

LIFE INSURANCE CORPORATION OF INDIA

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Concise

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SECTION 1 COMMON CHAPTERS

Chapter 1 Introduction to Insurance

Insurance – in simple language it means to transfer risk to someone who is capable of handling it generally to insurer (Insurance Company). It is considered as a process by which the losses of a few, who are unfortunate to suffer such losses, are shared amongst many those exposed to similar uncertain events/situations.

A) Life insurance history and evolution:-

- . The origin of insurance business started from London's Lloyd coffee house.
- . 1st life insurance company to be set up in India was The Oriental Life Insurance company Ltd.
- . 1st Non-life insurance company was Triton Insurance company Ltd.
- . 1st Indian insurance company was Bombay Mutual Assurance society Ltd.
- . National Insurance company Ltd. is the oldest insurance company founded in 1906.

B) How insurance works:- There must be an asset which has economic value (Car-physical; Goodwill-non physical; Eye-personal). These assets may lose value due to uncertain event. This chance of loss/damage is known as risk. The cause of risk is known as peril. Persons having similar risks pool (contribute) money (premium) together. There are 2 types of Risk Burdens –

- . Primary burden of risk – losses actually suffered. Eg. Factory getting fire.
- . Secondary burden of risk – losses that might happen. Eg. physical/mental Stress strain.

C) Risk management techniques:- The various types of techniques that can be used to manage risk are risk avoidance ; risk retention; risk reduction and control; risk financing.

D) Insurance as a tool for managing risk:-

- . Don't risk a lot for a little. Eg. There is no need to insure a ball pen as its cost is not high.
- . Don't risk more than what we can afford to lose. Eg. We cannot afford to not insure our house as its cost is high.
- . Don't insure without considering the likely outcome. Eg. Can anyone insure a space satellite.

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

Chapter 2 Customer Service

- A) Importance of customer service** – the commitment to serve their customers is the key for managing once customer and reach to top in insurance sales. Keeping the customer happy benefits the agent and company through customer's lifetime value. It may be defined as sum of economic benefits that can be derived from building a sound relationship with customer over a long period of time. Customer lifetime value consists of 3 parts –
- i) **Historic value** – premiums and revenues received through the customer is past.
 - ii) **Present value** – premiums that may be expected to be received if policies are to be retained.
 - iii) **Future value** – premiums that can be derived by persuading customers to buy new policies.

B) Agents role in customer service –

- i) **Point of sale** – the 1st point for service is the point of sale. The agent should be able to understand the needs and suggest products whose benefit features are best suitable. The role of an agent is like a personal financial planner and advisor.
- ii) **Proposal stage** – the agent has to help customers in filling the proposal form. It is important that the agent explains and clarifies the proposer's doubt while filling the form.
- iii) **Acceptance stage** – the promptness of agent in handing over FPR to customer develops surety in customer's mind. Delivery of policy bond is another major opportunity.
- iv) **Premium payment** – agents can be in continuous touch with their customers through reminder calls for premium due's in order to avoid lapsation of policy.
- v) **Claim settlement** – agents play crucial role during claim settlement by providing policy holder details required during investigation stage.
- vi) **Other services** – another opportunity that agents have in order to give their best is during other services such as nomination change, assignment, duplicate policy etc..
- vii) **Grievance redressal** – the time for high priority action is when the customer has a complaint, the issue of service failure can lead to 2 types of feeling/emotion – a) sense of unfairness, cheating; b) feeling of hurt-ego being made to look and feel small.

C) Communication skills - One of the most important set of skills that an agent needs to possess for effective performance is soft skills. Soft skills relate to one's ability to interact effectively with other workers, customers. What goes in to making of a good relationship is TRUST that you generate in your customer's mind through – Attraction; Being Present; Communication.

Communication can take place in several forms – **Oral; Written; Non-Verbal; Body Language**. Lastly possessing good listening skills and being not judgemental helps a lot. Elements of effective listening – paying attention, providing feedback, responding appropriately, empathetic listening and not being judgemental.

Chapter 3 Grievance Redressal Mechanism

A) Grievance redressal mechanism – IRDA has various regulations in order to render the consumer's grievances/complaints which come under protection of policy holder's interests regulation 2002.

- i) **Integrated grievance management system (IGMS)** – IRDA has launched an integrated grievance management system (IGMS) which acts as a central repository of insurance grievance data and as a tool for monitoring grievances in the industry. Policy holders can register on this system with their policy details. Complaints are then forwarded to the respective insurance company.
- ii) **The consumer protection act 1986** – the act was passed “to provide for better protection of the interest of consumers and to make provision for the establishment of consumer's disputes”.
 - . **service** – any provision made available to potential users such as banking, financing, transport, insurance etc.
 - . **consumer** – any person who buys any goods for a consideration or hires or avails of any services for a consideration.
 - . **defect** – it means any fault, imperfection, shortcoming, inadequacy in quality, nature, manner or performance for any service that is taken by the customer.
 - . **complaint** – it means any allegation given in writing regarding any unfair trade, defect in goods, deficiency in services hired or availed, excess pricing.

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

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

District forum	State commission	National commission
They take complaints where value of goods is upto Rs. 20 lacs. Established by each state govt. In each district.	They take complaints where value of goods is more than 20 lacs but less than 100lacs. Established by state govt. In each state. They take cases which are not settled at district forum.	They take complaints where value of goods is exceeding Rs. 100 lacs. Established by central govt. By notification. They take cases which are not settled at state level.

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

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

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

. return of goods price (premium in case of insurance)

. to remove defects or deficiencies in the services in goods.

. to discontinue unfair trade practice

. to provide adequate costs to the parties.

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

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

. **complaints to ombudsman** – any complaint should be made in writing, signed by the insured or his legal heirs. Complaints can be made if – complaint was initially made to insurer and was rejected or not received by insurer, no satisfactory reply given by insurer, complaint is made within 1yr from date of rejection from insurer, complaint is not pending in any court or consumer forum.

. **recommendations by ombudsman** – ombudsman has to give his recommendation within 1month of receipt of complaint. Copies of recommendation are sent to both complainant and insurer. **Recommendations have to be accepted in writing by complainant within 15days of receipt.** A copy of acceptance letter by the insured should be sent to insurer and his written confirmation within 15days of his receiving such acceptance letter.

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

Chapter 4 Regulatory Aspects of Insurance Agents

A) Insurance regulations and regulatory framework :-

- i) Importance of insurance regulations – some common concerns are: is insurance legal; are agents recognized by law; are insurers regulated or supervised; is document provided legally valid; will claim be paid if loss happens.
- ii) Requirement of insurance regulations – the prime purpose is policy holder's protection. As we have **RBI** in order to regulate all banks in India and **SEBI** (securities exchange board of India) to regulate all capital markets. Similarly we have **IRDA** (Insurance Regulatory and Development Authority) to keep check on all insurance companies in India.
- iii) Insurance regulatory framework – the insurance act 1938 is the basic insurance legislation of the country, which governs insurance business in India. The IRDA was established in 2000. The obligations prescribed by regulator to insurer are applicable –at the point of sale; towards policy servicing; claims servicing; control on expenses & investments; financial strength to meet the commitments to policy holder.

B) Regulations and code of conduct applicable to insurance agents :-

As per the insurance act 1938 (**section 42**), to work as an insurance agent, one must have a valid licence. IRDA deals with issuance of licences and other matters related to agents recruitment. Agents of life and non-life (general) insurance can do business for standalone health insurance companies as well. Agents who want to change their insurance companies need to submit NO-Objection certificate (NOC).

Rules governing licensing of insurance agents:-

- . **Qualification** – he must be 10th pass for all areas to be accepted.
- . **Practical training** – for 1st time applicants 50hrs training is required and composite license 75hrs.
- . **Examination** – the applicant must pass pre-recruitment exam.
- . **Fees payable** – Rs.250 is payable for issue of license to act as an agent.
- . **Cancellation of license** – in case of any disqualification mentioned, the license is cancelled.
- . **Duplicate license** – on payment of Rs.50 duplicate license can be issued in case of loss.
- . **Disqualification of license** – the applicants license can be disqualified if- he is minor; he is of unsound mind; he is found guilty of criminal misappropriation or breach of trust/ cheating or forgery; he is found committing fraud, dishonesty.
- . **Renewal of license** – after every 3yrs license is to be renewed along with 25hrs of training.

C) Agent's code of conduct :-

- . disclose his license to the proposer on demand.
- . explain carefully all information regarding the product.
- . indicate the premium to be charged
- . obtain required documents from the proposer
- . assist policy holder in filling up the form
- . disclose commission to be received on the policy if policy holder demands for it.
- . cannot solicit the business of insurance without holding valid license.
- . cannot offer different rates, terms and conditions which are not mentioned in policy.
- . cannot force any policy holder to close any policy.

Chapter 5 Legal Principles of Insurance Contract

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

For any contract to be a valid contract following elements should be there –

- 1) Offer and Acceptance – out of the 2 parties' one should offer and other party should accept. Usually offer is made by proposer (policy holder) and acceptance is made by insurer.
- 2) Consideration – premium paid by policy holder and the promise to indemnify by insurer is known as consideration.
- 3) Agreement between parties – both parties should agree to the same thing.
- 4) Free consent – there should be no pressure on proposer while taking policy. Consent is free when the policy is taken under no-coercion; undue influence; fraud; misrepresentation; mistake.
- 5) Capacity of the parties – proposer should be legally competent. I.e. Sound mind, not disqualified by law, should not be minor.
- 6) Legality – the object of contract must be legal.

Special features of Insurance Contract-

- 1) **Uberima Fides (or) Utmost good faith** – it means that every party to contract must disclose all material facts relating to the subject matter of insurance whether asked or not. The rule observed here is “**Caveat Emptor**” which means **buyer beware**.
- 2) **Material facts/Information** – proposers family history; medical history; financial details; occupational details; illness if any; habits etc are known as material facts.
Breach of utmost good faith: -
 - . **non disclosure** – not informing certain details.
 - . **Concealment** – intentionally not giving details.
 - . **Misrepresentation** – a) *Innocent* – by mistake giving wrong information
b) *Fraudulent* – intentionally giving wrong information.
- 3) **Insurable Interest** – it is the financial interest the proposer has in his belongings. I.e. Self; spouse; parents; house; car etc. is termed as insurable interest.

Note: In Non life Insurance – Insurable interest should be present both at the start and during claim.

In Life Insurance – Insurable interest should be present at the start of policy.

In Marine Insurance – Insurable Interest should be present at the time of claim.

- 4) **Proximate Clause** – it is the main reason behind the various activities taking place and there by resulting into any event.
- 5) **Free Look-In Period (or) Cooling off period** – if any proposer after entering into a contract i.e. After taking a policy if he wants to cancel or reject the policy then he or she take this decision within **15days** from receiving of policy.

SECTION 2 LIFE INSURANCE

Chapter 6 What Life Insurance Involves

Life Insurance Business Components

1. **Assets** – any physical or non-physical thing which has value ie. Can measured in terms of money is known as Asset. Every human being has a value which can be determined and is termed as Human Life Value (HLV). HLV helps to determine how much insurance one should have for full protection.

Eg. Mr. Mahesh earns Rs.120000 per annum and spends Rs.24000 on himself. Therefore net earning for family in case of Mr. Mahesh's death is Rs.96000 per annum. Suppose rate of interest is 8% then $HLV = 96000 / 0.08 = 12,00,000$.

2. **Risk** – there are various types of risk involved for a human being such as **Dying too early; Living too long; Living with Disability.**
3. **Indemnity** – in the occurrence of an event, the procedure to assess the loss and pay the compensation for this loss is known as Indemnity.
4. **Level Premium** – it is a premium fixed in such a manner that it does not increase with age but remains constant throughout the contact period.
5. **Principle of Risk Pooling** – it works on the principle of **mutuality**. Here premium collected from various people is collected in same pool for same risk and used for same kind of risk-claim. Under no circumstances money collected under one risk pool is used for another pool. It also makes use of **diversification**, where funds flowing from one source is invested / kept at many destinations.
6. **Contract** – taking insurance involves getting into a contract. Here the contract is between the Insurer (Insurance company) and Insured (Policy holder).

Chapter 7 Financial Planning

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

Goals – Short term – buying LCD Television; family vacation.

Medium term – buying a house

Long term – Children's education/ marriage; post-retirement provision.

A) Economic Life Cycle :-

- . Student Phase – this is pre-job phase. One is getting ready for earning phase.
- . Working Phase – this phase starts around 20-25yrs of age and lasts for 35-40yrs.
- . Retirement Phase – this phase is where-in one has stopped working.

B) Individual life cycle –

- . Learner [till age 25] – this is the learning phase of an individual.
- . Earner [25 onwards] – this is the phase when one starts earning.
- . Partner [28- 30yrs] – this is the phase when one gets married.
- . Parent [30-35yrs] – this is the phase when one move towards parenting.

- . Provider [35-55yrs] – this is the phase when parents have to fulfil children's needs.
- . Empty Nester [55-65yrs] – this is the phase when children get married.
- . Retirement [60 onwards] – this is the phase when one gets retired and there's no regular source of income. Health also gets deteriorating.

C) Individual Needs –

- . Enabling future transactions – making provision for future transactions such as education marriage.
- . Meeting contingencies – keeping money for unforeseen events like unemployment, hospitalization, death etc.
- . Wealth accumulation – this is to be done for increasing your money value.

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

- . Transactional product – bank deposits can be used for cash requirements.
- . Contingency product – Insurance can be used to protect against unforeseen events.
- . Wealth accumulation product – shares; bonds can be used to invest for wealth creation.

Role of Financial Planning :- It is a process in which clients current and future needs are considered and evaluated along with his risk profile and income assessment. Financial planning includes – Investing, Risk management, Estate planning, Retirement planning, Tax planning and financing daily and regular requirements. **Note** – the right time to start financial planning is when one starts receiving his 1st salary.

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

Chapter 8 Life Insurance Products I

Overview of life insurance products :-

- . Product can be turned on commodity, a goods bought and sold in market products can be tangible is-one which are physical objects (such as T.V) and intangible is-one which are just perceived (such as bank FD returns).
- . Life insurance is a intangible product where the customer is made to understand feature and returns of it. Life insurance products offer protection against the loss of economic value of an individual's productive abilities it is not only used for protection against death and disease; it is also a financial product for long term investment.
- . A rider is a provision typically added to basic policy in order to increase the death cover or supplementary benefits such as accident cover rider premium waiver, team rider, critical illness rider, and disability income benefit rider.

A) Traditional life insurance products:-

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

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

- II) **Whole life plan:** - whole life plan are permanent life insurance policy there is no fixed term, here the policy holder received money no matter when the death occurs. Premium of whole life plan is very higher. Whole life insurance in developing savings and creating wealth for the next generation.
- III) **Endowment assurance:** - it is a combination of 2 plans; term assurance plan and a pure endowment. Thus this plan has both death and survival (maturity) benefit. Endowment plans are bought in order to meet Certance purpose such on Childs education marriage etc. Money back policy, children policy etc are some variations of endowment insurance policy.

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

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

- I. For single premium policy it will be 125% of single premium for below 45 years and 110% of single premium for above 45 years.
- II. For regular premium, it will be 10 times of annualised premium for below 45 years and 7 times of annualised premium for above 45 years.

Chapter 9 Life Insurance Products II

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

- i) Cash value compared- it depends on assumptions such as mortality, interest rate, expenses.
- ii) Rate of return :- it is not certain what rate of return would be given on tradition
- iii) Surrender value :- it is also not certain what would be the exact surrender value on if depends on the actuarial reserve of the policy
- iv) Yield: - the yield on traditional policy may not be as high compared to others .due to above limitation in traditional policy people started drifting.

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

- i) **Unbundling** - separating the protection part and saving element of the policy. This led to discovery of new products like universal insurance, variable insurance, unit linked insurance.
- ii) **Investment linkage** - rather than giving only financial security, products with high yield and managed by fund managers were introduced.

- iii) **Transparency** - this brought in greater visibility in the rate of return and expenses incurred by insurer for their services were revealed.
- iv) **Inflation beating returns** - in order to fulfil the inflation beating return policy to policy holders investment linked insurance policy were introduced.
- v) **Flexibility** - policy holders were given the choice to decide on investment in death benefit and cash values .It also provided mix of funds.

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

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

- i) **Variable insurance plans (VIPs)** :- It is a kind of life policy where death benefit and cash value of the policy fluctuates according to investment performance of premium invested in it. The policy provides no guarantee with respect to interest rate or minimum cash value. This cash value is allotted in separate investment accounts and depending upon the performance of such separate investment account the cash value grows and earns interest. The main reason for purchase of VIPs is the policy holder must be able and willing to bear the investment risk on the policy.
- ii) **Unit Linked Insurance Plan (ULIPs)** :- ULIPs the investment of such policies is done in
 - . equity fund ie. In equity or equity related instruments;
 - . debt funds ie in government bonds, corporate bonds, fixed deposits;
 - . balanced funds ie. Mix of equity and debt funds;
 - . market funds ie. Treasury bills, certificates of deposits, commercial papers etc.
 In ULIPs the investment is invested in the form of units. The value of units is given by net asset value (NAV). The insured decides on the amount of premium to be contributed at regular intervals. In case of death sum assured or fund value whichever is higher is payable.

Chapter 10 Applications of Life Insurance

- A) Key man insurance** – it is used for business purpose. Keyman insurance does not indemnify the actual loss incurred but compensates with affixed monetary sum as specified in insurance policy. Thus keyman insurance can be described as an insurance policy taken out by a business to compensate that business for financial loss that would arise from death of an important member. Keyman insurance is a term insurance policy where the sum assured is linked profitability of company and not the key person's income. In case the keyman dies the benefit is received by the company.
- B) Mortgage Redemption Insurance** – it is an insurance policy that provides financial protection for home loan borrower. It is basically decreasing term life insurance policy taken by mortgagor to repay the balance mortgage in case of his/her premature death. It is also known as loan protector policy. The insurance cover decreases each year.
- C) Married Women's Property Act (MWP)** – section 6 of MWP act 1874 provides for security of benefits under a life insurance policy to the wife and children. Under MWP act the life insurance policy forms for a creation of trust. Features of policy under MWP act –
 - . each policy will be a separate trust. Either the wife or child can be trustee.
 - . policy will be beyond control of court attachments, creditors or even life assured.
 - . the claim money will be paid to trustees.

. the policy cannot be surrendered, nomination and assignment is not allowed.

Chapter 11 Pricing and Valuation in Life Insurance

A) Insurance pricing basic elements :-

- i) Premium – the price that is paid by an insured for purchasing insurance policy.
- ii) Rebates – insurance companies may offer certain discount on the premium. There are basically 2 such rebates – rebate for high sum assured and for mode of payment.
- iii) Extra charges – in case of certain policies where extra benefits are to be given such as rider benefits (eg. Double accident benefit) or for a customer with high risk are charged extra amount in premium.

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

- i) **Mortality and interest** – mortality tables designed by actuarial and interest ie. Discount rates assumed to arrive at present value of future claim payments to be made are used to arrive at net premium. Higher the mortality rate, higher is the premium. Higher the interest rate assumed lower is the premium.
- ii) **Expenses and reserves** – life insurers incur various operating expenses – agents training and recruitment, commission of agents, staff salaries, office accommodation, stationery, electricity etc. Lapses and withdrawal of policy also add for increase in expenses of the company.
- iii) **Bonus loading** – it is the margin of profits earned within the premium paid in order to provide cushion against unforeseen activities and also to be paid for policy holder's share of surplus distributed as bonus.

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

C) Surplus and bonus :-

- i) Surplus is the excess of value of assets over value of liabilities. ie. **Surplus = assets – liabilities**. The value of assets is determined using its book value (the price at which it was acquired); market value (the price of that asset in current market); discounted present value. The surplus earned is also to be allocated in proper manner in which is done using solvency requirement and free assets.
- ii) Bonus is an addition to the basic benefit paid to policyholder. The most common form of bonus is reversionary bonus. Bonus are payable even on surrender of policy. The various bonuses given on life insurance policies
 - . **simple reversionary bonus** – it is the percentage of the basic cash benefit under the contract. In India it is an amount per thousand sum assured.
 - . **compound bonus** – it is a percentage of basic benefit and already attached bonus. It is thus bonus on bonus.
 - . **terminal bonus** – it is given at the contractual termination (ie. Death or maturity). It depends upon the time duration of the contract.

Chapter 12 Documentation : Proposal Stage

A) Proposal stage documentation :-

- i) **Prospectus** - it is a formal legal document issued by insurer that provides details about the product. It states the terms and conditions, scope of benefits- guaranteed- non- guaranteed; entitlements; exception
- ii) **Proposal form** - it is a form to be filled by the proposer for giving all material required by insurer in order to decide whether the risk of the proposer to be accepted or rejected.
- iii) **Agent report** - agent is primary under writer. All material facts and particulars about the proposer such as health, habits, occupation, income, family etc.
- iv) **Medical examiners report** - the medical examiners report is required typically when the proposal cannot be considered under normal condition i.e. sum proposed is high or age is high or there are certain characteristics which call for examination and report by medical examiner.
- v) **Moral hazard report** - it is the likelihood that a client's behaviour might change as report of purchasing a life insurance policy and such a change would increase the chance of loss.
- vi) **Age proof** - age is a factor that insurer uses to determine the risk of proposal verification of correct age through appropriate document thus is important standard age proof- school certificate, birth certificate, passport, pan card, register, certificate baptism, I-card defence personnel, non-standard age proof- ration card, village-panchayat certificate, zero cope, self- declaration.
- vii) **Anti-money laundering (AML)** - the prevention of money laundering is the process of bringing illegal money into economy by hiding its origin. The act to curtail was passed in 2002 and person found guilty is punishable for 3-7 years imprisonment and fine upto 5 lakhs.
- viii) **Know Your Customer (KYC)** - It is the process used to verify the identity of their clients. The objective is to prevent financial institutions from being used by criminal elements for money laundering activities. Hence in order to determine the true identity of their customers following documents are called for- Photographs; Age proof – passport, school certificate, birth certificate; Address proof – electricity bill, aadhar card, ration card; Identity proof – pan card, passport, driving license, voter id; and income proof.
- ix) **Free-look period (or) Cooling off period** - suppose a person has purchased a new life insurance policy and received the policy document and if the policy holder is not satisfied with the terms and conditions of the policy then he can take his decision to continue stop such policy within 15 days from receipt of policy document / bond.
Thus free-look period of 15 days is available as privilege to policy holder in order to take decision to be continued or not.

Chapter 13 Documentation : Policy Condition I

- A) **First Premium Receipt (FPR)** - it is that document issued by insurer which gives the evidence that the policy contract has begun. The FPR contains – Name & address; policy number; premium amount; mode of payment; next due date; date of commencement; date of maturity; date of last premium; sum assured. The subsequent receipts given are known as renewal premium receipt (RPR).
- B) **Policy Document** - it is the evidence of the contract between the assured and the insurer. Policy document is to be signed and stamped according to the Indian stamp act. In case of loss of policy document, duplicate policy document can be issued from insurer. Policy document has 3 parts –
 - i) **Policy Schedule** – it is found on the front/ face page of the policy. It normally contains – name of the company, ombudsman's address, signature & policy stamp, promise to pay (this forms heart of the contract), some of specific details – name & address of policy holder, date of birth, plan term sum assured, amount of premium, premium paying term, date of commencement, date of maturity, name of nominee, mode of premium, policy number.
 - ii) **Standard Provisions** – standard policy provisions which are present in all insurance contracts, unless excluded such as term, single premium.

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

Chapter 14 Documentation : Policy Condition II

A) Policy conditions and privileges :-

- i) **Grace period** – the clause that grants the policy holder an additional period of time to pay the premium even after its due date is known as grace period. The standard length of grace period is 1 month or 31 days. The policy would be considered lapse if the premium is not paid after grace period is over. If the policy holder dies during grace period, the insurer would deduct the last premium and then give the benefits. In case of death after grace period insurer are not obliged for payment of claim.
- ii) **Lapse and Reinstatement / Revival** – the policy is considered to be lapse if the premium is not paid even after the grace period is over. Lapse policies can be revived. Revival / reinstatement of policy means to put back into force which have been stopped / terminated due to non payment of premiums or non-forfeiture. Revival of policies however is not unconditional right of insured. Insurer will do it if they think –there is no increase in risk for insurer, creation of reserve, payment of overdue premium with interest, satisfactory evidence of continued insurability, revival application within specific time period, payment of outstanding loan. Policy revival measures –
- . **Ordinary revival** – one which involves payment of arrears of premium with interest. It is affected when surrender value is acquired.
 - . **Special revival** – one which policy has not completed 3yrs and has not acquired surrender value and time from first unpaid premium (fup) is more.
 - . **Loan cum revival** – one in which simultaneous granting of loan and revival of policy is done. Arrears of premium and interest are calculated as pre ordinary revival.
 - . **Instalment revival** – sometimes policy holder is not in a position to pay arrears in lump sum. The arrears of premium are calculated and depending on mode of payment are asked to pay in future premiums as distributed.
- iii) **Non – Forfeiture provisions** - one of the important provisions that allow for accrual of certain benefits to policy holders even when they are unable to keep their policies in full force. If the policy has not been surrendered it shall subsist with reduced paid up value.
- . **Surrender value** – it is a percentage of paid up value. It is different at different term of policy. It depends upon the type and plan of insurance, term of policy, premium paying term. Surrender value is arrived as a percentage of premiums paid is called as guaranteed surrender value.
 - . **Policy loan** – policy holder can take loan on their policy as each policy has accumulated certain cash value and loan is given against its security. Policy loan amount is generally 90% of surrender value. No legal obligation to repay the loan but if the loan is not repaid it can be recovered by deducting it from policy benefits. No credit check is required.
- iv) **Special policy provisions and endorsements** –
- a) **Nomination** – it is the person who is entitled to receive the amount in case of the death of policy holder. Life assured can nominate one or more than one person. Nomination can be changed. In case of multiple nominees no specific share can be made for each nominee. Where the nominee is minor, the policy holder needs to appoint an appointee. The appointee needs to sign the declaration. Appointee loses its status once the minor

nominee attains 18yrs of age. In case of minor nominee death, money is paid to legal heirs. It comes under section 39.

- b) **Assignment** – the term assignment refers to transfer of property by writing as distinguished from transfer by delivery. On assignment, nomination is cancelled, except when assignment is made to insurer for loan. The person who transfers the rights is called assignor and the person to whom it is transferred is called assignee. There are 2 types of assignment –
- . **Absolute** – In such assignment all rights, title and interest are transferred to assignee without any reversion in policy.
 - . **Conditional** – In such assignment the policy shall revert back to assignor after the fulfilment of prescribed conditions in the policy. Conditions for valid assignment –
 - . First of the person who transfers ie. Assignor must have absolute right & title on policy.
 - . Assignment should be supported by value consideration, which may include love affection etc.
 - . It should not be opposed by any law in force.
 - . Assignee can do another assignment but cannot do nomination.
- c) **Duplicate policy** – a duplicate policy is issued to policy holder on loss of policy. Standard procedures are to be followed in case of loss of policy document. Satisfactory proof may be required to produce in order to deal with such cases. If required advertisement may be placed in national paper and produce indemnity bond.
- d) **Alteration** – the provision to make certain changes in policy document is known as alteration. Certain common alterations are change in name address, mode of payment, reduction in sum assured, change in term (if risk is not increased), change in date of commencement, splitting up of policies, removal of extra premium or certain clause, settlement option for payment of claim.

Chapter 15 Underwriting

A) Underwriting:- basic concepts

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

i) **Underwriting purpose** -

- a) to prevent anti selection or selection or selection against the insurer. Anti selection can be termed as the degree of risk where in it is high or low and thereby resulting in high loss, gain from insurance.
- b) To classify risks and ensure equity among risks. Equity among risks here refers to those applicants who are exposed to similar degree of risk and are to be grouped together and charged same premium.

ii) **Degree of risk (or) risk classification** -

- a) **Standard lives** – those applicants / proposers whose mortality rate is considered to be as per standard requirements.
- b) **Preferred lives** – those applicants / proposers whose mortality rate is significantly low and hence can be charged lower premium.
- c) **Sub –standard lives** – those applicants / proposers whose mortality rate is higher than standard lives but insurable. They are charged extra premium.

- d) **Declined lives** – those applicants / proposers whose mortality rate is very significantly high and cannot be insured at affordable cost.
- iii) **Selection process** - underwriting or selection process takes place at 2 levels
- a) **Field level (or) primary level** – it includes information gathering of proposer through agents. Hence agents are also termed as primary underwriters. He monitors if any information given by proposer is true or not as he is the person who is in direct contact with proposer. He sends his confidential report containing proposer's occupation, income, financial standing and reputation.
- b) **Department level** – at office level a specialist person who is expert in judging the collected data and considering this relevant data decides whether to accept or not the proposal. Such experts are known as underwriters.
- iv) **Underwriting decisions** - the various options available to underwriter besides accepting or rejecting the proposal are as follows.
- a) **Acceptance at ordinary rate (OR)** – it is the most common decision where in the proposal is accepted at same premium as it would apply for standard lives.
- b) **Acceptance at extra rate (ER)** – it involves charging extra premium for sub-standard lives.
- c) **Acceptance with lien** – it is kind of hold on sum assured amount. It implies if a policy is accepted under lien and if the proposer dies within lien period then the nominee is entitled to receive decreased sum assured. Lien is applicable normally for 1/3rd period of the total period.
- d) **Acceptance with restrictive clause** – for certain kind of hazards or restrictive clause is applied; if tomorrow claim arises due to such clause then full sum assured is not payable.
- e) **Decline or postpone** – if the proposer does not fit in any of the above conditions ie. They are very adverse and there is little chance of improvement then such cases are declined or decision on them is postponed for certain time period.

Rating factors in underwriting :-

- i) **Female insurance** – insurability of women depends upon various factors such as income source (own, heir); pregnancy problems; moral hazards- domestic violence.
- ii) **Minors** – insurability of minors look for capacity of parents; need for insurance; has properly developed physique; proper family history; parents adequately insured.
- iii) **Large sum assured** – insurability for large sum assured policies raise a doubt of concern. Generally S.A is to be 10-12 times of annual income.
- iv) **Age** – insurability for advanced age group is to be considered with utter care. As chances of moral hazard is very high. Some special reports may be called.
- v) **Moral hazard** – it is termed as characteristics of an individual's financial situation, lifestyle, habits, reputation, mental health that indicate his / her intentions.
- vi) **Occupational hazard** – insurability for people with occupational hazard may arise due to accident – driver / circus artists / stuntmen's; health – chemical factory workers / nuclear plant / deep sea divers; moral – criminal mind / night club workers.
- vii) **Lifestyle and habits** – drinking and smoking.
- v) **Non-medical underwriting** :- a large number of proposals get accepted without conducting medical examination. Such cases are termed as non-medical proposals. Depending upon the information given in proposal form such cases are underwritten under non-medical case. Conditions for non-medical underwriting-
. certain categories of female, like working women may be eligible.

- . upper limit of sum assured for eg. Cases above 5lac may need to undergo medical.
- . entry level of age. Proposers above 40-45 age may compulsory need medical.
- . term of the policy. Insurer might restrict term up to 20 yrs or maturity age till 60.
- . class of lives. Depending upon work area insurer might call for medical.

- vi) **Medical underwriting** :- the medical factors that would influence an underwriter's decision. They may often call for a medical examiner's report. Factors involved are-
- i) Family history – 3 factors are taken into consideration in order to understand family history of the proposer
 - . heredity – certain diseases can be transmitted from one generation to another.
 - . average longevity of family – if parents have died early due to cancer, heart trouble.
 - . family environment – the environment in which the family lives.
 - ii) Personal history – it refers to past impairment of various systems of human body which the proposer might have suffered.
 - iii) Personal characteristics –
 - . build – for a given age & height there is a standard weight, if the standard weight is too high or too low then such proposals need to be checked.
 - . blood pressure – another indicator to know personal characteristic. Average pulse rate should be 72 and varying between 50-90.
 - . urine-specific gravity – one's urine indicates the salts in the body. Its mal-functioning can be indicated through its test.

Chapter 16 Payments under a Life Insurance Policy (Claims)

A) Types of claims and claims procedure :-

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

- 1) **Survival claim** - claims payable even when the life insured is alive.
- 2) **Death claim** – claims payable on the death of the life assured.

A Claim event is said to have occurred when

- i) For survival claim the event has to be occurred as per stipulated conditions.
- ii) Maturity claim & money back claims are given based on determined dates.
- iii) Surrender value are claims to be given based on decision taken by insured.
- iv) Critical illness claims are processed based on medical and other records provided.

Payments to be done during the policy term :-

- i) **Survival benefits payment** – payments made at regular intervals by insurer at specified time during the policy term.
- ii) **Surrender of policy** – the voluntary decision taken by the policy holder to stop the policy contract. The amount payable to insured is surrender value.
- iii) **Rider benefit** – a payment done by insurer on occurrence of specified event according to terms and conditions. The policy continues even after the rider benefit payment is done.
- iv) **Maturity claim** – a payment done by insurer at the end of the policy term, if the insured survives the entire term of the policy. The insurance contract comes to an end after maturity claim is paid.

- v) **Death claim** – if the insured expires during the term of the policy, accidentally or otherwise, then the insurer pays the sum assured, bonus, etc to nominee; assignee or legal heir. Such payments are known as death claim. Contract comes to an end. Death claim can be
- . **early death claim** – claim that arises within 3yrs from start of policy.
 - . **non-early death claim** – claim that arises after 3yrs from start of policy.
- Forms to be submitted by nominee; assignee or legal heir on death are claim form; certificate of burial or cremation; treating physicians certificate; hospitals certificate; employers certificate; certified court copies of police reports in case of accidental death; death certificate issued by municipal authority.
- B) Repudiation of death claim** – if it is detected by insurer that the proposer had made any incorrect statements or had suppressed material facts relevant to policy, the contract becomes void. All benefits under the policy are forfeited.
- C) Indisputability clause** – a policy which has been in force for **2yrs** cannot be disputed on the ground of incorrect or false information. The insurer will have to prove in order to repudiate a policy after 2yr period.
- D) Presumption of death** – the Indian evidence act 1872 deals with presumption of death; under this act if an individual has not been heard off or seen for **7yrs** then they are presumed to be dead. It is necessary that premiums should be paid till the court decrees presumption of death.
- E) Claim procedure for life insurance policy -**
- . it is included in the IRDA(protection of policy holder's interests) regulation 2002.
 - . insurer will call upon the primary documents which are normally required.
 - . any query or requirement of **additional documents** are to be asked within **15days**.
 - . a **claim is to be paid** or be disputed giving all relevant reasons within **30days**.
 - . in case of any **dispute over the claim**, it shall initiate and complete within **6months** from the time lodging the claim.
 - . claim is ready for payment but cannot be done due to **lack of proper identification**, the life insurer shall **hold such amount** and shall earn interest as per schedule banks saving accounts rate (effective from **30days** following the submission of all papers and information).
 - .on **delay of payment** of claim on its completion would earn an **interest of 2%** above the prevalent rate of interest.
- F) Role of agent -**
- An agent shall render all possible service to the nominee, legal heir or the beneficiary in filling up the claim form accurately and assist in submission of these at insurer's office. Apart from discharging obligations, goodwill is generated from such a situation where by there exists ample opportunity for the agent to procure business or referrals in future.

SECTION 3 HEALTH INSURANCE

CHAPTER 17 INTRODUCTION TO HEALTH INSURANCE

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

- Lifestyle factors – those which are mostly in the control of the individual concerned eg. Exercising and eating within limits, avoiding worry and leading to good health; and bad lifestyles and habits such as smoking, drug abuse, unprotected sex and sedentary (no exercise) lifestyle.
- Environmental factors – safe drinking water, sanitation and nutrition are crucial to health, lack of which leads to serious health issues as seen all over the world. Certain diseases are also caused due to environmental factors eg. People working in certain manufacturing industries are prone to diseases related to occupational hazards such as coal miners facing lung problems.
- Genetic factors – diseases may be passed on from parents to children through genes. Such genetic factors result in differing health trends.

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

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

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

- Primary – it refers to the services offered by the doctors, nurses and other small clinics which are contacted first by patient for any sickness. For most of the primary care cases, the doctor acts like a 'family doctor'. Primary health care centres are set up both by government and private players.
- Secondary – it refers to services offered by medical specialists and other health professionals. It includes intensive care services, ambulance facilities, pathology, diagnostic and other relevant medical services.
- Tertiary – it refers to specialized consultative healthcare. It includes providers who have advanced medical facilities and medical professionals, eg. Oncology (cancer treatment), organ transplant, high risk pregnancy etc. it is to be noted as the level of care increases, the expenses associated with care also increases.

D) Factors affecting the health systems in India:-

- Demographic or population related – due to overpopulation people are exposed to various problems and the level of poverty has affected the ability to pay for medical care.
- Social – due to urbanization ie. People moving from rural to urban areas, lifestyle has become more sedentary. Also lack of availability & accessibility of medical facilities has affected a lot.
- Life expectancy – the average lifespan of people has increased resulting into old age diseases. So one has to cater issues related to longer lifespan.

E) Evolution of health insurance in India:-

- Employees' state insurance scheme – it was introduced under ESI act 1948. ESIC is the implementing agency which runs its own hospitals and dispensaries. Workers earning up to Rs.15000 are covered under contributory scheme wherein employee n employer contribute 1.75% and 4.75% of pay roll. State government contributes 12.5% of medical expenses.
- Central government health scheme – it was introduced in 1954 for central government employees including pensioners and their family members working in civil jobs. It is partly funded by the employees and largely by the employer. The contribution from employees is quite nominal though linked to salary scale – Rs.15 to Rs.150 per month.
- Commercial health insurance – it was offered by some of the non-life insurers before as well as after nationalisation of insurance industry. In 1986, 1st standardised health insurance product for individuals and their families was launched in India. This product Mediclaim was introduced to provide coverage for hospitalization expenses up to a certain annual limit and certain exclusions such as maternity, pre-existing diseases. Health insurance has grown tremendously but there is large untapped market even today.

F) Health insurance market:- it is made up of many players some providing the infrastructure, services, intermediaries and also other regulatory, educational as well as legal entities.

(1) Infrastructure –

- Public health sector – it operates at national, state n district level. These include anganwadi workers, trained birth attendants, ASHA (Accredited Social Health Activists). Sub centres have been established for every 5000 population, primary health centres which are referrals for 6 sub centres are established for every 30000 population, community health centres are referrals for 4 primary centres for every 1lac population. Rural hospitals, speciality and teaching hospitals include medical colleges, other agencies belonging to government, such as hospitals and dispensaries of railways, defence etc. however their services are restricted to their employees n dependants.
- Private sector providers – India has very large private health sector providers ranging from trusts, solo practitioners, diagnostic laboratories, pharmacy shops. Private health expenditure accounts more than 75%.
- Pharmaceutical industry – it is a large industry which has grown from Rs.10 cr in 1950 to Rs.55000 cr till now.

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

(3) **Intermediaries** –

- Insurance brokers – they are individuals or corporate and work independently of insurance companies. They represent people and are remunerated by insurers.
- Insurance agents – they are individuals who work only for 1 life, 1 non-life n 1 standalone insurance company. They are also remunerated by insurers.
- Third Party Administrators (TPA) – they provide administrative services to companies such as preparing data base, collecting bills, providing health cards etc.
- Web aggregators – they are the newest type of service providers through web and telemarketing. They are remunerated based on the leads converted to business.
- Insurance marketing firms – they have been permitted to sell insurance products of 2 life, 2 non-life and 2 stand alone health insurance companies. They are allowed to solicit or procure only retail business.

(4) **Other important organizations** –

- Insurance Regulatory and Development Authority of India (**IRDAI**) – it is a insurance regulator formed in 2000 by parliament act which regulates all business and companies in the market.
- General insurance and Life insurance council – they make recommendations to IRDAI.
- Insurance Information Bureau of India – it collects analyses and creates various sector-level reports for industry to enable data-based and scientific decision making including pricing and framing of business strategies.
- Educational institutions – institutes such as Insurance Institute of India (III), National Insurance Academy (NIA) provide variety of insurance and management related training.
- Medical practitioners – they assist insurance companies and TPA's in assessing health insurance risks of prospective clients and advise insurance companies in case of difficult claims.
- Legal entities – insurance ombudsman, consumer courts as well as civil courts also play vital role in health insurance market when it comes to redressal of consumer grievances.

CHAPTER 18 INSURANCE DOCUMENTATION

Proposal Forms :- The first stage of documentation is the proposal form through which the insured informs about herself and what insurance he/she needs.

The duty of disclosure of material information arises prior to the inception of the policy, and continues throughout the policy period

Insurance companies usually add a declaration at the end of the Proposal form to be signed by the proposer.

Elements of a proposal form usually include:

- i. Proposer's name in full
- ii. Proposer's address and contact details
- iii. Bank details in case of health policies
- iv. Proposer's profession, occupation or business
- v. Details and identity of the subject matter of insurance
- vi. Sum insured
- vii. Previous and present insurance
- viii. Loss experience
- ix. Declaration by the insured

An agent, who acts as the intermediary, has the responsibility to ensure all material information about the risk is provided by the insured to insurer.

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

Prospectus:- In health policies, a Prospectus is also provided to the insured and he has to declare in the proposal that he has read and understood it. It should clearly state the scope of benefits, extent of cover and other issues such as riders, warranties, exceptions and conditions. Premium related to all the riders taken together should not exceed 30% of the premium of main product.

Premium Receipt:- Premium is the consideration or amount paid by the insured to the insurer for insuring the subject matter of insurance, under a contract of insurance. Section 64VB of Insurance act states that risk will not commence until premium is received in advance. Payment of premium can be made by cash, any recognised banking negotiable instrument, postal money order, credit or debit card, internet, e-transfer, direct credit or any other method approved by authority from time to time.

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

Conditions and Warranties:- A condition is a provision in an insurance contract which forms the basis of the agreement. A warranty is a condition expressly stated in the policy which has to be literally complied with for validity of the contract.

Endorsements:- If certain terms and conditions of the policy need to be modified at the time of issuance, it is done by setting out the amendments / changes through a document called endorsement.

Interpretation of Policies:- The most important rule of construction is that the intention of the parties must prevail and this intention is to be looked for in the policy itself. An insurance policy is proof of a commercial

contract and the general rules of construction and interpretation adopted by courts apply to insurance contracts as in the case of other contracts. The meaning to be used for words is the meaning that the ordinary man in the street would understand.

Renewal Notice:- Most of the non-life insurance policies are issued on annual basis. There is no legal obligation on the part of insurers to advise the insured that his policy is due to expire on a particular date.

Anti-Money Laundering and KYC Guidelines:- Money Laundering means converting money obtained through criminal means to legal money and laws to fight this have been introduced worldwide and in India. An agent has a responsibility to follow the Know Your Customer guidelines and obtain documents as required by these guidelines.

CHAPTER 19 HEALTH INSURANCE PRODUCTS

Introduction to Health Insurance Products:- A health insurance policy provides financial protection to the insured person in the event of an unforeseen and sudden accident / illness leading to hospitalization. Life insurance companies may offer long term health products where as non-life and standalone health insurance companies may provide 1yr or maximum 3yr tenure products.

Broad Classification of Health insurance products:- Health insurance products can be classified on the basis of number of people covered under the policy: individual policy, family floater policy, group policy. They are also further classified in 3 categories

- i. Indemnity cover – these products pay for actual medical expenses incurred due to hospitalization.
- ii. Fixed benefit cover – also known as “hospital cash” pay for a fixed sum per day for the period.
- iii. Critical Illness cover – this is a fixed plan for payout on occurrence of a predefined critical illness like heart attack, stroke, cancer etc.

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

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

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

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

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

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

e) Common exclusions:- some of the exclusions in HIP policies are Pre-existing diseases, all non-medical items expenses, waiting period of 30days from start of policy.

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

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

- i. Sub limits and disease specific capping – one can put limit to per day room charges to 1% of sum insured and in case of ICU 2%.
- ii. Co-payment – a specified percentage of the admissible claim amount is bear by policyholder/insured.
- iii. Deductible – benefits given to insured before hospitalization and which are charged such deductibles are not payable by insurer.
- iv. New exclusions – genetic disorders, service charges, doctor's home visit all fall under exclusions.
- v. Zone wise premium – cities such as Delhi, Mumbai fall under highest premium zone.
- vi. Coverage of pre-existing disease – pre-existing diseases which were excluded are included after a waiting period of 4yrs. In high end products it is 3-4yrs.
- vii. Renewability – lifelong renewal option is available now as per IRDAI in all policies.
- viii. Coverage for Day-care procedure – policies are including treatment of illnesses which are done in 1day. Earlier only 7procedures were included now the list has gone up to 150.
- ix. Cost of pre-policy check up – insurer reimburses the cost of medical examination provided the policy is accepted.
- x. Duration of pre n post hospital covers – it is 60 and 90 days in most of the policies.
- xi. Add on covers – maternity, critical illness benefit policy with a provision to pay a lump sum amount on diagnosis of certain ailments which are life threatening, coverage of AYUSH up to certain percentage is included.
- xii. Value added covers – they provide other benefits such as Out-patient covers provide for medical expenses like dental treatments, vision care expenses, routine medical examinations and tests etc. that do not require hospitalization., Hospital daily cash which provides a fixed sum to the insured person for each day of hospitalization, donor's expenses, reimbursement of ambulance, recovery benefit is paid if total period of stay is less than 10days.

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

i) Senior Citizen policy:- entry age of such policy is 60yrs and lifelong renewable. Sum insured ranges from 50,000 to 5lac.

j) The fixed benefits cover:- provides adequate cover to the insured person and also helps the insurer to effectively price his policy. Some of the fixed benefit insurance plans are i. Hospital daily cash insurance ii. Critical illness insurance plan (also known as dreaded disease cover or trauma cover). Both these plans can be sold as standalone cover or add-on cover. In all critical illness policies **waiting period of 90days** and **survival clause of 30days** after diagnosis of illness is carried out.

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

Bhavisya arogya policy a pre funded insurance plan was designed long back in 1990 by general insurance companies. It was a deferred mediclaim policy with entry age of 25 to 55yrs and retirement age 55 to 60yrs with a condition of 4yrs gap between joining age n retirement age. In case of death or withdrawal before retirement

age refund of premium is allowed. Grace period of 7days for renewal premium is given, this plan also provides assignment.

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

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

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

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

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

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

- i) **Network provider** – they are hospitals or health care providers enlisted by TPA or insurer or both to provide medical services by cashless.
- ii) **Preferred provider network (PPN)**
- iii) **Cashless service**
- iv) **Third party administrators (TPA)** – any person who is licensed by IRDA and is engaged for a fee or remuneration by insurance company for the purpose of providing health services.
- v) **Hospital** – any institution having in-patient or day-care treatment facility and has atleast 10beds in city with population less than 10,00,000 and 15beds in other places along with trained nurses n doctors round the clock. Fully equipped operation theatre and maintain daily records of patients and makes accessible to insurer.
- vi) **Medical practitioner** – a person who holds valid registration from medical council.
- vii) **Qualified nurse** - a person who holds valid registration from Nursing council of any state/India.
- viii) **Reasonable and necessary expenses**
- ix) **Notice of claim** – claim documents for reimbursement is to be submitted within 15days of discharge.
- x) **Free health check** – for 4 claim-free policy years reimbursement is given for health check done.
- xi) **Cumulative bonus** – for every claim-free year the sum insured gets increased on renewal by fixed percentage which is maximum allowed upto 50% for ten claim-free renewals.
- xii) **Malus / Bonus** –
- xiii) **No-claim Discount** - Discount in next year's premium if it is claim-free year instead of bonus on sum insured.
- xiv) **Co-payment** – here insured bears some portion of the claim

- xv) **Deductible / Excess** – it is the fixed amount to be paid by insured before claim is paid by insurer.
- xvi) **Room rent restrictions**
- xvii) **Renewability clause** – Insurer can deny renewal on basis of fraud, misrepresentation or suppression or non-disclosure of material facts.
- xviii) **Cancellation clause** – Insurer can at any time cancel the policy with a minimum of **15days** notice in writing to insured.
- xix) **Free look in period** – Insured can cancel if the terms n conditions of the policy are not what he expected within **15days** from receiving of policy document.
- xx) **Grace period for renewal** – **30days** grace period is allowed for renewal from date of expiry.

CHAPTER 20 HEALTH INSURANCE UNDERWRITING

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

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

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

Factors affecting chance of illness Some of the factors which affect a person's morbidity are **age, gender, habits, occupation, build, family history, past illness or surgery, current health status and place of residence.**

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

- i) Standard risk – those people whose chance of falling ill is average.
- ii) Preferred risk – those people whose chance of falling ill is significantly lower than average and can be charged lower premium.
- iii) Substandard risk - those people whose chance of falling ill is higher than average but still considered for insurance subject to some restrictions or higher premium.
- iv) Declined risk - those people whose chance of falling ill is very high and cannot be insured.

Selection process it takes places at 2levels. The agent is the first (primary) level underwriter as he is in the best position to know the prospective client to be insured. The second level is at the department (office) level.

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

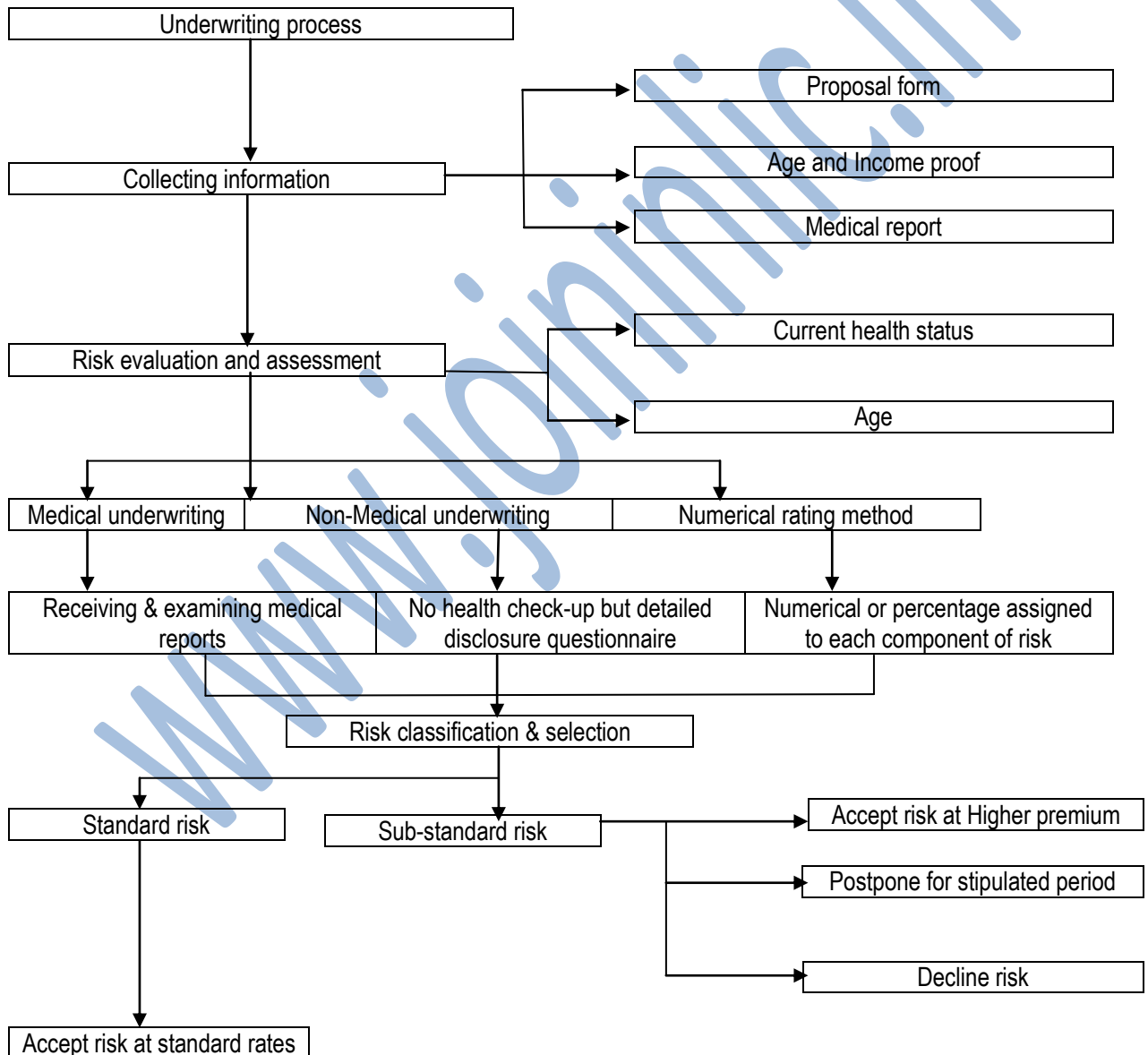
The key tools for underwriting are:

- i) proposal form – it is the base of the contract where all the critical information pertaining to health and personal details is mentioned.
- ii) age proof – premiums are based on the basis of the age of the insured. Valid age documents are divided in 2 categories i) standard age proofs – school certificate, passport, domicile certificate, pancard etc. ii) non-standard age proofs – ration card, voter id, elder's declaration, gram panchayat certificate etc.

- iii) financial documents – financial status of proposer is understood and reduces moral hazard.
- iv) medical reports – medical reports are asked depending upon the age and sum insured opted.
- v) Reports of salesperson – report given by sales people form an important information for policy acceptance.

Underwriting Process

- i) Medical underwriting is a process which is used by the insurance companies to determine the health status of an individual applying for health insurance policy.
- ii) Non-medical underwriting is a process where the proposer is not required to undergo any medical examination.
- iii) Numerical rating method is a process adopted in underwriting, wherein numerical or percentage assessments are made on each aspect of the risk.



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

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

- i) **Coinsurance** - it refers to acceptance of a risk by more than one insurer. Normally it is done by allocating certain percentage to each company.
- ii) **Reinsurance** - the process of insurer to re insure his risk with other insurance company is known as reinsurance.

CHAPTER 21 HEALTH INSURANCE CLAIMS

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

Stakeholders in claim process

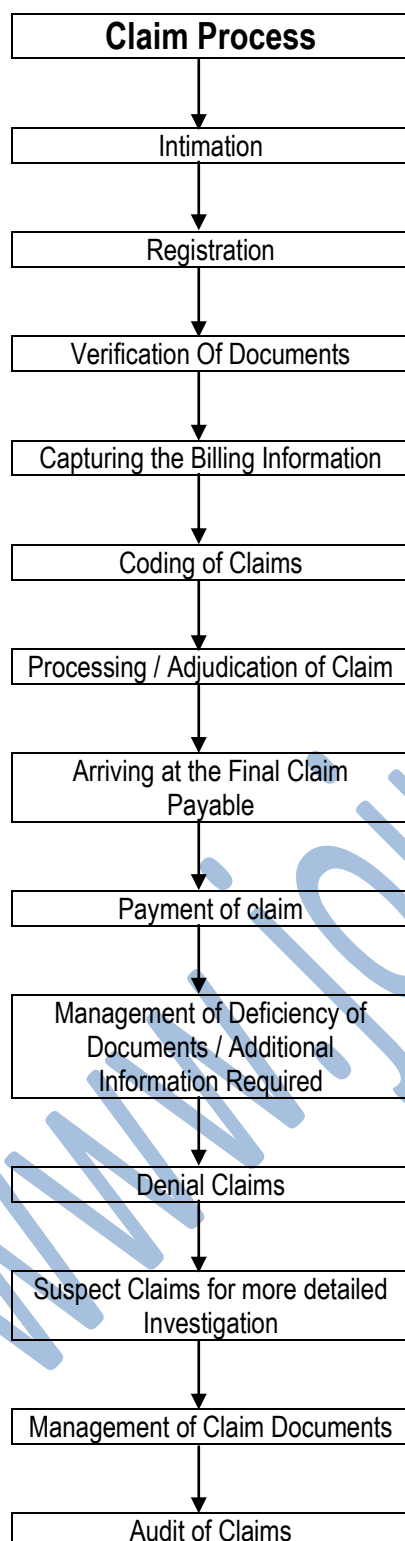
- Customers, who buys insurance is the primary stakeholder as well as the receiver of the claim.
- Owners have big stake as payers of claims, it is they who are liable to keep the promise.
- Underwriters understand the claims n design the products, decide policy terms, conditions n pricing.
- Regulator maintain order in insurance sector, protect policy holder's benefits
- Third Party Administrators (TPA) process health insurance claims.
- Agents/Brokers not only sell policies but also provide service in event of claim of policy
- Providers/Hospitals they ensure for smooth claim experience during cashless hospitalization.

Claim process in health insurance

- In Cashless claim a network hospital provides the medical services based on a pre-approval from the insurer / TPA and later submits the documents for settlement of the claim.
- In reimbursement claim, the customer pays the hospital from his own resources and then files claim with Insurer / TPA for payment.

Claim intimation is the first instance of contact between the customer and the claims team.

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



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

- Discharge summary – it gives the complete information about the condition of the patient and treatment
- Investigation reports – it helps in comparing the diagnosis and the treatment

- Consolidated and detailed reports – it decides what needs to be paid under the policy
- Receipt for payment – to claim the amount one requires formal receipt of amount paid from the hospital
- Claim form – it is the formal and legal request for processing the claim which is duly signed by customer
- Identity proof – for verification of the person covered and treated to be same his ID proof is taken.

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

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

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

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

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

- Providing networking services - in the form of hospitals with cashless claim payments.
- Call centre services – in the form of toll free number available 24*7*365
- Cashless access services -
- Customer relationship and contact management - to represent customer grievances
- Billing services – in order to code, verify and standardize the billing data
- Claim processing and payment services – in order to make sure the money is accounted and provided to the claimant on approval
- Management information services – to keep data of claims made and provided accurately time n when needed by insurance company.

THE END

How to prepare for IC38 Exam ?

DAY 1. Read all the chapters. It will take 2hrs to read all the chapters.

DAY 2/3. Go through the question set given to you along with this notes. Try to solve questions on your own before looking to answers.

DAY 4/5. Download IC33 / IC38 (if available) from google play store. The app contains around 10 question sets. Solve all those sets one by one and figure out how much you are scoring.

Names of app – Exawin IC33 (N) IC33 exam.

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

DAY 7. Exam day.

Tips for how to solve the paper?

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

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

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

3. Now you are left with questions which you are **doubtful** and which you **don't know** anything.

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

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

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

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

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

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

NO QUESTION SHOULD BE LEFT BLANK – ATTEMPT ALL.

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