



Insurance Institute of India

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INSUNEWS

- Weekly e-Newsletter

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• Quote for the Week •

“Everything comes to us that belongs to us if we create the capacity to receive it.”

Rabindranath Tagore

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Customer data portability coming in insurance sector - The Hindu Business Line - 2nd August 2018

It may soon be possible to take your data with you when you change your insurance company for continuity of benefits.

A panel on innovations in insurance and insurance technology and related regulatory aspects, formed by the Insurance Regulatory and Development Authority of India (IRDAI), has recommended portability of customer data when a customer moves from one insurer to another.

Short-term products

This will come in handy in the case of short-term products in non-life and health insurance. From a customer’s point of view, this ensures the continuity of benefits, which are based on data, such as no-claim bonus, disease or medical history.

An agency such as the Insurance Information Bureau of India could create the required mechanism for a repository to capture industry data related to insurance customers/policies.

“The consent of the customer to share data is a must,” it recommended. The committee has also suggested that insurers may be allowed to capture data as per their product requirements, and they should mention all data elements they wish to capture as part of their product-filing procedure with the regulator.

However, to ensure standardization of data capture across insurers for the creation of repository of generic data to benefit all, the basic standard data elements could be worked upon by the General and Life Insurance Councils, it added.

Stating that technology “could disrupt insurance business model and the insurer landscape”, the working group said big technology firms, with their technological and analytical advantage, will squeeze out traditional insurers.

Customer protection

The regulator, too, needs to reassess the existing guidelines to ensure that customers are adequately protected. “As the risk profile changes, it would be necessary to ensure that regulatory framework continues to adequately capture it,” it said.

The IRDAI is currently examining these recommendations, and is likely to come out with its decisions soon.

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FRDI bill to be withdrawn amid concern over ‘bail-in’ clause - Financial Chronicle - 1st August 2018

The government has decided to withdraw the controversial FRDI bill and has informed about it to the chairman of the parliamentary panel examining the legislation. The Union cabinet had earlier this month decided to withdraw the legislation in view of the concerns expressed by certain sections of people, including politicians, over the ‘bail-in’ clause, which they feared would harm the interest of depositors.

“The minister has written to the chairman of the committee saying that the government has decided to withdraw the bill. This is a victory of the opposition.

The bill, introduced in the Lok Sabha, on August 11 last year, had a ‘bail-in’ clause, which some experts said had the potential to harm deposits in savings bank accounts.

The ‘bail-in’ clause was included in the bill as one of the tools for resolution for bank failure. It provides for depositors to bear a part of the cost of the resolution by corresponding reduction in their claims.

This provision had raised concerns that deposits could be used to bail out the failing banks. It also provided for raising the security cover for bank deposits. At present, each depositor is protected only up to Rs 1 lakh by the deposit insurance and credit guarantee (DICG).

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FRDI: Panel accepts FM’s proposal, recommends withdrawal of Bill - The Hindu Business Line – 30th July 2018

The Joint Committee of Parliament on the Financial Resolution and Deposit Insurance (FRDI) Bill has decided to recommend to the House that the Finance Ministry can be allowed to withdraw the Bill.

A meeting of the panel here on Monday discussed Finance Minister Piyush Goyal’s letter to Chairman of the panel Bhupendar Yadav that the Centre intends to withdraw the Bill. It is learnt that the Minister has cited political and public opposition against the Bill as the reason for taking it back.

The panel will submit a brief report to both the Houses of Parliament recommending that the Bill may be withdrawn, a source in the panel said. He added that Goyal had submitted a “statement of reasons” on why the Centre has changed its mind on the controversial Bill.

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India: Good habits can lower insurance premiums – Asia Insurance Review

The IRDAI working group set up in December 2017 to examine innovations in insurance involving wearable and portable devices has published its recommendations. These recommendations will help the insurers assess risks better and can lead to reduced insurance premium for customers at the time of renewals.

Wearable devices can lower health insurance premium

The insurers will be able to discount the health insurance renewal premiums by 10% to 15% depending on the policyholders’ health and activity data. The product pricing and premium review could be based on the inputs received from the health data captured through the devices.

Tracking the policyholders’ health data will not only help promote a healthy lifestyle but also play an important role in underwriting exercise in both, life and health insurance.

Critical role in risk assessment

The report says, “The usage of wearables data in health insurance will have a critical role in risk assessment and improvement. Currently, insurers merely have access to a point-in-time data through medical tests or self-disclosures, which are often not adequate for risk assessment on an ongoing basis.”

The report also recommends that the insurers be allowed to provide incentives to customers either as discounts on premiums or any additional benefit that is clearly defined, and the specifics of such benefits are filed with the regulator as part of the product filing procedure.

Depending on its viability, the insurers can add the wearable data pricing option in the existing products as well. This should, however, not result in higher premiums or changes in terms and conditions that are in force currently and should be done with the consent of the insureds.

Telematics to track drivers on the road

The report has also recommended installation of smart telematic devices to track the driving habits of policyholders. This can lead to substantial adjustments in motor insurance premiums and promote safe driving culture on Indian roads. India has the dubious distinction of globally leading in fatalities caused by road crashes. 150,000 people die on Indian roads annually due to road crashes.

The introduction of telematics can also provide additional benefits by way of fuel conservation as drivers become more responsible.

The report says, “Motor Insurance in India is being priced based on parameters like the make and model of the vehicle, its capacity and the geographical use. There can be several other aspects to the use of a vehicle. Consideration of these factors (in underwriting) will lead to a more meaningful risk assessment and provide for a more accurate mechanism for pricing.”

Value added services

The working group’s recommendations also speak about value added services (VAS) as a by-product. It says that insurers should be allowed to provide VAS using IoT as a by-product and to recover the cost of the device in the product pricing by explicitly mentioning it in the policy document. This would also encourage preventive maintenance of their assets like cars, safe driving habits, and a healthy life style.

This would also enable home insurance policies to provide services for problems such as minor repairs for water supply, electrical work, gas supply line work, small workmanship required for furniture.

Data privacy would be supreme

The report, however, says that the consent of the customer to share his/her data is a must for participation in such products. The consent should be for specific data and the specific purpose for which it is being obtained. In all instances, the security and confidentiality of customer data shall be protected at all costs.

Regulatory framework for InsurTechs in India

Besides giving recommendations regarding the regulatory approach towards InsurTech in India and data related aspects, the report has listed recommendations on evolving a regulatory framework for InsurTech and challenges in supervision.

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Insurance Regulation

Insurers told to protect data obtained from wearables like Fitbit - Financial Chronicle - 3rd August 2018

Data privacy has caught the attention of insurance regulator Irdai as well. As fitness trackers like Apple watch, Fitbit, Garmin, and many others now track many advanced health parameters of users real time, Irdai now wants insurers to get the customer’s consent and take care of privacy issues.

Insurance companies are increasingly incorporating use of wearables for efficient underwriting.

The Insurance Regulatory and Development Authority of India (Irdai) acknowledged that wearable technology has significantly improved in the last few years, progressing from simple pedometers used to track steps to medical grade technology-based wearables which can track advanced health and biometric parameters like oxygen intake (VO2), heart rate and rhythm, blood pressure, and sleep quality, amongst others. Most smart phones today have the capability to capture some of these parameters themselves and are also interconnected with the wearable devices through various apps, Irdai said.

While the insurance companies use these wearables to differentiate bad apples from good, the consent of the customer to share his data obtained through wearables is a must for participation. Consent should be obtained for specific data and the specific purpose for which it is being obtained. These should be clearly explained to the customer before the consent is obtained.

Once the customer withdraws his consent, any discount offered for usage of such devices and its output shall be withdrawn. Insurers may be allowed to capture data as per their product requirements, but within the scope of insurance and underwriting need. Insurers should be required to mention all data elements that they are planning to capture as part of their product filing process.

The General Insurance Council and Life Insurance Council should send their recommendations to the regulator to ensure standardization of data capture across insurers for creation of a repository of generic data that may benefit the industry as a whole. An agency such as the Insurance Information Bureau of India could create the required mechanism that would also create a repository for capture of industry level data.

The insurer should provide a portal/app to the customer to access her/his wearables data and ensure that there is complete transparency with regards to benefits offered to the customer and her/his wearables/portable device data.

It would be necessary to ensure that portability of customer's data happens in the event there is a situation of him/her moving from one insurer to another. Even at the time of portability, the insurer may share this data only with the explicit consent of the customer. The insurer should not share the wearables data with any third-party, except as permitted in the framework.

Source

In all instances, the security and confidentiality of customer data shall be protected at all costs. Industry level data would only consist of masked data that enables generation of generic queries and reports, Irda said.

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Life Insurance

Telangana releases Rs 100 crore for farmers' insurance scheme - The Hindu Business Line - 1st August 2018

The Telangana government has released Rs 100 crore to the Agriculture Department for the implementation of the farmers' insurance scheme, which will be launched on Independence Day.

The 2018-19 budget had allocated Rs 600 crore for the scheme. "The government has authorized Rs 500 crore for the scheme. Of this, Rs 100 crore has been released to the department, towards implementation of the scheme," a Government Order said on Tuesday.

The state government has tied up with the public sector Life Insurance Corporation of India (LIC) to roll out the ambitious insurance scheme, that seeks to provide a cover of Rs 5 lakh to all farmers in the age group of 18 to 59 years. The scheme would cost about Rs 1,000 crore annually, with the state government agreeing to pay a premium of Rs 2,271 for a farmer.

The department has been assigned the job of preparing the list of eligible farmers, besides facilitating the roll-out of the scheme. LIC officials will work with the department to enrol farmers and hand over the policy documents to them. The policy holders can propose a nominee of his or her choice to receive the proceeds in case of his or her death.

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Govt to revamp flagship insurance schemes for poor - Financial Chronicle - 31st July 2018

The government is planning a major revamp of its flagship insurance schemes, including Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY). Post-restructuring, subscribers may be allowed to pay proportionately for the period they would be insured. The government objective is to make the scheme affordable to even the poorest of the poor.

The changes have been designed to push the agenda of financial inclusion and ensure that benefits of life insurance reach a larger section of the population. It is felt that even at Rs 330 a year, the premium for PMJJBY may pinch the poorest of the poor. A staggered payment mechanism would make the product more affordable.

As per the changes that have been communicated by the finance ministry to all banks and insurance companies, PMJJBY customers would be allowed to pay premium on pro-rata basis every quarter if they fail to meet the annual premium payment deadline. The pro-rata premium for enrolment under PMJJBY has been fixed with the minimum premium of Rs 86 for one quarter. This minimum payment could be made even if a person enrolls under the scheme just one or two months before the end of the policy year (i.e. if he enrolls in March, April or May).

The cover period under PMJJBY is June 1 of each year to May 31 of subsequent year. For the cover period-- June 1, 2018 to May 31, 2019-- subscribers are required to enroll and give their auto-debit consent by May 31, 2018. Those joining subsequently were required to pay full annual premium for prospective cover. Under staggered payment system now, the premium will be charged only for the period the policy is valid, to be calculated on quarterly basis.

According to a finance ministry letter to banks and insurers, the changes were done on the basis of the decisions taken in a May 2 meeting convened to review the performance of PMJJBY and Pradhan Mantri Suraksha Bima Yojana (PMSBY). LIC had also written a letter to the ministry on May 29 on this subject.

“For instance, if the enrolment for PMJJBY takes place during the months of June, July and August, the annual premium of Rs 330 is payable. If the customer fails and does in September, October or November – three quarters of premium @ Rs 86.00 i.e. Rs 258 is payable. Similarly, for December, January and February – for 2 quarters of premium @ Rs 86.00 i.e. Rs 172 is payable and in March, April & May – for 1 quarter premium @ Rs 86.00 is payable and the lien period of 45 days shall be applicable from the date of enrolment,” the letter added.

The move of the government aims to help eligible account holders of PMJJBY to get the benefit of their life cover. PMJJBY is available to people in the age group of 18 to 50 years (life cover up to age 55) having a savings bank account who give their consent to join and enable auto-debit. Under PMJJBY scheme, life cover of Rs 2 lakh is available at a premium of Rs 330 per annum per member and is renewable every year. In the case of a joint account, all holders of the said account can join the scheme provided they meet its eligibility criteria and pay the premium at the rate of Rs 330 per person per annum.

Confirming the development, a top official in the finance ministry told FC, “After a thorough review in the middle of June about these two flagship schemes floated by the government, we did not find any encouraging results in this regard. In the review, we observed that PMJJBY scheme showed the lukewarm response from the potential account holders and therefore, we decided to launch quarterly premium scheme for them so that they can get the benefit from the scheme.”

In its letter, finance ministry further said that in case of payment of pro-rata premium the administrative charges payable to the bank, which is currently, Rs 11 per subscriber per annum for premium of Rs 330, would be paid on pro-rata basis (ie; for quarterly premium of Rs 86, the bank will retain an amount of Rs 3.50, for two quarters of premium of Rs 172, the bank will retain of Rs 7 and for three quarters of Rs 258, the bank will retain Rs 10.50).

“Also, the commission charges payable to business correspondents, micro and corporate agents would also be payable on pro-rata basis (I.e; for quarterly premium of Rs 86, it would be Rs 7.50, for 2 quarters of Rs 172, it would be Rs 15 and for premium Rs 258, it would be Rs 22.50 for 3 quarters),” said the finance ministry.

According sources in the industry, even as insurance companies have requested the finance ministry to increase the premium rates of both the schemes, they have been informed that it would not be possible to do so. “Under PMJJBY, the claims ratio for companies during 2017-18 was over 110 per cent, while for PMSBY (Pradhan Mantri Suraksha Bima Yojana) it was around 175 per cent in the same period,” industry sources said.

PMJJBY and PMSBY are the government-backed insurance schemes, launched by prime minister Narendra Modi in May 2015. While the former provides life insurance cover of Rs 2 lakh at an annual premium of just Rs 330, the latter provides accident insurance cover of Rs 2 lakh at only Rs 12 per year to all bank account holders. State-owned insurance companies, which form around 75 per cent of market share in both the schemes, have been facing losses of around 90 per cent, especially in the PMSBY. As on May 14, 2018, nearly 5.35 crore people had enrolled under PMJJBY, and the total number of claims received till date were nearly 1,02,849.

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Unclaimed money with insurers grows 30% to Rs 15Kcr - Financial Chronicle - 30th July 2018

Maintaining KYC (know your customer) details is mandatory for every financial institution. Yet, insurance companies hold a whopping Rs 15,000 crore as unclaimed insurance policy amount as they are able to reach out to their customers. Despite regulator Irdai asking insurers to transfer unclaimed money that has been lying with them for 10 years to a social security fund, the amount has only grown by 30 per cent this year. The public sector behemoth, Life Insurance Corporation, has seen this going up by 77 per cent.

All the life insurance companies put together have Rs 15,166 crore as unclaimed policy amount as on March 30, 2018, as per the details presented before Parliament. At the end of FY17, the amount stood at Rs 11,668 crore and has grown by 30 per cent in a year.

The growth is over 37 per cent if one compares the nine- month period starting July 2017 considering that the Insurance Regulatory and Development Authority of India (Irdai) directed insurers in June to park this unclaimed amount into the social security fund.

LIC accounts for 69% of unclaimed policy money	
Name of the insurer	Unclaimed amount
Birla Sun Life Insurance	257.72
SBI Life Insurance	678.59
HDFC Standard Life Insurance	659.30
Bajaj Life Insurance	559.21
Kotak Mahindra Life Insurance	30.51
Canara HSBC OBC Life Insurance	15.72
Future Generali Life Insurance	70.50
PNB MetLife Insurance	203.46
Shriram Life Insurance	61.92
Star Union Di ichi Life Insurance	25.45
Max Life Insurance	38.17
Aviva Life Insurance	190.65
IDBI Federal Life Insurance	9.85
Bharati AXA Life Insurance	74.81
DHFL Pramerica Life Insurance	16.84
Aegon Life Insurance	37.65
India First Life Insurance	26.28
Exide Life Insurance	61.88
Tata AIA Life Insurance	134.05
Edelweiss Tokio Life Insurance	1.37
ICICI Prudential Life Insurance	807.40
Reliance Nippon Life Insurance	696.12
Pvt sector Life insurance companies (total)	4,657.45
Life Insurance Corporation of India	10,509.02
Grand total	15,166.47
As on 31.03.2018	Figures in Rs crore

LIC, which has the largest market share in the life insurance business, held 69 per cent of this unclaimed amount. The amount held by LIC grew to Rs 10,509 crore from Rs 5,934 crore last year.

The country's premier life insurer has so far transferred only about Rs 2,000 crore of this unclaimed amount, which has remained unutilised for over 10 years, to the Senior Citizen Welfare Fund, informed V Manickam, secretary general, Life Insurance Council. Among the private insurers, nine life insurers held amounts higher than Rs 100 crore but less than Rs 850 crore. Some of these insurers, including HDFC Life, Bajaj Allianz, Tata AIA, Aviva and PNB Metlife, have seen the unclaimed amount coming down. HDFC Life saw the amount coming down from Rs 946 crore to Rs 659 crore and Tata AIA brought it down from Rs 309 crore to Rs 134 crore. Some of the nine insurers also saw marginal increase in unclaimed amount.

Remaining life insurers held unclaimed amounts of less than Rs 100 crore. "The unclaimed amount belongs to the policyholder and that lying with the insurance company is not at all a good thing. We have a separate division to track this on a weekly and monthly basis and to get in touch with the customer to return the money. Hence, we have one of the lowest unclaimed amounts among insurers," said Vighnesh Shahane, whole-time director and CEO of IDBI Federal Life Insurance.

"We have taken concrete efforts to bring down the unclaimed amount. As a result we saw the amount come down from Rs 58 crore to Rs 26 crore," said Mohit Rochlani, director, operations

and IT, IndiaFirst Life Insurance.

Mostly the amount lies with insurer when the company is not able to contact the customer and transfer the money to him or his nominee on maturity of the policy, death of the policyholder or if the policy gets lapsed. It has been years since the regulator has made securing KYC details mandatory for financial institutions. Still many customers become unreachable for the insurer.

"Some of the policies would have been taken several years back and the customer would have probably changed his bank account or his address. The policy holder would have been paying the premium in cash and hence the bank account details probably were not captured by the company," said Rochlani.

Policies which get lapsed due to discontinuation of premium payment too account for a good chunk of the unclaimed amount, finds R M Vishakha, MD and CEO of IndiaFirst Life Insurance. "Policyholders who miss their premiums often forget to claim the paid amount also," she said.

However, insurance companies can bring down the unclaimed amount if they make efforts to secure the contact details of policyholders even before the policy nears maturity or soon after the policy gets lapsed.

"The insurance companies are no longer motivated to keep the money with them as it has to be transferred go a social security fund after 10 years," said Rochlani.

As per an earlier notification of IRDA, any unclaimed money with an insurance company will be moved to the Indian government's Senior Citizens Welfare Fund, if the amount has been lying unclaimed for 10 years from the date it was payable to the policyholder or the beneficiary. If no insurance claim is made for a period of 25 years after the transfer, it will belong to the government.

Manickam said policyholders also have to inform the insurance company when there is a change in address or account number. “For large companies it becomes a challenge to secure changed contact details of every customer,” he said.

However, he hopes that going ahead the unclaimed amount would come down as the KYC norms are now secured by all the insurers. “As the share of older policies come down we will see a change in the trend. We have also requested the government to make ‘common KYC’ applicable for the entire BFSI sector. In that case a person need not give separate KYC to each financial institution. Changes made to KYC details will be available for all institutions,” he said.

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Non-life Insurance

14 add-ons which will give your vehicle a full coverage - Financial Express – 1st August 2018

In 2015 and 2016, at least 10 lakh road accidents were reported in India, and nearly three lakh people lost their lives in the accident. A report from the transport research wing under the Ministry of Road Transport and Highways reveals that 34.5 per cent accidental death occurred on National Highways and 27.9 per cent accidental death took place on State Highways during these years. We cannot make these accidents negligible. However, the legislature has ensured that the liability originating from damage to property is diversified. As per the Motor Vehicles Act of 1988, a valid motor insurance is mandatory for plying any vehicle on road.

However, as customers, you don’t avail a hundred per cent immunity just by availing the mandatory third-party insurance. Even when you opt for a comprehensive insurance cover, it does not provide a full coverage to different degrees of damages. An individual should seek to add on cover vis-a-vis the risk exposure.

“It is wiser to opt for Emergency Assistance Cover which helps an individual in case of a breakdown, especially if an individual is stranded alone. Similarly, if an individual resides in a region that is prone to flooding, it is wiser to opt for Engine and Gearbox Protector Cover which will provide protection to the engine and electronic circuit in the car, especially during water-logging which increases the chances of damage to the engine.” says Animesh Das, Head of product Strategy- Acko General Insurance.

A full claim coverage often involves some add-ons. Here are 14 add-ons which will give you full coverage on your auto insurance

1) Return to Invoice

This will make sure the insurer gets the original invoice value of the car including the registration and road tax paid along with the value of the car at which it was insured during the purchase of the policy. In short, this add-on covers the gap between the insured declared value and the invoice value of the car. This add-on is not to be used to claim for repairs and small damages. It is used to retrieve the financial loss of a stolen car or a car that has been damaged beyond repair.

2) Emergency Roadside Assistance

With this, the insurer provides certain emergency services like refueling, towing, change of flat tyre, mechanic’s services and so on in case the car breaks down

3) Engine Protection Cover

If you are staying in an area that is prone to flooding during the rains, this add-on cover is a must for you. This cover provides coverage against damage to the engine of the vehicle due to water ingress leading to hydrostatic lock. It also covers cases like leakage of lubricating oil and damage to the gearbox.

4) Cost of Consumables

If the vehicle meets with an accident, the insurers exclude the cost of consumable replaced such as nuts and bolts, engine oil, bearings and so on in standard motor insurance policy. If the insured opts for this add-on, the value of such consumables will be included in the claim amount.

5) Multi-year policy

A multi-year policy covers the two-wheeler for a period of up to 3 years that will ensure coverage against legal liability for injury, death, owner-driver and optional personal accident cover for a pillion passenger, and property damage caused to a third party in the event of an accident.

6) Zero Depreciation Cover

This add-on is highly recommended for new cars, as this is helpful to reduce the cost of losses the insured would otherwise have to bear due to the wear and tear of replaced parts plastic/rubber, fibre, metal and paint material. Also known as nil depreciation or bumper, it leaves out the depreciation factor from the coverage, giving you the complete cover. It costs anywhere between 15-20% of the standard premium and proves to be beneficial for people with luxury cars and expensive spare parts.

7) Personal Accident Cover

Opting for a personal accident cover will ensure that an individual gets adequate protection against any physical loss or disability during a car accident

8) Accessories Cover

If an individual customizes his/her car, one must ensure that the changes made to the car do not nullify the insurance. For e.g.: Modification made to the engine or mechanical setups usually do not come under the standard cover. Additionally, there is a limit to the value of customisation that can be insured under any policy. It is important to check with the agent on any such limits before giving the car that facelift

9) Voluntary Deductibles

One could opt for the voluntary deductible in case they feel the cost of buying car insurance is expensive. Voluntary deductible lets an individual share the cost of repair in case of any claim.

10) No Claim Bonus (NCB)

Vehicle owners, who do not make a single claim during the term of the insurance policy, can avail a discount on renewal of the policy, known as No Claim Bonus (NCB). However, if an individual already has an NCB Certificate from the previous vehicle policy, which may have been sold, one can avail for the same in the new policy to get a discount on the premium.

11) Network Garages

It is important that vehicle owners are aware of the garages that are associated with the insurance company for cashless claims. This is helpful in case of a large claim amount. An individual will have to pay from their pockets, in case the car is taken to a garage that is not part of the insurer's network. In such cases, the policyholder will have to file the claims which will be paid as a reimbursement. Most insurers today offer the facility to file the claims online, which make it easy for the customers.

12) Engine protection

An engine is often described as the most important part of a vehicle. Usually, damages to the engine are not covered under a comprehensive policy. Your vehicle's engine will be insured against damages due to flooding, consequential losses etc. with the Engine Protection Add-on.

13) Personal Belonging Cover

Nowadays, people travel in cars with their expensive gadgets such as laptop, tablet, smartphone, etc. These gadgets can also be damaged if the car is involved in an accident. Damage to such gadgets is not covered under a vehicle insurance policy unless you have a Personal Belonging Cover. This also covers the loss of other personal belongings from your car.

14) Pillion Rider Cover

Just as a Personal Accident Cover is designed for the rider, the Pillion Rider Cover is meant for the passenger seated behind you on the bike. This cover is helpful to seek compensation for medical expenses incurred for catering to the medical needs of the injured pillion rider. If you own a car, you can opt for the Passenger Cover Add-on.

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India: Insurers stop giving cover to Iranian cargo – Asia Insurance Review

Indian insurance companies have stopped providing insurance cover to goods-- mainly crude oil-- imported from Iran.

Domestic insurers, including New India Assurance (NIA), United India Insurance and reinsurer GIC Re confirmed they have stopped providing insurance cover for Iranian cargoes, reports The Indian Express citing insurance sector officials.

“Indian general insurers have stopped giving any cover for Iran oil cargo since 8 May and no existing cover is valid beyond 4 November,” said an official. Public sector insurers rely on reinsurance from India’s only reinsurer GIC Re, which in turn depends on reinsurance companies in both Europe and the US to hedge risk. European and US reinsurers are wary of the risk of breaching sanctions. Without the backing of global reinsurers, Indian insurance companies will find it difficult to manage the risk.

India is the second biggest buyer of Iranian crude after China, and without insurance coverage to protect their plants, the country’s refineries may have to cut down their imports from Iran earlier than anticipated.

In May, the US said it plans to re-impose some sanctions against Iran starting in August, with full sanctions in place by November, after withdrawing from a 2015 nuclear accord with Iran. The first US sanctions on Iran will start on 6 August and a second set will begin on 4 November. Meanwhile, Iran is offering to insure oil cargoes to India in the face of the impending US sanctions, industry sources said.

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Motor Insurance

Supreme Court auto order: Non-life insurers find going tough – The Times of India – 3rd August 2018

Non-life insurers have pointed out to challenges in implementing the Supreme Court (SC) order asking them to issue three-year and five-year insurance policies for new four-wheeler and two-wheelers, respectively. Non-life insurers have recommended bifurcating the mandatory third-party insurance cover and the optional ‘own-damage’, or comprehensive insurance cover, which compensates for vehicle damage.

A key challenge will be in pricing the long-term cover given current regulations and practices. Currently, insurance commission is paid up-front. Additionally, capital has to be set aside based on premium collected while the advance premium cannot be recognized as earnings. This will increase the capital requirements for non-life companies. The price of third-party cover is revised every year, depending on compensation awards in the previous year. Since awards go up every year the absence of annual revision would hurt insurers.

Digit Insurance chairman Kamesh Goyal said, “On the one hand, the SC has asked insurers to ask for a PUC (pollution under control) certificate at point of sale (PoS) of policies, while another bench has asked for long-term, with the PUC validity being only six months, it negates the first proposal of the SC.”

Last month, the SC ordered that no new vehicle could be sold without a three-year cover for four-wheelers and five-year cover for two-wheelers. The order comes into effect from September 1. The court order followed the recommendations a SC-appointed committee on road safety. The objective was to reduce the number of uninsured vehicles on Indian roads.

Goyal has suggested that instead of putting the onus of enforcement on the insurance companies, insurers could pay the distribution charges to police, who could issue on-the-spot policies to those caught without mandatory cover.

If insurance regulator IRDAI were to allow bifurcation of the motor insurance into a third-party and a stand-alone comprehensive cover, it would require extensive changes to the insurers’ IT systems. Additionally, companies said that getting the products in place and IT systems changed in one month will not be possible. Since the stand-alone third-party insurance cover is a loss-making business, insurers do not actively market this cover.

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Health Insurance

Change in Mediclaim model in 3 months’ – The Times of India – 1st August 2018

Health minister Vishwajit Rane told the assembly on Tuesday that while the Deen Dayal Swashtya Seva Yojna (DDSSY), the universal Mediclaim scheme, is currently being implemented through a third-party administrator (TPA), the state government will decide on the best model to be followed for implementing the scheme within three months.

Replying to a question by Ponda MLA Ravi Naik, Rane told House that Rs 120 crore was paid to the insurance company that implements DDSSY and 25,384 beneficiaries availed the scheme.

The Ponda MLA said while the government spent a huge amount on DDSSY, comparatively, a few people have benefitted from it. He also complained that some hospitals send patients back, despite the patients holding DDSSY cards. He also demanded that the health minister announce the list of 51 hospitals empanelled under the scheme.

As regards complaints against hospitals, Rane said they will be submitted to the health department.

The complaints will be investigated, he assured the House. In a reply to another question, he told the House that the government collected Rs 1.45 crore in fees from non-Goan patients availing treatment at GMC and the district hospitals.

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Chhattisgarh gov't, insurers iron out differences - Financial Chronicle - 1st August 2018

BJP-ruled Chhattisgarh has saved major blushes for the Modi government by diluting a 'draconian' ruling imposed on insurers participating in the National Health Protection Mission (NHPM) or Ayushman Bharat scheme, often dubbed as Modicare, that aims to provide a health cover of Rs 5 lakh per family per year.

The clause in question is believed to have put the entire responsibility of underwriting and processing of the Rs 5 lakh scheme on insurers, inviting strong opposition from participating entities and putting a question mark on the rollout of the plan in the state.

Ironically, prime minister Narendra Modi had chosen Chhattisgarh to launch the first health centre under Ayushman Bharat scheme on April 14 coinciding with the 127th birth anniversary of B R Ambedkar. The PM is also expected to formally launch the universal health scheme while delivering his Independence Day speech.

"Chhattisgarh has finally allowed NHPM to be rolled out on the basis models suggested by the Centre that equally divides the financial responsibility between the Centre and states. Like the models adopted by other states, insurers in Chhattisgarh too would now be responsible for settling claims of up to Rs 50,000, while a higher claim up to Rs 5 lakh would be entirely paid by the state," said a source in the insurance sector.

The state government had earlier asked the insurers to take all the responsibility of processing even the balance Rs 4.5 lakh component of the scheme. Irked over the adamant attitude of the state government in imposing the draconian rule, the concerned insurers went on protesting the issue against the government's deliberate option during the pre-bidding meeting which was held at Raipur on July 19.

According to top insurance sources privy to development, a meeting was held on July 9 between several insurance companies and top government officials of the state in this regard, and finally they agreed upon the demand of insurers to run the show. The state now plans to close the bidding process in the scheme on August 3.

"We are happy that government withdrew the 'draconian' conditions imposed on us for the NHPM scheme in the state. Now, we are ready to participate in the scheme for the betterment of the people here," an insurer told FC on the condition of anonymity.

As far as the NHPM scheme is concerned, there are options like trust model or insurance mode or a mixed model. Insurance mode covers the entire gamut of health protection from sanitation and prevention to care during an illness, while insurance mode only covers expenses, even cashless related to hospitalization. Generally, states find it difficult to operate in a trust mode as the state government will rely on third party administrators (TPAs), which may have no accountability to prevent frauds or stop leakages.

The Centre has left the options to state governments. But Chhattisgarh went for a mix of trust and insurance models in which insurers will be responsible only for premium payment of Rs 50,000 claim cover and the balance Rs 4.5 lakh part of the cover has to be tackled by the state itself.

Under NHPM, the government has targeted an annual health cover of Rs 5 lakh every year to over 10 crore 'deprived' families as per Socio-Economic and Caste Census (SECC) data by FY20. For beneficiaries, it will be cashless at the point of use. The policy will also be distributed free of any charge or premium for BPL families as the entire burden would be taken upon by the state.

The scheme will cover pre-existing diseases, will allow for portability of insurance cover, will cover pre-hospitalization and post-hospitalization expenses to some extent, and provide for cashless hospitalization.

Sources said that the government's mega health insurance scheme might cost the exchequer around Rs 5,000 crore in FY19 because of the time taken to rollout the scheme.

"The scheme will cost over Rs 11,000 crore or more when it is rolled out pan-India by next year. As far as present status is concerned, this year only there would be around 8 crore beneficiaries, as 2 crore left to meet the target. "So far, 20 states have agreed to implement the scheme and have signed a memorandum of understanding (MoU) with the Centre."

Source

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Insurers do a check of office canteens to reduce health-related claims - The Economic Times (Delhi edition) - 30th July 2018

Insurance companies are conducting audits of workplace cafeterias and proposing changes to reduce claims related to gastroenteritis, colitis and heart-related ailments under group Medclaim policies. These audits are being done as part of wellness programmes, industry executives said.

The health insurance sector, which is growing at over 20% every year, is seeing a rise in claims for workplace-related health issues. Recently, ICICI Lombard conducted a wellness audit on the premises of a company where a worker had suffered a heart attack. The oxygen level in the work area was found to be low. The executives, cited earlier, said companies are focusing on cafeteria audits and ergonomics audit to help corporates assess the status of food safety, nutritional value of food served and musculoskeletal related issues.

"We have carried out audits of workplaces and found that the particulate matter was high and oxygen levels poor, leading to higher instance of respiratory and heart-related ailments," said Amitabh Jain, head of motor and health - underwriting at ICICI Lombard General Insurance. "We propose certain changes in the office upkeep and ventilation in such instances."

During these audits, insurers look at the hygiene and sanitary conditions in cafeterias and their adherence to the guidelines of the Food Safety and Standards Authority of India (Fssai) on prevention of cross-contamination while preparing, cooking, storing and serving of food. The executives said they test the water used for cooking, the process for procuring raw foods and ingredients and regularly test food and kitchen surfaces to check for growth of fungus and bacteria that can contaminate food.

"Our analysis of claim trends shows that over 8% of employee claims are from digestive disorders, and the average claim in this disease category is around Rs 42,000," said Prawal Kalita, director-benefit solutions, JLT Independent Insurance Brokers. For offices where people work in shifts, especially IT and ITeS companies, insurers focus on training cafeteria staff, especially on storage techniques, servicing skills and hygiene standards.

According to Kalita, once such an audit is done, most companies revamp their menu and look into hygiene issues. "They incorporate it in their wellness programme and take corrective measures," he said. Ergonomics-related audit looks into the positioning of computers, quality of chairs and their position. This follows a rising trend in claims against muscular skeleton issues because of sitting position and use of laptops. Group health, including government mass schemes, generated Rs 18,387 crore in premium in 2017-18, accounting for 40% of the health insurance industry's total premium of Rs 37,897 crore.

Source

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How Health Assure is 'consumerising healthcare' with customized products - The Hindu Business Line - 29th July 2018

Primary healthcare services aggregator HealthAssure is "consumerising healthcare" by "putting the economic purchasing power and decision-making in the hands of plan participants," Varun Gera, Founder and Chief Executive, HealthAssure, told BusinessLine.

Companies that sell health cover (health insurance products) give "finance cover" and not "healthcare", Gera noted. For instance, consider the case of a 28-year-old woman whose days are packed with work and home responsibilities. She develops a chronic headache, and after trying some home remedies decides to seek medical help. What follows is a battery of test recommendations including an MRI and CT scan. The outcome

reveals that the headache was due to stress. To diagnose the cause, she expended close to Rs 10,000. Wouldn't this bill add to her stress? This is a common enough healthcare conundrum faced the world over.

“There is a looming concern about this evolution in a country such as ours. We lack primary healthcare support to meet the needs of our rising populace,” Gera said.

The annual medical insurance perk offered by most corporates in the country is a bare thread that does not address the disease burden.

A survey conducted by Assocham in 2018 has revealed that only 3 per cent workers in the corporate sector are worried about their health. A majority do not have spare resources beyond their daily needs and in the absence of a provision for affordable health services (by the employer), emerging health issues are left unaddressed. The survey further revealed that 48 per cent of such staff is sometimes fearful about their future health, 37 per cent is not fearful, while the remaining 12 per cent is totally ignorant of future health susceptibilities.

HealthAssure designs network-based primary healthcare products for corporates and works as an enabler between the corporates and primary healthcare service centres as well as providers of health insurance, he said.

The seven-year-old company has established a primary care network with over 3,100 primary care centres. It currently services 20,000 individuals every month through its app.

Source

According to Gera, HealthAssure has serviced more than 7 lakh customers over the last six years and is aiming to reach 25 lakh in three years.

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Crop Insurance

Insurance companies to repay with interest for failing to clear claims of farmers - The Economic Times - 31st July 2018

Insurance companies, which fail to clear claims of farmers for crop loss within two months, will have to repay with 12 per cent interest, Union Agriculture Minister Radha Mohan Singh said today. Singh said in the Lok Sabha that the central government has introduced the 'Pradhan Mantri Fasal Bima Yojana' (PMFBY) from Kharif 2016 to address risks associated with agriculture.

The farmers will get full insurance cover as there is no capping of the sum insured and consequently the claim amount is not curtailed or reduced. "Those insurance companies which fail to clear claims of farmers for crop loss within two months, will have to repay with 12 per cent interest," he said during the Question Hour.

The minister said this scheme provides insurance cover at all stages of the crop cycle including post harvest risks in specified instances. Singh said the PMFBY addresses all shortcomings in the earlier schemes and is available to farmers at a very low rate of premium.

Source

Minister of State for Agriculture Gajendra Singh Shekhawat said 10 crore farmers in the country have taken the cover of the PMFBY and five crore of them availed insurance benefits so far.

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India: Insurers to pay farmers interest for delay in claim payouts - Asia Insurance Review

The government has said that insurance companies, which fail to clear claims for crop loss within two months, will have to pay interest to farmers, reflecting how delay in settling claims remains a major concern.

“Even the state governments will have to pay interest to farmers if they (the states) delay their shares (of premium),” said agriculture minister Radha Mohan Singh in Lok Sabha which is the lower house of Parliament. Responding to members’ concerns over delay in the payment of claims to farmers under the government backed crop insurance scheme, Pradhan Mantri Fasal Bima Yojana (PMFBY), Mr Singh said, “We are going to make these two reforms.” His comments were reported by Times of India.

He also told the House that the government had taken a number of measures that already reduced the claim period from one year to six months.

According to agriculture ministry data, claims amounting to INR105.05bn (\$1.54bn) and INR59.9bn have been estimated for the kharif 2016 (monsoon crop) and rabi 2016-17 (winter crop) season, respectively. The ministry claimed that claims of INR102.8bn and INR50.5bn respectively had already been paid for these seasons.

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Opinion

Can standardization of exclusions in health insurance policies help customers? – Mint – 31st July 2018

Malti Jaswal, chief operating officer, Health Insurance TPA of India Ltd

Need to rationalize scope of exclusions

One of the most contentious issues, which is also the reason for the highest number of grievances lodged by health insurance policyholders, pertains to “exclusions” under a health insurance contract. As more comprehensive products are being introduced, the list of exclusions by insurance companies (to avoid litigation and court awards) is also growing.

Different products carry different exclusions, and the same exclusion could mean different things, creating distress and distrust. The denial of a claim or unjustifiable deduction of expenses from the customer perspective usually stems from exclusions relating to treatment involving investigation only; treatment not requiring hospitalization; unproven treatment or new treatment or specific treatment involving advanced or expensive techniques; among others.

But sometimes even customers and doctors and hospitals fudge documents for circumventing exclusions. So, it's important to rationalize the number of exclusions, standardise wordings and scope of exclusions.

Mahavir Chopra, director, health, life and strategic initiatives, Coverfox.com

Interpreting policy will become simpler

The proposed standardization is a good initiative. Interpretations and comparisons of exclusions should become simpler. For instance, an important pain point today is comparison of 2-year waiting periods for specific treatments or diseases.

Most insurers earlier included very specific, minor treatments under this clause, but now a few plans exclude broader health conditions like diabetes and hypertension as part of time-bound exclusions, which can lead to grievances at the time of claims given the broad scope of such ailments. Another exclusion that needs correction is maternity.

The exclusion list today uses too many medical as well as legal jargons that can make even a discerning customer nervous, making her rely completely on the intermediary or not buying health insurance at all. There is a need to put exclusions in simple common language that consumers can understand. Health Insurance policies should catch up with advancement of medical science and start including various modern surgeries that are currently excluded.

Munish Daga, director and chief executive officer, Remedinet Technologies Pvt Ltd

Exclusions should be clearly defined

When an individual buys health insurance, the objective is to cover all medical situations. A significant aspect of health insurance that gives negative surprises to the policyholder at the time of need is exclusions, a term used for listing out medical conditions that are not covered under a particular policy. The wording of the exclusion clause is pretty open-ended leaving room for individual interpretation.

If one sees the language used to list exclusions, it is clear that depending on how the doctor words the discharge summary and interpretation of that by the person adjudicating the claim, the outcome can vary significantly.

Standards should be put in place to ensure that exclusions mentioned are clear and define the medical conditions as accurately as possible. Another set of exclusions that hit the consumer hard are related to pre-existing diseases. If no medical tests are done prior to issuing of a policy and customers are not aware of any pre-existing diseases they may have a potentially nasty surprise awaiting them.

Kapil Mehta, co-founder, Securenow. In**Few, unambiguous exclusions needed**

The first issue is when exclusions are included unilaterally at the time of renewal. Buyers assume that the contract will remain unchanged when they renew but that is not the case. Second, exclusion of specific treatment protocols. For example, certain cancer treatment drugs are excluded by a few insurers. This influences treatment protocols which should be the purview of doctors and not insurers. Third, exclusions should not be linked to the reason for ill health. For example, illnesses related to drinking or because of hazardous activity should be covered. A claim due to cirrhosis of the liver was initially denied because the insurer assumed that alcohol was the cause.

Finally, exclusions have to be considerate. Critical illness plans require a survival period of 30 days after the disease is diagnosed for a claim to be payable. This means that if someone has a heart attack and dies, their family will not get the claim but if they live the claim will get paid. Overall, policies with few, unambiguous exclusions and a reasonable price to cover all these contingencies are preferred.

Source

[Back](#)**Pensions*****Employees' social security contribution may be pared - The Economic Times (Delhi edition) - 1st August 2018***

Your take home salary could go up leaving you more to spend — though it could be at the cost of your savings — as the government is mulling lowering the social security contribution.

A labour ministry committee working on the contributory ceiling by the government towards universal social security for all workers is likely to recommend a lower contribution, a government official told ET. The committee is expected to finalize its recommendation by the end of August, the person said.

Initial estimate suggests that total contribution towards social security cover could be lower by at least 2 percentage points, with employers also contributing less. The labour ministry will hold consultation with stakeholders once the committee finalizes its recommendations, following which they would be incorporated in the social security code, the official said.



Currently, social security contribution is 24% of an employee's basic salary. This include 12% employee contribution, which entirely goes to provident fund account. Employer also contributes 12%, which is split among pension account, provident fund account and deposit linked insurance scheme. This contribution could fall to 10% for both, yielding a higher take-home

salary for workers. The 10% contribution is already applicable to establishments with less than 20 workers. This could be made uniform for every establishment.

"We are enhancing the scale of coverage by five-fold," the official said. "Hence, we think that going forward the contribution by and for each worker eligible for a social security cover will come down, benefitting both employee and the employer."

The govt expects to increase those covered under the social security scheme to 50 crore from the current base of about 10 crore people. In majority of cases, employer's contribution to PF and insurance is factored in workers' cost to company pay. In such cases, reduction in employer's contribution might also become available to the employee under some other head, boosting their take home salary further.

The higher salary will be available for spending or can be saved by the worker in other instruments. Employee unions have in general not favored reduction in the social security contribution rate, reasoning it would reduce social security cover available to workers.

Source

Retirement boon: Changes to EPFO will increase scheme's return potential, mean more freedom for subscribers - Financial Express – 30th June 2018

The labour ministry is mulling over a change that will enable EPFO subscribers to invest in equity or debt, as they see fit.

As per The Economic Times (ET), the change will see the existing restrictions placed on these class of investments removed. Equity exposure for EPFO subscribers, today, is capped at just 15%.

The proposed changes seek to match the EPFO with the NPS in terms of the rates of return, as NPS permits investment in all types of instruments, namely government securities, debt instruments, equity investments, money markets and infrastructure investment trusts.

The 5 crore EPFO subscribers can now look forward to improving rates of return, as the scheme's returns are 1-2 percentage points (8.5%) behind those of the NPS (10%).

EPFO started to invest in equities in 2015, with an initial 5% cap. Now, up to 50% of a subscriber's PF corpus can be invested in government securities, up to 45% in debt instruments, up to 15% in equity and 5% each in money markets and infrastructure trusts.

NPS gives subscribers—only from the private sector, though—the option to invest up to 75% in equities.

As per ET, government securities and debt bonds provide around 7% annualized returns to the EPFO, while the return on equity investments under the scheme has been over 16% since it started in 2015, highlighting the potential increases that diverting one's investments towards the stock market can bring.

For example, a corpus of `50,000 will deliver a 35% increase in interest earned over 30 years with just a one percentage point increase in return, from 8.5% to 9.5%.

The option to construct one's portfolio as one sees fit will also allow the more risk-averse investors to hedge and diversify their risks as much as possible, while allowing investors with a larger risk appetite to benefit from riding the the equity horse, after EPFO's irrational stranglehold that has prevented them from actualizing increased returns is done away with.

Source

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IRDAI Circular

Source

Updated List of Non-life Insurers is available on IRDAI website,

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Global News

Thailand: Life market grows steadily at 5% in 1H – Asia Insurance Review

The life insurance sector in Thailand reported 5% growth in total premiums for the first half of this year, driven mainly by bancassurance and insurance agents, says the Thai Life Assurance Association (TLAA).

Total premiums for the first six months were valued at THB312.53bn (\$9.4bn), comprising new life insurance premiums worth THB89.97bn and renewal premiums worth THB222.56bn, with a persistency rate of 84%, reports The Bangkok Post.

For new life insurance premiums, the total consisted of first-year premiums worth THB46.35bn and single premiums valued at THB43.62bn.

"Bancassurance contributed 48.4% of total premium income [during the first half], overtaking insurance agents, which contributed 44.61%," said TLAA president Nusara Assakul Banyatpiyaphod. "However, both remain the main distribution channels."

The low interest rate environment and the new accounting standard (International Financial Reporting Standards 9) were among key factors pushing life insurers companies to revise their products and shift focus from single premium, endowment, and guaranteed return products to protection products as well as unit-linked insurance plans, Mrs. Nusara said.

Source

Bancassurance reported premium income of THB151.24bn, up 6.1% year-on-year, while the agent channel contributed premiums of THB139.42bn, up 2.4% year-on-year. Other channels such as brokers, the Internet, counter services and walk-ins grew at a combined rate of 34% year-on-year to THB14.83bn, while direct marketing declined by 10% to THB7.1bn.

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