AN EVALUATIVE STUDY ON CELL FOR REDRESSAL OF GRIEVANCES OF POLICYHOLDERS IN INDIA – ITS IMPACT AND EFFECTIVENESS

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ABSTRACT:
There has been a vital change since last decade the market was opened up to the private sector insurance. As like any business, insurance companies seek to generate profit. However, there is an amassed awareness within all types of businesses that profits should not be generated at the expense of customers’ interests. Corporates have a responsibility to take the interests of all its stakeholders (including its customers) into account when making decisions about its operations. This also includes the pattern of communication that is usually understood by customers.

Policyholder’s interests are protected easily, if they are financially literate. But in present Indian scenario, this is not true. A major portion of the financial consumers are not financially literate. They are prone to get cheated or misguided easily by the financial agencies and by the agents. This holds good to Insurance consumers too. Hence there is a great responsibility on the part of the regulator to ensure that their dealings with customers are transparent, providing all information accurately and succinctly.

Thus, various measures have been taken and initiated by IRDA, insurers, insurance councils etc. with a view to provide insurance consumers the best of the services and to ensure their protection too. In this regard the regulator has obtained the following measures like:

- regulations by the IRDA for protection of policyholders’ interests;
- introduction of Insurance Ombudsman;
- insurers’ internal grievance redress cells;
- the IRDA’s Grievance Redress Cell; and
- the role of the Consumer Affairs Department of the IRDA;
- other measures taken to protect the policyholder.

In spite of the above measures taken by IRDA and other regulators, majority of the insurance consumers are either unaware or do not utilize the law for their protection. This paper looks into the aspects of redressal of grievances of policyholders and its effectiveness in Indian scenario. Also it will be analyzed as to what best can be done with respect to effectiveness of redressal grievance cell.

1.1 INTRODUCTION:
There has been a vital change since last decade the market was opened up to the private sector insurance. As like any business, insurance companies seek to generate profit. However, there is an amassed awareness within all types of businesses that profits should not be generated at the expense of customers’ interests. Corporates have a responsibility to take the interests of all its stakeholders (including its customers) into account when making decisions about its operations. This also includes the pattern of communication that is usually understood by customers.

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1.2 ABOUT IRDA

Till 1999, the Life Insurance Corporation of India was the sole life insurer in India. The breakthrough came with the passing of IRDA Act in 1999, where private players were also allowed to participate in insurance business. Concrete steps were taken for the establishment of IRDA to protect the interest of the holders of insurance policyholders, to regulate and promote the insurance business and also to ensure orderly growth of insurance industry and matter connected therewith.

1.3 Claim Settlement Ratio:

Claim Settlement Ratio (CSR) can be defined as the number of claims settled by the insurance company out of every 100 claims requests received by the Company. 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. For instance, if a life insurance company receives 1000 death claims and settles 980, the claim settlement ratio of that company would be 98%.

Selection of a proper life insurance policy is a basic requirement of individual’s risk management policy. At the same time proper claim settlement is also an important part of the risk management system. A claim is the payment made by the insurer to the insured or claimant on the occurrence of the event specified in the contract, in return for the premiums paid for the insured. The easy and timely settlement of a valid claim is an important function of an insurance company.

A claim may arise in three conditions:

1.4 IRDA REGULATION ON POLICYHOLDERS PROTECTION

The Insurance Regulatory and Development Authority has issued the Protection of Policyholders’ Interests Regulations, 2002. This regulation states the matters to be stated in the life insurance policy for the protection of policyholder’s interests. It also lays down the procedure to be adopted towards the settlement of claim under a life insurance policy.

Claims procedure in respect of a life insurance policy

- A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.
A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall be raised all at once and not in a piecemeal manner, within a period of 15 days of the receipt of the claim.

A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

Subject to the provisions of Section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).

Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

In Life Insurance business, all the companies will have a low Claim Settlement Ratio in their initial years of operations. This is because of the applicability of Section 45 of the Insurance Act. Any claims reported in the first 2 years of the policy are called early claims and insurance companies will be carrying out a detailed investigation to ensure the genuine nature of such claims. If it is found that the policy holder has deliberately suppressed material facts at the time of taking the policy, such claims will be repudiated. But after the first 2 years, the claims are called as non early claims and there will be a bit liberal view on these.

**Section 45 of the Insurance Act, 1938 – Indisputability Clause**

As per this Act, no policy of Life Insurance shall, after the expiry of two years from the date on which it was effected, be called in question by an Insurer on the ground that a statement made in the proposal for insurance or any report of a medical officer or referee or friend of the Insured or in any other document leading to the issue of the Policy, was inaccurate or false, unless the Insurer shows such statement was on material matter or suppressed facts and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making it that the
statement was false or that it suppressed facts which it was material to disclose.

1.5 CASE STUDIES:

Case 1: Mr. X has purchased a Term Policy of Rs. 50 Lakhs from a private company. This private company was not having a high Claim Settlement Ratio, as per the IRDA data. Since he is a diabetic, he disclosed his health condition. He has undergone the pre medical examination arranged by the insurance company and his premium was loaded by around 20% from the normal premium quoted earlier. Unfortunately, he died within 2 years of taking the policy. His nominee got the claim, because he had mentioned his health conditions correctly at the time of buying the policy.

Case 2: Mr. X has taken a policy from the company with the highest Claim Settlement Ratio. Here, he has not disclosed his diabetic condition. If there is a claim in the first 2 years like the nominee won’t receive the claim. This is because each claim will be investigated separately and will be decided on the merit of each case. In case the claim is asked for after 2 years, such claims will be treated as non early claim and will be treated differently. But, if there is a doubt on the claim, the insurance company can investigate such claim also. The applicability of Section 45 is that, in such cases, the insurance company has to prove that the policy holder has made misrepresentation of facts to get the policy and that he has done it deliberately.

If insured fills up all the correct information while buying the policy, he/she need not worry about the claim settlement ratio of the company. Insured will have to read each question in the proposal form and answer it correctly to the best of his/her knowledge. There will be questions on current health conditions, medication, family history of hereditary diseases, previous policies held by you etc. Habits like smoking and drinking also has to be disclosed. There can be a pre medical examination depending on the type of policy and its value. The insurance company will decide on each proposal based on the information given by the insured. If there is an adverse finding, the company will either charge a higher premium or reject the proposal.

If you are honest and disclose all the information while buying the policy, there is no need for you to worry about the “claim settlement ratio “of insurance companies. Normally, all insurance companies will honor the genuine claims or once can approach the appellate forums like Insurance Ombudsman and Consumer Court to get justice.

According to the latest annual report published by the Insurance Regulatory Development Authority of India (IRDAI), life insurance companies have done a better job of settling death claims in financial year (FY) 2014 than in FY13. In terms of the number of policies settled, 12 life insurance companies settled at least 90% of the death claims they received in FY14 compared with seven companies in FY13.

2.0 Data Analysis and Interpretation:

2.1 Classification of Life complaints for the last three years
Interpretation:

The chart depicts the classification of complaints for the last three years as obtained by IRDA. The various complaints would include claims, policy servicing, proposal processing, ULIP related and unfair business practices.

a) **Claims:** The insured amount which is to be paid at the end of the maturity period or which can be claimed during the death of the insured. We can see very clearly that the complaints with regards to claims have been significantly reducing year on year. This shows how well IRDA has made its regulations, while ensuring that the insured is getting the amount as mentioned in the policy document.

b) **Policy servicing:** This would include various kinds of services provided by the insurance company after taking insurance from them. It is very clear from the graph that policy servicing is second most frequent complaint in the past three years. Though there is a decrease in the number of complaints this year, it still remains a sector which is to be tackled.

c) **Proposal Processing:** This would include the technical difficulties involved by an individual to get his/ her proposal processed. The companies doing so are not very skilled in doing so is what you can learn from this.

d) **ULIP related:** Unit linked plans are market plans. The sum assured is dependent on the market in which the policy was invested. This plan is proportional to the market and much help cannot be rendered.

e) **Unfair Business Practice:** As we can interpret from the graph, unfair business practice ranks number one in terms of complaints across all the three years. Inspite of strict regulations and functions of IRDA, unfair business practices still tend to continue. But looking at last where we see around 69% decrease in the number of complaints as compared to the previous year gives us a ray of hope.
that someday there will be very minute degree of complaint in this field.

2.2 Graphs showing percentage claim settlement amongst top 10 companies 2011-12

Comment: As per the Annual Report of IRDA for 2011-12, LIC of India is having the highest claim settlement ratio of 97.42%. It has improved its claim settlement ratio from 97.03 in the previous year. This shows LIC settled 97.42% of the claims reported in 2011-12. Private life insurance companies are having a low claim settlement ratio compared to LIC. They have a ratio of 89.34% for the year 2011-12, compared to 86.04% in the previous year.

2.3 Status as on 2012-2013

Comment: We can see very clearly as per the Annual Report of IRDA for 2012-13, LIC has yet again topped the list with around 98% claim settlement ratio. We can that they have been constantly improving when compared to the previous year. At the same time we see that private
life insurance companies are not able to compete with LIC when it comes to claim settlement, but the companies are trying into improve year on year.

2.4 Status as on 2013-14

**Comment**: LIC again tops the chart with a claim settlement ratio of 98.14%. ICICI Prudential Life Insurance is on the top amongst private life insurers, with a claim settlement ratio of 94.01%, which is a decrease of -2.29% as compared to previous year (2011-2013).

2.5 Graphs showing percentage claim paid and rejected amongst top 10 companies 2012-13
Comments: The graph depicts the percentage of claims paid and rejected in the year 2012-2013. LIC has almost paid all the claims while rejecting 1.12%. ICICI Prudential is not far from LIC and has rejected only 3.63% claim. HDFC life and SBI life have also done pretty well when compared to other life insurance companies. From the graph it very clear that Star Union Dai-chi has paid only 89.70% while rejecting 2.71% claims. Also Canara HSBC is the highest in terms of rejecting claims i.e., 9.72% and Bharthi Axa which is 9.66%.

2.6 Graph showing claim settlement amongst top 3 companies from 2011-14

Comment: Claim settlement in top 3 companies from the year 2011-14 shows that LIC leads all throughout with 97.4% in the first year and 98.14% in the year 2013-14. We can see how improvements have been made in terms of claim settlement year on year by LIC. But, Private life insurance companies ICICI Prudential and HDFC life are not competent enough in terms of claim settlement ratio. Year on year they are deteriorating rather than improving. Though, various steps are taken to increase the percentage and reduce consumer grievance.

3.0 Findings:

Insurance Industry is basically a service industry and in the present day inexpensive market, the consumer expectations are ever rising and accordingly, dissatisfaction from the standard of services rendered by the insurance companies is also at rise. Booming to this situation, the Government and the Regulator have taken a number of initiatives. These creativities include institution of Insurance Ombudsman, in 1998 and Protection of Policy Holders Interest in 2002, through the IRDA Act, 1999. Despite the point that insurance industry has got a lot of legislation, rules, protocols, for formal grievance redressal, the mechanism is not reasonable and effective enough to cope with ever
increasing volumes of grievances turning into complaints and finally in legal disputes. The in-house grievance cells of insurance corporations have failed to win over the faith of policyholders whereas the grievance cell of IRDA has no adjudicatory powers. It can only monitor and supervise the dispute resolution mechanism of insurance companies with a power only to give guidelines to the respective companies.

Concerning the institution of Ombudsman, there is little evidence that it is actually serving the policyholders. They are mostly well-known in big cities, and hence are an expensive option for people from rural and semi-urban areas of the state. There is no facility of appeal from the award of Ombudsman and moreover, its award is not binding. On top of that, there is a monetary ceiling over their power that is of Rs. 20 lakhs.

On the other hand, Consumer Forums, though having a wider geographic spread, financial limits and greater area of adjudication, lack the expertise that is required in insurance matters. Here, insurance is taken as any other financial service and not as an enthusiastic one. Moreover, the awards passed by them are not governed by the basic principles of Insurance and Law of Agreement.

In light these state of affairs, it is essential to establish a statutory, comprehensive, effective, independent Grievance Redressal Authority (GRA), which can provide justice to all the insured’s, insurer’s and mediators of Insurance Industry. The GRA may be given inclusive authority to cover complaints from all types of insured irrespective of any financial boundary.

4.0 Conclusion:

In light these state of matters, it is essential to establish a statutory, wide-ranging, effective, independent Grievance Redressal Authority (GRA), which can provide fairness to all the insured’s, insurer’s and intermediaries of Insurance Industry. The GRA may be given complete jurisdiction to cover complaints from all types of insured regardless of any financial limit.

Reference:
www.irda.gov.in
www.policyholder.gov.in
www.licindia.in