About the Book

This is an edited book consists of best papers submitted to the National Seminar on 'Insurance Services: Issues and Challenges' organised by the Chair of Excellence on Consumer Law and Jurisprudence of the Tamil Nadu Dr. Ambedkar Law University, Chennai in association with Ministry of Consumer Affairs, Food and Public Distribution, Department of Consumer Affairs, Government of India on 26th November, 2016. The papers have been classified under four sections as follows: I. Life Insurance - A tool for risk management or investment for growth; II. Insurance other than Life Insurance: Opportunities and Challenges; III. Role of IRDA in regulating insurance; IV. Efficacy of Consumer Protection Act, 1986 and other Acts relating to insurance.

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The Tamil Nadu Dr.Ambedkar Law University is a premier institution for legal education, established in the year 1997 in pursuance of the Tamil Nadu Act No.43 of 1997. As a sui generis model, the University is the first of its kind in the country offering legal education both on its campus and through the affiliated law colleges in the State of Tamil Nadu. All the seven Government Law Colleges and one Private Law College stand affiliated to the Tamil Nadu Dr.Ambedkar Law University. The University has established the School of Excellence in Law in the University Campus.

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The Tamil Nadu Dr Ambedkar Law University

INSURANCE SERVICES: ISSUES AND CHALLENGES

Patron

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THE TAMIL NADU Dr.AMBEDKAR LAW UNIVERSITY
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Prof.(Dr.) P. Vanangamudi
Vice Chancellor

2nd Dec, 2016

Foreword

The paradigm shift in doctrine "Caveat Emptor" to "Caveat Venditor" has great impact in empowering consumers. Globalization is sweeping widely and effectively all the domains of human realities and its implication is inevitably felt in consumerism. The liberalized and privatized world venture radical restructure in the production industries in relation to goods and providers of service sectors.

When the world is transformed into a global village, goods and services produced and emanated from one hemisphere could easily reach and avail to the consumers of other hemisphere. As per the Demand and Supply theory, more number of consumers in the form of population would attract goods and services to the country where the populations is more. Asian continent is known for the density of the population and thereby more number of consumers comparatively. Naturally, producers of goods and providers of services would focus their concentration to this continent.

India with a population of 1.3 billion which constitute 17% of the Global population has been formed into the locus of producers of goods and providers of services. In consonance with the global pressure and federal needs of India, the 101st Amendment has been introduced to incorporate goods and services of related provisions as a part of the Constitution. The Model Goods and Services Act and the corresponding legislative enactment is likely to be given effect to the constitutional mandate.

In India, insurance sector is emerging as a dominant service sector due to its mammoth population. It is obvious that insurance service is inevitable wherever uncertainties loom large. In tune with the global changing dimensions of insurance services, service providers of insurances are also changing their schemes and policies so as to cover the micro and meso level uncertainties. Of late, India has been witnessing several man-made and natural calamities. During such catastrophies, it is this service sector that enable Indians to come out from the calamities and lead their life without being completely shattered by such events.

Insurance Service providers would meet all such speculations but the awareness of such services of their advantages are not adequately known to neither to the common masses nor to the educated people. It is the need of the time to create awareness about the needs of insurance services. For a very long period, insurance services were monopolized by public undertakings and people had the intention to

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be the consumers of services predominantly for tax purposes. Now in the changed global and national scenario, even private corporate bodies began to play the role of insurance service provider. There are different areas like Health, Vehicle, Travel and Fire Insurance etc. The new players ventured at all levels. However, the awareness of the common public is still in the low profile.

Shri.A.K.Ventaka Subramaniam Chair of Excellence on Consumer Law and Jurisprudence of the Tamil Nadu Dr.Ambedkar Law University, Chennai ably assisted by the Dept. of Consumer Affairs, Ministry of Consumer Affairs, Food and Public Distribution took the theme and organized an one day National Seminar on **"Insurance Services: Issues and Challenges"** on 26th November, 2016 and invited research articles from scholars throughout the length and breadth of the nation. This seminar elaborately deliberated various issues and challenges of Life Insurance, Non-life Insurance, Role of IRDA and the efficacy of the Consumer Protection Act, 1986. The Chair has discharged effectively its duties in disseminating knowledge to the consumers through scholarly deliberations. Publish or perish is the slogan of the day. The Chair has taken the efforts in compiling the articles of scholars and published as an edited book. This work of the organisers as well as the members of the Chair is highly appreciated. I hope the readers in general and the consumers in particular will be benefitted. I wish them good luck.

Prof.(Dr.) P. Vanangamudi

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Preface

A well developed and consumer friendly insurance sector is vital for the country as it serves two important objectives (i) it strengthens the risk taking ability of the people and (ii) it provides long term funds for infrastructure development.

The most significant steps with regard to insurance were taken by the Government when the life insurance sector was nationalized in 1956 and the general insurance business was nationalized in 1972. Life Insurance Corporation of India had monopoly over Indian Life Insurance sector till the late 1990s. The Insurance Laws (Amendment) Act, 2015 has removed some of the archaic and redundant provisions in the earlier legislations. It has provided for enhancement of the foreign investment cap in an Indian insurance company from 26% to a composite limit of 49% with the safeguard of Indian ownership and control. With the entry of private insurance players allying with foreign insurance experts, the Indian insurance market has turned into a highly competitive one, leading to significant growth in the sector. However, more than three fourths of India's insurable population has no life insurance, pension cover or post retirement protection cover. Both insurance penetration and insurance density have been at low levels in India compared to many Asian countries. Obviously this sector has tremendous potential for growth as there is still a huge untapped market.

Despite the enactment of several laws to safeguard the interests of the insured, many people feel that insurance companies take them for a ride in different ways: selling of policy by presenting a false picture, non-disclosure of risks and hidden charges, partial or total repudiation of claims on technical grounds, payment without interest, delay in policy delivery or settlement of claims, etc. There are complaints against some of the insurance agents of being indifferent once their policy is sold. The insurance companies, on the other hand, have their own problems such as rising costs, slowing growth, stalled reforms, lack of consumer awareness, non-disclosure of material facts by the people taking the policy (especially with regard to life and health insurance), fraudulent/ bogus claims, exaggerated claims, belated claims, etc. Lack of product innovation and customization is another problem.

The Insurance Laws (Amendment) Act, 2015 has provided the Insurance Regulatory and Development Authority of India Ltd., (IRDAI) set up in 1999 with the flexibility to discharge its functions more effectively and efficiently. The setting up of redressal machinery at the district, state and national levels under the Consumer Protection Act, 1986 has been a boon to the consumers.

There is no doubt that the insurance sector has made great strides and has the potential to contribute significantly to the country's growth. But there are several issues concerning the growth of this important sector that needed discussion. Whether life insurance is a tool for risk management or an instrument for investment for growth or both; how is the health of non-life insurance sector vis-à-vis the life insurance sector? What are the opportunities and challenges facing this sector? How has been the role

of IRDA in regulating the insurance sector, both from the viewpoint of the insurance company as well as the common man? Are the existing laws adequate to address the problems faced by the consumer with regard to insurance? To what extent the Consumer Protection Act 1986 has helped in grievance redressal? These issues were discussed in detail in a one day seminar on "Insurance Services: Issues and Challenges" organized by the Chair of Excellence on Consumer Law and Jurisprudence of the Tamil Nadu Dr. Ambedkar Law University, Chennai in association with Ministry of Consumer Affairs, Food and Public Distribution, Department of Consumer Affairs, Government of India on 26th November, 2016.

The papers presented at the seminar have been edited and grouped under the following sections.

Section I	Life Insurance - A tool for risk management or investment for growth.
Section II	Non-life insurance: Opportunities and challenges.
Section III	Role of IRDA in regulating insurance.
Section IV	Efficacy of Consumer Protection Act, 1986 and other Acts relating to insurance.

We thank Prof.(Dr.) P.Vanangamudi, Vice-Chancellor for his guidance and support in organizing the seminar and bringing out the publication.

The Editors record their deep sense of gratitude to the Hon'ble Justice Thiru. M.M. Sundresh, Judge of the Madras High Court for inaugurating the seminar and providing valuable inputs.

The Editors wish to thank the contributors of the papers for their spontaneous response. The views expressed in these papers are of the respective authors only. The Editors are no way responsible for the authenticity of the facts or the contents of the articles. We hope that readers will find this publication useful and interesting.

Chennai
07.12.2016

Editors.

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Section-I

Life Insurance – A tool for risk management or investment for growth

Employers' Liability Insurance with Special Reference to the Employees' Compensation Act, 1923: A Tool of Social Security for Workers

Dr. J. MAHALAKSHMI[1]

Abstract

The Employees' Compensation Act, 1923 was perhaps the first legislation that may be described as a social security measure. This paper analyzes the liability of the employer under the Act and how the employer's liability insurance as a tool of social security to ensure relief to persons affected by accidents.

Introduction

With the growing complexity of Indian industries, increasing use of machinery and consequent danger to workmen with their comparative poverty, it was felt that there should be legislation to protect the workmen from the hardship arising from accidents[2]. The modern society being a welfare society, it is the duty of the state to protect the interest of the citizen, who has contributed or is likely to contribute to his country's welfare against certain hazards[3]. The Employees' Compensation Act, 1923 is a welfare legislation and perhaps the first legislation which may be described as a social security measure in a broad sense[4]. It's object is to provide compensation in case of personal injury caused by accident and certain occupational diseases arising out of and in the course of employment resulting in death or disablement sustained by the employee, be paid to him or his family members without any delay[5].

The Act is based not on the fault or negligence of the employer but on employer-employee relation which constitutes a complete departure from common law liability. Since the Act is a mechanism for providing relief to victims based on no fault liability, it does not reduce the employer's liability. Hence it may impose a heavy burden to a small employer or employers who are in financial difficulty, as the payment of compensation is made without contribution from the workers. He may insure the liability but the ultimate responsibility rests with the employer[6]. The employer's liability policy covers the employer against liability to any person under a contract of service with the employer for any injuries arising out of and in the course of employment[7].

[1] Assistant Professor (SG), HOD i/c Department of Human Rights and Duties Education, TNDALU, Chennai

[2] Gazette of India, 1922, Part IV, p.313.

[3] Government of India, "Report of National Commission of Labour" (1969), p.162.

[4] Dr. Suresh. C. Srivastava, " Treatise on Social Security and Labour Law", (Lucnow: Eastern Book Company) 1985 Edition, p.3.

[5] C.S. Azad University of Agriculture and Technology Vs. Court of Workmen Commissioner, (2003) Lab IC, 140 (ALL).

[6] Government of India, " Report of Second National Commission of Labour" (2002), p.141.

[7] M.N. Srinivasan, "Principles of Insurance Law" (Nagpur: Lexis Nexis) 2009 Edition, p.1253.

This paper makes an attempt to analyze the liability of employer under the Employees' Compensation Act, 1923 and also employers' liability insurance as a tool of social security to ensure relief to the persons affected by the accidents[8].

The Employees' Compensation Act, 1923.

Prior to the enactment of the Employees' Compensation Act, 1923 the law relating to compensation payable by the employer to his employee covered employment injury in case of proved negligence. But the Employees' Compensation Act, 1923 has radically changed the employers' liability irrespective of negligence on the part of the employer or contributory negligence. The compensation is not the only benefit flowing from this Act; it has important effects in furthering work on the prevention of accidents, and giving workmen greater freedom from anxiety and in rendering industry more attractive.

Scope and coverage

The Act extends to the whole of India and it applies to railways and other transport establishments, factories, establishments engaged in making, altering, repairing, adapting, transport or sale of any article mines, docks, establishments engaged in construction, fire brigade, plantations and other employments listed in schedule II of the Act. Establishments which are covered by the Employees State Insurance Act are outside the purview of this Act.

Entitled employees

The Employees' Compensation Act (Amendment), 2009 has substituted the word employee for the word workmen as contained in the principal Act which has inserted the definition of the concept employee by adding clause (dd) and thereby omitting the definition of the workmen contained in the clause (n). However the definition of workmen is almost same[9] which is as follows: "employee" means a person who is:–

i. A railway servant as defined in clause (34) of section 2 of the Railways Act, 1989 (24 of 1989), not permanently employed in any administrative district or sub-divisional office of a railway and not employed in any such capacity as is specifies in schedule II; or

ii. (a) a master, a seamen or other members of the crew of a ship,
(b) a captain or other member of the crew of an aircraft,
(c) a person recruited as driver, helper, mechanic, cleaner or in other capacity in connection with a motor vehicle,
(d) a person recruited for work abroad by a company, and who is employed outside India in any such capacity as is specified in schedule II and the ship, aircraft or motor vehicle, or company, as a case may be, registered in India; or

[8] Report of the Royal commission on labour in India, P-298
[9] Dr. V.G.Goswami, "Labour and Industrial Laws (Allahabad: Central Law Agency) 2011 edition, p.41.

iii. employed in any such capacity as is specified in schedule II, whether the contract of employment was made before or after the passing of this Act, and whether such contract is expressed or implied, oral or in writing; but does not include any person working in the capacity of a member of the armed forces of the Union; and any reference to any employee who has been injured shall, where the employee is dead, include a reference to his dependants or any of the them.

Employees' Compensation Scheme: Conditions of liability

The liability of an employer under the Act is limited and is subject to the provisions of the Act. Under section 3(1) the liability to pay compensation relies on four conditions: (i) personal Injury; (ii) caused by accident; (iii) arising out of and in the course of employment; and (iv) the injury must have resulted either in death of workman or in his total or partial disablement for a period exceeding three days. A person below the age of 16 years would also be entitled to get compensation[10] under the category of employee if he fulfills the above conditions. It is essential to examine the conceptual dimension of some important notions which would enable us to identify and set certain goals and standards to be achieved through the scheme in order to protect the employment injury victims. The important notions such as personal injury, accident, arising out of and in the course of employment, occupational disease etc. are discussed as follows with the help of decided cases:-

Personal injury

Personal injury means both "physical and mental' injury i.e., a hurt to body or mind[11]. Thus a person suffering from nervous shock will be covered by the Act. Physical shock arises when the accident in all cases is the result of or at least accompanied by, some physical disturbance in the sufferer's system[12]. It was argued that personal injury meant exclusively and only a blow to the human flesh.

Under the Employees' Compensation Act, 1923 although no formal definition of personal injury has generally been given, the term may lead to death, or disablement or impairment of the powers of the body or mind in either of which event the employer is liable to pay compensation if the conditions laid down in sections 3(1) are satisfied[13]. Besides, personal injury includes psychological injuries like nervous shock strain even though there is no bodily injury[14].

Accident

An accident is described by Friedman as "an event or an occurrence which happens in such a way as to be totally unexpected by the person suffering the injury

[10] Oriental Insurance company Ltd., Vs. Rathnamma and another 2000 (86) FLR 330
[11] Per Lord Simon, Jones Vs. Secretary of St ate for social services 91972) Ac 944 at 1020.
[12] Per Lord Mackmillan in Bour hill Vs. young (1943) AC 92.
[13] Mt. Mariarnbai Vs. Maelkinnon mackenzie and co (private) Lid. AIR 1968 Born 187 at P-190.
[14] News Chronicle vs Mrs Laxarus AIR 1951 (Pnnj) 102.

in question[15]. Accident may also include occurrences intentionally caused by others for example, personal injury resulting from an assault is caused by accident[16]. As the term has not been defined statutorily, it must be interpreted carefully to test whether an occurrence is unexpected or not. Under section 3, accident included not only such occurrence as collisions tripping over floor obstacles, fall of roof but also less obvious ones causing injury like strain, causing rupture, exposure to draught, causing chill etc.[17] If a workman collapses and dies of heart failure as result of the ordinary strain or exertion of his employment, the employer is liable to pay compensation for personal injury by accident[18]".

Intentional and wilful injury: whether accident

If an accident is contemplated and without design on the part of the accident victim it may still be accident; although caused intentionally and willfully by another person. Atiyah correctly observes that[19]. "The notion of an 'accident' is not perhaps entirely self-evident. Indeed the term accident is, in a sense, a relative term. An intentional assault committed by A against B may not be an accident from A's point of view but it would not be odd to call the resultant injuries "accidental" injuries from B's point of view. Moreover, even from A's point of view the consequences of the assault may be 'accidental' even though the assault itself was deliberate. Therefore, in order to decide whether a particular occurrence is accident or not, it must be looked upon not only from the point of view of the person who causes it but also from the point of view of the person who suffers it[20]. In many cases, incidents like murder of a bank cashier[21] injuries sustained in bomb explosion at work place as a result of time-bomb placed by some unknown persons[22] murder of a gang-zarmadar while going to collect the wages of labourers from HP.W.D. office[23] have been held to be accidents.

Self-inflicted injuries - whether accident

Self-inflicted injuries cannot be said to have been caused by an accident. The mishap or accident must be looked at from the workmen's point of view i.e. personal injury not by design but by accident[24]. But, suicide resulting from insanity or mental derangement consequent on personal injury by accident has been held to be death resulting from injury. The claimant must show that the death is due to accident and that insanity is the direct result of injury[25].

[15] Quoted in Carby-Hall (J.R.), "Principles of Pndusdriarl Low", (London : Charles knight and co Iltd.), 1969 edition, P-373.
[16] Plalsbury's Laws of England 4th edition, Vs1.33, Para 486 at P-364.
[17] Pillai, Madhavanm "Labour and Industrial Laws", (Allahabad : Allahabad Law Agency) 1994 ED P-134.
[18] Oriental Fire and General Insurance co.Vs. Sunderbai Ramji 1992 Lab IC 1020
[19] Accident compensation and the law 3 91975) Quoted in Dr. Singh, Veer "Loc. Cit: P-70
[20] Union of Indian Vs. Gopaldan Virandmal 1955 II LLJ 635.
[21] Nishbet Vs. Rayne and Burn (1910) 2 K.B., 689
[22] Trustees of port of Bombay Vs. Ymunabhai, AIR 1952 BOM 382
[23] P.W.D Vs. Kaunsa, 1967 I ILJ 344
[24] Glasgo coal co.ltd. Vs. weish, 1915 SC 1020-
[25] Srivstava (K.D) "Commentaries on Workman's Compensation Act 1923, (Lucknow :eastern book company)

Arising out of and in the course of employment

To come within the Act, the injury by accident must arise both out of and in the course of employment[26]. Thus Indian Courts have given a wider meaning to the term employment. These twin conditions must co-exist before it can be said that the employers has incurred the liability[27].

Arising out of employment

The expression 'arising out of" suggests the cause of accidents i.e., it should convey the idea that there must be some sort of connection between the employment and the injury caused to the employee as a result of the accident. This expression applies to employment, such as its nature, its conditions, its obligations and its incidents and if by reason of any of these factors, the workman is brought within the zone of special danger, the injury would be one which arises out of employment.

Direct or indirect causes

Even when there is only an indirect relationship between the employment and the accident, the accident has been held to have arisen out of employment. It is wide enough to cover the circumstances attending the employment which would go to show that the workman received personal injury as a result of the accident arising out of his employment.

Proximate or remote cause

For an accident to arise out of employment, it requires some causal connection between the accidents and the employment but the cause should be proximate cause and not a very remote cause[28]. But at the same time the doctrine of position risks has been applied by the courts to consider that the accident is one arose out of employment[29]. The Doctrine of Positional Risk means that if the conditions or obligations of employees' employment require him to be in a particular place, an accident, due to some special risk or danger to which his presence in that place exposes him, arises out of the employment which has been applied by courts in cases of work-place accidents[30].

1999 Ed P-167

[26] Mackinnon mackenize and Co (P) Ltd, I.M. Issak 1970 Lab I.C 1906 : union of india Vs. Noorjahan 1979 Lab IC 652.

[27] Nawab Ali Vs. Hanuman Jute Mills AIR 993 Cal 513

[28] Quoted in Chakraverti (S) 'The Workmen's Compensation Act, 1923'(Allahabad The Law book Company Ltd) 1977 edition. B-126, Simpson Vs. Sirnilair 1917 ae 127.

[29] Uptron Vs. Great Central Railway Co. (1924) AC 302.

[30] Shyanoa Devi Vs. ESI Corporation AIR 1964 All 427 held that 'Death of an employee, due to stacked bund falling on him whole at work was an accident arose out of employment'. Bai Devi Kalluji Vs. Silver Cottoan Mills Lid AIR 1956 Born, 464 held : Workman suffering from heart disease died at work place after working of 8 hours on a hot day due to accident arising out of employment. Shmt Nanjamma Vs. the City Mnnicipai Council, Mysore, 1982 Lab. lI.C.1208: where Mahadevappa was required to assist the Health Inspector when the latter took roll call of sweepers assembled for work on a part of the road, kaocked dowa by a passing jeep and killed, held : death arose out of employment.

Test to determine the scope of "arising out of employment"

The full Bench of the Assam High Court in *Assam Railway and Trading Co. Vs. Saraswathi Devi*[31] laid down the following tests for determining whether an accident arose "out of employment"

i. The Workman was in fact employed or performing the duties of his employment at the time of the accident[32]

ii. The accident occurred at or about the place where he was performing these duties or where the performance of these duties required him to be present[33] and

iii. the immediate act which lead to or resulted in the accident had some form of causal relations with the performance of these duties and such causal connection could be held to exist if the immediate act which led to the accident is not so remote from the sphere of his duties or the performance thereof as to be regarded as something foreign to them[34]. All the above cases indicate that by and large judiciary bas been liberal in interpreting the phrase arising out of employment and has devised a number of very flexible principles to widen the scope of the phrase.

Accidents - in the course of employment

In the course of employment means during the currency of employment. In order to succeed in his claim an employee must show that he was at the time of accident engaged in the employer's business or in furthering such business and was not doing something for his own benefit or accommodation . He must prove that he was doing something in discharge of a duty to his employer directly or indirectly imposed upon him by his contract of service . The distinction between "arising out of' and arising in the course of employment is that the former conveys the idea that there must be some sort of connection between the employment and the injury caused to employee as a result of accidents and the latter suggests the point of time i.e., the injury was caused during currency of employment.

Doctrine of notional extension

The widening of the phrase 'course of employment' has been done through the principle of notional extension of factory premises by the courts, particularly in the content of commuting accident . Some jurists too have advocated that there is no reasonable principle why employers should not be protected 'for a reasonable', distance before reaching or after leaving the employer's premises .

As a general rule the employment of an employee does not commence until he has reached the place of employment and does not continue when he has left the place of employment, the journey to and from the place of employment being excluded. But

[31] AIR 1963 ASS. 127 (FA)
[32] Janki Ammal Vs. Divisional Engineer Highway, Kozhikode (1956) 2 LLJ 233.
[33] Trustees, Bombay Port Vs. Uamunabhai AIR (1952) Born 382
[34] Simpson Vs Sinclair 1977 Ac 127

under this doctrine of it optional extension of time and place, the employer's premises is expanded so as to include an area in which the employee passes and reposes in going and in leaving from the actual place of work. There may be some reasonable extension in both time and place and a workman may be regarded as in the course of his employment even though he had not reached or had left his employer's premises. In *B.E.S.T. undertakings Vs. Mrs. Agnes,* our Supreme Court has applied this doctrine and held that when a driver returning home or reporting for work uses the transport provided by his employer sustains any accident during such a journey it is considered to have happened in the course of his employment.

Employer's liability in case of occupational diseases

The fundamental duty of the state is the protection of health because disease in most cases attacks most important organs of the body. Injuries due to occupational disease are more serious than the injury by accident both from the aspect of the individual and society. In fact, disease in most cases attack the whole system of the body and so legislative provisions are made to provide compensation not only for industrial accidents but also for occupational diseases. According to ILO 'Any disease which occurs frequently only to persons employed in certain occupations or is a poisoning caused by a substance used in certain occupations, should, if the person suffering from such a disease was engaged in such an occupation, be presumed to be of occupational origin and give rise to compensation.' Thus it reflects the Disease-Employment nexus.

In Indian Law certain specified occupational diseases are also included by the Act for the purposes of fixing liability on the employer with a view to pay compensation under section (3) of the Act. Occupational diseases have been categorized in parts A, B and C of schedule III which is deemed to be personal injury caused by accident arising out of and in the course of employment. The following conditions should be satisfied for claiming compensation:

i) The disease is directly attributable to a specific injury by accident and

ii) It has arisen out of and in the course of his employment.

Employees' Compensation Scheme: Benefits

With increasing use of machinery and mechanical power in organized industries, the number of industrial accidents has become common in India also. Employees' need protection against industrial accidents and hence this Act provides for cash payment as benefit for the injuries resulting in death or disablement.

Death

Though of provisions for safety devices to be used in industrial establishments, mines, etc., have been incorporated in various labour laws, there is always some possibility of accident when the machines are huge and complicated. Hence payment of compensation can be supported on both humanitarian and economic ground by

recognizing the value of human life. This Act provides compensation in case of death under all circumstances. The amount of compensation where death results from the injury shall be 50% of the monthly wages multiplied by the relevant factor or Rs.1,20,000 whichever is more .

Disablement

Disablement means the loss of earning capacity due to injury caused to an employee by an accident arising out of and in the course of employment. Disablement can be classified as (1) Total and (2) Partial . It can further be classified as permanent and temporary. Disablement whether permanent or temporary is said to be total when it incapacitates an employee for a work and which he was capable of doing at the time of accident resulting in such disablement. Total disablement is considered to be permanent if a workman, as a result of an accident, suffers from any injury specified in part I of the Schedule I or from any combinations of injuries specified in part II of Schedule I as would cause the loss of earning capacity when amounts to one hundred percent or more. Disablement is said to be permanent partial when it reduces for all times, the earning capacity of a workman in every employment which he was capable of undertaking at the time of the accident. Every injury specified in part II of Schedule I shall be deemed to result in permanent partial disablement. Temporary partial disablement is, where the disablement is of a temporary nature and reduces the earning capacity of a employee in the employment in which he was engaged at the time of accident. The extent of disablement under the Act has to be assessed in terms of loss of physical capacity but should be assessed in terms of loss or reduction in earning capacity with reference to the nature of job the workman was going. So if an employee continues to do the same work with difficulty in spite of liability, it would not be proper or correct to hold that he suffers from 100% disability .

Amount of compensation

The amount of compensation payable by the employer shall be calculated in terms of loss or reduction in earning capacity. But if the physical defect or disfigurement renders the employee's labour unsaleable in the labour market, there would either be partial disablement or total disablement even though such physical defect or disfigurement may not impair the employee's capacity to work .

Conditions of non-liability

Though the Employees' Compensation Act, 1923 holds the employers liable statutorily for the injuries suffered by the employee due to employment in industrial accidents, the employers are liable not for any /every injury caused to an employee due to work related accidents during employment. The employer will not be liable to pay compensation under the situation mentioned in proviso to section 3 (1) which are as follows:

Waiting period

If the injury did not result in total or partial disablement for a period exceeding three days the employer is exempted from the liability of paying compensation.

Drink or drug

In order to disown any claim for compensation the employer has to show that the workmen had been at the time of accident under the influence of drink or drug exempting the employer from the liability.

Willful disobedience

In case of willful disobedience, a man does a thing willfully when he does it intentionally because he expects some benefit to himself, either some convenience or as easy way of doing a piece of work and so forth . Any willful removal or disregard by the employee of any safety guards or other device which he knows to have been provided for the purpose of securing the safety of the employee exempts the employer from his liability if the employee suffers injury out of it. The term 'willful disobedience' shows that mere disobedience is not sufficient because it may be the result of forgetfulness or the result of the impulse of the moment. The statute only exempts the employer from liability when the disobedience is willful, i.e., deliberate and intended. The above exceptions do not apply in the case of accident resulting in death unless the employer proves that the fatal accident was not arising out of and in the course of employment.

Administration of the scheme

Employees' Compensation Act, 1923 is a Central Act. But its day-to-day administration is entrusted to the State Governments. Under section 20, the State Government appoints Employees Compensation Commissioner for specified areas. The Employees' Compensation Commissioner performs the function of administrative adjudicators and settles disputed claims, revises periodic payment and registers agreements regarding mutual settlement of compensation claims under the provisions of the Act.

Employers' liability policy and the extent of liability of insurance company

The employers get insurance cover to meet the requirement of payment of compensation to the employee injured by accidents arising out of and in the course of employment. The commissioner appointed under the Employees' Compensation Act 1923 has jurisdiction to pass an order making the insurance company liable for the amount awarded as compensation against the employer who happens to be insured. In any event, in the execution of the order against the insured, i.e employer, the commissioner can enforce the liability against the insurance company under section 31 of the Act. But at the same time Insurance company is not liable to pay compensation in the absence of effective Insurance policy.

Circumstance under which an employee would be deemed to be covered under insurance policy of a vehicle

In the case of *United insurance company limited Vs. Shankerlal* , the claimant while working on a thresher attached with a tractor met with an accident and lost his right hand above elbow. He filed his claim petition before the Employees' Compensation Commissioner. But the insurance company refused to pay the compensation on the ground that only the risk of the tractor was covered but the thresher in question is not a motor vehicle which was neither registered nor insured at the time of alleged accident. The Commissioner for compensation awarded compensation with interest. But the insurance company filed an appeal challenging the award passed by the commissioner. The High Court observed that as per the judicial pronouncements tractor includes equipments used for the purpose of propulsion. Thresher is an equipment for the purpose of tractor and it cannot be a trailer or semi trailer so as to require separate registration or insurance cover. Moreover, in the provisions of the Act, it is no where mentioned that premium amount was received only to cover the risk of only of driver and not for any other employee. Therefore, it cannot be said that only the driver of the tractor was covered by the insurance policy and the employee i.e. the claimant would be deemed to be covered under the insurance policy of the vehicle.

Liability of the insurance company even in case the driver of the vehicle did not possess requisite type of license during accidents

In *New India Assurance Company Ltd., Vs. K. Venu* a pickup auto collided with a mini lorry resulting in the death of the driver of pick up auto while being carried to the hospital. His legal heirs filed a claim petition. But the insurance company refused the claim on two grounds. The first was that the deceased driver possessed a license only to drive a passenger vehicle but he drove a goods vehicle. The second ground was that the policy was granted to auto rickshaw that is a passenger vehicle. The commissioner rejected the contentions of the insurance company pointing out that the policy initially used as regards auto rickshaw was corrected as one issued for pickup auto and the correction was made under the signature and seal on behalf of the insurer and hence the insurance was given only for a passenger vehicle. Aggrieved by this, the insurance company appealed before the High Court on the ground that the deceased driver possessed only a license to drive a vehicle other than a transport a vehicle and therefore entrustment of a goods vehicle to such a person was in violation of policy condition. The High Court relied upon the decision of the Supreme Court in *National Insurance Co. Vs. Swaran Singh* , wherein it was held that if it is found that the accident was caused solely because of some other unforeseen or intervening process like mechanical failure and similar other causes having no nexus with the driver not possessing requisite type of vehicle, the insurance company will not be allowed to avoid its liability merely for technical breach of conditions concerning driving license. Hence, the High Court dismissed the appeal.

Liability of insurance company in case of employment of brother as truck driver

In *United Insurance Company ltd Vs. Vijaya Kumar*, the claimant was a truck driver who was employed by his brother on monthly salary. He met with an accident resulting in injuries and underwent an operation thereby spending Rs.50,000/- for his medical expenses. The commissioner for employees' compensation awarded the compensation of Rs.2,27,472/- along with the interest thereon. Aggrieved by this the insurance company filed an appeal in the High Court by rising the contention that the claim petition was filed collusively by the driver with his brother who was owner of the truck. But the court held that there was ample evidence to show that the claimant was employed on truck as driver and that he sustained injuries in an accident during the course of employment. It was further observed that there is no law which prohibits a person from employing his brother as a driver of the vehicle owned by him and there was no reason to hold that the claim was collusive.

In the past, when the livelihood was primarily based on agriculture and joint family system was in vogue, religious and charitable institutions and philanthropists provided security to the needy and helpless. Donations and subscriptions were collected from the members of the community also. But such help was restricted only to the members of a particular community. Later these institutions were withered due to the introduction of industrialization. As human needs were extended with the introduction of industrialization, it was above the ability of man to defend himself and his dependents against certain risks which are essentially contingencies when it could not be overcome by private combination with his fellows. So it was very much felt that the institution of social security has to be established.

Conclusion

All the industrial countries of the world have developed measures to promote economic security and welfare of the workers and their families. One of such measures is the concept of employers' liability to provide compensation to the workers in case of industrial accidents. The Employees' Compensation Act, 1923 was passed to provide security to workers regarding work-connected injuries. This Act made employers' liability more rigorous and therefore naturally the employers may have the chance of evading, delaying or denying the compensation to the workers. To avoid these kinds of violations, an employer may insure his liability to make the insurance company to be saddled with the liability of paying compensation to the employee even for the injury not specified in the schedule under the Act.

Apart from that, there are certain circumstances under which an employer is not liable to pay compensation under the Employees' Compensation Act, 1923. To be on the safe side, there are provisions in the workmen's' compensation insurance policy to an employer of insuring himself against his liability arising under the Act in order to ensure compensation to employees in respect of accidents and occupational diseases.

Insurance Coverage for Workers in Unorganised Sector with Special Reference to the Unorganised Workers' Social Security Act, 2008: Issues and Challenges

Dr. P. Balamurugan[1]

Abstract

The Unorganised Workers' Social Security Act, 2008 has sought to create a dedicated social protection environment for the unorganized work force. This paper analyses various social security schemes provided under the Act and critically reviews the working of the schemes. It advocates a single window architecture to prevent delivery deficit in providing social security benefits.

Introduction

Protection of life comes on top of all priorities in all situations. Everyone is exposed to the risk of untimely death due to disease or accident. The exposure in unorganised sector[22] is all the more because of sub-standard living and deficient care[33]. The need for life insurance cover for unorganised sector is more than those in organised sector because some or other sort of protection and benefit is available to them through employers and other institutions. The urgent need for this segment is a very simplistic module covering the basic element of risk cover made available to them at a very low cost. Such protection may be made available to them either from government funds, or on co-contribution basis[44]. Whereas addressing these reasons like improving standards is desirable on one hand, it is absolutely essential on the other to provide some sort of financial assistance for the family to carry on till alternatives emerge. The concept of life insurance addresses this issue, but the workers in un-organised sector can hardly afford individual life insurance policy for following reasons:[5]

1. Financial inadequacies
2. Not literate enough to understand concept of insurance and choose the right one
3. Sustaining the protection over a period of time

The National Commission for Enterprises in the Unorganised Sector has examined the conditions of work as well as livelihood issues of unorganised workers. The examination of the regulatory frame work to ensure minimum conditions of work for unorganised wage workers has shown that:

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[2] Section 2(l) of the Unorganised Workers' Social Security Act, 2008: "'Unorganised Sector' means an enterprise owned by individuals or self employed workers and engaged in production or sale of goods or providing service of any kind whatsoever, and where the enterprise employs workers, the number of such workers is less than ten.

[3] Government of India, Ministry of Labour & Employment, *"Report of the Working Group on Social Security for Twelfth Five Year Plan" (2012-2017), p.8.*

[4] *Ibid., at 9.*

[5] *Ibid., at 8-9.*

- There is lack of comprehensive and appropriate regulations in India.
- Even where regulation exists, there are inadequate and ineffective implementation mechanisms.

Hence, it has been felt that there is a need for comprehensive legislation for minimum conditions of work in the country. The commission has also reviewed and analysed the various perspectives on a comprehensive legislative framework for unorganised wage workers and has made appropriate recommendations. On account of their unorganised nature, these workers do not get adequate social security. Even though State governments are implementing welfare programmes for certain categories of unorganised sector workers, there is a huge deficit in the coverage of unorganised sector workers in the matter of labour protection and social security measures ensuring the welfare and well being of the workers[06]. Hence, the Unorganised Workers' Social Security Act was passed in 2008 to create a dedicated social protection environment for the unorganised work force. This paper makes an attempt to analyse the benefits provided to the unorganised workers through insurance schemes and the working of these schemes.

The Unorganised Workers' Social Security Act, 2008

The Unorganised Workers' Social Security Act, 2008 aims to provide for social security and welfare of the unorganised sector and for matters connected there with or incidental thereto. This National legislation is an important step for the universal coverage. It covers a home based worker, self employed worker, or a wage worker in the unorganised sector and includes workers in the organised sector who are not covered by any of the Acts mentioned in Schedule II to this Act[7]. The Act provides for social security benefits through insurance e.g. Rashtriya Swasthya Bima Yojana (a national health insurance scheme), Aam Aadmi Bima Yojana (a life insurance scheme) for the workers in the unorganised sector

Social security benefits

The Act provides for welfare schemes to be formulated and notified by the Central Government from time to time for the welfare of the workers of unorganised sector relating to the following matters[8]:-

- Life and disability cover;
- Health and maternity benefits;
- Old age protection; and
- Any other suitable benefit.

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[6] Statement of Objects and Reasons of the Unorganised Workers' Social Security Act, 2008.

[7] Section 2(m) of the Unorganised Workers' Social Security Act, 2008 defines Unorganised Worker.

[8] *Ibid.*, at Section 3.

The Act also provides that the State Governments may formulate and notify from time to time, suitable welfare schemes for unorganised workers in the following matters:

- Provident fund;
- Employment injury benefit;
- Housing;
- Educational scheme for children;
- Skill upgradation of workers;
- Funeral assistance; and
- Old age homes.

The workers need to register with the district administration for the benefits provided under the Act[9].

Schemes specified under schedule I of the Unorganised Workers' Social Security Act, 2008

The Act also provides in Schedule I a list of ten schemes as proof of Government's commitment to formulate new schemes.

- Indira Gandhi National Old Age Pension Scheme
- National Family Benefit Scheme
- Janani Suraksha Yojana
- Handloom Weavers' Comprehensive Welfare Scheme
- Handicraft Artisans' Comprehensive Welfare Scheme
- Pension to Master Craft Persons
- National Scheme for Welfare of Fishermen and Training and Extension
- Janshree Bima Yojana
- Aam Aadmi Bima Yojana
- Rashtriya Swasthya Bima Yojana

Social security schemes provided through insurance

The followings schemes are provided to the workers in the unorganised sector through insurance under the Unorganised Workers' Social Security Act, 2008.

1. Handloom Weavers' Comprehensive Welfare Scheme

Handloom Weavers Comprehensive Welfare Scheme comprises of two separate insurance sub-schemes viz., Health Insurance Scheme and Mahatma Gandhi Bunkar Yojana Health Insurance Scheme.

[9] *Ibid.*, at Section10.

i) Health Insurance Scheme

This scheme covers the handloom weaver, his wife and two children belonging to below poverty line categories. The scheme covers pre existing and new diseases including outpatient treatment and the annual limit per family is Rs.15,000/-. The limit for outpatient treatment as well as the limit per illness is Rs.7500[10]. It also provides for maternity benefit of Rs.2,500/- per child for 2 children. Further, expenditure towards Ayurvadic/Unani/Homeopathic/Siddha systems of medicine up to Rs.4,000/- is also provided[11].

ii) Mahatma Gandhi Bunkar Yojana Health Insurance Scheme

The scheme provides enhanced insurance cover to the handloom weavers in case of natural as well as accidental death and in cases of total or partial disability. To become eligible under the scheme, the weaver should be earning atleast 50% of his income from handloom weaving and should be between age group of 18 and 59 years. The weavers belonging to the State Handloom Development Corporation/apex/primary Handloom Weavers' Co-operative Societies will be covered under the scheme. Weavers outside co- operatives can also be covered under the scheme on a certificate from the State Directorate of Handlooms that they are fulfilling the eligibility conditions. The scheme provides for Rs.1.5 lakh cover for accidental death/total disability, Rs.75,000/- for partial disability and Rs.60,000/- for natural death. This scheme also provides scholarship of Rs.300/- per quarter per child to children studying in class IX to XII for a maximum period of four years or till they complete XII standard. Government of India contribute Rs.290/-, Weavers' contribute Rs.80/- and Life Insurance Corporation of India contributes Rs.100/-[12].

2. Handicraft Artisans' Comprehensive Welfare Scheme

This scheme has been envisaged to address the needs of artisans who lack proper care on their welfare. This scheme is also like Handloom Weavers' Comprehensive Welfare Scheme but it covers the handicraft artisan and three family members including spouse. It covers all handicraft artisans but the rate of premium is different for different categories. The welfare scheme comprises the following yojana:

Bima Yojana for Handicrafts Artisans (Aam Admi Bima Yojana (AABY)

The object of this scheme is to provide life insurance protection to the handicrafts artisans. Artisans between 18-59 years living below and marginally above the poverty line were provided insurance cover in the erstwhile JBY as well as in the newly merged AABY. The scheme is implemented through LIC of India. All crafts persons will be

[10] *See* Handlooms, Ministry of Textiles, Wcd.nic.in/ww/Bcconppt4.pdf.

[11] *See* www.delhi.gov.in/wps/wps/wcm/connect/5f8f7bfb004efbf483b01db9fe 99daf05a/hl_sch_hwcwshanloom.pdf?MOD=AJPERES&CACHIED=5f8f7b01df483b01db9fe99daf05a.

[12] *See* Ministry of Textiles, Office of the Development Commissioner (Handlooms), Handlooms.nic.in/writereaddata/1232.pdf. See Ministry of Textiles, Office of the Development Commissioner (Handlooms), Handlooms.nic.in/writereaddata/1232.pdf.

covered under the "AAB" Yojana for Handicrafts artisans subject to the conditions laid down by LIC from time to time. The scheme provides Rs.75,000/- in case of death due to accident, Rs.75,000/- in case of permanent total disability and Rs.37,500/- in case of loss of one eye or one limb in accident[13], Government of India contributes Rs.290/-, artisan contributes Rs.80/- and LIC contributes Rs.100/-.

3. Group Accident Insurance for Active Fisherman

The scheme provides insurance cover to the active fisherman between 18 years and 70 years below poverty line who are prone to accidents at sea due to rough weather and other natural calamities fisherman. The Scheme provides compensation of Rs.2,00,000/- in case of death at sea, Rs.2,00,000/- for permanent/total disability due to accident at sea, Rs.1,00,000/- for partial permanent disability due to accident at sea and cover of Rs.10,000/- towards hospitalisation expenses in the event of accident. The annual premium payable is RS.20.27 per beneficiary[14].

4. Janshree Bima Yojana (Public Insurance Scheme)

This scheme covers the events of natural and accidental death as well as partial or permanent disability. This scheme is implemented by the Life Insurance Corporation of India, wherein 50% of the annual premium of Rs.200/- is paid by the Government of India and the other 50% is paid either by the beneficiary, nodal agency or the State Government. The target groups are urban and rural poor who live below the poverty line or on the margin. This scheme provides a sum of Rs.30,000/- on natural death and Rs.75,000/- on accidental death to the beneficiaries. The scheme also provides in the case of total permanent disability Rs.75,000/- and Rs.37,500/- on partial permanent disability. Further, towards scholarship for 2 children studying in IX to XII class a sum of Rs.300/- per quarter per child is paid.

Janshree Bima Yojana Scheme has been merged with the Aam Admi Bima Yojana with effect from 01.01.2013.

5. Aam Aadmi Bima Yojana (Common People Insurance Scheme)

The role of life insurance is to cover the family earner in case of death are disability so as to assist the family in surmounting the economic hardship of having lost their main source of income[15]. The scheme is confined to members of land less unorganised workers in the rural households of the age group 18-59. The scheme is implemented through the agency of Life Insurance Corporation of India. The most current version of the scheme was launched in January 2013 by merging two previous Life Insurance Schemes Janashree Bima Yojana covering 45 occupation groups and Aam Aadmi Bima Yojana covering solely poor land less households in rural areas[16].

[13] *Ibid.*, at 6.

[14] See fisheries.goa.gov.in/wp-content/uploads/2016/04/7-Group-insurance.pdf.

[15] The Institute for Financial Management Research, *"Report of Comprehensive Social Security for the Indian Unorganised Sector"*, (2013), p.12.

[16] Ibid

The beneficiary has to pay premium of Rs.200/- per annum for a cover of Rs.30,000/-, out of which 50% premium will be subsidised from the Social Security Fund. In case of death due to accident Rs.75,000/-, Rs.75,000/- in case of permanent total disability and Rs.37,500/- in case of loss of one eye or one limb, in an accident is provided[17].

6. Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme)

This scheme provides provision of health insurance to workers families consisting of five units. The target groups are unorganised workers falling below the poverty line. The benefits are inpatient care which is restricted by package limits as it does not cover congenital external diseases, drug and alcohol induced illness, sterilization and family planning, vaccination, attempted suicide, and treatments from alternative medicines. In addition to that medicine for 5 days post hospitalisation and transportation costs of Rs.100/- per visit upto maximum of Rs.1,000/- are provided. The benefits, subject to an annual ceiling of Rs.30,000/- to a family, are covered on cash less basis. To claim this benefit, smart cards are provided in which Rs.30,000/- per year is credited to it for direct use at any empanelled hospital[18]. However, there is no provision to cover outpatient treatment, which constitutes a major part of the medical expenses.

With regard to premium, a contribution of Rs.30/- has to be paid by the beneficiaries as registration fee at the time of enrolment and at the time of renewal. The Central and State Governments contribute in the ratio of 75:25 respectively. In the case of North Eastern States and Jammu and Kashmir, the Central and State Government contribute in the ratio of 90:10 respectively.

Working of the insurance schemes

The definition of unorganised worker seems to exclude a major section of unorganised labourers whose income limit is expected to be notified by the Government that too mostly applicable only for below poverty line category. Hence, most of the unorganised workers in the urban areas may not fall under the below poverty line category.

Section 2(l) of the Act defines unorganised sector which restricts the coverage to those enterprises employing less than 10 workers. Contrary to the usual way of defining the unorganised sector as a residue of the organised, the Act defines organised as a residue of the unorganised. Moreover, limiting less than ten is violation of Article 14 of the Constitution of India because there is no reasonable classification between workers working with employee less than ten workers and working with one who is employing more than ten workers.

The Rashtriya Swasthiya Bima Yojana which was initiated in 2008, is a health insurance package that covers upto Rs.30,000/- for inpatient related expenses for families that hold below poverty line cards. But since this insurance covers the cost

[17] *See* https://www.licindia.in/aam_admi_features.htm.

[18] Supra note 14, at 19.

of hospitalisation, the informal workers still have to invest money often to outpatient treatments which include medical fees, cost of medicines and diagnostic facilities.

There is no universal coverage or integrated approach in implementation. It is like a collection of schemes in a piece-meal approach of leaving vast number of vulnerable workers as it covers only below poverty line workers and does not assure benefits to all workers as it applies only for below poverty line workers and there is no universal coverage or integrated implementation. Hence, it is a major challenge to extend social security measures effectively to unorganised sector.

Current social security schemes are run by various ministries. For instance, Aam Aadmi Bima Yojana is run by Ministry of Finance while Rastriya Swastha Bima Jojana is run by Ministry of Labour and Employment. This has led to a fragmented delivery of schemes which has resulted in difficulty to access them through multiple channels.

Moreover, the current schemes, implemented by various Ministries, are regulated by different bodies. For instance, health insurance is provided by insurance companies and hence it falls under the purview of Insurance Regulatory and Development Authority (IRDA). However, National Pension Scheme is regulated by Pension Fund Regulatory and Development Authority (PFRDA). The National Social Security Administration (NSSA) will have to provide clarity on regulation setting for social security products. There should be clarity between regulator and implementer.

Conclusion and suggestions

Despite the objectives of providing social security to the most vulnerable sections of the society, it is felt that a number of schemes have failed to deliver the desire results due to the problem of identification of beneficiaries, their enrolment and making them aware to participate in the scheme. Hence, the true challenge revolves around the identification of the unorganised workers. Secondly there are overlapping of the schemes provided by the Government units at Central and the State level which involves the problem of duplication of efforts, record keeping resulting in reaching the same person under different schemes by way of manipulation. Sometimes there is bound to be some amount of confusion at level of beneficiaries as to what exactly they are entitled. Therefore, it is suggested to have a proper strategy to identify unorganised sectors by requiring individual workers to register themselves as unorganised workers. Further, it is also suggested that every worker should be issued a single multipurpose smart card for variety of transactions in proving a single point interface between the workers and the social security providers. It is further suggested to have a single window architecture, governed by a single entity with a view to prevent delivery deficit in providing social security benefits.

Insurance Sector in India: An Overview

Dr. Nalini R[1] & Arun S[2]

Abstract

This paper gives an overview of the insurance sector in India today, its status and growth and the reforms that have taken place. The important features of the Insurance Laws (Amendment) Bill 2015 passed by Parliament have been highlighted. The market share of the Indian insurance industry within the country as also in the international context have also been discussed.

Introduction

The Insurance sector in India is governed by Insurance Act, 1938, the Life Insurance Corporation Act, 1956 and General Insurance Business (Nationalization) Act, 1972, Insurance Regulatory and Development Authority (IRDA) Act, 1999 and other related Acts. With such a large population and the untapped market area of this population Insurance happens to be a very big opportunity in India. Today it stands as a business growing at the rate of 15-20 per cent annually. Together with banking services, it adds about 7 per cent to the country's GDP .In spite of all this growth the statistics of the penetration of the insurance in the country is very poor. Nearly 80% of Indian populations are without Life insurance cover and the Health insurance. This is an indicator that growth potential for the insurance sector is immense in India. It was due to this immense growth that the regulations were introduced in the insurance sector and in continuation "Malhotra Committee" was constituted by the government in 1993 to examine the various aspects of the industry. The key element of the reform process was participation of overseas insurance companies with 26% capital. Creating a more efficient and competitive financial system suitable for the requirements of the economy was the main idea behind this reform.

Insurance market- Present scenario

The insurance market continues to attract new capital; barring a handful of mega-risks, there is more than adequate capacity to cover all the risks within the market. Post de-tariffing, competition for the existing pie intensified and premium-rates in all classes took a dip. However, insurers are chasing premium and booking losses and working up unviable combined ratios. It is felt that the bottom has been reached and an upswing in the rates is inevitable.

At present, the general insurance market has 20+ players already and some more large international ones are expected to enter shortly. Companies today are coming up with new ideas to stand out and they are offering the existing and prospective customers, new technology platforms that would streamline the business and would also be beneficial to them.

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The industry is going through a challenging phase now because of the general economic slowdown and this phase is expected to continue for some time. According to industry experts, the market will grow by 18% a year.

Insurance sector reforms

In 2004, the Law Commission recommended a comprehensive reform of the Insurance Act, 1938 (the "Insurance Act"). In 2005, the Narasimhan Committee made further recommendations for changes to the Insurance Act. The Bill, which amends the Insurance Act, 1938, the General Insurance Business (Nationalization) Act, 1972 and the Insurance Regulatory and Development Authority ("IRDA") Act, 1999 and incorporates the recommendations of the Law Commission and the Narasimhan Committee had been up for consideration by the Parliament since 2008. The bill was finally passed in 2015. The enactment of Insurance Laws (Amendment) Bill 2015 has reinforced the message to the global investment community that economic reforms are underway.

Key features of the bill

- The Bill provides for enhancement of the foreign investment cap in an Indian Insurance Company from 26% to an explicitly composite limit of 49% with the safeguard of Indian ownership and control.
- The Bill provides Insurance Regulatory and Development Authority of India (IRDAI) with the flexibility to discharge its functions more effectively and efficiently.
- The four public sector general insurance company which were required as per the General Insurance Business (Nationalization) Act, 1972 to be 100% Government owned, have now been allowed to raise capital, keeping in view the need for expansion of the business in the rural and social sectors, meeting the solvency margin for this purpose and achieving enhanced competitiveness subject to the Government equity not being less than 51% at any point of time.
- The Amended Law has several provisions for levying higher penalties ranging from Rs.1 crore to Rs.25 crores for violations including misselling and misrepresentation by agents/insurance companies.
- With the view to serve the interest of policy holders better, the period during which a policy can be repudiated on any ground, including mis-statement of facts will be confined to three years from the commencement of the policy and no policy would be called in question on any ground after three years.
- It is obligatory in the law for insurance companies to underwrite third party motor vehicle insurance as per IRDAI regulations.
- Lloyd's, the society of underwriters based in London is to be allowed to do business in India through joint ventures through Indian partners and to act as reinsurers through their branches in India or as investors in an Indian insurance company within the 49% cap.

- Appeals against the orders of IRDAI are to be preferred to Securities Appellate Tribunal (SAT).

Currently, there are 52 insurance companies operating in India. Out of these 52 companies, 1 is in the reinsurance business, 24 are in the life insurance business and 27 are in the non-life insurance business. The General Insurance Corporation is the sole national reinsurer in the country. Insurance penetration (measured as a ratio of the premium to the GDP) and insurance density (measured as a ratio of the premium to the total population) in India has been at significantly low levels in India compared to its peers in Asia. As of 2011, insurance penetration in the life insurance sector was 3.40 percent, whereas the penetration in the non-life insurance sector was in the range of 0.55 per cent. to 0.75 per cent. Insurance density as of 2011 was USD 49.0 for the life insurance sector and USD 10.0 in the non-life sector. The measure of insurance penetration and insurance density reflects the level of development of the insurance sector in a country. These low penetration levels suggest that the insurance sector in India has a promising potential for growth. Additionally, a rising population, a growing economy, increased domestic savings and greater awareness of insurance products are positive indicators for growth for the insurance industry.

The insurance industry in India does appear to be at a crossroad. A regulatory environment which is perceived to be discouraging to innovation and competitiveness has stifled the ability of insurance companies to remain profitable and seek ways to increase their product offerings. It is prescient that the IRDA in its annual report stated that "Since the opening up of the Indian insurance sector for private participation in 1999, India has reported an increase in insurance density for every subsequent year and for the first time reported a fall in the year 2011."

Insurance sector overview: Status and growth

After privatization, insurance industry has seen significant growth. Due to low penetration and huge potential, many foreign and domestic players have entered the sector. Moreover, several reforms and policy measures have provided a favorable environment for insurance companies to flourish in the country. The insurance sector in India is primarily divided into life and non-life, apart from a very small segment comprising reinsurance. Both the life and non-life insurance segments, which were nationalized in the 1950s and 1970s, respectively, witnessed an across-the-board liberalization process in 2000. After the reforms, the number of players has increased from one in life insurance and four in non-life insurance in 2000 to 23 players in each segment till May 2010 (including one re-insurer in the non-life segment) (as per the IRDA website). The reasons for the strong foundation for insurance services in India are: growing middle class segment, rising incomes, increasing awareness of insurance, as well as investments and infrastructure spending.

Growth in total insurance premiums

Statistics released by the IRDAI suggest that the life insurance industry in India collected weighted new business premiums of INR597 billion in the FY2015-16, indicative of a year-on-year growth of 11.3%. Weighted new business premiums are calculated as 100% of regular premium and 10% of single premium.

Despite the considerable year on year decline in weighted new business premium during the first half of FY2015-16, state-owned LIC noted a significant increase of 9.0% in its weighted new business premium collections in FY2015-16. Correspondingly, LIC recorded a marginal drop in its market share from 53.3% to 52.2%. LIC maintained a positive growth in group business during FY2015-16, witnessing a growth of 25.4%, healthier than the growth achieved by private players in this segment. Press reports suggest that LIC accredits its growth to the launch of new products, specifically Jeevan Labh, and an improvement in the performance of its sales team.

Meanwhile, private life insurers outperformed the state-owned insurer, recording a noteworthy year-on-year growth of 14.0% in their weighted new business premium collections during FY2015-16. This resulted in an increase in their market share to 47.8% from 46.7%.

ICICI Prudential Life has retained its position as the market leader amongst private insurers with a year on year growth of 9.9% in weighted new business premium collections. All of the top 10 private players have achieved a positive growth in weighted new business premiums with the exception of Reliance Life and Bajaj Allianz Life.

Tata AIG Life witnessed significant growth of 144.7% in its weighted new business premium collections, making its way to the top ten private players in terms of weighted new business premiums. Kotak Life and Shriram Life have also continued to witness considerable rise in their weighted new business collections, with growth in excess of 50% compared to previous year. On the contrary, Aviva Life and Aegon Life have recorded a fall in their weighted new business premium of 42.8% and 35% respectively.

Press reports suggest that Bajaj Allianz Life plans to improve its share of individual business to 50% over the next three years. As per the current statistics, total individual premium as at 31 March 2016 is 31% of its total premium. Analysis in a paper published by Investment Information and Credit Rating Agency (ICRA) suggests that the Indian life insurance industry is set to witness a growth of 12%-15% during FY 2016-17.

Market share of Indian insurance industry

The introduction of private players in the industry has added value to the industry. The initiatives taken by the private players are very innovative and have given immense competition to the one time monopoly of the market, LIC. Since the advent of the private players in the market the industry has seen new and innovative steps

taken by the players in this sector. The new players have improved the service quality of the insurance. As a result, LIC, over the years, has seen a declining phase in its career. The general insurance business in India is currently at Rs.78,000/- crore (US$ 11.44 billion) premium per annum industry and is growing at a healthy rate of 17 per cent.

India in the international context

The Indian insurance market is a huge business opportunity waiting to be harnessed. India currently accounts for less than 1.5% of the world's total insurance premiums and about 2% of the world's life insurance premiums despite being the second most populous nation. The country is the fifteenth largest insurance market in the world in terms of premium volume, and has the potential to grow exponentially in the coming years. Life insurance penetration in India is just 3.1% of GDP, which has almost doubled since 2000. In comparison, the U.S. has a penetration level of 7.5% and in Japan it is as high as 11%. The world average is 6.3%. In 2013, the life insurance premium volume for India was $52 billion. A fast growing economy (the World Bank forecasts 5-7% growth in GDP over the coming years), rising income levels and improving life expectancy rates are some of the many favorable factors that are likely to boost growth in the sector in the coming years. India's life insurance market – which is the largest market in the world in terms of the number of policies at 360 million – is expected to grow at a healthy pace of 12-15% in the next five years. This presents a massive opportunity for American insurance companies, especially with the new rules in place.

Conclusion

The prediction of new business and total premium for both private and public sector life insurance companies in India for the year 2016 also shows an upward trend which signifies that there is a lot of scope for life insurance business in India. The most common types include: term life policies, endowment policies, joint life policies, whole life policies, loan cover term assurance policies, unit-linked insurance plans, group insurance policies, pension plans, and annuities. Due to the growing demand for insurance, more and more insurance companies are now emerging in the Indian insurance sector.

Life Insurance – Issues and Challenges

K.S. Manoj Ram[1]

Abstract

This Paper traces the history of life insurance and general insurance in India, makes a mention of the laws governing insurance and discusses the issues and challenges faced by this Sector.

Introduction

Insurance allows someone who suffers a loss or accident to be compensated for the effects of their mis-fortune. It also protects an individual against everyday risks to health, home and property. Insurance now acts as a catalyst for the economic growth of a country.

Insurance in India started without any regulation in the nineteenth century. After independence, it took a theatrical turn. Insurance was nationalized. First, the life insurance companies were nationalized in1956 and the general life business was nationalized in 1972. It was only in 1999 that the private insurance companies have been allowed back into the business of insurance with a maximum of 26% of the foreign holding. After that the concept of insurance has been extended beyond the coverage of tangible asset.

Life Insurance in India

"Life insurance is the heartfelt love letter ever written. It calms down the crying of a hungry baby at night. It relieves the heart of a bereaved widow. It is the comforting whisper in the dark silent hours of the night"[2]

Life insurance is defined as a contract to pay a certain sum of money on the death of a person in consideration of the due payment of a certain annuity for his life calculated according to the probable duration of life[3].

Life insurance made its debut in India well over 100 years ago. Life insurance is superior to other forms of saving.

"There is no death. Life insurance exalts life and defeats death. It is the premium we pay for the freedom of living after death".

Saving through life insurance, guarantees full protection against risk of death of the saver. In life insurance, on death, the full sum assured is payable (with bonus wherever applicable) whereas in other saving scheme, only the amount saved (with interest) is payable. The object of the assured in taking policies from life insurance is to safeguard the interest of his dependents namely wife and children as the case may

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[2] Business Today, "The Minority Group Study On Insurance-I" March 22

[3] Poetry About Insurance on www. Shareourarticles.com

be, in the event of premature death of the assured as a result of happening in any contingency. A life insurance policy is also generally accepted as security for a commercial loan.

Non-Life Insurance

"Every asset has a value and the business of insurance is related to the protection of economic value of assets"

Non-life insurance means insurance other than life insurance such as fire, marine, accident, medical, motor vehicle and household insurance.

Indian laws for Insurance Regulation

There are several statutes made by legislation for life insurance and other insurance sectors in India.

1. The insurance Act of 1938 was the first legislation governing all forms of insurance to provide strict state control over insurance business.
2. Life insurance in India was completely nationalized on 19th Junuary,1956 through the life insurance Corporation Act,1956.All 245 insurance companies operating then in the country were merged into one entity, the life insurance corporation of India.
3. The General Insurance Business Act of 1972 was enacted to nationalize about 100 general insurance companies and merge them into four companies.
4. Until 1999, there were not any private insurance companies in India. The government than introduced the insurance Regulatory and development Authority Act in 1999, thereby de-regulating the insurance sector and allowing private companies. Furthermore, foreign investment were also allowed and capped* at 26% holdings in Indian Insurance Companies[4].

Major issues found in Life Insurance

The foremost issue is the endowment issue. If the insured takes life insurance in his own name, the property should devolve on his heirs after his death and in such case the insurance company cannot deny such process. The Courts have held that insured's main motive is to safeguard the insurance money mainly for him or for his family; the endowment insurance will safeguard his family[5].

The second issue is regarding the "Rashtria Swasthya Bima Yojana" scheme launched by the Government of India in 2008. This scheme aims to provide health insurance coverage to the people who are below the poverty line. But at present, RSBY has become a showcase tool than actually reaching people in any large number[6].

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[4] Dalby Vs London and India Life Assurance Company(1884)
[5] History of Insurance in India onwww.wikipeadia.org/wiki/life-insurance-in-India
[6] Barclays Bank Ltd vs Webb(1941),All ER 321

Thirdly, non participation of people in insurance or life insurance is also one of the major issues, because a common man thinks that taking insurance is expensive and will get him into trouble.

Fourthly, lack of trained agents and increasing the average age are also issues facing the sector.

Challenges faced by Life Insurance

i. Public Vs. Private

Has opening up the insurance industries for private participation, led to weakening of public sector, making it easier for the new arrivals to prosper? One would think that it may be so but it has not been the case with insurance sector. The public sector is still dominating even after a decade of opening the doors of the sector. But in the coming years, the competition between the public and the private insurance sectors will have an impact on life insurance service.

ii. Client serving

Making the potential customers understand about insurance products in a simple and meaningful way poses a big challenge to the insurance sector companies. It becomes difficult to make the customers understand about the policy as they do not fully appreciate the benefits of insurance.

iii. Staying profitable

It cannot be ignored that profitability is one of the major concerns of the insurance industry. The motive of profitability arises in both mind of insured and the insurer considering the fact that India is a price sensitive market and the increased competition has posed a challenge to the companies to limit their expenditure[7].

iv. Market challenges and drawbacks

Slowdown in single premium policies owing to a change in regulation is another challenge. Sustainability of single premium policies, especially post June 2006 when IRDA came into play could negatively impact the growth of single premium policies.

Managing the distribution network, especially the agent attrition rates and managing the cost as most of the insurance companies have already priced in higher economies of scale in their load structure are additional challenges facing the industry.

v. Non-Awareness of IRDA

The role of IRDA is critical for the growth of life insurance as well as general insurance. But IRDA's regulations are sometimes considered as stringent by some companies especially the insurance companies which are about to start as they have little awareness about IRDA.

[7] www.theHindu.com/Insurance-sector-in-India,p.107.

Conclusion

The IRDA has taken "a snail's phase" approach. It has been very cautious about granting licenses. It has set up fairly strict standards for all aspects of insurance business. Too many regulations may kill the newcomer's motivation and too relaxed regulations may induce failure and fraud (which led to nationalization in the first place). However, India is not unique among developing countries where the insurance business has been opened up to foreign competitors.

Indian Life Insurance Industry - The Recent Trends

M. Mohan Kumar[1]

Abstract

Insurance industry contributes to the financial sector of an economy and also provides an important social security net in developing countries. The growth of the insurance sector in India has been phenomenal. The insurance industry has undergone a massive change over the last few years and the metamorphosis has been noteworthy. There are numerous private and government insurance companies in India that have become synonymous with the term insurance over the years. Offering a diversified product portfolio and excellent services the many insurance companies in India have managed to make their way into almost every Indian household.

Introduction

According to IRDA, Indian insurance industry is set for some serious changes. The agents have adapted themselves to latest forms of marketing and very soon changes seen abroad will also be introduced in India.With an annual growth rate of 15-20% and the largest number of life insurance policies in force, the potential of the Indian insurance industry is huge. Total value of the Indian insurance market (2004-05) is estimated at Rs.450/- billion (US$10 billion). According to government sources, the insurance and banking services' contribution to the country's gross domestic product (GDP) is 7% out of which the gross premium collection forms a significant part. The funds available with the state-owned Life Insurance Corporation (LIC) for investments are 8% of GDP.

A Historical Review of Indian Insurance Industry

In 1818, a British company called Oriental Life Insurance set up the first insurance firm in India followed by the Bombay Assurance Company in 1823 and the Madras Equitable Life Insurance Society in 1829. Though all these companies were operating in India, they were insuring the life of Europeans living in India only. Later some of the companies started providing insurance to Indians with approximately 20% higher premium than Europeans as Indians were treated as "substandard". Substandard in insurance parlance refers to lives with physical disability. Bombay Mutual Life Assurance Society was the first company established in 1871 which started selling policies to Indians with "fair value". Insurance business was subjected to Indian Company Act 1866, without any specific regulation. In 1905, the slogan "Be Indian-Buy Indian" declared by Swadeshi Movement gave birth to dozens of indigenous life insurance and provident fund companies. In 1937, the Government of India setup a consultative committee and finally first comprehensive 'insurance act' was passed in 1938.

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In Oct. 2000, IRDA (Insurance Regulatory and Development Authority) issued license paper to three companies, which are HDFC Life Standard, Sundaram Royal Alliance Insurance Company and Reliance General Insurance. At the same time "Principal approval" was given to Max New York Life, ICICI Prudential Life Insurance Company and IFFCO Tokio General Insurance Company. Today as many as 22 life insurance companies including one in the public sector are successfully operating in India.

Changing competitive environment

With the opening of insurance sector in India, the share of private insurer was very less. Total share of private insurer was just 2% in 2001-02. It was because of many reasons which included poor credibility of private players. But soon because of innovative & customized products, novel distribution channels, aggressive marketing etc. private players gave a tough competition to public sector company (LIC). Gradually, the market share of private insurer went up and till financial year 2007-08, total share of private insurer reached as high as 40.35%.

The market share of LIC decreased after the entry of private insurer but it doesn't mean that the growth of LIC got down. LIC continued its growth even after a cut throat completion from the private players. Total revenue generated in 2007-08 by LIC is Rs.149783.99 crore against just Rs.51561.42 crore, generated by all 21 private players. It shows that even after opening of insurance industry and heavy competition from the new entrant, LIC observed a continuous growth in its revenue generation.

Product innovations

In fifties and sixties, the life insurance business was concentrated in urban areas and was confined only to the higher class of the society. Through the LIC Act 1956, the LIC was formed with the capital of 50 million. One of the basic objectives of setting up the LIC was to extend the reach of insurance cover and make it available to the lower segment of the society. LIC observed minimum growth in 1960s and 1970s. This slow growth was caused by the factors like poor infrastructure, low saving, low investment, high illiteracy etc. However the positive changes in industrialization, infrastructure, capital formation, saving rate etc. resulted in tremendous growth of LIC. Still the penetration of insurance sector was very low. A key catalyst in the Indian insurance market growth has been the entry of private players in 2000-01. With the entrance of private players and foreign collaborations, penetration of insurance sector in India has gone up from 1.02% in 1999-00 to 4 % of GDP in 2007-08. Life insurance business in India grew by 14.2 per cent in US Dollar terms in 2007-08.

Before entrance of private players, it was observed that only endowment and money back policies were popular among consumers. But the new, private insurers focused on providing customized products; products that contain innovative features to the customers created favorable demands for other type of policies like term

insurance, child plan, pension plans and unit linked insurance policies (ULIPs). Total life insurance products introduced in initial 44 years i.e. since the formation of LIC (1956-57) till the liberalization on life insurance industry, in 2000-01 were around 124 only. But the entry of private players brought tough completion among insurers and forced all of them to search for customized insurance products based on the needs of the customers. Within just 10 years of liberalization of the sector, the insurer like LIC also introduced 64 new policies in the market. Today a variety of products are available ranging from traditional to Unit linked, providing protection towards child, endowment, capital guarantee, pension and group solutions.

Recent trends in Life Insurance Policy

Along with the other objectives of insurance like financial security, tax benefits etc. one of the major objectives is saving and investment. Traditional life insurance policies like endowment were becoming unattractive and not meeting the aspirations of the policyholders as the policyholder found that the sum assured guaranteed on maturity had really depreciated in real value because of the depreciation in the value of money. The investor was no longer content with the so called security of capital provided under a policy of life insurance and started showing a preference for higher rate of return on his investments as also for capital appreciation. It was, therefore found necessary for the insurance companies to think of a method whereby the expectation of the policyholders could be satisfied. The objective of providing a hedge against the inflation through a contract of insurance pushed insurer to link the insurance policy with market and thus the industry observed the beginning of Unit linked insurance policy (ULIP).

Unit Linked Vs. Non Linked Insurance Plans

There are so many advantages that ULIPs have over traditional policies. The flexibility, transparency, liquidity and fund options available with ULIPs made it the preferred choice of customers and gradually it changed the trend of insurance policy.

The share of ULIPs increased from 82.3 % in 2005-06 to 90.33% in 2007-08 as far as private insurers are concerned. LIC too showed a tactical shift towards promoting linked products and soon the share of ULIPs rose from just 29.76% in 2005-06 to 62.37% in 2007-08 In order to encash the favourable environment for ULIPs, all the players in the industry are offering innovative and customized ULIPs with respect to entry age of the customer, term of the policy, maturity age etc

Conclusion

When almost all the industries in the world are trying hard for survival due to the major economic meltdown, Indian life insurance industry is one of the sectors that is still observing good growth. It is the changing trends of Indian insurance industry only that has made it to cope with the changing economic environment. Indian insurance industry has modified itself with the passage of time by introducing

customized products based on customers' need, through innovative distribution channels, Changing government policy and guidelines of the regulatory authority, IRDA have also played a very vital role in the growth of the sector. Move from non-linked to unit liked insurance policies is one of the major positive changes in Indian life insurance sector. Similarly, opening of the sector to private insurers broke the monopoly of LIC and brought in a tough competition among the players. This competition resulted in innovations in products, pricing, distribution channels, and marketing in the industry. Though the sector is growing fast, the industry has not yet insured even 50% of insurable population of India. Thus the sector has a great potential to grow. To achieve this objective, this sector requires more improvement in the insurance density and insurance penetration. Development of products including special group policies to cater to different categories should be a priority, especially in rural areas. The life insurers should conduct more extensive market research before introducing insurance products targeted at specific segments of the population so that insurance can become more meaningful and affordable. By adopting appropriate strategy along with proper government support and able guidance of IRDA, India will certainly become the new insurance giant in near future.

References

[1] Annual report of IRDA, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08.

[2] Annual report of LIC, 2003-04, 2004-05, 2005-06, 2006-07, 2007-08.

POTENTIAL SOLUTIONS TO INCREASE PENETRATION AND SCALING - UP OF THE INSURANCE SECTOR

K. Latika[1] & D.K. Hemamalini[2]

Abstract

The Insurance industry in India has undergone many changes over the last decade or so. Liberalization, globalisation and privatisation has led to the entry of the largest insurance companies in the world, who have taken a strategic view on India being one of the top priority emerging markets. The insurance industry's participants have been struggling to achieve profitability in the face of high operating losses primarily on account of distribution and operating models. In times where it is important to conserve capital and allocate capital to resources that will deliver sustainable returns, no insurer can remain rigid in their distribution or operating model. Changing lifestyles and buying preferences will constantly dictate the future models of distribution. This paper unravels innovative delivery models and examines some of them from an 'ideating' perspective which need to be adopted by insurance companies to be successful in business.

Microinsurance refers to insurance products which are designed to provide risk cover for low-income people. Potential solutions to further increase penetration and scaling-up microinsurance business requires a range of regulatory, technological and industry led change catalysts to address the challenges. The collected effect of these change catalysts should support the industry in meeting the objective of scaling up the microinsurance business.

Introduction

The Insurance industry in India has undergone transformational changes over the last 12 years. Liberalization has led to the entry of the largest insurance companies in the world, who have taken a strategic view on India being one of the top priority emerging markets. The industry has witnessed phases of quick growth along with spans of growth moderation, intensifying competition with both life and general insurance segments having more than 20 competing companies, and significant expansion of the customer base. There have also been a number of product innovations and operational innovations necessitated by increased competition among the players. Changes within the regulative surroundings had path-breaking impact on the event of the business. Since the year 2001, Indian insurance business has had 2 cycles : (i) the first one being characterised by a period of high growth (CAGR of approx. 31 percent in new business premium between 2001-10) and (ii) a flat period (CAGR of around 2 percent in new business premium between 2010-12). During this period, there has been increase in penetration (from 2.3 percent in FY01 to 3.4 percent in FY12), increased coverage of

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lives, substantive growth through multiple channels (agency, bank-assurance, broking, direct, corporate agency amongst others) and increased competitiveness of the market (from four private players in FY01 to 23 private players in FY12). The sluggish period being experienced today by the Indian life insurance companies brings to fore the big challenge of profitability. The industry's participants have been struggling to achieve profitability in the face of high operating losses primarily on account of distribution and operating models. In times where it is important to conserve capital and allocate capital to resources that will deliver sustainable returns, no insurer can remain rigid in their distribution or operating model. Changing lifestyles and buying preferences will constantly dictate the future models of distribution. However, life insurers would also need to decide on the resources that need to be deployed to build these future models. While the urban market today might be comfortable buying online insurance products, they might not resist the 'warm smile' of a life insurance agent. There are also successful models in other financial and non-financial services business that can be adapted to distribute life insurance products. It would be useful to examine some of them from an 'ideating' perspective.

Innovating with new delivery models

Peer-to-peer (P2P) insurance or social insurance

This draws its influence from P2P lending which is the practice of lending money to unrelated individuals or 'peers' without going through the traditional financial intermediary such as a bank or other traditional financial institution. The lending takes place online on peer-to-peer lending companies' websites using various lending platforms and credit checking tools. Many such platforms exist today in the United Kingdom and United States with the first one in India being the Bangalore-based DhanaX. In the UK, the first and most successful P2P lender is Zopa which was founded in 2005 and has issued loans in the amount of GBP 278 million with over 500,000 customers. There are now P2P lenders that are even using provision funds to safeguard lenders against borrower defaults. Following the success of these P2P lenders, this idea is currently being extended to insurance in Germany as insurance is essentially a social network to share risk. Friend insurance, a Berlin-based start-up, is essentially allowing individuals to develop their own risk pools. The service is a combination of a peer risk pool and a traditional insurance policy. Users of the service invite their friends to cover a small portion of any claims that are made and the rest of the claims are paid by a conventional insurance policy. This service, as claimed by the company, prevents insurance fraud and misconduct via means of social control and reduces sales costs, discourages small claims and cuts administrative overhead.

Direct delivery model

This is inspired by the Amway success of multi level marketing. The direct-to-customer approach means that the life insurance companies have to focus on four key

levers:–

i. Customer segmentation and analytics for targeted approach to marketing
ii. multi-channel strategy that creates value for the direct customer
iii. Product offerings should not be difficult and easy to understand; most importantly easy to explain to the customers.
iv. After sales support that should be technology-driven in order to remain cost-effective and easy to access for the customers

Customer data analytics based marketing strategy relies not on experience or 'gut-feel' but on an understanding of customer needs, preferences and price sensitivity. This enables insurers to interact with customers to maximise the retention (improvement in persistency ratios) and also identify cross sell opportunities. These interactions also provide a degree of comfort to the customers, fulfils the customers desire and builds confidence in the insurer and their own purchase decisions. Further, the acquisition cost should be kept variable as far as possible to make the model a success.

Mobile-based insurance model

There are over 865 million mobile users in India as of December 2012 of which around 535 million are urban users while 330 million are rural users. This means that it has become a necessity that there is a proposition to be offered to the mobile customers. Extending the business capabilities to mobile devices has quickly become a fundamental requirement for companies and it also plays a vital role. Customers increasingly expect it and business partners and employees have become more comfortable with communicating and sharing ideas anywhere, through any device.

In a recent IBM Insurance Global CIO study, it was found that there is huge potential to leverage the mobile platform for investments. In the same manner in which banks had taken to mobile banking applications a few years back and offering a mobile proposition, insurers might have to do the same. Till date, insurers have restricted themselves to creating applications for quote generation and simple affinity-based product sales. However, with the massive growth in mobile applications and smart phone usage, applications to assist in the sales process for agents/brokers/ dealers are being developed. Several insurance companies in India have pilot tested the use of smart phones for the initial product information and filling of application forms to reduce policy issuance time. Further, applications are being developed for agents to access their training and development modules and their performance to date on the smart phones uses. As mobile users are already KYC11 compliant, and with 'Aadhaar'-enabled bank accounts, piggy-backing on the mobile wallet, mobile banking platform to offer insurance solutions is a cost-effective method to tap a large market.

Technology-enabled model for urban India

There is enough evidence from developed markets that network penetration and usage have a positive correlation with the performance and activities of insurance

companies at various levels – lower customer acquisition costs, improved access to information, product innovation that cater to the needs of the customers and enhanced convenience. India has only 150 million internet users as of February 2013 with a penetration of 12 percent making it one of the least penetrated of BRIC7 nations. However, there has been a surge in volume and value of retail transactions in the last decade that reflects the comfort of the internet users to conduct financial transactions online.

Microinsurance

Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payment proportionate to the likelihood and cost of the risks involved. This definition is exactly the same as one might use for regular insurance except for the clearly prescribed target market: low-income people. The target population typically consists of persons ignored by mainstream commercial and social insurance schemes, as well as persons who have not previously had access to appropriate insurance products.

Microinsurance refers to insurance products which are designed to provide risk coverage for low-income people. Generally, this product area unit is targeted towards providing adequate coverage to the target client section with versatile payment schedules for the lower premiums. Although there are various benchmarks to distinguish microinsurance from insurance, product design (size of premium and risk cover) and access are key differentiators for microinsurance products. Simple products which are easily accessible through an efficient distribution process to keep the overall cost of products low are qualified under microinsurance. The microinsurance business took its roots in India with a few schemes launched by non government organizations (NGOs), micro finance institutions (MFIs), trade unions, hospitals and cooperatives to create an insurance fund against a specific peril. These schemes were outside the ambit of the regulations and operated more on good faith of these institutions.

The microinsurance landscape changed with the first set of regulations published in 2002 entitled the 'Obligations of Insurers to Rural Social Sectors.' The regulations essentially promulgated a quota system to force new private sector insurers to sell a percentage of their insurance policies to de facto low-income clients.

The Government of India formed a consultative group on microinsurance in 2003 to look into the issues faced by the microinsurance sector. The group highlighted the apathy of insurance companies towards microinsurance business, non-viability of standalone microinsurance programmes and huge potential of alternative channels amongst others. The Reserve Bank of India allowed regional rural banks (RRBs), which have good distribution reach in rural areas, to sell insurance as 'corporate agent,' in 2004.

In order to support the development and facilitate the growth of the sector, the insurance regulator Insurance Regulatory Development Authority (IRDA) came up with

the microinsurance regulation in 2005. It was a pioneering approach which put India among the few countries to draft and implement specific microinsurance regulations. While the microinsurance regulations had a relatively narrow scope, focussing only on the partner-agent model, it nonetheless relaxed some of the conditions to facilitate distribution efficiency and perpetrated the view to extend microinsurance from a social perspective to a commercial business opportunity.

Distribution channels

Distribution of micro insurance products is dependent on factors such as collaboration, relationship and trust with the low-income group while holding down associated costs. MFIs, NGOs, Regional Rural Banks, Self-help groups (SHGs) and their federations and cooperatives are the most-preferred distribution channels led by their vast established networks and proximity to the target market.

The selection of the right marketing mix primarily depends on the area and product segment. In India and the Philippines, MFIs are predominately being used to distribute microinsurance products, while, in Brazil, utility and telecom companies are increasingly being used.

However, insurers are continuously innovating and introducing distribution channels that are not only cost efficient but also have a larger reach. Technology is being extensively used to distribute microinsurance products more efficiently and effectively. For example, mobile banking is gaining prominence as it is not only an enabler of client communications, but is also helpful in premium and data collection. However, the channel has major disadvantage where face-to-face interaction is required.

Microinsurance, like regular insurance, may be offered for a wide variety of risks. These include both health risks (illness, injury, or death) and property risks (damage or loss). A wide variety of microinsurance products exist to address these risks, including crop insurance, livestock/cattle insurance, insurance for theft or fire, health insurance, term life insurance, death insurance, disability insurance, insurance for natural disasters, etc.

Potential solutions to further increase penetration and scaling-up microinsurance business:-

A range of regulatory, technological and industry led change catalysts exist to address the challenges. The collected effect of these change catalysts should support the industry in meeting the objective of scaling up the microinsurance business. The combined impact of these drivers is far greater than by themselves – changes in the regulatory structure must be accompanied by industry led innovation, which in turn must be enabled through the effective and effecient use of evolving technology.

Regulatory structure and policies

While the regulatory structure for the industry will continue to evolve, special attention will be paid to the regulatory framework for microinsurance.

Evolved regulations

- There is a critical need to set microinsurance goals at an industry level and then supporting the industry with the right set of policies and reporting procedures. Currently there are no microinsurance goals on business numbers. Microinsurance overlaps with rural category regulation for which the goal is on 'number of cases as a percentage of total cases'. There is a need for the regulator to create a supportive framework, such that the goals can be drawn on contribution to premium (as opposed to cases) which would also drive the insurers to devise innovative models to serve the target microinsurance population.
- There is a need to create grievance channels and a resolution system appropriate for low income policy holders.
- Regulating new channels for distribution and mandating risk carriers which are unregulated or under other authorities to become licensed.

Central and State Government funding for insurance: RSBY could be extended beyond health and transformed into the parent scheme for both life and health insurance. With extension of coverage beyond the poor class to low income self-employed groups, the risk profile is expected to improve and even savings and retirement schemes can be offered to the large segment.

Cost and Risk sharing models

- A microinsurance exchange, where graded portfolios (by underwriter, risk assessment, mortality statistics etc.) can be traded. Innovative structures at an industry level, such as the pool and the exchange, will enable microinsurance initiatives to be managed as a collective – rather than by the replication of underwriting risks and costs by each company.
- A microinsurance pool, enabled by the pooling together of all revenues accrued through initiatives run by insurance companies, the Government, postal services amongst others. Payment of claims will be managed by the pool based on information stored in smart cards or mobile phones.

Industry led change/innovation

The mantle of increasing the penetration of microinsurance in India will fall on the insurance industry. Enabled by favourable regulatory structures, the industry will be empowered and encouraged to innovate – in low-cost customer acquisition, product designs and pricing, customer service and in claims handling. While each insurance company will develop its own strategies/ modules and capabilities, it will also have the opportunity to create path-breaking collaborative models. The combination of internal

and collaborative models will be the catalyst for increased microinsurance penetration.

Creation of common databases for microinsurance

- The need to reduce operating costs in microinsurance will drive a model that includes shared infrastructure and a shared information / database. By itself, it will allow insurers to amortise costs, but linked to the microinsurance pool, it will have significant impact on decreasing the costs.
- The biggest advantage accruing from a shared database will be the availability of a significantly larger set of information required for modelling, risk analysis and fraud detection. This is similar in concept to a credit bureau's database accessed by all members.

Collaborative industry models

FMCG, telecom, retail, railways, cable TV, broadband and other mass distribution/reach companies can bundle insurance covers with their products or services and share the customer database leading to better understanding of segment behaviour.

Leveraging technology

The incredible innovations in technology, over the past 20 years, have transformed the way that humans and organisations exist. In areas like information aggregation and management, communications and human-machine interfaces, technology has enabled new paradigms and technology has placed a vital role in functioning of the insurance schemes. Future indicates an increase in the rate of technology innovation.

Wireless access

An increasing number of the Indian population will be connected to wireless networks – either as telecom subscribers or through embedded devices (smart cards, biometric devices, embedded identification tags etc.). With significant progress in the miniaturisation of wireless transmitters and the resulting low costs, almost everything will be connected in the future – PAN Card, AADHAR card (for individual identification), Voter ID card and many personal items. All of this will lead to the generation of massive amounts of segment specific data, enabling a sharper focus on product development for the target market.

Biometric devices, smart cards, embedded devices

- Leveraging of recent initiatives by the Central and many State Governments like issuance of smart cards to the 'poorest' Indians to keep track of financial payments and health records.
- The newer generation of smart cards will be enabled with one or two biometric sensors and a wireless interface. These cards will have enough memory to store financial transactions, health history for a significant period of time. These cards

will not be proprietary to any particular IT platform/ language/ Operating System to enable universal usage.

High powered computing engines and mass storage [cloud computing]

- In the future, large data stores will enable companies to collect, and manage the huge volumes of data that will be generated through the wireless devices and other customer interaction channels. These companies will use sophisticated data analysis tools to analyse all types of trends – by demographic or geographical profiling, multiple economic segments, products, risk classes, by channel views and finally for each individual customer.

Conclusion

For India to reach its rightful place as a developed nation, it must financially empower its entire population. A key element of this empowerment is a base risk cover that covers elements of life, disability and health. This empowerment can only be achieved through the collaborative efforts of the government, regulators and private enterprises, who must be able to build commercially viable and scalable models for financial inclusion.

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Section-II

Insurance other than Life Insurance: Opportunities and Challenges

Various Acts relating to Insurance Business in India

Dr. C. Mahendran[1]

Abstract

This paper gives a brief account of various laws connected with insurance. It stresses the importance of knowing the laws while handling insurance cases by legal practitioners.

Introduction

An Advocate or legal consultant for insurance has to have a fair knowledge of various Acts and Rules connected with it. The insurance principles and the laws relating to insurance complement each other. It's not enough for an insurance law practitioner to know the laws relating to insurance and the principles alone, but he/she should also be conversant with other laws enacted from time to time and also any Regulations on insurance by the Insurance Regulatory and Development Authority of India (IRDAI).

There are many types of insurances available in general insurance business. Broadly, they are Fire, Marine and miscellaneous. Under miscellaneous type of insurance, various other types of insurances business are underwritten. They are: Motor, Engineering, Personal accident, Workmen compensation, Health insurance, Burglary, Fidelity guarantee, Rural insurance and other contingency policies.

Among the various Acts, some Acts are specific to particular insurance and some are connected to more than one insurance business. Given below are the various Legislations and Acts influencing transaction of general insurance business in India. Annexure forming part of this write-up gives a clear picture on applicability of Act to the particular insurance product/policy.

The Aircraft Act, 1934

This Act makes better provision for the control of the manufacture in terms of its worthiness to fly, carry passengers, cargo, possession, use, operation, for the purpose of sale, import and export of aircraft. The Aircraft Rules are more elaborate on the Aircraft Act provisions.

Aircraft Rules, 1937

The Rules extend to the whole of India and apply to (i) aircrafts (including persons on board) registered in India, wherever they may be, and to (ii) all aircrafts (including person on board) for the time being in or over India. However, the regulations relating to registration, licensing of personnel, airworthiness and log-books provided in the Rules do not apply to foreign aircrafts which are governed by the relevant regulations of the respective countries in which the aircraft are registered.

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The Bill of Lading Act, 1855

This Act defines the character of the bill of lading as an evidence of the contract of carriage of goods between the ship owner and the shipper, as an acknowledgement of the receipt of the goods on board the vessel and, as a document of title. The bill of lading is one of the various documents required in connection with settlement of marine cargo claims.

Carriage of Goods by Air Act, 1972

The Act gives effect to the provisions of the Warsaw Convention, 1929 and the Hague Protocol, 1955 relating to international carriage of passengers and goods by Air. The Act defines the liability of the Air carrier for death of or injury to passengers and for loss of or damage to registered luggage and cargo. The provisions of the Act also apply, with some changes, to domestic carriage, i.e, carriage within India. For example, it keeps different time limit for international airlines and domestic airlines with regard to claims for loss of or damage to cargo and delay/non-delivery. The time limit for notice of claim is 6 months and for filing suit is within 3 years.

Carriage of Goods by Sea Act, 1925 (as amended effective 16.10.1992)

This Act defines the minimum rights, liabilities and immunities of a shipping Company in respect of loss or damage to cargo carried. Broadly speaking, the Act deals with aspects of shop owners liabilities towards cargo owners. They are;

a. the circumstances when the ship owner is deemed to be liable for loss or damage to cargo.
b. the circumstances when the ship owner is exempted from liability, i.e. when loss or damage is caused by events outside his control, e.g. perils of the sea.

The limits of liability of a ship owner for loss of or damage to cargo calculated in monetary terms per package or unit of cargo. It specifies the time limit for notice of loss or damage to the ocean carrier as (a) before or at the time of removal of the goods into the custody of the person entitled to delivery thereof (b) if the loss or damage is not apparent, within 3 days of such removal which shall be prima facie evidence of delivery by the carrier of the goods as described in the Bill of Lading.

The time limit for filing suit is reckoned generally from the general landing date declared by the carriers. Presently, the time limit for filing suit is within one year after delivery of the goods or the date when the goods should have been delivered/landing. This can be further extended to 3 months after expiry of one year.

The Carriers Act, 1865 (Repealed)

This Act defines the rights and liabilities of truck-owners or operators who carry goods on public hire, in respect of loss or damage to goods carried by them. The Act also prescribes the time limit within which notice of loss or damage must be filed with the road carriers.

Customs Act, 1962

Application for refund of duty in respect of pilferage, shortage and loss or damage to goods should be made to Assistant Collector of Customs within 6 months from the date of payment of duty. For goods belonging to government, the time limit is further extended to one year.

Employees State Insurance Act, 1948 (ESI)

This Act provides for certain benefits to employees in cases of sickness, maternity and employment injury and to make provision for certain other matters in relation thereof. Under the Act, the Employees State Insurance Corporation has been set up to administer the insurance Scheme. The scheme is applicable to industrial employees as defined.

Foreign Exchange Regulation Act, 1973 (FERA)

Exchange control regulations governing general insurance business written in India are set out in a Memorandum which was issued by the Reserve Bank of India under Sec. 73(3) of the Foreign Exchange Regulation Act.

General Insurance Business (Nationalization) Act, 1972

The transaction of general insurance business in India is governed by and is subject to this Act. This Act came into force on 1st January, 1973 with the following objectives:

1. to provide for the acquisition and transfer of shares of Indian Insurance companies and undertakings of other existing insurers.
2. to serve better the needs of the economy by securing the development of general insurance business in the best interest of the community.
3. to ensure that the activities of the economic system does not result in concentration of wealth to the detriment of common interest.
4. for the regulation and control of such business and for matters connected therewith or incidental thereto.

Indian Arbitration Act, 1940

Disputes regarding insurance claims relating to the amounts payable under the policy are settled through the process of arbitration provided in this Arbitration Act.

Arbitration and Conciliation Act, 1996

The standard Arbitration clause that is found in all the policies is as under:

"If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three

arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of Arbitration and Conciliation Act, 1996."

Indian Boiler Act, 1923

The manufacturing, supply, operation, registration of Boilers in India are governed by this Act. The boilers are insured under engineering section of insurance with specified risks covers and exclusions.

Indian Contract Act, 1872

Like any other contract, the contract of insurance is completed when one party accepts the offer made by the other party. The offer usually comes from the proposer and the offer is known as the proposal. When the premium is paid, the insurer issues receipt which is accepted by the insured. When the prospect pays the premium and the insurer accepts the risk, the contract of insurance is concluded. The policy issued by the insurer is the evidence of the contract.

Indian Factories Act, 1948

This Act defines Factory and provides for regulations for governing factories. This Act also provides for various provisions of safety for various types of machinery, plant etc. in factories.

Indian Mines Act, 1952

Similar to Factories Act, this Act defines mines and provides for regulations to ensure safety and security in mines. In policies like Personal Accident and Workmen Compensation, the nature of employment determines the premium. As the mining job is hazardous and prone to high risk, it attracts more premium. The employers are given instruction to keep the work area safe and be in a position to manage any casualty.

Indian Ports (Major Ports) Act, 1963

This Act defines the liability of Port Trust authorities for loss of or damage to goods whilst in their custody and prescribes time limits for filing monetary claim on, or suit against the Port Trust authorities. For giving notice of loss the time limit is different from port to port. For filing suit for such loss/damage is within 7 months from the date of landing.

Indian Post Office Act, 1898

This Act defines the liability of the Government for loss, mis-delivery, delay of or damage to any postal article in course of transit by post. The time limit for notice of loss is one month from the date of delivery in case of shortage/damage. Three months from booking in case of non-delivery. For filing suit, the time limit is 3 years after notice of 2 months.

Indian Railways Act, 1890

The Act deals with various aspects of Railways administration also relevant to Marine Insurance practice as it deals with the responsibility of Railways administration as carriers. The Railways are liable as bailee for failure to take reasonable care of the goods entrusted for transit. The time limit for giving notice of loss or damage is within 6 months from the date of booking. The notice is to be addressed to the General Manager or Chief Commercial Superintendent of Railway Administration. Suit for non-delivery or delay or damage can be filed within 3 years from the date of probable date of delivery.

Indian Stamp Act, 1899

The Act provides that a policy of insurance be stamped in accordance with the Schedule of rates prescribed by the state from time to time. Any unstamped document/policy cannot be valid before the court of law. The Act requires that a policy of insurance be stamped in accordance with the Schedule of rates for various classes of insurance prescribed therein. Except marine insurance, for all other types of insurance the insurer bears the stamp charges. Minimum value is Rs.One and maximum is based on the value of goods covered. After the country witnessed the fake stamp scam; the insurance companies pay the stamp charges in advance. Hence instead of affixing the insurance stamp in the policy, they affix a rubber stamp with wordings, ***"Consolidated amount paid towards stamp duty for insurance policy to be issued from ----- to ----- (policy period) to the government vide Estamp certificate No..... dated.....*** Hence the practice of affixing stamp on the face of the policy has been done away.

Inland Steam-Vessels Act, 1917

The Inland Steam-Vessels Act, 1917 as amended in 1977, provides for the application of the provisions of Chapter VIII of the Motor Vehicles Act, 1939 in relation to insurance of mechanically propelled vessels against third party risks. The Act makes it compulsory for owners or operators of inland vessels to insure against legal liability for death or bodily injury of third parties or of passengers carried for hire or reward and for damage to property of third parties. The limits of liability are also prescribed.

Insurance Act, 1938

The Act applies to the General Insurance Corporation of India and the four Subsidiary companies subject to exceptions, restrictions and limitations as specified by the Central Government under powers conferred by Section 35 of the General Insurance Business (Nationalization) Act. The important provisions of the Act relate, among other things, to registrations, accounts and returns, investments, limitations in expenses of management, prohibition of rebates, powers of investigation, licensing of agents, licensing of surveyors, advance payment of premium and Tariff Advisory Committee etc. This Act has got less scope for insuring public than the insurance employees and other stakeholders.

Marine Insurance Act, 1963

This Act codifies the law relating to Marine Insurance. With a few exceptions this Act closely follows the UK Marine Insurance Act, 1906. The contract of marine insurance is an agreement whereby the insurer undertakes to indemnify the assured, in the manner and to the extent thereby agreed, against marine losses, that is to say, the losses incidental to marine advent. A good working knowledge of these laws is necessary for underwriters to pursue rights of recovery from carriers or bailees under subrogation proceedings. This recovery job is entrusted to the legal professions, hence it is at most importance for the professionals to be thorough with the procedures. It describes the working of marine insurance starting from insurable interest, different types of loss settlement procedures etc.

The Merchant Shipping Act, 1958

The Act provides for protection to ship owners. The liability of a ship owner can be limited to certain maximum sums for certain losses, provided the incident giving rise to such claims has arisen without the actual fault or privity of ship owner, whether the claim relates to loss of life, personal injury, or damage to property on land or water. The Act also confers an obligation on the ship owner to send his ship to sea in a seaworthy and safe condition.

Motor Vehicles Act, 1939 (amended in 1988)

Chapter VIII provides for compulsory insurance of motor vehicles. According to this Act, no motor vehicle can be used in public places unless there is, in force, in relation to that vehicle, a policy of insurance issued by an authorized insurer. It provides for compensation in case of death, injury – partial or permanent, general damages and special damages.

The Motor Vehicles (Amendment) Act, 1988 has introduced changes which have far-reaching consequences. The changes also affect third party liability arising out of the use of the Motor Vehicles in a public place. As per the amendment, no jurisdiction is fixed to file the case and no time limit is fixed from the date of accident.

Sale of Goods Act, 1930

This Act provides for the rights and obligations of sellers and buyers of goods like, the merchantable quality of goods, the point or time at which ownership transfers from seller to buyer and so on.

Employees Compensation Act, 1923

The Act provides for the payment of compensation by employers to their workmen for injury by accident arising out of and in the course of employment. If a driver of a motor vehicle dies or injured whilst on duty and in the course of employment, he/his legal heir has got the option to file the case for compensation before the Motor Accident Claims Tribunal or Labour Commissioner, but not both.

In a leading judgement, the employee on duty is defined as, "the employment starts from the time the journey for employment stops and the employment stops when the employee commences his journey for home. When the employee is entrusted with job on his way home, the employment continues till he leaves that place after completion of the task." To appeal against the Labour court decision, the time limit is 60 days from the date of receipt of the award.

Consumer Protection Act, 1986

This Act is applicable to the buyers of goods and services. Insurance has been defined as a service for the purpose of the Act. Every buyer of insurance is a consumer. A consumer can file a complaint under the Act before the respective Forum for Redressal. Forums are appointed at different level to hear grievances. A District Forum has jurisdiction to entertain a complaint if the value of compensation is up to Rupees Twenty Lakhs. The financial limit for State commission is upto Rupees One Crore and cases where the compensation exceeds Rupees One Crore have to come to the National commission. The order of the Forum/Commission can be appealed against within 30 days.

The Railway Claims Tribunal Act, 1987

Under this Act, Railway Claims Tribunals have been constituted to adjudicate claims against railway administration arising out of loss, destruction, damage, non-delivery or deterioration of goods and for death, injury or loss to passenger in a railway accident.

The Public Liability Insurance Act, 1991

This Act provides for public liability insurance for the purpose of providing immediate relief to the persons affected by accident occurring while handling any hazardous substance and for matters connected therewith or incidental thereto.

This Act has been enacted subsequent to the Bhopal Gas leak disaster where MIC gas leaked from the plant of Union Carbide Corporation of India Ltd. and caused the death of over 3000 persons and serious injuries to a large number of others. The Government of India responded to the tragedy with a number of concrete legislative measures. Most notable was the umbrella Environment Protection Act, 1986 which materially expanded the Central government's powers to enter, inspect and close down facilities that were formerly under inadequate supervision. The Factories Act, 1987 and the Hazardous Wastes (Management and Handling Rules), 1989 also imposed various responsibilities on such industries. The innovative Public Liability Insurance Act, of 1991 required factory owners to insure against potential personal injury and property damage in certain circumstances.

Multi-Modal Transportation Act, 1993

Multimodal Transport means carriage of goods by two or more modes of transport from the place of acceptance of the goods in India to a place of delivery

outside India. The Act provides for registration of multi-modal transport operators who are engaged in transportation of goods under more than one mode of transport i.e. rail/ road and sea. The Act seeks to regulate business of multimodal transport operator, lays down standard contents and provision of the documents, delineates the responsibilities and liabilities of the MTO and regulates treatment in respect of dangerous goods, provides for limitation on legal action, jurisdiction, arbitration and other matter. The Act prescribes limits of liability of the operator, contents of documents issued by them, notice of loss etc.

Insurance Regulatory and Development Authority of India Act, 1999

This Act has been enacted to provide for the establishment of an Authority to protect the interest of holders of policies, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto and further to amend the Insurance Act 1938, the Life Insurance Corporation Act 1956 and General Insurance Business (Nationalisation Act 1972. The powers and functions of the Authority include the power to issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration. This Act also protects of the interests of the policyholders in matters concerning assigning of policy, nomination by policyholders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contract of insurance.

Prevention of Money Laundering Act, 2002 (Amended in 2005, 2009 and 2012)

This Act has been enacted to prevent Money Laundering and to provide for confiscation of property derived from money-laundering. PMLA and the Rules notified there under came into force with effect from July 1, 2005. The Act and Rules notified there under impose obligation on banking companies, financial institutions and intermediaries to verify identity of clients, maintain records and furnish information in prescribed form to Financial Intelligence Unit - India (FIU-IND).

Right to Information Act, 2005

Right to Information Act, 2005 mandates timely response to citizen requests for government information. The basic object of the Right to Information Act is to empower the citizens, promote transparency and accountability in the working of the Government, prevent corruption, and make our democracy work for the people in real sense. It goes without saying that an informed citizen is better equipped to keep necessary vigil on the instruments of governance and make the government more accountable to the governed. The Act is a big step towards making the citizens informed about the activities of the government. As the insurance business is open to the private players too, they are not governed by the RTI Act.

The Carriage by Road Act, 2007

The Carriers Act, 1865 has been repealed and replaced by the above Act. The common carrier must be registered. Couriers are included in the definition of common carrier. In the old Act, there is provision for limitation of carrier's liability by special contract. Under new Act, carriers limit can be increased. Specific formats for goods forwarding note and goods receipt have been prescribed. The time limit for notice of loss or damage is 6 months from the date of knowledge of loss and for filing suit, 3 years from knowledge of loss as prescribed by Limitation Act.

Scope for Legal Professionals

1. The insuring public require more legal consultants for filing cases with regard to dispute in claim settlement and service matters. Professionals with clear understanding of policy terms and conditions and knowledge in relevant Act/ Provisions are needed in the field.
2. In Marine claims as per the principal of subrogation, the insurers settle the claim and obtain the legal rights from the insured to take legal action against the carrier to recover the claim amount as they are responsible to deliver the goods in good condition. For this purpose, the insurers engage advocates to recover the amount from the carriers through the Court. So the scope for advocates in this profession is quite high.
3. For defending the case of insurers against the third party claims before Motor Accident Claims Tribunal (MACT), the insurers empanel more number of advocates standing in the profession.
4. Arbitration is another area where there is scope for the legal professionals to represent insurer/insured or as a third person.

Limitations

In this article, the writer has made an attempt to bring to the knowledge of the readers the various laws relating to insurance. However, Principles of insurance, the Rules and Regulations are restricted in this paper, keeping in mind the volume of input. Secondly, the information given on various laws are just illustrative only, not exhaustive. For more details, the readers may refer to the particular Act/Acts.

Conclusion

The public sector general insurance companies alone have lakhs and lakhs of cases pending before Motor Accident Claims Tribunal (MACT) throughout the country. The companies are empanelling practicing advocates with good standing in the profession. The advocate fees for a case have been revised to Rs.12,000/- for original petition cases in Metros like Chennai and Rs.9,000/- for other centres. Likewise, the fee for filing appeal cases at High Court is Rs.15,000/-. Also there is separate fees for taking legal opinion to decide about filing appeal and a sum above Rs.3,000/- is paid.

For advocates appearing for the petitioners, the fee is more attractive. In cases where the accident victims are more in a single accident, the cases are heard as a batch. In such cases, with less time and expenses involved, the fees receivable would be much lucrative. The private insurance companies employ legal professionals to draft counter petitions and appear for their cases arising out of all legal liabilities. In Marine insurance cases with reference to the recovery of claim amount against the carriers makes one understand the provisions of Carriers Act, Marine Insurance Act and marine insurance policy terms and conditions.

With the change in insurance products to meet the demand of the insuring public, the insurers issue tailormade policies. As the gap between the expectations of insured and fulfilment of promises by the insurers is widened, the cases end up with litigation. The tailormade policies are also issued to minimise the gap. Poor understanding of the policy terms conditions also contributes for gap. A thorough understanding of insurance principles is the basis to minimise insurance related litigation. Ever since the Bhopal gas tragedy occurred in December 1984, the awareness to take liability policy has increased and the insurers had also introduced more liability related products. Liability insurance today is more commonly classified as property and casuality liability i.e. acts of negligence resulting in loss or damage to property or death or injury of third party or financial liability i.e. negligence resulting in financial losses to third parties, example, professional liability, Director and Officers liability etc.

Apart from understanding principles of insurance, the legal professionals also need to know the various Regulations of Insurance Regulatory and Development Authority of India (IRDAI) issued from time to time. The principles of insurance are not only applicable to the Indian insurance context alone, but to the whole of the world. Hence the opportunity for the legal profession is global.

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ANNEXURE

Applicability of "Acts to the type of Insurance

ACTs	Other								
	Marine	Motor	WC	PA	Misc	Liability	Engg	Fire	Rural
1. The Aircraft Act	Yes								
2. Aircraft Rules	Yes								
3. The Bill of Lading Act	Yes								
4. Carriage by Air Act	Yes								
5. Carriage of Goods by Sea Act	Yes								
6. The Carriers Act, 1865	Yes								
7. Customs Act	Yes								
8. ESI Act				Yes					
9. FERA	Yes			Yes	Yes	Yes			
10. GIBNA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Indian Arbitration Act Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12. Arbitration and Conciliation Act	Yes			Yes		Yes			
13. Indian Boiler Act						Yes	Yes		
14. Indian Contract Act	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15. Indian Factories Act			Yes	Yes	Yes	Yes			
16. Indian Mines Act			Yes	Yes	Yes	Yes			
17. Indian Ports Acts	Yes								
18. Indian Post Office Act	Yes								
19. Indian Railways Act	Yes								
20. Indian Stamp Act	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
21. Inland Steam-Vessels Act	Yes								
22. Insurance Act	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
23. Marine Insurance Act	Yes								
24. Merchant Shipping Act	Yes								
25. Motor Vehicles Act		Yes	Yes	Yes		Yes			
26. Sale of Goods Act	Yes								
27. Workmen Compensation Act		Yes	Yes	Yes					
28.Consumer Protection Act	Yes	Yes			Yes				
29. Railway Claims Tribunal Act									Yes
30. Public Liability Insurance Act						Yes			
31. Multi-Modal Transportation Act	Yes								
32. IRDAI Act	Yes	Yes		Yes	Yes	Yes			Yes
33. FEMA	Yes			Yes	Yes	Yes			Yes
34. PML Act	Yes			Yes	Yes	Yes			Yes
35. RTI Act	Yes	Yes	Yes	Yes	Yes	Yes			Yes
36. Carriage by Road Act	Yes								

Health is Wealth - A Holistic Review of Health Insurance from Consumer Perspectives

Dr. D. Bhuvaneswari[1]

Abstract

This paper focuses on health – the meaning of health, the right to health as a fundamental right, health care in India, health under the umbrella of insurance etc. It also explains the concept of mediclaim policy and the exclusion of domiciliary treatment under that policy.

Introduction

Health especially relates to physical and mental well being of a person. From this stance human rights jurisprudence provides a useful legal and normative framework and a form of guidance for public health actions. Human rights and Public health have a commonalty in concept called well being of individuals. Human rights must be promoted and protected in order to address the underlying determinants of health including the empowerment of individuals and communities to respond the health challenges and to ensure equitable and effective delivery of services. The developmental phase of human rights could be discerned from different newer aspects of rights evolving day by day like right to know, right to development and even right to die.

International instruments like Universal Declaration of Human Rights[2], International Covenant on Economic, Social and Cultural Rights[3] play a vital role in this respect by declaring that everyone has the right to a standard of living adequate for the health and well being of himself and of his family. As said above, the right to health has been accorded the status of an aspirational right in prominent international instruments and through judicial decisions it has evolved to incorporate specific obligations upon States for implementation. Today, there exist a foundational logic for health concerns to be addressed through the language of human rights. The international human right instruments have created a normative framework for governmental action also. One such area of governmental action to implement this socio economic right is insurance.

Right to Health- A Conceptual Outlook

Health as every individual is entitled to possess in this universe commonly known to come under economic and social right[4]. On the floor contest, there seems to be a departure from the traditional focus of human rights, which has been on a guarantee of political freedoms such as the right to free speech and the unfettered practice of

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[2] Universal Declaration of Human Rights, adopted by the UN General assembly on December 10, 1948.

[3] International Covenant on Economic, Social and Cultural Rights Adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force 3 January 1976.

[4] Tony Evans A human right to health? Third World Quarterly, Vol 23, No 2, pp 197-215, 200

religion[5]. Socio economic rights are typically associated with positive entitlements such as health, education, and food; they are meant to ensure that citizens have the basic services and goods needed for their well-being.

A right to health is one of a range of socio economic rights for which States accept an obligation under International law. The preamble of the 1946 World Health Organization (WHO) Constitution defines health broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[6]. The Constitution of WHO defines the right to health as 'the enjoyment of the highest attainable standard of health[7] and enumerates some principles of this right as healthy child development; equitable dissemination of medical knowledge and its benefits; and government provided social measures to ensure adequate health. The 'enjoyment of the highest attainable standard of health' has been recognized as a 'fundamental right' by the international community since the adoption of the Constitution of the World Health Organization (WHO) in 1946[8].

The Universal Declaration of Human Rights, 1948 in its preamble states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care and necessary social services." The United Nations further defines the right to health in Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 which states: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the State Parties of present Covenant to achieve the full realization of this right shall include those necessary for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child, the improvement of all aspects of environmental and industrial hygiene, the prevention, treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

The Convention on the Elimination of All Forms of Discrimination Against Women[9] in its Article 12 of the United Nations Convention on the Elimination of All Forms of Discrimination against Women, 1979 outlines women's protection from gender discrimination when receiving health services and women's entitlement to specific gender-related healthcare provisions[10].

[5] Manjari Mahajan, The Right to Health as the Right to Treatment: Shifting Conceptions of Public Health, Social Research, Vol. 79, No. 4, Human Rights and the Global Economy (WINTER2012), pp. 819-836.

[6] The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on 7 April 1948.

[7] Article 1, WHO Constitution.

[8] Virginia A. Leary, JD, The Right to Health In International Human Rights Law , Health and Human Rights, Vol. 1, No. 1 (Autumn, 1994), pp. 24-56.

[9] CEDAW (Convention on Elimination of Discrimination Against Women) was adopted by the UN General assembly on 19th December 1979, and came into force on September 3, 1981.

[10] Article 12: States Parties shall take all appropriate measures to eliminate discrimination against women in the

India and Health Care

Prior to Independence healthcare in India was in muddle with large number of deaths and spread of infectious diseases. After Independence the Government of India paid attention and laid stress on primary health care and the country put in sustained efforts to better the health care system across the country. The concept of right to life enshrined in Article 21 of the Indian Constitution is very broad and is continuously expanding. This right signifies that life does not mean a mere animal existence but it encompasses everything that is required to achieve a decent and respectful living and hence a right to clean environment and right to have good health come within the purview of right to life. This fact is further reinforced by both High Courts and the Supreme Court as well[11]. The States' duty to provide health care arises from a human rights approach and is predicated on the responsibility of States to design health systems and implement health policies that are consistent with human rights requirements.

Though the Indian Constitution has not included the right to health care as a Constitutional right, the Supreme Court in its judgment has interpreted Article 21 (Fundamental right to life) and Article 47 of the Directive Principles (improving health of the citizens as one of the duties of the government) to mean the right to life as right to live with dignity, including access to basic health care as a right. In a landmark judgment, the Apex Court has opined that, right to health and medical care must be held as fundamental rights under Article 21 read with Articles 39(c), 41 and 43 of the Constitution. In *CESC Ltd. V. Subhash Chandra Bose*[12], the Supreme Court, relied on international instruments and concluded that right to health is a fundamental right and observed that: The term 'health' implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. The maintenance of health is a most imperative constitutional goal whose realisation requires interaction of many social and economic factors. Every individual therefore possesses a right to protect his health either through personal means or seek the assistance of any third party in this regard[13]. The Apex Court has interpreted broadly that right to life includes within its ambit the right to live with human dignity which further integrates to lead a healthy life.

Health and Insurance

In order to achieve the purpose stated above, States are given a mandate through

field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

[11] Akhil Bharatiya Soshit Karamchari Sangh (Railway) v. Union of India, (1981) 1 SCC 246; Maneka Gandhi v. Union of India, (1978) 1 SCC 248; Francis Coralie Mullin v. UT of Delhi, (1981) 1 SCC 608; Paramanand Katara v. Union of India, (1989) 4 SCC 286: 1989 SCC (Cri) 721.

[12] AIR 1992 SC573.

[13] United India Insurance Co. Ltd. v. Manubhai Dharmasinbhai Gajera, (2008) 10 SCC 404

international instruments and provisions both Constitutional and statutory, to ensure that health care provisions reach all. One such way found through is health insurance. Health insurance addresses a major area of public concern. The insurance industry has positioned itself as a basic pillar of our modern society. Insurance is a contract, *Uberrimae fidei*, whereby one party agrees to compensate the loss or discharge the liability of other person. Such promise is made in return of a payment required to be made by the other party. The parties are called insurer and insured respectively and it is the risk to life and property that the insurer takes upon him and provides other party an opportunity to lead a carefree life. Unlike other commercial contracts, the basis of contract profoundly lies upon observance of utmost good faith. Insurance has become an essential ingredient of the risk complexity management strategies for individuals, social groups and businesses.

There are two objectives that insurance fulfils. One is the direct or immediate objective under which it extends immediate financial or other assistance to the insured or his legal representatives. The second objective is to play an active role in the socio-economic progress of the community and the State. The insurance companies have ventured into new areas by way of floating various schemes under which insurers now offer to undertake risks that were henceforth not covered. One such area is insurance in health. In India there is a healthy increase in the demand for health insurance covers and today the sector is the fastest growing segment in the non-life insurance industry of India. It is a fact and also a realisation that people are generally not prepared and is not in a position to meet the unforeseen exigencies of health problems.

Diseases, having no frontiers and disablement due to accidents do not distinguish between the rich and the poor. On the other hand expenditure related to health spares no one. Everyone is equally affected and require equal treatment. In cases of minor health hazards public is ready to bear the cost of treatment but where the medicare requires very heavy and continuous expenditure, one cannot imagine the financial and psychological condition of the victims and their families. Under such situation, the existence of a health insurance acts like a boon or a blessing. No doubt whenever a health problem comes, the person suffers both physically and mentally but insurance cover provides him a relief towards the financial commitment. Assurance of such financial security in fact provides a kind of psychological peace and strength to fight with the unfortunate situations affecting human health. Health insurance or medicare insurance thrives to achieve this objective[14]. It plays an important role in reducing the impact of ill health on the standard of living of households, and in encouraging

[14] Origin of health insurance was first offered in the United States by Franklin Health Assurance Company of Massachusetts in 1850. The history of the concept health insurance can be traced back to the year 1883- 1884, when in Germany, compulsory accident and sickness insurance was initiated by Otto von Bismarck. The same concept was also adopted by Great Britain, France, Chile, the Soviet Union and other nations after World War I. Cf., Dr. V. Vijay Lakshmi, Health Insurance: Policy Renewal and Obligations of Public Insurer Health Insurance: Policy Renewal and Obligations of Public Insurer available at http://www.supremecourtcases.com, viewed on Nov. 15, 2016.

human and economic development. It is generally accepted that insurance against large and unpredictable health expenditures is a key component of social protection and a significant factor in economic development[15].

The constitutional and statutory provisions regulate these insurance contracts and the interest of the community is kept paramount in consonance with the Directive Principles of State Policy. Quoting the observations of the Five Year Plan of our country, the Gujarat High Court[16] observed that health care schemes including Mediclaim are devised to ease the financial burden of the high costs of hospitalization on the low and middle income group population. This would enable such persons, who are covered by such health insurance schemes to avail of a better quality of medical services which otherwise might be out of the reach of such persons. The Mediclaim Scheme is, therefore, not a subject of mere private concern of two contracting parties, but a result of national concern reflected in the norms of national health policy.

Mediclaim Policy- The Practical Difficulties

One of the areas that result in disputes between the insured and the insurer is the wording of policy. It was decided by the Supreme Court of India in *General Assurance Society Ltd. v. Chandmull Jain and another*[17], "In other respects there is no difference between a contract of insurance and any other contract except that in a contract of insurance there is a requirement of *uberrima fide* i.e. good faith on the part of the assured and the contract is likely to be construed *contra proferentem* that is against the company in case of ambiguity or doubt. A contract is formed when there is an unqualified acceptance of the proposal. Acceptance may be expressed in writing or it may even be implied if the insurer accepts the premium and retains it. In the case of the assured, a positive act on his part by which he recognises or seeks to enforce the policy amounts to an affirmation of it. In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves.

Further in *National Insurance Co. Ltd. Vs. Laxmi Narain Dhut*[18], it was held thus:- "It is also to be noted that the terms of the policy have to be construed as they are and there is no scope for adding or subtracting something. However liberally the policy may be construed, such liberalism cannot be extended to permit substitution of words which are not intended[19]. Therefore, the terms of the contract have to be construed strictly without altering the nature of the contract as it may affect the interest of parties adversely.

[15] Armando Barrientos , Health insurance - Essential to social development , International Union Rights, Vol. 7, No. 4, Struggling for a social wage: Focus on social security (2000), pp. 6-7 published by International Centre for Trade Union Rights.

[16] Cf., Purnima Prasad And Ors. vs The Oriental Insurance Company., 2007 ACJ 2213, AIR 2006 Pat 158.

[17] 1966) 3 SCR 500,

[18] (2007) 3 SCC 700, Para no.18.

[19] See also, Polymat India (P) Ltd. v. National Insurance Co. Ltd.,(2005) 9 SCC 174.

In this connection, more attention could be invited to decision of this Court in the case of *United India Insurance co. Ltd Vs. M.K.J. Corporation*[20] wherein it was observed as under: "After the completion of the contract, no material alteration can be made in its terms except by mutual consent." *Shrilekhavidhyarthi Vs. State of U.P*[21] is an authority for the proposition that the State Government has to act reasonably and without arbitrariness even with regard to the exercise of its contractual rights. In *Bimon Krishna Bose Vs. United India Insurance Ltd (2001)* the question was whether an insurance company could arbitrarily and unreasonably refuse the renewal of a policy. Considering that the insurance company, as a result of State monopoly in the insurance sector, had become 'State' under Article 12 of the Constitution, this Court held that the insurance company has to satisfy the requirement of reasonableness and fairness while dealing with the customers. Even in an area of contractual relations, the State and its instrumentalities are enjoined with the obligations to act with fairness and in doing so, can take into consideration only the relevant materials. They must not take any irrelevant and extraneous consideration while arriving at a decision. Arbitrariness should not appear in their actions or decisions. The latest decision in *M/S BHS Insustries Vs. Export Credit Guarantee Corporation* Contracts of insurance are contracts of *uberrima fides* (utmost good faith) and every material fact is required to be disclosed. In a contract of insurance, there is a requirement of good faith on the part of the insured and in case of ambiguity; it has to be construed against the company. The insurance policy has to be strictly construed and it has to be read as a whole and nothing should be added or subtracted. That apart, it is the duty of the Court to interpret the document as is understood between the parties and regard being had to the reference to the stipulations contained in it.

Viewing from the above dictum of cases a review could be made of the important issues that arise from Mediclaim policies. Most of the Mediclaim policies contain minimum 24 hours hospitalisation clause which seems to go against the purpose and objectives behind Mediclaim policy. In an era of social welfare State where the government aims at *'Health for all'* a wider sweep could be given and the concept of Mediclaim itself suggests it cannot be limited to hospitalisation, but must include domiciliary treatment or medical expenses incurred at home for a disease contracted or injury sustained. Hospitalisation is made compulsory or condition precedent to avail reimbursement in these cases.

There are incidents happening where the insurance companies deny reimbursement for ten minutes less than 24 hours of hospitalisation. In a land mark judgment *Satwant Kaur Sandhu Vs. New India Assurance Company (10th July 2009)* the Supreme court of India has held that "a Mediclaim policy is meant to assure the policy holder in respect of certain expenses pertaining to injury, accidents or hospitalisation."

[20] (1996) 6SCC 428.
[21] AIR 1991 SC 537.

The Court's interpretation of Mediclaim policy and use of the word 'or' implies if something could be treated at home hospitalisation need not be a condition precedent for reimbursement. The mental psychology of any person will be not to get admitted in a hospital unless it is essential. Moreover hospitalization entails not only extra cost which the insurer company is going to bear but also the danger of picking up of acute infections in hospitals that will prolong hospitalisation which may ultimately be a burden for the insurance company alone.

Being held that insurance is a uberriame fide contract insurance companies most of the time perform Produnova vault! The companies for convenience cite the minimum 24 hours of hospitalisation clause to deny a claim for domiciliary expenses. If hospitalized they would question about the need for hospitalisation. In the case of *Unnikrishnan Vs. New India Assurance* the Kochi ombudsman ruled in favour of the policy holder after the company repudiated a claim on the ground that a fracture did not require hospitalisation. Similarly in *Ganesh Chandra Roy Vs. Heritage Health TPA & National Insurance* the West Bengal State Consumer Disputes Redressal Commission rejected the argument of the company and held in favour of the holder when the company contended that he admitted his wife for blood transfusion only to get the benefit of a costly injection which was used for a pre-existing disease.

The Insurance Regulatory Development Authority in its circular titled 'Guidelines on Standardisation of Health insurance' (2013) has prescribed two conditions to avail 'domiciliary hospitalisation'[22]. The phrase used itself looks contradictory as a home will never be a hospital. The conditions are (1) the patient should be in no position to be moved to a hospital. (2) And the hospital should not have a room available. These conditions do not go in line with the present scenario for the following reasons. Living in a fast food world and age of even air ambulance the first condition would be rarest of rare cases. Today with the existence of comparatively wide network of hospitals, the question of non availability of room hardly arises. Article 47 of the Constitution casts a duty upon the State to improve public health. So the regulatory authority, an instrumentality of the State cannot scoff at the concept of domiciliary treatment that seems to catch on as seen above from the judicial pronouncements.

Conclusion

Healthy India makes Wealthy India and will hasten the progress of the country. The growth of Indian healthcare industry is at a rapid pace and there is growing evidence that the level of health care spending in India is considerably higher than that in many other developing countries. But still there exists a wide gap between the rural and urban population in its health care system. Improvement in healthcare infrastructure and facilities and ease of access to those services is the only way India can fight against all diseases. According to Annual Report on health by the Ministry

[22] Insurance Regulatory Development Authority, Guidelines on Standardization in Health Insurance IRDA/HLT/CIR /03<T/02/2013 20/02/2013.

of Health and Family Welfare, Government of India about 71% of the total health care expenditure in the country was borne by households out of their pockets. Despite such a high share of expenditure by individuals, the provision of health care, that is adequate in terms of quality and access, is becoming more and more problematic for the simple reason that the benefit implications of insurance schemes do not reach the people that result in lack of medically insured population. As discussed above the existence of more stringent provisions like excluding domiciliary treatment from the purview of insurance policy also goes anti-consumer. So a wider ramification is required whereby a balanced approach is taken on the issues arising between the insurer and the insured aiming at justice for all for which more concerted action on the part of the government is need of the hour.

Exclusion of Pre-Existing Diseases in Health Insurance Policies

Dr. C. Manohar[1]

Abstract

This Paper deals with the condition of pre-existing disease while taking an insurance policy. The circumstances under which "non-disclosure of material fact" will be invoked are discussed.

What are Pre-existing Diseases/conditions?

Diseases which existed prior to inception of the policy for the first time provided the policy is continuously renewed thereafter without any break.

Definition finalized by the Industry Body – General Insurance Council in India

Any condition, ailment or injury or related condition for which the insured had signs or symptoms, and/or was diagnosed and/or received medical advice/treatment, prior to inception of the first policy.

Do health insurance companies have a standard definition for pre-existing diseases?

Different health insurance policies have different definitions for pre-existing diseases. According to some policies, a pre-existing disease is that which shows in a person's past medical history, while other policies have a narrower definition that includes those diseases as pre-existing for which the insured person had sought consultation or was treated or was aware of the ailment during the last 4 years from the time he signs the proposal form.

Is pre-existing disease/ condition so simple?

No. Pre-existing condition is not only the term used for illnesses that a person has at the time of buying a policy but it also includes:

Medical history of illness	: History of heart attack, gestational diabetes, etc.
Hospitalization history	: Hospitalization in case of angioplasty, kidney stone, etc.
Signs	: Increase in sugar level, obesity, etc.
Symptoms	: Having brain fog, feeling sweaty, etc.
Medication for any disease or illness	: Hypertension medication, diabetes medication, etc.
Skin disorder	: Psoriasis, Vitiligo, etc.
Major accidental injury	: Head injury, having prosthetic limb, etc.
Diagnosed illnesses	: Diabetes, hypertension, etc. that the insured had before or has at the time of buying a policy.

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Why should there be Pre-existing diseases/conditions exclusion clause in Health Policies?

If this clause is not there, insuring public will be tempted to avail cover only when they know there is going to be a necessity for admission into a hospital for treatment of some known disease. As a result, most of the policies will end up in paying claims which in turn will result in hiking the premium rates in future. Moreover, this will defeat the very purpose of insurance. The main purpose of insurance is to mitigate UNFORSEEN and UNTIMELY MONETARY LOSS.

Pre-existing diseases are excluded under the policy and are invariably not covered in most of the policies during the first four years.

It is immaterial whether the pre-existed disease is

- Treated
- Not treated
- Declared in the proposal
- Not declared in the proposal

Exclusion is not limited to the pre-existed diseases alone but will include complication arising from such pre-existing diseases.

To understand how far the complication will create impact, complication from Diabetes and Hypertension is illustrated below:

Diabetes	Hypertension	Diabetes & Hypertension
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy
Diabetic Foot /wound	Internal Bleed/ Haemorrhages	Diabetic Foot
Diabetic Angiopathy	Coronary Artery Disease	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper / Hypoglycaemic shocks		Hyper / Hypoglycaemic shocks
Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular accident
		Hypertension Nephropathy
		Internal Bleeds/ Haemorrhages

In respect of the following policies, pre-existing disease are excluded for the first 48 months:

- Religare Care
- Apollo Munich Easy Health Standard
- New India Individual Mediclaim
- Oriental Insurance Individual Mediclaim

- National Individual Mediclaim
- Chola MS Individual Health Insurance (Basic Health Cover)
- Bajaj Allianz Health Guard
- Universal Sompo Retail Individual Health Insurance
- HDFC Ergo Health Suraksha
- Star Health Medi Classic
- Max Bupa Heart Beat Gold
- Tata AIG Medi Prime

There are a few exceptions where pre-existing diseases are covered from day one but of course with some rider.

Immediate coverage

- In Group policies pre existing diseases are invariably covered from day one. There is no waiting period of 4 years as in most of the individual policies.

Immediate, with conditions

- In Star Health Senior Citizen Red Carpet policy which covers the age group of 60-75 years, pre existing diseases are covered in the first year itself and the condition to be fulfilled is no treatment should have been availed for the pre existing diseases in the last 12 months period. Another condition is first 50% of any bills arising out of hospitalisation for pre existing conditions/diseases will be payable.

From second year

- Bajaj Allianz Silver Health Policy covers pre-existing diseases from second year onwards and the amount payable will be limited to 50% of the sum Insured.

From third year

- ICICI Lombard complete Health Insurance policy with Sum Insured of 3 lacs and above covers pre-existing diseases from third year onwards.
- SBI Life Smart Health Insurance also covers pre-existing diseases from third year onwards.

From fourth year

- L&T Classic and IFFCO Medishield covers pre-existing diseases from fourth year onwards.

To Declare or Not to Declare Pre-existing diseases.

Pre-existing disease is excluded from the scope of the policy whether it is declared in the proposal or not. But it is always better to disclose all the pre-existing diseases. If pre-existing diseases is declared, Insurer may charge higher premium and

may impose some additional conditions. Of course, Insurer cannot load its customer for any disease that occurs after issuing the policy and renewing it without any break as per IRDAI mandate. If it is not disclosed, Insurer will invoke the clause "Non disclosure of material fact" and may result in cancellation of the policy from the beginning.

It is always better to disclose the pre-existing diseases and one is saved from invoking of "Non disclosure of material fact" clause by Insurer.

In case of non disclosure of pre-existing diseases by insured, the insurers mainly rely on the discharge summary. But of late there have been many instances where the disease is found to be pre-existing as per hospital in-house case sheet whereas in discharge summary it is not pre-existing. Now insurers have started relying more on the details of in-house hospital case sheet rather than discharge summary.

Portability of Health Policies

If a health policy is ported from one insurer to another insurer the waiting period spent with the previous insurer will be taken into account by the current insurer. For example a person was having a policy with A insurance company where there is a waiting period of 4 years for his pre-existing disease diabetes. If the policy is ported to B insurance company after two years, waiting period for pre-existing diseases will be the balance 2 years only and not a fresh 4 years .

	I yr A Ins Co	II Yr A Ins Co	III Yr B Ins Co	IV Yr B Ins Co	V Yr B Ins Co
Pre-existing Diseases covered or not	No	No	No	No	Yes

Enhancement of Sum Insured and its effect on Pre-existing diseases

If Sum Insured is enhanced then the waiting period will start afresh for the enhanced Sum Insured. For example a person having pre-existing diseases declared in the proposal enhanced the sum insured from 3 lacs to 5 lacs in the fifth year policy. In the fifth year policy pre-existing diseases are no more under exclusion and payable but will be limited to the Sum Insured of Rs.3 lacs and not Rs.5 lacs which is the Sum Insured in the Fifth year policy. The 5 lacs will be effective for pre-existing diseases 4 years after the enhancement. Effectively in the ninth year in the instant case. The same is illustrated in the table below mentioned:

Year of Policy	Pre existing Diseases Sum Insured
First	0
Second	0
Third	0
Fourth	0
Fifth	3 Lacs
Sixth	3 Lacs
Seventh	3 Lacs
Eighth	3 Lacs
Ninth	5 Lacs

Conclusion

Always disclose pre-existing diseases/conditions and do not give chances for insurers to invoke the clause "Non disclosure of material fact" which may end up in cancellation of the policy from the beginning. Changing insurer does not elongate the waiting period. Increase in Sum Insured invites fresh waiting period.

Fraudulent Health Insurance Claims Jeopardize Insurance Industry and Nation's Economy

Dr. S. Raja Lakshmi[1]

Abstract

Insurance may be described as a social device to reduce or eliminate risk of life and property. Among the insurances health insurance is a very important one. Health care has always been a problem area for India, a nation with a large population and larger percentage of this population living in urban slums and in rural area, below the poverty line. The government and people have started exploring various health financing options to manage problem arising out of increasing cost of care and changing epidemiological pattern of diseases. A serious problem facing the sector is the growing number of fraudulent claims. Therefore, in this paper the focus is on fraud detection and elimination or minimization of fake claims.

Introduction

General insurance fraud is undergoing a sea change in its character. It is no more confined to the domain of white-collar crime, but surpassed into a full fledged scam, world over, posing a serious threat to the global economy. What's visible is only the tip of the iceberg and a lot more lies underneath. Difficult to prove, soft frauds in General Insurance are more rampant now than hard frauds. Practitioners of General Insurance are aware of the significant increase in soft fraudulent insurance claims[2]. This trend was noticeable even before the onset of recession. No attempt has been made in India to assess the extent of these fraudulent claims (both soft and hard) and the financial implication of such accumulation on balance sheet. It should however be appreciated that as long as there has been insurance, there have been fraudulent insurance claims also. These cannot be eliminated altogether. But these must be contained within a reasonable limit. This indeed is a challenge for the insurer. Soft frauds refer to the tendency of padding genuine claims for covering policy excess, insurance premium, etc. Some see claims as an opportunity to make some money. Hard frauds refer to claims which are staged (fake claims) with the sole purpose of making money. Whereas soft frauds are isolated crimes of opportunity, hard frauds refer to sophisticated organized crime.

Fraudulent health insurance claim

An insurance claim prepared with the intention to deceive, conceal or distort relevant information that eventually accounts for health care benefits for an individual or a particular group is defined as fraudulent health insurance claim. Thirty-five hospitals across the state of Tamil Nadu , including five in Chennai, have been blacklisted by

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[2] Health Insurance in India - Thomas K T , Sakthivel R

the Tamil Nadu[3] Health Systems Project (TNHSP) for fraudulent claims and other violations under the chief minister's health insurance scheme.

Frauds can be committed by anybody – either by a policyholder, a healthcare provider or even its employees.

Frauds committed by a policyholder could consist of members that are not eligible, concealment of age, concealment of pre-existing diseases, failure to report any vital information, providing false information regarding self or any other family member, failure in disclosing previously settled or rejected claims, frauds in physician's prescriptions, false documents, false bills, exaggerated claims etc

Frauds by Healthcare Provider or its employees include preparation of bogus claims by fake physicians, billing for products or services not rendered, exaggerated claims submission, billing prepared for higher level of services, modifications or alterations made in submission of claims, change in diagnosis of the patient, fake documentation, and fraud committed by the employees of a hospital or any other healthcare product/service provider in order to make a quick buck.

Fraudulent and dishonest claims are a major morale and a moral hazard not only for the insurance industry but even for the entire nation's economy. Concrete proof as evidence including documentation, statements made by the policyholder and his family members and even neighbors are taken into consideration.

Health insurance industry is growing and being chanted about like the new mantra, but, still India is facing a huge loss in this sector because of the everyday increasing fraud claims. Fraudulent health insurance claim actually is a claim generated to cover or deform information which is designed to provide health care benefits. Frauds can be of many types and committed by insurer or the insured.

Deliberate and Opportunity Fraud

Deliberate fraud is purposeful act of presenting accident or loss which is covered under the policy. Whereas, opportunity fraud is created by a policyholders by over stressing a genuine claim or providing wrong information related to the pre-existing diseases etc. to get the underwriting done in their favor.

External and Internal Fraud

External fraud is claimed by either an individual or entities like policyholder, beneficiaries, medical service providers or vendors against a company. Internal fraud on the other hand is carried out against a policyholder or its company by other employees like manager, executive or agents.

Policyholder's Fraud

Now-a-days, consumers have become aware of the norms, features and rules

[3] http://timesofindia.indiatimes.com/city/chennai/35-private-hospitals-pulled-up-for-fraudulent-insurance-claims/articleshow/19251169.cms

of the insurance and have started getting benefited by being involved in frauds. Policyholder frauds are divided into 3 categories – eligibility fraud, claim fraud and application fraud.

Eligibility Fraud

This fraud generally constitutes the falsification of the information provided about the insured's employment status, pre-existing diseases or information concerning the dependent. Here, the beneficiary is paid benefits illicitly, for example, if a person submits claim for the dependent or relative who is not covered under the policy. Another case is when a part-time employee is not covered under some health plan provided by the company for full-time employees but, my generating false records with any HR employee he is successful in receiving the benefits[4].

Application Fraud

It is generally committed in the health insurance sector where the consumer knowingly enters forged information in its application related to the pre-existing diseases, claim or important dates. For instance, a policyholder might not enter the details related to his pre-existing diseases or serious medical conditions in order to get an extensive cover and have problem free claim filing. Even, at times, the employer plays with the joining date of the employee by getting things approved from the insurance company.

Claim Fraud

When a consumer enters an illegal claim for whose benefit he is not entitled for, the fraud is called claim fraud. He can ask for a false claim which is especially seen under maternity covers. In such intentional cases, the provider and member are seen to go for collusion and thus, benefiting the physician. These kinds of groups are also known as fraud rings. Another case - a policyholder can even turn to create an insurance speculation, wherein, he purchases several health insurance policies without letting the insurance companies know this fact and enjoy claim settlement from all. Moreover, the agents or hospitals generate higher medical bills related to hospitalization, treatment etc. to cheer their pockets.

Fraud- Essential Components

The essential components of fraud include intention to deceive, derive benefits from Insurance industry, preparation of exaggerated or inflated claims or medical bills and malafide intention to induce the firm to pay more than it otherwise would. Devising innovative methods and tactics including pressure tactics, favoritism, nepotism etc form a part of fraud which is a hazard growing by leaps and bounds since the last decade. To establish that a fraud has been committed requires furnishing of relevant proof. An in-depth analysis of the policyholder's intention may also be taken into consideration.

[4] www.sas.com/industry/healthcare/insurer/fraud.html

Statistics in India and USA

According to a recent survey it is estimated that the number of false claims in the industry is approximately 15 per cent of total claims. The report suggests that the healthcare industry in India is losing approximately Rs.600-Rs.800 crores incurred on fraudulent claims annually. Health insurance is a bleeding sector with very high claims ratio. Hence, in order to make health insurance a viable sector, it is essential to concentrate on elimination or minimization of fake claims. Insurance companies in USA incur losses over 30 billion USD annually to healthcare insurance frauds.

Enactment of HIPAA by USA to deal with Health Insurance Fraud

Due to fraudulent cases especially health claims on the rise in USA, a special legislation was enacted by Congress with the introduction of HIPAA (Health Insurance Portability and Accountability Act) in 1996. This Act especially deals with healthcare fraud which is treated as a Criminal Offence accompanied with rigorous imprisonment up to 10 years with additional financial penalties depending on the fraud intensity.

Fraud Detection

Fraudulent Claim Triggers

It has been observed that frauds pertaining to health insurance usually possess some sort of common trends or patterns. There are certain parameters that can be employed as a trigger to detect false claims or practices which have been enlisted below:

- treatment expenses are usually on the higher side as compared to the etiology or routine healthcare expenses from that particular hospital.
- unnecessary and costly investigations are being carried out.
- diagnosis of the ailment and the investigations done are not in-sync with each other.
- duration of stay in the hospital is for an extended period, with no positive outcome.
- increased hospitalization admissions during a particular period.
- post-operative histopathology reports are not available (surgical cases).
- x-Ray films and reports are not available.
- in most fraudulent claims, the treating doctor, agents, and ailments are the same.
- medical bills are in serial order.
- patient residence and the hospital, chemist address, are not geographically same.
- fraud claimers usually purchase short-term policy with sum insured being low.
- increase in per-patient cost.
- higher number of per-patient average visits.
- higher number of per-patient average medical investigations.
- fluctuating monthly claims of the healthcare providers.

Measuring Fraud Data

Measurement of fraudulent data is an elusive target. No single method used for fraud detection is considered as wholesome or holistic. Collection of fraudulent data is mostly done by a group in unison. It is never done individually. It is a gradual process done on piecemeal basis. In short, it is an ongoing process. Different insurance companies gather data regarding insurance frauds in methods that vary considerably from each other. There is lack of agreement regarding a uniform method to be devised for detecting fraud committed by a policyholder or by a healthcare provider. The quality, volume of data, data specimens and their scope compiled in the database varies considerably in their features. In addition, there are numerous independent agencies, fraud detection agencies, investigation agencies, legal agencies, insurance industry squads, watchdogs that conduct research on fraudulent data[5].

Dealing with Fraud

Methods of dealing with Insurance Frauds

Legal Enquiry

A legal route is initiated to deal with frauds being committed in Insurance sector. A fraud committed in Insurance sector is treated as both – a civil and a criminal offence under law and the guilty individual can be punished under both the aforesaid offences. Such a fraud is also treated as a white-collar crime. Examples of white collar crime in insurance sector include insider trading, insurance fraud, tax fraud, securities and investment fraud, and identity theft.

Electronic Transactions

Electronic Transactions are currently being devised to overcome fraudulent Health Insurance Claims. E-transactions are in the process of coming up with the authorization approval process until the revenue accrual process becomes electronic in nature. Already IBM India has commenced online claim management solutions. In turn, this would lead to a maturing of the Revenue Cycle Management Business. On account of this development process, the speed of online processing operations will introduce a greater transparency with regards to the management of claims and their speedy settlement.

SAS software

SAS (Statistical Analysis System), this specialized software is being implemented in the market to deal with frauds in Insurance sector. Benefits of SAS software include:

- fraud Detection and Alert Management
- systematic detection of any sort of suspicious activity
- generation of alerts from multiple monitoring systems

[5] Health Insurance for Rich and Poor in India - Dr. L.P.GUPTA

- alert Prioritization
- fraud scoring engine

Implications of Fraudulent claims[6]

- It is treated as an offence – under both civil and criminal laws.
- The person is stripped of the benefits of insurance policy cover.
- The person is sentenced to rigorous imprisonment. The duration of imprisonment varies from nation to nation.
- A heavy financial fine is levied on the guilty individual.
- It has definite implications on the economy of the country.
- Increase in the number of fraudulent claims leaves the insurance sector bleeding and this in turn has an impact on the financial institutions of the country and subsequently impacts the economy.
- Instead of an upward graph, there is a downward slide observed in case of increase in number of fraudulent cases during a particular period.
- Instead of a blooming and a rosy economy, the economy becomes dark and gloomy on account of selfish motives by certain citizens of the country.

Fraudulent Health Insurance Claims and the role of Indian Penal Code

There is no separate legislation dealing with fraud as in the United Kingdom or the USA. Fraudulent activities are covered by the Indian Penal Code which defines the expression 'fraudulently' – 'a person is said to do a thing fraudulently if he does that with intent to defraud but not otherwise'. The expression fraudulently occurs in Sections 206, 207, 208, 242, 246, 247, 252, 253, 261, 262, 263 and Sections 421 to 424[7] of Indian Penal Code.

It is a matter of concern that 'insurance fraud' is not defined under the Indian Insurance Act. The Indian Penal Code (IPC) & Indian Contract Act, also do not offer specific laws to control Health Insurance Frauds. Sections of the IPC which deal with issues of fraudulent act, forgery, cheating etc. do not specifically target at insurance fraud and are inadequate for purpose of acting as an effective deterrent. IRDA recently quoted the definition provided by the International Association of Insurance Supervisors (IAIS) which defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties." IRDA has also made it mandatory for the Insurers to have a Board approved policy on Fraud Management so that outgo due to such claims can be checked. It will surely benefit the policy holders to whom the cost burden is transferred by hiking premium charges.

[6] www.insurancefraud.org

[7] The Indian Penal Code - Ratanlal , Dhirajlal

In the absence of specific laws and harsh punishments, prosecution will rarely be successful and if successful, the penalty inadequate to deter others. Frauds by Healthcare provider or its employees make the situation difficult for underwriters. The absence of regulatory vigil on such providers makes the task more difficult for the health insurers as they have little control over the medical care providers.

Conclusion

Health Insurance sector in India is witnessing a tremendous change. With the rising cost of healthcare expenses and awareness about insurance products, the health insurance portfolio in India is increasing rapidly. Let's develop a culture where it becomes difficult to commit fraud / leakages and get away with it. This is in the best interest of insuring public at large, the Insurance Companies as also the society. Claims settlement being a key service parameter, and therefore, while every effort should be made for speedy settlement of claims, a balance has to be maintained to ensure claims of doubtful nature are properly examined and looked into before they are passed.

Travel Insurance – Issues and Challenges

Dr. A.Vasanthi[1]

Abstract

This paper deals with the importance of travel insurance, the types of travels plans available, the initiatives taken by the Government to boost travel insurance, recent developments in the travel insurance sector and the opportunities and challenges facing the sector.

Introduction

Tourism industry is evidently a large international industry with huge potential for growth. Tourism is a complex industry because of its multi-faceted activities which together produce the tourism product. Industrialization enables societies especially the western countries to produce a range of consumer products in mass quantity. However like consumer products, tourism also assumed huge proportions, resulting in a multiplicity of products and sales intermediaries trying to get maximum share of the market.

Insurance

A financial risk management tool in which the insured transfers a risk of potential financial loss to the insurance company that mitigates it in exchange for monetary compensation known as the premium. Insurance industry of India consists of 53 insurance companies of which 24 are in life insurance business and 29 are non-life insurers. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company. Apart from that, among the non-life insurers there are six public sector insurers. In addition to these, there is sole national re-insurer, namely, General Insurance Corporation of India (GIC Re). Other stakeholders in Indian Insurance market include agents (individual and corporate), brokers, surveyors and third party administrators servicing health insurance claims. Out of 29 non-life insurance companies, five private sector insurers are registered to support policies exclusively in health, personal accident and travel insurance segments.

Trends in Outbound Travel Industry

The travel and tourism industry has emerged as one of the largest and fastest growing economic sectors globally. The growth in the Indian travel and tourism industry is driven by a combination of rising income levels and changing lifestyles, development of diverse tourism offerings, and policy and regulatory support by the government authorities. According to the Ministry of Tourism and World Bank, 18.33 million Indians travelled overseas in 2014 compared to around 16 million in 2013. UNWTO predicts that Indian outbound has potential to grow to 50million by 2020.

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Some of the reasons for the outbound growth are: GDP growing over 7%, growing air connectivity with LCC's expanding its footprint in India, urban middle class expected to cross over 500mn marks by 2025, growth of woman business travellers possibly by 89% by 2030 which is currently pegged at 25% of the total business travel and rise in senior travellers to 7.3 million by 2030 from 1.3 million in 2013. Among Indian travellers in the total outbound travel sector, 40 per cent is business travellers, 20 per cent pertains to leisure, 20 per cent to visiting friends and relatives (VFR) and 20 percent comes under others including students.

In terms of market size, World Travel & Tourism Council's Travel & Tourism Economic Impact 2014 says that the total expenditure on outbound travel in India was Rs.75,000 crore in 2013 and is projected to be Rs.160,500 crore in 2024. This has prompted several NTOs to adopt an aggressive strategy for Indian outbound market. Statistics suggests that Dubai, USA, Thailand and Singapore have already welcomed more than 1 mllion Indian guests and aiming to have a consistent double-digit growth. The UK, Australia, Indonesia, Turkey, Oman, Sri Lanka and Maldives have already set their targets for the Indian market. Countries like Canada, Indonesia, Philippines, Mauritius, Jordan, Taiwan and Kenya amongst others are also seeing an increase in influx of Indian tourists.

Importance of Travel Insurance

Travellers have for years, underestimated the significance of travel insurance, as its purpose only comes to fore when things go wrong. Travel insurance seems like an unnecessary expense. While travelling may take most exciting, exhilarating, colourful and vibrant corners of the planet, it also comes with a fair share of risks and dangers of the unforeseen. Political unrest, a natural disaster or a medical emergency can force to cut short the trip and return home earlier than planned. However, travel insurance is a special type of insurance designed to cover the individual from a variety of travel related perils.

The primary reasons to take travel insurance plan is to get assistance during situations like personal accidents, illnesses, hijacking, theft, personal liability expenses or any other travel-based issues, while visiting a new destination. Carrying a comprehensive travel insurance policy assures a safe trip. Given below are some of the key benefits of travel insurance plans:

- travel Insurance policies offer compensation for flight delays, trip delays, etc., when individuals make long trips abroad.
- an expense with regard to trip termination is also compensated through travel insurance plans.
- medical treatments, hospitalization and hotel accommodation for medical emergencies are also included under a travel plan.

- customers can get customized plans according to the destination they are travelling to. The premium amount varies as per the destination.
- travel insurance policyholders can also get cover for personal liabilities, accidental death, travel delays, legal expenses, dental treatments, repatriation and emergency reunion.
- insurers across the country offer 24/7 customer service support to policyholders providing them with assistance for loss of documents, accidents, etc.

Types of Travel Insurance Plans

There are number of options available to Indian travellers from various general insurance companies. These travel plans are offered according to the type of customer, destination travelled to and also the type of trip undertaken. The different types of travel insurance plans available in India are given below:

International Travel Insurance Plans

General insurance companies across India offer customised international travel insurance plans according to the destination travelled to. Each type of destination has a specific requirement with regards to insurance and companies ensure that every detail is covered in a comprehensive overseas travel plan. Most international travel plans offer standard features like cashless hospitalisation, no medical test requirement until the age of 80, easy online applications and hassle-free paperwork. In addition, some travel plans might offer other benefits like free international SIM cards, 24/7 customer support and cover for total loss of checked-in baggage. International Travel Insurance plans offered are as follows:

Overseas travel plans are categorised according to the geography of trip, i.e., unique plans for Asian countries, Schengen countries, Middle East, America, Canada, Australia and New Zealand, etc.

- Senior citizens can travel stress-free with a **Senior Citizen Policy** to any destination across the world with benefits like cashless hospitalisation, cover for delayed or missed flights, cashless medical facilities and medical concierge services.
- **A single round trip plan** can also be procured by individuals to get travel insurance for one trip to a single destination with a fixed duration of travel. The duration of the insured single trip will vary depending on the insurance company chosen by the customer.
- **Annual multi-trip plans** offer travel insurance protection covering several international trips for a period of one year. When a customer opts for a multi-trip policy, a certain number of trips for a specified duration of travel are insured by the policy with benefits like cashless hospitalisation, quality health care services and quick settlement of claims. These plans are ideal for frequent international travellers. Most annual multi-trip plans offer insurance cover for travel extending for a period of 30, 45 or 60 days.

Student Travel Insurance Plan

A comprehensive Student Travel Insurance plan offers financial and medical assistance to students travelling abroad to complete their higher education. Students might face emergencies or other financial hurdles while staying in a new country and a robust travel insurance plan helps them to continue with their education without any worries. These plans can be taken by student who are already pursuing their education abroad or are planning to go abroad. The insurance cover offered extends for the entire duration of the course.

Corporate Travel Insurance Plans

A Corporate travel insurance plan can be procured by corporate employers who intend to provide insurance protection to their employees while they are abroad. Corporate plans can be customised according to the requirements of the organisation. All plans offer adequate medical and travel-related cover for policyholders and are available as multi-trip and single round trip policies.

Domestic Travel Plans

Any individual travelling within India can also get a domestic travel insurance plan with covers for medical expenses, loss or theft of baggage, emergency medical evacuation, cancellation and delay of trips, 24/7 customer support, personal accident cover and emergency cash assistance.

Group Travel Insurance

Group travel plans can be availed if there are atleast 20 or more individuals travelling together to a single destination as a group. Most group insurance plans offer cover for trip cancellations and curtailments, delay and interruption of trips, loss of baggage and documents, etc. Since the travel is being done as a group, every member should be completely aware of the benefits offered under the policy that has been availed.

Family Travel Insurance

Family travel plans can be taken for a single family inclusive of the policyholder and his/her spouse and two children. Most family travel insurance plans offer floater benefits to individual family members under one policy. Medical expenses for hospitalisation, personal accident, hospital allowance, trip delays, loss of baggage, documents, home burglary insurance, etc.

Senior Citizen Travel Insurance

Senior citizens can travel around the globe without any trouble with a comprehensive travel insurance plan offering benefits like cashless medical services, medical concierge services, quality health care facilities, international SIM cards, cover for pre-existing conditions, accidental bodily injury, loss of documents, trip delays/

cancellation, third party damage, distress allowance, etc.

Customised Travel Insurance Plans

Some general insurance providers offer customised plans for special regions across the world.

Schengen Travel Insurance

Individuals travelling to the Schengen area for a maximum period of 90 days have to compulsorily avail a Schengen travel insurance policy or a health insurance plan along with the Schengen Visa. Schengen travel insurance policies generally include benefits like emergency medical expenses, repatriation, 24/7 assistance, accidental bodily injury, death or permanent disability, third party liability, extended protection for the family, etc. The countries included under Schengen travel are Austria, Czech Republic, Belgium, Denmark, Finland, Estonia, Germany, France, Iceland, Greece, Latvia, Hungary, Italy, Lithuania, Liechtenstein, Luxembourg, Malta, Netherlands, Norway, Portugal, Poland, Slovakia, Spain, Slovenia, Switzerland and Sweden.

Asia Travel Insurance

Travel insurance policies specific to Asian countries offer travellers comprehensive protection while visiting most Asian and Southeast Asian countries, excepting a few. The exclusions will be specified in the policy issued by the insurer. Benefits included under such policies are emergency medical cover, accidental bodily injury, third party liability, emergency financial assistance, loss of passport, distress allowance, etc.

Insurance Companies

Various insurance companies offering travel insurance plans are Apollo Munich Travel Insurance, Bajaj Allianz Travel Insurance, BHARTI AXA Travel Insurance, Cholamandalam Travel Insurance, Future Generali Travel Insurance, HDFC ERGO Travel Insurance, ICICI Lombard Travel Insurance, IFFCO Tokio Travel Insurance, Oriental Travel Insurance, Reliance Travel Insurance, New India Assurance Travel Insurance, National Insurance Travel Insurance, Religare Travel Insurance, Royal Sundaram Travel Insurance, SBI Travel Insurance, STAR HEALTH & ALLIED Insurance, United India Travel Insurance, TATA AIG Travel Insurance, Universal Sompo Travel Insurance etc.

Travel Insurance Coverage

The travel insurance policies normally cover the following areas:

- medical emergencies such as accident or sickness
- accidental death, disablement, or injury benefits
- evacuation on an emergency basis
- costs of funeral outside the country
- repatriating remains

- baggage, travel papers, or personal effects lost, damaged, or stolen
- returning a minor
- baggage delayed and substitution of necessary items on an emergency basis
- cancellation of trips
- missing flight connection owing to schedule of the carrier
- interruption of tours
- delays in travel owing to weather conditions

These plans also cover additional areas like the following:

- pre-existing conditions like diabetes or asthma
- extra accidental death and dismemberment coverage
- sports that are deemed to be risky like scuba diving and skiing
- insolvency of a third party supplier like airline or hotel that accept only non refundable payments
- travelling to countries where the risk factor may be higher due to situations like war, terrorist acts, or some sort of natural disaster

Government Initiatives

The Government of India has taken a number of initiatives to boost the insurance industry. Some of them are as follows:

- The railways has launched a scheme allowing a person to get an insurance cover of upto Rs.10 lakh on booking a train ticket online by paying less than one rupee. A person booking a train ticket through the IRCTC website will be able to opt for travel insurance cover for a premium of 92 paise only. However, while about 5.5 lakh travellers book their tickets online daily, only around 3.5 lakh are opting for the insurance coverage. The scheme is being implemented by IRCTC in partnership with ICICI Lombard General Insurance, Royal Sundaram General Insurance and Shriram General Insurance selected through a bidding process.
- There are more than 1.25 lakh people lost their lives and more than 5 lakh people get injured in road accidents in India. Ministry of Road Transport and Highways (MRTH) is planning to cap the maximum limit of compensation in case of death in road accident to Rs.15 lakh. Ministry is in process to bring in Road Transport and Safety Bill (RTSB) to replace the existing Motor Vehicles Act, 1988. In exiting law the compensation paid through third party insurance of motor vehicle is calculated by a formula and announced by an appropriate court. The formula takes into account the age, income, number of dependents of victim with some other factors. Depending on this formula different courts pronounced compensation money ranging from Rs.5 lakh to Rs.2 crore on case to case basis.

Issues and Challenges in Travel Insurance

However, there are many challenges in outbound travel. In India, companies tend to specialize in either inbound or outbound, few do both successfully. The skill sets and experience needed for both segments are unique and not complementary. The average Indian travel agent deals with customers who are extremely price sensitive and are inherent shoppers. Bargaining is a cultural trait.

Myths about Travel Insurance

- Nothing can happen on a Trip
- Collecting claim can be an impossible task unless there's been a calamity
- Travel insurance is just for the Adrenalin Junkies
- Travellers have a positive perception about contracting insurances
- To mistrust certain companies which do not provide an appropriate service or coverage
- Unawareness about the importance of travel insurance
- Sales promotion policy of outbound tourism
- Difficulties in choosing best plans

The reality is that most travellers want to secure their experience since they leave their homes and that they don't want to have risks when they are travelling. The market, in India, is still at its budding stage. But considering the growing tourism industry in the country, the travel trade has a tough task ahead. For an industry which so largely depends on goodwill and repeat customers. The safety of its travellers at any cost is something no agent can afford to mess with.

Recent Developments in the Travel Insurance Sector

To meet these issues and challenges various developments are introduced by the travel insurance companies. Some among these are: ICICI Lombard has made simple travel insurance products available in online with simple wordings and the premium charged is refunded back to the customer after deducting the cancellation charges. Thomas Cook is reaching out to the customers by explaining the benefits of choosing travel insurance plans to their customers and offer custom-made solutions best suited basis their age, duration of stay etc. They hand over a kit to customers which contain the policy wordings and claim procedures; and also provide necessary and additional information on the processes related to lodging, claiming and actions to undertake in emergencies. TrawellTag Cover-More India is working closely with travel agents and providing marketing support to their trade partners, particularly travel agents. One of their biggest initiatives is 'Travel Agent's Engagement Programme', which reaches out to travel agents across India to enhance their knowledge of travel insurance and enable them to up-sell.

Insurance Regulatory and Development Authority (IRDA) has introduced the Integrated Grievance Management System (IGMS) which is an online system for registration and tracking of grievances. If complaints have not been addressed by insurance company, we can contact IRDA Grievance Call Centre toll Free No: 155255. When a complaint is registered with IRDA, it facilitates resolution by taking it up with the insurance company.

Conclusion

India's insurable population is anticipated to touch 750 million in 2020, with life expectancy reaching 74 years. Furthermore, life insurance is projected to comprise 35 per cent of total savings by the end of this decade, as against 26 per cent in 2009-10. The future looks promising for the life insurance industry with several changes in regulatory framework which will lead to further change in the way the industry conducts its business and engages with its customers. Demographic factors such as growing middle class, young insurable population and growing awareness of the need for protection and retirement planning will support the growth of Indian life insurance. As per a report by Finaccord, the global market for stand-alone travel insurance and assistance was around USD 13.8 billion in 2013, and this figure is expected to rise to USD 18.1 billion by 2017.

The Indian travel insurance market is fixed around Rs.4,510 crore in 2013-14 and the industry is growing at the rate of 20-25 per cent annually. The penetration of travel insurance in the country is low, but given India's huge population base with a growing segment of travellers, India could become one of the largest travel insurance markets worldwide in the next decade. So a collective effort from all companies is necessary to take travel insurance to consumers and increase the travel insurance penetration among travellers.

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Right to Insurance for the Differently-abled

Dr. S. Elumalai[1]

Abstract

This paper deals with the rights of persons with disabilities in the context of insurance, the discrimination faced by them and how the judiciary has intervened effectively to remove such discrimination. The paper also makes an attempt to find the appropriate solution to promote a win-win situation for the insurance industry as well as the disabled. A few suggestions to promote the interest of persons with disabilities have also been given.

Introduction

Insurance is one of the important social security instruments available in the globalized economy. In the era of globalization and privatization, the private companies are performing public utility services including insurance. The private entities are working purely on profit motive even in the field of health insurance.

The right to health, right to public assistance including insurance has been guaranteed by the Constitution of India. It is unfortunate that this constitutional mandate is not fulfilled by the private as well as public sector entities. In this context the topic assumes more importance. Let us analyze the relationship between law relating to insurance and disability law, the constitutional mandate to promote access to quality and affordable insurance to the differently abled, the impact of globalization, the contribution of the judiciary in promoting the right to insurance of the differently abled, the emerging trend relating to right to insurance in the context of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and others.

Constituional Safeguards

The Constitution of India provides various measures to promote right to life[2], right to equality[3], right to health[4], promotion of welfare state concept[5] and right to public assistance[6]. Though it does not specifically confer the right to insurance for the disabled, the same has been embodied impliedly in Part III and Part IV of the Constitution of India.

Concepts relating to Insurance and Disability

Insurance is based on certain accepted principles based on the risk perception and at a financially viable price. In insurance, varieties of risks coexist some of which

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[2] See, Art. 21, Constitution of India.

[3] See, Art. 14, *ibid.*

[4] See, Art. 47, *ibid.*

[5] See, Art. 38 & 39, *ibid.*

[6] See, Art. 41, ibid.

are insurable risks and some uninsurable. Certain risks deserve acceptance, certain risks are accepted in a restricted manner and certain other risks are declined altogether. Therefore, all insurance policies all over the world have various exclusions, deductibles and other restrictions. Providing insurance cover to all risks equally without discrimination will go against the principles of insurance. The business of insurance is also based on commercial principles. Viability of the product is one of the basic requirements. Persons with mental illness are comparatively at a greater risk of having a concurrent physical illness going undiagnosed and untreated. This adds further to the existing risk and categorized as high risk in insurance[7].

In the insurance business a pool is created through contributions made by persons seeking to protect themselves from common risk. Premium is collected by insurance companies which also act as trustee to the pool. Any loss to the insured in case of happening of an uncertain event is paid out of this pool. It works on the principle of risk sharing. Therefore, prejudice would be caused to the normal insured persons in case of any casualty of the disabled persons, as disabled persons are more prone to accidental risks as compared to normal persons and the amount which is to be paid to the family of the deceased would be paid out of the same pool[8].

Laws governing Insurance Regime and Disability Rights

Presently the health and life insurance regime is governed by the following Acts:

a. Insurance Act, 1938

a. Insurance Regulatory and Development Authority of India Act, 1999

a. Life Insurance Corporation Act, 1956

None of them specifically addresses or provides protection to the disabled. In fact, the disabled were kept out of the coverage of insurance for quite a long time. Only in recent times the regulations framed by IRDA[9] and rules framed by the Postal department relating to postal life insurance[10] are specifically providing insurance protection for the disabled.

Right to Insurance and Disability Law

The Persons with Disabilities Act, 1995 did not specifically mandate providing of insurance for the disabled. However, it prohibits state based entities from making discrimination in the public utility services. It should be noted that the aforesaid Act promotes the concept of affirmative action to be discharged by the private as well as public entities. The concept of affirmative action can be given a wider interpretation for the purpose of providing insurance protection to the disabled.

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[7] See, Chander Mohan v. IRDA Case No.114/1092/12-13, para. 7.

[8] See, Vikas Gupta v. Union of India W.P. (C) No.10323/2009, para. 4.

[9] See, Regulation 2.4 and 2.7, Insurance Regulatory and Development Authority of India (Obligations of Insurers to Rural and Social Sectors) Regulations, 2015.

[10] See, Rule 17, Post Office Life Insurance Rules, 2011

The UNCRPD specifically mandates the International community to promote universal design to be used by the disabled as well as the non-disabled[11]. It mandates the member countries to prohibit all forms of discrimination in all walks of life including insurance based on disability[12]. It strongly mandates the member countries to abolish all the laws, regulations and other practices which are prejudicially affecting the rights of disabled people[13]. Above all, it specifically mandates all the member countries to provide insurance coverage to the disabled on fair and reasonable tariffs[14].

Judicial Contribution

The vulnerable groups including disabled have been kept out of insurance coverage for quite a long time till the intervention of the Supreme Court of India in the case of the *Life Insurance Corporation of India Vs. Consumer Education and Research Society*[15]. Even then the insurance companies continued to discriminate based on disability, for example, in matters pertaining to sum assured and payment of premium, etc. This discrimination has been undone by the High Court of Delhi in the case of *Vikas Gupta v. Union of India*[16]. Unfortunately the persons suffering from mental illness are not provided with any insurance coverage till date. The intervention made by the Chief Commissioner for Disabilities in the case of *Chander Mohan Vs. IRDA*[17] is highly appreciable.

Emerging Trends

The postal department has been mandated to provide health insurance in equal terms to the disabled as available to the non-disabled. The discrimination in the sum assured and extra premium has been done away with. The Government of India has framed a specific product under the *Niramaya* scheme to promote the right to health insurance for the disabled.

Conclusion

It is deeply regrettable that the state based entities such as the LIC and GIC as well as the postal department are following a discriminatory procedure in relation to insurance coverage to the disabled. This should be strongly condemned. It is very painful that the private entities are following discriminatory practices even in the selling of government health insurance products to the disabled consumers. This has been highlighted in the case of *Chander Mohan Vs. IRDA*. It is highly appreciable that the Government of Tamil Nadu has positively discriminated in providing health insurance to the disabled.

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[11] See, Art. 1, United Nations Convention on the Rights of Persons with Disabilities 2006.
[12] See, Art. 2, *ibid.*
[13] See, Art 4, *ibid.*
[14] See, Art. 25 (e), *ibid.*
[15] 1995 AIR 811.
[16] W.P. (C) No.10323/2009.
[17] Case No.114/1092/12-13.

The Chief Minister's Comprehensive Health Insurance Scheme has rightly abolished the income ceiling for availing of insurance benefits under this scheme. It extends the benefits of the scheme provided one member of the family is disabled irrespective of the income of the family. It is strongly recommended that the insurance companies both public as well as private entities and other governments should come up with a similar program with more flexibilities and benefits so as to promote the right to insurance of disabled including persons suffering from mental illness. It is also suggested that private entities should design better health care products for the disabled and avail benefit under the CSR scheme embodied under the Companies Act, 2013.

It is highly appreciable that the Government of India headed by Shri Narendra Modi has recently enhanced the tax exemption under the Income Tax Act for the medical expenses incurred for the treatment of disabled people. This will go a long way in promoting the interests of the disabled. A strong appeal is made to the Central Government through this paper to raise the exemption from Rs.50,000/- to at least Rs.2,00,000/-. It is also strongly recommended to the Government of India to consider the waiver of service tax so as to promote the affordability of health insurance to the disabled. No doubt the aforesaid measures will promote a win-win situation to both the stakeholders i.e. the insurance companies and the disabled.

Health Insurance Portability in India – Operational Issues and Major Concerns

Dhanya C.S[1]

Abstract

This paper analyses the concept of health insurance of portability in India and the major operational concerns. It draws lessons from the US experience and makes a critical review of the Health Insurance Portability and Accountability Act, 1996 in the US. It advocates specific legislation on health insurance portability in India.

Introduction

Health is wealth and insurance of health is essential in view of ever increasing cost of medical expenses. Nowadays individuals face a number of exposures driven by health and health related events and costs, the risks of which they can bear to differing degrees. These risks range from low ticket-size expenses like routine care to higher ticket size discretionary expenses like elective surgery. The treatment of health problems like heart ailment, kidney replacements, brain hemorrhages, cancer ailments and other important diseases are very expensive and unless there is a financial support from external source, they are not within the reach of a common man[2]. There is a need for well designed health insurance policy that may protect family savings in case of unexpected medical charges[3].

Health Insurance in India is not gaining ground because people are skeptical about the payment of claims and services provided by insurance company, illiteracy and lack of trust in health schemes. Customer satisfaction levels for health insurance in India have consistently ranked below when compared to many other developed and developing nations. The major reasons often cited are low coverage of plans in terms of both the diseases and number of hospitals covered. Unlike other homogenous general insurance products, premiums for medical plans are based on the health of an individual policyholder and this had lead to confusion and fraud in the Indian market and increased policy cancellations from customers who do not find any value in their health insurance policies.

Need for well designed Health insurance Schemes and Health Insurance Portability Facility

Health insurance is considered to be unique from all other kinds of insurance as it involves one more party that is the healthcare provider other than the insurer and insured. The health care provider plays a major role in determining what services are used, how much of the services are used and how much they cost, which makes

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[2] Sachin Rastogi,Insurance-Law and Principle 382 (Lexis Nexis Publications,1st edn.,2014).

[3] M.N.Mishra & S.B.Mishra, Insurance principles and practice 613 (S.Chand & Co.Ltd,1st edn.,2011)

it different and also complex. It may be provided through a governments sponsored social insurance program, or from private Insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Various health insurance schemes are available in India which are providing benefits to an individual to an entire family like family floater policies, critical illness policies which covers illness like blindness, deafness, Alzheimer's disease, kidney transplant, organ transplant, paralysis etc. Recently, there are various innovations in the health insurance sector like RSBY[4] for people below poverty line, Bhyavishya Arogya Policy[5], Hybrid Product which includes health Insurance and life insurance under one policy.

Even then, humans continue their quest to achieve security and reduce uncertainty. Health insurance portability is one of the recent developments in the health insurance sector which will allow policy holders to freely switch their policy to another insurance company without losing on benefits earned in the previous one. The IRDA vide circulars dated February 10, 2011[6] and September 9, 2011 had issued detailed guidelines on portability of health insurance policies. Portability can be done only at the time of renewal. At least 45 days before renewal, the person is required to give a request to the old insurance company regarding the details specifying company to which he wants to shift the policy. The old insurer has to provide the policyholder's medical and claims history to the new insurer within seven days thereafter. Apart from the waiting period credit, all other terms of the new policy including the premium are at the discretion of the new insurance company. IRDA has created a web-based facility to get and maintain data about all health insurance policies issued by insurance companies to individuals so that it can be accessed by the new company to which a policyholder wishes to port his policy which enables the new insurer to obtain data on history of health insurance of the policyholder wishing to port his policy. A person can port his policy from and to any general insurance company or specialized health insurance company or any individual/family policies or from one plan to another with the same insurer. The two insurers should complete the porting as per the timelines prescribed in the IRDA (Protection of Policyholders' Interests) Regulations and guidelines[7]. Health Insurance Portability (HIP) facility applies not only when a person move from one insurer to another but also from one plan to another with the same insurer[8].

[4] Rashtriya Swastiya Bima Yogana,available at https://www.healthcare-india.com/rsby_v2/Index.aspx accessed on 05/11/2016

[5] Dr. S.R. Myneni, Law of Insurance 521(Asia Law House,Hyderabad,1st edn.,2013).

[6] ibid.

[7] http://www.policyholder.gov.in/Portability_of_Health_Insurance.aspx accessed on 7/11/2016

[8] Circular issued by IRDA ,ref :IRDA/HCT/MISC/CIR/209/09/2011,available at https://dtf.in/wp-content/files/Circular_dated_09.09.2011_-_Re._Health_Insurance_Portability.pdf

Major operational concerns of Health Insurance Portability in India

All portability proposals are treated as new and put through the underwriting guidelines afresh. Underwriting involves measuring risk exposure and determining the premium that needs to be charged to insure that[9]. IRDA rules have given insurers the right to reject a person's application on the basis of their underwriting guidelines. Each insurer uses their own principles to assess customers' risk profile. If a customer wants to shift to an insurer who only accepts cases without claim history and has strict norms on body mass index (appropriate height and weight ratio), there are chances that his application will be rejected. Huge differences between exclusions and inclusions and other features between the policies of the two insurers may also lead to rejection.

Another major concern is with regard to age of the insurer. Most insurers are keen to insure the young. They don't accept portability proposals if the insured has a higher age and poor health. In fact, they put a lot of clauses and restrictions which are not encouraging for customers, who may drop the idea to port. A general rule is that applicants above 45 years of age are asked to undergo medical tests .The application may also be rejected on grounds of insufficient information, delay in submitting documents and poor claim history. Moreover, a person's current insurer cannot refuse to renew old policy if any chronic ailment was detected after he bought the policy. However, the new insurer may reject his portability request in such a case. It can be thus understood that portability helps a customer only as long as the policy is profitable, that is, when he had been paying premium regularly without claim. Till this point every insurance company is good to the insured. If there is no claim, there cannot be any dispute. Inadequate information, delay in filling of application, non-availability of previous policy documents and break in cover are some procedural issues on which the insurer can reject a portability request.

If a person's current insurer delays sharing of claim information, the other insurer may keep acceptance of the porting request in abeyance. In such a case, the person can apply to his insurer for paying premium for one-two months on a pro-rata basis and extend the cover till he gets an acceptance from the other insurer. The IRDA guidelines make it clear that the insurer cannot force a person to pay the whole year's premium in such a case. In addition to this, the insurer has to convey the decision in 15 days; otherwise, the application is understood to have been accepted.

Case study: Samir Dave, 42, a resident of Ahmedabad

Samir Dave applied to port his nine year old family mediclaim policy portability from New India Assurance to Apollo Munich on 22 October 2011.He wanted to switch because when his son was hospitalized and the old insurer did not pay the full claim as the policy had sub-limits on room charges whereas the later had a 'no-sub-limit policy'. His existing policy gave a cover of Rs.2 lakh each to him, his wife and child for an annual premium of around Rs.7,800/-. He had earned a cumulative bonus of

[9] Supra note 1 at 210

Rs.70,000/- on this policy. As per the guidelines, he was promised by one of the Apollo Munich sales representative that he was eligible for all the accrued benefits that is he will not have to serve the waiting period for covering pre-existing diseases and will be eligible for a cover of Rs.2.7 lakh for his family. However, he was shocked when he got the policy document. He found that none of the continuity benefits were passed on to him and he was asked to serve the waiting period for coverage of pre-existing ailments. Even the cumulative bonus was not added to the sum insured. When he enquired with the company, he was told that the continuity benefits were considered for only one year. On probing further, he came to know that the company had a policy of asking the insured to submit all previous policy documents to prove continuity. However, the sales representative had guaranteed that last year's papers were enough to get the continuity benefits. He had been following up with the company writing regularly to the grievance redressal cell. He had also approached the regulator, which instructed the company to sort out the case immediately. However, his application was still pending with the company.

According to Apollo Munich when they requested New India Assurance to share Dave's case history on IRDA's portal they did not get any response till 25 November 2011. So, based on the documents provided by Dave (only 2010-11 policy schedule of New India Assurance plus a self declaration from about his earlier insurance coverage),the company proceeded with their underwriting process and ported his policy to them. They accepted the application made by him to book the policy after extending one-year portability benefit. Even though Dave had mentioned about his previous policy coverage in self-declaration forms, the company needed policy documents to extend the portability benefits. The same have not been shared with by the previous insurer yet[10].

HIP facility is much similar to the Mobile number portability service (MNP) available in the telecom sector.MNP lets a person to continue using the same number (eg.Vodafone) but by changing the network operator (Eg.Airtel) if he is not satisfied with the services of the first operator (eg.Vodafone) even when moving to another state.MNP facility is available in our country since December 2010. According to TRAI, nearly 157.01 million people have applied for MNP till date. It reached a high in April when nearly 3.17 million applied for the service[11]. Cost and time is also not a deterrent factor since it is very nominal like Rs.19/- and seven days. Globally, MNP has a good track record and today it is common practice in many countries with some countries providing the facility free of cost and within very short period like two days.

It can be expected that health insurance portability facility too will increase the trust and confidence of customers to take health insurance policies because lack of

[10]http://www.businesstoday.in/moneytoday/cover-story/all-you-need-to-know-about-porting-health-insurance-policies/story/185673.html

[11]http://blogs.wsj.com/indiarealtime/2011/01/20/who-will-benefit-from-mobile-number-portability/ accessed on 06/11/2016

trust in companies regarding their services is one major issue faced by insurance sector in India.

Lessons from U.S Experience – A critical analysis of HIPAA

Health Insurance Portability and Accountability Act, 1996[12] (HIPAA) is a U.S legislation that provides data privacy and security provisions for safeguarding medical information. The Act was signed by President Bill Clinton in August 1996 and the U.S. Department of Health and Human Services finalized standards for the electronic exchange, privacy and security of health information in 2002. The HIPAA contains five sections or titles. It targets two main areas related to healthcare. First one is related to employee based health insurance provision. It enables the transfer and continuing health insurance coverage for workers, and their families, if they change or lose their jobs. Second one is related to guidelines and policies that are designed to protect confidential medical records from misuse. A short description on the contents of the title is as follows:

Title I deals with health insurance coverage for individuals who lose or change jobs. It also prohibits group health plans from denying coverage to individuals with specific diseases and pre existing conditions, and from setting lifetime coverage limits. Tile II contains provisions which direct the U.S department of Health and Human services[13] to establish national standards for processing electronic healthcare transactions. It also requires healthcare organizations to implement secure electronic access to health data and to remain in compliance with privacy regulations set by HHS. Title III includes Tax related provisions and guidelines for medical care whereas Title IV defines health insurance reform including provisions for individuals with pre existing conditions and those seeking continued coverage. The last title includes provisions on company owned life insurance and treatment of those who lose their U.S citizenship for income tax purposes[14]. The Act further mandates that each healthcare entity, including individuals, employers, health plans and healthcare providers, must have a unique 10-digit National Provider Identifier Number or NPI. The organizations must follow a standardized mechanism for electronic data interchange in order to submit and process insurance claims.

The HIPAA Omnibus rule was put in place by HHS in 2013 to implement modifications to HIPAA in accordance with guidelines set in 2009[15] concerning responsibilities of business associates of covered entities. The omnibus rule also increased penalties for HIPAA compliance violations to a maximum of $1.5 million per incident. Healthcare organizations have to notify patients following a data breach. In addition to the notification costs, healthcare organizations can encounter fines after HIPAA audits mandated by the HITECH Act and conducted by the Office for Civil

[12] Hereinafter referred as HIPAA
[13] Hereinafter referred as HHS
[14] http://searchdatamanagement.techtarget.com/definition/HIPAA, accessed on 04/11/2016
[15] Health Information Technology for Economic and Clinical Health (HITECH) Act,2009

Rights (OCR).Providers could also face criminal penalties stemming from violations of the HIPAA privacy and security rules. Further in U.S, Office for Civil Rights (OCR) conducts six educational programs on complying with the privacy and security rules; a number of consultancies too offer programs which will be beneficial for the healthcare organizations to lower their risk of regulatory action. HIPAA Act was amended several times since originally it raised deeply fundamental issues for health care providers, insurers, employers, policy makers, researchers, and those most concerned with patients and consumers of healthcare services and their families. Even though there are some demerits which need to be rectified, it is hard to dispute that HIPAA had a vast impact on patients, the healthcare industry, and many others over the last 20 years and will continue to shape healthcare industry for many more years to come. Following are some of the merits and demerits of the HIPAA legislation.

Merits

1. *Protection for health related information and privacy* - Health and Human Services allows physicians and insurance companies to exchange individually identifiable health information to pay a health claim, but would not allow them to release it publicly. Penalties for violating the regulations include civil fines of up to $50,000 per violation. The privacy rule also requires physicians, hospitals, insurers, and other health care entities to use and disclose only the minimum amount of information needed to complete the transaction or fulfill the request. For example, a physician should not send a patient's entire medical file to an insurer if just one page from the record will suffice to answer the insurer's query[16].
2. *Non-Discrimination Prohibition* - HIPAA also prohibits discrimination against employees and their family members based on health histories, previous claims, and genetic information, according to the Department of Labor. They cannot be charged more than similarly situated individuals based on any health factors. "Health factors" include medical conditions, claims experience, and genetic information.
3. *Insured friendly legislation* - HIPAA allowed patients the legal right to see, copy, and correct their personal medical information. It also prevented employers from accessing and using personal health information to make employment decisions. It enables patients with pre-existing conditions to change jobs without worrying that their conditions would not be covered under a new employer's health plan. HIPAA protects workers and their families.
4. Providing additional opportunities to enroll in group health plan coverage when they lose other health coverage, get married or add a new dependent.
5. Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on any health factors.
6. Preserving the state's role in regulating health insurance, including the states' authority to provide greater protections than those available under Federal law.

[16] http://www.livestrong.com/article/75368-pros-cons-hipaa/ accessed on 04/11/2016

However the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment[17].

Demerits

1. *Increased Legal formalities* - According to the American Medical Association, HIPAA has forced a mini-industry of companies and consultants who help medical professionals comply with the law's lengthy provisions.
2. *Too much caution* - In addition, some professionals who deal with medical paperwork have become overcautious about releasing protected information. For example, some physician's offices now refuse to mail test results, saying patients need to pick them up in person. And some hospitals require physicians to submit written requests on their own letterhead for information on a patient's condition, when the law allows this information to be provided by phone.
3. *Patient's do not have direct right to sue* - Even though their privacy rights may be violated, patient's don't have standing to sue companies'. The United States Department of Health and Human Services is charged with enforcing the provisions under HIPAA and affected patients would have to file a complaint with them.
4. *Shortcomings in Enforcement* - Private individuals have complained about HIPAA violations since it was enacted. There's a public perception that the United States Department of Health and Human Services does not actually enforce the act against institutions and professionals who violate HIPAA privacy rules. As a result, some patients lack confidence that HIPAA does anything, due to its shortcomings in enforcement .
5. *Extra Staff required* - Companies may have to hire extra staff to keep up with HIPAA requirements. Larger-sized companies need dedicated staff to work on the privacy of their patients. That results in extra costs that are eventually passed on to patients, and leads to an increase of their medical bills.
6. *Consent Not Required for Payment* - HIPPA privacy rules do not mandate that a hospital, doctor's office or agency obtain the consent of patient for submitting a claim to their insurance company. For example, if a patient reveals his health insurance information, the hospital management can immediately submit a claim for pay without asking patient permission first. That takes away patient's option of self-pay, or more importantly, individual decision to decide what claims they want to submitted to insurance company.
7. *Information Shared with Outsiders* - Companies often contract with other providers for services, such as billing and legal services. These contractors have access to patient records as part of doing their job. Patients don't have a choice about that, and their consent is not required under HIPAA rules. Companies do use written

[17] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/hipaa accessed on 04/11/2016

agreements with contractors to obtain their agreement to keep the information they receive confidential, but if there is a violation, the only option left is to give a complaint to USDHHS.

Conclusion

Health Insurance portability facility will surely be a beneficial step taken by our government. Rather than focusing on the negative effects of this facility, let us appreciate that there are so many merits behind it. Still as the age old proverb says "prevention is better than cure" we can be cautious enough about the demerits in the implementation in other countries where it is already implemented. As pointed already nationwide mobile number portability facility have proved to be beneficial to all subscribers because when they are not satisfied with the service they are left with an option to switch which means they have an option to always go for getting a better service. Network provider fearing to lose their old customer is compelled to provide quality services to build customer trust. Even though U.S government introduced the health insurance portability facility in 1996 itself, it actually took several years to get these regulations in place. Hence it can be concluded that HIP in India also in the long run will ensure adequate security for the policy holders and will result in more people taking health insurance coverage.

Suggestions

- *Need for a specific legislation on health insurance portability* – India should enact a specific legislation dealing exclusively on health insurance portability and accountability detailing provisions regarding violations for non-compliance with insured given the right to sue in case of violation of privacy rights.
- *Education* - Education is the critical element of Compliance. Everyone should be informed as much as possible about their rights while availing health insurance portability. Awareness regarding all aspects of health insurance policies should be increased and attractive health insurance policies should come in order to capture and increase market share of health insurance sector. Prospective clients should ask for more information from the insurance companies. IRDA intervention in making brochures and other promotional material, more transparent, will make the insurance companies more responsible.
- *Honesty and Integrity* - For healthy growth of health insurance sector all stakeholders should work with great honesty and faith and should not involve themselves in fraudulent activities. Do not make a false claim as insured may not be able to make a genuine second claim in the same year if the limit has been exhausted. Also, the insurer may load future premiums in case of an abnormal claim.
- *Role of Third Party Administrator* - TPA should work in harmony with all stakeholders. They should strictly follow all the guidelines and rules mandated by IRDA. They should focus on timely payment of all claims due on behalf of insurance company.

- *Need for Self Regulatory Measures* - There is also a need for self regulatory measures like reading and understanding policy document properly before taking a policy, clearing doubts on policy wordings if any, taking steps to amend medical records when necessary. Health insurance portability is not transferring your old policy to a new insurer but buying a new policy without the waiting period clause. But before switching, a person should know the product he is buying and its differences with his existing plan such as flexibility and slabs for sum insured, pricing, restrictions on entry age, renewal limits, waiting period, capping and co-payment clauses, ailments covered and the list of hospital network.

Recent Developments in the Insurance Sector with special reference to Satellite Insurance

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Abstract

Space insurance is gaining its importance in recent days because almost all nations around the world are interested in space exploration which actively involves investment of huge money. Theoretically, the opportunities in satellite and space technology are unlimited in the best sense of the world. In reality however, there are problems faced not only by the manufacturers and users of such products, but also by the insurance industry, which has had to go through a painful learning process when insuring large technical projects over the past few years. Under Space insurance one thing that always stands as a challenge for the space insurance companies is to insure satellites and generate profit out of it. Now in this paper we will see in detail about the hurdles faced by the space insurance companies in insuring satellites and the difficulties faced in estimating liabilities.

Introduction

Professors Mehr and Cammack, define Insurance as a device for reducing risk by combining a sufficient number of exposure units to make their individual losses collectively predictable. The predictable loss is then shared proportionately by all units in the combination[3]. In simple words, Insurance is a form of risk management primarily used to hedge against the risk of a contingent, uncertain loss. It involves equitable transfer of the risk of a loss, from entity to another in exchange for money. As any risk that can be quantified can potentially be insured, Space insurance is gaining its importance in recent days because almost all nations around the world are interested in space exploration which actively involves investment of huge money. Under Space insurance one thing that always stands as a challenge for the space insurance companies is to insure satellites and generate profit out of it.

Satellite Insurance

In simple words satellite can be described as an artificial object which has been intentionally placed into orbit. These satellites are of various types like military satellites, civilian earth observation satellites, communication satellites, navigation satellites, weather satellites and research satellites which are used for a large number of purposes. After the launch of the first satellite named Sputnik 1 in the year 1957 by the Soviet Union many other nations including the United States showed interest to overtake Soviet Union in the race of space exploration. These continuous interests of nations over space exploration made insurance industries to understand that soon

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[2] 3rd Year B.A.,B.L (Hons), Saveetha School of Law, Chennai.
[3] Principles of Insurance, Eighth sub edition August 1985 by Robert I. Mehr, Emerson Cammack and Terry Rose.

space will be a place for commercial exploitation. After which over the period of next 60 years so far about 6000 satellites have been launched. The latest estimates are that 3600 still remain in orbit[4]. Of those, about 1000 are operational[5].

Launching of satellites being a primary act of space exploration, in recent days almost all nations are showing interest in investing huge amount of money to successfully launch satellites into space. At the same time space exploration is a field where the feasibility of success can never be guessed. In case a space mission fails it is impossible for just the government or private parties to cover up the entire costs of damage or loss occurred. This led to the idea of insuring space missions.

Satellite insurance is a specialized branch of aviation insurance in which, as of 2000, about 20 insurers worldwide participated directly[6]. Others participated through reinsurance contracts with direct providers[7]. At the beginning, satellite risk was mainly placed in the international aviation market, simply because this market was more familiar with the problems of space flight than other insurance markets. However it soon became apparent that insuring satellite risk is difficult and requires highly specialized insurer knowledge for pricing and claims handling. Satellites are very complex machines which are manufactured and used by governments and a few larger companies. The budget for a typical satellite project can be in excess of billions of dollars and can run 5–10 years including the planning, manufacturing, testing, and launch. However in 1965 the first satellite insurance was placed with Lloyd's of London to cover physical damages on pre-launch for the "Early Bird" satellite Intelsat I. In 1968 coverage was arranged for pre-launch and launch perils for the Intelsat III satellite. Typically satellite insurance covers three risks: re launching the satellite if the launch operation fails; replacing the satellite if it is destroyed, positioned in an improper orbit, or fails in orbit; and liability for damage to third parties caused by the satellite or the launch vehicle[8].

Types of coverage under Satellite Insurance

Under the concept of satellite insurance many different types of coverage are made available by the insurance companies such as:

1. **Pre-launch insurance:** Pre-launch insurance provides coverage for loss or damage to satellite or its components from the time they leave the manufacturer's premises, during the transit to the launch site, through testing, fueling, and integration with the launcher up until the time the launcher's rocket engines are ignited for the purpose of the actual launch. That means during storage in launch area, the

[4] Rising, David (11 November 2013). "Satellite hits Atlantic — but what about next one?". Seattle Times

[5] "Global Experts Agree Action Needed on Space Debris". European Space Agency. 25 April 2013. "UCS Satellite Database". UCS Satellite Database. Union of Concerned Scientists. Retrieved 2013-11-12

[6] Gould, Allen J.; Linden, Orin M. (2000). "Estimating Satellite Insurance Liabilities" (PDF). Casualty Actuarial Society

[7] ibid.

[8] Mott, William H.; Sheldon, Robert B. (2000). Laser Satellite Communication: The Third Generation. Praeger. p. 142. ISBN 1-56720-329-9

configuration of satellite launch measures and the deployment of the satellite on the launch missile as well as during the whole launch preparation[9].

II. **Launch Insurance:** Launch insurance provides coverage for the period from the intentional ignition of the engines until the satellite separates from the final stage of the launch vehicle, or it may continue until completion of the testing phase in orbit. Typical coverage usually runs for a period of twelve months but is limited to 45–60 days in respect of testing phase in orbit. A failed launch may be due to explosion of the launch vehicle or the failure to deploy the satellite into a usable orbit. Launch failure is the greatest probability of satellite loss and approximately 7% of satellites have failed on launch. In simple words the launch[10] process is during the entire launch activities when the missile is to reach its planned eclipse, followed by functional tests which usually lasts several months. The only losses excluded from the coverage are those which result from or are due to war, ante satellite weapons, confiscation, radioactive contamination, electromagnetic or high frequency disturbances, and intent. Under the launch insurance coverage it covers three sequential periods namely, the first period begins when the pre-launch coverage ends and the first period ends with the separation of the satellite from the last missile stage. the second period is known as the stationing period in which the satellite reaches its final eclipse position on its own begins with the ignition of the apogee engine and ends when the satellite reaches its planned position in geostationary orbit[11]. The third period begins with the satellite reaching its final geostationary position in orbit[12].

III. **In orbit insurance:** Coverage while in orbit provides for physical loss, damage, or even failure of the insured satellite while in orbit or during orbit placement. Elements of risk attached to satellites during orbit are damage caused by objects in the hostile space environment, extremes of temperature, and radiation. Because it is not typically possible to repair a satellite once it is physically placed in orbit, the coverage is basically granted as a product guarantee. It is an all risk policy with pre-set total loss limits. It starts when the satellite begins to operate, and covers any total or partial loss of a satellite or its functionality in orbit where the satellite serves as either a communications or an earth exploration satellite[13]. The value to be insured is initially correlated with the replacement value, in other words the limit compromises the costs for a replacement satellite including the costs for a re-launch. But longer the satellite has been in service the more prone it becomes to losses in function which reduce its value. Therefore, coverage is granted for a certain period in reasonable relation to the satellite's life expectancy.

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[9] Plochinger,L.I., "Insurance of space risks", ESA bulletin, 53, PP. 84-87

[10] Gould, Allen J.; Linden, Orin M. (2000). "Estimating Satellite Insurance Liabilities" (PDF). Casualty Actuarial Society

[11] The space review, 1995, Airclaims Limited, London

[12] Willis Corrdon, 1996, Space risks. The Willis Corron inspace pocket guide to space and space insurance

[13] Zocher, H., 1998, "Neuere internationale Entwicklungen in der Raumfahrt und ihrer versicherung (IV)" , Versicherungswirtschaft 43, 2, PP. 147-55

IV. **Satellite liability insurance:** It includes coverage against liability for damages caused to third parties during the launch and in-orbit operations of the satellite. Third party liability is the final section of the policy, and is a statutory requirement of the Government of the nation where the launch will take place, regardless of the nationality of the satellite owner. A special license must be provided to the regulating authorities before a launch can take place. Coverage usually runs up to 90 days following the actual launch. Loss of revenue coverage is also available but is not purchased often. Compared to property insurance, liability premiums are fairly lower, due to the fact that the ratio of losses to premiums has been substantially lower[14].

Hurdles faced by Satellite Insurance Companies

Insuring satellites is not an easy job, it is a complex task. Insurance plays an important role in the scheme of any commercial space launch. It is therefore, extremely important that insurers are able to fulfil their functions adequately and effectively. Parallel on the other side there are a lot of technical, scientific and practical problems involved in it. Usually satellites are insured against many different kinds of failure. Space insurance is currently experiencing a hard market due to various reasons such as

I. **Launch failures affecting underwriting cycles:** Typically the underwriting cycle is the tendency of property and casualty insurance premiums, profits, and availability of coverage to rise and fall with some regularity over time. A cycle begins when insurers tighten their underwriting standards and sharply raise premiums after a period of severe underwriting losses or negative stocks to capital. Stricter standards and higher premium rates lead to an increase in profits and accumulation of capital. The increase in underwriting capacity increases competition, which in turn drives premium rates down and relaxes underwriting standards, thereby causing underwriting losses and setting the stage for the cycle to begin again[15]. Insurance markets are believed to be 'capacity constrained'[16]. In capacity constraint model of insurance cycles, changes to supply and demand of capital cause changes in capacity. Generally insurance means losses of the few are shared by many. This keeps the insurance companies profitable. The insurance cycle is easily visible in the space insurance market. A variety of factors make the market very volatile. The space insurance market is very unique that it involves a relatively small number of underwriters and expensive catastrophic coverage. In case of satellite insurance the risk is huge and requires highly specialised insurer knowledge for pricing and claims handling that in case if there is a launch failure it results in failure of the entire mission where there is no possibility of continuing it. The complex and

[14] Dr. Julian Hermida, Space inurance, Asst prof, Dept of Law and Politics, Algoma University, Sault Ste. Marie, Canada, Ph.D. (UCC), LLM., DCL (McGill), Postdoc (Ottawa)

[15] "Analysis and Valuation Of Insurance Companies." Center For Excellence in Accounting and Security Analysis: Industry Study Two 2 (2003

[16] Anne Gron, "Capacity Constraints and Cycles in Property-Casuality Insurance Markets" Rand Journal of Economics 25 (Spring 1994): 110-127

technical features of this line of insurance in combination with the possibility of large losses has resulted in a limited number of insurers offering this coverage. One launch failure could easily consume the entire premium. Statistics reveal that nearly 10 percent of all launches fail. In the 2002-2007 period alone the space insurer sector paid US $835 million in claims arising from launch failures[17]. This to a large extent affects the insurer cycle.

II. **Difficult to evaluate risks and damages:** The evaluation of the technology involved becomes increasingly difficult for insurers, so that even leading and well respected companies sometimes reach the point where they can no longer estimate ex ante the development risk. When looking at satellite insurance, there are only a limited number of launches, and we can count the number of satellites in the sky. However, the principle of average loss still applies. Most satellite losses are normally agreed and settled quickly. One should remember that even impaired satellites might have some use and therefore some value. It is rare that a satellite in orbit results in a total loss. So it is a hectic job for the insurers as it is difficult to assess the rate of damage over space and decide the cost of compensation. In undertaking reserve reviews, there are three components to consider. They are the value at risk; the unexpired risk period (which for launch is 100%) and the probability of a loss[18]. As it is difficult to measure the damages and loss over space, the probability of a loss is usually based on historical estimates of all losses, but with specific modification for the history, where appropriate, of the launch vehicle or satellite. New technology might involve a higher probability of loss assessment than those with a good history. Together, these components give an estimate of the incurred but not reported (IBNR) losses. In recent years there have been disputes over losses. However, case estimates in these situations tend to be prudent, and, as they are specific, the actuary can understand how the estimate is derived.

III. **Low number of similar risks:** Typically in case of insurance one of its main characteristics is that insurance companies survive in market because there are high number of similar risks. But in case of satellite insurance the number of similar risks are too low because there are only few nations around the globe that are interested in space exploration. Satellite launchings have been with us since the 1950's. While the earliest satellites orbiting the earth were government owned and funded, over time, privately owned and launched commercial satellites have become the norm in recent days. Currently there are hundreds of such satellites in orbit around the planet. So there are many new insurance companies coming up to insure satellites[19]. As the number of insurance companies increase the chance of insuring satellites gradually reduces. Further with the number of insured satellites also the insurance companies cannot gain any profit due to increased failures of satellites in launch,

[17] Derek Newton, "Satellite Insurance", Milliman Global Insuranceat P.8

[18] ibid at P.9

[19] Gould, Allen J.; Linden, Orin M. (2000). "Estimating Satellite Insurance Liabilities" (PDF). Casualty Actuarial Society

pre and post separation stages as it consumes almost the entire premium amount been paid.

IV. **Risk of accumulation of total losses:** With the large total losses of the 1980s in mind, the insurance industry had to address the question as to whether these complex technical satellite and space travel systems are manageable from an insurance perspective[20]. Insurance cycles, general economic conditions, launch and in-orbit losses, and commercial space industry changes have combined to decrease profitability for insurers and thus to harden the space insurance market. It is generally believed that a number of factors influence the insurance cycle. Interest rates (which affect insurance company premium and investment income) and time lags in information used to set pricing both contribute to the cyclical nature of the industry[21]. More importantly, insurance markets are believed to be "capacity-constrained"[22]. In the capacity constraint model of insurance cycles, changes to supply and demand of capital cause changes in capacity[23]. Insurance companies report lower capacity as the cost of raising external capital becomes higher than that of retaining earnings. Further, the annual number of insured commercial launches has decreased in recent years, although 2002 already has seen an increased volume of commercial launch activity compared to 2001. This general decline in launch activity drastically reduces the amount of premium income available to insurers and causes capacity offered to insurance customers to fall and premium rates paid by policyholders to rise.

Conclusion

Theoretically, the opportunities in satellite and space technology are unlimited in the best sense of the world. In reality however, there are problems faced not only by the manufacturers and users of such products, but also by the insurance industry, which has had to go through a painful learning process when insuring large technical projects over the past few years[24]. Although space insurance is currently experiencing a hard market, if space insurance continues to behave cyclically, conditions will eventually return to their previous soft market state. With a greater number of launches to prove reliability, rates for new launch vehicles may improve over time. Resolving technical problems on satellites will help to reduce in-orbit rates. Current high premiums and improving economic conditions will help insurers to rebuild capacity. As capacity

[20] Zocher, H., 1989, "Raumfahrtversicherung Von Schaden Stark Beansprucht", Versicherungswirtschaft 44, 1, PP. 63-69

[21] Neil A. Doherty and James R. Garven, "Insurance Cycles: Interest Rates and the Capacity Constraint Model" (working paper), November 1994.

[22] Anne Gron, "Capacity Constraints and Cycles in Property-Casualty Insurance Markets," Rand Journal of Economics 25 (Spring 1994): 110-127.

[23] Communication with Dr. Anne Gron, Kellogg Graduate School of Management, Northwestern University, 28 June 2002

[24] 'Risk management and insurance solutions for space and satellite projects' by Oliver Schoffiski published on The Geneva papers on risk and insurance Vol.24 No.2 203-215

improves, underwriters will lower premiums to compete for insurance clients[25]. The insurance industry does its share to assure technological progress and underlines its importance in the future development of commercial space travel.

[25] 'Commercial space and launch insurance' Fourth Quarter 2002 Quarterly Launch Report

Doctrine of "Pay and Recover" in Motor Vehicles Act, 1988 - Judicial Trends

Kiruthika .D[1]

Abstract

This paper mainly focuses and the Doctrine of "Pay and Recover" under the Motor Vehicles Act, 1988 with the background of decided case laws.

Introduction

In the modern age the use of motor vehicles, notwithstanding the attendant hazards, has become an inescapable fact of life. So, there is a need for safeguarding the interest of people from loss and uncertainty. And here comes the role of insurance in the society. Insurance may be described as a social device to reduce or eliminate risk of loss to life and property. The Motor Vehicle Insurance in India is governed by the Motor Vehicles Act of 1988. Third party insurance is that if the vehicle is insured and has a third party liability cover, the compensation sought by the third party for damages in case of an accident will be fully paid by your insurance company.

Liablity of the Insurer to satisfy the Judgments and Awards against the Insured

Section 149 of the Motor Vehicles Act, 1988 casts an obligation on an insurer to satisfy judgments and awards against persons insured in respect of third party risks, as if he were the judgment debtor[2]. For easy reference, the entire section is reproduced below:

149. Duty of insurers to satisfy judgments and awards against persons insured in respect of third party risks:-

(1) If, after a certificate of insurance has been issued under Sub-Section(3) of Section 147 in favour of the person by whom a policy has been effected, judgment or award in respect of any such liability as is required to be covered by a policy under Clause (b) of Sub-Section (1) of Section 147 (being a liability covered by the terms of the policy) [or under the provisions of Section 163A] is obtained against any person insured by the policy, then, notwithstanding that the insurer may be entitled to avoid or cancel or may have avoided or cancelled the policy, the insurer shall, subject to the provisions of this section, pay to the person entitled to the benefit of the decree any sum not exceeding the sum assured payable thereunder, as if he were the judgment debtor, in respect of the liability, together with any amount payable in respect of costs and any sum payable in respect of interest on that sum by virtue of any enactment relating to interest on judgments.

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[1] First Year- LL.M.(Business Law), Dr. Ambedkar Government Law College, Chennai.

[2] *National Insurance Co. Ltd., Vs. Swaran Singh and Others, 2004 ACJ 1*

(2) No sum shall be payable by an insurer under sub-section (1) in respect of any judgment or award unless, before the commencement of the proceedings in which the judgment or award is given the insurer had notice through the Court or, as the case may be, the Claims Tribunal of the bringing of the proceedings, or in respect of such judgment or award so long as execution is stayed thereon pending an appeal; and an insurer to whom notice of the bringing of any such proceedings is so given shall be entitled to be made a party thereto and to defend the action on any of the following grounds, namely:-

(a) that there has been a breach of a specified condition of the policy, being one of the following conditions, namely:-

(i) a condition excluding the use of the vehicle:-

(a) for hire or reward, where the vehicle is on the date of the contract of insurance a vehicle not covered by a permit to ply for hire or reward, or

(b) for organised racing and speed testing, or

(c) for a purpose not allowed by the permit under which the vehicle is used, where the vehicle is a transport vehicle, or

(d) without side-car being attached where the vehicle is a motor cycle; or

(ii) a condition excluding driving by a named person or persons or by any person who is not duly licensed, or by any person who has been disqualified for holding or obtaining a driving licence during the period of disqualification; or

(iii) a condition excluding liability for injury caused or contributed to by conditions of war, civil war, riot or civil commotion; or

(b) that the policy is void on the ground that it was obtained by the non-disclosure of a material fact or by a representation of fact which was false in some material particular.

(3) Where any such judgment as is referred to in Sub-Section (1) is obtained from a Court in a reciprocating country and in the case of a foreign judgment is, by virtue of the provisions of Section 13 of the Code of Civil Procedure, 1908 (5 of 1908) conclusive as to any matter adjudicated upon by it, the insurer (being an insurer registered under the Insurance Act, 1938 (4 of 1938) and whether or not he is registered under the corresponding law of the reciprocating country) shall be liable to the person entitled to the benefit of the decree in the manner and to the extent specified in Sub-Section (1), as if the judgment were given by a Court in India: Provided that no sum shall be payable by the insurer in respect of any such judgment unless, before the commencement of the proceedings in which the judgment is given, the insurer had notice through the Court concerned of the bringing of the proceedings and the insurer to whom notice is so given is entitled under the corresponding law of the reciprocating country, to be made a party to the proceedings and to defend the action on grounds similar to those specified in Sub-Section (2).

(4) Where a certificate of insurance has been issued under Sub-Section (3) of Section 147 to the person by whom a policy has been effected, so much of the policy as purports

to restrict the insurance of the persons insured thereby by reference to any condition other than those in Clause (b) of Sub-Section (2) shall, as respects such liabilities as are required to be covered by a policy under Clause (b) of Sub-Section (1) of Section 147, be of no effect: Provided that any sum paid by the insurer in or towards the discharge of any liability of any person which is covered by the policy by virtue only of this Sub-Section shall be recoverable by the insurer from that person.

(5) If the amount which an insurer becomes liable under this section to pay in respect of a liability incurred by a person insured by a policy exceeds the amount for which the insurer would apart from the provisions of this section be liable under the policy in respect of that liability, the insurer shall be entitled to recover the excess from that person.

(6) In this section the expression "material fact" and "material particular" means, respectively a fact or particular of such a nature as to influence the judgment of a prudent insurer in determining whether he will take the risk and, if so, at what premium and on what conditions, and the expression "liability covered by the terms of the policy" means a liability which is covered by the policy or which would be so covered but for the fact that the insurer is entitled to avoid or cancel or has avoided or cancelled the policy.

(7) No insurer to whom the notice referred to in Sub-Section (2) or Sub-Section (3) has been given shall be entitled to avoid his liability to any person entitled to the benefit of any such judgment or award as is referred to in Sub-Section (1) or in such judgment as is referred to in sub-section (3) otherwise than in the manner provided for in Sub-Section (2) or in the corresponding law of the reciprocating country, as the case may be. Explanation:- For the purposes of this section, "Claims Tribunal" means a Claims Tribunal constituted under section 165 and "award" means an award made by that Tribunal under Section 168.

Sub-Section (1) of Section 149 of the Act makes it clear that the said provision is attracted or comes into force only after a certificate of insurance has been issued under Sub-Section (3) of Section 147 in favour of the person by whom the policy has been effected. Otherwise the said section has no application at all. The said certificate should cover clause (b) of Sub-Section (1) of Section 147, being the liability covered by the terms of the policy or under the provisions of section 163A. This provision cannot therefore be used to enlarge the liability if it does not exist in terms of Section 147 of the Act. At this juncture, it would be necessary to test the logic behind Section 149 of the Act. The conditions under the said provision relate only to third party risks and claims.

The insurer can be made a party to the proceedings of the Motor Accident Claims Tribunal under Section 149[3]. The Apex Court in the case of *New India Assurance Co. Ltd., Vs. Kamala and Others*[4], interpreting Section 149(2) (4) and (5), held that Section 149(2) of the Act says that notice regarding the suit or other legal proceedings shall be given to the insurer if such insurer is to be fastened with such liability. The purpose

[3] *British India General Insurance Co., Ltd., Vs. Captain Itbar Singh and Others, AIR 1959 SC 1331*
[4] 2001 ACJ 843.

of giving such notice is to afford the insurer to be made a party in the proceedings for defending the action on any one of the grounds mentioned in the sub-section.

Permitted Defenses available to the Insurer

Section 149(2) talks about the permitted defenses available for the insurance company to avoid their liability. When once the insurance company establishes the ground mentioned in Section 149 (2) and further establishes breach of such conditions by the insured, not only the liability of the insurance company to the insured ceases, they are also under no obligation to pay the third parties in respect of the risk covered under the policy [5]. In several judgments of the Apex Court, it has been held that if there is no liability of the insurer to the insured, by virtue of their establishing the ground under Section 149 (2) of the MV Act, the insurance company cannot be made to pay to the third party and recover it from the insured[6].

Insurance Companies have been allowed no other defense except the following: -

1. use of vehicle for hire and reward.
2. for organizing racing and speed testing;
3. use of transport vehicle not allowed by permit.
4. driver not holding valid driving license or have been disqualified for holding such license.
5. policy taken is void as the same is obtained by non-disclosure of material fact.

The Insurance Company cannot avoid the liability except on the grounds and not any other ground, which have been provided in Section 149(2)[7]. The courts one after one have held that the burden of proving availability of defense is on Insurance Company and Insurance Company has not only to lead evidence as to breach of condition of policy or violation of provisions of Section 149(2) but has to prove also that such act happens with the connivance or knowledge of the owner[8].

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[5] *The Oriental Insurance Co Ltd vs Sri K C Subramanyam S/O Lt ...* on 12 July, 2012, Karnataka High Court.

[6] *New India Assurance Co.Ltd., .Vs. Asha Rani And Others* (2003 ACJ 1), *Oriental Insurance Co.Ltd., .Vs. Devireddy Konda Reddy and Others*(2003) 2 SCC 339), *M/S.National Insurance Co.Ltd., .Vs. Baljit Kaur and Others*(2004(1) CTC 210), *New India Assurance Co.Ltd., .Vs. Vedwati and Others* (2007 ACJ 1043), *Oriental Insurance Co.Ltd., Vs. Meena Variyal and Others* (2007(3) SUPREME 136), thokchom *Ongbi Sangeeta @ Sangi Devi .Vs. Oriental Insurance Co.Ltd.*, (CDJ 2007 SC 1163), *National Insurance Co.Ltd., .Vs. Prema Devi & Others* (CDJ 2008 SC 354), *National Insurance Co.Ltd., .Vs. Rattani and Others* (2009 ACJ 925), *Shanker Raju .Vs. Union of India* (2011) 2 SCC 132), *Branch Manager, United India Insurance Co.Ltd., Dharmapuri Town .Vs. Nagammal and Others* (2009 (1) TN MAC 1), *New India Assurance Co.Ltd., Thanjavur .Vs. Vinayaga Moorthi and Others* (CDJ 2008 MHC 4293), *Kashiram Yadav & Another Vs. Oriental Fire & General Insurance Co.*, 1989 ACJ 1078, *United India Insurance Co. Ltd. V. Gian Chand and Others*, 1997 ACJ 1065 and *The Oriental Insurance Company Vs. Sabita Kumari & Ors* on 18 March, 2015

[7] *British India General Insurance Co., Ltd., Vs. Captain Itbar Singh and Others*, AIR 1959 SC 1331, *National Insurance Co., Ltd., Chandigarh Vs. Nicolletta Rohtagi and Others*, 2002 (7) SCC 456 and *New India Assurance Co. Ltd., Vs. Kamala and Others*, 2001 ACJ 843

[8] *Sohan Lal Passi's v. P. Sesh Reddy*, 1996 SCC (5) 21, JT 1996 (6) 728 and *Supra note* 1.

Right of Recovery from Owner: Doctrine of Pay and Recover

If the statute covers the risk and the contract does not cover the risk, the insurer on account of the certificate of insurance issued[9], is bound to satisfy the award notwithstanding the fact that the said risk is not covered under the policy[10] and shall be entitled to recover from the insured the amount paid to the third parties under the proviso to sub-section (4) and under sub-section (5). This concept of "pay and recover" is conferred under Section 149 (4) and (5) of the MV Act. The aforesaid provision applies to the cases other than those in Clause (b) of Sub- Section (2) of Section 149 of the Act, but applies to case to which Clause (b) of Sub-Section(1) of Section 147 of the Act is attracted. There is no question of avoiding the liability. What is sought to be avoided is the liability to pay relying on a restrictive clause in the policy or the excess amount payable which is not permitted by law. It has no application to the cases of breach of the terms of the insurance policy or it has no application to the cases where the insurer makes out a ground for avoiding the liability as statutorily provided under Section 149(2) of the Act. The condition precedent for application of the rule 'pay and recover' is, there should be a valid policy of insurance and there is no breach of the terms and conditions of the policy.

Misunderstanding of the application of Principle

With the development of law, liability of the insurance Company has been made strict to the third party even if there is no negligence or defenses to the Insurance Company available. However, if there is a breach in the condition of policy, the insurer can recover the money from the insured[11]. In a recent judgment of the Supreme Court, it was held that the insurer and the insured are bound by the conditions enumerated in the policy and the insurer is not liable to the insured if there is violation of any policy condition. But the insurer who is made statutorily liable to pay compensation to third parties on account of the certificate of insurance issued shall be entitled to recover from the insured the amount paid to the third parties[12].

In recent times, Supreme Court while dealing with the provisions of Motor Vehicle Act has held that even if the defense has been pleaded and proved by the Insurance Company, they are not absolved from liability to make payment to the third party but can receive such amount from the owner insured[13]. After going through the judgments of the Supreme Court on this issue since 1959, it found that though there was no provision to 'pay and recover' in Section 149(2), the Supreme Court, by exercising its power under Article 142 to ensure complete justice, has been consistently

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[9] *United India Insurance Co. Ltd. vs. Laxmamma*, (2012) 4 Scale 409.

[10] New India Assurance Co. Ltd. v. Vimal, Devi, 2010 ACJ 2878 and Shantaben Vankar v/s Yakubbhai Patel, 2012 ACJ 2715.

[11] *National Insurance Company Limited Vs. Savitri Devi and Others*, ILR 2004 KAR 977

[12] *Supra note1 and N.I. Com. v/s Balbir Singh*, 2013 ACJ 1008.

[13] *N.I. Com. v/s Radhey Shyam*, 2013 ACJ 788.

directing insurance companies to pay third-party victims and recover the amount from the insured [14]. Unfortunately, in spite of the aforesaid judgments, still confusion prevails about the liability of the insurance company, the power of the Court and Tribunal to issue directions regarding "pay and recover".

Voice of the Statute

The legislature has expressly provided for the principle of 'pay and recover' in Sub Sections (4) and (5) of Section 149. However, the same is not provided in Section 149(2). The insurance being based on a contract, insurer may be entitled to avoid or cancel the insurance policy if the insured commits breach of terms of the contract, in which event, under the contract there would be no liability on the part of the insurer to indemnify the insured. Therefore, when once the insurer has issued a certificate of insurance covering the liability under Clause (b) Sub-Section (1) of Section 147 on the ground of breach of terms of the contract, it is open to him to avoid or cancel the policy.

Therefore, what follows is that if the case falls under Sub-Section (4) and (5) of Section 149, there is liability on the part of the Insurance Company to satisfy the decree at the first instance and then recover the amount paid in excess from the owner. This is the law which is holding the field for a long time. There cannot be any deviation. But if the case falls under sub-Section (2) read with sub-section (7) of Section 149, if the insurer establishes his defenses under Section 149(2), then there is no binding precedent holding the field which enables the Tribunal or the Court to direct the Insurance Company to satisfy the decree at the first instance and to recover the awarded amount from the owner or driver thereto[15].

Therefore, only in cases where he has contracted to pay less and he is made to pay more than what he has contracted to pay, he has to pay and he has right to recover the excess paid by virtue of express statutory provisions contained in the statute at Sub-Sections (3) and (4). If he is not liable to pay, under the contract any amount at all, because of breach committed by the insured not only is he is not liable to indemnify the insured, he is also not liable to pay the injured-third party.

As per the decision in *Sardari and others Vs. Sushil Kumar and others*[16], if there is apparent violation of contract of insurance on the part of the owner of the vehicle, the compensation should be paid only by him and not by the concerned Insurance Company. If there is any violation of the conditions of contract of insurance, the

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[14] *B.C.Chaturvedi .Vs. Union Of India and Others ((1995) 6 SCC 749), new India Assurance Co.Ltd., .Vs. Satpal Singh (I(2000) ACC 1 (Sc), National Insurance Co.Ltd., .Vs. Swaran Singh and Others (2004(1) TN MAC 104 (SC), Premkumari and Others .Vs. Prahlad Dev and Others ((2008) 3 MLJ 568 (SC), New India Assurance Co., V. Kamla and Others, AIR 2001 SC 1419 : (2001) 4 SCC 342, National Insurance Co. Ltd. vs. Yellamma & Another (2008) 7 SCC 526, Samundra Devi vs. Narendra Kaur (2008) 9 SCC 100 (vide para 16), Oriental Insurance Co. vs. Brij Mohan (2007) 7 SCC 56 (vide para 13), New India Insurance Co. vs. Darshan Devi (2008) 7 SCC 416 (vide para 21), etc. and Oriental Insurance Col Vs. Zaharulnisha & Ors.,2008 AIR SCW 3251*

[15] *Supra note 4.*

[16] 2008 ACJ 1307

concerned Insurance Company cannot be fastened with liability and further it is made clear that if violation of policy condition arises, the question of pay and recover does not arise as per law and it is purely discretion of the Court[17]. In spite of the relevant provisions of the statute, insurance still remains a contract between the owner and the insurer and the parties are governed by the terms of their contract. The insurer is not bound to pay amounts outside the contract of insurance itself or in respect of persons not covered by the contract at all.

It is to be remembered that *Swaran Singh*[18], has no application to cases other than, third party risks and it is only in case of third party risks, that the insurer has to indemnify the amount and if so advised, to recover the same from the insured. But this principal cannot be so stretched to direct the Insurance company to bear the burden without any basis

Sections 149 (1) and 149(2) have to be read along with Section 149(7) of the MV Act[19]. Sub-section (7) of Section 149 of 1988 Act clearly indicates in what manner sub-section (2) of Section 149 has to be interpreted. If so read, the intention of the legislature would be amply clear. Sub-section (7) of Section 149 provides that no insurer to whom the notice referred to in sub-section (2) or sub-section (3) has been given shall be entitled to avoid his liability to any person entitled to the benefit of any such judgment or award as is referred to in sub-section (1) or in such judgment as is referred to in sub-section (3) otherwise than in the manner provided for in sub-section (2) or in the corresponding law of the reciprocating country, as the case may be. The expression 'manner' employed in sub-section (7) of Section 149 is very relevant which means an insurer can avoid its liability only in accordance with what has been provided for in sub- section (2) of Section 149. Under Section 149(2) of the Act, the insurance company will get the right to defend on the grounds mentioned under Section 149(2) of the Act and there is no indication in the said provision that the right to defend and avoid the liability is only against the insured and not against the third party. The Parliament by introducing Section 149 (7) in the MV Act, has made its intention clear. Therefore, in the light of the express provision contained in Section 149(7) of the Act, once the insurance company establishes the grounds enumerated under Section 149(2), their liability to indemnify the insured and pay the third party does not exist. Therefore, this concept of directing payment to the third party and permitting the insurance company to recover the said amount from the insured is not applicable to the cases falling under Sections 149 (1), 149 (2) of the Act.

[17] Branch Manager, United Indian Insurance Co. Ltd, Branch Office Vs. Nagammal and others, 2009 (1) TN MAC 1 (FB).

[18] *Supra note 1.*

[19] *Ibid*

Tribunals not entitled to use the power under Article 142

In *Balajit Kaur*[20] and *Deddappa*[21] after holding that the Insurance Company is not liable by virtue of they making out a case under Section 149(2) of the Act, still they directed the Insurance Company to pay the third party and recover the same from the insured. Following the aforesaid two judgments again in *Zaharulnisha*[22] similar directions were issued. Those are the cases where by virtue of the power conferred under Article 142 of the Constitution, in order to do complete justice between the parties, the Apex Court has issued such direction[23]. Whether the Apex Court by virtue of the power conferred on it under Article 142 of the Constitution can pass an order directing the insurance company to pay the money to the third party and recover from the owner? It cannot be disputed that the power to be exercised under Article 142 is only by the Apex Court and not vested in the High Court and the Tribunal under the statute. Therefore, when the statute expressly states that once the liability could be avoided, under Section 149 (2)(b) of MV Act, the Courts have no power to direct the insurance company to pay and recover. In such circumstances, the Tribunal has no power to direct the Insurance Company to pay the third party and recover it from the insured. Such a direction has been issued by the Apex Court by virtue of the power conferred on them under Article 142 of the Constitution of India which power neither this Court nor the Tribunal constituted under the Act is entitled to exercise[24].

Swaran Singh Case: Not a Precedent

From the judgment in *Chaudhary,* it is clear that the High Court cannot brush aside the judgment of the Supreme Court when law is interpreted saying that it is not in conformity with the statutory provisions. Once the Apex Court lays down law in explicit terms and admits of no doubt, the High Court is bound to follow the said law. In *Suganthi Suresh Kumar*, the Apex Court has held that the High Court cannot overrule the decision of the Apex Court on the ground that the Supreme Court laid down the legal position without considering any other point. The law laid down by the Apex Court is binding on all Courts within the territory of India by virtue of Article 141 and the High Courts cannot question the correctness of the decision of the Supreme Court. In *Industrial Finance Corporation of India Limited Vs. Cannanore Spinning and Weaving Mills Limited and others*[25] the Apex Court held that a judgment of the Supreme Court does not cease to be a binding precedent as it is a short order and not a detailed judgment. In *Official Liquidator Vs. Dayanand and others*[26] the Apex Court has held that "there should be predictability and certainty in the judicial functioning

[20] *M/S. National Insurance Co. Ltd vs Baljit Kaur And Others* on 6 January, 2004, Supreme Court of India.
[21] (2008)2 SCC 595
[22] *2008 ACJ 1928 (SC)*
[23] *Supra note 4.*
[24] *The Divisional Manager, The New India Assurance Company Limited, Thanjavur .Vs. Vinayaga Moorthi & Others* (CDJ 2008 MHC 4293).
[25] AIR 2002 SC 1841
[26] (2008) 10 SCC 1

and therefore, the law laid down by the Apex Court cannot be ignored."

There cannot be any quarrel about these propositions of law. If the Apex Court declares the law, it is binding on all Courts in India by virtue of Article 141. But what is binding is the ratio of the decision and not any finding of facts. It is now well settled that a decision is an authority for what it decides and not what can logically be deduced therefrom. The ratio decidendi of the judgment is its reasoning which can be deciphered only upon reading the same in its entirety. The ratio decidendi of a case or the principles and reasons on which it is based is distinct from the relief finally granted or the manner adopted for its disposal. The only thing in a judge's decision binding as an authority upon a subsequent judge is the principle upon which the case was decided. The answer to the question would necessarily have to be read in the context of what is set out in the judgment and not in isolation. By reading a line here and there from the judgment, one cannot find out the entire ratio decidendi of the judgment.

In *National Insurance Co. Ltd., Vs. Swaran Singh and another,* the Court explicitly they made it clear that the said order may not be considered as a precedent. No order to pay and recover can be passed because though the Supreme Court in the case before them passed such orders, they made it explicitly clear that the said judgment would not be a precedent in future[27], the Court explicitly they made it clear that the said order may not be considered as a precedent. No order to pay and recover can be passed because though the Supreme Court in the case before them passed such orders, they made it explicitly clear that the said judgment would not be a precedent in future.

In fact, one of the Benches of the Supreme Court[28], doubting the correctness of this practice in the Supreme Court of directing pay and recover by exercising the power conferred under Article 142 of the Constitution, has referred the matter to a larger Bench.

Reframing the Legislation not within the ambit of the Court

Therefore, when the statute expressly states that once the liability could be avoided, under Section 149 (2)(b) of MV Act, the Courts have no power to direct the insurance company to pay and recover. That is why though the Supreme Court has zealously protected the interest of third party by applying the Doctrine of pay and recover, even though the statutory provision under Section 149(4) and Section 149(5) was not applicable, it has indicated its disinclination to extend the doctrine of "pay and recover" to other cases. Thus, it has demonstrated the judicial restraint and respected the concept of separation of power as enunciated in the Constitution. The legislature has expressly provided for the principle of 'pay and recover' in Sub Sections (4) and (5) of Section 149. However, the same is not provided in Section 149(2). But the Parliament consciously did not apply the said principle to cases under Section 149 (1) r/w.149 (2) of the Act. Therefore, intention is manifest. The Courts cannot, under the guise of

[27] 2004 ACJ 1

[28] *National Insurance com. Ltd. v/s Parvathneni,* 2009 (3) GLH 377 (SC).

harmonious interpretation, read into the provision which is specifically excluded by the Parliament. If done it amounts to re-writing the law. It is not permissible. The law on the point is fairly well settled. The Courts cannot reframe the legislation to make up deficiencies, as it has no power to legislate.

Conclusion

It is true that the provisions in Chapter XI of the Act are intended for the benefit of third parties with a view to ensure that they receive the fruits of the awards obtained by them and not to make them wait for a prolonged recovery proceeding as against the owner of the vehicle. But from that, it would not be possible to take the next step and find that the Insurance Company is bound to cover liabilities not covered by the contract of insurance itself[29]. It is well settled as held by the Apex Court in the case of *Regional Director ESI Corporation Vs. V.Ramanuja Match Industries*[30] that, we do not doubt that the beneficial legislations should have liberal construction with a view to implementing the legislative intent, but there is no warrant for the court to travel beyond the scheme and extend the scope of statute on the pretext of extending the statutory benefit to those who are not covered by the scheme. Courts cannot introduce words into the statute nor they could rewrite the statute. The concept of purposive interpretation has no application to cases relatable to Section 149 of the Act[31].

A Division Bench of the Karnataka High Court[32] has recommended to the Ministry of Law and Parliamentary Affairs, and the Law Commission of India that the Motor Vehicles Act should be amended and an express provision extending the benefit of the principle of "pay and recover" should be enacted even in cases where insurance companies establish violation of the terms of policy by the insured under Section 149(2) of the Motor Vehicles Act.

It is a conundrum that if a person commits a wrong or a mistake, he should bear its consequences. If a person has no connection whatsoever with the wrong or mistake, he cannot be forced to bear its outcome. It would not be possible to say that the Insurance Company is bound to cover liabilities not covered by the contract of insurance itself. It may take years for the insurance company to recover the amount from the owner of the vehicle, and it is also possible that for some reason the recovery may not be possible at all. If the insurance company has no liability to pay at all, then, it can not be compelled by order of the Court in exercise of its jurisdiction under Article 142 of the Constitution of India to pay the compensation amount and later on recover it from the owner of the vehicle. On the basis of the social philosophy liability cannot be fastened[33]. It amounts to the Court reframing the section, and legislating, for which it has no power.

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[29] *National Insurance Co. Ltd. V. Anjana Shyam & Others,* AIR 2007 SC 2870.

[30] 1985 AIR 278

[31] *Prem Kumari and others Vs. Prahlad Dev and others,* (2008) 3 SCC 193 and *National Insurance Co. Ltd. V. Laxmi Narain Dhut,* (2007) 3 SCC 700

[32] *Supra note 4.*

[33] *New India Assurance Company Limited .vs. C.M. Jaya and others,* AIR 2002 SC 651

Section-III

Role of IRDA in regulating Insurance

Free Look Option to protect Policyholder Interest - A Critical Review

Tmt. Sudha Ramanujam[1]

Abstract

This Paper explains the salient features of "Free Look Option", a consumer friendly provision introduced by Insurance Regulatory Development Authority of India (IRDA) in the year 2002.

I. Introduction

The mission statement of IRDA is to protect the interest and secure fair treatment to policyholders and to bring about speedy and orderly growth of insurance in India. With a view to achieve this objective and to ensure that the insurance product meets the needs of a policyholder, IRDAI, introduced a consumer friendly provisions under IRDAI Protection of Policyholders' Interests Regulations, 2002. In order to safeguard the interest of policyholders the regulator made it compulsory for the insurers to provide policyholders with a copy of proposal and 15 days time for the policyholders to review policy terms and conditions.

Under Regulation 6(2) of Protection of Policyholders Interests Regulations, 2002, relating to Free Look Option, insurers were mandated to provide time to policyholders to review the policy terms and conditions, and, in case of any disagreement, the policyholder would be entitled to a refund of premium, subject to deduction of a proportionate risk premium for the period on cover and expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In case of ULIP policies, in addition to the above, the policyholder would be entitled to repurchase the unit at the price prevailing on the date of cancellation.

Under Regulation 5 (g) of IRDA Health Insurance Regulations, 2013 the insurers have been directed to provide a Free Look Period (FLP) of at least 15 days under all health insurance policies. Accordingly the insured would be allowed a period of 15 days from the date of receipt of the health insurance policy to review the policy terms and conditions and return the same if not acceptable.

In case of insurance solicitation through Distance marketing the time provided to policyholder to review the policy terms and conditions is 30 days. Under 9.5(vi) of IRDA guidelines on Distance Marketing, in case of disagreement after review of policy terms and conditions, the policyholders are provided with 30 days to cancel and request refund of premium under any personal accident and health insurance policy contracts offered by insurers over distance mode with a term of 3 years or more, provided no claim has been already made on the policy.

[1] Deputy Secretary, Office of the Insurance Ombudsman, Chennai -18.

However, the refund of premium is subject to deduction of any expenses incurred by the insurer by way of medical examination, stamp duty etc. Where the risk has already commenced, premium refund is subject to deduction of proportionate risk premium for the period of cover.

II. Reckoning of FLP

From the above mentioned regulatory provisions and guidelines the commencement of Free Look Period starts from the date of receipt of the policy by the policyholder. Accordingly, the following emerge:

a. 15/30 days time provided under the regulations/guidelines should start from the date of receipt of the policy by the policyholder.

b. The date of receipt of policy is the date when the policyholder actually receives the policy at the address provided to the insurer and stated in the policy.

c. In case where the insured provides an address for communication, which is different from the one stated in the proposal/policy, then the date of receipt of the policy, by the insured, at the address for communication.

In case of any dispute regarding FLP, the onus is on the insurer to prove that the policy was delivered to the policyholder on time, and that the 15/30days time to review the policy terms and conditions were provided to him.

III. Delivery of policy other than the policyholder

Regulatory provision: Regulations 6(2) of IRDA Protection of Policyholders' Interest Regulations, 2002 states as under:

"While acting under regulations 6(1), in forwarding the policy to the insured, the insurer shall inform by a letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any those terms or conditions, he has the option to return the policy"

From the above regulation, it is clear that the policy has to be sent to the insured only. Where the policy document is delivered to a person other than the policyholder/ insured, the FLP shall not commence from the date of receipt of the policy by that person, unless he/she is authorised to do so, in writing, by the insured. In the absence of the same the FLP shall commence only when the policy is delivered to the insured by the insurer.

In the case of *Mr.V. Gopinath Vs. Aegon Religare Life Insurance Co. Ltd,* the Hon'ble Ombudsman at Chennai directed the insurer to refund the premium paid by the insured complainant, as the insurer was not able to provide the proof of delivery of the policy document to the complainant. In the instant case, policy the document was

delivered to the insured's neighbour, who was not authorised to receive the same on behalf of the policyholder[2].

IV. Delivery of Policy documents to policyholders by Insurance Agents

As per Clause II (4) of IRDAI GUIDELINES ON APPOINTMENT OF INSURANCE AGENTS, 2015, an ***"Insurance Agent"*** means an individual appointed by an insurer for the purpose of soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance.

As on 31st March 2015, the total number of individual agents operating in the insurance sector mainly, life insurance is around 20.68 lakhs, contributing to 71.42% of the Individual New Business Premium. The share of Individual agents to the aggregate premium is around 36.44%. The premium income of Life insurance industry in the year 2014-15 was Rs.328101.14 crores[3].

The above figures clearly indicate how important is the role of insurance agents in solicitation of insurance premium, particularly in the Life Insurance Industry. Further, under Clause VIII of IRDAI guidelines for Insurance agents relating to Code of Conduct, an Insurance agent shall:

- render necessary assistance and advice to every policyholder on all policy servicing matters including assignment of policy, change of address or exercise of options under the policy or any other policy service, wherever necessary;
- render necessary assistance to the policyholders or claimants or beneficiaries in complying with the requirements for settlement of claims by the insurer

Thus as per the code of conduct the insurance agent as part of policy servicing, shall deliver policy documents to the insured and obtain due acknowledgement from the insured. In such cases, the time limit of 15 days (Free Look Period) provided under the IRDA Protection of Policyholders' Interest Regulations, 2002 for review of policy terms and conditions would be reckoned from the date when the policy was delivered to the policyholder by the agent duly acknowledged by the policyholder.

In case of *Mr.S. Murali Sundaram Vs. LIC of India*, the Hon'ble Ombudsman, Chennai dismissed the request of the complainant to direct the insurer for refund of premium, under Free Look Period, on the grounds that the same was exercised by him beyond the time limit (i.e. after 15days) provided under the policy. In the instant case, the complainant contended that he had not received the policy document, but the insurer produced the proof of delivery of the policy document by the agent concerned, which was also duly acknowledged by the policyholder, to the Forum. The Forum informed that the proof of delivery by agent and acknowledgement by policyholder is a vital document in case of any dispute relating to Free Look Period, between the Insurer and Policyholder.

[2] Refer, IO/CHN/A/LI/0045/2015-16
[3] Annual Report IRDAI 2014-15

V. Suppression of material facts in proposal and FLP

As explained earlier, the IRDA regulations provide policyholders 15/30 days time to review the policy terms and conditions to enable the policyholder to return the policy and take premium refund in case of any disagreement.

Many a time it is observed that the claims are rejected on the basis of suppression of material facts in the proposal form submitted by the proposed insured at the time of inception of insurance. In case of life insurance, the prospect is guided by the provisions of Section 45 of the Insurance Act, 1938, in filling the form of proposal for insurance.

The prospect while filling the proposal form is required to furnish all information relating to his medical conditions, by way of a questionnaire forming part of the proposal. As proposal form is the basis of contract between the insurer and the insured, suppression of material information relating to the medical history is considered to be non disclosure of material information/misrepresentation of facts, and insurance contracts being in the nature of Utmost good faith, the claim are being rejected by insurers for non disclosure of material information in the proposal form submitted at the time of inception of insurance.

IRDA Protection of Policyholders' Interests Regulations, 2002, every insurer is mandated to provide a copy of proposal form to the policyholder along with the Policy terms and conditions. But it is commonly observed that the copy of the proposal form is not provided to the insured/policyholders along with the Policy terms and conditions.

Regulation 4(1) of the above mentioned regulations states as under:

"Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document." It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.

Regulation 2(d) has defined a "Proposal form" means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted.

Explanation: "Material" for the purpose of these regulations shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the insurer.

From the above, it is clear that a Proposal form is an essential part of the policy document. So any policy document not accompanied by a copy of the proposal is incomplete. Therefore review of terms and conditions of the policy by insured includes review of the proposal as well. For the purpose of exercising FLP, an insured should

have received the copy of proposal as well, along with the policy terms and conditions. So the 15/30 days time allowed to the policyholder should commence only from the date when the copy of the proposal and policy terms and conditions are received by the policyholder and not merely the policy terms and conditions. But in practice, the period of FLP is considered from the date of receipt of the policy terms and conditions, irrespective of the fact whether the copy of proposal was sent to the policyholder as required under the IRDA regulations.

VI. Is refund of premium by insurers under FLP compulsory?

Regulatory provision: Regulation 6(2) of IRDA Protection of Policyholders' Interest Regulations, 2002 further states that,

"the insured has the option to return the policy stating the reasons for objection, when he shall be entitled to a refund of premium, subject only to a deduction of proportionate risk premium...."

As Proposal Form is the basic document evidencing the contract of insurance between the insurer and the insured, the same has to be sent along with the policy terms and conditions. The FLP should be reckoned only from the date of receipt of both the documents viz. copy of proposal and Policy terms and conditions. Necessary guidelines should be issued to the insurers by the Regulator to ensure that the interest of the policyholders is fully protected.

A reading of the above regulatory provisions shows that the insured can upon receipt of the policy document; exercise his option to return the same, within the time provided under the policy, by stating the reasons for objection. He shall then be entitled to a refund of premium subject to expenses if any, already incurred by the insurer. Thus the refund of premium under FLP is subject to the insured providing reasons for cancellation of policy and return of premium.

VIII. FLP in case of Mis-selling by Insurance Agents/Intermediaries

In the case of *Mr.R. Illayaraja Vs. Bharti AXA Life Insurance Co.,* the complainant requested the Forum to direct the insurer to refund the premium paid to the insurer, based on an inducement in writing, that a free insurance coverage for 1 lakh would be given to him through a lucky draw. Further he was also asked to take an insurance policy wherein a loan would be granted under the policy, upon payment of one annual premium, after a certain specified period of time. The complainant also informed the Forum that he was advised by the agents/insurance advisors to approach the insurer for grant of loan, only after 15 days from date of receipt of policy documents, without opening the envelope containing the policy document. Accordingly he approached the insurer for grant of loan and was informed that as per the Policy terms and conditions, no loan could be granted, and that he was not entitled to any refund of premium under FLP, as the time limit available under the policy for review of policy terms and conditions was already over. Further the complainant also informed that his signature

was obtained in blank papers. The insurer contended that the Proposal form was signed by the complainant and that the policy document along with the copy of proposal was delivered to him for review of policy terms and conditions. However, the complainant had failed to exercise the Free Look Option available under the policy.

Upon scrutiny of documents submitted, the Forum observed that the information relating to personal details and income details of the complainant, shown in the proposal form were incorrect. In the instant case the Forum also observed that the insurance agents/ advisors have misguided the complainant/policyholder, and thereby the policyholder was deprived of taking the benefit of Free Look Option available under the policy. Keeping in view the facts and circumstances of the case, the Hon'ble Ombudsman, directed the insurer to refund the premium to the insured complainant. The insurer was informed to take suitable steps to prevent insurance mis-selling by insurance agents/intermediaries.

Thus in the instant case, although the insurer contended that the time limit available for FLP under the policy was over, the Forum was of the view that this is a clear case of mis-selling and that the policyholder was entitled to return of period and that the contention of the insurer that the request for cancellation and refund of premium beyond FLP is not tenable. In fact in the instant case, the policyholder acted as per the advice of the insurance agent/intermediary and was not provided an opportunity to review the policy terms and conditions, as required under IRDAI Protection of Policyholders' Interests Regulations, 2002.

Conclusion

Thus, in order to ensure that the interests of the policyholders are safeguarded and fully protected, and the objectives for which IRDA was set up is achieved it is important that the insurers strictly comply with the provisions of the IRDA Protection of Policyholders' Interests Regulations. Insurers should be heavily penalized in case of violation of any of the provisions by the insurers.

The Insurance regulator should issue guidelines to insurers directing them to compulsorily provide a copy of proposal along with the policy terms and conditions, to the policyholders. The fact that the proposal form is a part of the policy document should be emphasized and the insurers must be asked to deliver both the proposal and policy terms and conditions, to the policyholders, in one go, so as to enable them to exercise Free Look Option available under the policy, within the time limit specified. Free Look Period should be reckoned from the date of receipt of policy terms and conditions along with the copy of the proposal and not from the date of receipt of Policy terms and conditions.

Professional Liability Insurance: The Need of Today

A. Ravi Shankar &
K. Visweswaran[1]

Abstract

Professional Liability Insurance is a new form of Insurance emerging steadily around the world. The main aim of this Insurance is to protect the professionals in all the fields from any damages or liabilities incurred as a result of their actions. The study is divided into three parts. The first part discusses about the history and conflict of the nomenclature of Professional Liability Insurance. The second part discusses about position in India as well as the need for such insurance in the current scenario. The Final Part discusses about the advantages and disadvantages of the Professional Liability Insurance and its future prospects. Thus, this study aims to inform the readers about the concept of Professional Liability Insurance as a whole.

Introduction

Insurance provides a financial support as well as a financial guarantee for the indemnities arising out either through contractual obligations or common law. At first the concept of insurance had a confined scope and later it emerged into many fields. Insurance is not only confined to the matters such as life, death, fire etc. but also has a varied scope in the present century. One such expansion is the Professional liability insurance which is the new form of insurance emerged to protect the professionals from the contractual or common law indemnities. The Britannica Encyclopedia defines *"Professional Liability Insurance"* as *"Known as malpractice, or errors-and-omissions, insurance, professional liability contracts are distinguished from general business liability policies because of the specialized nature of the liability* [2]*"*. Prof Gregory defines Professional Liability Insurance as *"a typical policy will provide indemnity to the insured against loss arising from any claim or claims made during the policy period by reason of any covered error, omission or negligent act committed in the conduct of the insured's professional business during the policy period*[3]*"*

It is mostly taken with the view to avoid the special problems like high damage reward by the Courts of Law as well as to recover from the professional's slipshod performance. These Professionals include doctors, surgeons, lawyers, accountants, engineers etc. But the sad face of this form of insurance is that it is not known commonly

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[2] Encyclopedia Britannica, "Professional Liability Insurance", Encyclopedia Britannica Online, referred from the site http://www.britannica.com/EBchecked/topic/478109/professional-liability-insurance (Last Accessed on 29/11/2014).

[3] Arnall Gregory, "Negotiating Your Law Firm's Malpractice Insurance: How to Avoid Purchasing the "Never Pay Policy", The National Law Review, referred from the site http://www.natlawreview.com/article/negotiating-your-law-firm-s-malpractice-insurance-how-to-avoid-purchasing-never-pay-policy (Last Accessed on 29/11/2014)

by most of the professionals. The primary reason for taking the liability insurance is that it covers all the risks incurred by the policy holder during the course of his duty. It also protects the professional from any legal claims by the claimants though actually no harm would have incurred to the latter. For example: A company buys software from an engineer but it failed to work. The Engineer is ready to grant the refund of amount but still the company approaches the Court for damages done though there was no injury to the company. Professional Liability Insurance protects the professional from these sorts of claims too. Other common claims that professional liability insurance covers are negligence, misrepresentation, violation of good faith, violation of fair dealing and inaccurate advice[4].

Historical Background

The history of Professional Liability Insurance dates back to 20th century. It started with accountant Arthur Anderson in the year 1900 who had insured his Auditing and Accounting Firm against the losses incurred due to the activities of the partners in the firm. As a result of corruption of the partners of the firm, his firm had lost its importance and ultimately shut down. It was the first time that Mr. Arthur Anderson managed to recover the sum assured by the Insurer as a result of his shut down. Hence, this was the first time that the concept of the insurance for the professional liability came into the picture. Later, many insurance companies started this practice of insuring the professional against the liabilities incurred by them. In the beginning of the twenty first century, these insurances were made open to the individuals too. They include independently practicing doctors, solicitors, advocates, accountants etc. Later these forms of insurance were extended even to the Industries as well as other forms of association too including the Charitable trusts as well as Non- Governmental Organization.

Liability insurance initially provided a cover for the damages caused by the insured to the third parties concerned. Through the evolution in the past decade the scope of coverage expanded to include personal injury, contractual injuries and medical expenses similar to that of the motor vehicle insurance. In India, this type of insurance found its place only after 1975 when the Chola M/S announced their Professional Liability Insurance Scheme before the Doctors of a well known hospital. However, at the current scenario, there are many other insurance companies providing Professional Liability Insurance covering most of the liabilities incurred together with the other type of insurances. For Example: TATA AIG has an insurance plan combining Professional Liability Insurance as well as the Health Insurance. Thus, these forms of insurances have now increasingly becoming popular among the people. United States of America as well as the United Kingdom have the highest number of Professional Liability

[4] Solicitors, "What will professional indemnity insurance protect me from?", Total Insurance, referred from the site http://totalinsurance.uk.com/blog/Solicitors-PI-cover-protect-from (last Accessed on 29/11/2014)

Insurance takers in the world. Developing countries like India have very less awareness among its professionals with regard to these types of Insurances.

Conflict of Nomenclature

There was always a conflict of nomenclature with this type of insurance. This conflict was due to the nomenclature given out by the professionals who take it. The doctors called it as the Malpractice Insurance whereas the solicitors as well as the lawyers called it as Errors and Omissions (E&O) Insurance. The Engineers called this insurance as Professional Indemnity Insurance. Other professional called it as the Professional Liability Insurance. This type of insurance was called as mistake insurance by the Institutions and associations. It was also called as Commercial liability by the leading construction companies as well as the business giants. There arose a bigger confusion among the insurance companies as well as its agents whether or not to have a single name towards these insurance or to call up the names as given by each and every professional in the country. Later, the Insurance Regulatory and Development Authority stated that these type of insurance shall be called as "Professional Liability Insurance" and added that all the schemes herein further be called as "Professional Liability Insurance" at the Annual Meeting in the year 2000. Thus it ended the long standing conflict of nomenclature. The other names were not completely ignored but were called as the type of the Professional Liability Insurance[5].

Rise of the Policies

The Professional Liability Insurance has gained significance over the past three decades. In this growing age there were many litigations that came up before the Courts claiming damages for the injuries caused due to the negligence or other related activities of the professionals. Depending on the extent of the injury caused to the plaintiffs, the Court imposed a proportional sanction upon the professional who has caused such injury. In extreme cases especially in the medical field, doctors were levied a huge sanction that they were unable to pay and were forced to discontinue the profession. With the rising awareness among the consumers and the Courts becoming friendlier to the people on the whole, such instances are fast becoming a norm which can be gauged from the fact that several other patients have taken hospitals and doctors to court for malpractice or negligence and finally the courts have been ordering doctors and hospitals to pay up[6]. Thus, there were heavy risks of doctors losing jobs. To protect them from such liability, they started taking up these forms of Professional Liability Insurance schemes. Later it covered all the other related professional fields and there was considerable increase in the number of policies taken. It also gave rise to various schemes due to the increasing demands. These special forms of insurances

[5] Author, "Nomenclature of professional Liability Insurance", can be accessed from the site http://library.findlaw.com/1999.html (Last Accessed on 2/12/2014).

[6] Sanjeev Sinha (Economic Times), "Cover your Professional Risks with the indemnity Insurance", referred from the website http://articles.economictimes.indiatimes.com/2013-10-23/news/43326485_1_professional-indemnity-insurance-national-insurance-hdfc-ergo.html (Last Accessed on 2/12/2014)

were clubbed together with the conventional forms of insurance like the life insurance, health insurance etc.

Need for Professional Liability Insurance

Only medical practitioners had been the attack of Courts for their malpractice in the earlier days. But nowadays, the auditors are put into trouble due to submission of false accounts by their clients. An advocate or solicitor can be easily taken to Court for his professional misconduct[7]. An architect may find himself in the dock for poor construction of the building which he had designed. Not only the above, there are some other professionals who can be called to account by the Court for the failure on their part to deliver their task with a professional touch. The Courts sometimes slap fine in such a way that the fine amounts are beyond the capacity of the professional carrying out his service. Hence, in such a scenario, it would be helpful to these professionals to be indemnified by the insurers. Hence, it is very essential for the professionals of this century to have a Professional Liability Insurance in order to secure their career as well as their future.

Position in India

With respect to the Professional Liability Insurance in India, it has not reached its saturation but now it is gaining its importance. The necessity of the Professional Liability Insurance has been evident from the Judgment of the Supreme Court of India[8]. Indian professionals have now realized that the extent of damage as granted by the Court can be reduced if someone has already opted for professional indemnity insurance and any loss or damage caused to the victim is not the result of any deliberate act or willful neglect. Currently, almost all general insurance companies offer this cover to professionals, the prominent ones being New India Assurance, Tata AIG, Bajaj Allianz, HDFC Ergo, United India, National Insurance and ICICI Lombard. Some insurers even have separate policies for doctors, CAs, engineers, lawyers, architects and stock brokers against unintentional errors and omissions that may cause damage, loss or hardship to their clients[9]. However the scope of the coverage varies from professional to professional in India whereas this sort of distinction is not present in other countries like the Great Britain as well as the United States of America. Easwara Narayanan, Chief Operating Officer, Future Generali India Insurance Co. said in his interview about the scope of the Professional Liability Insurance in India as *"The policy indemnifies against compensation claims arising out of breach of duty by a negligent act, error or omission while discharging professional duty. The defense costs can also be covered"*[10].

He also adds that unlike other countries India offers Professional Liability Insurance

[7] ibid

[8] Shankerbhai Hemabhai Nadoda v. Gujarat State Cooperative Land Development Bank Limited (1995) 3 CPJ 97 (Guj.);New India Assurance Company Limited v. Hardip Singh (2003) 4 CLD 612 (NC)

[9] Supra note 6

[10] Tanvi Varma, "Cushion Against a Wrong Step", referred from the website http://businesstoday.intoday.in/story/now-get-insurance-cover-for-professional-mistakes-and-risks/1/191093.html (Last Accessed on 2/12/2014)

only on the following criteria and it also varies among the companies as follows:

- type of profession
- professional experience
- revenue
- limits opted by the insured
- jurisdiction/territory
- extension required
- claim experience

Thus, in the near future the concept Professional Liability Insurance will definitely gain its momentum in India. India is also in need of a statute discussing about the Professional Liability Insurance and the liability of the insurance company as there is no uniformity concerning the policy of Professional Liability Insurance among the different companies. If not a particular statute, the Insurance Regulatory and Development Authority must issue guidelines to all the Insurance companies under its control to bring in a uniform policy system.

Advantages and Disadvantages of Professional Liability Insurance

The biggest advantage of this form of Insurance is that it gives the insured a security as well as peace to perform his profession as the liabilities are borne to an extent by the third parties. The second advantage is it has given rise to various policies like the Critical Illness Insurance, Celebrity Insurance, Personal Accident Cover etc[11]. The other advantage is not only the person insured but also the family of the insured is getting protected by means of the schemes introduced by some of the companies. There is no limit as to the amount of the insurance to be taken. Rahul Aggarwal, CEO, Optima Insurance Brokers has said in an interview that *"Any limit of indemnity can be taken. Policies up to Rs.600 Crore have been issued in India[12]"*. The disadvantage is the Insurance Company does not protect them completely whereas only partially depending on the premium paid up by the insured. It also did not cover the Financial Services Industry.

No reason has been ascertained by the Insurance Companies till date as to why this Financial Services Industry has been left uncovered. Professional Liability Insurance also does not cover liabilities arising out of criminal acts or any act committed in violation of any law or ordinance. It also does not cover the acts of the agents and subordinates. For example: if a manager is held liable for the act of the subordinates the Professional Liability Insurance does not cover his liability. In the similar manner fines, penalties, punitive or exemplary damages are not covered. In fact, each insurer

[11] ibid
[12] Supra note 6

has its own list of exclusions which must be carefully taken into consideration before taking any cover. Also, there is no fixed limit of indemnity. Hence lack of uniformity is a black mark on the face of these forms of insurances.

The Professional Liability Insurance is gaining momentum in the country with a wider coverage of liability of the insured. Irrespective of the criteria of eligibility, there should be Professional Liability Insurance granted to every professional. The Insurance Companies must set targets to these forms of insurances through their agents. Ensuring the Professional Liability Insurance to every professional will also have an indirect effect on the economy of the country. The Professional Liability Insurance may stimulate the professionals to work harder as well as raise their economic status. The Insurance Regulatory and Development Authority must also get involved in this form of insurance. The coverage of these forms of insurances should also be expanded in India similar to that of the other foreign countries in order to ensure stimulation of our economy[13].

Conclusion

The concept of Professional Liability Insurance is a boon to the entire professional around the world. This form of insurance is a protector of the human rights as well as the human values in the world. When a client or a patient who has the right to get remedy through the concerned professional is affected as a result of the misconduct of the professional, these forms of insurance act a savior of their rights by providing them adequate compensation as the injury caused cannot be restored. Hence, Professional Liability Insurance is a protector both to the insured as well as the third party who were affected by the acts of the insured. Hence it can be rightly termed as "Insurance for Human Rights". The Professional Liability Insurance must also include the damages caused as a result of the actions of the subordinates as well as their agents.

The actual intent of introducing the Professional Liability Insurance in England were to defend the insured from any penalties, to indemnify the amount paid to the victims, to settle the reasonable claims of the victims or protect the insured from the breach of duty. The later countries which followed this concept of Professional Liability Insurance have taken them into a wider dimension. India, being a developing Country has to still educate the young professionals about these forms of insurance and their advantages. They must realize that in order to pursue a peaceful continuance of profession, the concept of Professional Liability Insurance is very much essential. To put it in a nutshell, the Professional Liability Insurance is a protector in every sense to professionals in our country.

[13] Swiss Re Sigma, "Liability claims trends: emerging risks and rebounding economic drivers", can be accessed from the site http://media.swissre.com/documents/sigma4_2014_en.pdf (Last Accessed 3/12/2014)

Role of ADR in Insurance Disputes - A Critical Study

Sree Krishna Bharadwaj .H[1]

Abstract

Consumer Protection Act was enacted in the year 1986 to enable speedy disposal of cases and protect the consumers from exploitation. However, even after 30 years of enactment there have been deficiencies and shortcomings in respect of its effective implementation and operation. The purpose of the three tier quasi-judicial structure was to give quick and inexpensive justice to the consumers; however, the machinery is riddled with many problems making it difficult for the complainant to get justice in the prescribed time. The problem is further aggravated by the low level of awareness among the consumers. Also, the scheme of insurance ombudsman has not gained any great success and consumers are still being exploited. This calls for intervention of new type of resolution mechanism. Alternative Dispute Resolution (ADR) offers excellent modes for amicable and quick settlement of disputes while preserving the relationship between the insurance company and the consumer. It is time the public and the government give high recognition to the scope which ADR has. This paper discusses the issues of consumer fora in India and also the advantages ADR has over the insurance ombudsman.

Introduction

Insurance is a form of risk management which is used primarily to hedge against the risk of a contingent, uncertain loss. Insurance is defined as the equitable transfer of the risk of loss, from one entity to another, in exchange for payment. Insurance is essentially an arrangement where the losses experienced by a few are extended among many who are exposed to similar risks. It is a protection against financial loss that may occur due to an unexpected event. The transaction involves the insured assuming a guaranteed and known, relatively small, loss in the form of payment to the insurer in exchange for the insurer's promise to compensate or indemnify the insured in the case of a large, possibly devastating, loss. The insured receives a contract called an insurance policy which details the conditions and circumstances under which the insured will be compensated. Insurance can be classified broadly into: (a) life insurance, and (b) general or non-life insurance[2].

Significance of Insurance

Insurance, particularly life insurance, is one of the ways of providing for the future. A life insurance policy which gives an annuity is a combination of protection and investment. It increases the creditworthiness of the assured person because it can provide funds for repayment in the event of death. It also reduces losses owing to theft,

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[2] Adgaonkar Ganesh, Insurance awareness of India, available at: http://www.allresearchjournal.com/archives/2015/vol1issue9/PartB/1-8-87.pdf (last visited on: august 21, 2016)

robbery, fire accidents, etc. In addition, it serves as a solution to social problems. For instance, while compensation is available to victims of industrial injuries and road accidents, financial difficulties on account of old age, disability or death is minimised[3]. The reason why it is required viz. the growing need for financial education for the families to take better financial decision and to increase their economic security has been widely recognized. It is felt that well informed and well educated customers can create economic ripples. They make better financial decisions for themselves and their families, increasing their economic security and well being. Secured families are more involved in their communities as home owners and voters. They are more involved as parents with their children's schools and teachers, enabling better educational and economic outcomes for their children. They contribute to vital, thriving communities, further fostering community economic development. Thus, being financially literate is not only important to the individual household and family, it is also important to communities and societies[4].

Issues relating to social security are listed in the directive principles of state policy. While social security and insurance, employment and unemployment form Item 23 of the concurrent list, the welfare of labour including conditions of work, provident fund, employee's liability, workmen's compensation, invalidity and old age pension and maternity benefits form Item 24, also of the concurrent list. During the initial years of development planning, it was believed that with the process of development, a greater number of workers would join the organised sector and eventually get covered by formal social security arrangements.

However, the actual experience has proved otherwise. There is now almost a stagnation of employment in the organised sector with increase in the inflow of workers into the informal sector. The unorganised workforce is characterised by scattered and fragmented areas of employment, seasonality, lack of job security and low legislative protection. Currently, out of an estimated workforce of nearly 400 million, only less than 10 per cent have the benefits of formal social security protection. Although the government has a few centrally funded social assistance programmes like National Old Age Schemes and National Family Benefit Schemes, the number of people covered as well as the benefits is very meagre. Furthermore, in a country like India, where there is no provision for unemployment benefits, the concept of insurance becomes extremely important[5].

Mahatma Gandhi, the father of nation, attached great importance to what he described as the "poor consumer", who according to him should be the principal beneficiary of the consumer movement. He said[6]:

[3] IRDA, Pre-launch Report of Insurance Campaign, available at: https://www.irda.gov.in/ADMINCMS/cms/Uploadedfiles/INSURANCE_AWARENESS_insdie_report_final_for_mail.pdf (last visited on: August 19, 2016)

[4] A.S. Norman, Importance of financial education in making informed decision on spending, available at: http://www.academicjournals.org/article/article1379511994_Norman.pdf (last visited on: August 16, 2016)

[5] Supra note 2.

[6] S.S. Singh, Sapna Chadah, Consumer Protection in India Some Reflections, available at: http://www.

"A Consumer is the most important visitor on our premises. He is not dependent on us we are on him. He is not an interruption to our work; he is the purpose of it. We are not doing a favour to a consumer by giving him an opportunity. He is doing us a favour by giving an opportunity to serve him."

Many of the consumers in insurance get cheated or given false or limited information. For example, according to a report [7], there are three broad categories of fraud: Policy holder and claims fraud: fraud against insurer by policyholder and/or other parties in the purchase and/or execution of an insurance product; Intermediary fraud: fraud by intermediaries against insurer and/or policyholders; Internal fraud: fraud against insurer by employee on his/her own volition or in collusion with parties that are internal or external to insurer. It was noted in the same report that 40% of the respondents felt that fraud cases in insurance companies have gone up substantially in the last one year. Furthermore, among the respondents who felt there has been a rise in fraud cases, almost 56% were of the opinion that they had gone up by up to 20% during this period. Another 22% of the respondents indicated that fraud cases have increased by 31–40% during the last one year.

Protection of Consumers in India

In India various Acts intended to protect the consumers against different forms of exploitation were enacted, such as, the Indian Penal Code, 1860; Indian Contract Act, 1872; Drugs Control Act, 1950; Industries (Development and Regulation) Act, 1951; Indian Standards Institution (certification marks) Act, 1952; Drug and Magic Remedies (Objectional Advertisement) Acts, 1954; Prevention of Food Adulteration Act, 1954; Essential commodities Act, 1955; Trade and Merchandise Marks Act, 1958; Hire purchase Act, 1972; Cigarettes (Regulation of Production, Supply and Distribution) Act, 1975; Prevention of Black-marketing and Maintenance of Supplies of Essential Commodities Act, 1980; Essential commodities (Special Provisions) Act, 1981; Multi-State-Co-operative Societies Act, 1984; Standard of Weights and Measures (Enforcement) Act, 1985; and Narcotic Drugs and Psychotropic Substances Act, 1985. Some significant consumer protection enactments of pre-independence time are the Sale of Goods Act, 1930; Agriculture Produce (Grading and Marketing) Act, 1837 and Drugs and Cosmetics Act, 1940.

Rights and remedies under the Consumer Protection Act, 1986

The Act enshrines the following rights:

a. The right to be protected against the marketing of goods which are hazardous to life and property;

consumereducation.in/monograms/1_consumer_orotection_%20in_India.pdf (last visited on: August 14, 2016)

[7] Fraud in insurance on rise Survey 2010–11 conducted by Ernst and Young, available at: http://www.ey.com/Publication/vwLUAssets/Fraud_in_insurance_on_rise/%24FILE/Fraud_in_insurance.pdf (last visited on: August 16, 2016)

b. The right to be informed about the quality, quantity, potency, purity, standard and price of goods so as to protect the consumer against unfair trade practices;

c. The right to be assured, wherever possible access to variety of goods at competitive prices;

d. The right to be heard;

e. The right to seek redressal against unfair trade practices or unscrupulous exploitation of consumer; and

f. The right to consumer education.

The Act provides for the establishment of the Consumer Protection Councils at the National, State and District levels. The objectives of these councils are to help the respective governments in adopting and reviewing policies for promoting and protecting the rights of the consumers. The composition of these consumer councils are broad based. The citizens and organisations representing different interest groups having implications for consumer's rights protection are members of these councils. One may like to add, that the Consumer Councils are required to be constituted on public-private partnership basis for better feedback and thereby review of the policy in the area of consumer's rights protection[8].

The main objective of these councils is to promote and protect rights and interests of consumers in the society. It also provides for Consumer Disputes Redressal Adjudicatory bodies established at three levels i.e. District, State and National. They are known as District Forums, State Commissions and National Commission. District Forum is composed of President and two members (one member is woman). Every member of the District Forum shall hold office for a term of five years or upto the age of 65 years, whichever is earlier and shall be eligible for reappointment. Now graduation is the minimum educational qualification for a member. The State Commission is presided over by Retired High Court Judge. The National Commission is presided over by the retired Supreme Court Judge. The District Forum can adjudicate on the matter upto Rs. 20 lakhs, State Commission upto one crore and National Commission above Rs. one crore. The proceedings before these adjudicatory bodies are regulated in accordance with the principles of natural justice[9].

The National Commission, State Commissions and District Forums are required to decide complaint, as far as possible, within a period of three months from the date of notice received by the opposite party where complaint does not requires analysis or testing of commodities and within five months if it requires analysis or testing of commodities. The Appeals are allowed within 30 days against the order of the District Forum to the State Commission and against the order of the State Commission, to the

[8] Consumer Education in India, available at: http://shodhganga.inflibnet.ac.in/bitstream/10603/7188/10/10_chapter%205.pdf (last visited on: august 15, 2016)

[9] S.S. Singh, Sapna Chadah, Consumer Protection in India Some Reflections, available at: http://www.consumereducation.in/monograms/1_consumer_orotection_%20in_India.pdf (last visited on: august 16, 2016)

National Commission. Appeal can also be preferred to the Supreme Court against the order of the National Commission within a period of 30 days. No appeal by a person who is required to pay any amount in terms of an order of the National Commission shall be entertained by the Supreme Court unless that person has deposited in the prescribed manner fifty percent of that amount or rupees fifty thousand, whichever is less. Similarly there is a requirement for depositing Rs.35,000/- and Rs.25,000/- in case of appeals to National Commission and State Commission[10].

Issues in Consumer Fora across India

The Act has been in operation for the last 30 years, but there are deficiencies and shortcomings in respect of its effective implementation and operation. The purpose of the three tier quasi-judicial structure was to give quick and inexpensive justice to the consumers; however, the machinery is riddled with many problems making it difficult for the complainant to get justice in the prescribed time. The problem is further aggravated by the low level of awareness among the consumers.

Even after 30 years of the consumer movement[11], concerns are being raised regarding the level of awareness of the consumers in spite of many steps taken at the central and state government level to generate awareness among the masses. It's time to evaluate the impact and effectiveness of the Consumer Protection Act and take remedial measure aimed at strengthening the consumer movement. Efficient functioning of Consumer Forums can be judged by considering the disposal of complaints within the stipulated time frame of 90 days and 120 days. In this regard study reveals that time frame has hardly been strictly adhered to. In fact, only 19 per cent (16% new and 3% old) of over all cases at State Commissions, 9 per cent (8.04 % new and 0.52% old) at District Forums Urban and 21 per cent (18.50 new and 2.50 old) at District Forums Rural were disposed within the stipulated time[12].

Only 25.2 percent of the consumers always enquire about the terms and conditions before making a purchase, 40.3 percent do it sometimes. 26.9 percent always enquire about the available choices, 31.8 percent always enquire about the contents of the product. However, 57.1 percent of the respondents always enquire about the price and 50.8 percent always see the expiry date. 70.2 percent of the respondents below 30 years of age are not aware about the Consumer Protection Act, while 61 percent above 50 years are not aware about the Act. 74.9 percent of the rural consumers are not aware about the Consumer Protection Act, while it is 56.3 percent in case of urban consumers. 59.5 percent could not say whether consumers are well protected under the laws in the country. Only 26.1 percent said they were well protected. 55.7 percent could

[10] Ibid

[11] IIPA, Evaluation Report on Impact and Effectiveness of Consumer Protection Act, 1986, available at: http://www.consumereducation.in/ResearchStudyReports/cpa_exec_sum.pdf (last visited on: august 23, 2016)

[12] Report of the Working Group on Consumer Protection Twelfth Plan (2012-17) Volume – II Sub-Group Report, available at: http://planningcommission.gov.in/aboutus/committee/wrkgrp12/pp/wg_cp2.pdf (last visited on: august 14, 2016)

not say whether the CP Act has been implemented well. Only 21.4 percent were of the view that the Act was implemented well. There are lot of other issues such as improper infrastructure, discrepancies in appointment of Presidents and members etc.

Furthermore, the functions of insurance ombudsman are limited and not always appealable. A lot of consumers have been finding issues in these two areas. The concept of ombudsman is not perfect with lot of conceptual differences. Ombudsman needs more power especially implementation and enforcement of orders. Other issues include appointment and infrastructure. However, Alternate Dispute Resolution (ADR) mechanism can be used considering the scope and number of cases filed every year. ADR offers fast and out of court settlement. The importance and the need to use ADR is elaborated below.

Importance of ADR

Alternative Dispute Resolution is today being increasingly acknowledged in the field of law as well as in the commercial sector. The very reasons for origin of Alternative Dispute Resolution are the tiresome processes of litigation, costs and inadequacy of the court system. It broke through the resistance of the vested interests because of its ability to provide cheap and quick relief. In the last quarter of the previous century, there was the phenomenal growth in science and technology. It made a great impact on commercial life by increasing competition throughout the world. It also generated a concern for consumers for protection of their rights. The purpose of ADR is to resolve the conflict in a more cost effective and expeditious manner, while fostering long term relationships. ADR is in fact a less adverse means, of settling disputes that may not involve courts. ADR involves finding other ways (apart from regular litigation) which act as a substitute for litigation and resolve civil disputes, ADR procedure are widely recommended to reduce the number of cases and provide cheaper and less adverse form of justice, which is a lesser formal and complicated system. Of late even Judges have started recommending ADR to avoid court cases[13].

Advantages and disadvantages of ADR

Advantages[14]:-

- *Cheapness* – The relative cheapness of ADR in comparison with the Courts is advantageous. Costs normally associated with court proceedings such as court fees, delays and having to follow complex court processes are not incurred with ADR.

[13] Dutta, Origin of Alternative Dispute Resolution System in India, available at: https://www.academia.edu/4371674/ORIGIN_OF_ALTERNATIVE_DISPUTE_RESOLUTION_SYSTEM_IN_INDIA (last visited on: august 21, 2016)

[14] The advantages and disadvantages of using alternative dispute resolution, available at: http://www.lawmentor.co.uk/resources/essays/the-advantages-and-disadvantages-ADR/ (last visited on: august 26, 2016)

- *Speed* – The use of ADR is much quicker. In particular one of the quickest and cheapest methods of ADR is negotiation and this is because parties get round the negotiation table themselves to solve the dispute without the need for representatives.
- *Control* – With ADR the parties retain control over the dispute and the way it is resolved rather than handing over control to the Courts. There is a saying with litigation in the courts to the effect that once started no matter how sure you are of the merits of your own case, there is no knowing when it will end.
- *Non-adversarial* – Court proceedings are adversarial and about winning not losing, whereas ADR is about finding possible solutions to disputes. As the proceedings are in private it can be a damage limitation exercise and this can be important if the parties expect to do business with each other in the future. ADR can avoid bad feeling between the parties.
- *Privacy* – Court proceedings are conducted in public. The press is admitted and it is possible for the case to be reported in the local or national newspapers. A clear advantage of ADR is that the methods used are private and again this may be an important factor if commercial reputations are at risk.
- *Expert Arbitrators* – With court proceedings the Judge may be an expert in the area of law involved but is not likely to be an expert in building or civil engineering or whatever the subject of the dispute is about. The judge relies upon facts being presented to him or her following detailed and expensive trial preparation. Expert witnesses may well be necessary and this will inevitably contribute to the length of the trial and the overall cost. When expert arbitrators are used they do not rely upon expert evidence in the same way, this means that the proceedings are usually quicker and cheaper.

Disadvantages[15]:-

- *Willingness to compromise* – The use of ADR is dependant upon the willingness of individuals to compromise and to this extent it is arguable that the parties are more likely to settle for less whereas once they have embarked upon court proceedings their expectations may be higher. It could be that one of the parties does not accept there is a problem and is not prepared to compromise.
- *Uncertainty* – Although ADR is generally quicker and cheaper this is not always the case. Even negotiations can drag on and become lengthy and expensive with no certainty of a resolution of the dispute. At least with court proceedings there is usually certainty.
- *Complexity and Expense* – Generally ADR is cheaper than using court proceedings but some formal arbitration hearings can still be complex and expensive depending on the subject matter of the dispute. There are professional and trained arbitrators and these can be expensive.

[15] *Ibid*

- *Making a statement* – Because ADR is confidential they are unsuitable if one party wants to make a point and put out a clear warning or send out a message about the proceedings and their outcome.
- *Immediacy* - ADR is not suitable where one party wants the other to stop instantly. This could be in the case of one party wanting to prevent another from selling goods which are of a similar design to something they are selling or in the case of harassment.
- *Time limits* – It is worth remembering that if there is a time limit involved in a legal claim it may not be appropriate to use ADR. It does not put a stop to any legal time limit and may mean that, if unresolved, the time to make a legal claim has passed.

Role of ADR in Consumer Protection

Even with these enhanced rights and protections for consumers, there will still be instances where problems arise. When consumers find that goods or services that they have purchased are not up to scratch, businesses are often keen to rectify any problems to preserve their reputation. But sometimes this is not possible – perhaps the circumstances surrounding the problem are disputed, or perhaps there is a reluctance to resolve the matter. In these instances, access to an effective alternative dispute resolution (ADR) mechanism can prove invaluable. ADR offers a quicker and cheaper alternative to the court system, when disputes cannot be resolved between the consumer and the business directly. The greater availability of ADR will strengthen consumer protection and improve consumer confidence[16].

Conclusion

Thus it can be said that ADR is not explored in insurance and needs to be utilised looking into the advantages it has over ombudsman and consumer fora. The relative cheapness of ADR in comparison with the Courts is a great advantage. With ADR the parties retain control over the dispute and the way it is resolved rather than handing over control to the Courts. A clear advantage of ADR is that the methods used are private and again this may be an important factor if commercial reputations are at risk. Every citizen has the right to be informed about the quality, quantity, potency, purity, standard and price of goods so as to protect himself against unfair trade practices. There is need to reassure the consumer that his rights are being guarded in one way or other and ADR is one of the best suited methods.

[16] Jo Swinson, Minister for Employment Relations and Consumer Affairs, UK in the report titled, "Alternative Dispute Resolution for Consumers" available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377522/bis-14-1122-alternative-dispute-resolution-for-consumers.pdf (last visited on: August 14, 2016)

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10. Jo Swinson, Minister for Employment Relations and Consumer Affairs, UK in the report titled, "Alternative Dispute Resolution for Consumers" available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377522/bis-14-1122-alternative-dispute-resolution-for-consumers.pdf (last visited on: August 14, 2016)

Insurance from Common Man's Perspective

S. Sabitha[1]

Abstract

This Paper addresses the need of insurance for a common man and also provides the detailed procedural aspects which a common man should know regarding the insurance.

Introduction

Insurance occupies an important role in the modern world. There is a growth in insurance business and various schemes are covered under the insurance sector. Insurance is like a risk management which is used to hedge against the uncertain loss. It is a protection against the financial loss. There are two types of insurance, life and general insurance. Insurance means sharing of losses of a few who are unfortunate to suffer such losses, among those exposed to similar uncertain events. Eg: If a factory gets destroyed by fire, the actual value of goods damaged or destroyed can be estimated and the compensation can be paid to the one who suffers such loss. If the person undergoes heart surgery, the medical cost of same is known and can be compensated.

Origin of Insurance in India

Insurance was first prevalent among the Greek. In India Insurance was prevalent at the time of 1818 when Anita Bhavsar started Oriental Life Insurance Company in Kolkatta. It had several European clients in it. So the Indians who opted for the Insurance schemes had to pay more premium than the Europeans. The company then failed in 1834. Then in 1870 British Insurance Act was passed. In 1907, the Indian Merchantile Insurance Ltd was established at Bombay.This was the first insurance company to transact all general insurance business.

Developments in the Insurance Sectors

Before deregulation in 1999, there were only two state insurers namely, Life Insurance Corporation (LIC) for life insurance and General Insurance Corporation of India (GIC) and its four subsidiaries for general insurance. At present there are 24 general insurance companies and 23 life insurance companies in our country. This statistics was given by the IRDA Insurance Regulatory Development Authority.

Awareness to be Made

The insurance companies should study the socio economic profile of the insured and non-insured families. There is report that states that Above Poverty Line (APL) insurers are higher in number than the uninsured. There are more number of insurers in the western region than in the southern region.

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The importance of creating awareness is that, there are a more number of uninsured than the insured in the urban as well as rural areas. But while the coverage is more in the case of life insurance, in case of health, accident, motor, tractor, livestock, crop, the number of insured number is much less. The percentage is also less. The proportion of male insurers is more comparing the female for all types of insurance, rural or urban.

Common Man and Insurance

A study reveals that, 20% of the rural households and 16% of the urban households have no idea about the insurance. Among the households, it is seen that whether they are rural or urban, the policy they take is more in Government than in private insurance sectors. It's all about the hope and faith they have towards the sector. The ratio of female members having insurance is higher in urban than in rural area. And on the whole, the ratio of male is higher than the female regarding the insurance. This indicates that there should be increased awareness among the urban people also. They should be free of fear to enter in to private insurance sector.

Life Insurance and Common Man

Among the uninsured households only 65% are aware of life insurance.It is all about the risk coverage. And for benefit of life it gives protection against the illness. Only small percentage of the people say that it has no benefit. Many of them say that, it is not important, it is too expensive, limited range of products, poor services, accessibility problem, complex policies, difficult procedure, no confidence and trust in the scheme, inadequate value on maturity. People have lack of knowledge as well as interest over the insurance.

The insurance agents should play a vital role both through media and through awareness programs. The insurance awareness campaign should be carried forward for both in rural and urban areas. The IRDA has launched insurance awareness campaign about the need for insurance among the public as well as their rights and duties.

Status of Insured and Uninsured Persons

The study revealed that, average annual income, expenditure and savings of insured households are higher than that of the uninsured.

Impact of Chennai Flood on the Insurance Sector

In November, 2015 there was a serious flood in Chennai city. At that time, lots of people were affected by this. Many of them lost their vehicles and houses and documents. After the floods, Insurance companies received around 50,000 claims amounting to Rs.4,800 crore on account of destruction of properties and loss of many human lives[2].

While most of the claims have come from property, automobiles and Small and

[2] http://indianexpress.com/article/india/india-news-india/chennai-floods-insurance-cos-get-rs-4800-cr-claims/

Medium Enterprises (SME) sectors, this is the biggest insurance claim from a natural disaster in recent times, according to a senior official of an insurance company. While individuals are opting for household insurance and motor insurance, industries are covering their properties under fire policy, machinery insurance and motor insurance.

"Before the floods, most of the industries financed by banks insured their property only to the extent of their loan amount. They are moving towards re-visiting the value for which their property was insured and revising insurance for the current value," said an official from New India Assurance. "Entire assets including the compound wall are insured and more emphasis is given to adequacy of insurance. They are now cautious enough to get comprehensive cover for the full value of their property."

Views of Insurance Sector on Chennai floods

According to Bajaj Allianz General Insurance, their home insurance portfolio has grown by 30 per cent since the floods. The premium generated has also substantially gone up by 124 per cent post the floods in December. Sasikumar Adidamu, Chief Technical Officer, Non motor, Bajaj Allianz General Insurance, said, "From January to December 2015, the company saw a month-on-month rise of 25 per cent in its home insurance premium and a 12 per cent increase in the number of home insurance policies sold in Chennai and surrounding areas."

A senior official from The New India Assurance Company Limited said that most of the individual houses were insured only for the depreciated value or cost incurred by them at the time of construction many years ago. "Hence, they could not get full claim for their loss as the property was not insured for the current re-instatement value. House owners are now opting for renewing the policy on present replacement value to make sure they get full protection," the official added.

Insurance agents agree that business has boomed after the floods. Madhavan, an insurance agent in T.Nagar, said, "In the last six months, I have enrolled people for various policies and my business has increased by 200 per cent post floods. Customers are looking at comprehensive coverage that would include their appliances. He said that the people are also willing to shell out more from their pocket for the premium".

According to reports, 2015 was one of the worst in aviation losses for insurance companies in India. Eight private jets owned by corporate houses were damaged in the Chennai floods last December that could cost up to Rs.500 crore for the general insurance players.

In the aftermath of the December floods, insurance firms have witnessed a 40-50 per cent increase in policy sales in Chennai and the surrounding areas. "The insurance claims touched Rs.5,000 crore after the floods," an insurance analyst pointed out.

At the 17th annual *FICCI (Federation of Indian Chambers of Commerce and Industry)*[3] insurance conference, IRDA Chairman TS Vijayan said, "despite claims being high, industry has settled the claims very well. Besides loss of lives, according to estimates, some 80,000 vehicles, four and two-wheelers combined, are estimated to have been damaged[4].

A large number of homes and commercial premises had been damaged. The extent of property losses will depend on insurance penetration. Indian government owned properties are not insured, and it is likely that only a very small number of the domestic homes that have been damaged or destroyed are protected by insurance cover.

About 386 people have lost their lives, with many more suffering injuries. This includes 18 fatalities in the ICU of a hospital where a power surge caused oxygen equipment to fail. There will be claims triggered under life insurance, personal accidents and mediclaim policies[5].

Certain motor vehicles losses relating to engine damage due to hydrostatic lock were not covered for many insured since they were excluded under the standard motor insurance terms (the standard terms are mandatory for Indian insurers), and ordinarily, policyholders do not obtain appropriate add-on covers to protect themselves from such consequential losses.

Steps taken by the Insurance Sector

General Insurance companies settle the claims if the following 7 things are met:

i) Policy - If the policy exists.

ii) Premium - If the premium is paid

iii) Period - If the loss takes place during policy period.

iv) Person - If the person covered has insurable interest as per the law.

v) Peril - If the cause of loss is covered under the policy & no specific exclusion applies.

vi) Place - If the loss takes place in the place it is covered.

vii) Property - If the property covered is the one which is damaged.

Further, the insurance companies reject claims if some specific policy conditions are breached, e.g. drunken driving, driving without license etc. Insurance companies also reject claims if there is an existence of fraudulent intent on part of the insured.

[3] Non-governmental trade association.

[4] http://articles.economictimes.indiatimes.com/2016-03-08/wealth/71309412_1_300-crore-to-rs-500-crore-insurance-sector

[5] http://www.mondaq.com/india/x/455192/Insurance/The+Chennai+Floods+The+Insurance+Impact

Conclusion

After a short historical review of insurance industry in India, it is found that the common man is not likely to be fully acquainted with the main features of the insurance industry. In a competitive environment, since the customer is the focus of business, not only do marketing practices acquire critical importance, but the manner in which customer is served deserves close attention.

Despite increasing improvement in financial sector in our country, still some set of people are not aware of the insurance sector schemes. Some are of the opinion that it is useless due to increase in premium of the schemes. On the other hand, some set of people have benefitted a great deal from the schemes introduced by both the private and Government sector. Ultimately it is the mindset of the people towards the insurance sector that will determine the benefits that would flow. For this, awareness has to be created in both rural and urban areas.

Suggestions

Documentation needed to lodge a claim

Insurers have eased the documentation process to file claims so that they can be settled faster. For example, when filing for a life insurance claim, if you do not have the death certificate of the policy holder, a list of deceased issued by any government agency or hospital will be accepted. Claimant's photo identity card and a written claim request are the only two documents needed to file a claim.

Ways to lodge a claim

To lodge a claim you can choose either an online mode or an offline one depending on your preference. Claims can be made by calling the dedicated helpline number of the insurance company, sending an email request as well as sending a SMS to the company claim helpline number.

Relaxed Settlement norms for Chennai Floods

In an attempt to ease the suffering of the residents of Tamil Nadu who faced unprecedented rains and floods, the Insurance Regulatory and Development Authority of India (IRDAI) have relaxed norms for filing and payment for insurance claims. The relaxed norms are available for all residents of Tamil Nadu, Andhra Pradesh and the flood affected Puducherry.

- Formation of special claims helpline: Insurers have set up special helpline numbers and email addresses where you can submit your claim requests. Insurers have also eased the required documentation list making it easy to file for claims. Most insurers are accepting claims with just a written claim request and claimant's photo identity card.
- Dedicated teams for claim settlement: Insurers have fastened their claim settlement and payment process by increasing the survey process for claims. Companies have

appointed nodal officers from outside the state of Tamil Nadu to decrease the claim settlement timeline. Insurers started taking claim requests on a daily basis, ensuring faster claim settlement.

- Direct Credit Using NEFT: Insurance companies were now promoting the use of direct money transfers so that claim funds can be credited quickly. Insurers are seeking NEFT details of claimants so that they do not have to deposit a cheque and wait for clearance to access the claim returns.

However, car owners who have met with damages to their vehicle during the flood will be having a tough time as there are several terms and conditions for damages arising from floods, especially for engine damage. However, if the vehicle is totally washed away in the flood, claims can be made under total loss and the insured will get the Insured Declared Value as compensation.

Government Scheme

Jan Suraksha Yojana-

The Jan Suraksha Yojana, under which the schemes were launched countrywide, is expected to reduce the number of zero balance bank accounts created. The scheme targets the poor and unorganized sector who are neither covered by any form of insurance nor get pension. Under *the accident insurance scheme*, a person will be provided cover of Rs.2,00,000/- for an annual premium of Rs.12/-. The cover is for accidental death or permanent total disability. The scheme will be available to people in the age group of 18 to 70 years with a savings bank account, who give their consent to join and enable auto-debit on or before May 31 for the coverage period of June 1 to May 31 on an annual renewal basis.

The *life insurance scheme* will offer a renewable one year life cover of Rs.2,00,000/- to all savings bank account holders in the age group of 18 to 50 years, covering death due to any reason, for a premium of Rs.330/- per annum per subscriber.

On the other hand, the *pension scheme* focuses on the unorganized sector and provides subscribers a fixed minimum pension of Rs.1,000/-, Rs.2,000/-, Rs.3,000/, Rs.4,000/- or Rs.5,000/- per month starting at the age of 60 years, depending on the contribution option exercised on entering at an age between 18 and 40 years.

While the scheme is open to bank account holders in the prescribed age group, the central government would also co-contribute 50 percent of the total contribution or Rs.1,000/- per annum, whichever is lower, for five years. The government contribution will be for those joining the scheme before December 31, 2015, are not members of any statutory social security scheme and are not income tax payers.

It is estimated that the unorganised sector workers, which constitute 88 percent of the total labour force of 47.29 crore, as per the 66th Round of National Sample Survey Office (NSSO), Survey of 2011-12, do not have any formal pension provision. So, from

the above it is clear that the Government Scheme is very useful for the common man.

Role of Banks

. Services provided by the bank need improvement. Even today, in some banks the customers are not being properly attended and they are treated as if they are being obliged. Even today, there are delayed payment of cheques, late demand drafts, inconvenience in withdrawing cash etc. Every now and then, customers are disturbed by the banks by calling them and informing about the new schemes and plans which annoy the customers. If a person from one city gets settled in another city, while opening a saving account, he needs to give a verification address of the previous city. Thus for clearing of verification, bank takes over a month which causes a lot of inconvenience. Even for old people, getting pension requires a long procedure and the inconvenience caused to them is often troublesome.

Technological overview:

Internet

Internet usage has drastically improved in the last decade. There was a tremendous increase in the use of technology by General Insurance Corporation (GIC) during the late 1990's. The company launched its website in the mid 1990's to offer basic services such as modifying policies (change of address, change of nominee, etc) and querying the status of the policy.

But today, the internet has completely changed the service delivery process. Internet is today used to even sell insurance policies. Internet is, in fact, proving to be one of the widely used distribution networks for selling insurance policies. Also internet is used for sending premium notices to policy holders through e-mails.

Also GIC has a special feature on its website. It has a premium calculator which accurately displays the amount of premium month wise and the remaining balance. One just has to enter the age, name of the insurance policy the sum assured and whether there is an accident cover or not. By keying in this information, the entire premium amounts are shown within no time. This has helped the customer in a way so that he/she doesn't have to travel all the way to the branch to ascertain the amount of premium to be paid.

Metropolitan Area Network (MAN) and Wide Area Network (WAN)

GIC has commissioned a MAN connecting more than 75 branches in Mumbai. This enabled the policy holders to pay their premiums and get their status report, surrender value quotations and loan quotation, from any branch in the city. Following the MAN in Mumbai, seven MAN centres (Chennai, Bangalore, Delhi, Calcutta, Pune, Hyderabad, and Ahmedabad) became operational. These MAN centers' were connected to each other by a WAN network. This WAN was designed for distributed processing without a central database - each division maintained a database of the

policyholders. The central office in Mumbai maintained an index of policy numbers and the corresponding IP addresses of the servers where the details of the policy were maintained.

Electronic Clearance Service (ECS)

Almost all the big organizations today provide the ECS facility to their customers. A policy holder having an account in any bank which is a member of the local clearing house can opt for ECS debit to pay premiums. The advantage here is that once the option is exercised, the policy holder need not visit a branch for paying the premium or collecting the receipts. On the day indicated by the policy holder, the premium amount will be directly debited to the bank account of the policyholder and the receipt will be issued by the designated branch office.

Bank ATM's

Many insurance companies have a tie-up with commercial banks so as to enable policyholders to use the facility of paying premiums through the bank ATM's. ICICI Lombard has a tie up with ICICI bank; Bajaj Allianz has a tie-up with Corporation bank and UTI Bank.

Call Centres and SMS Services

Almost all the insurance companies have their own call centres which cater to the phone based queries of the policyholders. This service is 24x7 and they have the Interactive Voice Response (IVR) systems at all the branches. Also, LIC and other companies now provide SMS services going with the new trends like SMS banking in the banking sector[6].

Loss Minimization

At common law, there is a duty on the part of the insured to observe good faith .This duty of good faith means that at all times the insured has to act as if he is uninsured. For example, the private car package policy provides , among other things , that the insured shall take all reasonable steps to safeguard the motor car from loss or damage and to maintain it in efficient condition. In the event of any accident or breakdown the motor car shall not be left unattended without proper precautions being taken to prevent further damage or loss.

Claim Forms

The contents of the claim form vary with each class of insurance. In general the claim form is designed to elicit full information regarding the circumstances of the loss such as date of loss, time, cause of loss, extent of loss etc claim forms are invariably sued in fire and miscellaneous insurance.

[6] http://www.ukessays.co.uk/essays/finance/general-insurance-business-in-india.php

Investigation and Assessment

On receipt of the claim form duly completed from the insured the insurers decide about the investigation and assessment of loss. If the loss is small the investigation to determine the cause and extent of loss is done by an officer of the insurers. Sometimes even this may be waived and the loss settled on the basis of the claim form only. The investigation of larger or complicated claims is entrusted to independent professional surveyors who are specialist in their line. The appointment of a surveyor is intimated to the claimant; the surveyor is furnished with all relevant claim papers such as claim form, policy copy etc. Sometimes surveyor is appointed and survey is carried immediately on receipt on notice of loss, that is even before claim form could be issued.

Claims Documents

In addition to the claim form, independent survey report is required to be submitted by the insured to substantiate the claim. For example for fire claims a report of the fire brigade, for motor claims driving license registration, copy of police report etc.

Settlement

The claim is processed on the basis of claim form, independent report from Surveyors, legal opinion, medical opinion etc as the case may be, various documents furnished by the insured, any other evidence secured by the insurers etc. If the claim is in order settlement is effected by cheque. The payment is entered in claims register as well as in the relevant process record. Appropriate recoveries are made from the insurers if any.

References:

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Section-IV

Efficacy of Consumer Protection Act, 1986 and other Acts relating to Insurance

Efficacy of Consumer Protection Act 1986 and other Acts relating to Insurance

Dr. T. Paul Rajasekaran[1]

Abstract

This paper highlights the revolutionary changes that have been brought about in the redressal of consumer grievances through the enactment of the Consumer Protection Act, 1986. A number of case laws have been discussed to illustrate deficiencies like delay in settlement of insurance claims, technical interpretations, partial settlements, non-payment of interest etc. The important role played by IRDA, the insurance regulator, has also been discussed.

Laws relating to Insurance business

Insurance is governed by common law which consists of decisions of courts. In India specific statutory laws are promulgated to safeguard the interest of the public. The other laws which relate to insurance business can be classified as follow.

1) Laws which provide a regulatory frame work for the conduct of insurance business viz., Insurance Act 1938 and the IRDA Act 1999.

2) Statutory laws which have direct and indirect bearing on the conduct of insurance business viz., Indian Contract Act, 1872 Indian Penal Code, 1860, Consumer Protection Act, 1986.

3) The insurance Act 1938 has got certain provisions such as registration, accounts and returns investments, limitation on expenses of management, prohibition of rebates, powers of investigation, need for survey (u/s 64 UM),advance payment of premium (u/s64VB). The act was amended in 1968 to establish tariff advisory committee. On the recommendations of Malhotra committee, IRDA Act was passed in 1999. IRDA has made certain amendments in the existing LIC Act 1956 and General Insurance Nationalization Act 1972. IRDA Act was amended in 2002 and introduced Regulations for protection of policyholder's interest.

4) The policy holder's regulation 9 provides "upon acceptance of an offer of settlement as stated under sub regulation (5) by the insured, the payment of the amount due shall be made within 7days from the date of acceptance of the offer by the insured. In case of delay in payment, the insurer shall be liable to pay interest at the rate of 2% above the bank rate prevalent at the beginning of financial year in which claim is reviewed by it.

The other laws relating to insurance are Motor Vehicles Act 1939, the Inland Steam Vessel Amendment Act 1917, Marine Insurance Act 1963, the Carriage of Goods by Sea Act 1925, the Merchants Shipping Act 1958, the Bill of Lading Act, 1855, the Indian Ports (Major ports) Act 1963, Indian Railways Act,1989, the Carriers Act 1865, the

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Indian Post office Act, 1898, the Carriage by Air Act, 1972, Multi modal Transportation Act,1993, Workmen's Compensation Act, 1923 Employees State Insurance Act 1948, Public Liability Insurance Act, 1991 the Sale of Goods act, the Indian Stamp Act 1899 and the Indian Penal Code 1860.

Consumer exploitation in India can be brought down only with proper awareness of the consumers about their rights. There are many platforms which they can approach to put in their complaints and achieve justice. The government understood the need to protect consumers from unscrupulous suppliers, and several laws have been made for this purpose. We have the Indian Contract Act, The Sale of Goods Act, The Dangerous Drugs Act, the Agricultural Produce (Grading and Marketing) Act, The Indian Standards Institution (Certification Marks) Act, The Prevention of Food Adulteration Act, The Standards of Weight and Measurement Act etc which to some extent protect consumer interests.

The Consumer Protection Act 1986 was enacted "to provide better protection of the interests of the consumers and for that purpose to make provision for the establishment of Consumer Councils and other Authorities for the settlement of Consumer Disputes and for matters concerned therewith". The Act provides speedy, inexpensive justice to the aggrieved consumer and the reliefs awarded by and large are compensatory in nature .

We make tall promises like "faithfully & friendly", "Serving to grow, growing to serve", "Where every individual is committed", "Service with traditional personal love", "Hum Hainan". All big promises are made through media, newspapers, television, commercial pamphlets, warranties, guarantees; the question is how faithful they are?

All these promises are not maintained after sales and hence the disputes between the trader and service provider. Every Act has a preamble which is a key to open the minds of the makers of the Act, and the mischiefs which they intended to redress. The preamble serves as preface to the Act. P.M Bakshi, an eminent jurist writes, 'the preamble is an integral part of the statute'. In the preamble, the new Forums are referred to as authorities but not as Courts. The Act envisages the setting up of dispute resolution authorities at the national, state and district level. They are quasi-judicial in nature brought into existence to render inexpensive and speedy remedy to consumers. They are not supposed to supplant but to supplement existing judicial systems. The Act revolves round the Consumer and is designed to protect his interest. The Act provides for resolution of business to consumer disputes and not business to business disputes. The redressal agency under CP Act is a Tribunal .

Concept of Consumer Dispute

According to Section 2(i) (e) of the Act, Consumer Dispute means, 'a dispute where the person against whom a complaint has been made, denies or disputes the allegations contained in the complaint'. If the persons agrees to the complaint, there is no consumer dispute.

According to Consumer Protection Act 1986, under section 2 (i) (c) Complaint means,

1. An unfair trade practice or a restrictive trade practice that has been adopted by any trader or service provider,
2. The goods bought by him or agreed to be bought by him, suffer from one or more defects;
3. The service hired or availed of or agreed to be hired or availed of by him suffer from deficiency in any respect,
4. A trader or service provider, as the case may be, has charged for the goods or for the service mentioned in the complaint a price in excess of the price fixed by or under any law for the time being in force
5. Displayed on the goods or any package containing such goods
6. Displayed on the price list exhibited by him or under any law for the time being in force
7. Agreed between the parties
8. Goods which will be hazardous to life and safety when used in contravention of any standards relating to safety of such goods
9. If the trader could have known with due diligence that the goods so offered are unsafe to the public.
10. Services which are hazardous or likely to be hazardous to life and safety of the public when used, are being offered by the service provider which such person could have known with due diligence to be injurious to life and safety.

According to CP Act 1986 under section 2(i) (b) Complainant means,

1. A Consumer or
2. Any voluntary consumer association registered under the Companies Act or under any other law for the time being in force, or
3. The Central Government or any State Government, who or which makes a complaint
4. One or more consumers, where there are numerous consumers having the same interest.
5. In case of death of a consumer, his legal heir or representative, who or which makes a complaint

According to Section 2 (i) (d) of Consumer Protection Act 1986, CONSUMER means, any person who:-

1. buys any goods for a consideration which has been paid or promised or partly paid and partly promised, under any system of deferred payment and includes any user of such goods other than the person who buys such goods for consideration paid or promised or partly paid or partly promised, or under any system of deferred payment

when such use is made with the approval of such person, but does not include a person who obtains such goods for resale or for any commercial purpose; or

2. Hires or avails of any services for a consideration which has been paid or promised or partly paid and partly promised or under any system of deferred payment and includes any beneficiary of such services other than the person who 'hires or avails of the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person but does not include a person who avails of such services for any commercial purpose;

Explanation: For the purposes of this clause, **"Commercial purpose"** does not include use by a person of goods bought and used by him and services availed by him exclusively for the purposes of earning his livelihood by means of self employment.

According to CP Act, 1986 under section 2(i) (f) **Defect** means, "any fault, imperfection or short coming in the quality, quantity, potency, purity or standard which is required to be maintained by or under any law for the time being in force or (under any contract, express or implied or) as is claimed by the trader in any manner whatsoever in relation to any goods".

According to CP Act, 1986 under section 2 (i) (g) **deficiency** means "any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service"

Section 2(i) (O) of the CP Act 1986 defines **Service** as "any description which is made available to potential users and includes, but not limited to, the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical and other energy, board or lodging or both, housing , construction, entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under contract of personal service" .

Section 2 (i) (oo) of C. P. Act 1986 (Act 62 of 2002) defines **"spurious goods and services"** as 'such goods and services which were claimed to be genuine but they are actually not so'. It does not differ from ordinary dictionary meaning. A reference is found in Section 2 (i) (r) to unfair trade practice. A complaint can be made that spurious goods are manufactured or are being offered for sale by trader adopting unfair trade practice.

Procedure on receipt of the Complaint

Complaint can be filed by the complainant as per the terms of section 2 (i) b of the CP Act.

The first step is to decide about the admissibility of the complaint within 21 days of its receipt.

Second step is to refer a copy of the complaint to the opposite party directing him to give his version of the case within a period of 30 days and can be extended by 15 days.

Where alleged defect in the goods is such that it cannot be determined without proper analysis or test of the goods, the forum should obtain the sample of the goods from the complainant and send it to an appropriate laboratory.

Finally, before issuing any final order the district forum will provide an opportunity to both the parties to present their view about the report before the forum.

The district forum, the State Commission or National commission shall not admit a complaint unless it is filed within two years from the date on which the cause of action has arisen.

Jurisdiction of the Forums

Jurisdiction can be seen on territorial and pecuniary limits. At the time of instituting the complaint the opposite party should reside or carry on business or have branch office or the cause of action should, wholly or in part, arise in the same local limits .

The District Forum can entertain claims if the value of goods or services and compensation if any claimed is up to Rs.20 lakhs; the State Commission can entertain claims if the value of goods and services or the compensation claimed exceeds Rs.20 lakhs but is less than Rs.1 crore; National commission can entertain claims exceeding Rs. one crore.

Relief available to Consumers

1. To remove the defects as complained in the complaint-petition
2. To replace the goods with new goods
3. To refund the price paid by the complainant
4. To award appropriate and reasonable compensation for any loss or injury caused to the consumer-complainant
5. To remove deficiencies in the service in question
6. Discontinue the unfair trade practice
7. To restrain or direct the opposite party to withdraw themselves from selling hazardous goods to life
8. Award apart from compensation adequate and reasonable cost to the parties

Responsibilities of the Consumer

1. Consumer should exercise his rights 2. Cautious consumer should not buy blindly or in a hurry 3. Before filing complaint for the redressal of genuine grievances, it is the responsibility of the consumer to approach proper person 4. Consumer must be quality conscious 5. Advertisements often exaggerate and therefore consumer should be beware of false advertisement 6. Consumer should not forget to get receipt and guarantee/warrantee card

Case Laws holding deficiency in service on the part of the insurance company

We would now examine the cases where deficiency of service has been proved and the redressal forum had passed awards against the insurance companies and where the liability was fixed on them.

Misrepresentation of fact in the proposal form

In *Delhi Steel Tubes industries Vs United India Insurance Co Ltd,* 1993,CCJ 86 Delhi (SC) the insurance company repudiated the liability with regard to the damaged machinery occurred in the previous year and the policy stood vitiated.

HELD: Facts about the damage of the machinery were known to the insurance company before the occurrence of the claim but it did not cancel the policy. Hence it cannot take a plea of misrepresentation and was not justified in repudiating the claim.

Wrongful Settlement

In *Pansukhlal Purushothmadas Lodia Vs LIC of India* 1993, CCJ 35, Gujarat (SC), the policy was taken for the benefit of Hindu undivided family, payment was agreed to be made from HUF fund and HUF only was entitled for tax benefits. The policy was taken by the complainant in the names of his three sons who were members of HUF but LIC paid the policy amount to only one son and not to the complainant who was the Karta of HUF. It was held that there was deficiency in service on the part of the LIC inasmuch as the payment was made contrary to the contract.

Delay

Unjustified delay in settlement of genuine claim of the insured is considered as major ground of deficiency in service by the Redressal forum. The Fora do not find any merit in the contention usually put by the insurance companies that a complaint relating to the failure on the part of the insurer to settle the claim of the insured within a reasonable time and the prayer for grant of compensation in respect of such delay will not fall within the jurisdiction of the Redressal Forums. The justification given is that the provision of facilities in connection with insurance has been specifically included within the scope of the expression "service" by the definition of the said word contained in Section 2(i) (O) of the Act. The other contentions raised by the insurance companies some times that no interest should be awarded because there is no provison in the contract of insurance to pay interest on the delayed settlement also does not find favor with the forums. It has been held that liability arises in such case just because of the lack of efficiency on the part of the insurance companies. The argument that the total amount awarded by the Forums (claim amount plus interest) shall not exceed the amount for which the insurance coverage has also been held wrong since the Forums do not consider themselves tied down to any such rigid limit while considering the aspect of deficiency. On the other hand, the Forums consider the quantification of the damage caused by the delay independently and come to the conclusion that the assessment made by them on this account is fair and reasonable *(Shri Umdilal Agarwal Vs. United India Insurance Co Ltd* 1991 CPJ 3, (NC) If some on account payment is made initially,

the Forums do expect that the balance amount is also paid to the insured within a reasonable time (say 3 or 4 months for taking a final decision on the final survey report received by the insurance companies). The justification for award of interest is the fact that such delay causes serious financial embarrassment to the complainant-insured. In *Manu Aima Shahakari Kattai Mills Lt Vs. Oriental insurance Co Ltd,* III (1993CPJ 375 (NC) one of the reasons for the delayed settlement was the ground that during that period the complainant was starved of funds and the insurance company continued to have funds in its hand for the period of delay.

We will study the observations of the Apex body under the Act which also cover relevant and important background to the case. The National commission held: "After going through the record and after hearing the counsel for the parties we come to the following conclusions."

a) The on account payment of Rs.50 lakhs was made on 2nd march 1988, nearly 11 months after the fire took place in April 1987 and nearly 10 months after the joint report of the two surveyors of May 1987. The Insurance company should have taken decision on the report of the Surveyors for making on account payment within a period of 3 to 4 months. As such interest should be allowed on the delayed release of payment of 'on account' amount of Rs.50 lakhs from 1st October 1987 to the end of February 1988

b) There has also been inordinate delay in making payment of the balance of the amount of Rs.52 Lakhs which has actually been paid on the 10th September 1991. There is no doubt that this delay must have caused serious financial embarrassment to the Complainant.

c) There is no merit in the contention of the Respondent insurance Company that under the contract of insurance there is no provision for payment of interest on the claim of the insured. The liability of the Respondent-insurance company to pay interest on the delayed payment under the insurance policy arises because of deficiency in service due to its negligence as per our findings above. May be that the Respondent insurance company continued to have the funds in its hands for the period of delay. The Respondent insurance company is therefore, liable to pay interest on the balance amount of Rs.52 Lakhs also from 1st October 1987, till the 10th September 1991 when the amount was actually paid. The rate of interest would be 15%.

Technical interpretation

In *United India Insurance Co Ltd Vs. Ram Prasad Agarwal,* II (1993) CPJ 196(NC), the complainant got a shop including Xerox machine and all other equipments insured with the insurance company. There was damage caused to the Xerox machine and insurance company repudiated the liability on the ground that damage was caused due to short circuit and overheating and not by fire and as such, the claim was not payable under Fire insurance policy. On the basis of the evidence adduced, the National Commission found that the loss occurred because there was spark on account of failure of electronic board of servo stabilizer to control electrical surge. The spark is nothing

but heat and flame. Therefore, the National commission came to the conclusion that it was futile to say that the damage to the Xerox machine was not caused by fire and on this basis it was held that there was deficiency in service on the part of Insurance Company.

Delayed Settlement without justification

The insurance policy covered three buffaloes and the complainant gave proof of death (Post mortem certificate) in respect of two buffaloes but the claim for the 3rd buffalo was not proved. The insurance company neither paid the claim nor repudiated the liability with regard to the 2 buffaloes for which documentary evidence was adduced. Insurance company was held liable for the claim of two buffaloes and interest of 18% was awarded (with regard to the claim of 3rd buffalo the complainant was advised to approach civil court).

Partial settlement – aspect of interest

S. Vellinayagam & Co Vs. New India Assurance Co Ltd 1993, CCJ 331 (NC). This was a case about the damage to the insured property by fire. The insurance company accepted the liability with regard to the loss as assessed by the surveyors but there was considerable delay in settlement of the claim though some pre payment was made with a view to give financial relief to the insured. The issue involved was whether the claimants were entitled for interest. It was held by the National Commission that the insurance company must compensate the insured for settling the claims beyond reasonable period. In this case the National commission granted interest @ 13.5% p.a. without counting the period of three months from the date of submission of report by the surveyor to the insurance company.

Wrongful repudiation on incorrect plea as also on the ground that the claim does not fall within the ambit of the policy:

Roshanlal Oil Mills Ltd Vs. United India Insurance Co Ltd (1993) CCJ 253 (NC):- In this case, as per the version of the insured, there was fire due to spontaneous combustion of mustard seeds stored in the silo. This was discovered when smoke was noticed coming out of the top of the silo, as seen by one of the supervisory employees of the complainant. The insured claimed 78.48 lakhs as compensation. The contention raised by the insurance company was that there was no evidence of fire in the stocks in the silo, that the mustard seeds were damaged due to spontaneous combustion without fire and therefore, the loss sustained by the insured did not come within the scope of cover. The main contention of the insurance company was that the insured had not lodged police complaint nor produced fire brigade certificate. In this case, the insurance company had collected additional premium in addition to basic premium for spontaneous combustion. National commission held that it was wrongful repudiation.

Misrepresentation by the insured in the proposal form about condition of health

In Supreme Court Civil Appeal No.2776 of 2002 *Sawant Kaur Sandhu – Appellant Vs. New India Assurance Company*, it was held that the statements made by the insured

in the proposal form as to the state of his health were palpably untrue to his knowledge. There was clear suppression of material facts in regard to the health of the insured and therefore the respondent insurer was fully justified in repudiating the insurance contract.

Memorandum of understanding vis-a-vis Marine Open Policy

In CC No:319/2008, dated October, 8th 2015 in the case of *KOG-KTV Products India Ltd Vs National Insurance Co Ltd,* the complainant had a master policy with the opposite party for importing edible palm oil along with memorandum of understanding stipulating various conditions and benefits. It was held that the said Memorandum of Understanding was against the general terms and conditions of Marine open policy. Both the parties to the dispute had signed the MOU and as per MOU clinkage loss was payable. The non settlement of claim amounted to deficiency of service and the forum directed the opposite party to pay Rs.2,77,894/- with interest at the rate of 9% p.a from the date of claim.

Insurance Regulator

The insurers are governed by the Regulator. The objective of the insurance regulator is to promote beneficial competition and to prevent destructive and harmful competition in various areas. Widespread misleading and abusive practices by insurers and agents in the past prompted the Regulator to address the problems and correct the abuses.

Insurance Regulatory Authority has brought in various rules and regulations to guide the insurers, surveyors and third party administrators and to assist consumers to avoid unfair trade practice, unhealthy competitions, false advertisements etc. Free look period, the Repository system and portability are the new inventions which help the consumers .

With regard to delayed submission of documents and denial of claims, the IRDA had issued circular dated 20.9.2011 advising insurers to incorporate additional wordings in policy documents suitably enunciating their stand to condone delay on merit for delayed claim where the delay proves to be beyond the control of the insured.

Under the provisions of Sec 14(1) and 2 (b) of IRDA Act 1999 health insurance policies should be renewed and should not be rejected on arbitrary grounds except fraud, moral hazard and misrepresentation.

By the Government of India notification No 293 Part III Section 4 dated 18.7.2016, six important changes have been brought out to health insurance rules. It replaced health insurance regulations of 2013. The six important changes are:

1. Combi plans can be a mix of any life(earlier only term plan) and health plan 2. Cumulative bonus in health plans allowed 3.Wellness benefits 4. Insuers have been asked to launch pilot products 5. Standard declarations format can be flexible and insurers may sign indemnity 6. Life insurers will not be allowed to offer indemnity based products.

Powers of the Redressel Agencies and enforcement of the orders

The District Forum, Sate Commission ad National commission have all the powers of civil court for the purpose of adjudicating a consumer dispute u/s 13(4, 14(1) of CP Act and Rule 10 of Consumer Protection Rule. As per Section 25 of the Act all persons, complainant and opposite parties are supposed to comply with the order. If anyone fails to comply with the orders pronounced, the Forum / Commission may punish him with imprisonment for a term ranging between one month and three years or with fine ranging between Rs.2000 or Rs.10,000 or both.

Conclusion

"Justice delayed is justice denied , justice hurried is justice buried". Serious attention is required to address the problem of huge pendency of cases before consumer dispute redressal agencies in India and to make provision for further improvement in the procedure and functioning. It is observed that though other grievance redressal agencies like Ombudsman mediation, arbitration and conciliation are available, the consumers prefer to file their grievances before consumer fora to get their grievances redressed. Unfortunately the huge pendency of cases with the consumer forums is because of non-filling of vacancies of Presidents, Members and staffs and frequent adjournments sought by the advocates and lack of accountability for delays. If the Government initiates measures to set right these deficiencies, consumers' grievances can be redressed speedily and the real purpose of establishing consumer forums will be achieved.

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A Critical Comparative Analysis of Misleading Advertisements in Insurance Sector in India

Anita A. Patil[1]

Abstract

In this paper, the problem of Misleading Advertisements in the insurance industry has been critically analysed. The two most common reasons that prompt mis-selling of insurance product are: lack of accountability and the incentive structure that govern the insurance agents. The author through this paper looks into the various regulations and statutes enacted by the government that keeps a check on both the insurance companies and the agents that sell the insurance. The Author also makes a critical comparative analysis as to how such misleading advertisements are effectively addressed in the most developed countries such as United States and United Kingdom.

1. Introduction

The question that arises is whether advertising is a boon or a curse. There are always two sides to the coin. Advertising is a must for economic growth but should not be allowed to mislead or become a nuisance factor. The insurance advertisers don't tell us about the certain important aspects that should not be overlooked by the insured when buying the insurance policy. These include representations in the nature of the insurance product (traditional/unit-linked), nature of guarantee (for instance, under what conditions can the guarantee be enforced), interest rates, financial health of the parent company and information relating to the past performance of the insurance product.

The IRDA (Protection of Policy Holders' Interest) Regulation, 2002 makes it mandatory on the insurer and his intermediaries to explain in the most explicit manner possible to the consumer, the extent of the cover, the exclusion clauses and the terms and conditions. The National Commission, in the case of *National Insurance Company v. Shri D.P Jain*[2] has even observed that those who fail to comply with these regulations will lose the right to repudiate their claims on the basis of the exclusion clauses[3]. The National Commission in the above case was looking at the exclusion clause in the insurance cover for mobile phones that prevented indemnification of the loss. The exclusion clause stated *that the insurance company would not be liable to pay if the theft has taken place without the use of force or violence or threat.* Hence a person whose phone is pick pocketed would not be indemnified, on the ground that there was no use of force or violence or threat. Unfortunately most people know about the same, only when he is denied the claim. The National Commission in the above case, held that the

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[2] Revision Petition 186/2007, National Consumer Disputes Redressal decide on 15 May, 2007

[3] Pushpa Girimaji, Clause and Effect, THE TELEGRAPH (June 4th, 2007) available at http://www.telegraphindia.com/1070604/asp/atleisure/story_7873188.asp

same should have been explained to the policy holder earlier and hence would be liable to indemnify the person who lost his phone[4].

Terms that give the firm the absolute right to decide if its products or services have met the requirements under the contract or to interpret any term of the contract as it sees fit are deemed unfair by the Financial Service Authority. So are terms that give the firm the absolute right to decide if its products or services have met the requirements under the contract, or to interpret any term of the contract as it sees fit. To ensure that there is transparency in the company in which one can secure insurance from, the IRDA has now made it mandatory that all insurance companies host on their public website the disclosures on financials and other information for a period of 5 years[5]. Since most policy contracts are non – negotiable, since they are reformulated, the policy holder is usually at a disadvantageous situation. Many countries have started including statutory protection against these actions by the Insurance Companies.

In Europe Article 2:304(1) Principles of European Insurance Contract Law (PEICL) provides that *a contract not individually negotiated shall not be binding on the policyholder, the insured or the beneficiary, if, 'contrary to the requirements of good faith and fair dealing, it causes a significant imbalance in his rights and obligations arising under the contract to his detriment'. In evaluating the unfair nature of a term consideration must be given to the nature of the insurance contract, all the other terms of the contract and the time the contract was concluded.*

2. Statutory Framework, Guidelines and Self-Regulatory Codes Governing Insurance Advertising in India

A network of instruments to protect consumers from misleading advertisements in the insurance sector already exists. In this part of this article, an attempt is made to evaluate this framework in the context of the challenges posed by misleading advertisements in the insurance sector. Some of the issues that are to be addressed in this part are as follows:-

- What are the various instruments that exist in India to protect consumers from misleading advertisements in the insurance sector?
- To what extent have these instruments been successful?
- Is there an overlapping among these instruments? If yes, how are we to address this confusion?

[4] National Insurance Company v. Shri D.P Jain (RP No. 186 of 2007), National Consumer Disputes Redressal Commission available at http://ncdrc.nic.in/RP18607.htm

[5] Guidelines on Advertisement, Promotion and Publicity of Insurance Companies and Insurance Intermediaries, Circular No. 007/IRDA/CIR/ADV/MAY-07, dated 14 May, 2007.

The framework is a mix of enforceable legislative provisions[6], delegated legislation that has taken the form of prescriptive guidelines to be followed by insurance advertisers[7], a set of guidelines issued by the regulatory authority to supplement the above regulations [8]and a voluntary code put in place by a self-regulatory organization[9].

2.1 Consumer Protection Act, 1986

The Consumer Protection Act, 1986 ("*COPRA*") was enacted with the objective of "*protection of interests of consumers and for that purpose to make provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for matters connected therewith*[10]." It would not be a stretch to say that the COPRA has proved to be one of the more successful Indian legislations. The judiciary has been quick to appreciate the intention behind the enactment, and has spearheaded the extension of the Act over products and services in diverse industry sectors, thereby heralding a new era for consumer protection in India. There is no doubt that insurance is a "service" within the meaning of the COPRA[11]. There is a plethora of case laws from the consumer courts that clarifies the various aspects of insurance vis-a-vis consumer protection law. For instance, in *Life Insurance Corporation of India v. Sheela Devi*[12], it was ingeniously argued that the term "insurance" in Section 2(1)(o) refers only to "general; insurance" and not life insurance. The Court, while rejecting this argument, noted that Section 2(1)(o) defines service in wide-ranging terms. This "phraseology casts the net very wide indeed and could well bring insurance of every kind within its ambit". However, as has been noted by the Court, "the Legislature has gone further to expand the same by expressly including therein all provisions and facilities connected with insurance." It has been helpfully pointed out in a commentary that "the very word 'insurance' has been used with the widest amplitude[13]." It is submitted that such an interpretation makes it clear that it would also cover the Unit-Linked Insurance Plans (ULIPs) and other hybrid instruments that contain elements of equity/debt. Therefore, peddlers of such insurance products cannot argue that they are not covered by the provisions of the COPRA.

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[6] Consumer Protection Act, 1986.

[7] Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000, enacted by the Authority under the power conferred to it by Section 26 of the Insurance Regulatory and Development Authority Act, 1999.

[8] Guidelines on Advertisement, Promotion and Publicity of Insurance Companies and Insurance Intermediaries, Circular No. 007/IRDA/CIR/ADV/MAY-07, dated 14 May, 2007.

[9] Advertising Standards Council of India's (ASCI) *Code for Self-Regulation in Advertising.*

[10] Preamble, Consumer Protection Act, 1986.

[11] Section 2(1)(o), Consumer Protection Act, 1986 - *"service" means service of any description which is made avail¬able to potential users and includes, but not limited to, the provision of facilities in connection with banking, financing insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service.*

[12] 1992 (1) CPR 318.

[13] P. K. Majumdar, Law of Consumer Protection in India, 5th Edition, 527 (2008).

In the COPRA, the term "deficiency" has been defined as follows[14],

"any fault, imperfection, shortcoming or inade¬quacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been *undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service"*

In other words, it is clear from the above-mentioned definition that a service can be considered to be "deficient" if it makes the promises that it does not keep. This condition is not just restricted to a contractual situation, as is evidenced by the use of the phrase "contract or otherwise." This can be extended to mean that a consumer can sue an insurer for "deficiency in service" if he enters into a contract with an insurer based on some or other claim that the insurer makes in an advertisement or any material which is used to solicit the customer. In a number of cases, it has been held that where deficiency in service on the part of an insurance company towards the insured was established in respect of the services to be rendered under an insurance policy, the jurisdiction of the Consumer Forums would be attracted if the complaint was lodged in terms of the provisions of the Act[15].

In any case, Section 2(1)(r) of the Act makes specific reference to misleading advertisements under the definition of "unfair trade practice"[16]. Unfair trade practices "being practiced by the organized sector of traders, manufacturers and businessman on the unorganized, innocent and poor consumers is the basic challenge of the day and it is the duty of the government, the consumer activists and the voluntary consumer organizations or associations to check the same[17]." As it is clear from its sheer length, Section 2(1)(r) is a rather comprehensive provision covering several different tactics that businessmen resort to mislead consumers. From the definition of "unfair trade practice", it is clear that the meaning of the term has been enlarged by Parliament by the deployment of the "inclusive" clause. It is well known that "include" is very generally used in interpretation clauses in order to enlarge the meaning of the words or phrases and must be construed as comprehending, not only such things as they signify according to their natural import, but also those things which the definition clause declares they should include[18].

2.2 Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosures) Regulations, 2000

The Insurance Regulatory and Development Authority (IRDA) is the regulatory body of the insurance sector that was established by the IRDA Act, 1999. The IRDA's

[14] Section 2(1)(g), Consumer Protection Act, 1986

[15] These cases include, New Jaipur Dyeing & Tents Works vs. Oriental Insurance Company Limited, 1991 (2) CPR 149 and Ramesh Flowers Ltd. vs. National Insurance Co. Ltd., 2001 (1) CPR 31 (NC), as cited in Majumdar, at 526.

[16] Section 2(1)(r), Consumer Protection Act, 1986

[17] J. N. Barowalia, Commentary on the Consumer Protection Act, 5th Edition, 497(2002)

[18] *Supra*, Barowalia, at 499.

mission, in its own words, is "to protect the interests of the policyholders, to regulate, promote and ensure orderly growth of the insurance industry and for matters connected therewith or incidental thereto[19]." Section 26 of the IRDA Act[20] empowers the Authority, in consultation with a body known as the Insurance Advisory Committee, to make regulations and rules that are consistent with the purposes of the Act. It is under the auspices of this Section that the Authority promulgated the Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000.

These regulations extend not just to insurers, but also insurance agents and intermediaries. The regulations were a significant step towards ensuring a separate and special regime for insurance advertisers. Of course, the Advertising Standards Council of India has a general self-regulatory code that companies may sign up for. That does not have specific rules targeted at insurance advertising. That is why the 2000 Regulations addressed a pressing need for a separate regime that is able to appreciate the character and peculiarities of the insurance business, which have already been discussed in great detail in Parts I and II of this article. Some of the salient features of the regulation are as follows:-

i) **Highlighting what constitutes a misleading advertisement in the insurance context:-** The Regulations take note of what may constitute an "unfair or misleading" advertisement in the insurance context. As a result, the definition of "unfair or misleading advertisement" in the Regulations is expansive and includes any advertisement, inter alia, that "describes benefits that do not match the policy provisions", "uses words or phrases in a way which hides or minimizes the costs of the hazard insured or the risk inherent in the policy", "illustrates future benefits on assumptions which are not realistic nor realizable in the light of the insurer's current performance" and "where the benefits are not guaranteed, does not explicitly say so as prominently as the benefits are stated or says so in a form or manner that may remain unnoticed"[21]. From the above examples, it is clear that the Authority's expert knowledge of the insurance industry has enabled them to envisage the ways in which consumers can be misled by insurance advertisers. The protection offered under these Regulations is therefore more specific than that offered by the unfair trade provision in the COPRA.

ii) **Insurers made responsible for advertisements by agents:-** The Regulations lay down that every advertisement by an insurance agent that affects an insurer must be approved by the insurer prior to its issue. It also mandates that while granting such approval, the insurer shall ensure that all advertisements pertaining to the

[19] http://www.irda.gov.in/Defaulthome.aspx?page=H1 (Last visited on 6th Sept., 2013).

[20] Section 26, Insurance Regulatory and Development Authority Act, 1999 - (1) The Authority may, in consultation with the Insurance Advisory Committee, by notification, make regulations consistent with this Act and the rules made thereunder to carry out the purposes of this Act, (2).....

[21] Regulation 2(d), Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000.

company, its products and performance comply with the Regulations are not deceptive or misleading[22]. It is submitted that this is a positive step since it was a common strategy among insurers to claim that they are not responsible for misleading or deceptive advertisements brought by their agents with respect to their products. This Regulation ensures that the insurer is ultimately responsible for the advertisement of products sold by it, regardless of whether such an advertisement is made by agent.

iii) **Rules relating to internet advertising:**- In recognition of the growth of the internet as an information source as also a medium for soliciting business, the framers of the Regulation have inserted a provision dealing specifically with advertising on the internet. It is provided that the web-site or portal of every insurer or intermediary shall include disclosure statements which outline the site's specific policies with respect to the privacy of personal information for the protection of their own businesses as well as the consumers they serve[23].

There are several other noteworthy provisions in the Regulations that seek to protect the consumer from misleading or deceptive insurance advertisements. These include rules relating to compliance and control[24], rules highlighting the disclosure of the identity of the advertiser[25], and also those relating to restrictions on endorsements of insurance products and third party involvement[26].

2.3 Guidelines on Advertisement, Promotion & Publicity of Insurance Companies and Insurance Intermediaries, 2007

The IRDA issued a set of Guidelines on Advertisement, Promotion & Publicity of Insurance Companies and Insurance Intermediaries, 2007 ("Guidelines") in May 2007[27]. In the Authority's own words, "these guidelines reinforce the extent regulations on all promotional communications with policyholders/prospective policyholders or targeted market segment with the objective of soliciting insurance business or otherwise[28]." The Authority also noted that the Guidelines are to be considered as the minimum standards to be adhered to, in addition to compliance with the Regulations and the code of conduct prescribed by ASCI[29].

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[22] Regulation 6, Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000.
[23] ibid at Regulation 8
[24] ibid at Regulation 3
[25] ibid at Regulation 9
[26] ibid at Regulation 10
[27] Vide Circular No. 007/IRDA/CIR/ADV/MAY-07, dated 14 May, 2007.
[28] Guidelines, available at http://www.irda.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo132&flag=1
[29] ibid.

The Guidelines consist of a comprehensive set of Do's and Don'ts for insurance advertisers. Like the Regulations, the rules specifically keep in mind the nature of complex and intricate financial products, and the risk that they pose to customers if they are not able to understand them properly. For instance, it has been provided that advertisers must ensure that the contents of the insurance advertisement should necessarily include:[30]

a. the nature of the insurance contract (whether it is traditional or unit-linked) and the type of the product (whether annuity, pension, health, home-owner's etc.)

b. the risks involved; the limitations and exclusions of the contract

c. illustrations which indicate the exact costs and charges; reasonable projections of benefits; and full disclosures of the basis and sources of information (for instance, disclosure of the date of Net Asset Value)

The advertisers have been specifically prohibited from highlighting the positive financial condition of the parent company without mentioning the financial condition of the insurer and/or indicating that the assets of the parent company can be banked upon when desired[31]. Insurance advertisers are also prohibited from drawing attention to favourable tax treatment without stating that they are subject to change in the tax laws[32]. The Guidelines also provide that all the provisions applicable to published advertisements apply equally to advertisements through all electronic media, which includes the internet and telephonic interactive mode[33]. It lends more specificity and greater clarity on how insurers can advertise on electronic media, given how popular and accessible these two modes have become in recent times.

The question now arises as to enforceability of these Guidelines. Para 11 of the Guidelines provides that the advertisements "inconsistent with the provisions of these guidelines should be withdrawn within two months of the Guidelines coming into force." So, what is the legal position of these guidelines? Are they justiciable? It is submitted that the Guidelines are supplementary to the 2000 Regulations of the IRDA. They must be viewed as a sort of extension, since the Guidelines lay down what is permissible and what is not for the benefit of insurance advertisers. The regulator should send out a message by taking action against the insurance advertisers who contravene these guidelines. There have been reports in the past of how the IRDA chooses to apply these guidelines selectively[34]. Clearly, this has given the impression that the Guidelines are not to be taken as seriously. Therefore, the ball is in the regulator's court to send out a strong message to insurance advertisers, however big or small they are.

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[30] Para 3.4.1.4 of the Guidelines, available at http://www.irda.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo132&flag=1

[31] ibid at Para 3.4.2.3

[32] ibid at Para 3.4.2.4

[33] ibid at Para 3.6

[34] Anita Bhoir, Shilpa Sinha, "How selective application of rules by RBI, IRDA & SEBI is creating mistrust", The Economic Times, 2nd May, 2012, available at http://articles.economictimes.indiatimes.com/2012-05-

2.4 Code of Conduct of the Advertising Standards Council of India

The Advertising Standards Council of India (ASCI) is a self-regulatory voluntary organization of the Indian advertising industry. Its mission is to enhance and maintain the public's confidence in advertising. It was formed with the support of all the four sectors of advertising in 1985 - advertisers, advertising agencies, media and others like market research and public relations companies. At the heart of ASCI's work is what is known as the Consumer Complaints Council (CCC), which investigates advertisements on the basis of complaints by consumers[35].

The ASCI has set out a Code for Self-Regulation in Advertising ("Code")[36]. The Code's rules form the basis of judgment whenever there may be conflicting views about the acceptability of an advertisement. The Code applies to advertisers, advertising agencies and the media. The Code also makes it clear that it is not in competition with the law. Its rules, and the machinery which is designed to implement those rules, are intended to complement legal rules and not usurp them[37]. Chapter I of the Code lays down the standards for honestly and truthfulness in advertising. It lays down that advertisers shall neither distort facts not mislead the consumer by means of implications or omissions. Additionally, advertisements shall not be framed so as to abuse the trust of consumers or exploit their lack of experience or knowledge. The Chapter also lays down examples are what are to be considered the appropriate standards of conduct. Example (e) in Chapter I deals with situations in which the public is invited to invest money. Insurance would definitely by one of the ways. It provides -

"Advertisements inviting the public to invest money shall not contain statements which may mislead the consumer in respect of the security offered, rates of return or terms of amortization; where any of the foregoing elements are contingent upon the continuance of or change in existing conditions, or any other assumptions, such conditions or assumptions must be clearly indicated in the advertisement."

Most significantly, the Code contains a special set of guidelines for three types of products/services - food and beverages, educational programmes and institutions and the automotive industry. There is no doubt that a special set of rules is warranted for these products/services, and ASCI have done a commendable job in laying these rules out rather comprehensively, especially in the case of food and beverages and educational programmes. But this leads to wonder whether there should the financial sector, generally, and the insurance sector, particularly, deserves to get its own set of rules such as the ones described above. It is submitted that such a set of rules is the need of the hour, given how customers are easily misled when it comes to the nuances of financial products, in which they do not have adequate or relevant knowledge

[35] http://www.ascionline.org/index.php/mission.html

[36] Code for Self-Regulation in Advertising, available at http://www.ascionline.org/images/pdf/asci_code1new.pdf

[37] *Code*, available at http://www.ascionline.org/images/pdf/asci_code1new.pdf

or experience. This aspect will be explored in the next part, and will be brought to the forefront when a comparison is undertaken with the self-regulatory regime in the United Kingdom, under the auspices of the Advertising Standards Authority.

III. Self-Regulation of Insurance Advertising in the United Kingdom - Making a case for healthy interaction with the law

The Advertising Standards Authority (ASA) is the United Kingdom's independent regulator of advertising across all media. They apply the Advertising Codes, which are written by the Committees of Advertising Practice. Their work includes "acting on complaints and proactively checking the media to take action against misleading, harmful or offensive advertisements[38]." The UK advertising regulatory system is a mixture of self-regulation for non-broadcast advertising and co-regulation for broadcast advertising[39].

3.1 How the Self-Regulation System Interacts with the Law in the UK

It is interesting to see how the self-regulation system for non-broadcast advertising interacts with the law in the United Kingdom, and to analyse the implications of this sort of arrangement. The advertising self-regulation regime administered under the ASA is flexible in its scope and adaptable to market conditions. Undoubtedly, it reflects requirements in law but in several cases, it goes beyond the scope of what the law requires. Why would industry agree to that? Simply because this not only makes further legislation unnecessary, but it also enable advertisers to demonstrate to the public their commitment to high standards in advertising[40].

Across the European Union, there is a harmonized legislation called the Unfair Commercial Practices Directive that has been put in place to prevent the use of misleading advertisements and unfair trade practices. This directive has been incorporate into the UK law to make sure that it is same as the rest of the EU. What the ASA does is work within the framework offered by this legislation to ensure that advertising in the UK is not misleading or unfair. Advertisers who refuse to work with the ASA can be referred to the Office of Fair Trading (OFT) for legal action. The OFT acts under Consumer Protection from Unfair Trading Regulations 2008, which governs how businesses interact with consumers and the Business Protection from Misleading Marketing Regulations 2008, which govern how businesses advertise to each other[41].

In other words, the ASA serves as some sort of compliance offer with respect to the above two legislations. Matters are not taken to court directly, but are first taken to the ASA to resolve. Only if the matter remains unresolved after the ASA's involvement do the courts come into the picture[42].

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[38] Available at http://www.asa.org.uk/About-ASA.aspx.
[39] ibid.
[40] ibid
[41] ibid.
[42] ibid.

The benefits of such an arrangement are many-fold. Apart from preventing the clogging up of the courts, what it does is ensure that the action is taken quickly and the matter is dealt without the hostility and expenses that are associated with a court-driven process.

3.2 Insurance Advertising Regulation by the ASA

There are separate codes in the UK for broadcast (BCAP Code) and non-broadcast advertising (CAP Code). Chapter 3 of the BCAP Code lays down the rules for misleading advertisement in general. The background to the chapter declares that "the ASA may take the Consumer Protection from Unfair Trading Regulations 2008 into account when it adjudicates on complaints about advertisements that are alleged to be misleading[43]." Here again, we see the interaction between the regulatory code and the law. There are separate misleading advertising provisions relating to issues such as substantiation, qualification, exaggeration, prohibited claims, prices, free claims, availability, comparisons, endorsements and testimonials and guarantees and after-sales services[44]. There is a separate Chapter of the BCAP Code that deals specifically with "Financial Products, Services and Investments[45]". The CAP Code[46] follows more or less the same format as the BCAP Code. Chapter 3 lays down the provisions for misleading advertisement that are similar to the broadcast code, and Chapter 14 contains special provisions for "Financial Products".

The ASA has been very proactive and succeeded in its objective of regulation. In the year 2012, they dealt with 31,298 complaints. As a result, nearly 3,700 advertisements were changed or withdrawn in 2012[47]. One of the more widely publicized rulings of the ASA was the its adjudication on RIAS plc., on 15th August, 2012. A television ad for RIAS car insurance began with a voiceover stating, *"Are you paying over £195 for car insurance? Here's why you should talk to RIAS."* Two complainants challenged whether the ad misleadingly implied that all of the advertiser's quotes would be £195 or less when, in their experience, that was not the case. In response, RIAS said it had simply invited viewers to get in touch with the insurance company if it was paying more than £195, and had made it clear through the use of on-screen text that while 20.4% of their new customers who took out insurance between October and December 2011 paid less than £195 for their insurance, there was no implication all quotes would be for less than that amount[48]. The ASA decided that since the statement "Why pay more than £195?" appeared both at the beginning and at the end of the ad, it reinforced the message that RIAS customers would not have to pay more than that amount for their insurance,

[43] The UK Code of Broadcast Advertising, available at http://www.cap.org.uk/Advertising-Codes/~/media/Files/CAP/Codes%20BCAP%20pdf/BCAP%20Code%200712.ashx

[44] ibid at Chapter 3

[45] ibid at Chapter 14

[46] Supra note 49

[47] Available at http://www.asa.org.uk/Rulings.aspx

[48] Charlie Thomas, "Car Insurance Firm RIAS Reprimanded Over Misleading Advertisement", Huffington Post, 15th Aug., 2012

which was admittedly not the case. The advertisement was found to breaching several provisions of Chapter 3 of the BCAP Code[49]. This is classic example of how insurance advertisers mislead consumers, and it is submitted that the ASA came to the right decision.

IV. Recommendations and the way forward

The example of the UK has been examined briefly in this paper only to indicate how the healthy interaction between the self-regulation and law can benefit all stakeholders involved in product and service advertising. In this context that it is submitted that it is necessary for the ASCI to develop a deeper link with the IRDA to curb cases of misleading advertising in the insurance sector. Admittedly, the IRDA does recognize the ASCI Code as an instrument that insurance advertisers must adhere to, as has been made clear by a provision in the Regulations[50]. It is also imperative to note that India has a robust network of instruments (legislation, guidelines and self-regulatory codes) to curb the menace of misleading advertisements in the insurance sector. However, enforcement has always been a lacunae. This framework will be redundant if insurance advertisers are allowed to get away with misleading innocent and gullible consumers, who obviously are in a position of disadvantage when it comes to understanding complex financial schemes and products. Unfortunately, what we are seeing is regulators arguing among themselves on the matter of jurisdiction. For instance, the Securities and Exchange Board of India and the IRDA are engaged in a battle over which one of them has jurisdiction over ULIPs[51].

The objective of self-regulatory codes in the advertising industry should be to supplement the law, fill gaps where the law does not reach and provide an easier way of resolving disputes. The value of self-regulation as an alternative to statutory regulation has even been recognized in the European Directives on misleading and comparative advertisement[52]. The self-regulatory authority is the first line of control in dealing with advertising matters, especially since it has the requisite expertise and know-how to deal with such situations. It is to remember that dealing with misleading advertisements is only one of the functions of the IRDA.

In this context better co-operation and co-ordination between ASCI and IRDA is suggested. Just like the ASA may take the Consumer Protection from Unfair Trading Regulations 2008 into account when it adjudicates on complaints about advertisements that are alleged to be misleading, ASCI should be encouraged to take recourse to the

[49] Available at http://www.asa.org.uk/Rulings/Adjudications/2012/8/RIAS-plc/SHP_ADJ_191335.aspx

[50] Regulation 12 of Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000 - Every insurer or intermediary shall follow standards of professional conduct as prescribed by the Advertisement Standards Council of India (ASCI) and discharge its functions in the interests of policyholders.

[51] "SEBI-IRDA differ on legal modalities over ULIP issue", The Hindu, 29th Apr., 2010, available at http://www.thehindu.com/business/companies/sebiirda-differ-on-legal-modalities-over-ulip-issue/article415307.ece

[52] The UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing, available at http://www.cap.org.uk/Advertising-Codes/~/media/Files/CAP/Codes%20CAP%20pdf/CAP%20Code%200712.ashx.

IRDA Regulations and the Guidelines to decide whether an insurance advertiser has misled consumers or indulged in unfair trading practices. If the ASCI is of the opinion that the matter is too technical in nature, and would be better addressed by the IRDA, then it may send the complaint to the regulator to be dealt with in the way it deems fit. If the complainant insists on having the matter resolved in court, then he or she can take recourse to the provisions of the COPRA, 1986. Reducing the workload of the IRDA will free it up to pursue its numerous other regulatory activities. By establishing a framework with the Regulations and Guidelines, the IRDA has provided a body of specialized rules that the ASCI can rely on while adjudicating insurance advertising complaints.

Upholding Consumer Rights – Role of The Consumer Protection Act, 1986

M.R. Krishnan[1]

Abstract

This paper looks at the insurance industry from a consumer's perspective. It analyses the problems faced by the consumer vis-a-vis the insurance companies, the role of IRDA in protecting consumer interests and the consumer redressal machinery that has been set up under the Consumer Protection Act, 1986.

Introduction

The insurance Industry in India had recorded a new premium income of Rs.1.38 trillion indicating a growth rate of 22.5%. In March 2016, the growth in general insurance has increased by 12%. In the next 10 years it may quadruple. India currently accounts for less than 1.5% of world total insurance premium, despite being the second most populous nation. The county is the 15th largest insurance market. With such a huge potential, the consuming public have a sorry state to tell. Complaints against insurance companies are rising day by day and the complaints in consumer dispute redressal fora in districts/state/national are on the increase.

Complaint is defined as any expression depicting, dissatisfaction of a consumer, about the service delivery system of the service providers. In Insurance sector, the complaints vary from "hard to understand policies" and hidden information to the unhelpful attitude of insurance companies in settling claims and raising unwanted objections to repudiate most of the claims.

Most of the consumers believe that the insurance policy taken by them will no way come to their rescue, when they want it most and the premium paid by them is only to offset the income tax payable by them. When a policy is sold to the consumer, neither the insurance firms nor the so called agent explains fully the advantages and handicaps in the policy. With the exception of motor vehicle insurance, most of the policies are therefore not wanted by the insured because of the constraints that go with the insurance policies.

Consumer Rights

The Consumer Protection Act, 1986 has enshrined six rights on the citizen. Out of these six rights, right to consumer education, the right to be informed, right to be heard and the right for redressel of grievances are relevant in our study.

What is right to consumer education?

Only an educated consumer can protect himself from exploitation of service providers. Consumer education must therefore be the prime concern of the insurer. The

[1] Deputy Director, Consumer Association of India, Vettuvankeni, Chennai.

insurance companies must explain all the salient points of the policy, in simple terms to the policy holder. The policy document should be simple, easy to understand, bereft of technical jargons and possibly in the native language of the region besides English. In a country like India, with 70% of rural consumers the need to address them in their language is most important. The insurance agent or consultant as they are called always make the policy holder err on the wrong side, without telling the ambiguities and pitfalls in the policy. These persons, never help the policy holder in solving problems, faced by them at the time of final claim etc., Therefore the insurance companies must educate their policy holders, periodically on the various issues involved. Do's and Dont's must be properly explained. In the absence of this consumer education there is a widening gap between the consumer and the insurer.

What is right to be informed?

This means that the facts needed by a consumer must be furnished to him, to enable him to make an informed choice. Though the policies are said to contain a lot of information, they are lengthy, printed in fine prints and not in regional language and thus this right is negated. The information disseminated is not properly done and insurance companies should aim to properly inform their clients.

What is right to be heard?

This right, a fallout of the United Nations guidelines, is about setting up of grievance settlement. The grievance redressal by the service providers can be classified into different segments like

- Pre grievance
- Grievance handling
- Grievance management
- Grievance settlement

While it is very much essential that the insurance sector, grows, provision of effective and timely grievance redressal and making people aware of them is none the less important. The IRDAI has issued necessary guidelines to redressal mechanism to be put in place by all the insurers. This includes monitoring the grievances settlement and informing the public about the facilities available. The preamble of IRDAI Act 1997 speaks about "the establishment of an authority to protect the interests of holders of insurance policies". Regulation 5 of the IRDAI tells that every insurer shall have in place, proper procedures and mechanism to address complaints and grievances of consumers effectively and shall communicate along with information about insurance ombudsman.

Grievance redressal by the companies will consist of entire process of receipt handling redressal and closure of grievances including using electronic and call centre platforms. As already stated, the grievance complaint is any communication that

expresses dissatisfaction or lack of action on the standard of service/ deficiency of service or any intermediating or remedial action.

What is grievance redressal?

The right to redressal under Consumer Protection Act 1986 speaks about the duty of welfare state to guarantee, every one to seek redressal. A welfare state should provide proper support for dispute resolution for all its citizens. The CP Act provides for separate enforcement machinery and redressal forum. Before going into the details of these provisions, we shall see how this is ensured by the insurers. The grievances can arise at any one of the following stages:

At the time of issuing the policy: Mis-selling, adopting unfair practices to sell the products, rejecting of free look provision will constitute the complaint at this stage.

During servicing: Non- renewal of lapsing of policy due to non payment of premium, non provision of medical benefits etc will happen at this stage.

Final claims: Non payment or delayed payment, unnecessary repudiation, insistence of documents, which cannot be easily provided by consumer.

These clearly explain how the policy holder due to lack of awareness and lack of exercising choice, falls into the hands of the insurance agent, whose only aim is to sell the policy at any cost. Similarly the insurance companies indulge in repudiating the claims for mundane reasons which result in disfavour to the insured. This leaves a feeling of being cheated. When the company quotes terms at claim stage, when the consumer is not aware of theses during service, despondency sets in. Therefore each insurance company should have an effective redressal system, which instils the much needed confidence to the consumer. Similarly various steps of conciliation, arbitration must be employed in simple, easy, inexpensive procedures without letting the consumer knock at the doors of IRDA.

Role of IRDA

The IRDA steps into the resolution procedure as an appellant authority and takes due cognizance of any lapses on the part of the insurer and provides the much needed help to the consumer. The regulatory body is much worried about the violation of CP rights by the insurance firms and endeavours to set right the lapses duly conferring the consumer his rights.

Grievance Redressal under CP Act

Salient features of grievance redressal under the Consumer Protection Act, 1986 are;

- Less expensive system
- Consumer friendly environment
- Summary procedure
- Speedy disposal

- No need for an advocate.

The consumer dispute redressal forum is a quasi judicial setup and will look into matters of deficiency in goods and services provided. Now let us find out, the different layers of consumer redressal machinery as provided in the CP Act.

Jurisdiction of these fora

Place	Pecuniary jurisdiction	Territorial jurisdiction
District forum	Rs.0-20 lakhs	District
State commssion	Rs.20 lakhs- 1 crore	State/ Union territory
National commission	Above one crore	The entire country except the State of Jammu and Kashmir

Limitation

This fora will admit a complaint within 2 years from the date of which cause of action has arisen. If the complainant satisfies the forum/ commission that he had sufficient reasons for not filing the complaint within time, this can be extended. The fora are quasi judicial with the president being a retired district judge and 2 other members from service organisation, one being a woman. The fora are empowered to order, refund/ repayment of money, with interest compensation for mental agony. Even imprisonment for a less than one month can be awarded. Some of the unfair practices are the following:

- Any contract which imposes penalty to a party for any breaches.
- Mis-selling
- Disclosing information provided by party to any other, without his consent
- Introducing new clauses after executing the agreement.
- There is proposal to permit online filing of disputes with these agencies.

Case studies

The following case studies will show the important role played by the Consumer Protection Act, 1986 in securing/protecting consumer rights:

1. *The Oriental Insurance Co. Ltd. (through its manager) and others Vs. Radhey Govind Steel & Alloys Pvt. Ltd.*

Complainant Company obtained a standard fire and special perils policy valid upto 28-08-2006 in respect of the plant set up by it to manufacture MS Ingots. On 26-06-2006, a blast took place in the furnace of the plant set up by the Complainant which resulted in damaging the entire furnace. The incident was reported to the insurance company which appointed a surveyor to conduct the survey of the plant. Vide letter dated 20-02-2007, the claim of the complainant was repudiated by the insurance company on the ground that the break down was the cause of the incident which was not covered under the fire insurance. The Complainant company filed complaint before

the Chhattisgarh State Commission which vide order dated 17.12.2009 directed the insurance company to pay a sum of Rs.21,71,298/- towards compensation along with Rs.10,000/- for mental agony and Rs.5000 as cost of litigation. Aggrieved by the said order, a Revision Petition was filed by the insurance company. The Revision Petition was dismissed by the National Commission which held that the policy did not exclude explosion on account of failure of the refractory or any other machinery.

2. *M/s. Royal Sundaram Alliance Insurance Co. Ltd. Vs. Mr. Rustam Shaukat Ali Khan*

The Complainant took an insurance policy from the Petitioner Company in respect of a trailer for the period of one year from 19-06-2010. On 02-06-2011, the said trailer along with 13 other trailers was loaded with goods. After unloading, all the trailers except the trailer in question returned back. On enquiry, the Complainant came to know that the aforesaid trailer had unloaded the goods on 05-06-2011. Since the complainant's efforts to locate the vehicle and contact the driver were not successful, he reported the matter to the Police on 07-06-2011. However, the Police registered FIR only on 07-06-2011. Since the Complainant's claim was repudiated by the Petitioner Company, a complaint was filed before the District Forum. Allowing the complaint, the Forum directed the Petitioner Company to pay Rs.9 lakh to the complainant with 9% interest p.a from the date of filing the complaint, Rs.10,000/- as compensation for mental agony and Rs.5,000 towards cost of litigation. On appeal by the Petitioner Company, the State Commission partly allowing the appeal, directed the Insurance Company to make payment of claim on non-standard basis i.e. 75% of the claimed amount along with interest at 9% p.a. Still dissatisfied, the Petitioner Company filed a Revision Petition before the National Commission. The National Commission dismissing the Revision Petition held that there was no breach of condition No.1 of the insurance policy that the insurance company should be informed immediately upon the occurrence of the accident or loss or damage. The Commission further held that the Complainant was not expected to rush the police without contacting the driver and finding out from him why he had not returned. There was therefore no delay in reporting to the matter to the police. As regards delay in filing FIR, the Commission held that it was for the concerned police officer to register FIR after receiving the complaint and that the blame cannot come to the Complainant.

Protection of policy holders interest regulations (2014)

These were issued in the interest of the policy holder by streamlining the redressal frame work, complaint handling procedures, enforcement of rights of consumers and model citizen charter. The rights of prospective buyers have been ensured by forming consumer protection committees. These guidelines are exhaustive and prepared with the interest of consumers in mind. An integrated approach covering the entire life cycle of grievance has been contemplated and is being suggested by insurance companies.

Concluding Remarks

Very large grievances happen because of the difference in understanding between the insurer and insured about the cause of loss, whether it is under covered risks, extent or loss validity of contract etc., Each grievance settlement should communicate lessons to both the insured and insurer to guard against such defects in future. An attempt has been made to present the problems involved in settling the grievances rights of insured and duties of insurer. If both the parties act in unison forgetting that it is not a sale but an essential service, the insurance industry and the insured are definitely at an advantage.

Foreign Direct Investment in Insurance Sector- Challenges and Prospects

Dr. D. Uma Maheswari[1]

Abstract

India is the most attractive destination for Foreign Direct Investment (FDI) in the world after the introduction of economic reforms. Many countries around the world consider it as an attractive country to invest in, particularly in its insurance sector. FDI can play an important role in the economic development of a country. In India, FDI is allowed in the insurance industry, and despite many debates on the modes of its regulation and control, there are lots of restrictions. Foreign Investors feel that these circumstances and uncertainties create restrictions and potential socio-economic risks. On the other hand, the Government is taking steps gradually to open the Insurance sector to a larger FDI. This paper's objectives are to study the insurance industry and review current policy and regulations in India to gain an understanding of the current issues and its ill effects on FDI.

Introduction

The insurance sector is essential for development and economic growth of any economy. It is overt by the Seventh Schedule of the Constitution of India that, Insurance is an important economic sectors of the country, which at present has widespread scope for expansion and development, to be at par with the insurance sectors in developed countries of the world. The significance of the insurance sector was also accredited in the first conference of United Nations Conference on Trade and Development (UNCTAD) in 1964 in which it was held that, "a sound national insurance and reinsurance market is an essential characteristic of economic growth"[2]. The insurance sector inculcates the savings habit, which in turn generates long-term investible funds for infrastructure building. The nature of insurance business ensures constant inflow of funds which is returned for a contingency related. This feature makes this public investment readily available for infrastructure building and its contribution to GDP is relatively significant. There are 52 insurance companies operating in India, out of which 24 are life insurance companies and the remaining 28 are the general insurance companies.

In July 1999, the Indian economy had the new economic policy via macro-economic reforms also known as "LPG"[3]. The concept of economic reform by and large refers to the process of deregulation, or reduction in deformation caused by such regulations for more efficient allocation of resources in the long run[4]. The liberalization

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[2] http://unctad.org (last visited on 6.11.2016)

[3] LPG: Liberalization, Privatization and Globalization

[4] The economic reform in the year 1991 by liberalization and deregulation was with the objective to deal with the crisis and to take the economy on a high growth path. Insurance sector in India was part of the process of the economic reforms following the recommendations of Malhotra Committee's report submitted in 1994.

of the Indian insurance sector has resulted in a number of private as well as foreign insurance companies entering the market both – life and non-life sector, but a single company cannot transact business in both. This has led to an increase in the available choices not only in terms of service providers but also in terms of products for customers. Globalization implies integration of the economy of the country with the rest of the world economy and opening up of the economy for FDI. Indian insurance industry was opened up for private players in the year 2000 with the enactment of IRDA Act. However to meet the capital requirement of private insurance companies the Government approved to enhance the FDI cap from 26% to 49%. In the last fourteen years of period the insurance industry has moved forward on multiple fronts. At the same time the industry is faced with many challenges. On this backdrop an attempt is made to study the significance of FDI and the challenges and prospects of insurance sector during the post reforms period. The present paper aims to study the pattern of FDI and the current trend in Insurance sector, the challenges and the prospects ahead.

Insurance Sector in India

The nationalization of Insurance sector was to create a monopoly and protect it from foreign and private competition. But there were resultant negative implications of such a conservative approach. Insurance sector faced problems such as capital scarcity, poor product quality and technological obsolescence. In the year 2000, life insurance penetration in India stood at an abysmal 2.4%[5]. The major reasons were that, there was a huge lack of proper awareness regarding the need of insurance. The insurance premiums are looked at as a means of tax evasion and savings. The true importance of insurance often gets overlooked. In addition to this, India is a country with a huge lower middle class section. In their daily struggle to try and get both the ends meet, insurance premiums come as a luxury[6]. The inflexible and expensive plans offered in the market make it more difficult for the common people to invest. The situation in rural India is even worse. A small fraction of the people have bank accounts, and the concept of insurance is very much alien. People have little disposable income, and the only form of life insurance is joint family [7].

The insurance industry till August 2000 had only two nationalized players they were the Life Insurance Corporation of India (LIC) and the General Insurance Corporation of India (GIC) along with its four subsidiaries. These two corporations had a monopolistic control over the market. Though these companies did a commendable job in terms of high growth in volume of business and reach but the shortcomings were that, they were not consumer-oriented, reluctant to advance technology and technical skills and therefore, were ineffective in operations. This corporation growth in volume

[5] Ranade A, Rajeev A. Life Insurance in India: Emerging issues, Economic and Political Weekly 1990; 34(3-4):16-23.

[6] Neha Sighvi and Prachi Bhatt (2008),"Distribution channels in life insurance'Bima quest-Vol. VIII-Issue 1.

[7] Sonika Choudhary and Priti Kiran (2011),"Life Insurance Industry in India: Current Scenario, IJMBS, Vol.1 Issue 3.

was mainly driven by income tax considerations and in India the vast rural area was untapped and went unnoticed. Simultaneously, the foreign insurance companies' pressure to open up the Indian insurance sector was high and inevitable[8].

All these factors resulted in a committee that was set up under the chairmanship of R.N.Malhotra to evaluate the Indian Insurance Industry and recommend its further direction in 1993. The committee submitted its report in 1994 and its major recommendations included: that, the Government is required to bring down its stake in insurance companies to 50%; the private companies with a minimum paid-up capital of Rs.100 crore to be allowed entering the insurance sector; with a restriction such as no single company be allowed to transact business in both – life and general insurance and also that the Foreign companies may be allowed to enter the industry in collaboration with domestic companies. The government recognized the global trend of market driven and competitive industry as per the recommendations of the Malhotra Committee, the insurance sector of India was opened up in August 2000. The Insurance Regulatory and Development Authority (IRDA) constituted in April 2000 under the IRDA Act 1999 is vested with the power to carry out the reforms in the insurance sector, and also to take steps for regulating and developing the insurance and reinsurance business[9]. The Reserve Bank of India had also given NBFCs permission to take up insurance agency business on a fee basis and without risk participation. The Insurance (Amendment) Act, 2002, allowed the cooperative societies to carry on insurance business and to enhance the insurance sectors coverage in rural areas.

Foreign Company in India Vs. Foreign Direct Investment in an Indian Company

Establishing a foreign company in India and foreign direct investment in an Indian company are two different concepts. A foreign company planning to set up business operations in India can incorporate a company under the Companies Act, 1956, as a Joint Venture or a Wholly Owned Subsidiary. The foreign company can appoint a Representative Office or a Project Office or a Branch Office of the foreign company which can undertake activities permitted under the Foreign Exchange Management (Establishment in India of Branch Office or Other Place of Business) Regulations, 2000. Whereas, Foreign Direct Investment (FDI) in and Indian company can be via two different ways. FDI through "Automatic Route" where, FDI is allowed under the automatic route without prior approval either of the Government or the Reserve Bank of India in all activities/sectors as specified in the consolidated FDI Policy, issued by the Government of India from time to time. The other way is FDI through "Government Route" where, FDI in activities not covered under the automatic route requires prior approval of the Government which is considered by the Foreign Investment Promotion Board (FIPB), Department of Economic Affairs in the Ministry of Finance. Thus,

[8] Shrivastava DC, Shashank Srivastava. Indian Insurance Industry, Transition and Prospects, New Century Publications Delhi, 2002.

[9] Pant N. The Insurance Regulation and Development Bill: An Appraisal Economic and Political Weekly 1999; XXXIV(45):3166-3169.

Foreign direct investment (FDI) is the process of controlling ownership in a business enterprise in one country by an entity based in another country. It is a direct investment into production or business in a country by an individual or company of another country, either by buying a company in the target country or by expanding operations of an existing business in that country[10].

Benefits of FDI in Insurance Sector

Foreign direct investment (FDI) plays a multidimensional role in the overall development of the host countries economies. For a country where foreign investments are being made, it also means achieving technical know-how and generation of employment. It may generate benefits through bringing in non-debt-creating foreign capital resources, the introduction of new technological upgrading, following skill enhancement of the workers, new employment opportunities , spillovers and allocate efficiency effects. Foreign companies invest in India to take advantage of cheaper wages, special investment privileges like tax exemptions etc.[11]. FDI inflow helps the developing countries to develop a transparent, broad, and effective policy environment for investment issues as well as, builds human and institutional capacities to execute the same.

There are various benefits of inviting FDI in the insurance sector. The Insurance companies will offer better and wide range of insurance products to its customers at competitive prices. Smaller insurance companies will break-even faster and help convert into currency the holdings of the promoters of the older life insurance companies. Insurers will get new technology and product expertise of the foreign partner who has the domain expert. The increased FDI in the existing companies will strengthen them and the new company will enter this sector, thereby enabling better options to the public at large. Insurance companies will be able to create more jobs to meet their targets of venturing into under insured markets through improved infrastructure, better operations and more manpower. Most of the private sector insurance companies have been making considerable losses. The increased FDI limit has brought some much needed relief to these firms as the inflow of capital of more than Rs.10,000/- crore is expected in the near term. This could go up to Rs.40,000/- crore in the medium to long term, depending on how things works [12]. For instance, if the Pension Fund Regulatory Development Bill links the FDI limit in the pension sector to the insurance sector the foreign direct investment in the pension funds will also be raised to 49 percent. The end beneficiaries are the consumers who are the common men. There is bound to be

[10] Rao T. Privatization and Foreign Participation in (Life) Insurance Sector, Economic and Political Weekly 2000; 25:1107-1120.

[11] Chaturvedi, I. (2011). Role of FDI in Economic Development of India: Sectoral Analysis International Conference on Technology and Business Management, March 28-30, 2011.

[12] Rastogi, S. and Runa Shankar, (2007): Enhancing Competitiveness: The Case of the Indian Life Insurance Company, Indian Institute of Management, Kozhikode. Timesofindia.indiatimes.com › Business 6. www.dipp.nic.in 7. www.irda.gov.in 8. www.irdaindia.org 9. www.licindia.com

stringent competition leading to competitive quotes, improved services and better claim settlement ratio.

Demerits of Increased FDI in Insurance

While FDI is expected to create positive outcomes, it may also generate negative effects on the host economy. The costs to the host countries economy can arise from the market power of large firms and their associated ability to generate high profits. The domestic savings, and not FDI, are crucial for any country's economic development. If the LIC is weakened, it may be forced to behave like a clone of the private insurers. The FDI hike will allow foreign capital with small investments to gain greater access and control over large domestic savings. The government needs to retain the control over domestic savings instead of allowing foreign investors to enjoy control over Indian savings. The Parliamentary Standing Committee came to the same conclusion. Insurance industry is one in which even with a small amount of investment, lakhs of crores of public money can be garnered. In India, LIC has provided Rs.7, 04,151/- crore to the 11th Five-Year Plan (2007-2012).India's life insurance sector was nationalized in 1956 after a series of failures and scandals in the private insurance companies [13]. The risk of the entry of profit-seeking foreign companies in the insurance sector, rationalizing the savings and interests of the people is real. Another issue could arise when insurers list their shares on stock exchanges. Indian law requires 25 per cent of a listed company to be owned by public. So if an insurer launches an initial public offering and the foreign partner increases its stake, then the Indian company would end up with a smaller holding in the joint venture.

Rational Management of FDI

The government is looking primarily on how much funds the insurance companies can bring with them, and not on the amount of business which these companies could generate as it is expected that their rural penetration would be low. To get listed on bourse to raise FIIs may not be attractive for all insurance companies. According to Insurance Regulatory and Development Authority (IRDA) norms, companies whose embedded value is two times their paid-up capital can list on the bourses. Embedded value is a common valuation measure in the insurance industry calculated by adding the adjusted net asset value and the present value of future profits of a firm[14]. The present value of future profits considers the potential profits that shareholders will receive in the future, while adjusted net asset value considers the funds belonging to shareholders that have been accumulated in the past.

There are always pros and cons of each decision. FDI will increase competition and basic economics would suggest that when the supply increases as compared to demand the prices will come down, thus benefiting the end customers. The insurance sector in India is still under developed as compared to developed countries, and

[13] Ahuja R. Insurance: Over the Transition, Economic and Political Weekly 2004; 39(32):3569-3571.
[14] IRDA Annual Report, 2013-14

despite private players now allowed to enter this sector, we only have a small number of providers. FDI would increase the number of insurance companies and may also make possible better plans at lower prices. But careful consideration is required to ensure that the investment stays for long term and does not get withdrawn, leaving the companies and their domestic customers in a miserable position, and not all profits are moved outside the country but some reinvested or spent in our country[15]. Regulations need to be revisited to ensure that Insurance Companies are subject to relevant and strict governance.

Foreign investment of up to 26%of the total paid up equity of the insurer would be allowed through the automatic route and the increase of FDI from 26% to 49% would be allowed through Foreign Investment Promotion Board, and not through automatic route, which means that FIPB would issue guidelines regarding the management control, which would lie with the Indian counterpart, also there are concerns about the voting rights of the foreign shareholders, which should not go beyond 26%.FIPB guidelines would also decide on the appointments of CEO's and CFO's of the insurance joint ventures. Another issue is the stability of Indian financial markets as there is a possibility of insurance companies bringing in contagion risk such as risky derivatives and contaminated balance sheet[16].

By 2020, India's insurable population is expected to touch around Rs.75 crore thus, the importance of life insurance in financial planning is only set to increase. With the new government's stress on reforms, steps taken by IRDA to make insurance more consumer-friendly and India's favorable demographics, the future of India's insurance industry looks good[17]. However, it remains to be seen how this sector impacts the unbanked sections of India, in the years to come [18]. The fundamental regulatory changes in the insurance sector would be significant for the future growth and would have huge impact on various sectors of economy. Active foreign participation is crucial for the sector as it would bring the best know how and implementing the best practices. India is one of the fastest growing insurance market and it is expected that Indian insurance industry can grow up to 125 % in the next decade[19]. However there is also a risk that unless given the management control the foreign insurers would be reluctant to invest in India.

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[15] Budhiraja Lovenish (2010), "Indian Insurance Sector Challenges and opportunities" IJRIME, Vol. 3, Issue 6

[16] https://www.irda.gov.in;https://www.irda.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=AR&mid=11.1(Accessed on October 10, 2016)

[17] Government of India (2013): 'Union Budget Documents; 2014-15', Finance Ministry, Government of India, New Delhi 2 IRDA (2013): "Handbook of Insurance Statistics and Annual Reports: Various Issues", IRDA 3 Parida T. K. (2014): 'Banking with Insurance in India: Agency or Broker', The Journal of Insurance Regulatory and development Authority (IRDA), 4 Chaturvedi, I. (2011). Role of FDI in Economic Development of India: Sectoral Analysis International Conference on Technology and Business Management, March 28-30, 2011. http://www.trikal.org/ictbm11/pdf/Globalization/D1314-done.pdf (Accessed on October 10, 2016)

[18] Bhat, Ramesh (2005), "Insurance Industry in India" Structure, performance and future challenges" Vikalpa, 30: 3-5

[19] http://www.trikal.org/ictbm11/pdf/Globalization/D1314-done.pdf (Accessed on October 10, 2016)

Conclusion

The insurance industry in India has passed through a period of structural changes under the combined impact of financial sector reforms in general and insurance sector in particular. With the liberalization of insurance sector, the paradigm for Indian insurance industry has witnessed a sea change during the last decade. FDI was much needed in the Indian insurance industry as it brought the requisite growth capital from foreign promoters, better insurance business practices not available in the country and of course the new type of international exposure from foreign players and thus helped in deepening the penetration of insurance products in the Indian rural markets, where the penetration level was too low. The privatization of the sector has also contributed in a great way by increasing the insurance density and also penetration in both – life and non-life segments. The FDI limit of 49% in insurance sector in India is the lowest internationally. China, Indonesia and Malaysia have an FDI limit of 50%, 80% and 51% respectively. Japan, South Korea, Vietnam, Hong Kong and Taiwan allow 100% FDI in the insurance sector[20]. In this context, the Union Budget moves to increase the FDI limit in insurance are a welcome move, which aims that the global investors to bring in the much required foreign capital to meet the industry needs.

There are leaders in the industry who all already well-established and they do not require additional capital. But at the same time there are also companies such that they do not have enough capital to diversify and therefore are not doing well. These are the ones that are going to benefit by the FDI reforms introduced in the sector. If the private sector is allowed to bring in 49% equity; according to an estimate; this can probably bring in Rs.50,000/- crore in the industry. And it is believed that this will enable the insurers to set up offices in the rural areas and thus, enable the general public to buy more policies. It above study clarifies the concept that, liberalization in insurance sector has brought many positive changes in the industry and at the same time it demands to strengthen CSR and Governance principles for sustainable growth in the industry. Therefore, it can also be said that in a way these reforms are going to make the industry more transparent and consumer-friendly, which clearly means that they are going to benefit not only the insurers but are also going to be beneficial for the insured.

[20] www.policyholder.gov.in/Annual_Reports.aspx(Accessed on October 10, 2016)

Role of Supreme Court on Insurance Services in India

M. Kannan[1] & R. Naveen[2]

Abstract

Insurance is designed to protect the financial well-being of an individual, company or other entity in the case of unexpected loss. Some forms of insurance are required by law, while others are optional. Agreeing to the terms of an insurance policy creates a contract between the insured and the insurer. In this paper some important judgments of the Hon'ble Supreme Court have been highlighted.

Introduction

Insurance is a means of protection from financial loss. The insurance transaction involves the insured assuming a guaranteed and known relatively small loss in the form of payment to the insurer in exchange for the insurer's promise to compensate the insured in the event of a covered loss. The loss may or may not be financial, but it must be reducible to financial terms, and must involve something in which the insured has an insurable interest established by ownership, possession, or pre existing relationship. Agreeing to the terms of an insurance policy creates a contract between the insured and the insurer. In exchange for payments from the insured (called premiums), the insurer agrees to pay the policy holder a sum of money upon the occurrence of a specific event. Insurance is a contract, represented by a policy, in which an individual or entity receives financial protection or reimbursement against losses from an insurance company. Insurance policies are used to hedge against the risk of financial losses, both big and small, that may result from damage to the insured or her property, or from liability for damage or injury caused to a third party.

Definition of Insurance Services

Insurance service is protection against loss. Among the available insurance services are contracts to protect property such as houses, furnishings and vehicles against loss; for reimbursement of health care costs; and to provide death benefits to designated beneficiaries of life insurance policyholders. Insurance services may differ from region to region.

Meaning of Insurance

Insurance is a contract whereby one party agrees to compensate the loss or discharge the liability of other person. Such promise is made in return of a payment required to be made by the other party. This sum is called a premium and the parties are called insurer and insured or assured respectively. In fact it is the risk to life and property that the insurer takes upon him and provides other party an opportunity to lead a carefree life. The basis of contract is observance of utmost good faith. Unlike

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other commercial contracts, contract of insurance is based upon the principle of good faith.

This doctrine envisages that there is a duty of disclosure upon each of the parties to disclose all the facts material to the formation of contracts. It is found that this duty is a little more on the insured as he is presumed to have better knowledge on the subject to be insured. Basing on the facts disclosed the insurer either accepts or rejects the risk subject to conditions. Fixation of premium is also based upon such disclosure. Greater the risk, higher is the premium. The significance of this principle lies in the fact that it is made a statutory requirement for the enforceability of insurance contracts.

Objectives of Insurance

Insurance fulfils two objectives. One is the direct or immediate objective under which it extends immediate financial or other assistance to the insured or his legal representatives. The second objective is to play an active role in the socio-economic progress of the community and the State. The premium that is collected forms a huge fund that is readily available for investment in various sectors. Personal loans are available to the individuals, corporate securities are undertaken. The Government secures the huge fund for various public purposes like laying of bridges, roads, construction of schools, hospitals, etc.

Kinds of Insurance

Broadly insurance services are divided into two categories, life and non-life insurance. Depending upon the nature of interest it is classified as non-proprietary and proprietary insurance. The former includes life, accident and health care products and the latter encompasses a very wide range of products that compensate the loss to properties against fire accidents, aviation and marine adventure, incidence of burglary and the like. A third category is liability insurance. Such liability arises against any class of persons like liability of employer for his employee or against any person of the society.

This is an illustration of public liability insurance. Yet another classification is statutory or compulsory insurance and non-statutory or voluntary insurance. Third-party insurance under the Motor Vehicles Act and insurance under the Employees State Insurance Act are some of the instances in this regard. All the other forms of insurances are placed under the non-statutory or voluntary form of insurance that also includes miscellaneous forms of insurances[3].

Regulatory Framework

Primarily all insurances are contracts and hence general principles of the Contract Act involving rules of offer, acceptance, consideration, performance and discharge are applied for the conclusion of contracts between the parties.

[3] Cite as: (2012) PL May S-52

In addition to these rules, principles like indemnity, insurable interest and good faith are followed. However, expansion of insurance business necessitated the enactment of special statutes to address the various issues that are characteristic of insurance industry. The Insurance Act, 1938 is the first legislation in this regard that is applicable to all forms of insurance in general. The Life Insurance Corporation Act, 1956 and the General Insurance Business (Nationalisation) Act, 1972 specifically deals with the life and non-life forms of insurances respectively. The Marine Insurance Act, 1963 deals with risks involved in maritime adventures and the Motor Vehicles Acts, 1988 and 1939 cover the insurance aspects of loss arising due to use of motor vehicle.

Insurance Regulatory and Development Authority of India (IRDA)

In India the Insurance Regulatory and Development Authority of India (IRDA) is the governing body responsible for promoting insurance business and introducing insurance regulations. The Insurance Regulatory and Development Authority, an agency of the Government of India, is the regulatory body for the insurance sector's supervision and development in India.

Supreme Court on Insurance Services

The Hon'ble Supreme Court of India in, *Life Insurance Corporation of India Vs. Consumer Education and Research Centre*[4] has ruled that the LIC discharges important Constitutional functions and the Policies issued by it are a measure of social security for the family of the life assured. It was held that trading in the Corporation' Policies offends the very essence of the life insurance contract and leaves the family of the life assured totally unprotected in the event of death of the life assured.

Further in, *LIC of India Vs. Insure Policy Plus Services*[5] the Hon'ble Supreme Court observed that "in order to prevent such speculation and wagering which causes harm to millions of families all over India, the Corporation has taken a policy decision to refuse the registration of assignments which are in the nature of trading. For this purpose, the Corporation has evolved a procedure to identify such transactions so as to preserve and protect the interests of genuine policyholders of the Corporation, and to leave untouched the genuine assignments by the life assured. Life insurance policies are the personal, movable property of the policy holder, and can be said to be an actionable claim within the meaning of Section 3 of the Transfer of Property Act.

This section has subsequently been amended by The Insurance Laws (Amendment) Act, 2015, and Section 38(2) now reads thus:

(2) The insurer may accept the transfer or assignment, or decline to act upon any endorsement made under sub-section (1), where it has sufficient reason to believe that such transfer or assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy.

[4] AIR 1995 SC 1811

[5] 29 December, 2015 , Vikramajit Sen J and Shiva Kirti Singh J.

The amendment to the Insurance Act by the Insurance Laws (Amendment) Act, 2015, is significant. As previously discussed, Section 38 as it now stands gives the insurer the discretion to decide whether or not to accept a transfer or assignment of an Insurance Policy. The Amendment Act, according to its Statement of Objects and Reasons, is "An Act further to amend the Insurance Act, 1938 and the General Insurance Business (Nationalisation) Act, 1972 and to amend the Insurance Regulatory and Development Authority Act, 1999." It is thus neither a declaratory or clarificatory piece of legislation. The language of the extant Section 38 cannot be interpreted to mean that this is what Section 38 had meant all along.

Furthermore, had the Legislature intended to amend Section 38 retrospectively, it would have said so explicitly. Instead, it has incorporated sub-section (9), which protects rights and remedies of assignees that arose prior to the commencement of the Amendment Act. It is thus clear that Parliament intended to allow all previous assignments and transfers provided that they complied with the requirements laid out in Section 38. In the face of this clear legislative intent, no other interpretation of Section 38 is possible. It is accordingly not incumbent for us to discuss whether insurance policies partake of the nature of social security, or whether the transfer of such policies tantamount to wagering contracts.

It is for these manifold reasons and in view of the analysis of the law prior to as well as post the amendments carried out in the Insurance Act that we find the appeal to be devoid of merits. The impugned Judgment is well -reasoned and takes within its sweep all the relevant documents raised. The Appeal is accordingly dismissed."

In *CESC Ltd. Vs. Subhash Chandra Bose*[6], the Supreme Court, relied on international instruments and concluded that right to health is a fundamental right and observed that:

"The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. The maintenance of health is a most imperative constitutional goal whose realisation requires interaction of many social and economic factors."

Again in, *Exposure Insurance Services Limited Vs. Larsen & Toubro Limited Case*[7], the Supreme court has observed that "the present petitioner sent a notice to the respondent Company demanding payment of the said two Bills of Exchange again indicating that it was the Holder in Due Course of the same. The defence taken by the respondent company indicates that there was a genuine dispute with regard to the claim put forward by the petitioner company.

[6] (1992) 1 SCC 441 : 1992 SCC (L&S) 313.

[7] Special Leave to Appeal (Civil) No(s).24772/2007, Justice Altamas Kabir and Justice Cyriac Joseph, on 21 April, 2009.

This is a matter which is required to be heard and decided in a properly constituted suit on account of the contentious nature of the objection taken by the respondent on account whereof the parties have been relegated to a suit. The Special Leave Petition is accordingly dismissed. But this will not prevent the petitioner company from pursuing its remedy before any other forum, in accordance with law."

Further in, *M/s. BHS Industries Vs. Export Credit Guarantee Corp. & Anr*[8], the Supreme court has held that,there has been no violation in terms of contracts of insurance. Again in, *Polymer India (P) Ltd. and Another Vs. National Insurance Co. Ltd.*[9] and others, the Supreme Court has held that "a reference may be made to a series of decisions of this Court wherein it has been held that it is the duty of the court to interpret the document of contract as was understood between the parties." Again in *Chauharya Tripathi & Ors. Vs. LIC of India & Ors.*[10] it was held that "the development officiers working in the LIC are not 'workmen' under Section 2(s) of the Act and accordingly we do not find any flaw in the judgment rendered by the High Court."

Conclusion

Insurance business has travelled a long way from being merely an arrangement between individuals to multibillion trade operated by corporate giants. Similarly their operation has expanded enormously from traditional life, fire or marine insurance to every field where there is risk of loss. No doubt it is one of the devices of risk management but it ultimately thrives to achieve social goals towards individuals, corporate entities or the State. Insurance is basically a contract. But unlike general contracts it is highly regulated through special Acts/Regulations of Parliament. All the players whether private or of public sector have to function within the statutory framework. Public insurance companies as an instrumentality of State cannot claim to have special privileges and include terms and conditions that are arbitrary or unfair. They must not take any irrelevant and extraneous consideration while arriving at a decision.

[8] Civil Appeal No.2729 of 2009 in the Supreme Court of India, Dipak Misra, J.
[9] (2005)9 SCC 174
[10] Civil Appeal Nos.5690-5691 of 2010 in the Supreme Court of India, Dipak Misra, J.