



Office of the
Governing Body of Insurance Council

**CONSOLIDATED ANNUAL REPORT
OF THE INSURANCE OMBUDSMEN
AND GBIC**

2012-13



बीमा परिषद नियंत्रण निकाय कार्यालय
Office of the Governing Body of Insurance Council

To:
All Partners/Stakeholders of
Governing Body of Insurance Council

CONSOLIDATED ANNUAL REPORT - 2012-13

As per Rule 20 of the Redressal of the Public Grievances Rules, 1998, the Ombudsman is required to furnish an Annual Report every year containing a general review of the activities of the Ombudsman. We have pleasure in forwarding herewith the Consolidated Annual Report and Audited Accounts of the Insurance Ombudsmen and GBIC for the year ending 31st March, 2013.

Through this Annual Report, it is our endeavor to bring to the information of all the Members, the areas which require their immediate attention, to make the functioning of the Ombudsman offices more effective.

We welcome your valuable comments/suggestions to make the Annual Report more meaningful, in future.

Mumbai
06.12.2013

(R.K. DEKA)
SECRETARY GENERAL

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

CONSOLIDATED ANNUAL REPORT OF INSURANCE OMBUDSMEN & GBIC FOR THE YEAR 2012-13.

I N D E X

<u>Sr. Nos.</u>		<u>Page Nos.</u>
1.	A) Introduction	1-2
	B) Insurance Ombudsman	3-5
	C) Complaints Statistics	6-7
	- Annexures to Complaint Statistics	6(A)-6(O)
	D) Accounts	8
	- Annexure to Accounts (Auditors' Report for GBIC and 12 Ombudsman offices)	8(A)-8(H)
2.	<u>Observations/Suggestions/Recommendations of Ombudsmen regarding quality of Services rendered by Insurers, Causes of Grievances, Etc.</u>	
	A) Both Life & General Insurance	9-12
	B) Life Insurance	12-13
	C) General Insurance	13-15
3.	<u>Ombudsman Centres Report</u>	
	1) Ahmedabad Ombudsman Centre	16-17
	2) Bhubaneswar Ombudsman Centre	18-26
	3) Chandigarh Ombudsman Centre	27-33
	4) Chennai Ombudsman Centre	34-35
	5) Delhi Ombudsman Centre	36-40
	6) Guwahati Ombudsman Centre	41-44
	7) Hyderabad Ombudsman Centre	45-48
	8) Kochi Ombudsman Centre	49-50
	9) Kolkata Ombudsman Centre	51-52
	10) Lucknow Ombudsman Centre	53-61
	11) Mumbai Ombudsman Centre	62-70

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

A. INTRODUCTION

The institution of Insurance Ombudsman has been created by Government of India through Gazette Notification of Redressal of Public Grievances Rules- 1998, on 11th November, 1998. The very purpose of creation of this Institution was to provide cost-effective, simple and speedy redressal of the grievance to the aggrieved policyholders.

In terms of Rule 20 of the Notification, Insurance Ombudsmen are required to furnish a report every year containing a review of quality of services rendered by the insurers with recommendations to improve these services; the activities of the Office of the Insurance Ombudsman during the preceding financial year, and such other information as may be considered necessary to the Government of India. Arising out of this rule, the Government vide its letter ref: F. No.11/02/2001-Vig (Ins.) dated 25th February 2002, directed the Governing Body of Insurance Council to consolidate the Annual Reports of all 12 Ombudsmen and submit such consolidated Report to Govt. of India. Accordingly, annual reports from the year 2002-2003 are being consolidated every year at the Office of GBIC and forwarded to Govt. of India.

The Annual Reports for the financial year 2012-2013 have been received from all Ombudsman Centres, except Bhopal, where there was no Ombudsman during this period. The consolidated Annual Report is **attached**.

- 1. All the Offices of Insurance Ombudsman have confirmed that the prescribed procedure as envisaged in RPG Rules 1998, in dealing with complaints is being followed.**
- 2. Many Ombudsman Centres have conducted outstation hearings for the convenience of the complainants as envisaged in the rules.**

3. Ombudsman Centres are submitting their monthly returns in respect of Complaint Statistics, Trial Balance, Bank reconciliation etc. in time regularly.
4. During the year, the IT Project called the Complaint Management System (CMS) was finalized and the same was implemented since July 2013. All the 12 Ombudsman centres have started working on the CMS module. In order to make the Module more foolproof we have been following up with the Ombudsman centres so that the valuable suggestions and inputs may be incorporated to make the module more user friendly as well.
5. Lucknow Ombudsman Centre arranged a meeting of Insurance Companies on 12.10.2012. It was attended by 85 participants (both Life & General side). Lucknow Doordarshan arranged tele-talk with the public on insurance complaints. It was well received by public at large. The role of Ombudsman's Office in resolving Customers' grievances was published by the Dainik Jagaran's Haldwani Office.

B. INSURANCE OMBUDSMAN

Sr. No.	Name of the Centre and Date of Inception	Name of the Current Ombudsman	State-wise Area of Jurisdiction
1.	Ahmedabad- July 1999	Shri P. Ramamoorthy, Ex-ED, LIC of India, Tenure from 21.7.2011 to 20.7.2014	State of Gujarat and Union Territories of Dadra and Nagar Haveli, and Daman and Diu.
2.	Bhopal- April-2000	Shri Raj Kumar Srivastava, Ex-District & Sessions Judge (Selection Grade) Tenure from 27.05.2013 to 26.05.2016	States of Madhya Pradesh and Chattisgarh.
3.	Bhubaneshwar- May-2000	Shri B.P. Parija, Ex-Super-Time District Judge, Tenure from 1.12.2010 to 30.11.2013	State of Orissa.
4.	Chandigarh- July- 1999	Shri Manik Sonawane, IAS, Ex-Chief Secretary to Government, Haryana Tenure from 21.9.2012 to 20.09.2015	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union Territory of Chandigarh

Sr. No.	Name of the Centre and Date of Inception	Name of the Current Ombudsman	State-wise Area of Jurisdiction
5.	Chennai- August 1999	Position vacant since demitting of office by Shri V. Ramasaamy, Ex- CMD, National Insurance Co. Ltd., on 09.08.2012. Shri Virander Kumar, Ex-General Manager, The New India Assurance Co. Ltd. from 09.05.2013.	State of Tamil Nadu and Union Territories- Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
6.	Delhi- July 1999	Shri S.P. Singh, Ex-Chief Commissioner of Income Tax, Tenure from 8.6.2010 to 7.6.2013	States of Delhi and Rajasthan.
7.	Guwahati- September 1999	Shri D.C. Choudhury, Ex-District & Sessions Judge, Tenure from 18.7.2011 to 17.7.2014	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
8.	Hyderabad- August 1999	Position vacant since demitting of office by Shri K. Chandrahas, Ex-Chief Commissioner of Income Tax, on 4.10.2012. Shri G. Rajeswara Rao, Ex- Chief Commissioner of Income Tax has taken on charge on 15.05.2013	States of Andhra Pradesh, Karnataka and Union Territory of Yanam- a part of Union Territory of Pondicherry.

Sr. No.	Name of the Centre and Date of Inception	Name of the Current Ombudsman	State-wise Area of Jurisdiction
9.	Kochi- June 2000	Shri R. Jyothindranathan, Ex-District & Sessions Judge, Tenure from 1.12.2010 to 30.11.2013	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe- a part of Union Territory of Pondicherry.
10.	Kolkata - March - 2000	Ms. Manika Datta, Ex-Chief Commissioner of Income Tax, Tenure from 9.6.2010 to 8.6.2013	States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.
11.	Lucknow - October 1999	Shri G.B. Pande, Ex-ED, LIC of India Tenure from 6.1.2011 to 5.1.2014	States of Uttar Pradesh and Uttaranchal.
12.	Mumbai- November 2000	Position vacant since demitting of office by Shri S. Viswanathan, Ex-ED, LIC of India, on 27.10.2012. Shri A.K. Dasgupta, Ex-Managing Director, LIC of India has taken charge on 16.05.2013	States of Maharashtra and Goa.

C. COMPLAINTS STATISTICS

The individual complaints statistics are as per details given by the Ombudsman Centres. Based on these details, the following consolidated statements as at 31.03.2013 are attached herewith:

1. Complaints disposal (Summary - Life & General Insurance combined)
- Statement - L1G1
2. Complaints disposal (Centrewise - Life Insurance) - Statement- L2
3. Complaints disposal (Company wise analysis - Life Insurance)
- Statement - L3
4. Complaints disposal (Centrewise - General Insurance) - Statement - G2
5. Complaints disposal (Company-wise analysis - General Insurance)
- Statement - G3
6. Details of awards & recommendations - Amount-wise (Centrewise - Life and General Insurance combined) - Statement - L4G4
7. Details of awards & recommendations - Amount-wise (Company- wise analysis - Life Insurance) - Statement - L5
8. Details of awards & recommendations - Amount-wise (Company-wise analysis - General Insurance) - Statement - G5
9. Summary of compliances awaited beyond 1 month of dispatch of agreed Awards/Recommendations - Life - Statement - L6
10. Summary of compliance awaited beyond 1 month of dispatch of agreed Awards/Recommendations - General - Statement - G6
11. Nature-wise classification of complaints received (Centrewise - Life & General Insurance combined) - Statement - L7G7
12. Nature-wise classification of complaints. received (Summary - Life)
- Statement - L8
13. Nature-wise classification of complaints received (Company-wise analysis - Life Insurance) Statement - L9

14. Nature-wise classification of complaints received (Centrewise – General Insurance) – Statement - G8
15. Nature-wise classification of complaints received (Company-wise analysis – General Insurance) – Statement - G9

D. ACCOUNTS

All the Ombudsman Centres have submitted their audited Trial Balances as at 31.03.2013. M/s Chaturvedi & Shah, Chartered Accountants, Mumbai who has been appointed as External Auditors for conducting audit of consolidated accounts of the Governing Body of Insurance Council and 12 Offices of the Insurance Ombudsman for the financial year 2012-13 have completed the audit and certified the Accounts. We are pleased to inform that the Audit Report submitted by the Chartered Accountants is without any qualification. A copy of the Consolidated Audit Report for the Governing Body of Insurance Council and the 12 Offices of the Insurance Ombudsman along with the Income and Expenditure Account and Balance Sheet as at 31.03.2013 is annexed as "Annexure A".

The consolidation of Final Accounts at GBIC for all the 12 Ombudsman Centres and Office of the GBIC was done in an automated manner, through "Tally-ERP 9" Package where all the schedules and accounts were generated automatically without error.

Expenses of the Ombudsman Centres and Office of GBIC are met by LIC of India upfront. Subsequently these expenses are distributed among all the GBIC Member Companies in proportion to the share of each company in the Gross Market Premium income. Accordingly, the expenses have been apportioned amongst the Member companies, and their respective share of expenses recovered and reimbursed to LIC of India.

During the previous year, it was decided by the Council that the Member companies share would be taken in advance, based on the previous year Market share on a provisional basis, and same will be adjusted as per final Market Share once the Audited Accounts of all Member companies are received. The matter is being looked into for reaching a feasible formula.

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal for the period from 01.04.2012 to 31.03.2013 (YEARLY)

STATEMENT L1 G1
LIFE & GENERAL INSURANCE

Name of Centre	Total No of Complaints			Number of complaints disposed off by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of the YEAR	Received during the YEAR	Total	Recomen-dations/Awards	Withdrawal /Settlement	Dismissal	Non-acceptance /NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total Disposed	Within 3 months	3 months to 1 Year	Above 1 Year	Total Outstanding as at 31.03.2013
Ahmedabad	706	1903	2609	67	87	598	1345	2097	1343	691	63	2097	134	378	0	512
Bhopal	384	250	634	0	50	0	23	73	28	33	12	73	82	178	301	561
Bubaneswar	133	500	633	78	39	83	269	469	282	187	0	469	59	105	0	164
Chandigarh	2070	3763	5833	472	845	126	2394	3837	2405	231	1201	3837	404	813	779	1996
Chennai	55	2005	2060	63	23	58	1728	1872	1845	27	0	1872	59	129	0	188
Delhi	979	3932	4911	583	62	490	2624	3759	2644	1031	84	3759	360	333	459	1152
Guwahati	88	398	486	193	21	11	142	367	185	170	12	367	64	55	0	119
Hyderabad	140	1723	1863	122	153	116	1222	1613	1606	7	0	1613	117	133	0	250
Kochi	506	1018	1524	204	122	93	386	805	399	216	190	805	147	446	126	719
Kolkata	339	2712	3051	204	215	311	1691	2421	1754	667	0	2421	291	339	0	630
Lucknow	138	1916	2054	287	140	120	1308	1855	1717	138	0	1855	167	32	0	199
Mumbai	1638	4662	6300	487	526	12	3164	4189	3068	1065	56	4189	427	1027	657	2111
Total	7176	24782	31958	2760	2283	2018	16296	23357	17276	4463	1618	23357	2311	3968	2322	8601

6(A)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal for the period from 01.04.2012 to 31.03.2013 (YEARLY)

STATEMENT L2
LIFE INSURANCE

Name of Centre	Total No of Complaints			Number of complaints disposed off by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of the YEAR	Received during the YEAR	Total	Recomen-dations/ Awards	Withdrawal /Settlement	Dismissal	Non-acceptance /NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total Disposed	Within 3 months	3 months to 1 Year	Above 1 Year	Total Outstanding as at 31.03.2013
Ahmedabad	51	690	741	17	16	54	617	704	616	88	0	704	17	20	0	37
Bhopal	231	180	411	0	31	0	2	33	10	13	10	33	68	149	161	378
Bubaneswar	55	328	383	29	37	42	186	294	200	94	0	294	38	51	0	89
Chandigarh	1341	3181	4522	319	654	90	2099	3162	2101	201	860	3162	321	626	413	1360
Chennai	13	1087	1100	18	2	19	1008	1047	1047	0	0	1047	20	33	0	53
Delhi	496	2599	3095	310	34	286	1765	2395	1779	591	25	2395	245	224	231	700
Guwahati	19	249	268	86	14	9	87	196	116	80	0	196	41	31	0	72
Hyderabad	62	1110	1172	36	95	47	915	1093	1086	7	0	1093	36	43	0	79
Kochi	224	613	837	80	59	55	267	461	273	105	83	461	91	235	50	376
Kolkata	137	1874	2011	81	165	185	1171	1602	1224	378	0	1602	199	210	0	409
Lucknow	136	1548	1684	220	1	120	1161	1502	1364	138	0	1502	150	32	0	182
Mumbai	81	2252	2333	63	11	2	2108	2184	2116	68	0	2184	66	83	0	149
Total	2846	15711	18557	1259	1119	909	11386	14673	11932	1763	978	14673	1292	1737	855	3884

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OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Complaints Disposal for the period from 01.04.2012 to 31.03.2013 (YEARLY)

**STATEMENT L3
LIFE INSURANCE**

Name of Company	Total No of Complaints			Number of complaints disposed off by way of							Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	Ofs at the Beginning of the YEAR	Received during the YEAR	Total	Recommen- dations/	Awards	Withdrawal /Settlement	non- acceptanc	Dismissal	NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total	Within 3 months	3 months to 1 Year	Above to 1 year	TOTAL
																		OUTSTANDING
Aegon Religare Life Ins.Co.Ltd.	67	539	606	0	54	14	1	18	303	390	312	51	27	390	61	105	50	216
Aviva Life	244	589	833	1	103	52	0	52	396	604	407	72	125	604	55	91	83	229
Bajaj-Allianz Life	217	733	950	3	98	57	6	74	520	758	580	113	65	758	48	87	57	192
BHARTI AXA LIFE	121	341	462	0	57	19	0	16	227	319	242	55	22	319	25	50	68	143
Birla-Sun Life	158	1250	1408	1	56	80	8	65	809	1019	833	114	72	1019	156	183	50	389
Canara HSBC Oriental Bank Life	5	34	39	0	2	1	1	5	23	32	27	4	1	32	2	4	1	7
DLF Pramerica Life Ins.Co.Ltd.	20	167	187	0	4	7	0	7	88	106	91	9	6	106	25	44	12	81
Edelweiss tokioiocco	0	3	3	0	0	0	0	0	3	3	3	0	0	3	0	0	0	0
Future Generali	40	171	211	1	12	22	0	9	113	157	120	21	16	157	22	22	10	54
Hdfc-Standard Life	302	1912	2214	2	130	125	8	71	1436	1772	1463	168	141	1772	188	209	45	442
ICICI-Prudential	130	1095	1225	4	42	50	4	57	832	989	854	108	27	989	87	85	64	236
IDBI Federal Life Ins.Co.Ltd.	16	62	78	1	2	4	1	11	40	59	46	8	5	59	7	8	4	19
IndiaFirst insurance co.	0	41	41	0	1	0	0	2	33	36	35	1	0	36	3	2	0	5
Ing-Vysya	29	181	210	1	10	17	0	2	142	172	147	10	15	172	16	20	2	38
Kotak Mahindra-OM	277	738	1015	1	71	100	1	55	472	700	496	114	90	700	67	149	99	315
LIC of India	577	4249	4826	17	264	292	38	296	3250	4157	3525	495	137	4157	223	308	138	669
Max Life Insurance	148	526	674	3	59	85	2	24	372	545	402	66	77	545	52	46	31	129
Met-Life	83	379	462	2	42	22	1	16	295	378	304	47	27	378	28	30	26	84
RELIANCE LIFE	184	988	1172	2	70	115	3	54	711	955	756	127	72	955	92	80	45	217
SAHARA India Life	0	5	5	0	0	0	0	0	5	5	5	0	0	5	0	0	0	0
SBI LIFE	109	905	1014	1	78	25	1	42	654	801	682	84	35	801	71	125	17	213
SHRIRAM LIFE	1	110	111	0	1	0	0	0	94	95	95	0	0	95	7	8	1	16
Star Union Dai-ichi Life Ins.Co.	5	48	53	1	1	3	1	1	38	45	40	5	0	45	0	4	4	8
TATA AIA LIFE	113	645	758	1	60	29	5	41	440	576	467	91	18	576	57	77	48	182
Total	2846	15711	18557	42	1217	1119	81	918	11296	14673	11932	1763	978	14673	1292	1737	855	3884

62

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal for the period from 01.04.2012 to 31.03.2013 (YEARLY)

STATEMENT G 2
GENERAL INSURANCE

Name of Centre	Total No of Complaints			Number of complaints disposed off by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of YEAR	Received during the YEAR	Total	Recomen-dations/ AWARDS	Withdrawal /Settlement	Dismissal	Non-acceptance /NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total Disposed	Within 3 months	3 months to 1 Year	Above 1 Year	Total Outstanding as at 31.03.2013
Ahmedabad	655	1213	1868	50	71	544	728	1393	727	603	63	1393	117	358	0	475
Bhopal	153	70	223	0	19	0	21	40	18	20	2	40	14	29	140	183
Bubaneswar	78	172	250	49	2	41	83	175	82	93	0	175	21	54	0	75
Chandigarh	729	582	1311	153	191	36	295	675	304	30	341	675	83	187	366	636
Chennai	42	918	960	45	21	39	720	825	798	27	0	825	39	96	0	135
Delhi	483	1333	1816	273	28	204	859	1364	865	440	59	1364	115	109	228	452
Guwahati	69	149	218	107	7	2	55	171	69	90	12	171	23	24	0	47
Hyderabad	78	613	691	86	58	69	307	520	520	0	0	520	81	90	0	171
Kochi	282	405	687	124	63	38	119	344	126	111	107	344	56	211	76	343
Kolkata	202	838	1040	123	50	126	520	819	530	289	0	819	92	129	0	221
Lucknow	2	368	370	67	139	0	147	353	353	0	0	353	17	0	0	17
Mumbai	1557	2410	3967	424	515	10	1056	2005	952	997	56	2005	361	944	657	1962
Total	4330	9071	13401	1501	1164	1109	4910	8684	5344	2700	640	8684	1019	2231	1467	4717

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OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal for the period from 01.04.2012 to 31.03.2013 (YEARLY).

STATEMENT G 3
GENERAL INSURANCE.

Name of Company	Total No of Complaints			Complaints disposed by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of the YEAR	Received during the YEAR	Total	Recomen-dations /Awards	Withdrawal /Settlement	Dismissal	NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total	Within 3 months	3 months to 1 Year	Above 1 year	TOTAL OUTSTANDING as at 31.03.2013
Agriculture Ins. Co.	0	2	2	0	0	0	2	2	2	0	0	2	0	0	0	0
Apollo Munich	47	168	215	19	19	13	88	139	102	33	4	139	17	36	23	76
Bajaj-Allianz General	83	234	317	28	23	22	144	217	160	42	15	217	23	51	26	100
Bharati AXA Gen. Ins.	28	87	115	5	10	8	56	79	56	19	4	79	3	14	19	36
CHNHB Association	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cholamandalam	27	78	105	7	4	4	49	64	52	8	4	64	5	19	17	41
ECGC	0	4	4	0	0	0	4	4	3	1	0	4	0	0	0	0
Future Generali Gen.	11	51	62	4	4	6	32	46	38	7	1	46	2	8	6	16
HDFC ERGO Gen. Ins.	39	124	163	13	12	12	82	119	79	29	11	119	13	21	10	44
ICICI-Lombard	191	393	584	45	61	42	246	394	275	95	24	394	37	103	50	190
IFFCO TOKIO	68	95	163	18	18	13	59	108	66	23	19	108	9	21	25	55
L & T General	0	10	10	0	0	0	6	6	6	0	0	6	2	2	0	4
LIBERTY VIDEOCON	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAGMA HDI GENERAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAX BUPA	6	98	104	0	4	4	72	80	65	15	0	80	9	12	3	24
Raheja QBE Gen. Ins.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reliance General	395	448	843	140	104	72	237	553	278	172	103	553	42	124	124	290
Religare Health Ins.	0	1	1	0	0	0	1	1	1	0	0	1	0	0	0	0
Royal-Sundaram	60	164	224	29	8	20	98	155	105	36	14	155	9	46	14	69
SBI General	0	14	14	0	0	0	11	11	9	2	0	11	1	2	0	3
Shriram Gen. Ins. Co. Ltd.	17	121	138	10	8	2	79	99	87	11	1	99	8	13	18	39
Star Health & Allied Ins.	223	594	817	72	170	42	300	584	347	214	23	584	55	114	64	233
TATA-AIG General	49	206	255	10	5	8	143	166	139	19	8	166	25	51	13	89
The National Insurance	596	1260	1856	214	125	195	691	1225	722	410	93	1225	125	307	199	631
The New India Assurance	993	1782	2775	340	247	238	934	1759	959	694	106	1759	200	483	333	1016
The Oriental Insurance	648	1163	1811	210	129	166	607	1112	707	318	87	1112	122	320	257	699
The United-India Ins.	837	1918	2755	334	207	237	938	1716	1051	542	123	1716	308	469	262	1039
Universal Sampo Gen.	12	56	68	3	6	5	31	45	35	10	0	45	4	15	4	23
Total	4330	9071	13401	1501	1164	1109	4910	8684	5344	2700	640	8684	1019	2231	1467	4717

(CE)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

RECOMMENDATIONS AND AWARDS FOR THE YEAR ENDED MARCH' 2013

**STATEMENT L4 G4
LIFE & GENERAL INSURANCE**

Name of the Centre	LIFE		GENERAL		TOTAL	
	No.	Recommended/ Awarded Rs. in 000'	No.	Recommended/ Awarded Rs. in 000'	No.	Recommended/ Awarded Rs. in 000'
AHMEDABAD	17	141	50	558	67	699.03
BHOPAL	0	0	0	0	0	0.00
BHUBANESHWAR	29	587	49	14	78	601.05
CHANDIGARH	319	37235	153	8996	472	46231.12
CHENNAI	18	4139	45	4091	63	8229.38
DELHI	310	22820	273	28502	583	51322.62
GUWAHATI	86	1051	107	2485	193	3536.43
HYDERABAD	36	7215	86	11389	122	18604.41
KOCHI	80	3220	124	11359	204	14579.19
KOLKATA	81	6213	123	7475	204	13687.84
LUCKNOW	220	14060	67	2334	287	16393.80
MUMBAI	63	2545	424	23280	487	25825.69
TOTAL	1259	99228	1501	100483	2760	199711.00

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
RECOMMENDATIONS AND AWARDS FOR THE YEAR ENDED MARCH' 2013

STATEMENT L 5
LIFE INSURANCE

Name of Insurer	RECOMMENDATIONS (Amount in '000)		AWARDS (Amount in '000)		AWARDS (Amount in '000)	
	UPTO THE MONTH		UPTO THE MONTH		UPTO THE MONTH	
	Number	Amount	Number	Amount	Number	Amount
Aegon Religare Life Ins.Co.Ltd.	0	0	61	5159	61	5159
Aviva Life	1	0	109	10827	110	10827
Bajaj-Allianz Life	3	100	120	7899	123	7999
BHARTI AXA Life	0	0	63	3658	63	3658
Birla-Sun Life	1	51	66	6115	67	6166
Canara HSBC Oriental Bank Life	0	0	2	0	2	0
DLF Pramerica Life Ins.Co.Ltd.	0	0	5	183	5	183
Edelweiss Tokio Life Ins.	0	0	0	0	0	0
Future Generali	1	60	14	1286	15	1346
HDFC Standard Life	3	44	141	15585	144	15629
ICICI-Prudential	4	125	50	2312	54	2437
IDBI Federal Life Ins.Co.Ltd.	1	25	5	300	6	325
IndiaFirst Life Insurance co.	0	0	1	0	1	0
Ing-Vysya	1	0	12	1242	13	1242
Kotak Mahindra-OM	1	150	81	4034	82	4184
LIC of India	28	417	301	15550	329	15967
Max Life Insurance Co.	3	19	65	5641	68	5660
Met-Life	2	71	45	2900	47	2971
RELIANCE LIFE	2	325	88	5254	90	5579
SAHARA India Life	1	100	0	0	1	100
SBI LIFE	0	0	85	4944	85	4944
SHRIRAM LIFE	0	0	1	400	1	400
Star Union Dai-ichi Life Ins.Co.	1	50	2	501	3	551
TATA AIA LIFE	7	150	68	3752	75	3902
Total	60	1687	1385	97541	1445	99228

**OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
RECOMMENDATIONS AND AWARDS FOR THE YEAR ENDED MARCH' 2013**

**STATEMENT G 5
GENERAL INSURANCE**

Name of the Insurer	RECOMMENDATIONS (AMOUNT IN '000)		AWARDS (AMOUNT IN '000)		RECOMMENDATION & AWARDS (AMOUNT IN '000)	
	UPTO THE MONTH		UPTO THE MONTH		UPTO THE MONTH	
	Number	Amount	Number	Amount	Number	Amount
Agriculture Ins. Co.	0	0.00	0	0.00	0	0.00
Apollo Munich	2	0.00	18	691.72	20	691.72
Bajaj-Allianz General	2	0.00	26	3875.04	28	3875.04
BharatiAXA Gen.Ins.	1	0.00	4	630.00	5	630.00
CHNHB Association	0	0.00	0	0.00	0	0.00
Cholamandalam	0	0.00	7	120.70	7	120.70
ECGC	0	0.00	0	0.00	0	0.00
Future Generali Gen.	0	0.00	4	179.00	4	179.00
HDFC ERGO Gen.Ins.	0	0.00	13	1374.02	13	1374.02
ICICI-Lombard	2	0.00	52	9031.69	54	9031.69
IFFCO TOKIO	0	0.00	17	1261.33	17	1261.33
L & T Genl. Ins. Co.	0	0.00	0	0.00	0	0.00
Liberty Videocon Gen.Ins.	0	0.00	0	0.00	0	0.00
Magma HDI Gen. Ins.Co.	0	0.00	0	0.00	0	0.00
MAX BUPA	0	0.00	1	0.00	1	0.00
Raheja QBE Gen.Ins.	0	0.00	0	0.00	0	0.00
Reliance General	13	435.10	127	12698.55	140	13133.65
Royal-Sundaram	1	0.00	26	1042.32	27	1042.32
SBI Genl. Ins. Co.	0	0.00	4	122.65	4	122.65
Shriram Gen.Ins.Co.Ltd.	0	0.00	5	427.31	5	427.31
Star Health & Allied Ins.	1	100.00	74	5653.03	75	5753.03
TATA-AIG General	1	0.00	12	856.23	13	856.23
National Ins.	18	439.66	178	11211.21	196	11650.87
The New India	17	106.61	324	14684.78	341	14791.39
The Oriental	7	584.79	212	14177.62	219	14762.41
United-India	10	153.67	323	18795.48	333	18949.15
Universal Sompo Gen.	1	0.00	36	1830.12	37	1830.12
Total	76	1819.83	1463	98662.81	1539	100482.63

G(H)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Compliance awaited for more than one Month as on MARCH 2013

STATEMENT L 6
LIFE INSURANCE

Centre	Ahmedabad	Bhopal	Bubaneswar	Chandigarh	Chennai	Delhi	Guwahati	Hyderabad	Kochi	Kolkata	Lucknow	Mumbai	Total
Name of Company													
Aegon Religare Life Ins.Co.Ltd.		0	0	0	0	6			0		0	0	6
Aviva Life		0	0	0	0	3			0		0	0	3
Bajaj-Allianz Life	1	0	0	0	0	7	4		0	2	0	0	14
BHARTI AXA LIFE		0	0	0	0	1			0		0	0	1
Birla-Sun Life		0	0	0	0	7	4		0		0	0	11
Canara HSBC Oriental Bank Life		0	0	0	0				0		0	0	0
DLF Pramerica Life Ins.Co.Ltd.		0	0	0	0				0		0	0	0
Edelweiss Tokio LIC Co.		0	0	0	0				0		0	0	0
Future Generali		0	0	0	0		1		0		0	0	1
Hdfc-Standard Life		0	0	0	0	6	4		0		0	0	10
ICICI-Prudential	2	0	0	0	0	2			0		0	0	4
IDBI Federal Life Ins.Co.Ltd.		0	0	0	0				0		0	0	0
IndiaFirst Life Ins. Co. Ltd.		0	0	0	0				0		0	0	0
Ing-Vysya		0	0	0	0				0		0	0	0
Kotak Mahindra-OM		0	0	0	0	17			0		0	0	17
LIC of India	2	0	0	0	0		34		0	2	0	0	38
Max- Life		0	0	0	0	1	2		0		0	0	3
Met-Life	1	0	0	0	0	2			0		0	0	3
RELIANCE LIFE	3	0	0	0	0	7	4		0		0	0	14
SAHARA India Life		0	0	0	0				0		0	0	0
SBI LIFE		0	0	0	0	4	1		0		0	0	5
SHRIRAM LIFE		0	0	0	0			1	0		0	0	1
Star Union Dai-ichi Life Ins.Co.		0	0	0	0	1			0		0	0	1
TATA AIA LIFE		0	0	0	0	3			0		0	0	3
Total	9	0	0	0	0	67	54	1	0	4	0	0	135

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Compliance awaited for more than one Month as on MARCH 2013

STATEMENT G 6
GENERAL INSURANCE

Centre Name of Company	Ahmedabad	Bhopal	Bubaneswar	Chandigarh	Chennai	Delhi	Guwahati	Hyderabad	Kochi	Kolkata	Lucknow	Mumbai	Total
Agriculture Ins. Co.		0		0	0					0	0	0	0
Apollo Munich		0		0	0					0	0	0	0
Bajaj-Allianz General		0		0	0		8			0	0	0	8
Bharati AXA Gen.Ins.		0		0	0					0	0	0	0
CHNHB Association		0		0	0					0	0	0	0
Cholamandalam		0		0	0					0	0	0	0
ECGC		0		0	0					0	0	0	0
Future Generali Gen.		0		0	0		1			0	0	0	1
HDFC ERGO Gen.Ins.		0		0	0	2	3			0	0	0	5
ICICI-Lombard		0		0	0		2			0	0	0	2
IFFCO TOKIO		0		0	0	1	5			0	0	0	6
L & T General Ins. Co.		0		0	0					0	0	0	0
Liberty Videocon		0		0	0					0	0	0	
Magma HDI General		0		0	0					0	0	0	
Max Bupa Health Ins. Co.		0		0	0					0	0	0	0
Raheja QBE Gen.Ins.		0		0	0					0	0	0	0
Reliance General	3	0	1	0	0	5		1		0	0	0	10
Religare Health		0		0	0		5			0	0	0	5
Royal-Sundaram		0		0	0	1	8			0	0	0	9
SBI General		0		0	0					0	0	0	0
Shriram Gen.Ins.Co.Ltd.		0	1	0	0					0	0	0	1
Star Health Insurance	2	0		0	0					0	0	0	2
TATA-AIG General		0		0	0					0	0	0	0
The National	11	0		0	0	1	28	3		0	0	0	43
The New India	14	0		0	0	1	20			0	0	0	35
The Oriental	2	0		0	0	3	15	1		0	0	0	21
The United-India	11	0	1	0	0	6	4	2	1	0	0	0	25
Universal Sompo Gen.		0		0	0		1			0	0	0	1
Total	43	0	3	0	0	20	100	7	1	0	0	0	174

65

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE PERIOD FROM 04.04.2012 TO 31.03.2013 (YEARLY).

STATEMENT L7 G7
LIFE & GENERAL INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL A+B
	Beyond Scope of Rule (12 b to f)	Not within Jurisdiction 13(1)	Not availed of Insurance Co. Grievance Redressal Mechanism 13 (a)	Sub-judice in courts/ forums 13 (c)	Time barred 13(b)	TOTAL A	Partial or total repudiation of claim.	Dispute in regards to premiums paid or payable in terms of policy.	Dispute on the legal construction of the policies in so far as such dispute relates to claim	Delay in settlement of claims.	Non-issue of insurance document to customer after receipt of premium.	TOTAL B	
AHMEDABAD	418	32	866	0	28	1344	535	19	1	2	2	559	1903
BHOPAL	4	1	2	1	0	8	56	20	119	42	5	242	250
BUBANESWAR	33	14	146	72	4	269	147	10	0	70	4	231	500
CHANDIGARH	222	69	2075	11	15	2392	214	1001	4	138	14	1371	3763
CHENNAI	1216	96	386	3	21	1722	269	3	0	8	3	283	2005
DELHI	336	373	1898	0	17	2624	615	533	94	45	21	1308	3932
GUWAHATI	13	10	117	0	2	142	90	10	43	111	2	256	398
HYDERABAD	763	16	405	7	31	1222	422	7	16	50	6	501	1723
KOCHI	145	0	240	0	0	385	575	33	6	17	2	633	1018
KOLKATA	459	12	1186	5	29	1691	405	430	12	157	17	1021	2712
LUCKNOW	306	32	927	1	42	1308	160	217	0	198	33	608	1916
MUMBAI	852	222	1950	4	13	3041	1470	71	15	28	37	1621	4662
Total	4767	877	10198	104	202	16148	4958	2354	310	866	146	8634	24782

6(K)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE PERIOD FROM 04.04.2012 TO 31.03.2013 (YEARLY).

STATEMENT L 8
LIFE INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL A+B
	Beyond Scope of Rule (12 b to f)	Not within Jurisdiction 13(1)	Not availed of Insurance Co. Grievance Redressal Mechanism 13 (a)	Sub-judice in courts/ forums 13 (c)	Time barred 13(b)	TOTAL A	Partial or total repudiation of claim.	Dispute in regards to premiums paid or payable in terms of policy.	Dispute on the legal construction of the policies in so far as such dispute relates to claim	Delay in settlement of claims.	Non-issue of insurance document to customer after receipt of premium.	TOTAL B	
AHMEDABAD	302	19	282	0	13	616	52	19	1	0	2	74	690
BHOPAL	0	1	1	0	0	2	14	19	119	23	3	178	180
BUBANESWAR	1	9	115	59	2	186	74	9	0	55	4	142	328
CHANDIGARH	185	49	1843	7	13	2097	14	987	1	72	10	1084	3181
CHENNAI	969	3	29	0	1	1002	74	0	0	8	3	85	1087
DELHI	200	239	1318	0	8	1765	151	529	91	43	20	834	2599
GUWAHATI	1	9	77	0	0	87	65	10	43	43	1	162	249
HYDERABAD	675	9	223	0	8	915	135	7	16	32	5	195	1110
KOCHI	99	0	168	0	0	267	313	26	2	3	2	346	613
KOLKATA	393	11	750	2	15	1171	147	430	12	99	15	703	1874
LUCKNOW	306	32	783	1	39	1161	95	217	0	45	30	387	1548
MUMBAI	409	184	1515	0	0	2108	142	0	0	0	2	144	2252
Total	3540	565	7104	69	99	11377	1276	2253	285	423	97	4334	15711

(7)9

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE PERIOD FROM 01.04.2012 TO 31.03.2013 (YEARLY).

STATEMENT G 8
GENERAL INSURANCE

NAME OF THE CENTRE	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL A+B
	Beyond Scope of Rule (12 b to f)	Not within Jurisdiction 13(1)	Not availed of Insurance Co. Grievance Redressal Mechanism 13 (a)	Sub-judice in courts/ forums 13 (c)	Time barred 13(b)	TOTAL A	Partial or total repudiation of claim.	Dispute in regards to premiums paid or payable in terms of policy.	Dispute on the legal construction of the policies in so far as such dispute relates to claim	Delay in settlement of claims.	Non-issue of insurance document to customer after receipt of premium.	TOTAL B	
AHMEDABAD	116	13	584	0	15	728	483	0	0	2	0	485	1213
BHOPAL	4	0	1	1	0	6	42	1	0	19	2	64	70
BUBANESWAR	32	5	31	13	2	83	73	1	0	15	0	89	172
CHANDIGARH	37	20	232	4	2	295	200	14	3	66	4	287	582
CHENNAI	247	93	357	3	20	720	195	3	0	0	0	198	918
DELHI	136	134	580	0	9	859	464	4	3	2	1	474	1333
GUWAHATI	12	1	40	0	2	55	25	0	0	68	1	94	149
HYDERABAD	88	7	182	7	23	307	287	0	0	18	1	306	613
KOCHI	46	0	72	0	0	118	262	7	4	14	0	287	405
KOLKATA	66	1	436	3	14	520	258	0	0	58	2	318	838
LUCKNOW	0	0	144	0	3	147	65	0	0	153	3	221	368
MUMBAI	443	38	435	4	13	933	1328	71	15	28	35	1477	2410
Total	1227	312	3094	35	103	4771	3682	101	25	443	49	4300	9071

6(17)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE PERIOD FROM 01.04.2012 TO 31.03.2013 (YEARLY).

STATEMENT G 9
GENERAL INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL A+B
	Beyond Scope of Rule (12 b to f)	Not within Jurisdiction	Not availed of Insurance Co. Grievance Redressal Mechanism	Sub-judice in courts/ forums	Time barred	TOTAL	Partial or total repudiation of claim.	Dispute in regards to premiums paid or payable in terms of policy.	Dispute on the legal construction of the policies in so far as such dispute relates to claim	Delay in settlement of claims.	Non-issue of insurance document to customer after receipt of premium.	TOTAL	
		13(1)	13 (a)	13 (c)	13(b)	A						B	
Agriculture Ins. Co.	0	0	1	1	0	2	0	0	0	0	0	0	2
Apollo Munich	15	11	59	0	0	85	67	2	1	13	0	83	168
Bajaj-Allianz General	51	3	78	3	5	140	71	6	0	15	2	94	234
BharatiAXA Gen.Ins.	13	2	39	0	1	55	28	1	0	3	0	32	87
CHNHB Association	0	0	0	0	0	0	0	0	0	0	0	0	0
Cholamandalam	18	6	20	0	5	49	22	1	1	5	0	29	78
ECGC	3	1	0	0	0	4	0	0	0	0	0	0	4
Future Generali Gen.	7	2	22	0	0	31	13	0	0	7	0	20	51
HDFC ERGO Gen.Ins.	30	7	41	0	0	78	34	3	2	5	2	46	124
ICICI-Lombard	97	18	116	3	4	238	117	8	3	23	4	155	393
IFFCO TOKIO	21	3	30	0	1	55	31	0	0	9	0	40	95
L & T General	2	0	4	0	0	6	1	0	0	3	0	4	10
Liberty Videocon	0	0	0	0	0	0	0	0	0	0	0	0	0
MAGMA HDI	0	0	0	0	0	0	0	0	0	0	0	0	0
MAX BUPA	25	1	42	0	0	68	15	7	2	3	3	30	98
Raheja QBE Gen.Ins.	0	0	0	0	0	0	0	0	0	0	0	0	0
Reliance General	57	14	152	1	4	228	168	6	2	41	3	220	448
Religare Health Ins.	0	0	1	0	0	1	0	0	0	0	0	0	1
Royal-Sundaram	36	13	43	0	2	94	66	2	0	2	0	70	164
SBI General	6	0	4	1	0	11	2	0	0	0	1	3	14
Shriram Gen.Ins.Co.Ltd.	17	7	53	0	0	77	31	0	0	13	0	44	121
Star Health & Allied Ins.	53	35	197	0	2	287	282	5	0	18	2	307	594
TATA-AIG General	41	9	86	1	0	137	44	7	1	5	12	69	206
The National	155	28	467	5	25	680	486	7	1	80	6	580	1260
The New India	251	58	569	11	18	907	775	23	9	64	4	875	1782
The Oriental	126	31	414	4	15	590	496	10	1	61	5	573	1163
The United-India	198	62	633	5	21	919	908	13	2	71	5	999	1918
Universal Sampo Gen.	5	1	23	0	0	29	25	0	0	2	0	27	56
Total	1227	312	3094	35	103	4771	3682	101	25	443	49	4300	9071

(6/11)

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE PERIOD FROM 01.04.2012 TO 31.03.2013 (YEARLY).

STATEMENT L 9
LIFE INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL A+B
	Beyond Scope of Rule (12 b to f)	Not within Jurisdiction 13(1)	Not availed of Insurance Co. Grievance Redressal Mechanism 13 (a)	Sub-judice in courts/ forums 13 (c)	Time barred 13(b)	TOTAL A	Partial or total repudiation of claim.	Dispute in regards to premiums paid or payable in terms of policy.	Dispute on the legal construction of the policies in so far as such dispute relates to claim	Delay in settlement of claims.	Non-issue of insurance document to customer after receipt of premium.	TOTAL B	
Aegon Religare Life Ins.Co.Ltd.	46	25	232	0	1	304	22	187	21	3	2	235	539
Aviva Life	116	16	263	0	1	396	42	120	14	5	12	193	589
Bajaj-Allianz Life	172	29	314	5	6	526	105	75	10	12	5	207	733
BHARTI AXA LIFE	58	12	151	1	5	227	34	67	9	3	1	114	341
Birla-Sun Life	211	52	547	5	2	817	60	323	26	17	7	433	1250
Canara HSBC Oriental Bank Life	11	0	13	0	0	24	5	3	1	1	0	10	34
DLF Pramerica Life Ins.Co.Ltd.	6	3	79	0	0	88	4	67	5	0	3	79	167
Edelweiss Tokio LIC Co.	1	0	2	0	0	3	0	0	0	0	0	0	3
Future Generali	23	7	83	0	0	113	15	33	5	4	1	58	171
HDFC-Standard Life	382	82	963	5	12	1444	84	338	31	5	10	468	1912
ICICI-Prudential	256	46	524	5	5	836	62	162	16	11	8	259	1095
IDBI Federal Life Ins.Co.Ltd.	14	3	23	0	1	41	11	10	0	0	0	21	62
IndiaFirst Life Insurance Co.Ltd.,	18	1	14	0	0	33	5	1	0	2	0	8	41
ING-Vysya	65	4	72	1	0	142	16	15	2	5	1	39	181
Kotak Mahindra-OM	118	22	330	1	2	473	41	200	16	2	6	265	738
LIC of India	1277	132	1787	37	55	3288	502	78	41	307	33	961	4249
Max Life Insurance Co.	119	12	243	0	0	374	38	88	17	8	1	152	526
Met-Life	85	19	189	1	2	296	24	49	7	2	1	83	379
RELIANCE LIFE	156	20	535	1	2	714	55	186	23	7	3	274	988
SAHARA India Life	3	0	0	0	2	5	0	0	0	0	0	0	5
SBI LIFE	197	50	403	4	1	655	70	136	21	22	1	250	905
SHRIRAM LIFE	49	5	40	0	0	94	3	11	2	0	0	16	110
Star Union Dai-ichi Life Ins.Co.	14	2	22	0	1	39	0	8	1	0	0	9	48
TATA AIA LIFE	143	23	275	3	1	445	78	96	17	7	2	200	645
Total	3540	565	7104	69	99	11377	1276	2253	285	423	97	4334	15711

(9)

INDEPENDENT AUDITOR'S REPORT

To
The Governing Body of Insurance Council and 12 Ombudsman offices,
Mumbai

Report on the Financial Statements

1. We have audited the attached Balance Sheet of Governing Body of Insurance Council and 12 Ombudsman offices as at 31st March, 2013 and the Statement of Income and Expenditure for the year then ended and a summary of significant accounting policies and other explanatory information. The financials statements of 11 Ombudsman offices have been audited by Other Auditors and same has been relied upon by us.

Management's Responsibility for the Financial Statements

2. Governing Body of Insurance Council and 12 Ombudsman offices Management are responsible for the preparation of these financial statements that give a true and fair view of the Balance sheet and Statement of Income and Expenditure of Governing Body of Insurance Council and 12 Ombudsman offices in accordance with the requirements of the Insurance Act 1938 and Redressal of Public Grievances Rules, 1998. This responsibility includes the design, implementation and maintenance of internal control relevant to the preparation and presentation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

3. Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with the Standards on Auditing issued by the Institute of Chartered Accountants of India. Those Standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence, about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to Governing Body of Insurance Council and 12 Ombudsman offices preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of the accounting estimates made by Management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our Audit opinion.



Head Office: 714-715, Tulsiani Chambers, 212, Nariman Point, Mumbai - 400 021, India. Tel.: +91 22 3021 8500 • Fax: +91 22 3021 8595
URL : www.cas.ind.in

Branches: Ahmedabad | Bengaluru | Delhi | Jamnagar

Opinion

4. In our opinion and to the best of our information and according to the explanations given to us, the financial statements have been prepared in accordance with the requirements of the Insurance Act 1938 and Redressal of Public Grievances Rules, 1998, to the extent applicable and in the manner so required, and give a true and fair view in conformity with the accounting principles generally accepted in India, as applicable to Governing Body of Insurance Council and 12 Ombudsman offices
- (i) In case of Balance Sheets give a true and fair view of the state of affairs of Governing Body of Insurance Council and 12 Ombudsman offices as at 31st March, 2013; and
- (ii) In case of Statement of Income and Expenditure, of the deficit for the year ended on that date.

Emphasis of Matter and Other Matters

Emphasis of Matter

5. Without qualifying our opinion, we draw attention to:
- a) Note 2 in Schedule B to the financial statements regarding purchase of fixed assets. As per the legal opinion the GBIC is not entitled to hold any fixed assets. Notwithstanding the legal position, The GBIC has procured fixed assets.
- b) Note 3 in Schedule B to the financial statements regarding Opening balances. The GBIC started its operations in 1998. Until 2000-2001, the Accounts were maintained by LIC. The GBIC started maintaining Accounts independently from the year 2001-2002. For the year 2001-2002, GBIC had only its Income & Expenditure Accounts certified by the Auditor. Hence, the opening balances brought down on 1st April, 2001 were unaudited figures.
- c) Note 4 in Schedule B to the financial statements regarding accounts of the 12 offices of Insurance Ombudsman have been audited by various auditors. The consolidation of the same is being done after considering the fact that the amount received from LIC towards its share of expenses is not a surplus, but an advance / re-imbusement towards its share of contribution. Further the amount received towards Capital Expenditure is reflected as a liability for contribution for Fixed Assets.
- d) Note 8 in Schedule B to the financial statements regarding non filing of Income Tax returns. In the opinion of the management, Income Tax Return for the assessment year 2013-14 and for the earlier years is not required to be filed, as GBIC is not doing any commercial activity.
- e) Note 9 in Schedule B to the financial statements regarding Balances of Sundry Creditors and Sundry Debtors which are subject to confirmations and reconciliations.



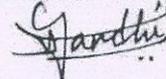
Other Matters

6. Audit of the previous year figures presented as comparatives was carried out by M/s Shankarlal Jain and Associates, Chartered Accountants, being the auditors of Governing Body of Insurance Council

Report on Other Legal and Regulatory Requirements

- a. we have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of our audit and have found them to be satisfactory;
- b. in our opinion and to the best of our information and according to the explanations given to us, proper books of account as required by law have been maintained by Governing Body of Insurance Council and 12 Ombudsman offices so far as appears from our examination of those books; and
- c. the Balance Sheet and Statement of Income and Expenditure of Governing Body of Insurance Council and 12 Ombudsman offices refer to in this report are in agreement with the books of accounts and returns.
- d. in our opinion, the Balance Sheet and Statement of Income & Expenditure comply with the applicable accounting standards

For Chaturvedi & Shah
Chartered Accountants
Firm Registration No.101720W



Vitesh D. Gandhi
Partner
Membership No. 110248



Place : Mumbai
Date : 04.09.2013

GOVERNING BODY OF INSURANCE COUNCIL & 12 OMBUDSMAN OFFICES

CONSOLIDATED BALANCE SHEET AS ON 31ST MARCH, 2013

LIABILITIES		As at 31/03/2013	As at 31/03/2012	ASSETS		As at 31/03/2013	As at 31/03/2012
		(Amt in Rs.)	Amt. in (Rs.)			(Amt. in Rs.)	(Amt. in Rs.)
Collection for Fixed Assets				Fixed Assets (At Cost)			
Upto Previous year	17,111,596.98			WDV (Opening)	9,235,791.48		
For Current year	-1,165,953.74			Additions during the year	1,277,970.50		
		15,945,643.24	17,111,596.98	Less depreciation for the year	1,894,246.31	8,619,515.67	9,235,791.48
Current Liabilities				(As per Schedule 'A' attached herewith)			
Vehicle Loan(Excess Recovery)			5,286.82	Debtors (Unsecured and considered good)			
Amount due to LIC of India		100,998,127.00	95,349,010.00	Amount due from GBIC members	101,624,552.53		
Sundry Creditors				Housing Loan Subsidy recoverable(LIC)	313600.84		
Outstanding Expenses	2,722,194.61			Other Miscellaneous Debit	86,089.20	102,024,242.57	95,429,415.93
Cheque Cancelled A/c	8,824.00			Advances to Staff		527,399.00	595,119.84
EMD received from Ameya Infovision Pvt.	50,000.00	2,781,018.61	4,168,852.99	Prepaid Expenses		717,714.00	320,756.00
				Deposits		903,523.00	1,020,306.00
				Stamps on Hand		3,200.96	4,120.96
				Cash Balance		42,046.01	44,315.01
				Bank Balance		6,887,147.64	9,984,921.57
Total		119,724,788.85	116,634,746.79	Total		119,724,788.85	116,634,746.79

Notes to Accounts as per Schedule "B" annexed.

AS PER OUR ANNEXED REPORT
FOR CHATURVEDI & SHAH
CHARTERED ACCOUNTANTS
Firm Registration No. - 101720W

(Signature)

(Vitesh D.Gandhi)
(PARTNER)
Membership No. 110248

PLACE : MUMBAI

DATE : 01/09/2013



(Signature)
DEPUTY SECRETARY

(Signature)
SECRETARY

(Signature)
SECRETARY GENERAL

8 (D)

GOVERNING BODY OF INSURANCE COUNCIL & 12 OMBUDSMAN OFFICES

CONSOLIDATED STATEMENT OF INCOME & EXPENDITURE FOR THE YEAR ENDED 31ST MARCH, 2013

Account Code	Expenses	Year ended	Year ended	Account Code	Income	Year ended	Year ended
		31/03/2013	31/03/2012			31/03/2013	31/03/2012
		(Amt. in Rs.)	(Amt. in Rs.)			(Amt. in Rs.)	(Amt. in Rs.)
401	Basic Salary to Ombudsman	4,406,129.53	4,110,853.76	303	LIC Designated Office A/c.	145,509,997.22	121,591,357.32
402	D.A. to Ombudsman	5,410,000.24	4,929,381.84	419	PLLI	0.00	7,201.24
403	HRA to Ombudsman	1,695,398.17	1,805,144.09	460	S.R. A/c.	8.45	
405	Conveyance to Ombudsman	1,330,580.67	1,238,981.19	501	Sundry Receipts	65,457.08	148,206.09
406	Basic Salary to Others	39,324,181.82	37,960,832.15		EXCESS OF EXPENDITURE OVER INCOME	1165953.74	
408	D.A. to Others	26,340,233.28	19,315,241.06				
409	HRA to Others	2,633,291.71	2,521,623.72				
410	CCA to Others	809,011.46	793,332.22				
411	FPA to Others	533,305.00	540,741.11				
412	Conveyance to Others	985,067.11	792,324.83				
413	Deputation Allowance to Others	4,052,071.25	1,533,907.53				
414	Functional Allowance to Others	136,069.20	4,500.00				
415	Washing Allowance to Others	1,800.00	1,800.00				
416	Qualifn. Pay to Others	396.10					
417	Other allowance to Others	30,210.97	51,255.94				
419	PLLI	79,798.00					
420	Employer's Contribution to Pension	2,973,845.27	2,875,986.68				
421	Employer's Contri. to PF	647,564.00	1,144,614.80				
422	Employer's Contri to Gratuity	1,576,458.59	1,543,054.38				
423	Employer's Contribution to Mediclaim	320,962.35	306,832.36				
424	Employer's Contribution to GSLI	34,352.10	26,257.75				
425	Leave Encashment	2,032,557.27	1,084,316.91				
426	Travelling Expenses on Tour	2,316,834.89	2,097,468.00				
427	Transfer T E	1,006,714.00	273,760.00				
428	E T C Expenses	1,601,410.80	1,064,540.00				
429	Motor Car Expenses	664,383.00	473,134.67				
430	Auditors Fees	163,375.60	168,952.40				
431	Law Charges	103,346.00	68,894.00				
432	Printing & Stationery	1,133,457.70	1,141,596.30				
433	Postage, Revenue Stamps	1,007,121.73	886,230.78				
434	Bank Charges	17,050.00	19,219.50				
435	Telephone Charges	1,076,380.13	981,301.01				
436	Electricity Charges	2,742,972.00	2,450,578.60				
437	Carriage & Freight	103,142.00	87,258.00				
438	Repairs & Maintenance	427,562.29	321,845.00				
439	Staff Amenities	2,386,847.10	1,938,040.81				
440	Lumpsum Medical Benefit	1,272,406.10	936,300.00				
441	All Insurance Premiums	165,625.50	152,230.93				
442	Entertainment Expenses	673,475.00	569,489.00				
443	Contractual Payments Other Than AMC	4,326,354.50	3,401,293.50				
444	AMC Payments	601,250.00	498,493.00				
445	Office Upkeep	609,410.00	549,494.90				
446	Subscription to Newspaper	346,738.00	327,403.50				
447	Conference Expenses	400,964.00	291,102.00				
448	Training Fees	171,910.80	104,585.00				
449	Consultancy Fees	20,978.00	23,390.00				
450	Rent, Rates & Taxes	24,912,116.58	17,477,743.96				
451	Depreciation	1,894,246.31	1,615,135.72				
452	PR and Publicity	749,138.00					
453	Other Misc Expenses	347,730.37	391,293.09				
454	Shifting Expenses	0.00	197,669.00				
455	Exp. Of Remodelling of Rented premises	90,020.00	585,260.00				
457	Sundry Office Equipment <Rs.5000/-	40,171.00	65,004.00				
460	S R A/c	0.00	0.66				
461	Library Expenses	15,001.00	7,075.00				
	Total	146,741,416.49	121,746,764.65			146,741,416.49	121,746,764.65

Notes to Accounts as per Schedule "B" annexed.

AS PER OUR ANNEXED REPORT
FOR CHATURVEDI & SHAH
CHARTERED ACCOUNTANTS
Firm Registration No. - 101720W

Vitsh D. Gandhi

(Vitesh D. Gandhi)
(PARTNER)
Membership No. 110248
PLACE : MUMBAI
DATE :



DM
DY. SECRETARY

Secretary
SECRETARY

Secretary General
SECRETARY GENERAL

CONSOLIDATED ACCOUNTS OF THE
GOVERNING BODY OF INSURANCE COUNCIL
& 12 OMBUDSMAN OFFICES

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2013

1. **SIGNIFICANT ACCOUNTING POLICIES**

A. **SYSTEM OF ACCOUNTING**

The GBIC has adopted the mercantile system of Accounting, except leave encashment which is accounted on Cash basis.

B. **FIXED ASSETS**

- i. Fixed Assets are stated at cost less depreciation.
- ii. Depreciation shall be provided at the rates prescribed as below and on the original cost of the assets on a Straight-Line Method as followed by the LIC of India. All assets costing upto Rs. 5000/- each shall be charged to revenue (written off to account code 457 – Sundry Office Equipment < Rs. 5000) in the year of purchase.

Account Code	Asset	Rate of Depreciation
216	Office Equipments(A)	4%
216	Office Equipments(B)	10%
217	Computers	30%
218	Air Conditioners, Fridge etc.	10%
219	Electrical Fittings	5%
221	Fax, Phone, EPABX etc.	10%
222	Xerox Machine	20%
223	Library Books	20%
224	Misc. Capital Equipments	10%

2. GBIC procures Fixed Assets for the smooth functioning of its activities at various locations. As per the Legal Opinion obtained, the GBIC is not entitled to hold any Fixed Assets. Notwithstanding the Legal position the GBIC has procured Fixed Assets. The Accounts have been prepared on the basis of actual transactions entered into by GBIC. The said Legal Opinion is not available for verification.
3. The GBIC started its operations in 1998. Until 2000-2001, the Accounts were maintained by LIC. The GBIC started maintaining Accounts independently from the year 2001-2002. For the year 2001-2002, GBIC had only its Income & Expenditure Account certified by the Auditor. Hence, the opening balances brought down on 1st April, 2001 were unaudited figures.



CONSOLIDATED ACCOUNTS OF THE
GOVERNING BODY OF INSURANCE COUNCIL
& 12 OMBUDSMAN OFFICES

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2013

4. The accounts of the 12 offices of Insurance Ombudsman have been audited by various auditors. The consolidation of the same is being done after considering the fact that the amount received from LIC towards its share of expenses is not a surplus, but an advance/re-imbusement towards its share of contribution. Further the amount received towards Capital Expenditure is reflected as a liability for contribution for Fixed Assets.
5. The GBIC receives lump sum amount from the LIC of India for the funding of its expenses. The GBIC then calculates the market share of each member; LIC, GIPSA Companies and other private companies. The amount, which has been received from LIC, is apportioned as per their market share. The amount received from LIC in excess of its share is to be refunded to LIC. The amount due to LIC as on 31.03.2013 is ₹. 100,998,127/-
6. Rent agreement with the Landlord i.e. LIC of India is yet to be executed and the same is provided for as per mutually agreed.
7. Till the end of Previous Year, LIC had claimed arrears of Municipal Taxes for earlier period of ₹. 174.68 lakhs and the same was not accounted for want of complete details and being disputed by the Council. In the Current Financial Year, as per letter dated 13th February, 2013, the final claim made by LIC was Rs. 68.07 lakhs instead of Rs. 174.68 lakhs which was paid on 22nd February, 2013. In the opinion of the management no further liability is accepted.
8. In the opinion of the management, Income Tax Return for the assessment year 2013-14 and for the earlier years is not required to be filed, as GBIC is not doing any commercial activity.
9. Balances of Sundry Creditors and Sundry Debtors are subject to confirmations and reconciliations.
10. In case of 6 centers, the salary is paid directly by respective Ombudsman Centre, whereas normally the parent company (such as LIC, New India Assurance etc.) pays the salary and the Ombudsman Centre reimburses it to them.
11. The provision for Leave Encashment is not made in case of the 12 Ombudsmen, whereas they are entitled to 30 days of earned leave for every completed year of service and as per CCS LEAVE RULES, 1972, eligible employees are entitled to Encashment of 50% of earned leave to his credit at any time.



CONSOLIDATED ACCOUNTS OF THE
GOVERNING BODY OF INSURANCE COUNCIL
& 12 OMBUDSMAN OFFICES

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2013

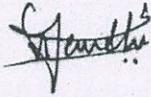
12. During the year, status of complaints are as under (as compiled by the management) :

Particulars	Complaints O/s. as on 01.04.2012	Received during the year	Disposed during the year	Outstanding as on 31.03.2013
For Life Insurance	2846	15711	14673	3884
For General Insurance	4330	9071	8684	4717
Total	7176	24782	23357	8601

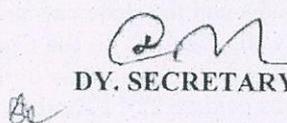
AS PER OUR REPORT OF EVEN DATE

For CHATURVEDI AND SHAH
CHARTERED ACCOUNTANTS
FIRM REGISTRATION No. 101720W

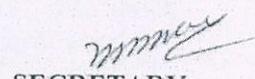
For GOVERNING BODY OF
INSURANCE COUNCIL



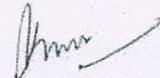
(VITESH D. GANDHI)
PARTNER
M.No. 110248



BY. SECRETARY



SECRETARY



SECRETARY GENERAL

PLACE: MUMBAI
DATE: 04/09/2013



OBSERVATIONS/SUGGESTIONS/RECOMMENDATIONS OF OMBUDSMEN REGARDING QUALITY OF SERVICES RENDERED BY INSURERS, CAUSES OF GRIEVANCES, ETC.

A) SUGGESTIONS PERTAINING TO BOTH LIFE & GENERAL INSURANCE:

i) Address and Telephone Number of Local Servicing Branch:

The public sector insurance companies incorporate the name, address and telephone number of the issuing branch and controlling office in the policy document, whereas the private sector insurers are not mentioning the same in any document issued to the policy holders other than giving names and addresses of the registered and corporate office. Consequently the policy holders find it very difficult to tender their basic servicing requirement like payment of renewal premium etc. and more so they approach Insurance Ombudsman offices for the same whose addresses and telephone numbers are invariably given on the policy document. It causes embarrassment to the complainants. It is therefore suggested that the insurer should give the address, e-mails and telephone numbers (mobile or landline and not merely Toll free number) of their local office and their Head office Grievance Department, on the policy document.

ii) Insurers to submit effective Self Contained Notes (SCN) in time, with supporting documents:

It has been observed that in many cases insurers do not submit Self-Contained Note (SCN) with supporting documents in spite of repeated reminders. SCN is an important document from the point of view of the insurer which allows the insurer to take defence giving detailed reasons for repudiation of claim etc. Non-submission of the same, at times, may allow inferring that insurer has nothing to represent in its defence.

In fact SCN should be a summary of the case, supplemented with relevant documents, on the basis of which action was taken by the insurer, which will help in knowing why the insurer is justified in taking a particular decision.

It may be noted that a proper Self Contained Note, with para-wise comments and supporting documents, submitted well in advance of hearing, helps Insurance Ombudsman to have clear understanding of the case and issue proper order.

iii) Insurers to present case properly during hearings:

Many times, during the hearings it transpires that the representatives of the insurers are not conversant with facts of the case. This is due to communication gap within the various offices of the insurer. Sometimes the policy is issued /claim is settled at the Central/Corporate office while officers at local/branch level are attending the hearings that are not well aware of the subject matter of the complaint. It is advisable that officers who are well acquainted with the complaint should attend the hearing.

iv) Insurers must learn from the past experience:

Despite orders passed by the Ombudsman in some cases, complaints of similar nature are registered against the same insurer time and again. This shows that the awards are not seriously examined by the insurer at the macro level to bring about the required systemic improvements.

The earlier awards/ decisions on identical situations should be examined and appropriate circulars should be issued by the concerned Corporate offices to enable the servicing branch to resolve the grievance/s at their level.

v) Non- furnishing of Terms & Conditions of the Policy:

The terms & conditions under a policy are not being supplied along with the Policy Bond/Cover Note especially by the PSU companies, even though it is mentioned in policy documents "as per terms and conditions attached" and the customer comes to know terms and conditions only when some grievance arises.

It should be made mandatory to supply the terms and conditions of the policy along with Policy Bond/Cover Note. Many complaints arise only because the customer is not made aware of the proper terms and conditions applicable.

vi) Policy and proposal forms in local languages:

It is noticed that the proposals as also the policy documents are issued in English language even where the policy holder has no knowledge of English. The insurers have to make earnest efforts to obtain the bilingual proposals, in the English as well as in the local language of the policy holder so that the huge gap that exists in understanding the statements made in the proposals is minimized. Likewise, the bilingual policy documents have to be issued so that the policy holder is clear about the terms and conditions of the policy which will minimize chances of mis-selling.

vii) Non implementation or Delay in implementation of the Awards by Insurers :

Some of the Offices of the insurers do not act swiftly on the Awards passed against them. The RPG Rules, 1998 are very categorical that the insurer has to implement the Award within 15 days of receipt of consent letter from the complainant. The Centres face serious embarrassment when replying to the complainants who report non- receipt of Award money.

Some insurers implement the Awards but do not report the same to the Centres. Company officials, who fail to implement the Awards, undermine the Institution of Ombudsman itself. The Ombudsmen have been demanding amendment to RPG Rules to make penal provisions for non compliance of Award.

viii) Repudiation of claims - Give appropriate Reasons:

Whenever claims are repudiated, it should be conveyed appropriately to the claimant, giving proper reasons for repudiation. If there are multiple grounds for repudiation, it is always better to convey all available grounds of

repudiation. This will help the claimant understand the position better, and will also help unnecessary appeals and complaints.

B) SUGGESTIONS PERTAINING TO LIFE INSURANCE:

i) Free Look Cancellation- Policy dispatch details and proof:

The “Free look” option though forms part of the policy conditions, is not known to the policyholders at the time of sale of policy. He comes to know when policy bond or renewal premium notice is received by him. It is the duty of Insurance Companies, not only to educate its customers, but also to give proper training to their intermediaries.

It is observed that the insured does not receive the policy document in time. There are instances, where the policyholder informs about non-receipt of policy document and the proof of acknowledgement shown by the insurance company is of someone who is not known to the insured policyholder. In a few cases, the insurers are also not able to produce the acknowledgement slips for having delivered the policy. It is suggested that the insurer should develop appropriate system to ensure that the documents are delivered in time to the right person so that the policy holders, in genuine cases, can avail the facility of free look option.

ii) Insurer to present supporting documentary proof for repudiation of death claims:

The repudiation letters need to be drafted appropriately to make the complainant aware of the reasons for repudiation of death claims. The insurers are prone to reject claims based upon the previous history mentioned in the discharge summary sheet issued by the hospital records at the time of death. Often the hospital record is contested by the complainants.

At the time of repudiation, the Insurer in addition to the hospital record in the form of admission sheet or discharge summary sheet must justify his case by proving through other documents like prescription, out-patient slip,

laboratory reports etc. relating to the pre-proposal stage and not after signing of the proposal form.

iii) Refund of fund value in respect of Death claim:

ULIP policies serve the twin objectives of investment return and life risk cover. All Unit linked policies are different from traditional insurance policies and are subject to different risk factors. Under these policies the investment risk in the chosen investment portfolio is borne by the insured. Hence the principle of "Utmost good faith" as regards suppression of material fact can operate only in relation to life risk which is covered by the insurer. In respect of that portion of premium which is invested in the capital market where the investment risk is fully borne by the insured, it cannot be enforced. But even in ULIP cases, the companies are repudiating all monies paid when suppression of material facts is proved. Since fund value is an investment portion, it should be refunded on death of policyholder.

C) SUGGESTIONS PERTAINING TO GENERAL INSURANCE:

I) General Insurance Mediclaim

a) Review of claims rejected by TPAs, by Insurer:

The repudiation is done without reference to the insurer with whom the complainant has the contract. When the claim is repudiated, it is observed from the repudiation letter that it is issued by the TPA but not by the insurer and it does not contain the clear reason for repudiation of the claim and in a few cases we find that the TPA simply mentions clause no. of the policy for repudiation. Many of the complainants who come to Ombudsmen Centre with the grievance are not able to understand as to why the claims were repudiated. The insurer does not take responsibility for the action of the TPA. Most general insurers do not have any established system for review of the claims rejected by their TPAs. Even when the complainant approaches the Grievance Cell, after repudiation of the claim by the TPA, the insurer seldom examines the claim dispassionately.

It is suggested that all the repudiation letters should go from the insurer giving full details for denying the claim and not from the TPA's. During the course of hearing, company official who represents the case on behalf of company argues that TPA/Claim hub has rejected the claim and not the company. This practice should be stopped by issuing the suitable instructions by the higher authorities of the public sector companies to all the office in charges. The regulation issued by IRDA on the subject is clear. It is only the insurer who can repudiate the claim not the TPA. Since TPAs are working on behalf of Insurance Companies, the insured has no direct relationship with TPA. The Insurance Companies must review decisions taken by the TPAs.

b) Changes in policy terms & conditions:

There are general complaints from the insured public that the changes are not brought to their notice during the renewal. They also plead that they are not provided with the detailed terms and conditions. It is, therefore, suggested that any change in the terms and conditions which has a direct bearing on the claim settlement should be highlighted in the renewal notices and also on the first page of the policy schedule and they should be provided detailed policy schedule, with all relevant Terms & Conditions.

c) Pre-existing diseases should be specified on the schedule of the policy:

It is observed that the Mediclaims are repudiated on the ground of pre-existing diseases. It differs from one company to another company.

In the Medclaim policies, there is a need to specify the pre-existing diseases of the individual on the schedule of the policy so that the insured is aware of the exclusion clause at the time of insurance. This should be in addition to the general exclusion given in the Terms & Conditions. It is suggested that a uniform criteria should be adopted by all insurance companies in this regard.

II) Motor Insurance:

Vast difference between assessments for motor insurance claim:

It is experienced that there is a gulf of difference in the assessment of loss by the deputed Surveyors and loss submitted by the Insured on the basis of estimate submitted by garages. While assessing quantum of loss in

motor damage claims, the surveyor at time do not allow certain items, which is not informed to the insured. Sometimes, the deputed Surveyors assess the loss at a very unreasonable amount without any justification.

It is suggested that a copy of Survey Report should be made available to the Insured explaining the assessed amount in details. This will minimize the controversies between the parties.

OMBUDSMAN CENTRES REPORT

An edited version giving important points dealt by the various Centres are given hereunder:

(1) Ahmedabad Ombudsman Centre:

From the desk of the Insurance Ombudsman.

I hereby submit the Annual Report for the Financial Year 2012-13 to the Government and Governing Body of Insurance Council pursuant to the provisions of Rule No. 20 of the Redressal of Public Grievances Rules, 1998, Government of India, Ministry of Finance, Department of Economic Affairs, Insurance Division. This is the 11th Annual Report of the Office of Insurance Ombudsman, at Ahmedabad for the State of Gujarat, and Union Territories of Dadra & Nagar Haveli and Daman and Diu.

It has been observed that more number of complaints have been received from Non-life sector Mediclaim Insurance Policyholders. Hence adequate and suitable steps should be taken to curtail this trend immediately.

Annual review of the quality of services rendered by Insurers:

- 1) The Grievance Redressal Mechanism or complaint management procedure by all insurers needs improvement. When the policyholder appeals for reconsideration of rejected claim totally or partially by the higher authority of the Insurer, it was observed that in many cases the Insurer simply forwarded the complaint to TPA, in mediclaim cases, which is not correct. The customers get agitated saying they are holding Policy of Insurance Company and not TPA.
- 2) Some of the nominated officials of the Insurance companies are not in a position to defend or explain their decision properly at the time of hearing with reference to Policy Terms and conditions. In mediclaim repudiation cases they simply reply it was repudiated by TPA and they do not know the details.

Recommendations to improve these services:-

1. Appeal for review by complainant should be considered and examined by the appropriate authority of the Insurer and the review decision communicated to the aggrieved Policyholder by the Insurance company.
2. Nominated officials should attend hearing and should come prepared to explain or defend the decision together with supporting documents/evidences.
3. Nominated official who attend hearing should also have Financial Authority to sign for compromise resolution of the complaint, in case of necessity as per RPG Rules, 1998.
4. Any changes in policy coverage, terms, conditions must be communicated to policyholders and concerned Officials who deal with complaint made with Ombudsman office.
5. Training required to be given to official who deal with complaint made to Ombudsman office in respect of RPG Rules, 1998.
6. Latest circulars relating to subject matter of policy must be sent to this office while dealing with complaint lodged with Office of Ombudsman.
7. Fake Insurance Certificate was detected during the year purported to have been issued by one Insurer. Hence Insurer to take precautionary steps to prevent the same.

AUDIT AND ACCOUNTS

M/s R.S. Patel & Co., Chartered Accountants, Ahmedabad, had been appointed as Auditors for the year 2012-13. The Audited Accounts for the year ending 31st March, 2013, along with Schedules duly signed by the Auditors and the Auditors' Report, were submitted to the GBIC. There were no adverse comments in the Auditors' Report.

(2) Bhubaneswar Ombudsman Centre:

From the desk of the Ombudsman

The forum of Ombudsman in the insurance sector has been established to redress the grievance of the insured who feels aggrieved by the decision/action of his/her insurers. The relationship between the insured and the insurer comes into existence when the contract of insurance is entered into by them. The benefits sought under the policy by the insured are determined on the basis of the terms & conditions of a policy as are understood by the insurer. I feel it appropriate to record some of my thoughts based on the observations, I made while dealing with different issues arising for consideration in the past. Experience gained over the period of time in course of examination of the grievances against the insurer often gives the impression that most of the insured persons remain totally ignorant of the policy terms and conditions. Their ignorance lands them in the position of no return leading to repudiation of claim and often loss of the premium amount deposited on the policy. The points canvassed by the gullible insured before this forum are that the material conditions which are to affect his/her rights for deriving the policy benefits were actually not brought to his/her notice at the time of or subsequent to taking the policy. For many of the insured persons, concept of insurance has continued to be understood as a system of money deposit made to gain more money comparatively at a shorter space of time than what other financial institutions offer. For them it is an investment pure & simple which is capable of earning double or three times of the amount deposited in couple of years of time. This aspect needs to be taken care of at the insurer's level so that confidence of the insured on the insurance system can be restored and the credibility gap between the insured and the insurance company can be minimized.

One of the area of grievances which the insured often raises before this forum is relating to the free-look clause. The policy of insurance allows a period of 15 days time commencing from the date of receipt of policy document by the policy-holder to exercise his/her option for getting refund of his deposit if the terms of the policy are found unacceptable to him/her. Experience shows that the policy holder usually depends on the Agent for filling up the proposal form and rarely he/she verifies the entries in the proposal to confirm himself/herself that the same has been filled in as

per his/her version. The submission made is that money was paid as one time deposit but later on he/she receives the letter from the company to pay the next premium. He/ She then runs for solution to the Agent who hardly is available to provide him/her any assistance. By that time, as per company record, the free-look period is over. Consequently the poor policyholder loses even the premium deposit, if the policy is not continues/received in time. True it is, the option to the policyholder to seek for cancellation of policy and refund of premium during the free-look period is a part of policy conditions but in reality such stipulation in the policy is not specifically made known to him/her when policy is taken and that printing of policy conditions is made in such a shape that the policyholder would often miss this stipulation in the haze of the policy conditions. It is for the insurer to consider if the free-look clause needs to be highlighted in such a manner that it would easily attract the attention of the policyholder when he/she gets the policy. At the time of acceptance of the proposal, the personal history of the life to be insured and the financial capacity of the policyholder to continue with the policy may be once again ascertained to avoid discontinuance of the policy in future by raising grievance in relation thereto.

During the year gone by, substantial number of complaints regarding discrepancy in return of fund value in ULIP policies were received. In such policies, a small time investor cherishes a dream of earning good amount out of his/her humble investment. But, it is observed that in majority of cases, the policyholders are ignorant of the typical policy provisions. Neither, they are conversant with Net Asset Value (NAV) nor about the effect of Capital Market fluctuations to take timely decision on such policies. When fund value received becomes much less than the invested amount, he/she feels bitterly aggrieved.

Repudiation of death claim for suppression of material fact is another major item of grievance raised in the life policies by the nominees before this forum. In the proposal the policyholder is required to provide information about his past ailment and previous policies etc. In most of the cases, it is not the proposer who fills up the proposal forms. Later when issue on the above matter are raised, it is often pleaded that nothing in relation thereto is enquired by the Agents who for obvious reason, avoid to record such facts which would create hindrance in the acceptance o the policy. In the event of death of the life assured, when claim is lodged, the insurer repudiates the claim on the ground of concealment of material fact while ultimately causing dissatisfaction in the claimant who loses the financial benefit out of the

policyholder's hard earned money deposited for financial security of the family after his death. Such situation emanates either from the malafide intention or ignorance of the policyholder. It is suggested that the policyholders should be educated by attaching pamphlets to the proposal forms containing "Dos & don'ts" mentioning "please read before signing the proposal form" so as to provide caution message to them about the effect of misinformation in the proposal. Programmes in electronic media on such problems may be conducted for better awareness of customers.

In General insurance sector, it has often come to the notice of the forum that in the event of an accident involving the insured vehicle, the claimant submits the estimate for repair containing items to be replaced/repaired. But the survey report seldom reflects if all or any item mentioned in the estimate were allowed for replacement & repair. No reason is often assigned while disallowing repair of certain damaged items. The result is that the claimant is neither convinced nor satisfied with the assessment made by the surveyor. The claimant has a right to know why a motor part asked for repair/replacement is not allowed. It is suggested that instructions may be imparted to surveyors to include in the assessment report, all items given in the repair estimate by the claimant and to record the reason for inclusion/exclusion of the said items in the assessment of damage/loss.

OBSERVATIONS & SUGGESTION ON THE DEFICIENCIES IN THE WORKING SYSTEMS WHILE DEALING WITH OMBUDSMAN CASES

1. Self Contained Note (SCN) :

Insurers are submitting SCN but not in time. Sometimes they submit the same on the date of hearing. This poses a problem for us to process the complaints. In many SCNs relevant information relating to the complaint is missing, as a result timely decision is not possible.

2. General Grievances of Complainants:

- (a) In life sector, delay in settlement of claim is the major cause of grievance of the complaints. The reason for delay may be probed and necessary steps may be taken to reduce such delay.
- (b) In a number of cases especially general insurance it is observed that the claims are repudiated without assigning any reason or the reason is not properly explained. Sometimes the insured does not receive the

repudiation letter though insurer records shows that the same is dispatched by insurer.

- (c) Sometimes policies are issued without furnishing terms & conditions there of and such conditions are cited at the time of hearing.
- (d) Sometimes the policy is issued / claim is settled at the Central / Corporate office while officers at local / branch level are attending the hearing who are not well aware of the subject matter of the complaint. It is advisable that officers who are well acquainted with the complaint should attend the hearing.

3. Lacunae specific to Life Insurers:

- (a) Insurers are giving their customer care help line numbers for providing clarification or assistance to their customers. But most often their customers dial to the Ombudsman office to get clarifications which need servicing from insurers office only.
Further the office of Ombudsman redresses complaints of specific nature only which are mentioned in RPG Rules. The insurers should also mention these specific natures of complaints above the place where the addresses of all Ombudsmen are mentioned. This will inform the customer to interact with the office of Ombudsman only when such exigency arises.
- (b) It is found that in many cases, proposal forms are filled by the agents instead of the insured person. The Agent misrepresents the facts in many columns of proposal form or gives information suitable to his / companies advantage. At the time of hearing the insured always alleges that the answers in the columns of the proposal were filled in by the agent of the insurer. But the forum holds the view that the agent filled the column on behalf of insured. In the circumstances the insured person loses his cases and the award goes against the insured person. Hence the intermediary should educate the insured to personally fill up the proposal to avoid misrepresentation of fact.
- (c) Many times the agents, especially of the private insurers give the understanding to the insured person that the policy is taken by him for a single premium deposit of policy. But after completion of one year the

insured person gets a notice from insurers seeking to deposits renewal premium. Mostly this happens with the innocent customers who are persuaded to invest the same with the insurer with a promise of handsome returns to their deposit. When such poor insured persons receives notices to pay huge annual premium beyond their capacity they feel shocked and do not find any solution for the same. Some go to the extent of attempt to commit suicide. In such circumstances, the insurer has to prove that the insured had prior knowledge of same, otherwise the agent has to be taken to tasks.

- (d) The investigator has to take care to collect the supporting documentary evidence to substantiate the finding noted in the report in all investigations.
- (e) IRDA Protection of Policyholders Interest Regulation, 2002 stipulates under column 6(2) that a Life Insurer acting under regulation 6(1) in forwarding the policy to insured, should inform by letter that he has a period of 15 days from the date of receipt of policy document to revise the terms and conditions of policy and where the insured disagrees to such terms and conditions, he has option to return the said policy stating the reasons for the said option. Some of the insurers are not reflecting the said option in the face of the said forwarding letter.
- (f) Return of Fund Value – Repudiation of Claim for suppression of material fact.

In respect of some companies who have sold the ULIP policies, it is observed that when the life insured dies, the Insurers take a stand that even fund value is not payable, when claim is denied for suppression of material facts. It is opined that the stand taken by these companies is not justified since the risk in respect of the investment is being fully borne by the insured. Since substantial percentage of the premium is taken towards various charges they should pay the fund value that is available to the insured on the date of intimation of the death. Considering the larger investment amount, it is suggested that the Insurance companies should offer fund value in these kinds of cases.

- (g) Lapsed policy – Payment after lock-in-period

In respect of complaints where the customer does not get the money in a lapsed unit linked policy, even after the expiry of the mandatory lock in

period, insurers have to review the rules with appropriate intervention by IRDA. Companies are requested to consider revision of the regulation for refund of monies under a lapsed unit linked policy so that complaints of such nature can be fully removed.

(h) Repudiation of life insurance death claims on the basis of previous history of illness as per hospital case sheets.

In life insurance cases major portion of the complaints relate to the repudiation of death claims. The insurers are prone to reject claims based upon the previous history mentioned in the discharge summary sheet of the hospital records at the time of death. Often the hospital record is contested by the complainants. The insurers must realize that in addition to the hospital record in the form of admission sheet or discharge summary, it is necessary to obtain other evidence of illness, such as prescriptions /out-patient slips, etc. relating to pre-proposal stage.

(i) Repudiation of claims due to suppression of material facts both during 'original' policy and during 'revival' of the policy - educate the public - copy of proposal form to be given with policy document:

The most common complaints under life insurance pertains to repudiation of death claims for concealment of material facts relating to past ailments, occupation, income, previous policies etc. In the proposal form suppression of material facts is a very serious issue, which is usually completed by the agents and is not given due consideration by the proposer. Due to suppression of material facts, the contract of insurance is held to be void.

Most of the proposers solely depend on the agents/intermediaries to get their proposal form completed and in the process fail to mention or disclose material facts knowingly or unknowingly. The insurance companies should educate the insuring public and also the Agents about the importance of exact disclosure of the material facts at the time of filing up the proposal form and also at the time of revival of the lapsed policy. This will help in increasing the customers' trust in the insurer as well as building a better customer-insurer relationship.

- (j) Repudiation of claim in policies sold on wrong lives of poor and illiterate people with disease – Action on Agents required.

Policies are sold on wrong lives like illiterate and poor people who have no means to pay the premium or people suffering from terminal diseases. The claims are obviously repudiable but it causes great hardships to the nominees. The Agents may be taken to task in such matters.

4. Lacunae specific to Non Life Insurers

- (a) Mediclaim proposals must mention the names of diseases of common suffering so that the insured can tick the disease suffered by him. This would avoid misrepresentation of fact, as mostly proposal forms are filled in by agents, who are unaware of proposer's disease. Subsequent renewals must be made after obtaining fresh proposal / disclosure, so that policyholder is not penalized for a disease suffered after the first proposal.
- (b) Denial of renewal of mediclaim policies put the policyholders into lots of inconvenience, which under appropriate directions from IRDA, should make arbitrary denials unjustifiable.
- (c) Benefits under mediclaim policies are denied in most cases on grounds of pre-existing of disease. Compulsory medical check- up at the proposal stage would reduce such complaints on pre-existing disease.
- (d) Processing of claims through TPAs often causes inordinate delay and TPAs show lack of responsibility in settlement of claim. The insurer must exercise due control over the TPAs and coordinate their activities in regard to settlement of claim. TPAs decision on settlement of claim should not be final and the matter should be reviewed by the insurer to arrive at a judicious decision. Instead of shifting responsibility to TPAs to prove the reason of repudiation by them, insurer should formulate a committee consisting of medical practitioners, law officer and an officer not below the rank of Chief Manager, who should review the repudiation effected by TPA and intimate the decision to the insured.
- (e) Many a motor claims get repudiated for original Driving License (DL) being verified and found fake. Most of the Transport Vehicle owners verify the driving license of their driver for the running period, without attaching importance to the previous details. With computerization of DL by RTOs,

the menace of fake DL will reduce, but the already existing fake DLs on which several renewals have been effected, need to be addressed.

- (f) The private General Insurers have mostly centralized their claim settlement through a hub. The insured is expected to report the loss through the help line. But most of the policyholders are not conversant to their system and are not receiving due assistance from the local office of insurer. This results in delay in loss assessment and claim settlement. GBIC and IRDA need to suitably address to the problem.
- (g) Several complaints arise on quantum of loss in motor portfolio. The assessment of surveyors is at times not in tune to the desired repairs and reasons of not allowing the estimated items are not properly explained. In tie up garages the insured is not consulted during survey, thereby causing future complications. As far as possible the surveyors must ensure to obtain a satisfactory report from the insured while completing assessment and disagreement if any be also on record.
- (h) In most of the cases it is observed that the insurer receives only the copy of policy schedule without the detailed terms and conditions. Therefore certain complaints arise because of ignorance of the policy terms and conditions by the claimant.
- (i) Under Bank assurance scheme the insurer gets the proposals and premium directly from the bank, without involving the insured. When claim arise it is seen that proper type of insurance was not taken, there by hampering the party's interest, even though premium was charged on his loan account. As far as possible the insured's consent by way of signature on the proposal must be taken.
- (j) Delay in submission of FIR to Police

Most of the motor theft claimants are denied their claim by insurer, due to late intimation of theft of vehicle to police. When the theft claimant goes to the police station for lodging FIR, the incharge of police station does not immediately register the case. He advises the claimant to look out for the vehicle for some time and come back to police station and lodge FIR, but the theft claim is repudiated by insurer for delayed reporting to police and violation of policy condition of delayed intimation. The claimant is also not aware of the fact that in the event of denial of police authority to register the FIR he has the option to send the FIR direct to police SP under

registered post. As such a lot of motor theft claimants are deprived of their genuine claim, which problem needs to be addressed.

5. Circulars:

Technical circulars issued by Insurance Companies should be furnished to the Ombudsman Centres. Circulars are essential to keep abreast of changes in the various policies, terms and conditions thereof. All insurers may be requested to add the Ombudsman Offices address in their mailing list in furnishing the circulars.

REMARKS

The craze for New Business, communication gap between the insurer and insured, casual approach in filling up proposal forms, nondisclosure of terms and conditions of policy and above all, the indifferent approach in settlement of claims being the genesis of most complaints, the insurer should take necessary steps to plug these loopholes.

Last but not the least – the insurer must try to learn from their past experience i.e. the cases they have lost in consumer forums, Ombudsman and other courts. Accordingly, they must review the terms and conditions of each policy and make necessary changes in the claim settlement procedure.

AUDIT AND ACCOUNTS:

The audit was conducted by Auditors M/s Patro & Co., Chartered Accountants, who were appointed as the auditors during the year. The accounts for the financial year 2012-13 were finalized without any adverse comments from the Auditors.

(3) Chandigarh Ombudsman Centre:

From the desk of the Ombudsman

It is a great pleasure to present an Annual Report of Insurance Ombudsman, Chandigarh- the post which somehow remained vacant from 15.11.2009 till 21.09.2012 when I joined as "Bima Lokpal" after my retirement on 31.07.2012 as an Additional Chief Secretary to Govt. of Haryana.

Initially, there was a huge backlog of 2383 complaints from Life Insurance and General categories. But, as the saying goes "Well begun is half done", a ball was set rolling in right earnest with commencement of a hearing in a systematic manner. Originally, about 30 to 35 cases were listed daily for expeditious clearance of the backlog. Obviously, my appointment resulted in an enhancement of the complaints. Till date, with tireless and dedicated efforts of the entire staff, we have decided 2014 complaints in a span of exactly nine months. Naturally, with this pace, the pending complaints showed a declining trend despite a sizeable influx of fresh ones at regular interval.

As a matter of fact, the institution of Insurance Ombudsman has turned out to be an vibrant and indispensable organization in its existence of a decade and a half through its deliverance of cost effective justice to its logical end. Surprisingly, the previous five public sector insurance companies of year 2000 have increased 10 times and as on today, 51 companies are offering a wide spectrum of products to cater the growing insuring community. In this context, a dire need is felt to amend the Grievance Redressal Rules 1998 by taking into account the current scenario so as to enable existing institutional framework to be strengthened to make it more responsive to the expectations of insuring public.

I am of a firm view that a qualitative and constructive interaction between the insurance companies, ombudsman centres, Governing Body of Insurance Council and Insurance Regulatory and Development Authority will pave a road-map conducive to the growing needs and aspirations of the ever demanding Indian public.

Last but not the least, a Monthly Review of Ombudsman Centres by Governing Body of Insurance Council on the basis of good performance parameters could paint a

realistic picture for a constructive and healthy competition so that shortcomings, if any, could be plugged to address problems of an emerging economy. Admittedly, with Proper Planning, Rigorous Review and Meticulous Monitoring a concerted efforts shall always achieve the designated goals. Undoubtedly, this would go in a long way to face challenges of the dynamic global financial market in general and an enlightened public in particular.

Type of Complaints

It would be seen that the proportion of complaints regarding dispute in regard to premium paid or payable is high in Life segment. In the case of Non-Life segment, however, the proportion of complaints in respect of partial or total repudiation of the claims has been very high.

Statutory Audit

M/s. Datta Singla & Co., Chartered Accountants, were appointed as external Statutory Auditors by the GBIC who conducted the statutory audit of the accounts of the Centre for the financial year ending 31.03.2013. Final accounts duly signed by the Statutory Auditors for the financial year ending 31.03.2013 were submitted to GBIC on 07.05.2013.

OBSERVATIONS & SUGGESTIONS

ISSUES RELATING TO UNDERWRITING AND CUSTOMER SERVICE

Mis-sale of Insurance Policies

It has been observed that cause of complaint arise mostly due to unethical selling and unprofessional conduct of the agents.

In order to avoid mis-selling by the agents, the insurers need to professionalize their agents and resort to awareness campaign among the insuring public. This will enhance the image of the agent as well as the insurer and ultimately the customer shall be benefited and satisfied.

Premium collection in cash by the Insurance Agents:

It has been observed that Insurance Agents collect cash in respect of fresh proposals as well as renewal premium which at times are not deposited with the insurer. In case

of complaints in such cases, the insurer does not endorse the action of the agent and the insured is left in the lurch. To avoid such incidents, the insurer should make wide publicity to the effect that the customers should not hand over cash premium to the agents and if they do so it would be at their own risk and responsibility.

Completion of Proposal Form

It has been observed that the proposal form is filled up by the agent and the proposer is not properly briefed about the terms & conditions of the policy by him. This implies mis-sale of policy and leads to repudiation of claim for no fault of the insured. There needs to be more active involvement of the insurer at the time of filling up of proposal form.

Dispatch of Policy Documents

Policy documents are being sent by some of the insurers through courier services and are not being received by the insured at times. This is giving rise to grievances among the customers. It is advised that the policy documents should only be sent through Registered AD to ensure timely delivery to the customers concerned and also to maintain uniform practice among all the insurers.

Copy of Proposal Form

The copy of the proposal form is not being furnished along with the Policy Bond/Cover Note by most of the companies although it is mandatory as per IRDA regulations.

Changes in Terms and conditions

From time to time the insurers change the terms and conditions depending on their experience. However, these are not intimated to those clients who have been given policies under the old terms and conditions and renew their policies with the same insurer. The changes need to be communicated to the insured so that they can decide whether to renew their policy with the same insurer or not.

Non-furnishing of Terms & Conditions of the Policy (Non-life)

The terms & conditions under a policy are not being supplied alongwith the Policy Bond/Cover Note especially by the PSU companies, even though it is mentioned in

policy documents "as per terms and conditions attached" and the customer comes to know terms and conditions only when some grievance arises.

It should be made mandatory to supply the terms and conditions of the policy alongwith Policy Bond/Cover Note. In absence of terms and conditions not being supplied to the customer under proper acknowledgement, the terms of acceptance of a contract are incomplete.

Pre-existing diseases under Mediclaim policies

In the Mediclaim policies, there is a need to specify the pre-existing diseases of the individual on the schedule of the policy so that the insured is aware of the exclusion clause at the time of insurance. This should be in addition to the general exclusion given in the Terms & Conditions.

Poor servicing of claims by TPA under Mediclaim policies:

Cashless facility which is the main attraction of availing service through TPAs under Mediclaim policy is conspicuous by its non-implementation. The very purpose of Mediclaim policies thus gets defeated. The insured feels cheated in the event of denial of cashless facility by the hospitals on the panel of TPA.

After the denial of cashless facility, the time taken by the TPAs to settle the claim is too long. Moreover, the repudiation is done without reference to the insurer with whom the complainant has the contract. The insurers do not take responsibility for the action of the TPA.

Proposed Amendments in the Policy Bond

An "Executive Summary" of the terms and conditions of the policy bond must be enclosed with the policy document to enable the policy holder to go through salient features of the plan at a glance.

Keeping in view the prevalent policy of Government of India, it would be ideal to print the policy bond in a bilingual with a local vernacular language in order to ensure a better comprehension by rural public.

ISSUES RELATING TO CLAIM SETTLEMENT AND SATISFACTION OF AWARDS

Delay in settlement of claims

The maximum number of complaints pertains to delay. The insurers are at time asking documents which can be dispensed with. Moreover, they are asking documents in piece-meal which leads to delay and harassment of policy holders. The IRDA guidelines stipulate settlement of claims within 15 days from the date of the receipt of claim documents. However, this has not been adhered to by the insurers leading to increase in the number of complaints.

Delay in Investigations

There are cases of abnormal delays in investigations, being carried out by the companies. Sometimes, insurers take abnormally long periods, ranging from one year to four years, in completing the investigations. Guidelines may be issued by IRDA regarding time limit for investigations failing which the claims should be settled on the basis of available records.

Non - Disclosure of grounds of Repudiation

The repudiation letters need to be drafted appropriately to make the complainant aware of the reasons for repudiation both in respect of life and non-life segments.

In the Non Life cases, the repudiation letters are cryptic one liners. The basis of repudiation needs to be elaborated in order to minimize the complaints.

Requirement of Police Report in respect of Motor theft claims

A number of complaints under Motor policies relate to delay in settlement of theft claims on account of non-submission of non traceable report issued by the Competent Court. Insurers often take the plea that the Police Report duly accepted by the Court under Section 173 Cr. PC should be submitted by the claimant for release of claim amount. It is observed that requirement of Police Report under a Criminal Procedure Code is at times misunderstood as it relates to the criminal proceedings of the police to be reported to the Court and should not have anything to do with the contractual liability under the insurance policy, since it does not form part of the policy terms and conditions.

Transfer of RC of vehicle in case of Theft

At time companies are insisting on transfer of RC in case of theft. This leads to harassment of the individual and unnecessary delays. Many States do not agree to transfer of RC unless they inspect the vehicle. Signatures of the insured on Form 28 and 29 and letter of subrogation should suffice for settling the claims. In case the vehicle is recovered later, the RC can be transferred at that time.

Non submission of Self-contained note by insurers & Communication Gap within the offices of the Insurers

It is observed that in many cases insurers do not submit self-contained note with supporting documents inspite of repeated reminders. Self-contained note is an important document from the point of view of the insurer which allows it to take defence giving detailed reasons for repudiation of claim etc. Non submission of the same, at times, may allow inferring that insurer has nothing to represent in its defence.

Many times, during the hearings it transpires that the representative of the insurer is not aware of the background of the case. This is due to communication gap within the various offices of the insurer. The procedures need to be streamlined.

Mechanism for Implementation of Ombudsman's awards

At present there is no satisfactory system in place for implementation of Ombudsman's awards. IRDA as the regulator should issue directions/guidelines in this regard so that the awards of the Insurance Ombudsman are implemented within the stipulated time.

Lack of Systematic improvements based on Awards/Orders of the Ombudsman

Despite orders passed by the Ombudsman in some cases, complaints of similar nature are registered against the same insurer time and again. This shows that the awards are not seriously examined by the insurer at the macro level to bring about the required systemic improvements.

The Orders passed by the Ombudsman need to be examined and discussed at appropriate levels to bring about suitable changes in the operational levels for future.

'Appeals' against the order of Insurance Ombudsman

The scheme of Ombudsman was evolved to give early relief to policy holders and protect their interests. However, the insurance companies are resorting to delay tactics in the implementation of awards by going in 'appeal'. There is no provision in the Ombudsman Scheme for filing an appeal. IRDA may like to issue strict instructions to the insurers not to take recourse to lengthy litigations.

Moreover, the companies are making Ombudsman as a party while filing an 'appeal'. Ombudsman is not a party to the dispute. This is not in accordance with set judicial practices.

(4) Chennai Ombudsman Centre:

Jurisdiction of the Chennai Centre

The Office of the Insurance Ombudsman has been functioning in Chennai since 02.08.1999 with the State of Tamilnadu and Union Territory of Puducherry (limited to Towns of Puducherry and Karaikal) coming under its territorial jurisdiction. This Centre has been successful in providing fair, equitable and expeditious redressal of the grievances of insuring public in its territorial jurisdiction.

An analysis of complaints reveals the following facts:

LIFE INSURANCE COMPLAINTS

1. An analysis of the complaints on life-side reveals that 33.57 % (25 %) of the complaints pertain to matters of deficiency, related to day-to-day service and administrative matters of the insurer and 3.68 % of the complaints pertain to subjects not related to insurance at all. This indicates that the insuring public continues to equate the Insurance Ombudsman with a grievance-redressal wing of the insurer and they are not clearly aware of the real purpose and role of the forum. This calls for further education of the general insuring public of the role of this forum
2. Other complaints pertain to surrender value on policies, revival not effected, and other service-related and administrative matters. Every complaint, entertainable or non-entertainable, is followed up with the Insurer effectively for redressal of grievance and it is ensured that complainants' grievances are appropriately redressed.
3. Apart from written complaints, oral enquiries and complaints over phone are also attended to on day- to- day basis. Complaints through e-mail are attended and processed on day-to-day basis. It had been brought to the notice of this Centre by several complainants that the insurers have not effectively disseminated information about the addresses of their service or support centres and are merely indicating the details of their corporate office or Toll Free numbers which are rarely reachable. It may be mentioned here that the above problem is persisting for several years now. The centre has been interacting periodically with the insurers operating in the area to ensure that such grievances do not persist.

NON-LIFE COMPLAINTS

This year also, majority of the cases pertain to Mediciclaim followed by Motor claims. Percentage-wise, the distribution is as follows:-

	2012-13	2011-12	2010-11
Mediciclaim	66%	69.50%	70%
Motor claims	24%	21.88%	22%
Others	10%	8.62%	8%

IMPLEMENTATION OF AWARDS:

As per Rule 16(6) of the Redressal of Public Grievances Rules 1998, the Insurer has to comply with the award within 15 days from the date of receipt of consent for acceptance of the award from the complainant. During the period 2012-13, all awards are taken as complied with by the Insurers as we have not received any intimation from the complainants about non-compliance.

AUDIT AND ACCOUNTS:

During this financial year, all the major expenses were well within the budgeted limits and the expenditure under many heads was kept at the bare minimum. The audit was conducted by Auditors M/s Vaithisvaran & Co, Chennai, who were appointed as the auditors during the year. The accounts for the financial year 2012-13 were finalised without any adverse comments from the Auditors. The Auditing of Accounts for the year under review was completed and signed on 13.05.2013.

OBSERVATIONS & RECOMMENDATIONS:

As per Rule 20 of the Redressal of Public Grievances Rules, 1998 the Ombudsman Centre is required to prepare annual report in which the statistical information in respect of complaints handled for both life and general insurance companies are furnished. Since the forum gets different kinds of complaints, each case is analyzed thoroughly and based on our observations some of the important issues are highlighted for the attention of all stake holders for their information and if required for taking corrective action.

(5) Delhi Ombudsman Centre:

From the desk of the Ombudsman

At present, 24 companies of Life Insurance and 28 companies of General Insurance are engaged in insurance business in our country. Global exposure of business practices of insurance has changed the Indian insurance industry also to some extent. Innovative Insurance products are offered with different terms and conditions by the respective Insurance Companies. General public not being convincingly informed about the effects of all the clauses contained in the insurance policy contract has aggressively increased the number of grievances. It appears to be the sole reason for increase in the number of grievances in the recent years, which is also affecting the reputation of Insurance Companies. It is also responsible for sudden increase in the no. of grievances related to mis-selling of policies.

The area of jurisdiction of this office is the administrative jurisdiction of state of Delhi and Rajasthan. During the financial year 2012-13, it was found that the centre was receiving sizable number of complaints relating to the state of Rajasthan. Keeping in view the number of the complainants from the state of Rajasthan, centre arranged outstation hearings at Jaipur, Ajmer and Jodhpur. It was done with a view to impart justice at the very door step of the complainants and they need not travel too far for attending hearings.

OBSERVATIONS AND SUGGESTIONS

1. It is observed that insurance companies mostly in public sector are found to be somewhat reluctant in submission of self contained note. In some cases only one sheet giving reasons for action taken is submitted by the company without giving any supporting document.

In fact SCN should be summary of the case to be supplemented with documents on the basis of which action is taken because furnishing the reasons only does not help in justification of the action.

2. The public sector insurance companies incorporate in the policy document the name and address of the issuing branch and controlling office, whereas the private sector insurers are not mentioning the same in any document issued to

the policy holders other than giving names and addresses of the registered and corporate office. Consequently the policy holders find it very difficult to tender their basic servicing requirement like payment of renewal premium etc. and more so they approach Insurance Ombudsman offices for the same whose address is invariably given on the policy document. It causes embarrassment to the complainants.

3. In majority of cases, complainants have mentioned that the life assured had only signed the proposal form without knowing the contents of the proposal. Even during the hearing they confirm the above version. It is clearly noted that the intermediaries responsible for selling these products, had not properly briefed the life assureds and it appears that the life assured were not aware of the benefits they may get from the policy. When the claim was preferred, even though the insurer was able to establish suppression of material facts, a question that is to be addressed is, to what extent the life assured or the complainants, who take up the case after the death of life assured, are responsible for the mis-selling of the policy by the intermediaries.
4. We also observed that the insured have not received policy document in time. There are cases, where they have mentioned that they have not received the policy copy and also admitted that they have forgotten to follow up with the insurer for the document. It is also observed during the hearing that the insurer could not clearly prove whether they have sent the policy with terms and conditions to the insured and this gives a scope for the complainant to misuse the cooling off period of 15 days time for taking a decision to cancel the policy. Hence the insurer has to evolve a system whereby they can prove the date of receipt of policy document with the terms and conditions by the customers.
5. We have observed that in few cases, pre-proposal medical examination done by Insurer's Doctor has certified for the good health of the proposer and the policy was issued. Subsequently, it turned out that life assured was suffering from DM/HTN etc. and the claim was denied due to suppression of material facts. The complainants were arguing that since pre-proposal check up was done, they presume that they are covered fully without any exclusion. The agent who had

canvassed the business has not explained to them the terms and conditions. It appears that medical examination is not being done with any seriousness.

6. One of the new issues which we wanted to point out is relating to free look cancellations. During the year, we have received a few complaints relating to the above. In all these cases, we find that the insurer has been arguing that they have sent the policy documents by courier for which they have an acknowledgement copy duly signed by somebody. The insured complain that they have not received the policy document and the person who is supposed to have signed the acknowledgement is not known to them. In a few cases, the insurers are also not able to produce the acknowledgement slips for having delivered the policy. It is suggested that the insurer should evolve a fool proof system to ensure that the documents are delivered in time to the right person so that the policy holders, if they want, can avail the facility of free look option.
7. When the claim is repudiated, it is observed from the repudiation letter that it is issued by the TPA but not by the insurer and it does not contain the clear reason for repudiation of the claim and in a few cases we find that the TPA simply mentions clause no. of the policy for repudiation. Many of the complainants who come here with the grievance are not able to understand as to why the claims were repudiated. It is suggested that all the repudiation letters should go from the insurer giving full details for denying the claim. During the course of hearing, company official who represents the case on behalf of company argues that TPA/Claim hub has rejected the claim and not the company. This practice should be stopped by issuing the suitable instructions by the higher authorities of the public sector companies to all the office in charges. Since TPA's are working on behalf of the companies and the insured have got no direct relationship with the TPA, so claim repudiation letters should go from the company and not from the TPA's.
8. When the Sum Assured is increased at the time of renewal, some companies while settling the claim are not recognizing the increased sum assured and claims are settled only on the basis of previous sum assured. In the policy of many companies, there is no specific policy condition, with the result the claim

settlement is being questioned by the insured. This requires suitable incorporation in the policy terms and conditions.

9. While making the change in policy terms and conditions, the general complaint from the insured public is that the changes are not brought to their notice during the renewal, they also plead that they are not provided detailed terms and conditions. It is, therefore, suggested that any change in the terms and conditions which has a direct bearing on the claim settlement should be highlighted in the renewal notices and also on the first page of the policy schedule and they should be provided detailed policy schedule.
10. Some companies have stipulated specific time limit in the policy that the claim intimation should be given to the Insurer within 48 hours of occurrence of theft of the insured vehicle. This stipulation is invariably not noticed by majority of the insured persons and they intimate the Insurers only after getting FIR from the police. It is suggested that Rubber Stamp may be affixed prominently on the face of the policy schedule and also the Agents be educated on this aspect to guide the customers, so that genuine claims arising out of theft should be considered and settled by the Insurers.
11. It is observed that fresh policies are issued against the cheques issued by policyholder/s for the renewal premium with false information and without obtaining signatures from insured and without any request. Sometimes fresh receipts are issued for new policies which show the previous policy number and this gives the false impression to the policyholder that their renewal premium of policy/policies is paid.
12. For preventing/ stopping mis-selling, agents are required to be sensitized by the respective companies. Prospective policy holders need to be completely briefed about the policy benefits and its other terms & conditions.
13. RPG rules 1998 need to be amended for provisions of imposition of penalty in case of non compliance of award.

14. It is observed not only by me but also by complainants who argue that the print fonts on the policy document provided by the insurance company are too small to be read. Therefore, it is suggested that the policy bond should be printed in a manner that it can be read and understood by everybody easily. It needs to be brief and concise, and important points need to be highlighted.

AUDIT AND ACCOUNTS

Annual accounts of 2012-13 for this office were audited by Arun Singh & Co., New Delhi. The Auditors after examining the annual accounts submitted their report on 13th May, 2013 without any adverse comments.

(6) Guwahati Ombudsman Centre:

From the desk of the Ombudsman

Guwahati Centre has jurisdiction over the insuring public of 7 (seven) North Eastern States of Assam, Arunachal Pradesh, Meghalaya, Manipur, Mizoram, Nagaland and Tripura. Though the jurisdiction of this Centre is over the insuring public of seven States, most of the complaints are received from the State of Assam both from the Life and Non-life Insurance Companies. Receiving of complaints from some States are very negligible. During the financial year not a single complaint was received from the State of Manipur from the Non-life Sector and only one complaint was received from the Life Sector. The scenario of the other states except Assam is also not satisfactory. This is perhaps due to the lack of awareness of the policy-holder regarding the scheme of Ombudsman. It is high time that we should take some awareness programme in those remote parts of the Country..

While discharging duties, I observed that mis-selling complaints are growing at an alarming rate in respect of Private Life Insurance Companies. People are being cheated by telephonic communications from different corners in the name of insurance. It is high time that all concerned is to ponder over the matter seriously and take appropriate step by the appropriate authority.

State-wise distribution of Complaints

Almost 90 percent of complaints come from the state of Assam while percentage of complaints from other states in the North East, the area under jurisdiction of this centre, is negligible, varying from a little over 5 percent to nil.

It would be wrong to deduce that the working of the insurance companies operating in those states is without any blemish. The main reason for negligible number of complaints may be attributed to lack of awareness on the part of the insuring public.

GBIC may give due consideration to this aspect and devise ways to raise awareness among the people. Frequent news paper advertisements rather than two three times in a month in a period of two three years, arranging awareness campaigns in the state capitals and other important towns in the state taking help of the respective State

Government, town committees etc where Insurance Ombudsman and some senior officers from his office may be present and address the insured may be some of the ways.

OBSERVATIONS AND SUGGESTIONS

- (1) Self Contained Note (SCN) : We do not receive SCN immediately from the insurers. In some cases no SCN is submitted at all. In others we receive a very brief note from the insurer with a statement like “as the policy holder concealed illness history the claim has been repudiated”.

Now, a sentence like that does not help the cause of the insurer. What is needed is the document that proves beyond any doubt that there was actually any concealment.

Besides, timely submission of SCN supported by sustainable documents may help the Insurance Ombudsman to pass an order without going for any hearing.

It must be noted here that the SCNs submitted by most of the private insurers are really praiseworthy. They reveal that a lot of effort was put in to prepare it.

- (2) Address of the Branch offices or at least premium points where the policy holder may pay his premium: This is a problem in case of private insurers. No where in the policy bond there is any mention where the policy holder may pay his/her premium. The poor policy holder very often sends a cheque or draft to us as payment of premium. We have seen cases where policy holders came from places as far as 250 kilometers to this office to pay premium in cash. Earlier we suggested that the insurer may provide with an addendum along with the bond in case they find it difficult to mention it in the body of the bond itself which will consist names of the branches in the nearby places. We hope that the insurers will give a serious thought to it.

- (3) Policy Document : Policy documents should be issued in the language of the policy holders so that they can clearly understand the terms and conditions of the policy. It is our experience that sometimes they see the terms and conditions of the policy in the hand of the Insurers on the date of hearing only who attend the hearing. The Insurer claims that they sent the terms and conditions along with policy document. It

should be made mandatory that policy terms and conditions should be included in the policy documents themselves so that Insurers cannot hide the policy terms and conditions and the Complainants also cannot take the plea that they did not receive the terms and conditions of the policy.

- (4) Mediclaim cases : It is seen that the Insurer in Life Insurance Sector and Non-Life Sector in mediclaim cases repudiate the claims on the basis of previous history of illness mentioned in the Discharge Summary of the Hospital records at the time of death. These are denied vehemently by the Complainant. The Insurer must justify repudiation by proving through other documents like prescription, out-patient slip, laboratory reports etc. relating to the pre-proposal stage not after signing of the proposal form.
- (5) Copy of proposal form to be attached with policy document : It is observed that some of the private Insurance Companies attach a copy of the proposal form with the policy document. This should be made mandatory for all Insurance Companies. This will minimize the controversies between the parties.
- (6) Pre-existing disease : In medi claim policies the pre-existing diseases should be specified on the schedule of the policy so that the Insured is aware of the exclusion given in the terms and conditions of the policy.
- (7) Survey report : It is our experience that there is a gulf of difference in the assessment of loss by the deputed Surveyors and loss submitted by the Insured on the basis of estimate submitted by garages. Sometimes, the deputed Surveyors assess the loss at a very unreasonable amount without any justification. It is suggested that a copy of Survey Report should be furnished to the Insured explaining the assessed amount in details. This will minimize the controversies between the parties.

- (8) Miss-selling : Miss selling cases are increasing tremendously particularly in respect of private companies. Customers are harassed and cheated by the fake telephonic calls assuring extra benefits if insurance is taken. Appropriate authority should take note of it and steps to stop this kind of unethical practices is expected.

AUDIT AND ACCOUNTS

The audit was conducted by Auditors M/s Span & Associates, Chartered Accountants, Guwahati, who was appointed as the auditors during the year. The accounts for the financial year 2012-13 were finalized without any adverse comments from the Auditors.

(7) Hyderabad Ombudsman Centre

General Information

The office of Insurance Ombudsman, Hyderabad established in 1999 has been engaged in redressing, under the Redressal of Public Grievances Rule, 1998, the grievances of the policy holders in the States of Andhra Pradesh, Karnataka and Yanam, a part of the Union Territory of Pondicherry. All major Life and Non-Life insurance business concerns having their offices at various centres are operating within the territorial jurisdiction of this office. For the sake of the convenience of the complainants residing in the State of Karnataka, hearings are being conducted in Bengaluru almost once every month. There was no complaint from Yanam, the Union Territory of Pondicherry, during the year.

Analysis of Complaints Processed

Although the number of complaints received against life policies was large, the number of complaints entertained under the RPG Rules was not high. The complaints which were not entertained broadly related to deficiency of service, delay in receipt of the policy and the like, which are not grievances that could be redressed under the RPG Rules. The culprit for this is the policy document issued by the insurers, which usually supplies the following information for the benefit of the policy holder:

"In case you have a complaint/grievance, you may approach the grievance redressal officer or Insurance Ombudsman."

The IRDA has issued a directive to the insurers to inform the policy holders about the institution of Insurance Ombudsman for grievance redressal. The insurers in life sector seem to have complied with the directive but seemed to have overlooked to inform that the policy holder could approach the Insurance Ombudsman only in relation to the specified grievances mentioned under the RPG Rules, 1998 and not any kind of grievance. If the policy documents clearly mention the kind of grievances that could be taken up with the Insurance Ombudsman, the office of Insurance Ombudsman would not be processing so many non entertainable complaints which it presently is handling.

In non-life sector, the percentage of non-entertainable complaints is 52.38%. This is not as high as in life sector but even in this sector, our office can do with more entertainable complaints and less non entertainable ones. This can happen when the insurers specify that the policyholders could approach Insurance Ombudsman only after their representation had been rejected by the insurer instead of directing every complaint, rejection, etc. to Insurance Ombudsman straightway.

Areas of Concern

- (i) In life segment, often the agent is responsible for wrong selection of proposers. Collusion of agents with the policy holders especially in relation to declaration of health for revival of lapsed policies was noticed in many cases.
- (ii) In non-life segment, complaints on account of mediclaim, motor and PA/GPA/JPA policies together accounted for 74% of the aggregate complaints, indicating that policies in these fields are prone to varied interpretations because of vagueness in terms and conditions in the policy document or that the claims do not get processed as objectively as they ought to be. The insurers do not seem to be clear about the amplitude of PED clause. Often the definition is too loose and the insurer is put to loss on that score.
- (iii) Insurers often reject the claims on just one ground while it could be possible to reject on various grounds. This sometimes works against the interests of the insurers when the ground on which rejection occurred is untenable while rejection on some other ground, not cited by the insurer, might be apt and sustainable.

Compliance by Insurers

- (i) Insurers have been found to be slack in furnishing self contained note. The officers who do not furnish the note have to be made to realize that their case could be lost just on this premise. It is also noticed that the insurers often do not present their case in the hearing adequately. Since the hearings are held in open, their arguments have to be precise and valid.
- (ii) The insurers are found to be somewhat slow in reporting settlements as per the awards passed.

QUALITY OF SERVICES BY INSURERS AND SUGGESTIONS TO INSURERS

General Suggestions

- (i) Most insurance companies have internal grievance redressal mechanism in place as required under IRDA (Protection of Policyholders' Interests) Regulations, 2002.
- (ii) Some of the offices of the insurers do not act swiftly on the awards passed against them. The RPG Rules are very categorical that the insurer has to implement the award within 15 days of receipt of consent letter from the complainant. Delay in implementing the award undermines the authority vested in the Ombudsman under the RPG Rules. The list of awards not complied with or about which this office has no feedback as at the end of 31.3.2013 is at Annexure 4.
- (iii) It is noticed that the proposals as also the policy documents are issued in English language even where the policy holder has no knowledge of English. The insurers have to make earnest efforts to obtain the proposals in the language of the policy holder so that the huge gap that now exists in understanding the statements made in the proposals is minimized. Likewise, the policy documents also have to be issued in the language of the policy holder so that the policy holder is clear about the terms and conditions of the policy. A contract which apparently is understood only by one party could always run into interpretational difficulties.

Life Insurance

Majority of complaints relate to repudiation of death claims. The insurers are prone to reject claims basing upon the previous history mentioned in the discharge summary sheet of the hospital records at the time of death. Often the hospital record is contested by the complainants. The insurers must realise that in addition to the hospital record in the form of admission sheet or discharge summary, it is necessary to obtain other evidence of illness, such as prescriptions/out-patient slips, etc. relating to pre-proposal stage.

General Insurance

- (i) It is noticed that the insurers rejected claims invoking pre-existing disease clause without reliable evidence to establish that the insured suffered from such ailment before commencement of insurance. In many cases, claims were rejected on presumptions and surmises.

- (ii) Most general insurers do not have any established system for review of the claims rejected by their TPAs. Even when the complainant approaches the Grievance Cell, after repudiation of the claim by the TPA, the insurer seldom examines the claim dispassionately.
- (iii) Often, the insurers issue policy documents without attaching terms and conditions of the policy. This gives rise to serious grievances. The insurers must ensure that the policy document is issued together with the terms and conditions.
- (iv) A grievance of the complainants is that the insurers' agents/ representatives are at their best behaviour until the policy is sold while they do not even show minimum courtesy when claims are made. The complainants state that they have not received any reply from the insurer although they have written and called on phone.

AUDIT AND ACCOUNTS:

The audit was conducted by Auditors M/s M. Anandam & Co., Chartered Accountants, Secunderabad, who was appointed as the auditors during the year. The accounts for the financial year 2012-13 were finalized without any adverse comments from the Auditors.

(8) Kochi Ombudsman Centre:

From the desk of the Ombudsman

It is my privilege to place the 13th Annual Report of the Office of the Insurance Ombudsman, Kochi, for the financial year 2012-13, before the Governing Body of Insurance Council and other Constituent Authorities under Rule 20 of the RPG Rules 1998.

Times are changing and we are living in an era where public awareness and activity are at their peak. During my two and a half years of holding this office, I could gauge that this Forum is held in high esteem by the public mainly because we are viewed as a fair and impartial Forum delivering justice to the aggrieved complainants. However, I must, honestly, admit that many a time, my hands are tied because of the lacunae in the Redressal of Public Grievances (RPG) Rules, 1998, in their existing form. Though time and again, the necessity for amending the Rules has been pointed out and the GBIC had also taken efforts in the right direction, it is with disappointment I note that the efforts have not yet been fruitful. The continued success of this Forum depends on the sustained confidence of the knowledgeable public about its efficacy and impartiality which in turn depends on the end result, viz., power to ensure implementation of the awards. Hence, it is desired that the amendments which have already been discussed and finalized are implemented at the earliest.

There has been a steady increase in the number of complaints over the years. Hence, it is quite appropriate at this juncture, the GBIC is in the process of introducing the Complaint Management System (CMS) which would help to streamline the flow of complaints. It would also ensure faster services to the complainants and better tracking of complaints. This system would ensure that the outstanding number of complaints at any point of time, would be readily available to the insurance companies, at their finger tips, so that they may work proactively to resolve them even before the complaints come up for hearing.

The GBIC also needs to bring in necessary systems and procedures to ensure uniformity amongst all Ombudsman Centres, in the matter of deciding on the entertainability/ otherwise of complaints; this is required, more so, in the case of Unit Linked policies/ mis-selling etc.

The Officers of this Office, though drawn from LIC and other Nationalised Insurance Companies, have been extremely prudent and unbiased and were able to erase the possible misgivings of the complainants that this Institution is yet another arm of the Insurance Companies. I am happy to say that these Officers have always upheld the prestige of the institution as an independent quasi judicial body.

Jurisdiction of the Kochi Centre

The territorial jurisdiction of the Office of the Insurance Ombudsman, Kochi extends to the entire State of Kerala besides the Union Territory of Lakshadweep and Mahe – an integral part of the Union Territory of Pondicherry.

During the year under review, we have received

AUDIT AND ACCOUNTS

M/s R Rajan Associates, Chartered Accountants, Coimbatore, had been appointed as our Auditors for the year 2012-13. The Audited Accounts for the year ending 31st March, 2013, along with Schedules duly signed by the Auditors and the Auditors' Report, were submitted to the GBIC. There were no adverse comments in the Auditors' Report.

(9) Kolkata Ombudsman Centre

From the Desk of the Ombudsman

The Kolkata Ombudsman centre has been in existence for 13 years and during this period it has seen a robust growth in all activities. An analysis of the company wise distribution of complaints shows that in life insurance stream, 26% complaints were filed against LIC and 74% against private Life Insurance Companies as compared to 45% against LIC and 55% against others last year. The drastic reduction of complaints against LIC speaks volume of the efficiency of its internal grievance redressal machinery and customer centric approach. However, the scenario is very different in respect of private sector insurers with steadily growing complaints against them. This adverse trend must be arrested before it becomes unmanageable. As regards the general insurance complaints, the ratio of distribution between public and private companies is 81% and 19% respectively.

This centre has jurisdiction over the insuring public in the states of West Bengal, Bihar, Jharkhand, Sikkim and Andaman and Nicobar Islands. While, 75% of complaints were received from West Bengal, followed by Bihar and Jharkhand contributing 16%, just one complaint each was received from Andaman & Nicobar Islands and Sikkim. Data collected from non contributing states show that substantial number of policyholders are approaching the Consumer Forum indicating total lack of awareness about the scheme of Insurance Ombudsman among the insuring public in these places. We have already taken steps to reach out to such policyholders by way of distribution of leaflets. I am sure of the positive impact of our efforts to spread awareness in these remote areas.

Another important issue I would like to touch upon is mis-selling of insurance products. While it is heartening to note that complaints on mis-selling is almost nil in the case of LIC, it is quite disappointing to see that such complaints are growing at an alarming rate in the case of the private life insurance companies. The complaints range from simple mis-selling (without properly explaining the charges, benefits and other features), to cheating (false promises), forgery (scanned signatures) and fraud (diverting the funds without consent). Mostly the victims of mis-selling are pensioners, housewives and uneducated middleclass public who are duped of their life-long savings by the unscrupulous sales personnel, brokers and corporate agents. The issue is very serious and calls for drastic preventive and remedial measures by the

insurance companies. The answer to mis-selling lies in simplifying the products, explaining the need and benefits to the customers, mentioning complete transparency in sales process, right selection and training of sales persons and stringent action against them if found guilty. The insurer must realize that it is not easy for a complainant to establish mis-selling as the dealings are not documented but a thorough investigation into the sales process can give a fair idea about the dubious intentions of the sales persons. Genuine cases must be attended promptly and due relief should be given without waiting for Ombudsman intervention.

ACCOUNTS AND AUDIT

Annual accounts of 2012-13 for this office were audited by M/s SBA Associates., Chartered Accountants, 27, Mirza Galib Street, 5th Floor, Kolkata – 700 016, West Bengal. The accounts for the year 2012-13 was audited and duly certified by the Auditors without any adverse remark.

(10) Lucknow Ombudsman Centre

From the desk of the Ombudsman

At present 52 Insurance Companies are in existence (24 Life and 28 Non Life side). Various products & different practices are adopted by these companies. More often than not Insurance Ombudsman is treated as extended arm of the internal Grievances Machinery of Insurance Companies by some complainants. The customer approaches directly without exhausting the alternative remedy available within the Insurance Company. During the Year 2012-13 total complaints received by our center was 1942; compared to 1790 complaints received in previous year. The entertainable complaints received during the year were 537. The analysis of complaints pertaining to Life side shows that there is spurt in complaints pertaining to mis-selling, as against 109 complaints last Year, this year 214 complaints were received. Lack of awareness is root cause of mis-selling which is clear from the representations received by us.

Though, by & large there is an improvement in cooperation rendered by Insurance companies but most of companies still are not serious in sending Written Statement within stipulated time. As a result our unit has to follow up time & again also at time ex-parte decisions are taken. It also hinders our sincere efforts to achieve 90 days disposal limit set by RPG Rules 1998. However, It is heartening to note that barring a few stray cases most of the companies have implemented award-100%, I compliment them for their cooperation. In a few cases, the Insurers delay implementing of awards which compels the complainant to approach us. The GBIC should intervene in such cases. Also, as proposed in RPG Rules 1998, amendments, penalty/fine should be imposed on defaulter companies.

Lacunaes- Life & General stream :

The analysis of complaints pertaining to life stream shows that there is phenomenal increase in no. of mis-selling complaints. The lack of knowledge of customers, malpractices adopted by Agents/ Salesman to earn hefty commission led to this malpractice. Unfortunately in some of the cases the Insurance company, instead of taking corrective/ punitive action against erring intermediaries, tried to defend them. On the other hand some of companies had taken bold steps such as educating customers through electronic & print media and also filling FIR against the guilty salespersons. The matter has been dealt in detail in a separate chapter.

In general stream, mediclaim complaints occupied dominated position. Here the approach of Insurance Companies some time appears to be mechanical rather than practical. The mandatory 24 hours hospitalisation & exclusion clauses were used to deny even the legitimate claims. It is also observed that in respect of General Insurance Complaints the Policyholder is not aware about various terms & conditions of policy & he comes to know the conditions when Insurance Company repudiates his claim. One should not forget that educating Policyholders is a sine-que-non for robust growth of industry, which the insurer should take care.

INFORMATION TECHNOLOGY :-

Leveraging Information Technology for resolving insurance disputes received by Insurance Ombudsman Centre has become essential in view of galloping no. of complaints. As suggested in earlier Annual Reports of this Unit, in view of large volume of complaints coming to Insurance Ombudsman Centre, It is my humble suggestion that the system of Video Conferencing should be introduced for smooth, speedy, cost effective dispensing of justice by this forum. A cue can be taken from the model adopted by the CIC (Central Information Commissioner) for disposal of RTI cases. Introduction of Video Conferencing will prove to be a boon to the complaints, Insurance Companies as well as for Ombudsman Centers. It will reduce the time lag, will be cost effective & convenient to all end users. The initiative taken by GBIC in Integrating Complaint Management System is a welcome step but need of the hour is it to adopt resolution of complaint through "On Line" system.

During the period under review, it has been observed that private Insurance Companies & some GIPSA companies do not submit self-contained note (SCN) in time. In some of the cases it is submitted on the date of hearing which makes our task difficult. Many complaints which do not fall in the category of "entertainable" are received by this forum. This no. is as high as 76%. The analysis of complaints received in the center shows that complaints received from life stream are far more than General Insurance complaints. The total no. of Life Insurance complaints are 79% as compared to 21 % of General Insurance companies complaints. In Life side, the complaints emanating from LIC is highest, being the major player in the market. LIC's percentage is 37 %. The complaints received from Private Life Insurance Companies constitute 63%. In respect of General Insurance Companies, complaint received from

GIPSA Companies dominate the show it is 54% as against private general insurance companies complaint which is 46%.

Over the years, with the opening of Insurance sector the volume of Insurance business has gone up manifold. Accordingly the number of complaints has also gone up. However, a study conducted by IRDA shows that the percentage complaints to total no. of policies sold is minuscule.

In order to give justice at the door step of policyholders, our unit has held many out station hearings also. Generally, adjournments are avoided but in exceptional situation it is allowed. As discussed in earlier pages, mis-selling occupies top slot in respect of Life Insurance complaints. Here again, major role is played by private insurance companies. Compared to total no. of complaints, mis-selling complaints of LIC of India are negligible (9%). However, settlement of Death Claim / Repudiation by LIC of India occupies major share on this count (67%). It is observed that repudiation by the insurance companies is done on flimsy grounds without sufficient & cogent evidence as a result they lose the case. LIC of India should also strengthen its investigation mechanism by employing professional investigator at least in those cases where claim amount is substantial. In respect of Death Claim pertaining to ULIP policies it is observed that Fund Value is not paid by some Life Insurance Companies though as per rules, it is to be paid even if Death Claim is repudiated.

Life Insurance contract is a long term contract. If a customer feels cheated due to mis-selling by agent it affects the very basis of trust on which the edifice of Life insurance is created. Wrong selling/ mis-selling not only affects customer badly but creates a bad image for the Insurance company and ultimately credibility of whole insurance industry suffers.

Most of the time, illiterate or simple citizens are duped by unscrupulous agents, and they lose faith in insurance company because they were sold the product which they never wanted. The Policy terms & conditions are so minutely printed that a common man cannot read it. The "Free look" option though forms part of the policy conditions, is not known to the policyholders at the time of sale of policy. He comes to know when policy bond or renewal premium notice is received by him. It is the duty of Life Insurance Companies, not only to educate its customers but also to educate & give proper training to their intermediaries. Panel/ remedial action against erring persons must be ensured.

In respect of General Insurance claims, mediclaim policies are often rejected on the ground that the insured was not hospitalised for 24 hours. With the advancement of medical science & innovation in treatment, this condition needs to be addressed by the General Insurance Companies. Though certain exceptions of above rules are provided in the policy itself but Insurance Companies do not conform to it. It is found that in a Family Floater policy if an insured suffers from pre-existing disease the General Insurance Company cancels entire policy, depriving security to other members of the family. It is not fair. This aspects can be re-examined by General Insurance Companies. The repudiation of Motor Theft Claim on the ground of delay are mostly observed by this forum. It is a common knowledge that in India FIR is not lodged easily by Policy Officials. The complainant is first asked to search the vehicle. In this process valuable time is lost. When claim is preferred by the aggrieved customers it is denied by General Insurance Company on the ground of delay. While assessing quantum of loss in motor damage claims, the surveyor at time do not allow certain items. This is not known to the insured. It is suggested that the copy of survey report should be made available to the insured so that he is aware about items which are excluded.

In respect of Mediclaim & Motor Claim, it is observed that claim is basically repudiated by the TPA & Insurer do not apply his mind. This position is not correct. The regulation issued by IRDA on the subject is clear. It is only the insurer who can repudiate the claim not the TPA. Since TPAs are working on behalf of Insurance Companies, the insured has no direct relationship with TPA. The Insurance Companies must review decisions taken by the TPAs.

During the course of hearing, it is found that the some of the General Insurance companies do not provide policy terms & conditions to insured as such he is not aware of these conditions.

It is observed that representative of respondent insurance company who come to defend the insurance company are not well versed with the case. It is suggested that officers who are well acquainted with the complaint should only be deputed for the purpose.

Administrative Jurisdiction:

This office was set up in the year 1999 with its jurisdiction covering the state of Uttar Pradesh but with the carving out of Uttarakhand from that state, its jurisdiction also covers the newly created state.

MIS-SELLING

During the fiscal year 2012-2013, complaints pertaining to mis-selling have assumed alarming proportion. Current year the number of mis-selling complaints received by this forum were 51% of the total complaints. It is an admitted fact that no Insurance company as a corporate policy encourages wrong selling/mis-sellings. It has been observed that mis-selling is resorted to mostly by:-

Brokers

Bank Assurance channels

Agents &

Others

The modus operandi adopted differs from sales persons to sales persons, place to place and situation to situation. The victims of mis-selling are mostly-senior citizens who retired recently, house hold ladies, Army personnel and professionals, as they are soft targets.

The types of mis-selling observed during the year under review were as under :-

- i. Single premium mode modified to regular premium
- ii. Policy holder asked for short term but given long term policy
- iii. Policy issued in the name of House Wife by changing her profession (Cat I /Cat II)
- iv. Life assured wanted policy on his life but issued on minor's name
- v. By fabricating income, policies are issued in the name of uninsurable person.
- vi. Illiterate persons are insured by procuring fake D.L/School certificate.
- vii. ULIP plans are sold instead of conventional plan
- viii. In place of mediclaim policy term plan was given

- ix. Renewal premium used for issuing fresh policy
- x. Surrendering existing policy new policies are issued without the consent of life assured
- xi. Allurements like gold coin/trip to abroad/mobile tower etc are also used for mis-selling of policy

The reason for mis-selling resorted to by unscrupulous elements are:-

- (1) Greed for earning more and more commission.
- (2) Elevation in the present cadre by achieving target by ethical or unethical means.
- (3) New Business Pressure
- (4) Ignorance and lack of awareness of customers
- (5) Due to migration of agents the tendency of mis-selling also increases
- (6) Orphaned policies are the main target of mis-selling
- (7) Blind faith on intermediaries/agents is also responsible for mis-selling
- (8) "Get rich quick" mentality of some people also fuels the menace of mis-selling
- (9) Some of the Insurance companies defend the action of mis-selling of their agents which in turn emboldens them to repeat such activities.
- (10) Dearth of qualified intermediaries-

Most of the agents/sales person are not aware of product features, various charges and market segment for which product is designed. Need of the hour is to educate the customers, take punitive and remedial measures against guilty persons. However, some of the Pvt. Insurance companies as well as LIC has woken up to this challenge and have started customer education/awareness through print and electronic media.

Some of the Pvt. Insurance companies have strengthened their internal grievance machinery by appointing "Internal Ombudsman" which has helped them to curb the malady.

The regulator has also taken steps by introducing "Bima Bemisal" and "IGMS" to educate the insuring People. The introduction of proposed standard proposal form by the regulator is a move in the right direction. However many more steps need to be taken by the insurance companies to educate the intermediaries and also to keep a close watch on their selling techniques.

GENERAL OBSERVATIONS AND SUGGESTIONS

1. The written statement or Self Contained Note (SCN) are received very late from some private insurance company and GIPSA Co's. Most of the time the written statement does not contain details of subject matter in dispute. This makes our task difficult.
2. While repudiating claim, some General Insurance companies do not give reasons for repudiation. They simply quote the decision of T.P.A. This is not correct.
3. It has been observed that mediclaim/health insurance claims are denied on the ground of delay. The regulator has already issued instructions in this behalf. It is not legal and ethical to deny claims only on the ground of delay if otherwise they are genuine.
4. The job of insurance ombudsman office is technical in nature. It requires trained man power. But while posting staff in our office the state run life and General Insurance companies mostly do not keep this thing in mind. Persons who are well versed in legal/ claim matter should only be posted in Ombudsman office.
5. The R.P.G Rules 1998 allow Ombudsman to mediate in some cases. But the persons representing insurance company some time do not have authority to furnish any solutions during the course of hearing, which makes the whole exercise futile.
6. Our office receives legal notices from Consumer Court, Civil Court etc. Being quasi-judicial body, it is not warranted. GBIC may think introducing of suitable amendments in the RPG rules 1998 in this respect.
7. The present financial limit of Ombudsman needs to be amended in view of higher amount cases coming to this forum.
8. Sometimes it is found that some insurance companies deliberately delay the implementation of award pronounced by this forum. This leads to unnecessary harassment to the complainant. The GBIC should evolve a mechanism for time bound implementation of awards.
9. As discussed in earlier pages mis-selling occupies major time of this forum, therefore the life insurance companies should evolve a suitable mechanism to tackle this challenge.

10. Various technical circulars are issued by the insurance companies concerning implementation of policy conditions. Insurer may be requested to provide such circulars which affect our decision, to our office.

SUGGESTIONS PERTAINING TO LIFE INSURANCE

1. In respect of death claim pertaining to LIC, it is observed that the quality of Investigation report is poor. At times, claims are repudiated merely only on the recommendation of Investigating officer, which is not correct. It is suggested that LIC may also engage suitable outside agencies where Sum Assured is large or where very early Death Claim is reported.
2. In order to curb mal practices of mis-selling, it is suggested that a copy of proposal form duly filled and signed both by intermediary and proponent should be handed over at the time of closing of sale. This will avoid tempering of signatures, alteration in mode, plan etc subsequently.
3. Benefit illustrations should be in quantum (not in percentage as is the practice now.)
4. Private Life Insurance companies should give more thrust on vigorous training of Agents/ intermediaries. The ethical discipline should also be enforced ruthlessly. Erring sales persons should be given exemplary punishment.
5. The proposal form must be in bilingual so that ordinary customer can also understand it's terms & conditions which will minimize chances of mis-selling.
6. The address of policy issuing branch is not found in private life insurance company's policy bond, it should be prominently displayed on the top of the Policy.
7. The Life insurance companies should launch a vigorous drive to educate general public about the malpractice of mis-selling. Print Media & electronic media can be used to propagate the information.
8. It has been observed that in respect of Death claim in ULIP policies, the Insurer do not refund the fund value it is not correct. Since fund value is an investment portion so it should be refunded on death of policyholder.

SUGGESTIONS PERTAINING TO NON-LIFE INSURANCE

1. In respect of non-life cases it is observed that the Mediclaim are repudiated on the ground of pre-existing deceases. It differs from one company to another company. It is suggested that a uniform criteria should be adopted by all insurance companies in this regard.
2. In respect of Mediclaim most of the companies deny the claim on the ground that 24 hours hospitalization condition was not fulfilled. Due to advancement in medical science and technological advancement it is not correct to deny the claim merely on the above ground, if attending Doctors and hospital do not feel so.
3. In respect of motor claims the estimate submitted by the complainant is not verified or taken cognizance by the surveyor.
4. Delay in lodging motor theft claims mostly occurs as FIR is not registered by police authorities at first instance. The complainants are not aware that FIR can even be registered by sending it under registered post. Most of the motor theft claims are denied on the ground of delay which needs to be addressed by the general insurance companies.
5. In family floater policy, when claim of a family member is denied on the ground of pre-existing decease, generally insurance companies cancel the policy. This puts other member of the family without security cover. This approach needs a re-look.
6. When General insurance companies alter the terms and conditions in the existing policy, the consent of insured is not taken. It is suggested that any change which has a bearing on a claim settlement should be brought to the notice of insured.

AUDIT AND ACCOUNTS

The audit was conducted by Auditors M/s R.M. Lall & Co., Chartered Accountants, Lucknow, who were appointed as the auditors during the year. The accounts for the financial year 2012-13 were finalized without any adverse comments from the Auditors.

(11) Mumbai Ombudsman Centre

Analysis of Complaints (Life Insurance)

In Life Sector mis-selling of products continues to be one of the major items of serious grievance raised by the policyholder. This is mainly directed against agents and at times against Sales team of the insurers. It is brought to the notice of the forum that while canvassing for business these intermediaries promise and assure to the prospective customers many benefits including galloping growth of the one time investment in couple of years. The key feature of the policy which the policy holder should know are printed in small letters and in a manner the common man is likely to get confused or might have missed the basic features. Unless the intermediary takes steps to explain all the charges, benefits and restrictions under the policy there is bound to be an element of mis-selling. Another major complaint under Life Insurance Sector pertains to repudiation of death claims.

Analysis of Complaints (Non-Life Insurance Segment)

This year also the number of non-entertainable complaints is sizeable. Many a non-entertainable complaint comes under the bracket of time barred complaints and it can probably be attributed to the lack of awareness about the Institution of Ombudsman among insuring public. We also note that a number of complaints which are not entertainable fall under the bracket of commercial lines of insurance which is beyond the scope of Institution of Ombudsman.

ISSUES AND RECOMMENDATIONS SPECIFIC TO LIFE INSURANCE:

The major issues in Life Insurance are Repudiation of Claims due to suppression of material facts and mis-selling of ULIPs.

It is now a settled law that suppression of material facts relating to past ailments, occupation, income, previous policies etc. in the proposal form with a motive to make undue profits from Insurance Cover is a sufficient ground to avoid the contract and repudiate the claim. However, suppression is to be established by the insurer with strong and credible evidence and not based on conjecture or surmise. Experience has shown that there are two main reasons for this situation. First, true discloser of material facts, which is vital for claim settlement is underplayed by the agents and not taken seriously by the proposers, most of proposers who solely depend

on the agents/intermediaries to get their proposal form completed. Second reason is that insurance companies do not distinguish between material and non-material facts, casual and deliberate suppression, presumption and actual suppression. In several cases it is seen that mere casual remark by a Doctor about history of some disease become the sole ground to reject the claim and the insurers do not make further effort to collect cogent evidence like prescription, treatment papers, investigation reports to establish the ground. Hence all the insurers are requested to make the extra efforts to investigate the case before holding that the deceased made false declaration as it adds insult to injury. Moreover they have to educate the intermediaries who are also known to the proposers and are well aware of his present health condition or of his previous policies, to guide the customers properly and not hide facts which may not meet medical or financial underwriting norms. This will help in increasing the customer's trust in the insurer as well as building a better customer-insurer relationship.

While every attempt is made to entertain all complaints that fit into the provisions given under RPG Rules 1998, 12(1)(a) to (f) and Rule 13, it becomes really difficult to entertain complaints of mis-selling. This is because the Insurance Companies take a stance that the proposer has signed all the relevant documents and Benefit illustration chart after the features of the product have been fully explained. The signing of the documents makes it binding on the proposer and under such circumstances it is highly impossible to adjudicate on the complaint and the Complainant will not get any relief though the facts may be otherwise.

The complaints of mis-selling are very difficult to deal with basically due to lack of clarity on the part of insurer as well as the insured regarding the terms and conditions. Vast majority of customers whether educated or uneducated, blindly sign the proposal form and Benefit Illustration Chart and have simply fallen for the solicitation of the intermediary coupled with strong brand name of the company. The complaints of mis-selling relate to the following:-

- 1) Selling a policy under a regular mode of payment of policies, when the customers has sought a single premium.
- 2) Conversion of Bank fixed deposits to Unit linked Policy at the time of renewal of such deposits through Bancaassurance channel.
- 3) Selling Long term policies for 18-20 years to Senior Citizens.

- 4) Issuing the policy in the name of the nominee instead of the proposer by scanning signatures from ID Proof, PAN or Bank Accounts.
- 5) Keeping the Proposers in dark about various allocation charges.
- 6) Non-delivery of policy documents to the policyholders in time, thus denying them the opportunity of free look cancellation.

Suggestions specific to Life Insurance Companies

1. Denial of Fund Value under early death claims in ULIPs:

Today the life insurance business in the country is driven by the sale of Unit Linked insurance policies. These policies serve the twin objectives of investment return and life risk cover. All Unit linked policies are different from traditional insurance policies and are subject to different risk factors. Under these policies the investment risk in the chosen investment portfolio is borne by the insured. Hence the principle of "Utmost good faith" as regards suppression of material fact can operate only in relation to life risk which is covered by the insurer. In respect of that portion of premium which is invested in the capital market where the investment risk is fully borne by the insured, it cannot be enforced. But even in ULIP cases, the companies are repudiating all monies paid when suppression of material facts is proved. The present market condition in the Life Insurance Industry has shown a marked preference for ULIP and in such a case, where Life Insurance policies fulfill the twin benefits of risk cover and return on investment, in all fairness, the Life Insurance Companies should not deny the fund value while repudiating early claims. Hence Life insurance companies should revisit the provisions of repudiating claims under Unit Linked Insurance Plans.

2. Proper maintenance of records of proof of delivery of the policy:-

Sometimes the insurers argue that they have sent the policy documents by courier for which they have an acknowledgement copy duly signed by somebody. The insured complain that they have not received the policy document and the person who is supposed to have signed the acknowledgement is not known to them. In this scenario, the benefit of doubt may have to be allowed to the complainant. In few cases, even the insurers are not able to produce the acknowledgement slips for having delivered the policy. It is suggested that the insurer should evolve a full proof system and maintain necessary documentary

evidence to ensure that the documents are delivered in time to the right person so that the policyholders, if they want in genuine cases, can avail the facility of free look option.

3. Contact details of the Insurer:

It is found that the details of the office of Insurance Ombudsman are printed on the policy documents along with the details of customer care center and this results in many complaints being addressed to this office. There is a need to redraft the wordings in the policy document to bring out the fact that the customer should approach the Office of Ombudsman only after exhausting the grievance redressal avenues of the company. It is also necessary that the sales persons and intermediaries should be educated in this direction and companies should take steps to popularize their internal grievance redressal machinery among their customers.

4. Proper scrutiny and calling of document at the proposal stage itself:-

It should be the endeavour of Life Insurance companies "To ask all questions" before the cover is granted and it should be "No questions asked" at the time the insured event happens. The plight of the poor widows who approach this forum, that too, when the cover is very small makes it sad sight to reckon with.

5. Setting up proper IT Support:-

An attempt should be made to have a database of all life covers enjoyed by an individual with multiple insurers. Such a database will enable the insurers to share appropriate information on the risk, which is being underwritten and help prevent adverse selection against the insurer.

ISSUES AND RECOMMENDATIONS SPECIFIC TO NON-LIFE INSURANCE:

1. Detailed explanation in quantum dispute :

Whenever there is quantum dispute the reasons for deductions or disallowance is not clearly given by the company. Company should clearly spell out with proper reasons the amounts allowed/disallowed so that customer is satisfied.

2. Issues regarding TPAs:

As far as Mumbai is concerned the maximum number of complaints is received under mediclaim policies. By and large the complaints that are received by the forum indicate that the policyholders get a raw deal at the hands of TPA as well as the company. Many of the cases received by this forum reveal the fact that the TPAs take a lot of time in settling the claims as well conveying the decision for repudiation. However the forum is of the view that the TPA should process the claim and whenever the claim warrants repudiation, the final decision should be taken by the insurer and conveyed to the insured.

3. Co-ordination between Company and TPAs.

TPAs allege that the Companies do not respond to them and vice versa. Similarly, the Companies allege that the TPAs do not give them the papers in advance so that proper defence can be taken by the Company. The Companies have to revisit the entire gamut of their relationship with TPAs.

4. Reasonability Clause:

Deductions under reasonable and necessary charges are another area which gives rise to innumerable disputes. The deductions in surgeon's /anesthetist's fees are not backed up with supporting data like comparative charts of other hospitals by the companies. Complainants however argue that surgeon's fees is dependent on many factors like competency of the surgeon, time taken for surgery etc. Instead of applying reasonability clause, the companies can introduce the system of co-pay by which the insured will know well in advance that he/she has to bear a portion of the total claim.

5. Issues relating to Group Mediclaim:

Complaints are received under cases where the insurer repudiates the claims by maintaining the stand that they have cancelled a policy mid way since the group does not confirm to the norms prescribed by the IRDA and in such cases proportionate premium for the unexpired terms of the policy is refunded to the insured group and seldom beneficiary member is aware of the facts. It is also seen that no effort is done by the company to reach out to the end user beneficiary. It is also seen that insured beneficiary is totally in dark about the rights and responsibilities and is in possession of a Prospectus issued by the

Group which contains all tall claims. It is also found that such group collect exorbitant amount from the insured beneficiaries towards the cover whereas the premium ceded to the insurer is very small proportion of the amount collected. It is also seen that there are no valid premium receipts issued by the Insurer and the certificates of Insurance are also not given by the Insurance Company.

6. **Advancement of Medical Technology:-**

Company should determine and recognize medical technology which does away with conventional treatments and not foreseen at the time of introduction of policies. For instance Anti Vascular Endothelial Growth Factor (VEGF) injections like Lucentis for Age related Macular Degeneration (ARMD), intra articular injections for joint problems, External Enhanced Counter Pulsation (EECP) and Act Treatments for heart problems, pegasys injection for hepatitis, Radio Frequency magnetic Quantum Resonance (RFMQR) for joint problems, Deep brain stimulations in Parkinson's disease etc. The Companies should have some mechanism to regularly overview such advancements and take a stand on the admissibility of claims.

7. **Inadequacies in Personal, Motor Vehicle Policies:**

The following inadequacies are same in complaints received at this forum in personal Motor Vehicle Policies.

- There is no co-ordination between the Garage, Surveyor and the insured regarding the extent of loss and quantification of the loss.
- Many a times the insured is totally in dark about the surveyors' assessment since he is not present at the time of survey.
- Even in case of transfer of ownership of a vehicle the insured is ignorant of the express provision of the Motor Vehicle Act that the change of ownership should be incorporated in the policy within the mandatory period and the policy does not contain required express provision printed in the face of the policy.
- There are also cases where the insured has shifted the vehicle policy from one insurer to another and the second insurer issues the policy with No Claim Bonus without making proper verification. Subsequently

when the claim happens the insurer repudiates the claim on the grounds of misrepresentation.

8. Cashless Facility:-

It is well known fact that the cash less facility as it is existing today is not giving any value addition to the customer. Many a times there is no relevance to the requirement raised by the Hospital and the amount sanctioned by the TPAs. The TPA should be fully equipped with the details of the policyholder so as to give proper assistance at the time of facilitating the cashless facility. If the amount sanctioned does not meet the requirement of the policyholder, then the purpose of the cashless facility is defeated.

Suggestions specific to Non- Life Insurance Companies

1. Today the Regulator is talking about seamless portability of health insurance cover from one company to another. Under such a situation, the aspect of coverage of pre-existing diseases and coverage of certain ailments after specific waiting period assume significance. We have come across complaints where companies deny benefits on the grounds of waiting period of 1 year or 2 years, after switching over from one company to another without taking into account the coverage period in the previous company. Therefore the concept of waiting period and coverage of pre-existing diseases have to be rationalized and the provisions should be made uniform in all health insurance policies in this regard. To maintain the intention and spirit of the decision taken by General Insurance Council for uniform coverage of the existing diseases, the forum is of the opinion that there is a need for Regulator's intervention.
2. Another aspect where the intervention of the Regulator and a collective decision by the industry is required is the aspect of recognizing the customer for good claim experience. There are various practices among the companies by which we find some are giving cumulative bonus by way of increasing the sum insured whereas some are giving relief in premium by way of discount on premium. It is also seen that sometime during the past whenever a claim is lodged companies are scaling down the cumulative bonus in phases but now it is seen that the entire cumulative bonus is wiped off when a single claim is lodged. This seems

to be extremely unfair on the part of the company. Hence the need of the hour is an immediate intervention by the Regulator in:-

- Prescribing the standards in recognizing good claim experience with appropriate education campaign to keep customers informed
 - Ensuring that every company maintains a proper data base of all mediclaim policyholders and their claim history and creating a centralized data base of mediclaim policies of all companies.
3. Ensuring proper system for exchange of data of policyholders so that probability of mediclaim policies will become meaningful adding to better service standards.
 4. Mere delay in intimation of claim should not absolve the insurance company of its liability to pay the claims and the internal grievance redressal mechanism of the companies should be empowered to condone the delay in such cases and settle the claim.
 5. We come across cases of Group Mediclaim Policies issued/ renewed to credit card holders wherein the pre-existing diseases are permanently excluded. The Regulator has made it very clear that such permanent exclusions are not fair and just.
 6. In the present environment of the country there is wide variation in the manner in which hospitals and Doctors levy the charges and there is no means to regulate these charges. Under the circumstances, what would determine the quantum of reimbursement should be the limit of sum assured a person enjoys under the policy.
 7. The question of denying a claim that hospitalization is not warranted seems to be very unfair. It is general experience that a person cannot be admitted in a hospital unless a qualified Doctor recommend such admission and there is no way an individual can go against the advise of the Doctor. Again the stand that no active line of treatment was given is nothing short of making an intrusion into the domain of a qualified Doctor. When the forum had asked the Insurance Companies or TPAs as to the meaning of Active Line of Treatment we got a

blank response. The mediclaim policy meets the healthcare need of an individual and hence insurance companies should avoid denial of benefits on such grounds.

AUDIT AND ACCOUNTS

The books of accounts and all transactions for the fiscal 2012-13 were audited by M/s Chaturvedi & Shah, Chartered Accountants, Mumbai. The audit was completed without any adverse qualifications and the Accounts were signed on 6th May, 2013.

