct to furnish such returns, statements and other particulars in regard to any proposed or existing programme for the
promotion and development of the insurance industry as the Central Government may, from time to time, require.

Without prejudice to the provisions of sub-section(1), the Authority shall, within nine months after the close of each financial year, submit to the Central Government a report giving a true and full account of its activities including the activities for promotion and development of the insurance business during the previous financial year.

Copies of the reports received under sub-section (2) shall be laid, as soon as may be after they are received, before each House of Parliament.

**ESTABLISHMENT OF INSURANCE ADVISORY COMMITTEE**

The Authority may, by notification, establish with effect from such date as it may specify in such notification, a Committee to be known as the Insurance Advisory Committee.

The Insurance Advisory Committee shall consist of not more than twenty-five members excluding ex-officio members to represent the interests of commerce, industry, transport, agriculture, consumer fora, surveyors, agents, intermediaries, organisations engaged in safety and loss prevention, research bodies and employees' association in the insurance sector.

The Chairperson and the members of the Authority shall be the ex-

---

officio Chairperson and ex-officio members of the Insurance Advisory Committee. The objects of the Insurance Advisory Committee shall be to advise the Authority on matters relating to the making of the regulations under section 26. Without prejudice to the provisions of sub-section (4), the Insurance Advisory Committee may advise the Authority on such other matters as may be prescribed.

**Power of investigation and inspection by Authority**

The Authority may, at any time, by order in writing, direct any person (hereafter in this section referred to as "Investigating Authority") specified in the order to investigate the affairs of any insurer and to report to the Authority on any investigation made by such Investigating Authority:

Provided that the Investigating Authority may, wherever necessary, employ any auditor or actuary or both for the purpose of assisting him in any investigation under this section.

Notwithstanding anything to the contrary contained in section 235 of the time, and shall, on being directed so to do by the Authority, cause an inspection to be made by one or more of his officers of any insurer and his books and account; and the Investigating Authority shall supply to the insurer a copy of this report on such inspection.

---

It shall be the duty of every manager, managing director or other officer of the insurer to produce before the Investigating Authority directed to make the investigation under sub-section (1), or inspection under sub-section (2), all such books of account, registers and other documents in his custody or power and to furnish him with any statement and information relating to the affairs of the insurer as the said Investigating Authority may require of him within such time as the said Investigating Authority may specify.

Any Investigating Authority, directed to make an investigation under sub-section (1), or inspection under sub-section (2), may examine on oath, any manager, managing director or other officer of the insurer in relation to his business and may administer oaths accordingly.

The Investigating Authority shall, if he has been directed by the Authority to cause an inspection to be made, and may, in any other case, report to the Authority on any inspection made under this section.

On receipt of any report under sub-section (1) or sub-section (5), the Authority may, after giving such opportunity to the insurer to make a representation in connection with the report as, in the opinion of the Authority, seems reasonable, by order in writing:

(a) require the insurer, to take such action in respect of any matter arising out of the report as the Authority may think fit; or
(b) cancel the registration of the insurer; or

c) direct any person to apply to the court for the winding up of
the insurer, if a company, whether the registration of the
insurer has been cancelled under clause (b) or not.

The Authority may, after giving reasonable notice to the insurer,
publish the report submitted by the Investigating Authority under sub-
section (5) or such portion thereof as may appear to it to be necessary.

The Authority may by the regulations made by it specify the
minimum information to be maintained by insurers in their books, the
manner in which such information shall be maintained, the checks and
other verifications to be adopted by insurers in that connection and all
other matters incidental thereto as are, in its opinion, necessary to enable
the Investigating Authority to discharge satisfactorily his functions under
this section.

Offences by Companies\textsuperscript{8}

Where any offence under this Act has been committed by a
company, every person who, at the time the offence was committed, was
in charge of, and was responsible to, the company for the conduct of the
business of the company as well as the company shall be deemed to be
guilty of the offence and shall be liable to be proceeded against and
punished accordingly;

\begin{flushright}
\textsuperscript{8}. Insurance Regulatory And Development Authority Act, 1999. para 105A, 19.
\end{flushright}

(168)
Provided that nothing contained in this sub-section shall render any such person liable to any punishment, if he proves that the offence was committed without his knowledge or that he had exercised all due diligence to prevent the commission of such offence.

Notwithstanding anything contained in sub-section (1), where any offence under this Act has been committed by a company and it is proved that the offence has been committed with the consent or connivance of, or is attributable to any neglect on the part of, any director, manager, secretary or other officer of the company, such director, manager, secretary or other officer shall be deemed to be guilty of that offence and shall be liable to be proceeded against and punished accordingly.

**Penalty for failure to comply with section 32B**

If an insurer fails to comply with the provisions of section 32B, he shall be liable to a penalty not exceeding five lakh rupees for each such failure and shall be punishable with imprisonment which may extend to three years or with fine for each such failure.

**Penalty for failure to comply with section 32C**

If an insurer fails to comply with the provisions of section 32C, he shall be liable to a penalty not exceeding twenty-five lakh rupees for each such failure and in the case of subsequent and continuing failure, the registration granted to such insurer under section 3 shall be cancelled by the Authority.
Objectives of IRDA Act, 1999

1. To protect the interest of and secure fair treatment to policyholders;

2. To bring about speedy and orderly growth of the insurance industry (including annuity and superannuation payments), for the benefit of the common man, and to provide long-term funds for accelerating growth of the economy;

3. To set, promote, monitor and enforce high standards of integrity, financial soundness, fair dealing and competence of those it regulates;

4. To ensure that insurance customers receive precise, clear and correct information about products and services and make them aware of their responsibilities and duties in this regard;

5. To ensure speedy settlement of genuine claims, to prevent insurance frauds and other malpractices and put in place effective grievance Redressal machinery;

6. To promote fairness, transparency and orderly conduct in financial markets dealing with insurance and build a reliable management information system to enforce high standards of financial soundness amongst market players;

7. To take action where such standards are inadequate or ineffectively enforced;

---

8. To bring about optimum amount of self-regulation in day to day working of the industry consistent with the requirements of prudential regulation.

1. **Tariff Advisory Committee**

The Tariff Advisory Committee is a body corporate, which controls and regulates the rates, advantages, terms and conditions offered by insurers in the general insurance business. The Advisory Committee has the authority to require any insurer to supply such information or statements necessary for discharge of its functions. Any insurer failing to comply with such provisions shall be deemed to have contravened the provisions of the Insurance Act. Every insurer is required to make an annual payment of fees to the Advisory Committee of an amount not exceeding in case of reinsurance business in India, one percent of the total premiums in respect of facultative insurance accepted by him in India; and in case of any other insurance business, one percent of the total gross premium written direct by him in India.

2. **Insurance Association of India, Councils and Committees**

All insurers and provident societies incorporated or domiciled in India are members of the Insurance Association of India (‘‘Insurance Association’’) and all insurers and provident societies incorporated or

---

domiciled elsewhere than in India are associate members of the Insurance Association. There are two councils of the Insurance Association, namely the Life Insurance Council and the General Insurance Council. The Life Insurance Council, through its Executive Committee, conducts examinations for individuals wishing to qualify themselves as insurance agents. It also fixes the limits for actual expenses by which the insurer carrying on life insurance business or any group of insurers can exceed from the prescribed limits under the Insurance Act. Likewise, the General Insurance Council, through its Executive Committee, may fix the limits by which the actual expenses of management incurred by an insurer carrying on general insurance business may exceed the limits as prescribed in the Insurance Act.

3. **Ombudsmen**

The Ombudsmen are appointed in accordance with the Redressal of Public Grievances Rules, 1998\(^\text{12}\) to resolve all complaints relating to settlement of claims on the part of insurance companies in a cost-effective, efficient and effective manner. Any person who has a grievance against an insurer may make a complaint to an Ombudsman within his jurisdiction, in the manner specified. However, prior to making a complaint, such person should have made a representation to the insurer

---

and either the insurer has rejected the complaint or has not replied to it.\textsuperscript{13} 

Further, the complaint should be made not later than a year from the date of rejection of the complaint by the insurer and should not be any other proceedings pending in any other court, Consumer Forum or arbitrator pending on the same subject matter. The Ombudsmen are also empowered to receive and consider any partial or total repudiation of claims by an insurer, any dispute in regard to the premium paid in terms of the policy, any dispute on the legal construction of the policies in as much such a dispute relates to claims, delay in settlement of claims and the non-issue of any insurance document to customers after receipt of premium.

The Ombudsmen act as a Counsellor and mediator and make recommendations to both parties in the event that the complaint is settled by agreement between both the parties. However, if the complaint is not settled by agreement, the Ombudsman may pass an award of compensation within three months of the complaint, which shall not be in excess of which is necessary to cover the loss suffered by the complainant as a direct consequence of the insured peril, or for an amount not exceeding rupees two million (including ex gratia and other expenses), whichever is lower. Ombudsman within his jurisdiction, in the manner specified. However, prior to making a complaint, such person should

have made a representation to the insurer and either the insurer has rejected the complaint or has not replied to it.

Further, the complaint should be made not later than a year from the date of rejection of the complaint by the insurer and should not be any other proceedings pending in any other court, Consumer Forum or arbitrator pending on the same subject matter. The Ombudsmen are also empowered to receive and consider any partial or total repudiation of claims by an insurer, any dispute in regard to the premium paid in terms of the policy, any dispute on the legal construction of the policies in as much such a dispute relates to claims, delay in settlement of claims and the non-issue of any insurance document to customers after receipt of premium.

The Ombudsmen act as a counsellor and mediator and make recommendations to both parties in the event that the complaint is settled by agreement between both the parties.\(^\text{14}\) However, if the complaint is not settled by agreement, the Ombudsman may pass an award of compensation within three months of the complaint, which shall not be in excess of which is necessary to cover the loss suffered by the complainant as a direct consequence of the insured peril, or for an amount not exceeding rupees two million (including ex gratia and other expenses), whichever is lower.

Registration of Insurance Company

Every insurer seeking to carry out the business of insurance in India is required to obtain a certificate of registration from the IRDA prior to commencement of business. The pre-conditions for applying for such registration have been set out under the Act of 1938, the IRD Act and the various regulations prescribed by the Authority.

1. General Registration Requirements

The following are some of the important general registration requirements that an applicant would need to fulfill:

(a) The applicant would need to be a company registered under the provisions of the Indian Companies Act, 1956. Consequently, any person intending to carry on insurance business in India would need to set up a separate entity in India.

(b) The aggregate equity participation of a foreign company (either by itself or through its subsidiary companies or its nominees) in the applicant company cannot not exceed twenty six per cent of the paid up capital of the insurance company. However, the Insurance Act and the regulations there under provide for the manner of computation of such twenty-six per cent.

(c) The applicant can carry on anyone of life insurance business, general insurance business or reinsurance business. Separate

---

companies would be needed if the intent were to conduct more than one business.

(d) The name of the applicant needs to contain the words “insurance company” or “assurance company”.

2. Capital Structure Requirements

The applicant would need to meet with the following capital structure requirements:

(a) A minimum paid up equity capital of rupees one billion in case of an applicant which seeks to carry on the business of life insurance or general insurance.

(b) A minimum paid-up equity capital of rupees two billion, in case of a person carrying on exclusively the business of reinsurance.

In determining the aforesaid capital requirement, the deposits to be made and any preliminary expenses incurred in the formation and registration of the company would be included.

A “promoter” of the company is not permitted to hold, at any time, more than twenty-six per cent of the paid-up capital in any Indian insurance company. However, an interim measure has been permitted percentages higher than twenty six percent are permitted if the promoters divest, in a phased manner, over a period of ten years from the date of commencement of business, the share capital held by them in excess of twenty six per cent.
3. **Procedure for obtaining a certificate of registration**

An applicant desiring to carry on insurance business in India is required to make a requisition for a registration application to the IRDA in a prescribed format along with all the relevant documents. The applicant is required to make a separate requisition for registration for each class of business i.e. life insurance business consisting of linked business, non-linked business or both, or general insurance business including health insurance business.

The IRDA may accept the requisition on being satisfied of the bona fides of the applicant, the completeness of the application and that the applicant will carry on all the functions in respect of the insurance business including management of investments etc. In the event that the aforesaid requirements are not met with, the Authority may after giving the applicant a reasonable opportunity of being heard, reject the requisition. Thereafter, the applicant may apply to the Authority within thirty days of such rejection for re-consideration of its decision. Additionally, an applicant whose requisition for registration has been rejected may approach the Authority with a fresh request for registration application after a period of two years from the date of rejection, with a new set of promoters and for a class of insurance business different than the one originally applied for.

In the event that the Authority accepts the requisition for registration application, it shall direct supply of the application for registration to the applicant. An applicant, whose requisition has been accepted, may make an application along with the relevant documents evidencing deposit, capital and other requirements in the prescribed form for grant of a certificate of registration. If, when considering an application, it appears to the Authority that the assured rates, advantages, terms and conditions offered or to be offered in connection with life insurance business are in any respect not workable or sound, he may require that a statement thereof to be submitted to an actuary appointed by the insurer and the Authority shall order the insurer to make such modifications as reported by the actuary.

After consideration of the matters inter alia capital structure, record of performance of each promoters and directors and planned infrastructure of the company, the Authority may grant the certificate of registration. The Authority would, however, give preference in grant of certificate of registration to those applicants who propose to carry on the business of providing health covers to individuals or groups of individuals. An applicant granted a certificate of registration may commence the insurance business within twelve months from the date of registration.

In the event that the Authority rejects the application for
registration, the applicant aggrieved by the decision of the Authority may within a period of thirty days from the date of communication of such rejection, appeal to the Central Government for reconsideration of the decision and the decision of the Central Government in this regard would be final.

4. **Renewal of Registration**¹⁷

An insurer who has been granted a certificate of registration should renew the registration before the 31st day of December each year, and such application should be accompanied by evidence of fees that should be the higher of:

- fifty thousand rupees for each class of insurance business, and

- one fifth of one per cent of total gross premium written direct by an insurer in India during the financial year preceding the year in which the application for renewal of certificate is required to be made, or the application for renewal of certificate is required to be made, or rupees fifty million whichever is less; (and in case of an insurer carrying on solely re-insurance business, instead of the total gross premium written direct in India, the total premium in respect of facultative re-insurance accepted by him in India shall be taken into account).

---
This fee may vary according to the total gross premium written direct in India, during the year preceding the year in which the application is required to be made by the insurer in the class of insurance business to which the registration relates but shall not exceed one-fourth of one percent of such premium income or rupees fifty million, whichever is less, or be less, in any case than fifty thousand rupees for each class of insurance business. However, in the case of an insurer carrying on solely re-insurance business, the total premiums in respect of facultative re-insurance accepted by him in India shall be taken into account.

5. **Suspension of registration**

The registration of an Indian insurance company or insurer may be suspended for a class or classes of insurance business, in addition to any penalty that may be imposed or any action that may be taken, for such period as may be specified by the Authority, in the following cases:

- conducts its business in a manner prejudicial to the interests of the policy-holders;
- fails to furnish any information as required by the Authority relating to its insurance business;
- does not submit periodical returns as required under the Act or by the Authority;
- does not co-operate in any inquiry conducted by the Authority;
- indulges in manipulating the insurance business;
• fails to make investment in the infrastructure or social sector as specified under the Insurance Act.

6. **Cancellation of certificate of registration**

The Authority, in case of repeated defaults of the grounds for suspension of a certificate of registration, may impose a penalty in the form of cancellation of the certificate. The Authority is compulsorily required to cancel the registration of an insurer either wholly or in so far as it relates to a particular class of insurance business, as the case may be:

• if the insurer fails to comply with the provisions relating to deposits; or

• if the insurer fails, at any time, to comply with the provisions relating to the excess of the value of his assets over the amount of his liabilities; or

• if the insurer is in liquidation or is adjudged an insolvent; or

• if the business or a class of the business of the insurer has been transferred to any person or has been transferred to or amalgamated with the business of any other insurer; or

• if the whole of the deposit made in respect of the insurance business has been returned to the insurer;

• if, in the case of an insurer, the standing contract is cancelled or is

---

suspended and continues to be suspended for a period of six months, or

- if the Central Government of India so directs.

In addition to the above, the Authority has the discretion to cancel the registration of an insurer 19

- if the insurer makes default in complying with, or acts in contravention of, any requirement of the Insurance Act or of any rule or any regulation or order made or, any direction issued thereunder, or

- if the Authority has reason to believe that may claim upon the insurer arising in India under any policy of insurance remains unpaid for three months after final judgment in regular course of law, or

- if the insurer carries on any business other than insurance business or any prescribed business, or

- if the insurer makes a default in complying with any direction issued or order made, as the case may be, by the Authority under the IRDA Act, 1999.

- If the insurer makes a default in complying with, or acts in contravention of, any requirement of the Companies Act, or the

LIC Act, or the GIC Act or the FEMA, 2000.

The order of cancellation shall take effect on the date on which notice of the order of cancellation is served on the insurer. Thereafter, the insurer would be prohibited from entering into any new contracts of insurance, but all rights and liabilities in respect of contracts of insurance entered into by him before the cancellation takes effect shall continue as if the cancellation had not taken place. The Authority may, after the expiry of six months from the date on which the cancellation order takes effect, apply to the Court for an order to wind up the insurance company, or to wind up the affairs of the company in respect of a class of insurance business, unless the registration of the insurance company has been revived or an application for winding up has already been presented to the Court.

7. **Revival of registration**

The Authority has discretion, where the registration of an insurer has been cancelled, to revive the registration, if the insurer within six months from the date on which the cancellation took effect:

- makes the deposits, or
- complies with the provisions as to the excess of the value of his assets over the amount of his liabilities, or
- has his standing contract restored, or

---

• has the application accepted, or
• satisfies the Authority that no claim upon him remains unpaid, or
• has complied with any requirements of the Insurance Act or the IRDA Act, or any rule or regulation, or any order made thereunder or any direction issued under these Acts, or
• that he has ceased to carry on any business other than insurance business or any prescribed business.

CONSUMER PROTECTION

There are different ways of looking at a consumer’s grievance – ranging from a genuine grievance arising out of a deficiency of service, to the manifestation of one’s frustration over an avoidable non-issue. While the grievances of the second kind can be managed by counselling, hand-holding etc., there is a dire need to take a serious look at the genuine grievances of customers. Ideally, if both the parties to the contract are totally at agreement with the reciprocal obligations and their fulfilment, there is hardly any space for deficiency of service. In the domain of financial services in general, and insurance in particular; this is one aspect that is hard to achieve. This compels us to analyse the various types of grievances, and take stock of the situation in ensuring that there is discernible progress over a period of time.²¹

In insurance, rendering a service to the client commences at the stage of solicitation itself when the insurer offers to bring the prospect into its fold; and in this regard, the competitive market plays a very vital role. If one of the players holds an ill reputation for disservice, it is unlikely that he would pose a challenge for the competitors in acquiring business. Especially in a world where communication is very fast, such negative trends of functioning would have a serious impact on the business interests of the players. In order to obviate such a scenario, there must be continuous analysis of the reasons for customer grievances and wherever necessary, put in place methods to ensure that such grievances do not recur.

Apart from mis-selling which continues to be a very commonly reported reason for customer grievances, some other frequently observed areas of operation where insurers need to concentrate are: Claims Management, Premium notices, Change of address and other administrative services etc. in the life sector; and surveyor-related issues, amount of claims, extent of coverage etc. in the non-life domain. Special attention must be paid to such of those areas where press reports, courts and other consumer bodies often comment about the poor service rendered. The adoption of technological support wherever possible and necessary, must be quickly accomplished as it would certainly add to the levels of efficiency in customer service. While there is no doubt that there
has been great progress in this regard, the extent of customer dissatisfaction still existing in the insurance domain leaves a lot to be desired. Insurers must ensure a major turnaround in this area, sooner than later.  

Insurance is a service, where contract certainty (the promise made is adhered to), and financial indemnification (assured payment is made to the extent of covered loss), are essential in creating value. Given that even normal insurance purchase tends to produce anxiety for the buyer, customer confidence building is possible only when insurers free the customer from the many potential pain points that can arise for the customer across the insurance value chain.

A life insurance value chain from the consumer view point may be as seen as shown below:

1. **Advice and Sales**

The advice and sales area is rife with pain points which ultimately results in mis-selling and loss of confidence in insurance services per se. The starting point is misleading, improper or ignorant advice. Therefore

---

an insurance advisor or sales person, who may be an in-company employee, an external tied agent, a corporate agent or a broker, needs to be trained (not merely in mandated training), but in rendering trust building advice which needs perceptive product knowledge in the context of customer’s life cycle moment – in terms of economic, demographic, social, life cycle, or other vulnerability contexts; keeping in mind the level of risk aversion that the customer has.

The insurance advisor must be guided by the underwriter in assuring the contextualization of risk for the customer and offering a suitable product. Insurance is not to be hard sold today, but to be discussed in the risk milieu of the customer and the financial planning needed to meet the life situation of the customer. The context of insurance is primarily risk transfer for the customer, not investment or covering loan ‘risks’ and so on. However, many of the sales and advice teams do not see customer needs in terms of customer good only, but push products in terms of the urgencies of the insurer, the commission returns for the intermediary and the concerns of other stakeholders such as lenders and so on. So the concept of 'treating customers fairly', needs to become an active concept from the starting of the relationship itself.

The second aspect is the offer that the customer needs to make to the insurer and the disclosures on risk that needs to be elicited so that the insurer has all relevant information as disclosed by the customer to
understand the real risk exposures, so as to fashion the right product and price point for the customer. The intermediary needs to play the lead role in preventing attempt at fraud, non-disclosure and misrepresentation so that genuine customers can be served better and wrong costs are not added to the insurer pool. Thus the intermediary service is vital in removing knowledge and service asymmetries for both the contracting parties as under:

<table>
<thead>
<tr>
<th>VALUES THAT INTERMEDIARIES OFFER</th>
<th>To the Customer</th>
<th>To the Insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers to be motivationally pushed as they may not enjoy buying insurance</td>
<td>Advises the right products and the methods to determine the best buy and remove the search costs for the insured</td>
<td>Insurer aided to attract good risks by reducing the knowledge asymmetry between insurer and the insured.</td>
</tr>
<tr>
<td>Explains the complex language of insurance and reduces the uncertainty costs of the insured</td>
<td>Reduces the frictional costs that can arise out of asymmetric information</td>
<td>Makes pricing of risks far more accurate, by distinguishing the risks as per the risk categories made by the underwriters</td>
</tr>
<tr>
<td>Intermediaries reduce the procedural hassles involved as also the complexity costs involved.</td>
<td>The intermediary brings to the table the behavioural aspects of the insured’s risk</td>
<td>Intermediaries match buyer needs with insurer’s products and also give feedback on customer demands and aspirations</td>
</tr>
<tr>
<td>They help insured in additional services such as endorsements, renewals, refunds etc. to enhance the value of the coverage.</td>
<td>In claims the insured needs all the hand holding he can get to speed assessment and settlement.</td>
<td>The intermediary helps to communicate insurer requirements in case of claim and to help in speedy settlement of the claim</td>
</tr>
<tr>
<td>They evaluate customer needs and help to sell the full line of products based on life cycle and occupational needs.</td>
<td>They can make transparent the product and how it provides the security as needed by the customer.</td>
<td>Intermediaries provide the full information required to help proper underwriting and rating.</td>
</tr>
<tr>
<td>They help to carry out research, test and develop new products, or new services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(188)
The intermediary can offset the actuarial mind-set of an insurer who may treat insureds as a mere risks to berated. They help customers to trade up to better products when made available. They offer relevant risk management, informational, and relational services to the insured. They help insurer competitiveness by collection of risk specific or general information. They assist in policy renewal and the lifelong retention of the customer. They give feedback on the quality of service rendered by the insurer.

2. Underwriting

Underwriting is the most important service that helps insured customers in analysing and understanding their risks; and good underwriters can help them to minimise their risks through better risk management based on compliance to warranties and conditions; and obtain a price based on the merit of the risk to be insured. Here the pain points can be many arising from numerous occasions for errors that significantly affect the validity and utility of the cover due to inaccuracies and omissions creeping in the underwriting assumptions made, the rating approach and the many limitations set in the policy. The type of cover given, the width and depth of coverage, the relevance of the exclusions, conditions and warranties make underwriting service very value oriented. An underwriter's aim is to prevent, reduce and transfer risk; and therefore take stock of the frequency and size of claims, and to tackle any unnecessary costs in the service of insurance. By doing this, insurers help to bring down the cost of insurance, grow markets, and improve customer

experience in the mastery of risk. The underwriting process helps the underwriter to be familiar with the peculiarities of the risk to be accepted and how potential losses can arise; and to what extent the onus can be put on the insured to take steps to prevent the occurrence of a loss, so that the loss probability of the matter insured is equal to the risk premium charged.

Real service in underwriting is the possibility of introducing scientific risk rating factors based on IT platforms to ensure that more and more factors relevant to the risk are introduced so that the best merit rating possible can be offered to the insured using real time data bases. The practice of redlining or rejecting or improper loading of rates based on arbitrary reasons becomes serious pain points for customers and is against legal, regulatory and actuarial ruling sand principles.

3. Policy Administration and Service

This is an area where the logistical services of the insurer need to be efficient and the process flow error free. Scrutiny of the proposal, acceptance of the premium, issuance and checking of the policy with relevant clauses, conditions and exclusions, adding the names of nominees or others interested in the policy such as the bank, despatching the policy to the insured in time, sending a copy of the proposal form back to the insured, amendments to the policy, making available channels
for the further guidance to the insured etc. form part of the policy administration and service.

Toll free call numbers, FAQs on websites, ‘dos and don'ts’ for the customer while the policy cover is running are some of the services that are given to ensure that customers can manage the tenure of the policy against any error or misunderstanding. In this regard the use of vernacular in policy language along with the original version in English is also a definite value addition. In the logistics of service insurers are injecting (and need to inject even more) technology and IT services to get services rendered hassle free and to the extent possible cost free.

Anywhere, anytime service, past history of insurance coverage and claims, and benefit entitlements like no claim bonus or discounts, better hand holding during times of claims etc. are issues on which customers will seek instant services and relief. Similarly small customers will not get ignored or elbowed out if technology aids them in self-service, co-creation of relevant product packages and in reporting their requirements on electronic platforms so as to get instant service.25

4. Renewal Service

Renewal service is of utmost importance and every effort must be taken to contact the insured by letter, email, over phone or by sms. It was expected that agents would personally hand over renewal notices and take

the premium cheque but it is natural for the insurer to establish direct contact to avoid any service failure and especially so when the renewal terms may undergo change, such as increase in premium rates; changes in terms and conditions; other changes may be made by the company, by the industry or as directed by courts, the regulator and so on.

Management of renewal can remove many pain points such as gaps in insurance, updating of insured details, changes in the risk details, revision of sum insured, upgrading the policy coverage, taking on new add-ons and so on. Even though under policy terms and conditions there may be no obligation to renew or invite to renew, there are increasing moral and regulatory compulsions to ensure that proper renewal services are offered as foundational to ensure lifelong coverage service to the customer.

5. Claims Service

In the context of insurance, everyone is afraid of the failures in claim service as the focus of insurance is on protection in case of the unforeseen eventuality of claims. Even good customers, who try to avoid losses and not claim, if claims are within their tolerance, have nightmares about claim service. Insurers need to check as whether the body language of the company changes, when a claim arises. This need not be so, as good underwriting is supposed to forecast the claim frequency and severity to a large extent in a normal year.
Insurance presupposes the fact that what may be uncertain to an individual is more certain when there are large numbers and this is how claims are forecasted based on past experience tempered with current realities. A bad perception about a company’s claim service attitude can damage irreparably a company’s brand equity and reputation. In claims there are two types of urgencies – time and correctness of the settlement.

Insurers are fixated about reducing the claims outgo and in the process they let go the time urgencies felt by the insured and those others like banks that are waiting for the loss amount to restart the economic activity impaired. Where customers understand that the final amount to be paid may take time, they would be highly relieved if an ‘on account’ payment can be released because it makes it clear that liability has been admitted and the initial finance to restart operations can be had.

From the time of claim intimation to the final payment of the claim cheque, there are many processes and requirements on the part of the insurer, intermediary and the insured. Any slackness from any side is bad for the outcome, but the driver of the service is the insurer; and insurer pro-activeness is fundamental to this service and insurer commitments are to be made transparent in this area.

There are two types of claims from the perspective of service delivery. It is more or less simple to handle random claims from various
customers at various time points. However, there are occasions of great disasters such as floods, earthquakes, etc. where the resources of insurers, surveyors, repairers and public authorities are stretched.

Lack of access to the sites of loss, the non-availability of insureds who may have to leave their houses/localities, the lack of sufficient repairers, the higher costs of parts and other logistical problems, the difficulty in obtaining insured's documents and the inability of public authority to record losses for the purposes of claim processing are all part of the hurdles in service. Managing these extraordinary situations calls for insurers/ reinsurers and all intermediaries and public authorities to act together and show the resolve to settle such claims quickly to demonstrate commitment to the underlying insurance concept of social solidarity and public good.

**Grievance Management**

Customer complaints are common in the financial services area. Hence Regulators, Ombudsmen, Consumer Forums and the Judiciary are hard on insurers who fail to honour their commitments by using interpretations that are one sided or rely on the fine print without the application of mind.

Grievances can arise in all areas of insurance service, but some of them are routine and can be handled quickly by insurers if tight processes
and timelines are maintained in service. However, in the area of claims, renewal service e.g. gap in renewal and in similar issues, there are areas of dispute where insurers may have been unable to take the right decision in the first instance. However, when the insured comes up with a grievance, the insurer must utilise more experienced people to examine the grievance and take a decision based on the new inputs given by the customer.

Traditionally, insurers are blamed for not distinguishing between real and technical reasons for denying claims. This is where grievances have a real role for a merit based relook. Technical reasons have validity when they touch the core areas of the claim but in some cases they are invoked ignorantly or owing poor interpretational capability.

After repeated grievances are reported regarding the same matter, insurers need to examine the root causes that create frequent grievances and take action to remove such causes to prevent the flow of repeating grievances. Grievances are also the feedback mechanism for insurers to sense the emerging pain points and take the opportunity to become proactive to plug them, and to move on from the corrective to the creative. In any industry, innovation and sensitiveness to customers’ changing needs are rendered necessary for sustainability and success and is done by deepening, widening and sharpening service offerings.
In the emerging area of risk management through insurance, there is still great scope in reaching assured risk mitigating services, and this service offers multi-tier benefits because losses impact individuals and families, the community and local society and the larger political economy. The flow of grievances and customer queries through the many channels of communication to the company should be sieved through for collecting the points for setting new directions for product offering and service standards. Therefore grievance management can emerge as a point for strategic approaches in customer engagement and better customer experiences.

In conclusion, business success is the result of actual customer experience and the resulting customer advocacy based on a day to day excellence in service, proving that the insurer/intermediary delivers on promises enshrined in the vision and mission of the organisation. So there is a need for holistic investment in achieving positive customer experiences, using the right technology, knowledge power, systems and processes, the right attitude and service culture to power the organisation's service-speak. This must be even more so in case of service failures. The Indian insurance sector is set to grow by leaps and bounds in the years to come, but its real mettle will be tested in the maturity of organisations to deliver real value and error free service.
CONCLUSION

This chapter includes the KSFs for success in the insurance business. Success in business is the result of actual customer experience and the resulting customer advocacy based on a day to day excellence in service, proving that the insurer/intermediary delivers on promises enshrined in the vision and mission of the organisation. There is a need for holistic investment in achieving positive customer experiences, using the right technology, knowledge power, systems and processes, the right attitude and service culture to power the organisation's service-speak. It is more so in case of service failures. The Indian insurance sector is set to grow by leaps and bounds in the years to come, but its real mettle will be tested in the maturity of organisations to deliver real value and error free service.

Objectives of IRDA have also been discussed which include to protect the interest of and secure fair treatment to policyholders; to bring about speedy and orderly growth of the insurance industry (including annuity and superannuation payments), for the benefit of the common man, and to provide long-term funds for accelerating growth of the economy; to set, promote, monitor and enforce high standards of integrity, financial soundness, fair dealing and competence of those it regulates; to ensure that insurance customers receive precise, clear and
correct information about products and services and make them aware of their responsibilities and duties in this regard; to ensure speedy settlement of genuine claims, to prevent insurance frauds and other malpractices and put in place effective grievance Redressal machinery; to promote fairness, transparency and orderly conduct in financial markets dealing with insurance and build a reliable management information system to enforce high standards of financial soundness amongst market players; to take action where such standards are inadequate or ineffectively enforced; and to bring about optimum amount of self-regulation in day to day working of the industry consistent with the requirements of prudential regulation.

Customer complaints are common in the financial services area. Hence Regulators, Ombudsmen, Consumer Forums and the Judiciary are hard on insurers who fail to honour their commitments by using interpretations that are one sided or rely on the fine print without the application of mind.

Grievances can arise in all areas of insurance service, but some of them are routine and can be handled quickly by insurers if tight processes and timelines are maintained in service. Traditionally, insurers are blamed for not distinguishing between real and technical reasons for denying claims. This is where grievances have a real role for a merit based relook. Technical reasons have validity when they touch the core.
areas of the claim but in some cases they are invoked ignorantly or owing poor interpretational capability.

PROVIDING THE RIGHT PROTECTION