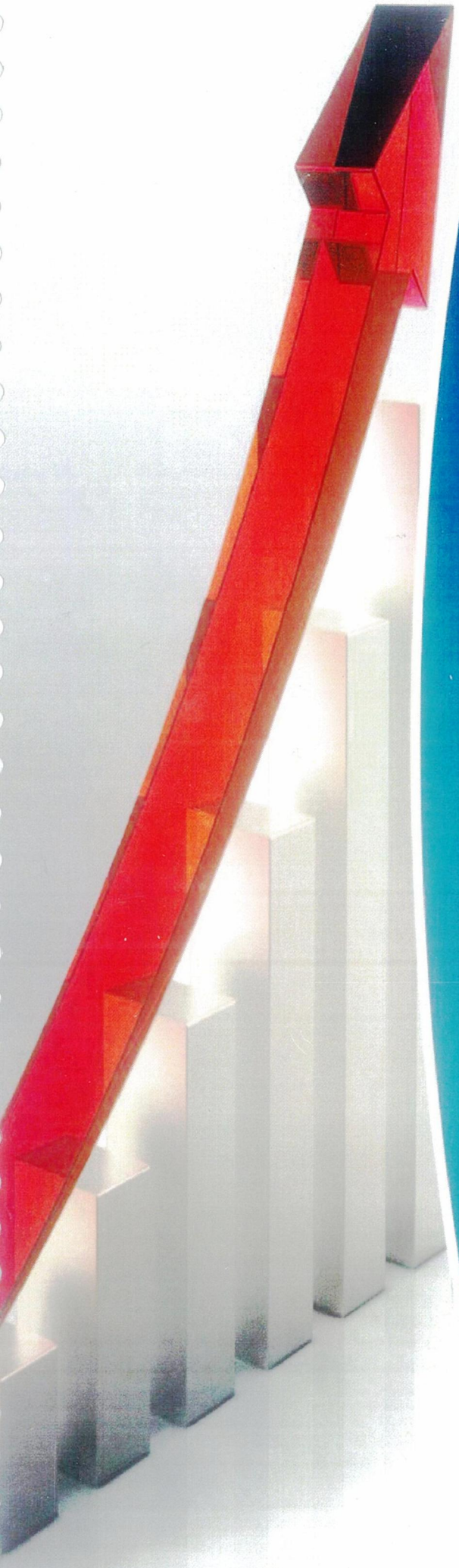

CONSOLIDATED ANNUAL REPORT OF

THE GOVERNING BODY OF INSURANCE COUNCIL & OFFICES OF THE INSURANCE OMBUDSMEN

FOR THE YEAR 2013-14

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

All Partners/Stake Holders of
Governing Body of Insurance Council

CONSOLIDATED ANNUAL REPORT FOR THE YEAR 2013-14

We have pleasure in presenting herewith the Consolidated Annual Report and Audited Accounts of the Offices of the Insurance Ombudsmen and the Governing Body of Insurance Council for the year ended 31st March, 2014.

Through this Annual Report, it is our endeavour to bring to the attention of all the Members the areas which require their immediate attention to make the functioning of the Offices of the Insurance Ombudsmen more effective.

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

(Smt. RAMMA BHASIN)
SECRETARY GENERAL(GBIC)

Mumbai
2nd December, 2014.

जीवन सेवा अनेक्स, तीसरी मंजिल, एस. वी. रोड, सांताक्रुझ (प), मुंबई - 400054. दूरभाष: 26106889/6671, फॅक्स: 2610 6949, ई-मेल: inscoun@gmail.com
Jeevan Seva Annexe, 3rd Floor, S. V. Road, Santacruz (W), Mumbai - 400 054. PBX: 26106889/6671, Fax: 26106949, Email: inscoun@gmail.com

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 2013-2014 have been received from all Ombudsman Centres even though Ombudsman position was vacant at 5 Centres viz. Bhubaneswar, Delhi, Kochi, Kolkata and Lucknow as at 31.03.2014. The consolidated Annual Report is annexed.

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. Some Ombudsman Centres (Bhopal, Chennai, Hyderabad and Mumbai) have conducted outstation hearings for the convenience of the complainants as envisaged in the rules.

3. Insurers' Meets were arranged by some of the Ombudsman Centres like Bhopal, Guwahati and Mumbai during the financial year.

4. Ombudsman Centres are submitting their monthly returns in respect of Complaint Statistics, Trial Balance, and Bank reconciliation etc. in time regularly.

5. Complaint Management System (CMS) was successfully rolled out effective 1st July, 2013 at all the Office of the Insurance Ombudsman . As at 31.3.2014, the number of outstanding complaints in the CMS module was reconciled with the number of outstanding complaints as per the Manual IRDA Report which was being submitted by all the Offices of the Insurance Ombudsman. From April, 2014 onwards, the Complaint Disposal Statistics are being generated with the aid of the CMS Module. The system is stabilizing with the exception of minor issues relating to statistics which are being escalated with the IT vendor, Ameya Infovision Pvt. Ltd.

   We are grateful to all the 52 Insurance Companies who have provided their SPOCs and who now have access to the CMS.

   We have also successfully rolled out the Auto Generated SMS alerts which are sent to the complainants during Scheduled Hearing, Rescheduling of Hearing and Complaint Withdrawn Stages.

   The AMC for Complaint Management System is being entered with the present IT vendor M/s Ameya Infovision Pvt. Ltd. at mutually acceptable terms and conditions

   Discussions are being held with IRDA for linking CMS with IGMS (IRDA software on customer complaints.

6. The Governing Body of Insurance Council has finalized purchase of Email Solution for GBIC and 15 Offices of the Insurance Ombudsman for 49users.

7. We have launched new GBIC website from 11.11.2014. It has also been decided that henceforth 11th November will be celebrated as a 'Bimalokpal Day' with an aim to create awareness among the policyholders about Insurance Ombudsman Scheme.

***

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	At present position vacant. Shri P. Ramamoorthy, Executive Director (Retd.) , LIC of India, demitted office of Insurance Ombdsman, Ahmedabad on 20.7.2014.	State of Gujarat and Union Territories of Dadra and Nagar Haveli, and Daman and Diu.
2.	Bengaluru-August-2014	Shri M. Parshad, Ex-CMD, Agriculture Co. Ltd. Tenure from 14.08.2014 to 14.11.2016	Pending for approval by Council
3.	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.
4.	Bhubaneshwar-May-2000	Shri B.P. Parija, Ex-Super-Time District Judge, demitted office o 30.11.2013 Shri B.N. Mishra, Ex-District & Sessions Judge, Tenure from 22.07.2014 to 21.07.2017	State of Orissa.
5.	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
6.	Chennai- August 1999	Shri Virander Kumar, Ex-General Manager, The New India Assurance Co. Ltd. Tenure from 09.05.2013 to 08.05.2016	State of Tamil Nadu and Union Territories-Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
7.	Delhi- July 1999	Shri S.P. Singh, Ex-Chief Commissioner of Income Tax, demitted office on 7.6.2013 Smt. Sandhya Baliga, IRS Ex-Member(Customs, legal & Judicial)CBEC Tenure from 15.07.2014 to 14.07.2017	States of Delhi and Rajasthan.
8.	Guwahati- September 1999	Shri D.C. Choudhury, Ex-District & Sessions Judge, demitted office on 17.07.2014 At present position vacant.	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
9.	Hyderabad- August 1999	Shri G. Rajeswara Rao, Ex- Chief Commissioner of Income Tax. Tenure from 15.05.2013 to 14.05.2016	States of Andhra Pradesh, Karnataka and Union Territory of Yanam- a part of Union Territory of Pondicherry.
10.	Jaipur- October 2014	Shri Ashok K. Jain,IRS Ex-Chief Commissioner of Income Tax, Bhopal Tenure from 10.10.2014 to 09.10.2017	Pending for approval by Council

Sr. No.	Name of the Centre and Date of Inception	Name of the Current Ombudsman	State-wise Area of Jurisdiction
11.	Kochi- June 2000	Shri R. Jyothindranathan, Ex-District & Sessions Judge, demitted office on 30.11.2013 Shri P.K. Vijayakumar, IRS Ex-Director General of Income Tax(Investigation), Kochi Tenure from 14.07.2014 to 13.07.2017	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe- a part of Union Territory of Pondicherry.
12.	Kolkata – March – 2000	Ms. Manika Datta, Ex-Chief Commissioner of Income Tax, demitted office on 8.6.2013. Shri K.B. Saha, Ex-Executive Director, L.I.C. of India, Tenure from 30.07.2014 to 29.07.2017	States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.
13.	Lucknow – October 1999	Shri G.B. Pande, Ex- Executive Director, LIC of India, demitted office on 5.1.2014 Shri N.P. Bhagat, IRS Ex-Director General of Income Tax(Investigation), Patna, Tenure from 04.08.2014 to 03.08.2017	States of Uttar Pradesh and Uttaranchal.
14.	Mumbai- November 2000	Shri A.K. Dasgupta, Ex-Managing Director, LIC of India. Tenure from 16.05.2013 to 15.05.2016.	States of Maharashtra and Goa.

Sr. No.	Name of the Centre and Date of Inception	Name of the Current Ombudsman	State-wise Area of Jurisdiction
15.	Patna- September 2014	Shri Sadasiv Mishra, Ex-General Manager, The New India Assurance Co. Ltd. Tenure from 09.09.2014 to 08.09.2017.	Pending for approval by Council
16.	Pune- September 2014	Shri A.K. Sahoo, Ex-Executive Director, LIC of India. Tenure from 10.09.2014 to 09.09.2017.	Pending for approval by Council

C

ACCOUNTS

All the Ombudsman Centres have submitted their audited Trial Balances as at 31.03.2014. 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 2013-14 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 31.03.2014 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 consolidated statements of accounts were generated automatically without error.

At present, 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.

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, 2014 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, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. 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.

CHATURVEDI & SHAH MUMBAI CHARTERED ACCOUNTANTS

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, 2014; 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-imbursement towards its share of contribution. Further the amount received towards Capital Expenditure is reflected as a liability for contribution for Fixed Assets.

d) Note 6 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 7 in Schedule B to the financial statements regarding Balances of Sundry Creditors and Sundry Debtors which are subject to confirmations and reconciliations.

CHATURVEDI & SHAH MUMBAI CHARTERED ACCOUNTANTS

Continuation sheet...

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

CHATURVEDI & SHAH MUMBAI CHARTERED ACCOUNTANTS

Vitesh D. Gandhi
Partner
Membership No. 110248

Place : Mumbai
Date : 18/09/2014

GOVERNING BODY OF INSURANCE COUNCIL & 12 OMBUDSMAN OFFICES

CONSOLIDATED BALANCE SHEET AS ON 31ST MARCH, 2014

LIABILITIES		As at 31/03/2014 (Amt in Rs.)	As at 31/03/2013 Amt. in (Rs.)	ASSETS		As at 31/03/2014 (Amt. in Rs.)	As at 31/03/2013 (Amt. in Rs.)
Collection for Fixed Assets				Fixed Assets (At Cost)			
Upto Previous year	15,945,643.24			WDV (Opening)	8,619,515.67		
For Current year	-2,530,851.24			Additions during the year	1,195,193.40		
		13,414,792.00	15,945,643.24	Less: depreciation for the year	1,777,508.18		
				Scrape value	12,641.00		
Current Liabilities				(As per Schedule 'A' attached herewith)		8,024,559.89	8,619,515.67
Amount due to LIC of India		110,474,183.00	100,998,127.00				
				Debtors (Unsecured and considered good)			
				Amount due from GBIC members	110,474,183.00		
				Housing Loan Subsidy recoverable(LIC)	524418.00		
Sundry Creditors				Other Miscellaneous Debit	79,361.00	111,077,962.00	102,024,242.57
Outstanding Expenses	2,255,708.40						
Income Tax other than salary	1,387.00	2,257,095.40	2,781,018.61	Advances to Staff		538,907.00	527,399.00
				Prepaid Expenses		317,673.00	717,714.00
				Deposits		1,241,019.00	903,523.00
				Stamps on Hand		12,465.96	3,200.96
				Cash Balance		30,121.78	42,046.01
				Bank Balance		4,903,361.77	6,887,147.64
Total		126,146,070.40	119,724,788.85	Total		126,146,070.40	119,724,788.85

Notes to Accounts as per Schedule "B" annexed.

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

(Vitesh D.Gandhi)
(PARTNER)
Membership No. 110248
PLACE : MUMBAI
DATE : 18/09/2014

CHATURVEDI & SHAH * CHARTERED ACCOUNTANTS * MUMBAI

SECRETARY

SECRETARY GENERAL

GOVERNING BODY OF INSURANCE COUNCIL & 12 OMBUDSMAN OFFICES

CONSOLIDATED STATEMENT OF INCOME & EXPENDITURE FOR THE YEAR ENDED 31ST MARCH, 2014

Account Code	Expenses	Year ended 31/03/2014 (Amt. In Rs.)	Year ended 31/03/2013 (Amt. In Rs.)	Account Code	Income	Year ended 31/03/2014 (Amt. In Rs.)	Year ended 31/03/2013 (Amt. In Rs.)
401	Basic Salary to Ombudsman	4,613,136.95	4,406,129.53	112	Licence Fee deduction	5932.38	0
402	D.A. to Ombudsman	6,389,808.97	5,410,000.24	303	LIC Designated Office A/c.	160,833,893.78	145,509,997.22
403	HRA to Ombudsman	1,784,915.12	1,695,398.17	460	S R A/c	0	8.45
405	Conveyance to Ombudsman	1,497,226.06	1,330,580.67	501	Sundry Receipts	56,722.27	65,457.08
406	Basic Salary to Others	41,562,618.63	39,324,181.82		EXCESS OF EXPENDITURE OVER INCOME	2530851.24	1165953.74
408	D.A. to Others	35,607,459.40	26,340,233.28				
409	HRA to Others	2,849,892.31	2,633,291.71				
410	CCA to Others	860,674.35	809,011.46				
411	FPA to Others	560,865.33	533,305.00				
412	Conveyance to Others	958,844.70	985,067.11				
413	Deputation Allowance to Others	4,071,473.42	4,052,071.25				
414	Functional Allowance to Others	4,990.00	136,069.20				
415	Washing Allowance to Others	1,800.00	1,800.00				
416	Qualifn. Pay to Others	5,020.00	396.10				
417	Other allowance to Others	58,789.73	30,210.97				
419	PLLI	59,891.01	79,798.00				
420	Employer's Contribution to Pension	2,940,247.13	2,973,845.27				
421	Employer's Contri. to PF	807,568.48	647,564.00				
422	Employer's Contribn to Gratuity	1,838,254.62	1,576,458.59				
423	Employer's Contribution to Mediclaim	447,457.69	320,962.35				
424	Employer's Contribution to GSLI	15,512.84	34,352.10				
425	Leave Encashment	1,946,356.55	2,032,557.27				
426	Travelling Expenses on Tour	2,938,389.48	2,316,834.89				
427	Transfer T E	428,138.00	1,006,714.00				
428	L T C Expenses	1,813,752.00	1,601,410.80				
429	Motor Car Expenses	878,395.00	664,383.00				
430	Auditors Fees	163,796.80	163,375.60				
431	Law Charges	51,813.00	103,346.00				
432	Printing & Stationery	1,333,798.25	1,133,457.70				
433	Postage,Revenue Stamps	1,043,529.00	1,007,121.73				
434	Bank Charges	17,619.80	17,050.00				
435	Telephone Charges	1,250,883.63	1,076,380.13				
436	Electricity Charges	3,084,982.00	2,742,972.00				
437	Carriage & Freight	116,455.00	103,142.00				
438	Repairs & Maintenance	447,008.50	427,562.29				
439	Staff Amenities	3,715,302.20	2,386,847.10				
440	Lumpsum Medical Benefit	974,687.00	1,272,406.10				
441	All Insurance Premiums	169,422.71	165,625.50				
442	Entertainment Expenses	815,962.50	673,475.00				
443	Contractual Payments Other Than AMC	6,459,491.00	4,326,354.50				
444	AMC Payments	591,139.34	601,250.00				
445	Office Upkeep	608,404.50	609,410.00				
446	Subscription to Newspaper	356,910.00	346,738.00				
447	Conference Expenses	251,229.00	400,964.00				
448	Training Fees	379,216.00	171,910.80				
449	Consultancy Fees	49,947.00	20,978.00				
450	Rent,Rates & Taxes	23,906,497.12	24,912,116.58				
451	Depreciation	1,777,508.18	1,894,246.31				
452	PR and Publicity	349,074.00	749,138.00				
453	Other Misc.Expenses	418,993.87	347,730.37				
455	Exp. Of Remodelling of Rented premises	60,371.00	90,020.00				
457	Sundry Office Equipment<Rs.5000/-	47,594.00	40,171.00				
460	S R A/c	25.50	0.00				
461	Library Expenses	44,261.00	15,001.00				
	Total	163,427,399.67	146,741,416.49			163,427,399.67	146,741,416.49

Notes to Accounts as per Schedule "B" annexed.

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

(Vitesh D.Gandhi)
(PARTNER)
Membership No. 110248
PLACE : MUMBAI
DATE : 18/09/2014

CHATURVEDI & SHAH MUMBAI CHARTERED ACCOUNTANTS

SECRETARY

SECRETARY GENERAL

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

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2014

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. 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.

3. Opening Balances as on 1st April, 2003 have been taken from the figures certified by the Management of GBIC. 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.

CHATURVEDI & SHAH ★ MUMBAI ★ CHARTERED ACCOUNTANTS

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

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2014

4. The accounts of the 12 offices of GBIC 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-imbursement 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 31.03.2014 is ₹. 11,04,74,183/-

6. In the opinion of the management, Income Tax Return for the assessment year 2014-15 and for the earlier years is not required to be filed, as GBIC is not doing any commercial activity.

7. Balances of Sundry Creditors and Sundry Debtors are subject to confirmations and reconciliations.

8. In case of 6 centers, the salary of officials on deputation from the LIC of India 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.

9. 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.

CHATURVEDI & SHAH MUMBAI CHARTERED ACCOUNTANTS

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

SCHEDULE 'B'

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31-3-2014

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

Particulars	Complaints O/s. as on 01.04.2013	Received during the year	Disposed during the year	Outstanding as on 31.03.2014
For Life Insurance	3884	17512	15672	5724
For General Insurance	4717	8803	9627	3893
Total	8601	26315	25299	9617

AS PER OUR REPORT OF EVEN DATE

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

CHATURVEDI & SHAH CHARTERED ACCOUNTANTS MUMBAI

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

PLACE : MUMBAI
DATE : 18/09/2014

SECRETARY

For GOVERNING BODY OF INSURANCE COUNCIL

SECRETARY GENERAL

Office of the Governing Body of Insurance Council Mumbai

D COMPLAINT STATISTICS

The individual complaints statistics are as per details given by the Ombudsman Centres. Based on these details, the following consolidated statements as at 31.03.2014 are attached herewith:

No	Description	Statement
1	Complaints Disposal (Summary – Life & General Insurance combined)	L1G1
2	Complaints Disposal Centre Wise Life Insurance)	L2
3	Complaints Disposal (Company Wise Analysis- Life Insurance	L3
4	Complaints Disposal (Centre Wise General Insurance)	G2
5	Complaints Disposal (Company Wise General Insurance)	G3
6	Details of Awards & Recommendations – Amount Wise (Centre Wise- Life & General Insurance Combined)	L4G4
7	Details of Awards & Recommendations – Amount Wise (Company Wise Analysis – Life Insurance)	L5
8	Details of Awards & Recommendations – Amount Wise (Company Wise Analysis – General Insurance)	G5
9	Summary of Compliances awaited beyond 1 month of dispatch of agreed Awards/Recommendations – Life	L6
10	Summary of Compliances awaited beyond 1 month of dispatch of agreed Awards/Recommendations – General	G6
11	Nature wise classification of complains received (Centre Wise- Life & General Insurance Combined)	L7G7
12	Nature Wise Classification of complaints received (Summary-Life)	L8
13	Nature wise Classification of Complaints received (Company wise analysis – Life Insurance)	L9
14	Nature wise Classification of complaints received (Centre wise – General Insurance)	G8
15	Nature wise classification of complaints received (Company wise analysis – General Insurance)	G9

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Complaints Disposal statement FOR THE PERIOD FROM 01.04.2013 TO 31.03.2014(YEARLY).

STATEMENT L1G1

LIFE AND GENERAL INSURANCE

Name of Centre	Total No of Complaints			Number of complaints dispoesd off by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of the Year	Received DURING 2013-14	Total	Recomen-dations/ Awards	Withdrawal /Settlement	Dissmissal	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 Oustanding
Ahmedabad	512	1802	2314	57	172	627	1072	1928	1104	824	0	1928	144	242	0	386
Bhopal	561	633	1194	108	68	88	279	543	297	42	204	543	68	166	417	651
Bubaneshwar	164	555	719	47	16	68	306	437	310	127	0	437	59	183	40	282
Chandigarh	1996	3897	5893	746	1546	574	1640	4506	1663	1629	1214	4506	562	813	12	1387
Chennai	188	1775	1963	233	47	144	1525	1949	1676	271	2	1949	14	0	0	14
Delhi	1152	4319	5471	48	14	64	3155	3281	3158	84	39	3281	237	907	1046	2190
Guwahati	119	401	520	254	3	21	154	432	222	199	11	432	10	78	0	88
Hyderabad	250	1670	1920	253	118	193	1177	1741	1561	174	6	1741	122	57	0	179
Kochi	719	1080	1799	163	99	78	461	801	471	52	278	801	156	410	432	998
Kolkata	630	3102	3732	34	202	62	1739	2037	1838	166	33	2037	300	891	504	1695
Lucknow	199	1952	2151	373	108	78	1233	1792	1651	141	0	1792	243	95	21	359
Mumbai	2111	5129	7240	1244	1146	14	3448	5852	3472	1099	1281	5852	209	285	894	1388
Total	8601	26315	34916	3560	3539	2011	16189	25299	17423	4808	3068	25299	2124	4127	3366	9617

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Complaints Disposal Statement for the year 2013-2014

STATEMENT L2
LIFE INSURANCE

Name of Centre	Total No of Complaints			Number of complaints dispoesd off by way of					Durationwise disposal of				Durationwise Outstanding complaints			
	O/s at the Beginning of the Year	Received During 2013-14	Total	Recomen-dations/ Awards	Withdrawal /Settlement	Dissmissal	Non-acceptance/ NE	Total Disposed	Within 3 months	3 months to 1 year	Above 1 Year	Total Dispose	Within 3 months	3 months to 1 Year	Above 1 Year	Total Oustanding
Ahmedabad	37	778	815	40	69	66	525	700	553	147	0	700	49	66	0	115
Bhopal	378	437	815	66	31	40	199	336	216	12	108	336	34	131	314	479
Bubaneshwar	89	364	453	15	14	42	209	280	210	70	0	280	47	103	23	173
Chandigarh	1360	3156	4516	314	1337	434	1205	3290	1214	1372	704	3290	496	730	0	1226
Chennai	53	1080	1133	64	1	55	1011	1131	1062	69	0	1131	2	0	0	2
Delhi	700	3170	3870	13	10	15	2395	2433	2396	36	1	2433	171	595	671	1437
Guwahati	72	286	358	154	2	14	128	298	176	122	0	298	4	56	0	60
Hyderabad	79	1076	1155	86	45	94	850	1075	928	141	6	1075	55	25	0	80
Kochi	376	717	1093	62	52	40	343	497	344	33	120	497	102	242	252	596
Kolkata	409	2260	2669	12	167	40	1235	1454	1326	121	7	1454	235	630	350	1215
Lucknow	182	1691	1873	309	51	78	1128	1566	1425	141	0	1566	212	95	0	307
Mumbai	149	2497	2646	198	42	0	2372	2612	2453	10	149	2612	31	3	0	34
Total	3884	17512	21396	1333	1821	918	11600	15672	12303	2274	1095	15672	1438	2676	1610	5724

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal Statement for the Year 2013-2014

STATEMENT L3
LIFE 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 2013-14	Total	Recomen-dations	Awards	Withdrawal /Settlement	Non-acceptance	Dissmissal	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
Aegon Religare Life Ins.Co.Ltd.	216	418	634	2	83	71	26	46	185	413	240	119	54	413	45	102	74	221
Aviva Life	229	486	715	0	56	87	18	61	300	522	332	104	86	522	41	79	73	193
Bajaj-Allianz Life	192	812	1004	10	69	73	50	50	502	754	588	92	74	754	52	112	86	250
BHARTI AXA LIFE	143	420	563	4	46	73	13	22	255	413	284	67	62	413	39	52	59	150
Birla-Sun Life	389	1667	2056	3	86	230	103	57	831	1310	969	269	72	1310	173	422	151	746
Canara HSBC Oriental Bank Lif	7	52	59	0	2	5	4	1	35	47	43	4	0	47	3	4	5	12
DLF Pramerica Life Ins.Co.Ltd.	81	226	307	1	26	64	3	17	94	205	104	67	34	205	30	54	18	102
Edelweiss Tokio LIC Co.	0	13	13	0	0	2	0	0	8	10	8	2	0	10	3	0	0	3
Future Generali	54	183	237	0	14	33	8	8	120	183	149	24	10	183	18	16	20	54
Hdfc-Standard Life	442	2651	3093	3	145	203	124	79	1674	2228	1858	242	128	2228	199	453	213	865
ICICI-Prudential	236	1302	1538	5	69	128	86	48	807	1143	952	145	46	1143	101	177	117	395
IDBI Federal Life Ins.Co.Ltd.	19	122	141	0	4	19	8	3	61	95	83	10	2	95	14	21	11	46
IndiaFirst insurance co.	5	58	63	0	3	3	3	4	40	53	50	3	0	53	6	2	2	10
Ing-Vysya	38	264	302	1	10	18	15	7	171	222	200	15	7	222	32	31	17	80
Kotak Mahindra-OM	315	625	940	3	37	153	20	90	350	653	392	161	100	653	46	153	88	287
LIC of India	669	3833	4502	0	396	179	310	215	2483	3583	3011	366	206	3583	274	354	291	919
Max Life Insurance	129	626	755	1	30	89	45	39	407	611	471	101	39	611	36	49	59	144
PNB Met-Life	84	383	467	2	28	35	16	14	219	314	243	57	14	314	41	74	38	153
RELIANCE LIFE	217	1762	1979	2	49	225	58	47	1056	1437	1176	190	71	1437	166	287	89	542
SAHARA India Life	0	3	3	0	0	1	1	0	1	3	2	1	0	3	0	0	0	0
SBI LIFE	213	928	1141	0	72	53	37	78	597	837	664	123	50	837	82	131	91	304
SHRIRAM LIFE	16	141	157	1	6	19	2	5	87	120	91	25	4	120	9	21	7	37
Star Union Dai-ichi Life Ins.Co.	8	52	60	0	2	7	6	1	36	52	44	5	3	52	3	3	2	8
TATA AIA LIFE	182	485	667	0	62	51	52	26	273	464	349	82	33	464	25	79	99	203
Total	3884	17512	21396	38	1295	1821	1008	918	10592	15672	12303	2274	1095	15672	1438	2676	1610	5724

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
Complaints Disposal for the year 2013-2014

STATEMENT G2
GENERAL INSURANCE

Name of Centre	Total No of Complaints			Number of complaints dispoesd off by way of					Durationwise disposal of Complaints				Durationwise Outstanding complaints			
	O/s at the Beginning of the Year	Received during 2013-2014	Total	Recomen-dations/ Awards	Withdrawal /Settlement	Dissmissal	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 Oustanding
Ahmedabad	475	1024	1499	17	103	561	547	1228	551	677	0	1228	95	176	0	271
Bhopal	183	196	379	42	37	48	80	207	81	30	96	207	34	35	103	172
Bubaneshwar	75	191	266	32	2	26	97	157	100	57	0	157	12	80	17	109
Chandigarh	636	741	1377	432	209	140	435	1216	449	257	510	1216	66	83	12	161
Chennai	135	695	830	169	46	89	514	818	614	202	2	818	12	0	0	12
Delhi	452	1149	1601	35	4	49	760	848	762	48	38	848	66	312	375	753
Guwahati	47	115	162	100	1	7	26	134	46	77	11	134	6	22	0	28
Hyderabad	171	594	765	167	73	99	327	666	633	33	0	666	67	32	0	99
Kochi	343	363	706	101	47	38	118	304	127	19	158	304	54	168	180	402
Kolkata	221	842	1063	22	35	22	504	583	512	45	26	583	65	261	154	480
Lucknow	17	261	278	64	57	0	105	226	226	0	0	226	31	0	21	52
Mumbai	1962	2632	4594	1046	1104	14	1076	3240	1019	1089	1132	3240	178	282	894	1354
Total	4717	8803	13520	2227	1718	1093	4589	9627	5120	2534	1973	9627	686	1451	1756	3893

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Complaints Disposal Statement for the year 2013-2014

STATEMENT G 3
GENERAL INSURANCE.

Name of Company	Total No of Complaints			Complaints disposed by way of							Durationwise disposal of Complaints				Durationwise Outstanding complain			TOTA
	O/s at the Beginning of the YEAR	Received during 2013-14	Total	Recomen-dations	Awards	Withdrawal /Settlement	Non-acceptance	Dissmissal	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	OUTSTANDING
Agriculture Ins. Co.	0	15	15	0	0	0	0	0	14	14	14	0	0	14	0	1	0	1
Apollo Munich Health	76	167	243	0	26	21	3	11	93	154	101	38	15	154	16	29	44	89
Bajaj-Allianz General	100	234	334	0	42	37	5	26	133	243	155	52	36	243	17	40	34	91
Bharati AXA Gen.Ins.	36	102	138	0	20	19	0	13	61	113	66	23	24	113	7	8	10	25
CHNHB Association	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cholamandalam MS	41	48	89	0	21	11	0	4	27	63	33	14	16	63	2	8	16	26
ECGC	0	3	3	0	0	1	0	0	2	3	2	1	0	3	0	0	0	0
Future Generali Gen.	16	49	65	0	12	7	3	4	25	51	32	13	6	51	3	8	3	14
HDFC ERGO Gen.Ins.	44	150	194	0	16	29	1	14	82	142	91	29	22	142	10	19	23	52
ICICI-Lombard	190	530	720	1	69	117	10	47	337	581	398	99	84	581	28	66	45	139
IFFCO TOKIO	55	91	146	1	15	25	0	8	54	103	58	17	28	103	8	14	21	43
L & T General	4	10	14	0	2	1	1	0	6	10	7	1	2	10	0	2	2	4
LIBERTY VIDEOCON	0	3	3	0	0	0	0	0	3	3	2	1	0	3	0	0	0	0
MAGMA HDI Genl.	0	1	1	0	0	0	0	0	1	1	1	0	0	1	0	0	0	0
MAX BUPA Health	24	223	247	0	3	36	6	5	142	192	145	31	16	192	23	23	9	55
Raheja QBE Gen.Ins.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reliance General	290	265	555	7	118	88	3	47	152	415	176	107	132	415	16	41	83	140
Religare Health Ins.	0	20	20	0	1	1	0	0	14	16	15	1	0	16	1	3	0	4
Royal-Sundaram	69	156	225	3	30	23	5	18	90	169	115	27	27	169	12	20	24	56
SBI General	3	45	48	0	2	5	0	3	31	41	32	8	1	41	4	1	2	7
Shriram Gen.Ins.Co.Ltd.	39	65	104	0	19	12	0	7	34	72	41	13	18	72	5	7	20	32
Star Health & Allied Ins.	233	563	796	2	97	104	8	58	280	549	359	126	64	549	69	81	97	247
TATA-AIG General	89	186	275	0	21	49	3	15	135	223	149	39	35	223	13	11	28	52
The National	631	1189	1820	3	251	149	50	152	609	1214	718	270	226	1214	93	239	274	606
The New India	1016	1952	2968	3	524	485	27	221	862	2122	910	639	573	2122	140	330	376	846
The Oriental	699	1118	1817	6	295	212	17	167	510	1207	616	332	259	1207	103	239	268	610
The United-India	1039	1573	2612	3	604	275	25	270	700	1877	851	643	383	1877	113	252	370	735
Universal Sompo Gen.	23	45	68	0	10	11	1	3	24	49	33	10	6	49	3	9	7	19
Total	4717	8803	13520	29	2198	1718	168	1093	4421	9627	5120	2534	1973	9627	686	1451	1756	3893

OFFICE OF GOVERNING BODY OF INSURANCE COUNCIL

RECOMMENDATIONS AND AWARDS FOR THE PERIOD FROM 01.04.2013 TO 31.03.2014(YEARLY)

RS. IN THOUSAND

L4G4

Name of the Insurer	LIFE RECOMMENDATION AND AWARDS 2013-2014		GENERAL RECOMMENDATION AND AWARDS 2013-2014		TOTAL RECOMMENDATION AND AWARDS 2013-2014	
	Number	*Amount*	*Number*	*Amount*	*Number*	*Amount*
AHMEDABAD	40	664	17	26	57	690
BHOPAL	66	4590	42	798	108	5388
BHUBANESHWAR	15	8	32	0	47	8
CHANDIGARH	314	43367	432	37200	746	80567
CHENNAI	64	6884	169	8098	233	14982
DELHI	13	1536	35	2540	48	4076
GUWAHATI	154	1078	100	1879	254	2957
HYDERABAD	86	12806	167	23422	253	36228
KOCHI	62	2487	101	7044	163	9531
KOLKATA	12	2558	22	2006	34	4564
LUCKNOW	309	11147	64	1075	373	12222
MUMBAI	198	3983	1046	70045	1244	74028
Total	1333	91108	2227	154133	3560	245241

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
RECOMMENDATIONS AND AWARDS FOR THE YEAR 2013-2014

STATEMENT L 5
LIFE INSURANCE
(FIGURES IN '000)

Name of Insurer	RECOMMENDATIONS 2013-2014		AWARDS 2013-2014		RECOMMENDATIONS & AWARDS 2013-2014	
	Number	*Amount*	*Number*	*Amount*	*Number*	*Amount*
Aegon Religare Life Ins.Co.Ltd.	2		83	10853	85	10853
Aviva Life	0		56	6185.71	56	6185.71
Bajaj-Allianz Life	10		69	6941.58	79	6941.58
BHARTI AXA Life	4	260	46	4777.91	50	5037.91
Birla-Sun Life	3		86	2849.75	89	2849.75
Canara HSBC Oriental Bank Life	0		2	700.00	2	700.00
DLF Pramerica Life Ins.Co.Ltd.	1		26	2188.00	27	2188.00
Edelweiss Tokio Life Ins.	0		0	0.00	0	0.00
Future Generali	0		14	502.32	14	502.32
HDFC Standard Life	3	9.90	145	7745.09	148	7754.99
ICICI-Prudential	5	100	69	5869.90	74	5969.90
IDBI Federal Life Ins.Co.Ltd.	0		4	9.73	4	9.73
IndiaFirst Life Insurance co.	0		3	0.00	3	0.00
Ing-Vysya	1		10	965.42	11	965.42
Kotak Mahindra-OM	3		37	2713.58	40	2713.58
LIC of India	0		396	13458.46	396	13458.46
Max-Newyork Life	1	1400	30	3288.81	31	4688.81
Met-Life	2	150.88	28	3296.78	30	3447.66
RELIANCE LIFE	2	200	49	5852.84	51	6052.84
SAHARA India Life	0		0	0.00	0	0.00
SBI LIFE	0		72	6446.48	72	6446.48
SHRIRAM LIFE	1	99.85	6	2074.00	7	2173.85
Star Union Dai-ichi Life Ins.Co.	0		2	60.00	2	60.00
TATA AIG LIFE	0		62	2108.56	62	2108.56
Total	38	2220.63	1295	88887.92	1333	91108.55

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

INDEX

Sr No.		Description	Page Nos.
1	A	Introduction	3 to 4
	B	Insurance Ombudsman	5 to 8
	C	Accounts	9
		Annexures to Accounts (Auditors' Report for GBIC & 12 Offices of Insurance Ombudsman)	10 to 17
	D	Complaint Statistics	18
		Annexures to Complaint Statistics	19 to 33
2		Observations/Suggestions/Recommendations of Ombudsmen regarding quality of Services rendered by Insurers, Causes of Grievances, etc.	34 to 46
		Both Life & General Insurance	34
		Life Insurance	38
		General Insurance	41
3		Reports of the Office of the Insurance Ombudsmen	47 to 84
	i)	Ahmedabad	47 to 48
	ii)	Bhopal	49 to 50
	iii)	Bhubaneswar	51 to 52
	iv)	Chandigarh	53 to 55
	v)	Chennai	56 to 58
	vi)	Delhi	59 to 63
	vii)	Guwahati	64 to 66
	viii)	Hyderabad	67 to 70
	ix)	Kochi	71
	x)	Kolkata	72 to 75
	xi)	Lucknow	76
	xii)	Mumbai	77 to 84

CE OF THE GOVERNING BODY OF INSURANCE COUNCIL

RECOMMENDATIONS AND AWARDS FOR THE YEAR 2013-2014

STATEMENT G 5

GENERAL INSURANCE

Name of the Insurer	RECOMMENDATIONS		AWARDS		RECOMMENDATION & AWARDS	
	2013-2014		2013-2014		2013-2014	
	Number	*Amount*	*Number*	*Amount*	*Number*	*Amount*
Agriculture Ins. Co.	0		0		0	0.00
Apollo Munich	0		26	477.96	26	477.96
Bajaj-Allianz General	0		42	1510.32	42	1510.32
BharatiAXA Gen.Ins.	0		20	1270.70	20	1270.70
CHNHB Association	0		0			
Cholamandalam	0		21	1873.05	21	1873.05
ECGC	0		0			
Future Generali Gen.	0		12	441.12	12	441.12
HDFC ERGO Gen.Ins.	0		16	1876.45	16	1876.45
ICICI-Lombard	1		69	6104.22	70	6104.22
IFFCO TOKIO	1	19.43	15	818.00	16	837.43
L & T Gnel. Ins. Co.	0		2	1900.50	2	1900.50
Liberty Videocon Gen.Ins.	0		0		0	0.00
Magma HDI Gen. Ins.Co.	0		0		0	0.00
MAX BUPA	0		3	220.00	3	220.00
Raheja QBE Gen.Ins.	0		0		0	0.00
Reliance General	7	25.85	118	7845.05	125	7870.90
Religare Health Ins.	0		1	324.08	1	324.08
Royal-Sundaram	3	26.61	30	1108.00	33	1134.61
SBI Genl. Ins. Co.	0		2		2	0.00
Shriram Gen.Ins.Co.Ltd.	0		19	3314.64	19	3314.64
Star Health & Allied Ins.	2	35.60	97	4042.15	99	4077.75
TATA-AIG General	0		21	1422.03	21	1422.03
National Ins.	3	19.12	251	16075.21	254	16094.33
The New India	3	48.73	524	22578.63	527	22627.36
The Oriental	6	14.92	295	17418.57	301	17433.49
United-India	3	22.00	604	62710.50	607	62732.50
Universal Sompo Gen.	0		10	589.95	10	589.95
Total	29	212.26	2198	153921.13	2227	154133.39

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Compliance awaited for more than one Month as on 31-3-2014

STATEMENT L 6

Centre	Ahmedabad	Bhopal	Bubaneshwar	Chandigarh	Chennai	Delhi	Guwahati	Hyderabad	Kochi	Kolkata	Lucknow	Mumbai	Total
Name of Company	*	*	*	*	*	*	*	*	*	*	*	*	
Aegon Religare Life Ins.Co.Ltd.	0	0	0	0	0	3	0	0	0	0	0	0	3
Aviva Life	0	0	0	0	0	0	0	0	0	0	0	0	0
Bajaj-Allianze Life	0	0	0	0	0	0	0	0	0	0	0	2	2
BHARTI AXA LIFE	0	0	0	0	0	0	1	0	0	0	0	0	1
Birla-Sun Life	3	0	0	0	0	3	8	0	0	0	0	0	14
Canara HSBC Oriental Bank Life	0	0	0	0	0	0	0	0	0	0	0	0	0
DLF Pramerica Life Ins.Co.Ltd.	0	0	0	0	0	0	0	0	0	0	0	0	0
Edelweiss Tokio LIC Co.	0	0	0	0	0	0	0	0	0	0	0	0	0
Future Generali	0	0	0	0	0	0	0	0	0	0	0	0	0
Hdfc-Standard Life	4	0	0	0	0	0	0	0	0	0	0	0	4
ICICI-Prudential	0	0	0	0	0	0	2	0	0	0	0	0	2
IDBI Federal Life Ins.Co.Ltd.	0	0	0	0	0	0	1	0	0	0	0	0	1
IndiaFirst Life Ins. Co. Ltd.	0	0	0	0	0	0	0	0	0	0	0	0	0
Ing-Vysya	0	0	0	0	0	0	0	0	0	0	0	0	0
Kotak Mahindra-OM	0	0	0	0	0	1	0	0	0	0	0	0	1
LIC of India	0	0	0	0	0	0	0	0	0	0	0	0	0
Max Life Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0
Met-Life Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0
RELIANCE LIFE	1	0	0	0	0	0	3	0	0	0	0	0	4
SAHARA India Life	0	0	0	0	0	0	0	0	0	0	0	0	0
SBI LIFE	0	0	0	0	0	1	1	0	0	0	0	0	2
SHRIRAM LIFE	0	0	0	0	0	0	0	0	0	0	0	0	0
Star Union Dai-ichi Life Ins.Co.	0	0	0	0	0	0	0	0	0	0	0	0	0
TATA AIA LIFE	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	8	0	0	0	0	8	16	0	0	0	0	2	34

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL

Compliance awaited for more than one Month as on 31-3-2014 G-6

* * * * * * * * * * * **STATEMENT G 6

Centre	Ahmedabad	Bhopal	Bubaneshwar	Chandigarh	Chennai	Delhi	Guwahati	Hyderabad	Kochi	Kolkata	Lucknow	Mumbai	Total
Name of Company													
Agriculture Ins. Co.	0	0	0	0	0	0	0	0	0	0	0	0	0
Apollo Munich Health	0	0	0	0	0	0	0	0	0	0	0	0	0
Bajaj-Allianz General	0	0	0	0	0	0	3	1	0	0	0	0	4
BharatiAXA Gen.Ins.	0	0	1	0	0	0	0	0	0	0	0	0	1
CHNHB Association	0	0	0	0	0	0	0	0	0	0	0	0	0
Cholamandalam	0	0	0	0	0	0	2	0	0	0	0	0	2
ECGC	0	0	0	0	0	0	0	0	0	0	0	0	0
Future Generali Gen.	0	0	0	0	0	0	3	0	0	0	0	0	3
HDFC ERGO Gen.Ins.	0	0	0	0	0	0	1	0	0	0	0	0	1
ICICI-Lombard	0	0	0	0	0	0	3	0	0	0	0	1	4
IFFCO TOKIO	0	0	0	0	0	0	0	1	0	0	0	3	4
L & T General Ins. Co.	0	0	0	0	0	0	0	0	0	0	0	0	0
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 Bhupa Health Ins. Co.	0	0	0	0	0	0	0	1	0	0	0	0	1
Raheja QBE Gen.Ins.	0	0	0	0	0	0	0	0	0	0	0	0	0
Reliance General	0	0	2	0	0	0	2	1	0	0	0	5	10
Royal-Sundaram	0	0	0	0	0	0	1	0	0	0	0	0	1
SBI General	0	0	0	0	0	0	0	0	0	0	0	0	0
Shriram Gen.Ins.Co.Ltd.	0	0	0	0	0	0	0	0	0	0	0	0	0
Star Health & Allied Insurance	0	0	0	0	0	0	1	0	0	0	0	2	3
TATA-AIG General	0	0	0	0	0	0	0	0	0	0	0	0	0
The National	0	0	2	0	0	0	12	4	1	0	0	13	32
The New India	1	0	1	0	0	0	3	2	0	0	0	99	106
The Oriental	0	0	0	0	0	0	4	2	0	0	0	13	19
The United-India	0	0	0	0	0	1	4	8	2	0	0	69	84
Universal Sompo Gen.	0	0	0	0	0	0	0	0	1	0	0	0	1
Total	1	0	6	0	0	1	39	20	4	0	0	205	276

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE YEAR 2013-2014.

STATEMENT L 7G7
LIFE INSURANCE & GENERAL INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL
	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	729	27	282	2	32	1072	615	114	0	1	0	730	1802
BHOPAL	156	14	94	5	10	279	127	146	25	49	7	354	633
BUBANESWAR	9	1	256	33	7	306	162	6	1	80	0	249	555
CHANDIGARH	171	55	1396	6	12	1640	217	1827	23	183	7	2257	3897
CHENNAI	1081	33	400	0	11	1525	248	0	0	1	1	250	1775
DELHI	725	497	1688	26	219	3155	469	653	6	16	20	1164	4319
GUWAHATI	1	3	149	1	0	154	123	44	13	61	6	247	401
HYDERABAD	626	29	501	5	16	1177	456	1	18	17	1	493	1670
KOCHI	183	6	272	0	0	461	487	119	7	5	1	619	1080
KOLKATA	702	69	909	45	14	1739	427	757	15	143	21	1363	3102
LUCKNOW	407	5	738	20	63	1233	190	424	0	101	4	719	1952
MUMBAI	806	245	2370	1	26	3448	1608	13	2	41	17	1681	5129
Total	5596	984	9055	144	410	16189	5129	4104	110	698	85	10126	26315

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE YEAR 2013-2014.

STATEMENT L 8
LIFE INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL
	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*	A+B
AHMEDABAD	407	16	86	1	15	525	139	114	0	0	0	253	778
BHOPAL	131	7	57	0	4	199	51	145	24	11	7	238	437
BUBANESWAR	1	1	196	6	5	209	93	5	1	56	0	155	364
CHANDIGARH	109	33	1050	1	12	1205	24	1814	12	97	4	1951	3156
CHENNAI	1011	0	0	0	0	1011	67	0	0	1	1	69	1080
DELHI	552	416	1201	25	201	2395	98	650	6	2	19	775	3170
GUWAHATI	1	3	123	1	0	128	70	40	12	30	6	158	286
HYDERABAD	534	19	292	1	4	850	195	0	18	12	1	226	1076
KOCHI	135	3	205	0	0	343	258	111	3	2	0	374	717
KOLKATA	613	63	514	42	3	1235	150	749	15	96	15	1025	2260
LUCKNOW	403	3	641	19	62	1128	98	423	0	38	4	563	1691
MUMBAI	401	186	1785	0	0	2372	115	2	0	6	2	125	2497
Total	4298	750	6150	96	306	11600	1358	4053	91	351	59	5912	17512

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE YEAR 2013-2014.

STATEMENT G 8
GENERAL INSURANCE

NAME OF THE CENTRE	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL
	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*	A+B
AHMEDABAD	322	11	196	1	17	547	476	0	0	1	0	477	1024
BHOPAL	25	7	37	5	6	80	76	1	1	38	0	116	196
BUBANESWAR	8	0	60	27	2	97	69	1	0	24	0	94	191
CHANDIGARH	62	22	346	5	0	435	193	13	11	86	3	306	741
CHENNAI	70	33	400	0	11	514	181	0	0	0	0	181	695
DELHI	173	81	487	1	18	760	371	3	0	14	1	389	1149
GUWAHATI	0	0	26	0	0	26	53	4	1	31	0	89	115
HYDERABAD	92	10	209	4	12	327	261	1	0	5	0	267	594
KOCHI	48	3	67	0	0	118	229	8	4	3	1	245	363
KOLKATA	89	6	395	3	11	504	277	8	0	47	6	338	842
LUCKNOW	4	2	97	1	1	105	92	1	0	63	0	156	261
MUMBAI	405	59	585	1	26	1076	1493	11	2	35	15	1556	2632
Total	1298	234	2905	48	104	4589	3771	51	19	347	26	4214	8803

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR 2013-2014.

STATEMENT L 9
LIFE INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL
	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 payabl 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	TOTAL A+B
Aegon Religare Life Ins.Co.L	57	18	129	0	7	211	26	176	0	0	5	207	418
Aviva Life	128	22	146	2	20	318	22	135	2	7	2	168	486
Bajaj-Allianz Life	208	31	291	5	17	552	131	108	11	6	4	260	812
BHARTI AXA LIFE	90	25	145	4	4	268	22	121	3	3	3	152	420
Birla-Sun Life	288	65	556	5	20	934	77	629	7	9	11	733	1667
Canara HSBC Oriental Bank	21	2	15	1	0	39	2	9	1	1	0	13	52
DLF Pramerica Life Ins.Co.L	14	9	68	2	4	97	6	120	0	3	0	129	226
Edelweiss Tokio LIC Co.	1	0	7	0	0	8	2	2	0	1	0	5	13
Future Generali	36	6	81	0	5	128	16	36	0	2	1	55	183
HDFC-Standard Life	536	140	1061	10	51	1798	73	755	11	7	7	853	2651
ICICI-Prudential	320	57	472	4	40	893	77	321	5	5	1	409	1302
IDBI Federal Life Ins.Co.Ltd	30	9	28	0	2	69	10	42	0	0	1	53	122
IndiaFirst Life Insurance Co.	25	2	15	1	0	43	10	3	0	2	0	15	58
ING-Vysya	86	11	85	1	3	186	18	59	0	1	0	78	264
Kotak Mahindra-OM	132	32	184	6	16	370	23	218	3	8	3	255	625
LIC of India	1328	110	1268	28	59	2793	574	170	26	259	11	1040	3833
Max-Newyork Life	190	28	213	8	13	452	25	141	1	7	0	174	626
Met-Life	87	7	132	0	9	235	22	120	2	1	3	148	383
RELIANCE LIFE	252	80	755	6	21	1114	58	570	8	8	4	648	1762
SAHARA India Life	2	0	0	0	0	2	0	1	0	0	0	1	3
SBI LIFE	254	59	305	9	7	634	97	176	7	13	1	294	928
SHRIRAM LIFE	45	10	31	0	3	89	6	42	1	2	1	52	141
Star Union Dai-ichi Life Ins.	16	5	19	1	1	42	3	7	0	0	0	10	52
TATA AIG LIFE	152	22	144	3	4	325	58	92	3	6	1	160	485
Total	4298	750	6150	96	306	11600	1358	4053	91	351	59	5912	17512

Total column of A, B and A+B are FORMULA DRIVEN

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
NATURE WISE CLASSIFICATION OF COMPLAINTS RECEIVED FOR THE YEAR 2013-2014.

STATEMENT G 9
GENERAL INSURANCE

NAME OF THE INSURER	NON ENTERTAINABLE						ENTERTAINABLE						TOTAL
	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	TOTAL A+B
Agriculture Ins. Co.	14	0	0	0	0	14	1	0	0	0	0	1	15
Apollo Munich	30	3	63	0	0	96	64	1	1	5	0	71	167
Bajaj-Allianz General	43	9	84	1	1	138	80	0	0	16	0	96	234
BharatiAXA Gen.Ins.	14	9	38	0	0	61	35	0	0	5	1	41	102
CHNHB Associates	0	0	0	0	0	0	0	0	0	0	0	0	0
Cholamandalam	6	4	16	1	0	27	15	0	0	6	0	21	48
ECGC	2	0	0	0	0	2	1	0	0	0	0	1	3
Future Generali Gen.	10	0	18	0	0	28	17	1	1	2	0	21	49
HDFC ERGO Gen.Ins.	28	10	44	0	1	83	59	3	0	4	1	67	150
ICICI-Lombard	121	23	195	3	5	347	159	8	1	15	0	183	530
IFFCO TOKIO	14	3	36	0	1	54	32	0	1	4	0	37	91
L & T General	3	0	3	1	0	7	2	0	0	0	1	3	10
LIBFETY VIDEOCON	2	0	1	0	0	3	0	0	0	0	0	0	3
MAGMA HID	0	0	1	0	0	1	0	0	0	0	0	0	1
MAX BUPA	42	11	95	0	0	148	69	1	2	2	1	75	223
Raheja QBE Gen.Ins.	0	0	0	0	0	0	0	0	0	0	0	0	0
Reliance General	47	11	88	4	5	155	90	0	0	17	3	110	265
Religare Health Ins.	6	0	8	0	0	14	5	0	1	0	0	6	20
Royal-Sundaram	25	5	63	2	0	95	53	5	1	2	0	61	156
SBI General	10	2	19	0	0	31	10	3	0	1	0	14	45
Shriram Gen.Ins.Co.Ltd	3	1	27	1	2	34	21	0	0	10	0	31	65
Star Health & Allied In	55	16	210	2	5	288	261	2	0	10	2	275	563
TATA-AIG General	44	7	87	0	0	138	40	3	0	3	2	48	186
The National	165	32	428	15	19	659	442	6	1	76	5	530	1189
The New India	248	38	572	6	25	889	976	7	2	74	4	1063	1952
The Oriental	145	24	336	6	16	527	529	5	5	50	2	591	1118
The United-India	213	26	456	6	24	725	791	6	3	44	4	848	1573
Universal Sompo Gen.	8	0	17	0	0	25	19	0	0	1	0	20	45
Total	1298	234	2905	48	104	4589	3771	51	19	347	26	4214	8803

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

==========

LIFE & GENERAL INSURANCE:

- **Contact Details 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. The insurer should , therefore, 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.

- **Proper submission of Self Contained Notes with supporting documents**

  The Self Contained Note is a summary of the case, supplemented with relevant documents, on the basis of which action is taken by the insurer. The SCN helps in knowing why the insurer is justified in taking a particular decision. The SCN is an important document which also allows the insurer to defend the case giving detailed reasons for repudiation of claim etc. The SCN with para-wise comments and supporting documents, submitted well in advance of hearing helps the Insurance Ombudsman to have a clear understanding of the case and issue proper order. It is observed that in many cases the insurers do not submit the SCN with supporting documents in spite of repeated reminders. Non- submission of the same, at times, may infer that the insurer has nothing to represent in its defence.

- **INSURERS TO PRESENT CASES 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 the 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 and are not well aware of the facts of the case. It is advisable that officers who are well acquainted with the complaint should attend the hearing.

- **UPDATES ON PRODUCTS**

Insurance companies should furnish important circulars to Offices of the Insurance Ombudsman to keep them well informed of the changes in the Terms and Conditions of their products. This will help the Ombudsman to have latest updates and keep themselves abreast of changing rules and products.

- **DISPLAYING OF ADDRESS OF GRIEVANCE REDRESSAL OFFICER**

The public sector insurance companies incorporate the name and address 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 avail their basic servicing requirements like payment of renewal premium , redressal of grievances etc. Since the address of the Insurance Ombudsman is invariably given in the Policy Document, the policyholders directly approach the Office of Insurance Ombudsman instead of first referring the matter to the Grievance redressal cell of the company. This causes discomfort/ harassment to the complainant when he is advised by the Office of the Insurance Ombudsman to approach the Grievance Redressal Officer of the company first. The address of GRO should, therefore, be prominently displayed.

- **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 Corporate offices of the concerned insurers to enable the servicing branch to resolve the grievance(s) at their level.

- **NON- FURNISHING OF TERMS & CONDITIONS OF THE POLICY**

  The Terms & Conditions of the Policy are not attached to the Policy document while forwarding the same to the policy holder even though it is mentioned in policy document "**as per terms and conditions attached**" . The customer comes to know the terms and conditions when some grievance arises. It should be made mandatory to supply the terms and conditions of the policy along with Policy Bond/Cover Note. 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.

- **LEGIBILITY OF POLICY DOCUMENT**

  The complainants argue that the print fonts on the policy document provided by the insurance company are too small to be read . It is, therefore, suggested that the policy bond should be printed in such a manner that it can be read and understood by everybody easily. It should be precise and brief, highlighting all the important Terms & Conditions.

- **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 the English language. The insurers should make earnest efforts to obtain the proposal forms in 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 proposal is minimized. Likewise, 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. The insured should be educated to personally fill up the proposal form and avoid misrepresentation of facts which may lead to repudiation of claims.

- **NON IMPLEMENTATION/DELAY IN IMPLEMENTATION OF AWARDS**

Some of the offices of the insurers do not act promptly on the Awards passed by the Insurance Ombudsman against them which causes serious embarrassment when replying to the complainants who report about non- receipt of Award money.. 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.

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. Amendment to RPG Rules to make penal provisions for non compliance of Award is a necessity.

- **APPROPRIATE REASONS TO BE GIVEN FOR REPUDIATION OF CLAIMS.**

Repudiation of claims should be conveyed properly to the complainant along with the 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 to understand the position better, and will also help in avoiding unnecessary appeals and complaints.

- **EMPOWERMENT FOR GRANT OF EX-GRATIA**

The Institution of Insurance Ombudsman plays a very effective role in redressing the public grievances within its sphere. Considering the fact that a large number of complaints come from lower strata of society, the Ombudsman can be empowered to grant an ex-gratia towards expenses in deserving cases where the complaints are dismissed.

- **OPTION OF ACCEPTANCE OF TERMS & CONDITIONS**

As per column 6(2) IRDA Protection of Policyholders Interests Regulation 2002, the life insurer should inform by letter that the policyholder has a period of 15 days either to change the terms and conditions of policy or return the policy if the insurer disagrees to such terms and conditions. Some insurers are not reflecting the said option in the face of the said forwarding letter.

- **BOGUS CLAIMS:**

  Attempts to get wrongful claims and encouraged by inadequate investigation mechanism of the insurer are coming to light. A few cases have been successfully thwarted while in some of the cases the companies had to pay due to lack of evidence. Such claims getting cleared by the system resulting into leakages should be thoroughly looked into.

SUGGESTIONS PERTAINING TO LIFE INSURANCE:

- **EVIDENCE OF PRIOR MEDICAL HISTORY**

  Most of the complaints relate to repudiation of death claims. The insurers are prone to reject claims based upon the past 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 have cogent evidence of prior medical history.

- **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.

- **PROPER DELIVERY OF POLICY DOCUMENTS**

  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. The Insurer should develop a fool proof system to ensure that that the documents are

delivered in time to the right person and the policy holders, in genuine cases, can avail the facility of free look option.

- **REFUND OF FUND VALUE IN RESPECT OF DEATH CLAIM:**

ULIP polices serve the twin objectives of investment return and life risk cover. All Unit linked polices are different from traditional insurance policies and are subject to different risk factors. Under these polices 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.

- **BENEFIT ILLUSTRATIONS**

Benefit illustrations should be quantum wise and not in percentage as is the practice now.

- **ENFORCEMENT OF ETHICAL DISCIPLINE**

Private Life Insurance companies should give more thrust on vigorous training of Agents/ intermediaries. Ethical discipline should also be enforced ruthlessly. Erring sales persons should be punished.

- **MIS-SELLING OF PRODUCTS**

Misselling by intermediaries is rampant in sales through alternate channels and particularly by the banks and brokers by promising exorbitant returns, loans with zero percent interest, hiding information about the charges, canvassing single premium policies and selling long term. Because of implicit trust in the banks, the customers do not bother to critically examine the fine prints and have been duped in many cases. It is surprising to note that the companies have accepted proposals

where renewal premiums are much higher than the income of the proposer and concept of KYC and proper financial underwriting were given a go by.

- **DUBIOUS BENEFIT ILLUSTRATIONS**

  Cases have been reported where policyholders were sold long term policy for 15 years and the benefit illustration in the policy bonds indicate that benefits are drastically reduced after 13 years and the maturity/death benefits in 14th/ 15th years are practically nil or minimal. The fonts used in the policy bond are too small to be deciphered even by the Company representatives. The point is whether designing/approval and/or marketing of such products are appropriate?

- **CHECKS & CONTROLS ON CHARGES LEVIED**

  Although the insurance regulator has standardised Premium Allocation charge/Policy Administration charges now, the policies sold earlier are subject to excessive charges and the correct information about the charges were not divulged to policyholders at the time of purchase. No checks and controls about the correctness of the charges levied are shared. There are cases where Policyholders were kept in dark about 35% charge levied during the first year by both the insurance company as well as the bank which sold a policy to a retired person where the first premium was equivalent to the retirement benefits received by him.

- **HOME LOAN POLICIES:**

  Banks/housing finance companies have been selling policies packaged with home loans. No detailed proposal forms are called for and only minimal information about the policy is shared. Mortgage Redemption Policies under Single Premium mode were sold and the premium is deducted from the loan amount. Normally the proposal forms and answers are filled up by the finance company and medical conditions are kept relaxed so that there is no hitch in selling policies even at advanced ages. The catch here is unless they take the policy, loan is not sanctioned and if they declare true state of health the policy cannot be given. In many such cases claims have been denied because of alleged wrong statement about health

conditions by the policyholder. **There is a strong case of delinking the policy from the home loan so that the conditions are not manipulated by either of the parties.**

- MANIPULATION OF DOCUMENTS

  In a few incidences, the insurance company has declined claims based on the reports from their investigators on the grounds of life assured not divulging the information about hospital treatment prior to taking the policy. However on examination of two such cases, it was observed that the investigator manipulated the documents and created false hospital records from non-existent hospitals to help the company in declining the claims. On intervention, the Company decided to settle the cases and terminate the investigator . Hence, it is necessary that **the Company examines all the cases declined on the basis of at least the particular investigator's reports.**

SUGGESTIONS PERTAINING TO GENERAL INSURANCE:

- JOINT SURVEY REPORTS TO BE MADE MANDATORY

  The surveyors are authorized by the regulator and they have to conform to certain standards. On many occasions the surveyors display lack of standards and independence by giving one sided reports to favor the company and are not able to instill the confidence in the minds of the customer as to the fairness of their opinion. Joint survey reports should be made mandatory to allow the policy holders to reflect their points of view. The companies should take decisions on the basis of joint survey only.

MEDICLAIM

Around 85% of the claims under Non-Life segment are related to Mediclaim.

- REVIEW OF CLAIMS REJECTED BY TPA, BY INSURER:

  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 and not by the insurer without the clear reasons for repudiation of the claim. It is also found that the TPA simply mentions the clause

number of the policy for repudiation. Many of the complainants who come to Office of the Insurance Ombudsman 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 necessary 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 . Suitable instructions should be issued by the higher authorities of the public sector companies to all its offices. IRDA Regulations are clear on the subject. 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.

- **IMPROVEMENT IN TRANSPARENCY OF POLICY CONDITIONS**

Certain terms in the policy documents are found non-transparent and are interpreted in favour of the Companies. One of the areas of disputes is proportionate deduction of various expenses like Surgeon's fee; Anesthetist fee; OT Charges, various investigation charges. There are very few hospitals where these variable charges exist as per room rent. But this is done at random by deducting proportionately even for the hospital where there are no variable charges. This aspect needs to be examined.

- **PAYMENTS TO SURGEON OUTSIDE THE MAIN HOSPITAL**

Payment to the surgeon outside the main hospital: Many reputed hospitals in Mumbai avail the services of Super Specialist surgeons/physicians for treatment of certain critical illness /procedures and such doctor's charges are not included in the bills of the hospital and are raised separately by such doctors. Whereas some companies allow for certain percentages of such bills, most of the companies do not allow such bill and as a result even the genuine expenses of the policyholders are not

paid. Where no fraud is suspected and insured is able to provide proper receipt and the proof of payment through cheque/ bank statement; there should not be any reason for denial of the same.

- **TECHNOLOGICAL ADVANCEMENTS**

  The approach of the insurance companies, most of the time, appears to be mechanical/technical rather than practical. Mandatory 24 hours hospitalization may not be necessary in the present day due to advanced medical technology. Policy conditions need review at regular interval to ensure matching with advanced medical technology. Most of the general insurance companies provide only schedule of the policy without terms and conditions to the insuring public and the policyholder is not made aware of the various terms and conditions of the policy and they come to know only when their claims are repudiated.

- **PRE-EXISTING DISEASES SHOULD BE SPECIFIED ON THE POLICY SCHEDULE:**

  One of the grounds for repudiation of Mediclaim is pre-existing diseases. It differs from one company to another company. 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. A uniform criteria should be adopted by all insurance companies in this regard.

- **LIMITS FOR SURGERY**

  Many insurance companies have authorized some hospitals as Preferred Provider Network (PPN) hospitals. At the time when a policyholder goes for a planned treatment with proper information to the insurer they are not advised to use the services of these hospitals and neither there are restrictions in availing the services of any other hospitals nor the policy holder is informed about the actual eligibility. In case of emergency, there may not be any scope of going to PPN hospitals at all. The policy documents do not specify the rates that will be applicable in case of taking treatment from other places and often the PPN hospitals do not honor their pre-

decided rates with the companies. **It is necessary that the customer should be given clear information about the eligibility whenever need arises.**

- **CATARACT TREATMENT**

A number of complaints received for Cataract Treatment is due to the difference in quantum to be paid among the PSU Companies. There is also no mention in the policy conditions regarding the type of lens to be allowed in settlement of claim. There should be a clear mention about the fixed amount for lens. The Insurer may mention certain percentage of sum insured for the eligibility of amount for lens in the policy conditions clearly.

- **AGE RELATED MACULAR DEGENERATION**

A large number of complaints involving Age Related Macular Degeneration(ARMD) are received. However, with the introduction of specific exclusions of ARMD, these complaints have been reduced. This treatment is very costly and does not require 24 hours hospitalization. Due to advancement in technology, though this disease may not require 24 hours hospitalization it can be included after specified waiting periods.

- **GROUP MEDICLAIM POLICY:**

Cases have come to light where companies have insured groups highly heterogeneous in nature. There is neither any established linkage amongst the members nor are they bound by any agreement. Definite patterns in the claims from these groups are noticed and these have been brought to the notice of the Insurers . Companies should safeguard themselves as these groups are siphoning public money in a planned manner. These groups have been continuously shifting from one insurer to another and it is most surprising that in spite of having complete knowledge about the composition and claim pattern, the companies are accepting these groups. It is also observed that huge amounts in excess of premium are collected from the group members with the assurance of getting the money back with profits through claims. **Stricter underwriting norms should be put in place to stop such organised frauds.**

- **FRAUDS**

A few cases of attempted fraud mostly from Mediclaim had come to light. It is observed that some hospitals are players in the racket and all the Insurance companies are affected. It may be appropriate to share the facts amongst the insurers and black list these hospitals to avoid losses and also protect genuine policyholders when they approach the TPAs. It is also necessary to popularise the concept of PPN hospitals and to create proper investigation machinery. Because of delayed action by the TPA sometimes evidences disappear and the Companies are not able to prove their point. Similar is the situation in Motor cases where inadequate investigation leads to wrongful denial or settlement. The following suggestions be examined to control the incidence of fraud in General Insurance:

- Have a common portal like CIBIL for sharing fraudulent claim data.
- Pursuits of civil litigation or complaint with the appropriate authorities against those involved in fraud and close cooperation with law enforcing agency.
- Seek the help of voluntary organizations / NGOs.
- Make widespread publicity to increase public awareness regarding hospital frauds.
- Appoint quality investigators like doctors or ex-police officials who have the knack and tact to get to the depth of the case.

MOTOR INSURANCE

- **COPY OF SURVEY REPORT TO BE MADE AVAILABLE TO INSURED**

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 times does 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. 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.

- **ROLE OF SURVEYORS**

  The surveyors are authorized by the regulator and they have to conform to certain standards. On many occasions the surveyors display lack of standards and independence by giving one sided reports to favor the company and are not able to instill the confidence in the minds of the customer as to the fairness of their opinion. Joint survey reports may be made mandatory to allow the policy holders to reflect their points of view. The companies should take decisions on the basis of joint survey only.

- **MODE OF SETTLEMENT**

  Complaints are mostly disputes related to the method of settlement whether on Total Loss or Constructive Total Loss basis. Motor Tariff prescribed settlement of Construction Total Loss when the repair cost of a vehicle exceeds 75% of the IDV (value of the vehicle), but this is not mentioned in the policy conditions. The Insurer also does not write their settlement clearly to the Insured that this 75% is to be calculated after applying policy excess. Copy of survey report is not handed over to the insured at the time assessment and as a result, the insured also remains unaware about the settlement method which ultimately land as disputes with the Insurer.

REPORTS OF THE

OFFICES OF THE INSURANCE OMBUDSMEN

An edited version citing important issues dealt at various Offices of the Insurance Ombudsman Centres is given hereunder:

AHMEDABAD

FROM THE DESK OF THE INSURANCE OMBUDSMAN.

The 11th Annual Report of the Office of Insurance Ombudsman, Ahmedabad , for the State of Gujarat, and Union Territories of Dadra &Nagar Haveli and Daman and Diu for the year 2013-14 is submitted 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.

Annual review of the quality of services rendered by Insurers:

1. Around two-thirds of the complaints received have been from Non-life sector particularly Mediclaim Insurance Policyholders. The major areas of complaints are Policy clause of mediclaim Policy - Reasonable, Customary and Necessary expenses are reimbursable, Surgeon's charges etc. payable linked to the entitled "Room Category, Policy terms and conditions not provided with policy schedule and TPA's decisions are not reviewed by the Insurance companies. Steps need to be taken to curtail the trend.
2. The major area of complaint in respect of Life Insurance Policies relate to Mis-selling of Life Insurance Policies.
3. Majority of the complaints arose due to the lack of awareness of the Policyholders about the Policy Terms and conditions .
4. The policyholders still continue to rely upon the advice of their Agents and / or intermediaries. Hence it is imperative to improve the quality of the agents and / or intermediaries and their accountability.

Recommendations to improve these services:-

1. Create awareness amongst policy holders about the Terms & Conditions of the Policy, the difference between Insurance Policy and an Investment Product. Insurance companies should arrange at least one meeting in a year at Branch Level exclusively for its policyholders to create awareness and be more transparent

2. Since the policyholders rely upon the advise of their Agents/Intermediaries/Consultants, it is imperative to improve the quality of agents/intermediaries and also make them accountable.

AUDIT AND ACCOUNTS

M/s Manubhai & Shah, Chartered Accountants, Ahmedabad, had been appointed as Auditors for the year 2013-14. The Audited Accounts for the year ending 31st March, 2014, 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.

***

BHOPAL

FROM THE DESK OF THE INSURANCE OMBUDSMAN.

The Annual Report and Statements of the Office of Insurance Ombudsman, Bhopal , for the year 2013-1 4, having territorial jurisdiction over the insuring public of two states namely Madhya Pradesh and Chattisgarh was submitted in compliance with Rule 20 of the Redressal of Public Grievance Rules, 1998.

OBSERVATIONS ON LIFE & GENERAL COMPLAINTS

1. A major cause of customer dissonance towards insurers and insurance is the fact that claims do get rejected for one reason or the other.
2. Settlement of claims for amounts lesser than the actual entitlement is also equally serious and needs to be treated at par with total repudiation.
3. There is a phenomenal increase in the number of mis-selling complaints. The perception of the product created in the mind of the policyholder at the point of sale plays a crucial role in building the expectations at the time of claim. Hence, from a customer's point of view, it is extremely essential to be clear on several aspects of the product and post sale service at the point of sale itself. It is unfortunate that insurance companies instead of taking corrective/punitive action against erring agents/intermediaries try to defend them and their company.
4. Under non-life category, Mediclaim complaints occupies a dominant position. Here, the approach of the insurance companies, most of the time, appears to be mechanical/technical rather than practical. Mandatory 24 hours hospitalisation which is not necessary in the present scenario due to advanced medical technology. Policy conditions need review at regular interval to ensure matching with advanced medical technology. Most of the general insurance companies provide only schedule of the policy without terms and conditions to the insuring public and the policyholder is not made aware of the various terms and conditions of the policy and the policyholders come to know these conditions when their claims are repudiated.

5. The Life and General Insurance Companies are not submitting certified copies of the proposal form, policy document with the terms and conditions, investigator reports, survey reports etc. The plea of the private insurers is that all the original documents are in their centralised office and they are unable to produce the same.
6. In view of the galloping number of complaints, distances, commuting time and expenses of the complainant and the respondent, Video conferencing should be introduced which will help to reduce the time lag, be cost effective and convenient to all uses

AUDIT AND ACCOUNTS

M/s R.Shah & Co., Chartered Accountants, Bhopal , had been appointed as Auditors for the year 2013-14. The Audited Accounts for the year ending 31st March, 2014, 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.

***

BHUBANESHWAR

FROM THE DESK OF THE INSURANCE OMBUDSMAN.

Rule 20 of the Redressal of Public Grievances Rules, 1998 mandates that the Ombudsman shall furnish an Annual Report containing general review of the activities of the office of the Insurance Ombudsman during the preceding financial year to the Central Govt. This Annual Report is presented accordingly. The office of the Insurance Ombudsman, Bhubaneshwar was lying vacant from December, 2013 to July, 2014. It is true that the vacancy of the office for a period of about 8 months has given rise to substantial increase in pendency of the complaints thereby tracing an extra burden on the office. This situation demands extra efforts and all efforts would be made to clear the backlog on a priority basis.

The office of the Insurance Ombudsman, Bhubaneshwar has a territorial jurisdiction over all insurance offices in the State of Odisha .

OBSERVATIONS & SUGGESTIONS

1. Late or non-submission of Self Contained Notes. Timely decisions are not possible.
2. Delay in settlement of claims one of the major reasons for complaints. Reasons for delay should be probed and necessary steps be taken to reduce delays.
3. Under Non-life, a number of cases are repudiated without assigning any reason or reasons are not explained. Sometimes the policy holder has no intimation of repudiation but the insurer shows records of despatch of the intimation.
4. Policies are issued without the Terms and Conditions of the Policy.
5. It is advisable that officers well acquainted with the complaint should attend hearings.
6. The insured should be educated to personally fill up the proposal form and avoid misrepresentation of facts which may lead to repudiation of claims.
7. Repudiation of claim in policies sold on wrong lives of poor and illiterate people with disease – Action on agents required.
8. As per column 6(2) IRDA Protection of Policyholders Interests Regulation 2002, the life insurer should inform by letter that the policyholder has a period of 15 days either to change the terms and conditions of policy or return the policy if the insurer

disagrees to such terms and conditions. Some insurers are not reflecting the said option in the face of the said forwarding letter.

9. Mediclaim proposals must mention the names of diseases of common suffering so that the insured can tick the diseases suffered.
10. Insurers must exercise due control over the TPAs and coordinate their activities in regard to settlement of claim. TPAs decision should not be final and should be reviewed by the insurer to arrive at a judicious decision.

AUDIT AND ACCOUNTS:

The audit was conducted by Patro & Co., Chartered Accountants, who were appointed as the auditors during the year. The accounts for the financial year 2013-14 were finalized without any adverse comments from the Auditors.

***

CHANDIGARH

FROM THE DESK OF THE INSURANCE OMBUDSMAN

The Annual Report of Office of Insurance Ombudsman Chandigarh for a financial year 2013-14 is presented as per Rule 20 of Redressal of Public Grievances Rules 1998.

During the year, there has been a steady increase in number of incoming complaints which is also keeping pace with their disposal. As a matter of fact, prompt decisions on pending cases has left an indelible mark. Obviously, a quick/efficient consideration of pending complaints did propagate an interest/awareness amongst the insured public to seek cost effective redressal mechanism. Consequently, a steady benchmark was set in motion to list at least 25-30 cases daily for a hearing which facilitated in clearing a sizeable number of complaints.

It would be worthwhile to clarify that presently an awareness amongst general public seems to be quite high as reflected by number of incoming complaints. Likewise, local print media is continuously highlighting/projecting a latest factual position/prevailing status of exhibition of cost effective/relatively hassle free justice.

During the year under review, a Seminar 'Policyholder Protection and Welfare' was held on 27.11.2013 held at Mumbai. There was an interaction with Senior Public/Private Sector Functionaries from Insurance field to reiterate a common goal of reduction of public grievance in a date bound manner. This opportunity was availed to highlight an important issue like enhancement of financial powers from ₹20 lakhs to ₹50 lakhs on the pattern of State Level Consumer Disputes Redressal Forum especially when Chandigarh Centre looks after 5 States of Punjab, Haryana, Himachal Pradesh, Jammu and Kashmir and Union Territory of Chandigarh.

Attaining excellence is dynamic in nature for which "Sky is the Limit", if one really wishes to contribute one's mite in furtherance of a core objective in mind. Naturally, there is a necessity to spread this resolution to each and every corner of the North-Western Region through a sustained publicity in media/portals of the company. In this context, a possibility has to be explored for modifications/amendments of Governing Body of Insurance Council Rules framed in 2000 in order to meet hopes, aspirations and expectations of public.

Last but not the least, our consistent hallmark for achieving professional excellence/ growth/development is through Proper Planning, Meticulous Monitoring and Rigorous Review.

OBSERVATIONS & SUGGESTIONS

1. Presentation by some insurers during the hearing leaves much to be desired. The representatives who come for hearings are sometime not familiar with the facts of the case. Often hearings have to be deferred due to non-production of documents. In some cases company representatives fail to turn up despite being duly informed in advance about the hearing which lead to ex-parte hearings.
2. Scope of the RPG Rules need to be clarified as complaints which are not admissible under the Rules are also received. These include complaints against poor servicing by agents and insurance companies, cases of frauds and cheating or mis-selling and general harassment by insurance officials. There is a need for periodical publicity by IRDA/GBIC/Insurance Industry clarifying the scope of RPG Rules. All insurers should display a board in their offices notifying the Ombudsman Scheme and address of Ombudsman's Office.
3. Insurance companies should furnish important circulars to Ombudsman Centres to keep them well informed of the changes in the Terms and Conditions of their products. This will help the Ombudsman Centres to have latest updates and keep them abreast of changing rules and products.
4. Interaction of Insurance Ombudsman and Officials of Ombudsman centres should be held periodically to ensure uniformity in interpretation and implementation of rules and better decision making.
5. It is observed that most of the representative of the insurers who attend the hearing are not inclined to settle the claim even when they find the contention of the

complainant are genuine and they stand on weak grounds. Hence Senior rank officials who have clear mandate from their company to settle the claim through conciliation should attend hearings.

AUDIT & ACCOUNTS

M/s. S. Tandon & Associates, 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 31.03.2014. The Final accounts duly signed by the Statutory Auditors for the financial year ending 31.03.2014 without any adverse remarks.

****

CHENNAI

FROM THE DESK OF THE INSURANCE OMBUDSMAN

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

Besides, publicity related activities were also taken up by the Office. A programme was organized by CARE a Micro Financial Institution which was attended by various insurers engaged in Micro Insurance and was addressed by the Insurance Ombudsman. Bishop Heber College, Trichy conducted a National Actuarial Summit on "Protection for Insured and the Insurer which was addressed by the Secretary, Insurance Ombudsman. An interface with representatives of various General Insurance Companies on various aspects for improving the quality of personal hearings as well as strict adherence to IRDA guidelines was also conducted.

OBSERVATIONS & RECOMMENDATIONS:

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.

1. The Insurers are advised to ensure that the policy documents issued to their customers contain the details such as the policy issuing office address and contact phone numbers in addition to toll free numbers for any queries and claim intimations etc.
2. The Insurers are advised to incorporate in their policy conditions about the requirement of exhausting the internal grievance redressal mechanism first, before approaching the Insurance Ombudsman. This will facilitate the customers to avail of the grievance redressal process without any loss of time. The details of

Grievance Redressal Mechanism should be highlighted in the terms and conditions of the Policy.

3. The Insurers are advised to ensure that while dealing with issuance of policies, claims, and handling of grievances, the relevant IRDA Regulations and the relevant Acts like MV Act etc are also taken into account appropriately while taking decisions.

4. We have received several complaints during the year 2013-14 for non settlement of claims due to delayed claim intimation, especially in case of Two wheeler theft claims. In this regard, the Insurer's attention is drawn to the IRDA Circular reference IRDA/HLTH/MISC/CIR/216/09/2011 dtd 20.9.2011 wherein the guidelines are specified for condoning the delay in genuine cases. The Insurers are therefore advised to process such claims keeping in mind the said guidelines issued by IRDA.

5. The Insurers are advised to ensure that the policyholders are informed in writing about the proposed changes to be effected in the policy conditions after obtaining IRDA's approval for the same, strictly as per the guidelines issued by IRDA. Likewise, customers should be properly informed of the "closure or withdrawal" of a product and the procedure as laid down by IRDA in this regard should be strictly followed.

6. All Officers in the policy issuing and claims Departments of the Insurers should be well educated about the IRDA guidelines in respect of all underwriting and claims aspects and also Grievance Redressal procedures.

7. The Regulation 4 (4) of the IRDA Protection of Policyholders Interest Regulations 2002 stipulates that the Insurer should furnish a copy of the proposal form or confirmation of the recorded information obtained orally from the proposer within a period of 15 days and incorporate such information in the cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded where the Insurer claims that the proposer suppressed any material information or any matter material to the grant of a cover. It is observed that many Insurers do not furnish the copy of the proposal form to the Insured as stipulated by IRDA. The Insurer's are advised to follow this guidelines strictly.

8. We have come across in some cases under Life Insurance segment, where declarations were made in the DGH Form at the time of revival duly witnessed by

the Agent. The Agents even after knowing about the illness of the Life Assured, arranged Revival of the policies thereby leading the Life Assured to believe that his/her claim shall be honoured without any problem. This is a violation of Regulations 3(2), 3(3), 3(4) & 3(5) of the PPI Regulations 2002. The Life Insurers are advised to take suitable remedial measures in the interest of the policyholders.

9. We observe that mediclaim policies issued by some General Insurers contain a clause relating to "reasonably & necessarily incurred expenses to be considered" for claim settlement. This clause has not been properly understood by many insured persons since the policy does not contain the definition for the words "reasonable" and "necessary" leading to disputes referred to the forum. The insurers are advised to ensure that these words are clearly explained in the policy conditions without any ambiguity.

10. The Insurers are also advised to mention the limits applicable in respect of certain medical treatments taken in the Network Hospitals under the PPN Package in the mediclaim policies.

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 Suri & Co, Chennai, who were appointed as the auditors during the year. The accounts for the financial year 2013-14 were finalised without any adverse comments from the Auditors.

***

DELHI

FROM THE DESK OF THE INSURANCE OMBUDSMAN

The Annual Report of the Office of Insurance Ombudsman, Delhi and Rajasthan, for the financial year 2013-2014 was presented in compliance with Rule 20 of the Redressal of Public Grievances Rules 1998. This Annual Report provides a true and fair picture of the activities of this centre during the year and records the changes in the office set up, trends and nature of the customer grievances, budget and accounting arrangement.

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 number of grievances related to mis-selling of policies.

Increased inflow of complaints is an indicator that there is growing awareness amongst the public about the functioning of the forum of Insurance Ombudsman. It is also a warning signal that Insurance companies should take pragmatic steps to improve their customer service. While many Companies have taken pro-active steps and created various consumer redressal mechanisms, some are still to respond to the complaints in a sensitized manner. Experience has shown that creating a responsible and accountable Agency force perhaps would be the best preventive measure

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. Moreover, when a grievance arises they directly approach the Office of Insurance Ombudsman (OIO), address of which is invariably given in Policy document / kit, instead of first referring the matter to the Grievance redressal cell of the company This causes discomfort/ harassment to the complainant when he is advised by the Office of the Insurance Ombudsman to approach the GRO of the company first . The address of GRO should , therefore, be prominently displayed.

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. It is 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. 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 has to be pointed out relates 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. The complainants argue that the print fonts on the policy document provided by the insurance company are too small to be read . It is, therefore, 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 precise and brief, highlighting the important Terms & Conditions.

AUDIT AND ACCOUNTS

Annual accounts of 2013-14 for this office were audited by Arun Singh & Co., New Delhi. The Auditors after examining the annual accounts submitted their report without any adverse comments.

***

GUWAHATI

FROM THE DESK OF THE INSURANCE OMBUDSMAN

This Annual Report presented in compliance with Rule 20 of the Redressal of Public Grievances Rules, 1998 reflects a brief resume of the activities and performance of the Office of the Insurance Ombudsman, Guwahati for the financial year 2013-14.

The Office of the Insurance Ombudsman, Guwahati has jurisdiction over the insuring public of Seven States of Assam, Meghalaya, Manipur, Arunachal Pradesh, Nagaland, Mizoram and Tripura in North Eastern India. Though the jurisdiction of the centre is over the Seven States, most of the complaints received are from the State of Assam both against Life and Non-life Insurance Companies. From all other states, the number of complaints received is negligible. During the financial year 2013-2014, no complaints were received from the States of Manipur and Mizoram against non-life sector. Only one and six complaints were received from the States of Mizoram and Manipur respectively from life sector during this financial year. No complaint was received from the state of Nagaland under life segment and only one complaint was received from non-life segment during the financial year 2013-2014. This may be due to lack of awareness of the policy holders regarding the Scheme or Ombudsman. Awareness programmes about Insurance Ombudsman should be taken up in these remote parts of the country'

While discharging duties as Insurance Ombudsman, it was 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 ponder over the matter seriously and take appropriate steps.

OBSERVATIONS AND SUGGESTIONS

1. The Self Contained Note is either not submitted or is received late from the Insurers. Timely submission of SCN supported by sustainable documents will help the Insurance Ombudsman to pass an order without any loss of time.
2. The Self Contained Notes submitted by most of the private insurers are elaborate in comparison with the Self Contained Notes submitted by other insurers.
3. Address of the Branch Offices or at least premium points where the policy holder may pay his premium should be mentioned in the policy bond. This is a problem in case of private insurers. Nowhere in the policy bond is there any mention of offices where premium can be paid or contact the concerned insurer for their services. The Insurers should give a serious thought to this aspect.
4. Copy of proposal form should be attached with policy document to minimize controversies between the parties.
5. Non-compliance / delay compliance of Award : Many Insurers do not comply with the order of the Ombudsman for a long time. They turn up only after continuous correspondence . This is not conducive. The insurers should ensure timely compliance of the awards .
6. Inclusion of disease : In Medical policies the list of diseases which are included should be specified on the schedule of the policy so that the Insured is aware of the coverage.
7. Policy document should be bi-lingual (English and regional language) so that policy holder can understand the terms and conditions of the policy. It should be made mandatory that policy Terms and Conditions should be included in the policy documents themselves so that insures cannot hide the Terms and Conditions of the policy.
8. The major area of concern for complaints in respect of Life Insurance policies relate to Miss-selling of policies. Nowadays most of the complaints are registered for miss - selling and all miss-selling cases have come from the private insurers. Therefore private Insurer's are requested to ponder over this matter and to take some suitable measurers in this respect.

AUDIT AND ACCOUNTS

The audit was conducted by M/s Debashis Mitra & Associates, Chartered Accountants, Guwahati, who were appointed as the auditors during the year. The accounts for the financial year 2013-14 were finalized without any adverse comments from the Auditors.

***

HYDERABAD

FROM THE DESK OF THE INSURANCE OMBUDSMAN

The fourteenth Annual Report of the Insurance Ombudsman for the financial year 2013-14 is furnished in accordance with Rule 20 of the Redressal of Public Grievances Rules, 1998. The jurusdication of the Office of the Insurance Ombudsman, Hyderabad covers the states of Andhra Pradesh, Karnataka and Yanam portion of the Union Territory of Pondicherry. The post of Ombudsman remained vacant from 1.4.2013 to 14.5.2013. The Institution of Insurance Ombudsman has been playing a very effective role in redressing the public grievances within its sphere. Considering the fact that a good chunk of the complaints come from lower strata of the Society, it is suggested that the Ombudsman be empowered to grant an ex-gratia towards expenses in deserving cases where the complaints are dismissed.

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. Hearings were also conducted at Centres like Visakhapatnam, Vijayawada and Rajahmundry for the convenience of the complainants from Mofussil locations in Andhra Pradesh. 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 is presently handling.

In non-life sector, the percentage of non-entertainable complaints is 42.68%. 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.

GENERAL SUGGESTIONS

(i) Most insurance companies have internal grievance redressal mechanism in place as required under IRDA (Protection of Policyholders' Interests) Regulations, 2002. 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 negates the very objective of the Institution of Ombudsman under the RPG Rules.

(ii) 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 minimised and also that the policy holder is clear about the terms and conditions of the policy. A contract which apparently is understood only by one party can always run into interpretational difficulties.

LIFE INSURANCE

Most of the complaints relate to repudiation of death claims. The insurers are prone to reject claims based upon the past 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 have cogent evidence of prior medical history.

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. Further, in some cases, the insurer depends on the TPA to present cases before the Ombudsman.

(iii) Quite often, the policy documents are issued by the Insurers without attaching the Terms and Conditions of the policy. This gives rise to serious grievances. The insurers must ensure that the policy document is issued along with the Terms and Conditions of the Policy.

(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 lodged complaints in writing and over telephone.

AUDIT AND ACCOUNTS:

The audit was conducted by Auditors M/s M. Anandam & Co., Chartered Accountants, Secunderabad, who were appointed as the Auditors during the year. There were no adverse comments from the Auditors on preparation and finalization of the Accounts for the financial year 2013-14.

***

KOCHI

Shri R. Jyothidranathan, Hon'ble Insurance Ombudsman , Kochi demitted office on 30th November, 2013. Shri P.K. Vijayakumar has been appointed as Insurance Ombudsman, Kochi. Shri Vijayakumar has taken over charge as Insurance Ombudsman, Kochi, on 14th July, 2014.

The 14th Annual Report of the Office of the Insurance Ombudsman, Kochi, for the financial year 2013-14, is submitted as per provision under Rule 20 of the RPG Rules 1998.

JURISDICTION

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.

AUDIT AND ACCOUNTS

M/s R Rajan Associates, Chartered Accountants, Coimbatore, had been appointed as our Auditors for the year 2013-14. The Audited Accounts for the year ending 31st March, 2013, along with Schedules were duly signed by the Auditors . There were no adverse comments in the Auditors' Report.

***

KOLKATA

The Office of Insurance Ombudsman, Kolkata, became operational from March 2000 with jurisdiction over West Bengal, Bihar, Jharkhand, Sikkim and Andaman & Nicobar Islands. A large number of insurance offices - both life and non-life – are located in this area, making it one of the highest complaints receiving Ombudsman Centres in the country during the year 2013-14.

OBSERVATIONS & SUGGESTIONS

Under Non Life segment, 85% grievances are from Mediclaim and 10% from Motor claim and rest from others.

MEDICLAIM GRIEVANCES:-

1. Improvement in transparency of policy conditions required:-

   Certain terms in the policy documents are found non-transparent and the interpretations are made in favour of the Companies. One of the disputes are proportionate deduction of various expenses like Surgeon's fee; Anesthetist fee; OT Charges, various investigation charges. There are very few hospitals where these variable charges exist as per room rent. But this is done at random by deducting proportionately even for the hospital where there is no variable charges. This aspect needs to be examined.

2. Doctor's/ Surgeon fee not included in the hospital bill.

   Some of the Insurers are disallowing doctor's/surgeon fee if raised separately and not included in the hospitalization bill. Hospitalization is an event and such expenses if incurred during the period of hospitalization should be treated as a part of hospitalization bill and should be allowed. Moreover, the general tendency on the part of the treating doctor/surgeon to hire O.T. of a hospital or nursing home. In such case, the doctor raises separate bill and the hospital raises separate bill. It is opined that the clause, does not mean for proportionate deduction but restricting the charges for the said heads applicable to entitled category if variable charging system does exist in the Hospital in relation to Room Charges.

3. PPN Hospital's Rate:-

The Insurance Companies have authorized some hospital as PPN Hospitals. They have also fixed charges for different kind of diseases. But this is not informed to the Policy holders nor are these charges mentioned in the policy conditions. When the policy holders are going for a planed treatment under intimation to the Insurer and/or TPA, they are not advised to use the services of PPN hospitals and their applicable rates. It is also a fact that these PPN hospitals are not always charging the pre-decided rates and in many cases, an undertaking is taken from the patient admitted that charges if any in excess of approved rates, will be borne by the Insured. In this way, these PPN Hospitals are charging higher amount than prescribed by the Insurers.

4. Cataract Treatment:-

A good number of complaints received by this forum for Cataract Treatment as there is difference in quantum to be paid among the PSU Companies. There is also no mention in the policy conditions regarding the type of lens to be allowed in settlement of claim. There should be a clear mention about the fixed amount for lens. The Insurer may mention certain percentage of sum insured for the eligibility of amount for lens in the policy conditions clearly.

5. ARMD Claims:-

There were good number of complaints involving Age Related Macular Degeneration(ARMD) claims. However, with the introduction of specific exclusions of ARMD, these complaints have been reduced. This treatment is very costly and does not require 24 hours hospitalization. It is, therefore, felt that that due to advancement in technology, though this disease may not require 24 hours hospitalization it can be included after specified waiting periods.

6. Claims for enhanced sum insured:-

A good number of complaints pertain to partial settlement without considering the enhanced sum insured. Some Insurers have not mentioned this method clearly in their policy conditions for which disputes arises.

MOTOR CLAIM GRIEVANCES:-

1. Complaints are mostly disputes related to the method of settlement whether on Total Loss or Constructive Total Loss basis. Motor Tariff prescribed settlement of Construction Total Loss when the repair cost of a vehicle exceeds 75% of the IDV (value of the vehicle), but this is not mentioned in the policy conditions. The Insurer also does not write their settlement clearly to the Insured that this 75% is to be calculated after applying policy excess. Copy of survey report is not handed over to the insured at the time assessment and as a result, the insured is also remain unaware about the settlement method which ultimately landed with disputes with the Insurer.

2. Another aspect in motor claim settlement which resulted disputes under repair liability of accidental claim, is that the surveyor did not explain the reasons for disallowing certain parts clearly to the insured at the time of his assessment. The Companies have to take decisions on the fairness of the survey reports.

PERSONAL ACCIDENT GRIVANCES:-

Very few numbers of claims have been received b y this forum. However, claims are most related to loss of vision which is claimed as loss of sight as mentioned in the policy conditions of Personal Accident Policy. More clear definition of loss of partial or total loss sight is required to avoid disputes. The Insurance Companies may examine the matter.

The issue of "EXGRATIA AWARD" is contentious. The present RPG rules empowered the Ombudsman to pass ex-gratia awards. The Insurers have contested that it is not required. For general and life insurance claims in certain situations where the decisions can be taken either way to deny or to accept liability , Insurer always takes decisions in their favor. Such cases need to be looked into considering the background of whole issue. The Ombudsman should have power to pass ex-gratia awards in some of such deserving cases.

Mis-selling cases are rampant in the market particularly for Life Insurance product. Every authority concerned is aware of this menace. IRDA is seriously introducing certain measures. In all these mis-selling cases Blank Proposal Forms are signed by proposers and subsequently filled up by agents/Brokers. Hence, from legal point of views it is very difficult to prove that the product was mis-sold through false promises. Power of ex-gratia payment by Ombudsman may give some relief to the deserving proposers.

However, Ex-gratia awards may be restricted up to certain percentage of disputed amount or maximum liability under policy whichever is lower. There should be a re-look on these issues.

ACCOUNTS AND AUDIT

Annual accounts of 2013-14 for this office were audited by M/s SBA Associates., Chartered Accountants. The accounts for the year 2013-14 was audited and duly certified by the Auditors without any adverse remarks.

***

LUCKNOW

The Office of the Insurance Ombudsman, Lucknow was established in the year 1999 to cater to the state of Uttar Pradesh & Uttarakhand (which was carved out of the northern part of the state of Uttar Pradesh in the year 2000). The Annual Report pertaining to the financial year 2013- 14 has been submitted in compliance with Rule 20 of Redressal of Public Grievances Rules 1998 notified on 11.11.1998 by the Ministry of Finance, Government of India.

Shri G.B.Pande, Hon'ble Insurance Ombudsman, Lucknow, demitted office of the Insurance Ombudsman, Lucknow on 5th January, 2014.

AUDIT AND ACCOUNTS

The audit was conducted by Auditors M/s R.M. Lall & Co., Lucknow, who were appointed as the auditors during the year. The accounts for the financial year 2013-14 were finalized without any adverse comments from the Auditors.

***

MUMBAI

From the desk of the insurance ombudsman

It has been observed that growing awareness in the Indian market and creation of various consumer redressal mechanisms and steps initiated by the regulator have made it obligatory for the companies to address the issue of customer sensitivity seriously. While many Insurers have tried to respond to it proactively but still in many cases we observed that the customers were on the receiving side. It is seen that the number of complaints received by the centre is not in proportion to the market share of the companies and is more related to the business model in case of Life companies and control over TPA's and decision process in case of General Ins. companies. In fact, the share of complaints for a company as a ratio to the total complaints received by the centre is an indicator of the effectiveness of the grievance redressal machinery of the companies. As an example, the customer base of LIC is the highest but their complaint share is much lower in comparison to the market share.

Success of the forum, to a great extent depends upon the co-operation and support of the company in strengthening the mechanism, willingness to resolve at the Company level and build competency and empowerment at the decision making level . Agents, TPA's and Surveyor's have become significant contributors to the growing number of disputes. To facilitate mutual understanding, the number and level of interactions with the companies was increased and two separate meets with the Life and General Insurance Companies were arranged at Mumbai where valuable inputs from either side was exchanged and it has helped in reduction of grievances as marked improvements in the number of cases getting settled at the Company level without our specific intervention has been observed .

During the year the IRDA as well as the Companies have taken many initiatives which also resulted in improvement in the decisions taken by the companies . Nevertheless, there are areas where further improvements are still needed. There are areas where regulatory interventions may be necessary. With emphasis on giving the customers their rightful dues, some areas have been identified and are as listed below:

Functionality of grievance redressal machinery in the companies:

In spite of having the integrated grievance redressal mechanism in place, many a times the grievances are not attended within stipulated time and manner and often closed arbitrarily

without referring back to the customers. The forum has observed that in several cases the Insurance Companies do not send repudiation letters to the customers at all. The rejection letter from the TPA's is the only correspondence held by them. In many cases even after references have been made to the redressal machinery, the Companies did not bother to respond properly and treated the complaints as closed. As a result the effectiveness of the system is seriously compromised and status of the complaints are not correctly reflected in the IRDA's records. It has been observed that many companies instead of guiding their customers to approach inhouse grievance machinery are directing them to Ombudsman, thus short circuiting the whole system and intentionally reducing its effectiveness in a planned manner.

Common areas of grievances :

Life Business

i. **Misselling by intermediaries:** This is rampant in sales through alternate channels and particularly by the banks and brokers by promising exorbitant returns, loans with zero percent interest, hiding information about the charges, canvassing single premium policies and selling long term. Because of implicit trust in the banks, the customers do not bother to critically examine the fine prints and have been duped in many cases. What is surprising is that the companies have accepted proposals where renewal premiums are much higher than the income of the proposer and concept of KYC and proper financial underwriting were given a go by.

ii. **Dubious benefit Illustrations:** We have come across cases where policyholders were sold long term policy for 15 years and the benefit illustration in the policy bonds indicate that benefits are drastically reduced after 13 years and the maturity/death benefits in 14th/ 15th years are practically nil or minimal. The fonts used in the policy bond are too small to be deciphered even by the Company representatives. **The point is whether designing/approval and/or marketing of such products are appropriate?**

iii. **Premium Allocation charge/Policy Administration charge:** Although regulator has standardised these charges now, yet the policies sold earlier are subject to excessive

charges and the correct information about the charges were not divulged to policyholders at the time of purchase. No checks and controls about the correctness of the charges levied are shared. There are cases where Policyholders were kept in dark about 35% charge levied during the first year by both the insurance company as well as the bank which sold a policy to a retired person where the first premium was equivalent to the retirement benefits received by him.

iv. **Home Loan policies:** Banks/housing finance companies have been selling policies packaged with home loans. No detailed proposal forms are called for and only minimal information about the policy is shared. Mortgage Redemption Policies under Single Premium mode were sold and the premium is deducted from the loan amount. Normally the proposal forms and answers are filled up by the finance company and medical conditions are kept relaxed so that there is no hitch in selling policies even at advanced ages. The catch here is unless they take the policy, loan is not sanctioned and if they declare true state of health the policy cannot be given. In many such cases claims have been denied because of alleged wrong statement about health conditions by the policyholder. There is a strong case of delinking the policy from the home loan so that the conditions are not manipulated by either of the parties.

v. **Delay in issue of policy bonds**: Wherever there is delay in issue of policy bonds or there is no response from the companies, the policy holders are often at dilemma and quite often the companies have used it to deny free-look benefits. Moreover the Companies do not keep any evidence of delivery/receipt of the policy and as a result they are also in difficulty at some point of time. The process can be streamlined to minimise such incidences.

vi. **Role of investigator:** In a few incidences, the insurance company has declined claims on the basis of reports from their investigators on the grounds of life assured not divulging the information about hospital treatment prior to taking the policy. However when two such cases were examined, it was observed that the investigator manipulated the documents and created false hospital records from non-existent hospitals to help the company in declining the claims. When the forum intervened the Company decided to settle the cases and terminate the investigator but the forum

believes that it would be appropriate for the Company to examine all the cases declined on the basis of at least the particular investigator's reports.

General Insurance Business:

i. ***Non-transparent policy conditions***: The policy documents contain terms for which proper interpretations are not available in the policy document and as a result when the claim arises the companies interpret these to their advantage. It is necessary that policy document be made unambiguous and transparent. The terms and conditions attached to policy document do not bear Policy Number/Date, leading to several complaints. The company is also unable to categorically prove that the conditions were attached to the policy at the time of issue. The Companies must ensure that the conditions attached to the Policy are affixed with a rubber stamp with the Policy Number and Date duly signed to avoid any ambiguity.

ii. **Role of Surveyors:** The surveyors are authorized by the regulator and they have to conform to certain standards. On many occasions the surveyors display lack of standards and independence by giving one sided reports to favor the company and are not able to instill the confidence in the minds of the customer as to the fairness of their opinion. Joint survey reports may be made mandatory to allow the policy holders to reflect their points of view. The companies to take decisions on the basis of joint survey only.

iii. **Mediclaim cases**: Almost 90% of General Insurance complaints received here are Mediclaim cases. Few areas of dispute are as under :

a) ***Reasonability clause:*** Claims are often denied using this clause and the Customers are not informed why a particular expense is unreasonable. It is felt that this clause is to be used judiciously and in a highly restricted manner. Many of the companies also resort to proportionate reduction of various expenses like Surgeon's fee; OT charges etc. on the basis of room rent eligibility which is contrary to the policy conditions. This is done even for hospitals where there are no differential

rates on the basis of room rent etc and fairness of such reductions under reasonability clause against the policy conditions need to be examined.

b) **Limits for Surgery** - Many insurance companies have authorized some hospitals as PPN hospitals. At the time when a policyholder goes for a planned treatment with proper information to the insurer they are not advised to use the services of these hospitals and neither there are restrictions in availing the services of any other hospitals nor the policy holder is informed about the actual eligibility. In case of emergency, there may not be any scope of going to PPN hospitals at all. The policy documents do not specify the rates that will be applicable in case of taking treatment from other places and often the PPN hospitals do not honor their pre-decided rates with the companies. It is necessary that the customer should be given clear information about the eligibility whenever need arises.

c) **Cataract Treatment:** A lot of complaints are received relating to Cataract treatment because even within the PSU companies, one company mentions in the policy conditions that they will pay only ₹24000/- for surgery of one eye irrespective of Sum Assured whereas some others pay either a fixed percentage of Sum Assured or there is no capping. It is not understood why a policyholder with Sum Assured of ₹1 lakh and another with a Sum Assured of ₹10 lakhs be eligible for same amount of ₹24000/- while the second one pays ten times higher premium, which is not equitable.

Again there is no mention about the type of lens to be used in the policy document but while settling many companies refuse to pay the cost of multifocal lens citing internal circulars. The policy conditions should clearly mention the eligibility restrictions, if any and internal circulars cannot be cited as a basis of denying a policyholder's legitimate right as it is not part of the contract. It definitely calls for some uniformity in the benefit pattern and the policy conditions should have regulatory approval.

d) **Advancement in technology**: The policy conditions in health insurance need to be regularly updated because with the advancement in technology many surgical

procedures have undergone a sea change. Quite a few surgeries do no longer require 24 hours confinement because of use of very high and sophisticated equipments. If the policyholder is to be denied certain things, the exclusions and entitlement should be very clearly specified in the policy document and it needs to be updated from time to time.

e) ***Genetic disorders:*** The policy documents of a few company clearly excludes external genetic disorders and there are others where even the internal genetic disorder is excluded. We however feel that in those cases where the policyholder himself becomes aware of the genetic disorder after paying premium for 10 to 15 years, denial appears to be harsh as insurance contract is a contract of good faith and there is no fraudulent non-disclosure. It is felt that that in case of those products where "Internal Genetic disorder" is excluded it will be appropriate to cover such cases after certain period.

f) **Payment to the surgeon outside the main hospital:** Many reputed hospitals in Mumbai avail the services of Super Specialist surgeons/physicians for treatment of certain critical illness /procedures and such doctor's charges are not included in the bills of the hospital and are raised separately by such doctors. Whereas some companies allow for certain percentages of such bills, most of the companies do not allow such bill and as a result even the genuine expenses of the policyholders are not paid. **It is felt that that where no fraud is suspected and insured is able to provide proper receipt and the proof of payment through cheque/ bank statement; there should not be any reason for denial of the same.**

g) **Group Mediclaim policy:** Cases have come to light where the companies have insured groups highly heterogeneous in nature. There is neither any established linkage amongst the members nor are they bound by any agreement. Definite patterns in the claims from these groups are noticed and these have been brought to the notice of the Insurers . Companies should safeguard themselves as these groups are siphoning public money in a planned manner. These groups have been continuously shifting from one insurer to another and it is most surprising that in

spite of having complete knowledge about the composition and claim pattern, the companies are accepting these groups. It is also observed that huge amounts in excess of premium are collected from the group members with the assurance of getting the money back with profits through claims. Estimates show that the organisers of one such group have collected crores of Rupees over a small period. It is recommended that stricter underwriting norms should be used to stop such organised frauds.

h) **Bogus claims**: Attempts to get wrongful claims and which are encouraged by inadequate investigation mechanism with the Company are coming to light. A few cases have been successfully thwarted, in some of the cases the companies had to pay due to lack of evidence. It is apprehend that such claims are getting cleared by the system resulting into leakages.

i) **Frauds:**

It is observed that some hospitals are players in the on-going racket and all the Insurance companies are affected. It may be appropriate to share the facts amongst the insurers and black list these hospitals to avoid losses and also protect genuine policyholders when they approach the TPAs. It is also necessary to popularise the concept of PPN hospitals and to create proper investigation machinery. Because of delayed action by the TPA sometimes evidences disappear and the Companies are not able to prove their point. Similar is the situation in Motor cases where inadequate investigation leads to wrongful denial or settlement. It may therefore be examined whether following points may be considered to control the incidence of fraud in Gen Insurance:

- Have a common portal like CIBIL for sharing fraudulent claim data.
- Pursuits of civil litigation or complaint with the appropriate authorities against those involved in fraud and close cooperation with law enforcing agency.
- Seek the help of voluntary organizations / NGOs.
- Make widespread publicity to increase public awareness regarding hospital frauds.

- Appoint quality investigators like doctors or ex-police officials who have the knack and tact to get to the depth of the case.

Awards:

The forum received many reminders from complainants that in spite of clear instructions in the Award with regards to settlement by the Company, there is a delay in implementation of the Award. The undue delay on the part of the Companies defeats the purpose of the exercise and also causes dissatisfaction amongst the complainants.

AUDIT AND ACCOUNTS

The books of accounts and all transactions for the fiscal 2013-14 were audited by M/s Chaturvedi & Shah, Chartered Accountants, Mumbai. The audit was completed without any adverse qualifications.

***

Note