**MODULE 5**

**RISK MANAGEMENT ENVIRONMENT**

**Introduction**

**The purpose of risk management is to increase organizations capability to achieve objectives and help manage threats, adverse situations and take advantage of any opportunity that make increase that capability. The opportunities are identified through environmental aspects.**

Environmental Risks Management is a set of activities aiming to supervise and control an organization regarding environmental risk.

Environmental risk is the result of a function that links the probability of occurrence of a damage, or accident in a given scenario and the negative consequences on the natural, human and socioeconomic environment.

**Insurer**: The main purpose of an insurance policy is to provide financial compensation when the insurance customer suffers a loss.

The insurer is the company that pays out that compensation. They’re the company that designs the insurance policy and sets the terms of the agreement. The word “insurer” is usually interchangeable with “underwriter.” An insurance policy is a promise to reimburse the policyholder for a loss; insurers are responsible for fulfilling that promise.

Functions of insurer

Three Functions of Insurance

• Protect insured in case of loss – transfers risk from risk averse to risk neutral or less risk averse

• Risk Pooling or diversification – “the whole risk is smaller than the sum of its parts” Law of Large Numbers

• Risk Allocation – “insurers set a price that is proportional to the degree of risk posed by each insured”

A. Ratemaking - A rate "is the price per unit of insurance for each exposure unit, which is the unit of measurement used in insurance pricing".**Rate making** , is the determination of what rates, or premiums, to charge for insurance. A **rate** is the price per unit of insurance for each **exposure unit**, which is a unit of liability or property with similar characteristics.The **insurance premium** is the rate multiplied by the number of units of protection purchased.

**Insurance Premium = Rate × Number of Exposure Units Purchased**

Ratemaking Principle (CAS)

1. A rate is an estimate of the expected value of future costs.

2. A rate provides for all costs associated with the transfer of risk.

3. A rate provides for the costs associated with an individual ri ks t f rans er.

4. A rate is reasonable and not excessive, inadequate, or unfair disscriminatory

5. the rate structure should tend to encourage loss prevention among those who are insured.

Objectives of rate marketing

Rate making has several objectives under regulatory requirements regulated by the states and business objectives due to the goal of profitability: The goal of insurance regulation is to protect the public and three regulatory objectives are placed to meet certain standards:

* The first regulatory requirement is that rates must be adequate; meaning the rates the insurers charge should be able to cover expenses.
* The second regulatory requirement is that rates must not be excessive; meaning rates should not be so high that policyholders are paying more than the actual value of their protection.
* The third regulatory objective is the rates must not be unfairly discriminatory; meaning exposures that are similar with respect to losses and expenses should not be charged significantly different rates.

**Rate making methods**

In property and casualty insurance, there are three basic rate-making methods:

* Judgment Rating is used when the factors that determine potential losses are varied and cannot easily be quantified. There are no statistics regarding quantity of future losses and probability. This means an underwriter rates each exposure individually.
* The second rate making method is class rating, or manual rating. This rating means that exposures with similar characteristics are placed in the same underwriting class, and each is charged the same rate. The advantage of class rating lies with its easy application and ability to quickly be obtained.
* The third rate making method is merit rating. This rating means a plan which class rates, or manual rates are adjusted upward or downward based on individual loss experience. Merit rating is based on the assumption of loss experience will differ substantially from other loss experiences.

**Types of rating**

**1.class rating/manual rating: Class rating** is used when the factors causing losses can either be easily quantified or there are reliable statistics that can predict future losses. These rates are published in a manual, and so the class rating method is sometimes called a **manual rating**. The class is defined through statistical studies as a group with specific characteristics that reliably predict the insured losses of that group. A class rating must be applied to a rate class that is large enough to reliably forecast losses through statistical analysis but small enough to maintain homogeneity so that the premium covers the loss exposure and is competitive for each member of the class. A class rating is a grouping of people with similar risk profiles for the purpose of issuing them an insurance rate that roughly corresponds to their risk levels.

Class rates are the most common rate in insurance business. Insured risks are classified on the basis of one or several important features and all that belong to the same class are subject to the same rate per unit of exposure. The rate charged reflects the claims experience for the class as a whole. It is based on the assumption that future losses to insured will be determined largely by the same set of factors. This type of rating is also termed as manual rating because the various classifications and the respective rates are in the form of printing manuals. Life insurance is one of the line where class rates are used viz. rates based on age, gender, healthiness, smoking and drinking habits etc. Class rating is also used for homeowners insurance, automobile insurance, workers compensation and health insurance.

The class rate may be determined by dividing the amount of incurred losses and loss adjustment expenses by the number of exposure units. Incurred losses include all losses paid during the accounting period, plus amounts held as reserves for the future payment of losses that have already occurred during the same period. Loss adjustment expenses are the expenses incurred by the company in adjusting losses during the same accounting period.

2. individual rating: Individual ratings are used when many factors are used to predict the losses and those factors vary considerably among individuals. Additionally, individuals can exercise loss control measures that will reduce losses, so those individuals will pay a lower premium.

3. **Judgment ratings:**  are used when the factors that determine potential losses are varied and cannot easily be quantified. Because of the complexity of these factors, there are no statistics that can reliably assess the probability and quantity of future losses. Hence, an underwriter must evaluate each exposure individually, and use intuition based on past experience. This rating method is predominant in determining rates for ocean marine insurance, for instance.

4. Schedule rating: Under this plan, each exposure is individually rated. In calculation of schedule rates the first step is to examine the risk (the person or object insured) in order to identify the features that are likely to cause losses or to prevent them. Then the risk is compared with the average or standard risk of its type. Finally deductions are made from the standard rate, for this risk's desirable features and additions are made for its undesirable features, the resultant rate is rate that is tailored made to reflect the characteristics of risk for which it is used. The scheduled rating system (for a building) takes into account the following major factors :

• Occupancy

• Construction

• Location

• Protection

• Maintenance

The various additions to and subtractions from the basic rate are based upon the judgement of the person who develop the overall scheduled rating system and important feature of this system is that it identifies the factors entering into an Insurer's rate.

4. Experience rating:

This type of rating modifies the class rate on the basis of claim experience of a particular exposure. The actual losses for a period generally of two or three years are compared with the average risks in the same class. The rate is reduced if the risk has a better record than the average, it is increased if the record is worst than average. Experience rating is used only for large risks viz. large enough to have many losses each year reflecting a trend. Hence, this type of rating is generally limited to larger firms that generate a sufficiently high volume of premiums and more crEidible experience.

5. Retrospective rating

Contrary to experience rating retrospective rating modifies the insurance cost on the basis of current experience. This is generally done by making a provision in the policy contract that final rates will be determined retrospectively. Generally a range indication maximum and minimum is specified and the final premium is determined after the policy expires and depends upon the amount of losses incurred during the year. If the losses are very small the insured will pay the minimum premium otherwise if they are very large the insured will be charged the maximum premium. Usually the premium lies between maximum and minimum premium. Retrospective rating increases the insured's incentive to control losses, because the pay-off in premium savings can be substantial. It is generally applied to large liability and workers compensation policies.

**Rate Making Entities**

Professiontional Rate-making Organisations :

Professional rate making organisations are the specialists that perform the rating work for the insurance companies. The reason for existence of such organisations is that many companies do not have the sufficient data of their own. By working together and pooling their premium and loss data, they can develop a more reliable rating information. Co-operative rate-making is also suitable for smaller companies.

**Actuaries:**

A person with expertise in the fields of economics, statistics and mathematics, who helps in risk assessment and estimation of premiums etc for an insurance business, is called an actuary.

Actuaries are the specialists in the mathematics of insurance, who carry out the prime responsibility of the rate-making process either working in companies or otherwise. An actuary is a professional who specialises in the field of analysing financial risks by implementing statistical, financial and mathematical theories. In insurance, actuaries aid in assessing risks which help companies in the estimation of premiums for their policies.    They make financial sense of the future by applying mathematical models to problems of insurance and finance. Actuaries are experts who perform actuarial analysis of insurance rates, rating procedures, rating plans, and schedules of insurance companies. These are profeSSionals who are experienced in reviewing and analysing insurance operations, reserves and underwriting procedures and provide technical assistance regarding actuarial matters to policy examiners and other technical staff.

They perform the following functions :

(a) Developing new forms of insurance to meet the changing needs of consumers.

(b) Determining the reserves needed to meet the future obligations.

(c) Analysing the expenses and earnings and providing database for distribution of surpluses.

(d) Conducting research studies on claims experiences, projecting future claims and earnings.

(e) Communicating with the company officials, agents, policyholders, and regulatory authorities about company policies and practices

### Who can be Appointed as Actuaries for Insurance Companies?

As per the Appointed Actuary regulations put forth by the Insurance Regulatory and Development Authority of India, any insurer or insurance company should mandatorily appoint an actuary to manage financial risks and uncertainty of the insurance business.

To be appointed as an actuary with any insurance company, an individual has to fulfil the following criteria, as put forth under regulations:

* He/she should be a resident of India.
* Should be a fellow member as per the Actuaries Act, 2006.

**In the case of life insurance:**

* He/she should have passed a specialisation subject related to life insurance. Currently, specialisation refers to a Specialist Application subject as put forth by the Institute of Actuaries in India.
* A prospective candidate should have at least 3 years of post-fellowship experience pertaining to the annual statutory value of life insurers.
* A minimum of 10 years’ experience in the life insurance industry, out of which, at least 5 years should be that of the post-fellowship experience.

**In the case of**[**general insurance**](https://www.godigit.com/guides/types-of-general-insurance)**:**

* He/she should have passed a specialisation subject related to general insurance. As per the Institute of Actuaries in India, currently, specialisation refers to a Specialist Application subject.
* He/she should have at least 1 year of post-fellowship experience pertaining to the annual statutory value of a general insurer.
* A minimum of 7 years’ experience in the general insurance industry, out of which, at least 2 years should be that of the post-fellowship experience.

**In the case of**[**health insurance**](https://www.godigit.com/health-insurance)**:**

* He/she should have passed a specialisation subject related to health or general insurance. Similar to the above two categories, as per the Institute of Actuaries of India, currently, specialisation refers to the Specialist Application subject.
* He/she should have at least 1 year of post-fellowship experience pertaining to the annual statutory value of a health or general insurer.
* A minimum of 7 years of experience in the general or health insurance industry, out of which, there must be at least 2 years of post-fellowship experience.

Apart from these, an individual can be eligible for the position of Appointed Actuary with any [insurance company](https://www.godigit.com/) if they comply with the following criteria:

* Should be an employee of an insurance company.
* Is not already appointed as an actuary with any other insurance company in India.
* Is not over the age of 65 years.
* Possesses a Certificate of Practice from the Institute of Actuaries in India.
* Has not committed any professional breach or is not guilty of any other misconduct.

Individuals satisfying the above criteria can be appointed as an actuary for insurance companies by the IRDA.

Insurance business requires advanced statistical and analytical skills for evaluation of risks and returns associated with each proposal. Insurance companies employ these experts from the field of economics, statistics, mathematics, risk assessment and management.  
  
Actuaries play a crucial role in the operation and profitability of any insurance business. They help the firm with their expertise in calculation of premiums of various insurance policies, rating methods and reserves, etc.

**Pooling in Insurance:**

Pooling of risks is the underlying feature of insurance. Insurance companies try to make a group or pool of homogenous exposures with a view to reduce the losses arising from that exposure. It is most advantageous when the losses are uncorrelated. When the group agrees to bear the losses in some proportion, the burden on a given member is reduced. This has the effect of loss distribution for the group flatter and flatter. The application of large numbers and pooling suggests that normal curve becomes flatter any flatter when the members are added to a grouplogically, because of reduction in the variance and likely concentration towards mean.

**B. Production and Design**

# What is a insurance product?

A customer buys insurance to protect against property loss or financial risk. The actual insurance product takes the form of a policy binder which states all the terms and conditions, including an overview of what events would lead to a claim payout.

Insurance products include a wide range of solutions. Common insurance products include home, auto, life, health, dental, mortgage and asset protection. Products can also be customized for various purposes, including to protect professional athletes from lost income due to injury. The costs associated with the purchase of an insurance product are often called premiums or insurance rates. Paid in periodic increments, rates are determined based on a variety of risk factors that affect the likelihood the insurer would have to payout, as well as the coverage amount

# Why insurance companies needs new product?

Insurance companies throughout the world are constantly looking for new areas to sell insurance. For instance, many are now insuring specific types of deaths (i.e. cancer-related, Parkinson’s, etc.). Even non-insurance companies practice this behavior.

A primary objective for a company introducing a new product is to increase their after tax income. To achieve that objective, companies must charge the appropriate price for their product. This is one reason insurance companies employ actuaries, in order to create optimal prices for certain policies and readjust them as certain factors change over time.

The assigned goal of this project was to create a new insurance product and determine how to price the product. Developing rollercoaster insurance, which provided many challenges and obstacles, was chosen.

Insurance companies often respond to a growing market need or a potential technological disruptor when deciding new products/ tweaking old ones. They may be trying to address a certain business problem or planning new revenue streams for the organization. Typically, new products are built with the customer in mind. The more ‘benefit-rich’ it is, the easier it is to push on to the customer.

Normally, a group of business owners will first identify a broader business objective, let’s say — providing fire insurance protection for sub-urban, residential homeowners in North California. This may be a class of products that the insurer wants to open. In order to create this new product, they may want to study the market more carefully to understand what the risks involved are; if the product is beneficial to the target demographic, is profitable to the insurer, what is the expected value of claims, what insurance premium to collect, etc.

There are many forces external to the insurance company — economic trends, the agendas of independent agents, the activities of competitors, and the expectations and price sensitivity of the insurance market — which directly affect the premium volume and profitability of the product.

***The new products introduced in any sector are classified into two groups:***

* New products that arise from technological innovations: These are the products that have new functional value.
* New products that arise from marketing oriented modifications: These are the new versions of the existing products. The products may look new because of some changes in the existing product design, adding a new feature to the existing product, presenting the existing product with a new sales strategy to a new market segment.

**Stages in new product development in insurance**

Stages of product development differ from one company to another. Generally, product development is carried out at the top-level management. The different stages of product development are:

1. ***Generating Ideas –*** While developing a new product, the main challenge is to avoid mistakes and reduce risk. Before developing the product, the company should conduct a formal market research. This can help get some ideas on the customer needs and thus, develop the product accordingly. The different sources of information are customers, product development executives, consumer groups, intermediaries, legal pronouncement, employees, journals, magazines, and so on.
2. ***Screening Ideas –***After generating the ideas, screening of those ideas take place. The evaluation committee must screen the product for its objectives, policies, and so on. All the ideas need not be thoroughly followed. While screening the products, it is better to determine the following:

a.Is the new product an improvement over the existing product?

b.Is there any need for the new product?

c.Is it in the same line of business or different from the business?

3. **Concept testing –** This is the third stage in the process of development of a new product. In this stage, the product concept is tested. It is a function of customer market research. It tests whether the customers have understood the product idea, whether they have interest in the idea, whether they need the product, and so on. This testing helps the company to make the concept of the new product clear.

**4. Business analysis –** This stage of the product development life-cycle helps in designing the product based on the market analysis. It indicates the customer interest in the product, and thus helps in deciding whether to proceed with the project or not. In this stage, the impact of the project on the financial position of the organisation with and without the new product is compared, and calculated. While comparing and evaluating the products, different departments of the organisations have their own responsibilities.

**5. New product development –** In this stage, the elements of the products are identified and highlighted. The prototypes of the products are developed in this stage, and after their approval, the actual product is developed. At this stage of product development the organisation is generally committed to the new product.

In the development of the product, the production and marketing departments of the organisation are also actively involved apart from the research and development department.

**6. Commercialisation –** In this stage, the organisation releases the product to the market. Insurance companies distribute their products through various channels including banks.

# Product development process in insurance

Any business organisation faces problem due to the threats from the environments like political and economical conditions, social, technology and supply conditions, changes in client requirements, and so on. The clients ask for better products and services. They seek more benefits in the products they buy, and more value for money. In addition to this, competition is another threat-causing factor. In order to overcome these threats and fulfill the customer requirements, business organisations have to develop new products. The new products provide new opportunities for the growth and security of the organisation.

The new products are also needed to ensure profits to the company. The products that already exist have some limitations in improving the profit level of the organisation. Therefore, it is very important that the organisation introduce new products to substitute the old, declining and losing products.

Thus, the new products become a part of the growth requirements of the organisation, and yields profits to the organisation. Therefore, new product development is an important part of the product policy of any organisation. For an organisation to grow higher, it has to go beyond the existing product as it cannot obtain its desired growth just by appraising the existing product appropriately.

**Product development process is an important process for an insurance company. Developing insurance products include the following steps:**

**1.  Customer requirement analysis –** In the first step, the customer requirements are analysed. In this phase, the information on the amount to be insured, total income, client biometrics such as age and family size, current purchasing habits, and so on are analysed.

**2.  Business analysis –** In the business analysis stage of product development, different departments of the insurance company have the following responsibilities.

* Marketing department has to perform the market analysis to know the customer needs, and make a forecast for sales.
* Underwriting department has to prepare the manuals.
* Customer service department assesses the procedural requirements of the new products.
* Actuarial department develops the specifications of the product, and the resulting impact on product portfolios.
* Accounting department reports the financial requirements of the new product.
* Information systems department checks whether the insurer has enough operating systems to accommodate the new product or not.
* Investment department along with the actuarial department determines the investment needs for the new product.

***3.   Prototype development –***In this step, a prototype of the product is designed and testing is carried out.

***4. Pricing the product –*** The pricing of the insurance products plays an important role in the design and development of the product. The price of the product should include the risk premium that the insurance company needs for accepting the policy, and the cost for distributing and administering the product to the client. The policy price that is charged to the client includes the risk premium and the cost of the distributor.

***5.   Product release –***This stage is called as the ‘technical design stage’. It involves creation of drafts for policy documents, commission structure, underwriting, forms and procedures and issue specifications. Before the product is released to the market the insurance companies have to take care of the following:

* Arrangement of training material.
* Designing promotional materials for the products.
* Releasing all the information that is needed to understand the product.
* Administration of the product after release.
* Complete policy filing, the process by which the organisation obtains all the regulatory approvals from all the applicable authorities that are needed to release the product.
* Educating and training the staff and the sales agents on administrative procedures and forms that are needed to sell, administer and service the product.

The environment in which the insurer functions inspires its product development. This comprises of the legal framework which the insurance industry has to follow and social and economic factors. Any stage of product development has to be carried out in accordance with the customer’s interest.

Thus, since 1973, the Indian Insurance sector has directed the product development towards meeting this goal. In the last three decades, the General Insurance Company (GIC) together with its four subsidiaries has developed 150 new products, and has met its customer requirements.

To control poverty and provide employment in the rural areas, the insurance sector developed the Integrated Rural Development Program (IRDP).Besides this, the industry developed a solution for the healthcare products like mediclaim and also introduced travel-related products.

**C. Underwriting:**

Underwriting is the prices of selecting and classifying exposures. It is directly related to ratemaking or the pricing function of an insurer, because computed rates contemplate some composition of loss-producing characteristics to which they will be applied.

Underwriting is the insurance function that is responsible for assessing and classifying the degree of risk a proposed insured or group represents and tnilking a decision concerning coverage of that risk.

Underwriting includes all the activities necessary to select risks offered to the insurer in such a manner that general company objectives are fulfilled. Insurance underwriters are professionals who evaluate and analyze the risks involved in insuring people and assets. Insurance underwriters establish pricing for accepted insurable risks. The term underwriting means receiving remuneration for the willingness to pay a potential risk. [Underwriters](https://www.investopedia.com/terms/u/underwriter.asp) use specialized software and actuarial data to determine the likelihood and magnitude of a risk.

The person responsible for evaluation and acceptance/rejection of risks and computation of premium is called as the underwriter. Accordingly, the decision made by the underwriter concerning risk classification and rating is called as the underwriting decision. Underwriting decisions are crucial for insurers since they can make or mar an insurance company. Good underwriting helps the insurance companies in many ways. It make them financially stronger and helps secure competitive advantage. This is obvious in the sense that if risks are assessed properly, pricing will be effective and therefore the company can well compete and build up reputation.

In life insurance business, underwriting is performed by home or regional office personnel, who scrutinize applications for coverage and make decisions as to whether they will be accepted, and by agents, who produce the applications initially in the field, but these decisions may be subj~t to post underwriting at a higher level because the contracts are cancellable on due notice to the insured. In life insurance, agents seldom have authority to make binding underwriting decisions. In all fields of insurance, however, agency personnel usually do considerable screening of risks before submitting them to home office underwriters will decide the premium for the policy based on the primary and secondary factors influencing the premium, and the premium rates the company's actuaries have set for your risk profile.

As a consumer, here is the hard part to understand in getting a policy : insurance companies have different underwriting guidelines. This is why the least expensive policies are the most stringent on their guidelines. Throughout every step of the underwriting process, the life insurance agent normally provides with details, keeps abreast of where the insured stand in the process and guide and answer to the questions. Ultimately, making the underwriting process less intimidating and more manageable. If the proposed insured presents a risk more than the risk which the insurance company is willing to cover, the application will be declined by the underwriter.

4.Policy Writing In life insurance the policy is usually written in a special department whose main task is to issue written contracts in accordance with instructions from the underwriting department and, because most policies are long term in nature, to keep a register of them for future reference. Insurance companies generally use automated systems which generate the computerised client record, records of payment of premium and they do verify that all the requirements of underurriting have been met.

Insurance underwriters are professionals who evaluate and analyze the risks involved in insuring people and assets. Insurance underwriters establish pricing for accepted insurable risks. The term underwriting means receiving remuneration for the willingness to pay a potential risk. An underwriter is any party that evaluates and assumes another party's risk for a fee, which often takes the form of a commission, premium, spread, or interest.

In general, underwriters are tasked with determining the level of the risk involved in a transaction or other kind of business decision. Investors rely on underwriters because they determine if a business risk is worth taking. Underwriters also contribute to sales-type activities. For example, in the case of an initial public offering (IPO), the underwriter might purchase the entire IPO issue and sell it to investors.

In the insurance industry, the practice of underwriting refers to the process of accepting or rejecting risks. It is the very heart of insurance and is the first step taken by an insurance company to generate premiums. Originally, insurance and underwriting were synonymous. That is, underwriting referred to the operation of the insurance business. As the insurance industry developed, underwriting took on a more specialized meaning.  
  
An underwriter is the person who decides whether or not to insure risks for which applications have been submitted. The underwriter's task is to evaluate a risk, estimate the potential exposure, determine the likelihood of loss, then make a decision whether or not to accept the application for insurance.

The term "underwriter" developed in the early days of marine insurance. It was common practice for individuals seeking insurance for a ship and its cargo to meet with those desiring to write such insurance in coffeehouses. A person seeking insurance for his ship and its cargo would bring a paper describing the ship, its contents, crew, and destination to the coffeehouse. The paper would circulate, with each individual who wished to assume some of the obligation signing his name at the bottom and indicating how much exposure he was willing to assume. An agreed-upon rate and terms were also included in the paper. Since these people signed their named under the description of the risk, they became known as underwriters.

As insurers changed from individual to companies, signatures on insurance contracts became those of company officers. The term underwriter continued to be used in a more restrictive sense; it applied only to the person who performed the process of selecting risks and determining the terms of insurance. Risk selection and determination of policy terms continue to be the basic duties of underwriters today.

Underwriters work for insurance companies. In addition to on-the-job training, they may earn an Associate in Underwriting designation from the Insurance Institute of America. In the life insurance segment, underwriters may enter a program of study that leads to the designation of Chartered Life Underwriter (CLU). Most CLU's are engaged in some aspect of insurance sales as well. In the property and casualty insurance segment, underwriters may work toward the designation of Chartered Property Casualty Underwriter (CPCU).

## UNDER WRITING'S FOUR BASIC FUNCTIONS

The process of underwriting involves four basic functions: 1) selection of risks, 2) classification and rating, 3) policy forms, and 4) retention and reinsurance. By performing these four functions the underwriter increases the possibility of securing a safe and profitable distribution of risks.

### RISK SELECTION.

In this step the underwriter decides whether or not to accept a particular risk. It involves securing factual information from the applicant, evaluating that information, and deciding on a course of action. The underwriter is typically aided by a list of acceptable and prohibited risks.

### CLASSIFICATION AND RATING.

Once the risk has been accepted, the underwriter then classifies and rates the policy. Several tentative classifications are usually assigned before a final decision on classifying the risk is reached. The purpose of using classifications is to separate risks into homogeneous groups to which rates can be assigned. Insurers may have their own classification and rating system, or they may obtain a system from a rating bureau.

### POLICY FORMS.

After determining the acceptability of an applicant and assigning the proper classification and rating, the underwriter is ready to issue an insurance policy. The underwriter must be familiar with the different types of policies available as well as be able to modify the form to fit the needs of the applicant.

The first three underwriting functions—risk selection, classification and rating, and policy selection—are interdependent. That is, the underwriter determines that a certain risk is acceptable when specified rates and forms are used. The underwriter also performs a fourth separate function on every risk before the underwriting is complete: reinsurance.

### RETENTION AND REINSURANCE.

Reinsurance involves protecting the insurance company against a certain portion of potential losses. Every risk presents the possibility of loss that will equal or exceed the policy limits. It is up to the underwriter to protect his or her company from undue financial strain. The underwriter does this by retaining only a certain portion of the risk and securing reinsurance for the remainder of the risk.

Underwriting is the process through which an individual or institution takes on [financial risk](https://www.investopedia.com/terms/f/financialrisk.asp) for a fee. This risk most typically involves [loans](https://www.investopedia.com/terms/l/loan.asp), insurance, or investments. The term underwriter originated from the practice of having each risk-taker write their name under the total amount of risk they were willing to accept for a specified premium.

* Underwriting is the process through which an individual or institution takes on financial risk for a fee.
* Underwriters assess the degree of risk of insurers' business.
* Underwriting helps to set fair borrowing rates for loans, establish appropriate premiums, and create a market for securities by accurately pricing investment risk.
* Underwriting ensures that a company filing for an IPO will raise the amount of capital needed, and provides the underwriters with a premium or profit for their services.
* Investors benefit from the vetting process that underwriting grants by helping them make informed investment decisions.

Underwriting involves conducting research and assessing the degree of risk each applicant or entity brings to the table before assuming that risk. This check helps to set fair borrowing rates for loans, establish appropriate premiums to adequately cover the true cost of insuring policyholders, and create a market for [securities](https://www.investopedia.com/terms/s/security.asp) by accurately pricing investment risk. If the risk is deemed too high, an underwriter may refuse coverage.

Risk is the underlying factor in all underwriting. In the case of a loan, the risk has to do with whether the borrower will repay the loan as agreed or will default. With insurance, the risk involves the likelihood that too many policyholders will file claims at once. With securities, the risk is that the underwritten investments will not be profitable.

Underwriters evaluate loans, particularly mortgages, to determine the likelihood that a borrower will pay as promised and that enough [collateral](https://www.investopedia.com/terms/c/collateral.asp) is available in the event of [default](https://www.investopedia.com/terms/d/default2.asp). In the case of insurance, underwriters seek to assess a policyholder's health and other factors and to spread the potential risk among as many people as possible. Underwriting securities, most often done via [initial public offerings (IPOs)](https://www.investopedia.com/terms/i/ipo.asp), helps to determine the underlying value of the company compared to the risk of funding its IPO.

## Types of Underwriting

### Loan underwriting

All loans undergo some form of underwriting. In many cases, underwriting is automated and involves appraising an applicant's credit history, financial records, and the value of any collateral offered, along with other factors that depend on the size and purpose of the loan. The appraisal process can take anywhere from a few minutes to a few weeks, depending on whether the appraisal requires a human being to be involved.

### Insurance underwriting

With insurance underwriting, the focus is on the potential policyholder—the person seeking health or life insurance. In the past, medical underwriting for health insurance was used to determine how much to charge an applicant based on their health and even whether to offer coverage at all, often based on the applicant’s pre-existing conditions. Beginning in 2014, under the [Affordable Care Act](https://www.investopedia.com/terms/a/affordable-care-act.asp), insurers were no longer allowed to deny coverage or impose limitations based on pre-existing conditions.

### Securities underwriting

Securities underwriting, which seeks to assess risk and the appropriate price of particular securities—most often as it relates to an IPO—is performed on behalf of a potential investor, often an investment bank. Based on the results of the underwriting process, an [investment bank](https://www.investopedia.com/terms/i/investmentbank.asp)would buy (underwrite) securities issued by the company attempting the IPO and then sell those securities in the market.

The Undenwriting Process:

The underwriting of life assurance is in quite a different category from other forms of personal insurances. This is because the underwriter assesses the risk at inception only. The company is then guaranteeing cover for sometimes, up to 30 years, or even throughout life. Life assurance underwriting involves looking at medical, occupational and avocation factors as well as the individual's lifestyle. In particular, the extra risk posed by AIDS has led to an increased number of questions on proposal forms, or on a separate questionnaire, about lifestyle, which are designed to identify if the proposer is likely to be in a high risk group for AIDS or HIV.

The underwriting process for life assurance involves-(l) performing field underwriting, (2) reviewing the application in the office, (3) gathering additional information, if required and (4) taking and underwriting decision. Additional information is often required by the underwriter in order to reach a decision. This can be in the form of detailed questionnaires, a report from the proposer's own doctor (Medical Attendant's Report), an examination by an independent doctor (Medical Examiner's Rep~rt) and/or specific tests. Following steps are generally followed by underwriters :

1. Receiving Proposals/Applications The applicatio,n for insurance is the source of insurability information that the life insurance company's underwriter will evaluate first. These are generally collected by the field personnel, the agents. There are two basic parts to a typical life insurance application: (1) General Information, and (2) Medical Information. The General Information section of an application asks general questions, including name, age, address, birth date, sex, income, marital status and occupation. In addition, details about the requested insurance coverage such as type of policy, amount of insurance, name and relationship of the beneficiary, other insurance that the client owns, and additional insurance applications pending as on date. The Medical Information section of an application focuses on insured's health and asks a number of questions about health history, history of his/her family's as well. The medical section of the application is fairly extensive and must be fully completed. In addition to this, information may also gathered through a medical examination, depending on age and the face amount of coverage.

2. The Medical Report :The average medical examination (which is generally at no cost to the applicant except in case of revivals) may be conducted. Depending on the medical questions are answered, an insurance company may ask the medical doctor(s) of the client for more detail on any conditions in question. This gathering of information is practically a standardized method used with all domestic insurance companies. Life Insurance Companies generally have several sources of information about medical and financial history to assist them in the underwriting process. These. include personal medical records and doctor, the Medical Information Bureau, Special Questionnaires, Inspection Reports and even Credit Records.

3. Underwriting Review :Once all of the information has been gathered, an individual from the insurance company (called an underwriter) evaluates the data. At this evaluation, the underwriter is seeking to classify the risk presented to the company. In addition, the underwriter will determine the premium for the

**Questions**

### Where did the word 'underwriting' come from?

The term "underwrite" originates in the 17th century when marine vessels would be underwritten for insurance risk for overseas voyages. The insurance company would sub-scribe (literally to write underneath, or under-write) the policy by signing their name at the bottom of the document and acknowledging consent that the policy is in force.

### What is the purpose of underwriting today?

Underwriting, whether it be for an insurance policy or a loan, revaluates the riskiness of a proposed deal or agreement. For an insurer, the underwriter must determine the risk of a policyholder filing a claim that must be paid out before the policy has become profitable. For a lender, the risk is of default or non-payment. Similarly, securities underwriting by investment banks evaluates newly issued shares and bonds to determine their risk-adjusted value.

### Can an underwriter deny an insurance policy or loan?

Yes, if the riskiness of a borrower or insurance policy applicant is deemed too great, the underwriter can either recommend higher rates or else deny the application entirely - so long as they are not breaking any anti-discrimination laws and are only evaluating objective risk metrics.

### How long does the underwriting process take?

With the advent of information technology, the underwriting process for insurers and lenders has shortened from a matter of weeks or months to just a few days or even hours in some cases.

## ****What is the Difference between Underwriters and Agents/Brokers?****

The following table illustrates the distinction between an underwriter and an agent/broker.

|  |  |  |
| --- | --- | --- |
| **Basis of difference** | **Underwriter** | **Brokers/Agents** |
| Definition | They assess, evaluate, and assume risk on behalf of other parties. | They act as portals between customers and organisations. |
| Scope of functioning | These individuals solely represent the interests of the company they work for. | These entities represent the interests of both the customer and their employers. |
| Authority | They hold the final say on whether to assume risk or not. | They submit applications from clients but have no significant weight on the matter of approval or rejection. |

An underwriter plays a crucial role in financial markets. They ensure that all transactions and business decisions take place under fair and stable conditions.

**D. Loss Adjustment**

The Loss Adjuster’s job is to investigate insurance claims on behalf of the insurer once they reach a certain size. The Loss Adjuster plays a crucial role in the insurance claims process and is usually the first person you will come into contact with from the insurance company after a claim is logged.

The Loss Adjuster will typically visit your property within a few days of the claim being initiated by the insurance company. The purpose of this visit is to obtain all the necessary facts, in order for your insurance company to determine whether the claim is valid and ensure the amount paid to you is correct, in accordance with your policy. This information is presented to the insurance company in the form of the Loss Adjuster’s report.

Insurance is important because it provides [indemnification to the insured](https://thismatter.com/money/insurance/indemnity.htm) for their losses. However, an [insurance company](https://thismatter.com/money/insurance/insurance-companies.htm) will not just pay money to the insured because of a filed claim. Otherwise, they could lose money through fraud or exaggerated claims. Moreover, insurance companies realize that the prompt, fair, and courteous payment of claims is a great way to retain customers and to be competitive in the insurance market. Hence, insurance companies have special people that investigate claimed losses. For life insurance companies, they are called **claim representatives** or **benefit representatives**. In product liability and other insurance, they are called **claims adjustors**, **claims auditors**, **loss adjusters**, or just **adjusters**. The process of settling or denying a claim is called a **claim settlement** or a **loss adjustment**. Loss adjustment is most important property insurance, where losses are usually partial and the amount may be hard to determine. [Life insurance](https://thismatter.com/money/insurance/types/life/life-insurance-fundamentals.htm), on the other hand, rarely involves loss adjustment, since the full policy amount is paid when the insured has died. However, an investigation may be conducted if the insured died soon after buying the policy.

Our loss adjustment assistance starts with the notification on the claim sent to the Insurer on behalf of our Client and ends when the full sum of reimbursement is paid. Loss Adjustement Office provides free of charge services for our Clients and other Companies which order to handle their claims with the Insurers on their behalf.

The loss adjustment process is initiated by MENTOR S.A. by reporting the loss or claim to the Insurer on behalf of the Client. Loss adjuster first verifies the claim in terms of the legitimacy of insurance cover within the scope of the concluded policy and estimates its value.

The first stage of loss adjustment process begins with reporting the loss or claim to the Insurer and ends with the Insurer's decision to either grant compensation or refuse to pay it.

In case of the Insurer's refusal to pay the indemnity or granting a lower indemnity than the value of the claim, the loss adjuster informs the broker in charge of the Client and works on further actions (this doesn't apply to situations when the Client accepts the decision of the Insurer). If the refusal to pay the indemnity is unjustified, the loss adjuster lodges an appeal to the Insurer. If the refusal is justified, yet it is crucial for the Client to receive the indemnity from the Insurer, then loss adjuster will negotiate with the Insurer an ex gratia payment of the indemnity in order to maintain good business relations with the Client.

Furthermore, the Loss Adjustment and Insurance Analysis Office uses a unique on-line specialized computer program - Electronic System of Loss Information (ESIS), where all records related to loss adjustment process are kept. This program enables loss adjusters to ensure that the Insurers' indemnity payments do not fall into arrears. Through this program our Clients have access  to all the data regarding loss adjustment process, value of indemnity already paid and all the outstanding procedures to be completed.

**What do Loss Adjusters do?**

##### **Loss adjusters investigate insurance claims arising out of losses such as fires, car accidents and burglaries. They determine the amount of damage or loss covered by the insurance policy. Adjusters make recommendations regarding payment of benefits, based on the coverage noted on the insurance policy and negotiate payment and settlement. Loss adjusters also:**

* **Ensure** that those who have suffered a loss receive all of the benefits and assistance to which they are entitled.
* **In disputed claims, may also be required to investigate** the cause of the loss - how a fire started, why a plane went down, etc.
* **Investigate, negotiate and settle** a variety of claims in an efficient manner and in compliance with a variety or requirements.  
  conduct witness interviews, take statements and consult with police reports.
* **Report** in a variety of ways - in writing, through e-mail or on-line, and must present or report on these findings, propose solutions and negotiate settlements and agreements with third parties, clients or other concerned parties.
* **Inspect and/or evaluate** damages when required, estimate costs or commercial value, examine reports or other documents, evaluate losses, establish claims guidelines and quantifying settlement amounts.
* **Participate** in private and/or mandatory mediation, settlement meetings, settlement conferences, pre-trails, court proceedings and other dispute resolution methods as required.

**E. Investment Function**

Insurance companies typically function on two dimensions, including underwriting activity which is mainly centered on collecting premiums and second, investment activity which is meant to dispense assets into various investments that earn additional revenues in the form of interests, dividends and capital gains.

The latest Indian insurance sector reforms have built a new competitive environment that has lead to competitiveness for more complex investments, better customer services, innovative products and rapid development of technology.

An insurance company smartly invests the crores of rupees that are collected through premiums by millions of investors. The investment experts working for the insurance company calculates the probability of insurance claims every year and the long-term returns that can be gained from a variety of financial investment instruments such as government bonds, stocks, debentures and others, as approved by the IRDA.

**Principles of Investment**

Investment management is of great importance to insurance companies, especially where huge funds are collected as premiums. Since these funds are not immediately required, most companies are able to invest a major chunk of it in investible assets and earn optimum rate of return on it. Investment operation of insurance companies increases the profitability of business, and can reduce the cost of insurance. While making investment, insurance companies are guided by certain fundamental principles:

* Safety because the company is entrusted with the responsibility to pay claims as and when the need arises.
* Profitability ensures the company runs its business on a solvent basis, depending on how they have invested their fund.
* Liquidity, which represents convertibility of investments into cash without undue loss of capital for the company.
* Diversification helps spread the investment over different channels, not relying unnecessarily on a single class of investment
* **Why invest in insurance plans with confidence?**

With an objective to provide superior risk adjusted returns over the long term, IRDA regulates the investment practices for the insurance companies in India. To start with, insurance companies need to have a minimum capital and all insurers must maintain a minimum solvency ratio of 150% to reduce the risk of bankruptcy. This means all insurance companies are needed to set aside the amount that consists of their entire liabilities as well as an additional 50% of that amount.

The high competition in the Indian Life Insurance sector have forced companies to follow best practices and maintain a good quality in their portfolio of investments. To conclude, insurance companies such as [Canara HSBC OBC Life Insurance](https://www.canarahsbclife.com/index.html) operate a diversified investment portfolio to manage your insurance premiums in the safest possible manner. Therefore, you should not worry as they are working hard to give you maximum benefits from insurance schemes that help secure the future of your loved ones.

**How Does Investment Insurance Work?**

Insurance investment plans are like a two-for-one investment. When you pay your insurance premiums, part of your premiums become investments after a certain period. As the value of your premiums grow, so does your investment.

This will result in an ROI which you can access even before you receive your insurance pay out due to unfortunate circumstances. Your actual insurance, on the other hand, will remain untouched and whatever is agreed upon on your policy coverage will uphold. So, if by a good chance of fate you’ll never need to receive a payout from your insurance policy, you get both your insurance premium returned as well as the money you’ve received from your investment.

The only caveat here, however, is that because your premiums go to both your insurance and to your investment, you cannot withdraw from your account more than your policy’s minimum value. Other than that, you’re free to take out your ROI and spend or invest it wherever you see fit.

**What Are the Benefits of Investment Insurance?**

Investment insurance plans come with many benefits for you and your family.

* Benefits from Flexible Premiums – The more you pay, the more you earn. Our variable universal life insurance gives you the option to pay more than the average premium. When you pay more than the minimum, the excess is added to your investment, which helps your fund grow faster.
* Funds for Emergencies and Leisure – Having an investment on top of your insurance allows you to earn back some of your investment which you can spend or invest on anything you want. We recommend re-investing your ROI to stay on track, but having that extra income can help pay for family emergencies not covered in your insurance policies or simply for leisure purposes.
* Higher Returns – Unlike traditional insurance policies, investment insurance maximizes your earning potential by linking some of your investment to stocks and bonds. These can result in bigger funds compared to what you hoped to gain with your premium.
* You Don’t Compromise Your Policy – Many types of investments depend on the state of the market and can result in a loss. Your ROI may depend on the value of your premiums. However, this will not affect your insurance policy and will not be compromised by the results of your investment.

**F. Reinsurance**

Reinsurance is a transaction in which one insurer agrees, for a premium, to indemnify another insurer against all or part of the loss that insurer may sustain under its policy or policies of insurance. The company purchasing reinsurance is known as the ceding insurer; the company selling reinsurance is known as the assuming insurer, or, more simply, the reinsurer. Reinsurance can also be described as the "insurance of insurance companies".

Reinsurance provides reimbursement to the ceding insurer for losses covered by the reinsurance agreement. It enhances the fundamental objective of insurance-to spread the risk so that no single entity finds itself saddled with a financial burden beyond its ability to pay. Reinsurance can be acquired either directly from a reinsurer or through a broker or reinsurance intermediary.

Objectives of Reinsurance

Insurers purchase reinsurance for essentially four reasons: (1) to limit liability on specific risks; (2) to stabilise loss experience; (3) to protect against catastrophes; and (4) to increase capacity. Different types of reinsurance contracts are available in the market commensurate with the ceding company's goals.

Limiting Liability:

By providing a mechanism in which companies limit loss exposure to levels commensurate with net assets, reinsurance allows insurance companies to offer coverage limits considerably higher than they could otherwise provide. This function of reinsurance is crucial because it allows all companies, large and small, to offer coverage limits to meet their policyholders' needs. In this manner, reinsurance provides an avenue for small-to-medium size companies to compete with industry giants. In calculating an appropriate level of reinsurance, a company takes into account the amount of its available surplus and determines its retention based on the amount of loss it can absorb financially. Surplus, sometimes referred to as policyholders' surplus, is the amount by which the assets of an insurer exceed its liabilities.

A company's retention may range from a few lakh rupees to thousands of crores. The reinsurer indemnifies the loss exposure above the retention, up to the policy limits of the reinsurance contract. Reinsurance helps to stabilise loss experience on individual risks, as well as on accumulated losses under many policies occurring during a specified period.

Stabilisation:

Insurers often seek to reduce the wide swings in profit and loss margins inherent to the insurance business. These fluctuations result, in part, from the unique nature of insurance, which involves pricing a product whose actual cost will not be known until sometime in the future. Through reinsurance, insurers can reduce these fluctuations in loss experience, thus stabilising the company's overall operating results.

Catastrophe Protection:

Reinsurance provides protection against catastrophic loss in much the same way it helps stabilise an insurer's loss experience. Insurers use reinsurance to protect against catastrophes in two ways. The first is to protect against catastrophic loss resulting from a single event, such as the total fire loss of a large manufacturing plant. However, insurers also seek reinsurance to protect against the aggregation of many smaller claims, which could result from a single event affecting many policyholders simultaneously, such as an earthquake or a major hurricane. Financially, the insurer is able to pay losses individually, but when the losses are aggregated, the total may be more than the insurer wishes to retain.

Through the careful use of reinsurance, the disruptive effects catastrophes have on an insurer's loss experience can be reduced dramatically. The decisions a company makes when purchasing catastrophe coverage (e.g., size of retention and coverage limits) are unique to each individual company and vary widely depending on the type and size of the company purchasing the reinsurance and the risk to be reinsured.

Increased Capacity :

Capacity measures the rupee amount of risk an insurer can assume based on its surplus and the nature of the business written. When an insurance company issues a policy, the expenses associated with issuing that policy-taxes, agent commissions, administrative expenses-are charged immediately against the company's income, resulting in a decrease in surplus, while the premium collected must be set aside in an unearned premium reserve to be recognised as income over a period of time. While this accounting procedure allows for strong solvency regulation, it ultimately leads to decreased capacity because the more business an insurance company writes, the more expenses that must be paid from surplus, thus reducing the company's ability to write additional business.

Companies experiencing rapid expansion are particularly susceptible to the timing problem between expenses (which must be debited immediately) and income (which must be credited over time) generated by new business. By reinsuring a portion of the business it writes, an insurance corrt:pany reduces the problem of decreased surplus. Through reinsurance, the company shares a portion of its underwriting expenses with its reinsurer and reduces the drain on surplus.

Reinsurance also permits the ceding company to expand capacity by permitting the ceding company to take credit for reinsurance on the annual accounting statement it files with state regulators. If the reinsurer satisfies certain regulatory requirements intended to assure the security of the reinsurance arrangement, the ceding company may count as asset reinsurance payments owed to it on claims it has paid, thus expanding its surplus. The ceding company can also reduce liabilities and loss reserves attributable to the business ceded to the reinsurer.

In..addition, the cedirlg company often receives a ceding commission from the reinsurer as reimbursement for expenses, such as agent commissions and overhead, associated with acquiring the business being reinsured. The ceding commission is added directly to the ceding company's surplus, thus increasing it further.

Another type of reinsurance transaction, which may affect surplus, is known as loss portfolio transfer. In such an arrangement, one insurer cedes to another insurer its reserves for incurred but unpaid losses and loss adjustment expenses. Typically, these reserves are associated with a particular class or line of business, such as medical malpractices. The ceding insurer transfers cash to the assuming insurer equal to the assuming insurer's estimate of the present value of these liabilities, plus an amount the reinsurer may require to carry the additional risks involved in the transfer

. In addition, reinsurers often provide insurers with a variety of other services. Some reinsurers provide guidance to insurers in underwriting, claims reserving and handling investments and even general management. These services are particularly important to smaller companies or companies interested in entering new lines of insurance.

**Role of the Reinsurers**

Reinsurance is governed by the same principles as for insurance. But instead of covering property or casualty risks directly, the reinsurer insures insurance companies. Reinsurance spans the diversity of situations specific to each type of insurance and is consequently more complex and much broader in range, since it covers the whole world. An insurance company issues contracts called policies. The insurance company is the direct or primary insurer of an individual or a business. The policy is written in its name, making it liable for all claims arising under the policy. The insured deals exclusively with the insurance company. But the insurance company spreads its risks arising under the policy by transferring all or part of those risks to one or more reinsurance compa~ies

.l In the event of a claim, the insurance company must pay to the insured the full amount of compensation due under the policy. It is then up to the insurance company to recoup the sums corresponding to the risk transferred from its reinsurers. At the beginning of each year, the insurance company takes out contracts with one or more reinsurance companies to cover it for policies issued to its customers for the year in question. Reinsurers in tum usually cede a share of the risk they accept to other reinsurers known as retrocessionnaires; this system is roughly equivalent to bank syndicates. To put it differently, the reinsurer performs three essential services, together with a number of additional services.

First, reinsurance enables direct writing companies to even out their results when major, exceptional, losses occur: a hurricane or an earthquake for instance can seriously affect the accounts of an insurance company. Reinsurance considerably reduces this type of potential imbalance.

Second, insurance companies use reinsurance to increase the maximum amount they are aQle to cover as primary insurer for any given potential loss or loss category; in other words, their available capacity is increased. As a result, insurance companies can write more risks, or larger risks, without becoming over-extended.

Third, reinsurance also provides insurers with the larg'e amounts of cash needed in the event of a major loss, enabling them to manage their assets safely and profitably.

The reinsurance coverages can be broadly classified into two-treaties and facultatives.

**Reinsurance Treaties**

Reinsurance treaties are a form of comprehensive coverage bought by ceding companies, either directly or through a reinsurance broker, to protect all or a share of their portfolios for a given class of business. All policies covering risks insured under a treaty are automatically reinsured; in other words the reinsurer cannot decline a risk coming under the treaty. Treaties may be either proportional or non-proportional.

Facultatives

Facultative insurance is an optional case by case method that is used when the ceding company receives application for insurance that exceeds its retention limit. Facultative treaties are inter company agreements for optional or voluntary reinsurance transactions. Facultative covers are written on an individual risk basis when a primary company insures risks for amounts in excess of its treaty capacity or risks not covered by its treaties. The lead reinsurer assesses each risk individually and, in consultation with the insurance company, sets the rates and terms of the primary cover. Facultatives serve essentially to cover major industrial and civil engineering risks and, for much smaller amounts, insurers' exposure to liability claims. The reinsurer retains the right to accept or reject any business offered by the insurance company.

**Reinsurance Arrangements**

Quota Share Reinsurance:

In this type of arrangement, the reinsurer receives a quota share of both the exposures and the premiums less agreed costs incurred by the ceding company in writing the business.

Pro-rata Reinsurance :

It states that the reinsurer will assume all risk upto some specific policy and will cede a portion of the risk above the retention limit.

Excess-of-loss Reinsurance:

It specifies the extent of reinsurance in terms of losses rather than in terms of liability. Under such a treaty, the ceding company would pay all claims upto a specified amount per event or per period. Any losses over the agreed amount would be paid in full or part as agreed by the reinsurer. This is different from quota and pro-rata arrangements in the sense that agreement does not refer to any specific policy but covers all of the insurer's business. This type of arrangement is in the nature of catastrophe coverage.

Loss Ratio Reinsurance:

It provides for reimbursement by the reinsurer when a specific loss ratio is exceeded. The loss ratio is generally the ratio of losses incurred to premiums earned. The loss ratio is generally fixed in such a fashion that it is over the normal one and, at such a level that the insurer could not bear without sustaining severe damages to its financial condition. Therefore, this arrangement is also a kind of catastrophe coverage.

Certain fundamental principles underlie all reinsurance contracts, regardless of how simple or complex the reinsurance transaction. First, the only parties to a reinsurance contract are a reinsured company and its reinsurer. All contractual rights and obligations run only between these two companies. Second, the proceeds collectible under the reinsurance contract are an asset of the ceding company. Finally, as a contract of indemni£icatipn, the reinsurance is payable only after the reinsured company has paid losses due under its own insurance or reinsurance agreements, unless there is an insolvency clause, which allows the receiver of an insolvent insurer to collect on reinsurance contracts.

**REGULATION OF INSURANCE BUSINESS IN INDIA**

Exact details of laws regulating insurance companies may vary from country to country, but they typically follow the same pattern. First, legislators prescribe a licensing system controlling access to the national insurance market. Usually unlicensed insurers are also forbidden from transacting business. Secondly, the regulatory authority is given special powers to enable it to monitor the trading activities of licensed insurers. The more important of these 'ongoing' regulatory powers usually takes the form of financial and accounting requirements. The licensing and control of insurance companies are discussed in detail later on, but first a short rationale for the general regulation of insurance companies is necessary.

Insurance is a federal subject in India.

Two statutes primarily regulate the insurance business-

(a) Insurance Act 1938 and

(b) Insurance and Regulatory Development Authority Act, 1999.

The Insurance business is classified into four classes-(l) Life Insurance, (2) Fire, (3) Marine and (4) . Miscellaneous insurance. Life Insurers transact life insurance business and General Insurers transact the rest. Apart from this, GIC and its subsidiaries are regulated by General Insurance Business (Nationalization) Act, 1972 and LIC of India being regulated by The Life Insurance Corporation Act, 1956.

THE REASONS FOR REGULATING INSURERS

The regulator of insurance business in India is IRDA constituted by the IRDA Act, 1999. Regulation of Insurance business provides the insurance market with direction, management control and correction. Insurance, generally, all over the world is widely regulated. This is because of the . following reasons

: (a) Widespread severe impact of insurer solvency. Since solvency ensures that insurance transactions are certain ad predictable, promotion and maintenance of insurer solvency are at the heart of all regulatory activity. Insureds are generally incapable of self-protection and if the insurance company becomes insolvent, the results may be disastrous. Insurance generally mobilise savings, and therefore they bear a kind of fiduciary relationship as that of a banker and customer, and therefore, it requires public regulation.

(b) Unequal knowledge and bargaining power of the buyers and seller-insurance contacts are complex and the insurance itself is an intangible product~

(c) Insurance pricing is-typical and unique and requires estimation before the costs are fully known

. (d) Social welfare-insurance by definition is a sound device and optimally should be made available to public at large without discrimination.

Protecting consumers : Controlling and managing an insurance company involves custody of large sums of money belonging to policy claimants, beneficiaries, policyholders and shareholders, among others; this is particularly true in the case of life insurance companies. The financial collapse of an insurance company can involve serious political repercussions. The insolvency of a life insurer can be particularly traumatic. As a result of such a financial failure, many policyholders or their dependents could lose the benefits of their life's savings at a time when they were too old to make alternative pension or other arrangements. Accordingly, government control or regulation of life insurers (which may be part of a wider concern for investor protection) has often been stricter than the supervision of non-life insurers, extending to matters such as approval of premium rates (and, as a result, lowering, if not altogether eliminating, price competition within a national market). Obviously the rationale underlying government regulation of insurers is the prevention of insolvencies amongst insurance companies. Virtually all governments seek to ensure that insurance companies operating within their national market are financially sound and transact business in a responsible manner.

The life insurance business in India was done by the Life Insurance Corporation of India as a statutory corporation and as a monopoly in life insurance business till 1991. After the new economic policy the life insurance business in India was liberlized so much so that even foreign companies can do life insurance business in India but subject to Government governance. As a result the TIC

of India has become one of the companies doing life insurance business in India. An attempt has been made in this chapter to summarize to a possible extent the regulation of insurance business by the Government of India. The regulation of insurance business in India is being summarized under the following heads.

1.Indian Contract Act, 1872

2. Insurance Sector Reforms

3.Insurance Regulatory and Development Authority Act, 1999

4.Insurance Regulatory and Development Authority

5.The Insurance Act 1938 as amended in 2002

5 The competition Act

**Indian Contract Act, 1872** : Insurance contracts are agreements between insurance companies and insured for the purpose of transferring from insured to the insurer a part of the risk of loss arising out of contingent event. Therefore all the provisions of Indian Contract Act, 1872, in general are applicable to insurance contracts. Under Section 10 of the Indian Contract Act, following conditions are necessary to form a valid contract : ' (a) Agreement between two parties (b) Lawful object (c) Capacity to contract (d) Legal purpose (e) Consideration (j) Possibility of performance etc.

**INSURANCE SECTOR REFORMS**: In 1993, Malhotra Committee, headed by former Finance Secretary and RBI Governor R.N. Malhotra was formed to evaluate the Indian insurance industry and recommend its future direction. The Malhotra committee was set up with the objective of complementing the reforms initiated in the financial sector. The reforms were aimed at creating a more efficient and competitive financial system suitable for the requirements of the economy keeping in mind the structural changes currently underway and recognizing that insurance is an important part of the overall financial system where it was necessary to address the need for similar reforms. In 1994, the committee submitted its report and some of the key recommendations are as follows

1. STRUCTURE Government stake in the insurance companies to be brought down to 50 percentage. Government should take over the holdings of General Insurance Corporation (GIC) and its subsidiaries so that these subsidiaries can act as independent corporations. All the insurance companies should be given greater freedom to operate.
2. COMPETITION Private companies with a minimum paid up capital of Rs. 100 crores should be allowed to enter the sector. No company should deal in both life and general insurance through a single entity. Foreign companies may be allowed to enter the industry to enter the industry in collaboration with the domestic companies. Postal life insurance should be allowed to operate in the rural market. Only one state level life insurance company should be allowed to operate in each state.
3. REGULATORY BODY The insurance act should be changed. An insurance regulatory body should be set up. Controller of insurance — a part of the finance ministry — should be made independent.
4. INVESTMENTS Mandatory Investments of LIC life fund in government securities to be reduced from 75 percentage to 50 percentage. General Insurance Corporation (GIC) and its subsidiaries are not to hold more than 5 percentage in any company (there current holdings to be brought down to this level over a period of time).
5. CUSTOMER SERVICE LTC should pay interest on delays in payments beyond 30 days. Insurance companies must be encouraged to set up unit linked pension plans. Computerization of operations and updating of technology to be carried out in the insurance industry.

The committee emphasised that in order to improve the customer services and increase the coverage of insurance policies, industry should be opened up to competition. But a the same time, the committee felt the need to exercise caution as any failure on the part of new player could ruin the public confidence in the industry. Hence, it was decided to allow competition in a limited way by stipulating the minimum capital requirement of Rs. 100 crores.

The committee felt the need to provide greater autonomy to insurance companies in order to improve their performance and enable them to act as independent companies with economic motives. For this purpose, it had proposed setting up an independent regulatory body. The Insurance Regulatory and Development Authority.

Reforms in the Insurance sector were initiated with the passage of the IRDA Bill in Parliament in December 1999. The IRDA since its incorporation as a statutory body in April 2000 has fastidiously stuck to its schedule of framing regulations and registering the private sector insurance companies. Since being set up as an independent statutory body the IRDA has put in a framework of globally compatible regulations. The other decision taken simultaneously to provide the supporting systems to the insurance sector and in particular the life insurance companies was the launch of the IRDA online service for issue and renewal of licenses to agents. The approval of institutions for imparting training to agents has also ensured that the insurance companies would have a trained workforce of insurance agents in place to sell their products.

**INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (IRDA) ACT** **1999**:

To provide for the establishment of an authority to protect an interest of holders insurance policies, to regulate, promote and ensure orderly growth of insurance industry and for matters corrected therewith the IRDA Act 1999 was passed. The Act was intended to create an authority called the insurance regulatory and development authority. The authority considered of a body of individuals appointed by the central Government from person ability, integrity and stability we have knowledge or experience in life insurance, general insurance, Actuation science, finance, economy, law, agricultural any other discipline which option of central government useful could the authority.

Insurance Regulatory and Development Authority (IRDA)

Insurance Regulatory and Development Authority (IRDA) is a statutory body set up for protecting the interests of the policyholders and regulating, promoting and ensuring orderly growth of the insurance industry in India.

1991: Government of India begins the economic reforms programme and financial sector reforms

1993: Committee on Reforms in the Insurance Sector, headed by Shri R. N. Malhotra (Retired Governor, Reserve Bank of India) set up to recommend reforms in insurance sector.

1994: Malhotra Committee recommends reforms after studying the insurance sector and taking inputs from all the stakeholders.

Key recommendations of Malhotra Committee are:

Private sector companies should be allowed to promote insurance companies

Foreign promoters should also be allowed

Government to vest its regulatory powers on an independent regulatory body answerable to Parliament

1996: Setting up of an interim body called the Insurance Regulatory Authority

1999: Enactment of the Insurance Regulatory and Development Authority (IRDA) Act, 2000: Formation of the Insurance Regulatory and Development Authority as an autonomous regulatory body on 19.4.2000

Since 2000, IRDA has been serving as an independent regulatory authority for the insurance industry and to instill confidence among the policyholders in the financial viability of the insurance companies. IRDA has been playing a pivotal role in the insurance sector with a fundamental commitment to discharge its mandate for orderly growth of insurance sector.

IRDA has played a very important role in the growth and development of the sector by protecting policyholders' interests; registering and regulating insurance companies; licensing and establishing norms for insurance intermediaries , regulating and overseeing premium rates and terms of non-life insurance covers; specifying financial reporting norms, regulating investment of policyholders' funds and ensuring the maintenance of solvency margin by insurance companies; ensuring insurance coverage in rural areas and of vulnerable sections of society; promoting professional organisations connected with insurance and all other allied and development functions.

The Authority acts as the regulator of the insurance industry in India and oversees the functioning of the Life Insurance and General Insurance companies operating in the country. The main objective of the IRDA is to protect the interests of the policyholder and regulate the insurance industry. To know the various functions and the role of IRDA in the Indian insurance sector, read on to learn about the apex body of insurance providers in India.

## What is the Insurance Regulatory and Development Authority (IRDA)?

The Insurance Regulatory and Development Authority is the main organization or supervisory body that regulates the insurance sector in the country. It sets rules and regulations for the functioning of the insurance industry. Its sole purpose is to protect the interest of policyholders and to develop the industry on the whole.

The IRDA or IRDAI regularly issues advisories to insurance companies in case of changes to the rules and regulations. The regulator guides the insurance industry in promoting the efficiency in the conduct of insurance business all the while controlling the rates and other charges related to insurance. This article dwells on the functioning of the IRDA, features and benefits as well as answers to frequently asked questions at the end of this reading.

### Establishment of IRDA:

The Government of India was the regulator for the insurance industry until 2000. However, to institute a stand-alone apex body, the IRDA was established in 2000 following the recommendation of the Malhotra Committee report in 1999. In August 2000, the IRDA began accepting applications for registrations through invites and allowed companies from other countries to invest up to 26% in the market.

The IRDA has outlined several rules and regulations under Section 114A of the Insurance Act, 1938. Regulations range from registration of insurance companies for operating in the country to protecting policyholder’s interests. As of September 2020, there are 31 General Insurance companies and 24 Life Insurance companies who are registered with the IRDA.

### Scope of Insurance Regulatory and Development Authority:

### The Insurance Regulatory and Development Authority has been authorized to register the new insurance companies in India. The list of new insurance companies also includes the collaborations of the renowned insurance companies overseas with the existing Indian companies. The insurance companies in India are required to approach the Insurance Regulatory and Development Authority for the purpose of renewal of the of the insurance registration. The Insurance Regulatory and Development Authority are allowed to withdraw registration of the companies and even cancel the registration of a company if required. It is also authorized to modify the registration procedure for a company.

### Objective of IRDA:

The main objective of the Insurance Regulatory and Development Authority of India is to enforce the provisions under the Insurance Act. The mission statement of the IRDA is:

* To protect the interest and fair treatment of the policyholder.
* To regulate the insurance industry in fairness and ensure the financial soundness of the industry.
* To regularly frame regulations to ensure the industry operates without any ambiguity.

## Important Role of IRDA in the Insurance Sector in India:

The insurance industry in India dates back to the early 1800s and has grown over the years with better transparency and focus on protecting the interest of the policyholder. The IRDA plays an integral role in emphasizing the importance of policyholders and their interest while framing rules and regulations. **Here are the important roles of the IRDA:**

* To protect the policyholder’s interests.
* To help speed up the growth of the insurance industry in an orderly fashion, for the benefit of the common man.
* To provide long-term funds to speed up the nation’s economy.
* To promote, set, enforce and monitor high standards of integrity, fair dealing, financial soundness and competence of the insurance providers.
* To ensure genuine claims are settled faster and efficiently.
* To prevent malpractices and fraud, the IRDA has set up a grievance redress forum to ensure the policyholder is protected.
* To promote transparency, fairness and systematic conduct of insurance in the financial markets.
* To build a dependable management system to make sure high standards of financial stability are followed by insurers.
* To take adequate action where such high standards are not maintained.
* To ensure the optimum amount of self-regulation of the industry.

## Functions of IRDA:

Below are the important functions of the IRDAI in the insurance industry in India:

* Grant, renew, modify, suspend, cancel or withdraw registration certificates of the insurance company.
* Protecting the interests of the policyholder in matters concerning the grant of policies, settlement of claims, nomination by policyholders, insurable interest, surrender value of the policy and other terms and conditions of the policy.
* Specify code of conduct, qualifications and training for intermediary or insurance agents.
* Specify code of conduct for loss assessors and surveyors.
* Levying fees and charges for carrying out the provisions of the Act.
* Undertaking inspection, calling for information, and investigations including an audit of insurance companies, intermediaries, and other organizations associated with the insurance business.
* Regulate and control insurance rates, terms and conditions, advantages that may be offered by the insurance providers.

Apart from the above-mentioned core functions of the IRDA, there are several functions that the regulator performs keeping the policyholder’s interest as its priority.

**Composition of Authority**

The Authority shall consist of nine persons as per details given below:.

Chairperson.

Not more than 5 whole time members.

Not more than 4 part time members.

These persons shall be appointed by the Central Govt. from amongst persons of ability, integrity & standing who have knowledge or experience in life Insurance, general Insurance, actuarial science, finance, economics, law accountancy, administration or other discipline which would in the opinion of the Central Govt. be useful to the Authority.

**Tenure (Section 5)**

z The Chairman tenure will be for 5 years and eligible for reappointment till he attains the age of 65 years.

z The appointment of members will be for 5 years and eligible for reappointment but not exceeding the age 62 years.

Removal of Members (Section 6)

The Central Government can remove any member of the Authority if he :-

a) Is declared bankrupt

b) Has become physically or mentally incapable of acting as a member

c) Has been awarded punishment by any Court.

d) Has acquired such financial or other interest which affect his function as a member.

e) Has so abused his position as to render his continuation in office detrimental to the public interest.

But no member can be removed form the office unless & until the reasonable opportunity of being heard is given to such member in the matter.

## How Does IRDA Work?

The apex body of the insurance industry, the IRDA, ensures it frames rules and regulations without any ambiguity towards any particular insurance company. To ensure fairness and the financial soundness of the industry, the main work of IRDA revolves around the policyholder’s interests. Refer to the following roles that the IRDA is mainly involved in:

* Issues certificate of registration to new insurance companies.
* Sets rules and regulations to ensure the interests of the policyholder are taken care of.
* Monitors all claims are settled in all fairness and that no insurer will deny any claim on their own free will.
* Regulates the code of conduct of the insurance companies, insurance intermediaries, and others associated with the insurance industry.
* Provides solutions in case of disputes through the IRDA ombudsman.
* Controls and regulates the rates of insurance to prevent unwanted price hikes in the insurance premium.
* The apex body is responsible for setting the minimum percentage limit of insurance companies for General and Life Insurance, thereby developing both urban and rural sectors.

## Features & Benefits of IRDA:

Following are the salient features of the apex body, the Insurance Regulatory and Development Authority of India:

* Acts as a regulator for the insurance industry.
* Protects the policyholder’s interests.
* Rules and regulations are framed by the apex body under Section 114A of the Insurance Act, 1938.
* It is entrusted under the Insurance Act to grant the certificate of registration to new insurance companies to operate in India.
* Oversees the insurance industry’s activities to ensure sustained development of insurers and policyholders.
* Corporate body by the aforesaid name which means it will act as group of persons, called members, who will work jointly not as an individual person like Controller of Insurance.
* Having perpetual succession which means any member may resign or die but the Authority will work.
* A common seal with power to enter into a contract by affixing a stamp on the documents.
* Sue or be sued means the Authority can file a case against any person or organization and vice versa.

## Types of Insurances Regulated by the IRDAI:

Insurance is mainly divided into Life and Non-Life/General Insurance. These are further classified into other types of insurance. Below are the [types of insurance](https://www.acko.com/articles/general-info/types-of-insurance/) regulated by the IRDAI:

* Life Insurance
  + Term Plans
  + Endowment Policies
  + Unit-linked Insurance Policies
  + Retirement Policies
  + Money-back Policies
* General Insurance
  + [Health Insurance Policies](https://www.acko.com/health-insurance/)
  + [Vehicle/Motor Insurance Policies](https://www.acko.com/motor-insurance/)
    - [Car insurance](https://www.acko.com/car-insurance/)
    - [Bike Insurance](https://www.acko.com/two-wheeler-insurance/)
  + Property Insurance Policies
  + [Travel Insurance Plans](https://www.acko.com/travel-insurance/)
  + Gadget Insurance Plans

## Difference Between IRDA and SEBI on Their Functions:

Different industries or sectors are regulated by an apex body. They frame rules and regulations, monitor the functions of companies and ensure that they protect the stakeholders. Hence, the apex body for the insurance sector is the IRDA or Insurance Regulatory and Development Authority. A

for SEBI of Securities Exchange Board of India, it regulates securities and commodity sectors in the country. Below is the comparison between IRDA and SEBI:

|  |  |
| --- | --- |
| IRDA  Regulates the insurance industry | SEBI  Regulates the securities and commodity industry |
| Established in 1999 | Established in 1992 |
| Protects the interests of insurance policyholders | Protects the interests of investors in securities |
| Grant certificate of registration to insurance companies to issue insurance policies. | Grant certificate of registration to stockbrokers, bankers, sub-brokers to issue deeds. |
| Frames rules and regulations under the Insurance Regulatory and Development Authority Act | Frames rules and regulations under the Securities and Exchange Board of India Act |

## New Rules and Guidelines for Health and Mediclaim Insurance by IRDA:

The IRDA is the apex body which is responsible for framing new rules and guidelines for health insurance in the country. The regulator has issued new IRDA rules for health and mediclaim insurance in 2020, and they are:

* **Rejection of Claims:** The insurer cannot reject a claim if the policyholder has renewed the policy for eight years without any break or lapse. This period will be known as the moratorium period. The insurer cannot appeal to the IRDA for the rejection of the claim except in case of fraud or in case the claim is raised against the exclusion of the policy.
* **Inclusion of Telemedicine:**With the advent of digitalization, the medical service has changed and one can consult a doctor through online consultations. IRDA has asked insurers to include telemedicine consultations in the insurance policy.
* **Settlement of Claims:**If the insurer delays settling the claim, then the insurance company is liable to pay interest on the claim amount. It should ensure the claim is settled within 30 to 45 days from the submission of the last document by the policyholder.

Insurance Regulation Insurance is regulated, for the most part, at the state level, meaning that each state has the right to determine what insurance policies are sold, how they are sold, by whom they are sold, and even what types of provisions are required in each type of policy. There are also federal laws that affect the insurance industry. One of the most important is the Fair Credit Reporting Act

**Fair Credit Reporting Act**

The FCRA is designed to protect the privacy of consumer report information and to guarantee that the information supplied by credit reporting agencies is as accurate as possible. Consumer reports may include information on an applicant’s credit history, medical conditions, driving record, criminal activity, and hazardous sports. Amendments to the FCRA, which went into effect in 1997, increase the legal obligations of insurers who use consumer reports.

When an adverse action is taken – such as the decision to deny insurance, increase rates, or terminate a policy- and it is based solely or partly on information in a consumer report, the FCRA requires the agent to provide a notice of the adverse action to the consumer. This applies to new applicants as well as current policyholders. The notice must include:

The name, address, and telephone number of the credit reporting agency that supplied the consumer report, including the toll-free telephone number for credit bureaus that maintain files nationwide

A statement that the credit reporting agency that supplied the report did not make the decision to take the adverse action and cannot give the specific reasons for it

A notice that the individual’s right to dispute the accuracy or completeness of any information the credit reporting agency furnished, and the consumer’s right to a free credit report from the credit reporting agency upon request within 60 days

Disclosure of this information is important because some consumer reports may contain errors. The adverse action notice is required even if the information in the consumer report was not the main reason for the denial or rate increase. Even if the information in the report played only a small part in the overall decision, the applicant must still be notified.

There are legal consequences for insurers who fail to get an applicant’s permission before requesting a consumer report containing medical information or who fail to provide required disclosure notices. The FCRA allows individuals to sue insurers for damages in federal court. A person who successfully sues is entitled to recover court costs and reasonable legal fees. The law also allows individuals to seek punitive damages for deliberate violations. In addition, the Federal Trade Commission, other federal agencies, and the states may sue insurers for noncompliance and obtain civil penalties

### Privatisation in insurance sector

Insurance has always been a politically sensitive subject in India. After 40 years of government protectionism of this massive sector, the government is touching dangerous yet interesting ground with their intentions of opening this sector to private Indian business houses, as well as international players. Within less than 10 years of independence, the Indian government nationalized private insurance companies in 1956 to bring this vital sector under government control to raise much needed development funds.. The term is also used in a quite different sense, to mean government out-sourcing of services to private firms. In Indian insurance sector privatization is a boon because it places the risk in the hands of business or private enterprise, Private enterprise more responsive to customer complaints and innovation, the govt. should not be a player and an umpire, and it leads to lower prices and greater supply, Competition in privatization increases differentiation.

Insurance has always been a politically sensitive subject in India. Within less than 10 years of independence, the Indian government nationalized private insurance companies in 1956 to bring this vital sector under government control to raise much needed development funds. Since then, state-owned insurance companies have grown into monoliths, lumbering and often inefficient but the only alternative. They have been criticized for their huge bureaucracies, but still have millions of policy holders as there is no alternative. GIC was formed in 1972and LIC of India was formed in 1956 to take over the insurance business in India. Privatization in insurance sector is a bane because it is expensive and generates a lot of income in fees for specialist advisers, Public monopolies have been turned into private monopolies with too little competition, so consumers have not benefited as much as had been hoped, The nationalized industries were sold off too quickly and too cheaply. In almost all cases the share prices rose sharply as soon as dealing began after privatization, the privatized businesses have sold off or closed down unprofitable parts of the business and so services, Wide share ownership did not really happen as many small investors took their profits and didn‟t buy anything else.

**Meaning of Privatisation**: In broader sense, the term privatization indicates to include and enlarge the share of private sector in the production of goods and services and fewer control and regulation by the state in the economic activities (Paul Starr). It is a policy change and process that creates major institutional and structural changes in different segments of our society. Privatisation means allowing the private sector to setup more and more of industries that were previously reserved for public sector alone. The degree of privatization judged by the extent of ownership transferred from public sector to private sector. Privatisation is the transfer of property or responsibility from the public sector to the private sector. It is the process or activities of enterprise that were once performed and operated by the public sector are performed, managed and owned by private business enterprises or individuals.

Privatisation has many objectives in an economy. Privatisation may improve the efficiency and competition in an industry. It avoids too much political interference in the management of an enterprise and also it enlarge the ownership of economic assets. Privatisation has some other objectives also; it enhances the size and dynamism of the private sector, redistribution of property rights to a larger number of populations. It encourages and facilitates the flow of foreign capital, generates adequate revenue to state and reduces the administrative burden of the state. In short, privatization leads to a transformation of the economy from a commanding economy to a market friendly economy

**Privatization in insurance** :The Narasimha Rao government (1991-96) which unleashed liberal changes in India's rigid economic structure could not handle this political hot potato. Ironically, it is the coalition government in power today which has declared its intention of opening up insurance to the private sector. Ironical because this government is at the mercy of support from the left groups which have been the most vociferous opponents of any such move. All segments of the financial sector had been opened to private players with better product, services & social objective International players are eyeing the vast potential of the Indian market and are already making plans to come in. With the cabinet approving amendments to the Insurance Act of 1938, to raise the cap on foreign direct investment (FDI) in insurance companies from 49 to 74 per cent, the process of implementing the next stage of reducing public control over Indian insurance has begun.

Since 1956, with the nationalization of insurance industry, the LIC held the monopoly in India‟s life insurance sector. GIC, with its four subsidiaries, enjoyed the monopoly for general insurance business. Both LIC and GIC have played a significant role in the development of the insurance market in India and in providing insurance coverage in India through an extensive network. For example, currently, the LIC has a network of 7 zones, 100 divisions and over 2,000 branches. LIC has over 550,000 agents and over 100 million lives are covered. From 1991 onwards, the Indian Government introduced various reforms in the financial sector paving the way for the liberalization of the Indian economy. It was a matter of time before this liberalization affected the insurance sector. A huge gap in the funds required for infrastructure was felt particularly since much of these funds could be filled by life insurance funds, being long tenure funds. Consequently, in 1993, the Government of India set up an eight-member committee chaired by Mr. R. N. Malhotra, former Governor of the Reserve Bank of India, to review the prevailing structure of regulation and supervision of the insurance sector and to make recommendations for strengthening and modernizing the regulatory system. The Committee submitted its report to the Indian Government in January 1994. Two of the key recommendations of the Committee included the privatisation of the insurance sector by permitting the entry of private players to enter the business of life and general insurance and the establishment of an Insurance Regulatory Authority. It took a number of years for the Indian Government to implement the recommendations of the Malhotra Committee. The Indian Parliament passed the Insurance Regulatory and Development Act, 1999 (IRD Act) on 2nd December, 1999 with the aim “to provide for the establishment of an Authority, to protect the interests of the policy holders, to regulate, promote and ensure orderly growth of the insurance industry and to amend the Insurance Act, 1938, the Life Insurance Corporation Act, 1956 and the General Insurance Business (Nationalization) Act, 1972”.

**Need of Privatization in India’s General Insurance Sector:**

* Privatization leads to more competition in the general insurance sector.
* Customers of general insurance services will get wide range of products and

services.

* There is increased awareness of products, prices and services among the people
* Privatisation leads to easy access of insurance services.
* Privatisation helps to bring Indian general insurance sector to international standards.
* Privatisation may bring improved technology, managerial skill, cost efficiency⎫ and product innovations.
* It helps to improve the low insurance penetration and low insurance density in India.
* Privatisation of insurance services expected to bring increased productivity and increased volume of business and new employment opportunities.

**Privatization is a boon**

In Indian insurance sector privatization is a boon because it places the risk in the hands of business or private enterprise, Private enterprise more responsive to customer complaints and innovation, the govt. should not be a player and an umpire, and it leads to lower prices and greater supply, Competition in privatization increases differentiation. Potentials of privatization is stated below

1. Improved Efficiency.:The main argument for privatisation is that private companies have a profit incentive to cut costs and be more efficient. If you work for a government run industry, managers do not usually share in any profits. However, a private firm is interested in making profit and so it is more likely to cut costs and be efficient. Since privatisation, companies such as BT and British Airways have shown degrees of improved efficiency and higher profitability
2. Lack of Political Interference. It is argued governments make poor economic managers. They are motivated by political pressures rather than sound economic and business sense. For example a state enterprise may employ surplus workers which are inefficient. The government may be reluctant to get rid of the workers because of the negative publicity involved in job losses. Therefore, state owned enterprises often employ too many workers increasing inefficiency.
3. Short Term view. A government many think only in terms of next election. Therefore, they may be unwilling to invest in infrastructure improvements which will benefit the firm in the long term because they are more concerned about projects that give a benefit before the election.
4. . Shareholders It is argued that a private firm has pressure from shareholders to perform efficiently. If the firm is inefficient then the firm could be subject to a takeover. A state owned firm doesn‟t have this pressure and so it is easier for them to be inefficient.
5. Increased Competition. Often privatisation of state owned monopolies occurs alongside deregulation – i.e. policies to allow more firms to enter the industry and increase the competitiveness of the market. It is this increase in competition that can be the greatest spur to improvements in efficiency However, privatisation doesn‟t necessarily increase competition; it depends on the nature of the market.

**Privatization is a bane**

Privatization in insurance sector is a bane because it is expensive and generates a lot of income in fees for specialist advisers, Public monopolies have been turned into private monopolies with too little competition, so consumers have not benefited as much as had been hoped, The nationalized industries were sold off too quickly and too cheaply. In almost all cases the share prices rose sharply as soon as dealing began after privatization, the privatized businesses have sold off or closed down unprofitable parts of the business and so services, Wide share ownership did not really happen as many small investors took their profits and didn‟t buy anything else. Privatization is a cuss which determines

1.Monopoly. A natural monopoly occurs when the most efficient number of firms in an industry is one. For example tap water has very significant fixed costs; therefore there is no scope for having competition amongst several firms. Therefore, in this case, privatisation would just create a private monopoly which might seek to set higher prices which exploit consumers. Therefore it is better to have a public monopoly rather than a private monopoly which can exploit the consumer.

2. Public Interest. There are many industries which perform an important public service, e.g. health care, education and public transport. In these industries, the profit motive shouldn‟t be the primary objective of firms and the industry. For example, in the case of health care, it is feared privatizing health care would mean a greater priority is given to profit rather than patient care. Also, in an industry like health care, arguably we don‟t need a profit motive to improve standards. When doctors treat patients they are unlikely to try harder if they get a bonus.

3. Government loses out on potential dividends. Many of the privatized companies are quite profitable. This means the government misses out on their dividends, instead going to wealthy shareholders.

4. Problem of regulating private monopolies. Privatisation creates private monopolies, such as the water companies and rail companies. These need regulating to prevent abuse of monopoly power. Therefore, there is still need for government regulation, similar to under state ownership.

5. Fragmentation of industries. In different countries, rail privatisation led to breaking up the rail network into infrastructure and train operating companies. This led to areas where it was unclear who had responsibility. For example, the Hatfield rail crash was blamed on no one taking responsibility for safety. Different rail companies have increased the complexity of rail tickets.

**INSURANCE ACT.1938**

This Act was passed in 1938 and was brought into force from 1st July, 1939. This act applies to the GIC and the four subsidiaries. The act was amended several times in the years 1950, 1968, 1988, 1999. This Act specifies the restrictions and limitations applicable as specified by the Central Government under powers conferred by section 35 of the General Insurance Business (Nationalization) Act. The important provisions of the Act relate to:

Registration: Every insurer is required to obtain a Certificate of Registration from the Controller of Insurance, by making the payment of requisite fees. Registration should be renewed annually

. Accounts and audit: An insurer is required to maintain separate accounts of the receipts and payments in each class of insurance viz. Fire, Marine and Miscellaneous Insurance. Apart from the regular financial statements, the companies are required to maintain the following documents in respect of each class of insurance:

* Record of Cover notes specifying the details of the risk covered
* Record of policies
* Record of premiums
* Record of endorsements
* Record of Bank guarantees
* Record of claims Register of agency force and business procured by each with details of commission
* Register of employees
* Cash Books Reinsurance details
* Claims register

Investments: Investments of insurance company are usually made in approved investments under the provisions of the Act. The guidelines and limitations are issued by the Central Government from time to time.

Limitation on management expenses: The Act prescribes the maximum limits of expenses of management including commission that may be incurred by an insurer. The percentages are prescribed in relation to the total gross direct business written by the insurer in India. Prohibition of Rebates: The Act prohibits any person from offering any rebate of commission or a rebate of premium to any person to take insurance. Any person found guilty would be punished with a fine up to five hundred rupees.

Powers of Investigation: The Central Government may at any time direct the Controller or any other person by order, to investigate the affairs of any insurer and report to the central government.

Other Provisions: Other provisions of the Act deal with the licensing of agents, surveyors, advance payment of premium and Tariff Advisory Committee (TAC).

* Prohibition of rebates
* Powers of investigation Licensing of agents
* Advance payments of premiums
* Tariff Advisory Committee

**Insurance Act, 1938 – Amendments Section 38**

(1) A transfer or assignment of a policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the transferor or by the assignor or his duly authorised agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made

(2) An insurer may, accept the transfer or assignment, or decline to act upon any endorsement made under sub-section (1), where it has sufficient reason to believe that such transfer or assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy

(3) The insurer shall, before refusing to act upon the endorsement, record in writing the reasons for such refusal and communicate the same to the policyholder not later than thirty days from the date of the policyholder giving notice of such transfer or assignment (4) Any person aggrieved by the decision of an insurer to decline to act upon such transfer or assignment may within a period of thirty days from the date of receipt of the communication from the insurer containing reasons for such refusal, prefer a claim to the Authority

(5) Subject to the provisions in sub-section (2), the transfer or assignment shall be complete and effectual upon the execution of such endorsement or instrument duly attested but except, where the transfer or assignment is in favour of the insurer, shall not be operative as against an insurer, and shall not confer upon the transferee or assignee, or his legal representative, any right to sue for the amount of such policy or the moneys secured thereby until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or a copy thereof certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer: Provided that where the insurer maintains one or more places of business in India, such notice shall be delivered only at the place where the policy is being serviced

(6) The date on which the notice referred to in sub-section (5) is delivered to the insurer shall regulate the priority of all claims under a transfer or assignment as between persons interested in the policy; and where there is more than one instrument of transfer or assignment the priority of the claims under such instruments shall be governed by the order in which the notices referred to in sub-section (5) are delivered: Provided that if any dispute as to priority of payment arises as between assignees, the dispute shall be referred to the Authority

(7) Upon the receipt of the notice referred to in sub-section (5), the insurer shall record the fact of such transfer or assignment together with the date thereof and the name of the transferee or the assignee and shall, on the request of the person by whom the notice was given, or of the transferee or assignee, on payment of such fee as may be specified by the regulations, grant a written acknowledgement of the receipt of such notice; and any such acknowledgement shall be conclusive evidence against the insurer that he has duly received the notice to which such acknowledgement relates

(8) Subject to the terms and conditions of the transfer or assignment, the insurer shall, from the date of the receipt of the notice referred to in sub-section (5), recognise the transferee or assignee named in the notice as the absolute transferee or assignee entitled to benefit under the policy, and such person shall be subject to all liabilities and equities to which the transferor or assignor was subject at the date of the transfer or assignment and may institute any proceedings in relation to the policy, obtain a loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to such proceedings

(9) Any rights and remedies of an assignee or transferee of a policy of life insurance under an assignment or transfer effected prior to the commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by the provisions of this section

(10) Notwithstanding any law or custom having the force of law to the contrary, an assignment in favour of a person made upon the condition that

(a) the proceeds under the policy shall become payable to the policyholder or the nominee or nominees in the event of either the assignee or transferee predeceasing the insured; or

(b) the insured surviving the term of the policy, shall be valid: Provided that a conditional assignee shall not be entitled to obtain a loan on the policy or surrender a policy

(11) In the case of the partial assignment or transfer of a policy of insurance under sub-section (1), the liability of the insurer shall be limited to the amount secured by partial assignment or transfer and such policyholder shall not be entitled to further assign or transfer the residual amount payable under the same policy

Section 39

(1) The holder of a policy of life insurance on his own life may, when effecting the policy or at any time before the policy matures for payment, nominate the person or persons to whom the money secured by the policy shall be paid in the event of his death: Provided that, where any nominee is a minor, it shall be lawful for the policyholder to appoint any person in the manner laid down by the insurer, to receive the money secured by the policy in the event of his death during the minority of the nominee

(2) Any such nomination in order to be effectual shall, unless it is incorporated in the text of the policy itself, be made by an endorsement on the policy communicated to the insurer and registered by him in the records relating to the policy and any such nomination may at any time before the policy matures for payment be cancelled or changed by an endorsement or a further endorsement or a will, as the case may be, but unless notice in writing of any such cancellation or change has been delivered to the insurer, the insurer shall not be liable for any payment under the policy made bona fide by him to a nominee mentioned in the text of the policy or registered in records of the insurer

(3) The insurer shall furnish to the policyholder a written acknowledgement of having registered a nomination or a cancellation or change thereof, and may charge such fee as may be specified by regulations for registering such cancellation or change

(4) A transfer or assignment of a policy made in accordance with section 38 shall automatically cancel a nomination: Provided that the assignment of a policy to the insurer who bears the risk on the policy at the time of the assignment, in consideration of a loan granted by that insurer on the security of the policy within its surrender value, or its reassignment on repayment of the loan shall not cancel a nomination, but shall affect the rights of the nominee only to the extent of the insurer's interest in the policy: Provided further that the transfer or assignment of a policy, whether wholly or in part, in consideration of a loan advanced by the transferee or assignee to the policyholder, shall not cancel the nomination but shall affect the rights of the nominee only to the extent of the interest of the transferee or assignee, as the case may be, in the policy: Provided also that the nomination, which has been automatically cancelled consequent upon the transfer or assignment, the same nomination shall stand automatically revived when the policy is reassigned by the assignee or retransferred by the transferee in favour of the policyholder on repayment of loan other than on a security of policy to the insurer

(5) Where the policy matures for payment during the lifetime of the person whose life is insured or where the nominee or, if there are more nominees than one, all the nominees die before the policy matures for payment, the amount secured by the policy shall be payable to the policyholder or his heirs or legal representatives or the holder of a succession certificate, as the case may be

(6) Where the nominee or if there are more nominees than one, a nominee or nominees survive the person whose life is insured, the amount secured by the policy shall be payable to such survivor or survivors

(7) Subject to the other provisions of this section, where the holder of a policy of insurance on his own life nominates his parents, or his spouse, or his children, or his spouse and children, or any of them, the nominee or nominees shall be beneficially entitled to the amount payable by the insurer to him or them under sub-section (6) unless it is proved that the holder of the policy, having regard to the nature of his title to the policy, could not have conferred any such beneficial title on the nominee

(8) Subject as aforesaid, where the nominee, or if there are more nominees than one, a nominee or nominees, to whom subsection (7) applies, die after the person whose life is insured but before the amount secured by the policy is paid, the amount secured by the policy, or so much of the amount secured by the policy as represents the share of the nominee or nominees so dying (as the case may be), shall be payable to the heirs or legal representatives of the nominee or nominees or the holder of a succession certificate, as the case may be, and they shall be beneficially entitled to such amount

(9) Nothing in sub-sections (7) and (8) shall operate to destroy or impede the right of any creditor to be paid out of the proceeds of any policy of life insurance

(10) The provisions of sub-sections (7) and (8) shall apply to all policies of life insurance maturing for payment after the commencement of the Insurance Laws (Amendment) Act, 2015

(11) Where a policyholder dies after the maturity of the policy but the proceeds and benefit of his policy has not been made to him because of his death, in such a case, his nominee shall be entitled to the proceeds and benefit of his policy

(12) The provisions of this section shall not apply to any policy of life insurance to which section 6 of the Married Women's Property Act, 1874, applies or has at any time applied: Provided that where a nomination made whether before or after the commencement of the Insurance Laws (Amendment) Act, 2015, in favour of the wife of the person who has insured his life or of his wife and children or any of them is expressed, whether or not on the face of the policy, as being made under this section, the said section 6 shall be deemed not to apply or not to have applied to the policy

Section 41

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer. Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this subsection if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bonafide insurance agent employed by the insurer

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees

Section 45

(1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later

(2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival, of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based

(3) Notwithstanding anything contained in subsection (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive

(4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of mis-statement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation

(5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal

**The Indian Stamp Act, 1899**: The Indian Stamp Act requires that a policy of insurance be stamped in accordance with the schedule of rate prescribed.

**The Consumer Protection Act, 1986**

The Act applies to all goods and services unless specifically exempted by Central Government. The provisions of the Act are compepsatory in nature. It enshrines the following rights of the consumers :

* 1. The right to be protected against the marketing of goods which are hazardous of life and property;
  2. The right to be informed about the quality, quantity, potency, purity, standard and price of goods so as to protect the consumer against unfair trade practices; .
  3. The right to be heard and to be assured that consumers interest will receive due consideration at appropriate forum;
  4. The right to seek redressal against unfair trade practices or unscrupulous exploitation of consumers;
  5. The right to consumer education. Under Section 2(e) of the Act, the insurance is recognised as services. Chapter 32 of the-Ad elaborates various consumer rights.

**Laws Applicable to General Insurance Business**

Apart from the legal enactment discussed in the previous section, following laws are also applicable to general insurance business.

1. **Motor Vehicles Act, 1988**: Motor Vehicles Act, 1988 provides for compulsory insurance of motor vehicles. The Act provides that no motor vehicle can be used in a public place unless there is in force in relation to vehicle a policy issued by an authorised insurer. This policy covers the insured person's liability in the event of death, bodily injury of certain persons or damage to property of third persons.
2. **The Inland Steam Vessels Act, 1917 and the Amended Act, 1977 :** The Act provides that the provisions of Chapter VII of the Motors Vehicles Act, 1955 regarding insurance of mechanically propelled vessels against third party risks are applicable to steam vessels. The Act maker it compulsory for the owners of operators of inland vessels to insure against legal liability of death, bodily injury or damage caused to the property of third persons and passengers.
3. **Marine Insurance Act, 1963** : Marine Insurance Act, 1963 (based on Marine Insurance Act 1906) codifies the law relating the conduct of marine insurance business in India. The provisions of the Act inter-alia includes provisions relating to basic insurance principles (Indemnification, insurable interest, utmost goodfaith, subrogation and contribution, valuation, losses, warranties, return of premiums etc.
4. **The Carriage of Goods by Sea Act, 1925 :** The Act defines the minimum rights, liabilities and immunities of a shipowner on loss or damage to cargo. The act deals with three aspects of a shipowners liabilities towards cargo owner :
   1. the circumstances when the shipowner is deemed to be liable for loss or damage to cargo unless he proves otherwise;
   2. (ii) the circumstance when the shipowner is exempted from liability, i.e., when loss or damage is caused by events outside his control, e.g., perils of the seas;
   3. (iii) the limits of liability of a shipowner for loss of or damage to cargo calculated in monetary terms per package or unit of cargo.
5. **The Merchant Shipping Act, 1958** : This Act also provides a certain protection to shipowners. For example, the liability of a shipowner can be limited to certain maximum sum for certain losses, provided the incident giving rise to such claim has arisen without the actual fault or privy of the shipowner. These claims may relate to loss of life, personal injury or loss of or damage to property on land or water. The Act also confers the obligation on the shipowner to send his ship to sea in a seaworthy and safe condition.
6. **The Bill of Lading Act, 1855** : This Act defines the character of the Bill of Lading as an evidence of the contract of carriage of goods between the shipowner and the shipper, as an acknowledgement of the receipt of the goods on board the vessel and, as a document of title. The bill of lading is one of the various documents required in connection with settlement of marine cargo claims.
7. **The Indian Ports (Major Ports) Act, 1963**: This Act defines the liability of Port Trust Authorities for loss of or damage to goods whilst in their custody and prescribes time limits for filing monetary claim on, or suit against, the Port Trust Authorities.
8. **The Carriers Act, 1865** : The Act defines the rights and liabilities of truck owners or operators who carry goods for public hire in respect of loss or damage to goods carried by them. It also prescribes the time limit within which notice of loss or damage must be filed with the road carriers.
9. **The Indian Post Office Act, 1898**: This Act defines the liability of the Government for loss, misdelivery, delay of or damage to any postal articles in course of transmission by post.
10. **Multi Modal Transportation Act, 1993**: The Act provides for registration of multi-modal transport operators engaged in transportation of goods under more than one mode of transport, i.e., by rail/road and sea. It prescribes limits of liability of the operator, contents of documents to be issued by them, notice of loss, etc.
11. **Workmen's Compensation Act, 1923** : The Act provides for the payment by employers to their workmen of compensation for injury by accident, arising out of and in the course of employment. The object of this legislation has been stated as follows-The growing complexity of industry in this country, with the increasing use of machinery and consequent danger to workmen, along with the comparative poverty of the workmen themselves render it advisable that they should be protected as far as possible, from hardship out of accidents. It provides certain benefits to employees in case of accidents during employment, sickness, maternity etc.
12. **Employees State Insurance Act, 1948** :The Employees' State Insurance Act, 1948, has been described as an Act "to provide for certain benefits to employees in cases of sickness, maternity and employment injury and to make provision for certain other matters in relation thereof 'Under the Act, the Employees' State Insurance Corporation has been set up to administer the Insurance Scheme. The Scheme is applicable to industrial employees as defined in the Act. The Act operated in certain industrial areas as notified by the Government from time to time. It is intended that the Act will be eventually extended to all industrial areas in the country. Under the scheme a fund is maintained consisting of contributions from the employees, employers and the Government.

**CONCEPT OF INTERMEDIARIES**

A basic definition defines an intermediary as ‘action between two parties - mediatory’ or ‘situated or occurring between two things - intermediate’. The latter form refers more to a position within a process or level of achievement. The former, by contrast, refers to an intermediary as an agent in some form, as ‘one who acts between others - a do-between or mediator’, or as ‘something acting between things persons or things’. As actors then, what intermediaries do is mediate, they work in-between, make connections, enable a relationship between different persons or things. Indeed in common parlance the meaning implied by the concept intermediary tends to refer to a neutral player trying to mediate between different sets of interests. The assumption of neutrality is however, problematic. Rather than focus on everything as an intermediary, the interesting question is to ask in what ways, where, when and how particular things, people, organisations etc. are/ become defined as ‘intermediaries’. Further still, there is the question of the active role that intermediaries play in defining the relationship between other actors.

In Insurance industries, an insurance intermediary is a person or a company that helps you in buying insurance. Insurance intermediaries facilitate the placement and purchase of insurance, and provide services to insurance companies and consumers that complement the insurance placement process. Traditionally, insurance intermediaries have been categorized as either insurance agents or insurance brokers.

Insurance Intermediaries: Insurance is a complex product representing a promise to compensate the insured or third party according to specified terms and conditions in the event of the occurrence of a covered contingency. In most insurance transactions there is usually an intermediary - an insurance agent (individual or corporate) or an insurance broker. Insurance intermediaries serve as a bridge between consumers (seeking to buy insurance policies) and insurance companies (seeking to sell those policies).

Insurance intermediaries facilitate the placement and purchase of insurance, and provide services to insurance companies and consumers that complement the insurance placement process. Traditionally, insurance intermediaries have been categorized as either insurance agents or insurance brokers. The distinction between the two relates to the manner in which they function in the marketplace. An intermediary has a distinct role to play in the entire life cycle of a product, from the point of sale 2 3 through policy servicing, up to claim servicing. An intermediary shall provide all material information with respect to a proposed cover to enable the prospect to decide on the best one. The intermediary is expected to advise the prospect with complete disclosures and transparency.. After the sale is effected, the intermediary must coordinate effectively between the customer and the insurer for policy servicing as well as claim servicing.

IRDA has prescribed regulations for protecting the interests of policyholders casting obligations not only on Insurers but also Intermediaries. These prescribe obligations at the point of sale as well as policy servicing and claims servicing .

There are many market players in insurance industries i.e.

(a) Agents,

(b) Brokers,

(c) Surveyors & Loss Assessors,

(d) Health Third Party Administrators,

**Insurance Agent**

Section 2(10) of the Insurance Act, 1938, defines an Insurance Agent as an insurance agent licensed under Section 42 of the said Act and who received or agrees to receive payment by way of commission or other remuneration in consideration of his soliciting or procuring insurance business including business relating to the continuance, renewal or revival of policies of insurance.

Principal-Agent Relationship- Legal Implications and Status

Sections 182 to 238 of the Indian Contract Act, 1872 govern the relationship between a Principal and an Agent. An insurance agency contract is also governed by the principles enshrined therein. An Agent (“Insurance Agent”) is a person employed to do any act for another or to represent another in dealings with third persons. The function of an agent is to bring his principal into contractual relations with third persons. A Principal (“Insurer”) is a person for whom the above act is done or who is so represented.

There are two important rules of agency:

1. Whatever a person can do personally, he can do through an agent

2. He who does an act through another does it by himself

In this regard, it is pertinent to note the provisions of Section 237 of the Indian Contract Act, 1872 on the extent to which the acts of the Agent bind the Principal. Where an Agent has, without authority, done acts or incurred obligations to third persons on behalf of his principal, the principal is bound by such acts or obligations, if he has by his words or conduct induced such third persons to believe that such acts and obligations were within the scope of the agent’s authority.

Further Section 238 of the Indian Contract Act, 1872 states that misrepresentation or frauds committed by the agent acting in the course of business for their principals, have the same effect on agreements made by such agents as if such misrepresentation or frauds had been made or committed by the principals. But misrepresentation or frauds committed by agents in matters which do not fall within their authority do not affect the principals.

For example, if an insurance agent misrepresents to the customer while selling an insurance product, the policy contract (agreement between insurer and policyholder) may become voidable at the option of the Policyholder.

TYPES OF INSURANCE AGENTS

The following are the different types of Insurance Agents recognised under the Regulations:

(a) Individual Agent

(b) Corporate Agent

(c) Micro Insurance Agent

INSURANCE BROKER

Regulation 2(i) of the IRDA (Insurance Brokers) Regulations, 2002, defines Insurance Broker as a person for the time being licensed by the Authority under Regulation 11, who for remuneration arranges insurance contracts with insurance companies and/or reinsurance companies on behalf of his clients.

Insurance brokers typically work for the policyholder in the insurance process and act independently in relation to insurers. Brokers assist clients in the choice of their insurance by presenting them with alternatives in terms of insurers and products. Acting as “agent” for the buyer, brokers usually work with multiple companies to place coverage for their clients. Brokers obtain quotes from various insurers and guide clients in determining the adequate policy from a range of products.

**Role of an Insurance Broker**

Regulation 3 of the IRDA (Insurance Brokers) Regulations, 2002 summarises the functions of a Direct Broker:

(a) Since a Broker represents a client, he is expected to obtain detailed information on client’s business and risk management philosophy and familiarise himself with the client’s business

(b) Render proper advice to the client in selecting the appropriate insurance as well as terms of insurance

(c) Possessing a detailed knowledge of insurance markets to be in a position to advice his client

(d) Submitting quotation received from insurance companies for consideration of a client

(e) Providing the information required about the client or the subject matter to be insured, to enable insurer to properly assess the risk and give a premium quotation

(f) Updating customer about the progress of the proposal submitted and providing written acknowledgements

(g) Assisting clients in paying premiums under Section 64VB of the Insurance Act, 1938

(h) Assisting clients in negotiation of claims and maintenance of claim records

**Difference between Insurance Agent and Insurance Broker**

The basic difference between an Insurance Broker and an Insurance Agent is that while an Insurance Broker represents the client, while an Insurance Agent represents the insurance company. As a corollary to the above, an Insurance Broker is licensed to recommend the products of any insurance company, whereas Insurance Agent at any point in time can sell the insurance products of only one insurance company with which he is attached.

**SURVEYORS AND LOSS ASSESSORS**

A Surveyor or a Loss Assessor is relevant for general insurance business, where assessment of the loss of the subject matter insured is very important for deciding the claim amount. As general insurance contracts are indemnity contracts in nature, the amount paid by the insurance company cannot exceed the amount of actual loss incurred. The job of the Surveyor or a Loss Assessor is therefore to arrive at the exact amount of loss incurred and his role is critical to a general insurer.

Every person who is a student-member of the Institutes of Surveyors and Loss Assessors intending to act as a Surveyor or Loss Assessor is required to be licensed by IRDA before he starts performing his functions for any general insurer. A licence issued for a Surveyor or a Loss Assessor shall be valid for a period of 5 years after which it is required to be renewed.

A Surveyor and Loss Assessor shall be categorized into 3 categories, The three categories are Licentiate, Associateship and Fellowship which is awarded by the Institute of Surveyors and Loss Assessors. The nature of surveyor or loss assessment work which can be undertaken would depend upon the categorisation. Further IRDA shall also allot the department or the area work for the Surveyor and Loss Assessor from time to time.

**THIRD PARTY ADMINISTRATORS-HEALTH**

A Third Party Administrator (‘TPA’) is a person appointed by an insurance company to render services in connection with health insurance business or health cover, excluding the insurance business of an insurer and soliciting or procuring insurance business directly or through an intermediary or an insurance agent.

TPAs are normally engaged to provide services in connection with hospitalisation of an insured under a health insurance policy taken through a general insurance company or a standalone health insurance company or under health insurance rider covers offered by life insurance companies. They also offer certain other services like arranging for medical examination of the insured before a policy is issued by an insurance company etc.

**CORPORATE AGENT:**  
A corporate agent is an intermediary other than an individual, may be a firm, company or a registered society, representing an insurance company. A Designated Person means an officer normally in charge of marketing operations, as specified by an insurer, and authorized by the Authority to issue or renew licenses under the applicable regulations.

ROLE OF INTERMEDIARIES IN INSURANCE INDUSTRY

As players with both broad knowledge of the insurance marketplace, including products, prices and providers, and an acute sense of the needs of insurance purchasers, intermediaries have a unique role – indeed many roles – to play in the insurance markets in particular and, more generally, in the functioning of national and international economies.

Intermediary activity benefits the overall economy at both the national and international levels:

The role of insurance in the overall health of the economy is well-understood. Without the protection from risk that insurance provides, commercial activities would slow, perhaps grinding to a halt, thus stunting or eliminating economic growth and the financial benefits to businesses and individuals that such growth provides. The role of insurance intermediaries in the overall economy is, essentially, one of making insurance – and other risk management products – widely available, thereby increasing the positive effects of insurance generally – risk-taking, investment, provision of basic societal needs and economic growth

. There are several factors that intermediaries bring to the insurance marketplace that help to increase the availability of insurance generally:

Innovative Marketing:

Insurance intermediaries bring innovative marketing practices to the insurance marketplace. This deepens and broadens insurance markets by increasing consumers’ awareness of the protections offered by insurance, their awareness of the multitude of insurance options, and their understanding as to how to purchase the insurance they need.

Dissemination of information to Consumers :

Intermediaries provide customers with the necessary information required to make educated purchases/ informed decisions. Intermediaries can explain what a consumer needs, and what the options are in terms of insurers, policies and prices. Faced with a knowledgeable client base that has multiple choices, insurers will offer policies that fit their customers’ needs at competitive prices.

Dissemination of Information to the Marketplace:

Intermediaries gather and evaluate information regarding placements, premiums and claims experience. When such knowledge is combined with an intermediary’s understanding of the needs of its clients, the intermediary is well-positioned to encourage and assist in the development of new and innovative insurance products and to create markets where none have existed. In addition, dissemination of knowledge and expansion of markets within a country and internationally can help to attract more direct investment for the insurance sector and related industries.

Sound Competition:

Increased consumer knowledge ultimately helps increase the demand for insurance and improve insurance take-up rates. Increased utilization of insurance allows producers of goods and services to make the most of their risk management budgets and take advantage of a more competitive financial climate, boosting economic growth.

Spread insurers’ Risks:

Quality of business is important to all insurers for a number of reasons including profitability, regulatory compliance, and, ultimately, financial survival. Insurance companies need to make sure the risks they cover are insurable – and spread these risks appropriately – so they are not susceptible to catastrophic losses. Intermediaries help insurers in the difficult task of spreading the risks in their portfolio. Intermediaries work with multiple insurers, a variety of clients, and, in many cases, in a broad geographical spread. They help carriers spread the risks in their portfolios according to industry, geography, volume, line of insurance and other factors. This helps insurers from becoming over-exposed in a particular region or a particular type of risk, thus freeing precious resources for use elsewhere.

Reducing Costs:

By helping to reduce costs for insurers, broker services also reduce the insurance costs of all undertakings in a country or economy. Because insurance is an essential expense for all businesses, a reduction in prices can have a large impact on the general economy, improving the overall competitive position of the particular market. Of course, the insurance cycle of “hard” and “soft” markets can have a significant impact on the benefits – both good and bad – of increased availability. Generally, however, increased availability benefits the consumer by leading to product competition, price competition, and improved services. By reducing insurance costs across markets, intermediaries make an important contribution to improving the economic conditions in a country.

**Valuing Insurance Coverage**

How much an insurance company will pay for a loss covered by the policy depends on what the policy says about how it will value losses, and how it will split the loss amount with the insured. The definitions below are common in insurance policies and determine how much will be paid for a loss

**Actual Cash Value**: . An amount equivalent to the replacement cost of lost or damaged property at the time of the loss, less depreciation. With regard to buildings, there is a tendency for the actual cash value to closely parallel the market value of the property.

**Replacement Cost**. :The cost of replacing property without a reduction for depreciation. By this method of determining value, damages for a claim would be the amount needed to replace the property using new materials.

Market Value.: The price for which something would sell, especially the value of certain types of assets, such as stocks and bonds. It is based on what they would sell for under current market conditions.

Stated Amount:. An agreed amount of insurance which is shown on the policy, and which will be paid in the event of total loss regardless of the actual value of the property.

Valued Policy. :A policy which states that in the event of a total loss, a specific amount will be paid, that being the amount stated in the policy. The effect is to eliminate the need for determining the actual cash value of an item of property in the event of a total loss. It is generally used with certain more valuable items, such as fine arts, antiques, and furs.

Open Policy. :An open policy is one in which the value of the subject matter is not agreed upon, but is left to be ascertained in case of loss.

Agreed Amount Clause. Under this clause, the insured and the insurer agree that the amount of insurance carried will automatically satisfy the coinsurance clause. The effect is to eliminate the necessity of determining whether or not the amount carried is equal to the stated percentage of the actual cash value indicated in the coinsurance clause.

Blanket Insurance. A form of property insurance that covers, in a single contract, either multiple types of property at a single location or one or more types of property at multiple locations

Specific Insurance. A policy which describes specifically the property to be covered. This is in contrast to a policy which covers on a blanket basis all property at one or more locations without specific definitions. In the case of overlapping coverages, specific insurance is considered the primary one

**Pricing of the Products**

The pricing of the policy in insurance sector has a definite being ON INSURANCE BUSINESS. The price always has an impact of the demand and supply of the products and the services. So the pricing of the insurance products will have a bearing impact on the insurance business in the country. The pricing of the product undergo change and the regulator will have to monitor it in order to create a healthy competition and insurance market in the country in view, entry of private players. The provider and the receivers both will have to interact very closely to secure a fair deal on the pricing of the deal, as the good state insurance sector will no longer be in a monopolized position. There should be meaningful and viable price for any product to be marketed and sustained. However the responsible company can afford to cut prices to a certain point, if they are to preserve their own financial stability and ability to meet their obligations. This is an area which provides unlimited opportunities in the Indian context for consultancy, broking, and education in the post privatization phase with new employment opportunities

## What Is a Valuation Clause?

The valuation clause is a provision in some insurance policies that specify the amount of money the policyholder will receive from the insurance provider if a covered hazard event occurs. This clause stipulates a fixed amount to be paid in the event of a loss for an insured property.

Several types of valuation clauses can be written, including replacement cost, actual cash value, stated amount, and agreed value.

CLAIM PROCEDURE AND MANAGEMENT

Filing a Life Insurance Claim: Claim settlement is one of the most important services that an insurance company can provide to its customers. Insurance companies have an obligation to settle claims promptly. You will need to fill a claim form and contact the financial advisor from whom you bought your policy. Submit all relevant documents such as original death certificate and policy bond to your insurer to support your claim. Most claims are settled by issuing a cheque within 7 days from the time they receive the documents. However, if your insurer is unable to deal with all or any part of your claim, you will be notified in writing.

**Types of claims**

Maturity Claim – On the date of maturity life insured is required to send maturity claim / discharge form and original policy bond well before maturity date to enable timely settlement. Most companies offer/issue post dated cheques and/ or make payment through ECS credit on the maturity date. Incase of delay in settlement kindly refer to grievance redressal.

Death Claim (including rider claim) - In case of death claim or rider claim the following procedure should be followed.

Follow these four simple steps to file a claim:

1. Claim intimation/notification The claimant must submit the written intimation as soon as possible to enable the insurance company to initiate the claim processing. The claim intimation should consist of basic information such as policy number, name of the insured, date of death, cause of death, place of death, name of the claimant. The claimant can also get a claim intimation/notification form from the nearest local branch office of the insurance company or their insurance advisor/agent. Alternatively, some insurance companies also provide the facility of downloading the form from their website.

2. Documents required for claim processing The claimant will be required to provide a claimant's statement, original policy document, death certificate, police FIR and post mortem exam report (for accidental death), certificate and records from the treating doctor/hospital (for death due to illness) and advance discharge form for claim processing. Based on the sum at risk, cause of death and policy duration, insurance companies may also request some additional documents.|

3. Submission of required documents for claim processing For faster claim processing, it is essential that the claimant submits complete documentation as early as possible. A life insurer will not be able to take a decision until all the requirements are complete. Once all relevant documents, records and forms have been submitted, the life insurer can take a decision about the claim. 4. Settlement of claim As per the regulation 8 of the IRDA (Policy holder's Interest) Regulations, 2002, the insurer is required to settle a claim within 30 days of receipt of all documents including clarification sought by the insurer. However, the insurance company can set a practice of settling the claim even earlier. If the claim requires further investigation, the insurer has to complete its procedures within six months from receiving the written intimation of claim.

Claim intimation In case a claim arises you should:

Contact the respective life insurance branch office.

Contact your insurance advisor

Call the respective Customer Helpline Claim requirements

For Death Claim:

Death Certificate

Original Policy Bond

Claim Forms issued by the insurer along with supporting documents

For Accidental Disability / Critical Illness Claim:

Copies of Medical Records, Test Reports, Discharge Summary, Admission Records of hospitals and Laboratories.

Original Policy Bond

Claim Forms along with supporting documents

For Maturity Claims:

Original Policy Bond

Maturity Claim Form

Foreign insurers in india

A major role played by the insurance sector is to mobilize national savings and channelize them into investments in different sectors of the economy. FDI in insurance would increase the penetration of insurance in India; FDI can meet India’s long term capital requirements to fund the building of infrastructures.

Insurance sector has the capability of raising long-term capital from the masses, as it is the only avenue where people put in money for as long as 30 years even more. An increase in FDI in insurance would indirectly be a boon for the Indian economy.

The role of Foreign Direct Investment in the present world is noteworthy. It acts as the lifeblood in the growth of the developing nations. The wave of liberalisation and globalization sweeping across the world has opened many national markets for international business.

Insurance Regulatory & Development Authority (IRDA) is in favour of an increase in foreign equity capital in the insurance joint ventures. The public sector Insurance companies have continued to dominate the insurance market. India is among the most promising emerging insurance markets in the world.

Questions

**Can I convert my existing physical paper policy documents into electronic or digital format?**

Yes, you can convert it to electronic policies. You have to raise a request with the insurance company or the Insurance Repository to make the required changes.

**Which types of insurance policies can be held in electronic format?**

All types of Life Insurance, General Insurance, Health Insurance and Annuity Policies that are issued by insurance companies registered by the IRDA can be held in electronic format.

**What is an insurance ombudsman?**

It is a scheme introduced by the Central Government for efficient, cost-effective and impartial settlement of policyholder’s grievances.

**Under what circumstances do I approach the insurance ombudsman?**

You can approach the ombudsman in case of:  
  
>Delay in claim settlement.  
>Disputes over the insurance premium.  
>For any total or partial repudiation of claims by the insurance company.  
>Disputes in the policy terms and conditions.  
>Disputes on the legal aspects of the policy.  
>Disputes related to servicing of the policy.  
>Any violations of rules and regulations of the Insurance Act, 1938.

**How do I lodge a complaint with the insurance ombudsman?**

You need to lodge the complaint in writing duly signed by the complainant or via their legal heirs, assignees or nominees. You can either lodge the complaint in person or through post/email/fax followed by a hard copy.

**What is an insurance repository?**

An insurance company formed and registered by the IRDA for maintaining the data of insurance policies in electronic format on behalf of insurance companies is known as Insurance Repository. The main aim of the insurance repository is to provide policyholders a facility to keep policies in electronic format.

**What is the IRDA Act?**

The Act provides comprehensive regulation of the insurance sector in the country. To examine the structure of the insurance sector and to recommend revisions to the rules and regulations to make it more efficient and effective, a committee was set up by the Government of India to submit a report on the same. In 1999, the Insurance Regulatory and Development Authority was tabled in the parliament. The bill was debated and discussed before the Bill became the Insurance Regulatory and Development Authority (IRDA) Act, 1999.

**How many insurance companies are under the IRDA in India?**

There are Life and Non-Life/General Insurance Companies in India. Under the Life Insurance category, there are a total of 24 Life Insurance companies and 34 [Non-Life or General Insurance](https://www.acko.com/general-info/non-life-insurance/) companies registered under the IRDA. For detailed information about the insurance companies, visit the [IRDA website](http://www.irdai.gov.in/).

**How to approach the IRDA for grievances?**

You should approach your insurance company for all queries or to address your grievances; however, if you feel that your issue has not been resolved, you can approach the Insurance Ombudsman, which acts as the grievance redressal forum for policyholders.

**Does the IRDA grant licenses for insurance agents?**

Yes, the IRDA is responsible for granting licenses for insurance agents. It grants licenses to those who clear the required exam. This was incorporated in the IRDA Regulations and consists of the rules for applying and availing an insurance agent license.

. **List the Composition of Authority**.

The Authority shall consist of nine persons i.e. Chairperson, not more than 5 whole time members and not more than 4 part time members.

**3. Mention the maximum age of the Chairperson of IRDA.**

a. Maximum age of Chairperson of IRDA is 65 years.

1.Who is an Insurance Intermediary?

Ans. An Insurance Intermediary means individual agents, corporate agents including banks and brokers –they intermediate between the customer and the insurance company. Insurance Intermediary also includes Surveyors and Third Party Administrators but these intermediaries are not involved in procurement of business. Surveyors assess losses on behalf of the insurance companies. Third Party Administrators provide services related to health insurance for insurance companies.

Q. Who is an Agent?

Ans. An agent is a person who is licensed by the Authority to solicit and procure insurance business including business relating to continuance, renewal or revival of policies of insurance. An agent could be an Individual Agent or a Corporate Agent. An Individual Agent, as the name suggests is an individual who in an intermediary representing an insurance company while a corporate agent is an intermediary other than an individual, representing an insurance company.

Q. What does Designated Person of a Corporate Agent mean?

Ans. A Designated Person means an officer normally in charge of marketing operations, as specified by an insurer, and authorized by the Authority to issue or renew licences under the applicable regulations.

Q. Who is a Composite Insurance Agent?

Ans. A Composite Insurance Agent means an insurance agent who holds a licence to act as an insurance agent for a life insurer and a general insurer

Q.Who is an Insurance Broker?

Ans. An Insurance Broker means a person licensed by Insurance Regulatory and Development Authority who arranges insurance contracts with insurance companies on behalf of his clients. An Insurance Broker may represent more than one insurance company

Q.What is the difference between an “Agent” and a “Broker”?

Ans. While an Agent represents only one insurance company ( one general, one life or both if he is a composite agent, apart from a health insurance company), a Broker may dealt with more than one life or general or both.

Q. Are “Surveyors” and “Third Party Administrators” also Intermediaries?

Ans. Surveyors and Third Party Administrators are also termed as Intermediaries but they are not involved in marketing of insurance. Q. Are “Agents” and “Brokers” required to be licensed?

Ans. Yes. Agents and Brokers have to be licensed by the Insurance Regulatory and Development 8 9 Authority (IRDA) for life insurance or general insurance or both. They also are bound by a Code of Conduct laid down in the respective regulations.

Q. Can the Intermediary give me a discount on the premium I am supposed to pay?

Ans. No intermediary can offer any discount to you to induce you to take the policy. If any such inducement is resorted to, it is in violation of Section 41 of the Insurance Act, 1938 and all parties involved would be subject to prosecution as provided by the Law. Any discount on premium you receive would be only in terms of what the policy allows and it is given by the insurance company.