BCOM
Paper Code: BCOM 314
Principles of Insurance

UNIT-I: Insurance fundamentals

- Origin of insurance, concepts, meaning of insurance
- Definition, nature, functions, history of insurance
- Different classifications, comparison of life insurance with other insurances

UNIT-II: Basic principles of insurance

- Key concepts, economic principles
- Principles of Insurance viz. Utmost good faith
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- Types of Insurance, various forms in use, policy forms
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- Rating practices, premium payment regulations
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UNIT 1

INSURANCE FUNDAMENTALS

MEANING AND DEFINITION OF INSURANCE:-

Insurance is a social device for spreading the chance of financial loss among a large number of people. By purchasing insurance, a "person" shares risk with a group of others, thereby reducing the individual potential for disastrous financial consequences. Transacting insurance includes soliciting insurance, collecting premiums and handling claims.

By insurance a person can protect himself and his dependents from loss arising from future uncertain events like fire, accidents, early death and so on. Thus the risk is not averted but the loss on the occurrence is shared by the members. The function of insurance is to spread this loss over a large number of person through the mechanism of co-operation.

Some of the important definition of insurance is given as under:-

a) *Insurance is a co-operative device to spread the loss caused by a particular risk over number of persons who are exposed to it who agree to insure themselves against that risk.* **Prof. R.S. Sharma**

b) *Insurance is a Co-operative form of distributing a certain risk over a group of persons who are exposed to it.*

Prof. Ghosh and Agarwal

c) *Insurance is an instrument of distributing the loss of few among many.* **Mr. Disnadle**

In insurance one party (the insurance company) agree to pay to the other party (the insured or his beneficiary) a certain sum upon a given contingency (the risk) against which insurance is sought in return of a sum of money as a premium paid by insured to the insurance company.

Advantages of insurance or Importance of insurance

In the word of George Pancham, Insurance is a great and progressing industry. Importance of insurance is much more in our under developed country because following are the advantages of insurance to the different groups.

Advantages of Insurance to Business

1. Means of Economic Security
2. Insurance increase business efficiency
3. It enhance credit
4. Business Continuation
5. Welfare of Employee
6. Helps in establishing International Trade

Advantages of Insurance to Individual

1. Insurance provide Security and safety
2. Insurance eliminate dependency
3. Insurance protects mortgaged property
4. Life Insurance promote saving
5. Exemption from Tax.
6. Insurance provide profitable investments

Advantages of Insurance to the society

1. Source of Employment
2. Wealth of the society is protected
3. Reduction in inflation
4. Economic growth of the country
5. Capital Formation

ORIGIN OF INSURANCE

The history of insurance dates back to ancient times. There has always been a need for insurance. The basic concept of insurance is to spread the risk among a large enough pool so that no one person suffers the entire cost of the loss. Ancient insurance concepts date back to the days of early hunters. Hunters went on hunting expeditions in groups to minimize the risk of a person's injury by a wild animal.

CONCEPT OF INSURANCE

Insurance is a type of financial arrangement that helps individuals, businesses and other organizations protect themselves against unexpected or unpredictable losses or expenses. Insurance can protect against a variety of losses or damage such as personal injury and property damage.

NATURE OF INSURANCE

The purpose of any insurance is to provide economic protection against the losses that may be incurred due to chance events such as:

1. Death
2. Disability
3. Medical expenses
4. Home or automobile damage, etc.

One party (the insurer), for a set amount of money (premium), agrees to pay the other party (the insured or beneficiary), a sum of money (benefit) upon the occurrence of an event which may or may not occur, during the effective time of the contract, which is called a policy.

FUNCTIONS OF INSURANCE

Insurance is defined as a co-operative device to spread the loss caused by a particular risk over a number of persons who are exposed to it and who agree to ensure themselves against that risk. Risk is uncertainty of a financial loss. It should not be confused with the chance of loss which is the probable number of losses out of a given number of exposures.

It should not be confused with peril which is defined as the cause of loss or with hazard which is a condition that may increase the chance of loss.

Finally, risk must not be confused with loss itself which is the unintentional decline in or disappearance of value arising from a contingency. Wherever there is uncertainty with respect to a probable loss there is risk.

Every risk involves the loss of one or other kind. The function of insurance is to spread the loss over a large number of persons who are agreed to co-operate each other at the time of loss. The risk cannot be averted but loss occurring due to a certain risk can be distributed amongst the agreed persons. They are agreed to share the loss because the chances of loss, i.e., the time, amount, to a person are not known.

Anybody of them may suffer loss to a given risk, so, the rest of the persons who are agreed will share the loss. The larger the number of such persons the easier the process of distribution of loss, In fact; the loss is shared by them by payment of premium which is calculated on the probability of loss.

In olden time, the contribution by the persons was made at the time of loss. The insurance is also defined as a social device to accumulate funds to meet the uncertain losses arising through a certain risk to a person insured against the risk.

The functions of insurance can be studied into two parts (i) Primary Functions, and (ii) Secondary Functions.

Primary Functions:

(i) Insurance provides certainty:

Insurance provides certainty of payment at the uncertainty of loss. The uncertainty of loss can be reduced by better planning and administration. But, the insurance relieves the person from such difficult task. Moreover, if the subject matters are not adequate, the self-provision may prove costlier.

There are different types of uncertainty in a risk. The risk will occur or not, when will occur, how much loss will be there? In other words, there are uncertainty of happening of time and amount of loss. Insurance removes all these uncertainty and the assured is given certainty of payment of loss. The insurer charges premium for providing the said certainty.

(ii) Insurance provides protection:

The main function of the insurance is to provide protection against the probable chances of loss. The time and amount of loss are uncertain and at the happening of risk, the person will suffer loss in absence of insurance. The insurance guarantees the payment of loss and thus protects the assured from sufferings. The insurance cannot check the happening of risk but can provide for losses at the happening of the risk.

(iii) Risk-Sharing:

The risk is uncertain, and therefore, the loss arising from the risk is also uncertain. When risk takes place, the loss is shared by all the persons who are exposed to the risk. The risk-sharing in ancient time was done only at time of damage or death; but today, on the basis of probability of risk, the share is obtained from each and every insured in the shape of premium without which protection is not guaranteed by the insurer.

Secondary functions:

Besides the above primary functions, the insurance works for the following functions:

(i) Prevention of Loss:

The insurance joins hands with those institutions which are engaged in preventing the losses of the society because the reduction in loss causes lesser payment to the assured and so more saving is possible which will assist in reducing the premium. Lesser premium invites more business and more business cause lesser share to the assured.

So again premium is reduced to, which will stimulate more business and more protection to the masses. Therefore, the insurance assist financially to the health organisation, fire brigade, educational institutions and other organisations which are engaged in preventing the losses of the masses from death or damage.

(ii) It Provides Capital:

The insurance provides capital to the society. The accumulated funds are invested in productive channel. The dearth of capital of the society is minimised to a greater extent with the help of investment of insurance. The industry, the business and the individual are benefited by the investment and loans of the insurers.

(iii) It Improves Efficiency:

The insurance eliminates worries and miseries of losses at death and destruction of property. The carefree person can devote his body and soul together for better achievement. It improves not only his efficiency, but the efficiencies of the masses are also advanced.

(iv) It helps Economic Progress:

The insurance by protecting the society from huge losses of damage, destruction and death, provides an initiative to work hard for the betterment of the masses. The next factor of economic progress, the capital, is also immensely provided by the masses. The property, the valuable assets, the man, the machine and the society cannot lose much at the disaster.

HISTORY OF INSURANCE AND DIFFERENT CLASSIFICATIONS

The **history of insurance** consisted of the development of the modern business of insurance against risks, especially regarding cargo, property, death, automobile accidents, and medical treatment. The industry helps to eliminate risks (as when fire insurance companies demand the implementation of safe practices and the installation of hydrants), spreads risks from the individual to the larger community, and provides an important source of long-term finance for both the public and private sectors. The insurance industry is generally profitable and provides attractive employment opportunities for white collar workers.

Ancient world

In some sense, we can say that insurance dates back to early human society. We know of two types of economies in human societies: natural or non-monetary economies (using barter and trade with no centralized nor standardized set of financial instruments) and monetary economies (with markets, currency, financial instruments and so on). Insurance in the former case entails agreements of mutual aid. If one family's house gets destroyed, the neighbours are committed to help rebuild it. Granaries embodied another early form of insurance to indemnify against famines. These types of insurance have survived to the present day in countries or areas where a modern money economy with its financial instruments is not widespread.

The first methods of transferring or distributing risk in a monetary economy, were practiced by Chinese and Babylonian traders in the 3rd and 2nd millennia BC, respectively. Chinese merchants travelling treacherous river rapids would redistribute their wares across many vessels to limit the loss due to any single vessel's capsizing. The Babylonians developed a system which

was recorded in the famous Code of Hammurabi, c. 1750 BC, and practiced by early Mediterranean sailing merchants. If a merchant received a loan to fund his shipment, he would pay the lender an additional sum in exchange for the lender's guarantee to cancel the loan should the shipment be stolen or lost at sea.

Achaemenian monarchs in Ancient Persia were presented with annual gifts from the various ethnic groups under their control. This would function as an early form of political insurance, and officially bound the Persian monarch to protect the group from harm.[2]

At some point in the 1st millennium BC, the inhabitants of Rhodes created the 'general average'. This allowed groups of merchants to pay to insure their goods being shipped together. The collected premiums would be used to reimburse any merchant whose goods were jettisoned during transport, whether to storm or sinkage.

The ancient Athenian "maritime loan" advanced money for voyages with repayment being cancelled if the ship was lost. In the 4th century BC, rates for the loans differed according to safe or dangerous times of year, implying an intuitive pricing of risk with an effect similar to insurance.

The Greeks and Romans introduced the origins of health and life insurance c. 600 BC when they created guilds called "benevolent societies" which cared for the families of deceased members, as well as paying funeral expenses of members. Guilds in the Middle Ages served a similar purpose. The Jewish Talmud also deals with several aspects of insuring goods. Before insurance was established in the late 17th century, "friendly societies" existed in England, in which people donated amounts of money to a general sum that could be used for emergencies.

Medieval Era

Separate insurance contracts (i.e., insurance policies not bundled with loans or other kinds of contracts) were invented in Genoa in the 14th century, as were insurance pools backed by pledges of landed estates. The first known insurance contract dates from Genoa in 1347, and in the next century maritime insurance developed widely and premiums were intuitively varied with risks.

These new insurance contracts allowed insurance to be separated from investment, a separation of roles that first proved useful in marine insurance. The first printed book on insurance was the legal treatise *On Insurance and Merchants' Bets* by Pedro de Santarém (Santerna), written in 1488 and published in 1552.

Modern insurance

Insurance became more sophisticated in Enlightenment era Europe, and specialized varieties developed. Some forms of insurance developed in London in the early decades of the 17th century. For example, the will of the English colonist Robert Hayman mentioned two "policies of insurance" taken out with the diocesan Chancellor of London, Arthur Duck. Of the value of £100 each, one related to the safe arrival of Hayman's ship in Guyana and the other was in regard to "one hundred pounds assured by the said Doctor Arthur Ducke on my life".

Property insurance

Property insurance as we know it today can be traced to the Great Fire of London, which in 1666 devoured more than 13,000 houses. The devastating effects of the fire converted the development of insurance "from a matter of convenience into one of urgency, a change of opinion reflected in Sir Christopher Wren's inclusion of a site for 'the Insurance Office' in his new plan for London in 1667".A number of attempted fire insurance schemes came to nothing, but in 1681, economist Nicholas Barbon and eleven associates established the first fire insurance company, the "Insurance Office for Houses", at the back of the Royal Exchange to insure brick and frame homes. Initially, 5,000 homes were insured by his Insurance Office.

In the wake of this first successful venture, many similar companies were founded in the following decades. Initially, each company employed its own fire department to prevent and minimize the damage from conflagrations on properties insured by them. They also began to issue 'Fire insurance marks' to their customers. These would be displayed prominently above the main door of the property and allowed the insurance company to positively identify properties that had taken out insurance with them. One such notable company was the Hand in Hand Fire & Life Insurance Society, founded in 1696 at Tom's Coffee House in St. Martin's Lane in London. It was structured as a mutual society, and for 135 years it operated its own fire brigade and played an important part in shaping fire fighting and prevention. The Sun Fire Office is the earliest still existing property insurance company, dating from 1710.

This system was soon exposed as terribly flawed; as rival brigades often ignored burning buildings once they discovered that it had no insurance policy with their company. Eventually, a solution was agreed upon in which all the insurance companies would supply money and equipment to a municipal authority charged with stationing fire prevention assets and firefighters equally around the city to respond to all fires. This did not solve the problem entirely, as the brigades still tended to favor saving insured buildings to those without any insurance at all.

In Colonial America, the first insurance company that underwrote fire insurance and was formed in Charles Town (modern-day Charleston), South Carolina in 1732. Benjamin Franklin helped to popularize and make standard the practice of insurance, particularly Property insurance to spread the risk of loss from fire, in the form of perpetual insurance. In 1752, he founded the Philadelphia Contribution ship for the Insurance of Houses from Loss by Fire. Franklin's company made contributions toward fire prevention. Not only did his company warn against

certain fire hazards, it refused to insure certain buildings where the risk of fire was too great, such as all wooden houses.

Business insurance

At the same time, the first insurance schemes for the underwriting of business ventures became available. By the end of the seventeenth century, London's growing importance as a centre for trade was increasing demand for marine insurance. In the late 1680s, Edward Lloyd opened a coffee house on Tower Street in London. It soon became a popular haunt for ship owners, merchants, and ships' captains, and thereby a reliable source of the latest shipping news.

It became the meeting place for parties in the shipping industry wishing to insure cargoes and ships, and those willing to underwrite such ventures. These informal beginnings led to the establishment of the insurance market Lloyd's of London and several related shipping and insurance businesses. In 1774, long after Lloyd's death in 1713, the participating members of the insurance arrangement formed a committee and moved to the Royal Exchange on Cornhill as the Society of Lloyd's.

Life insurance

The first life insurance policies were taken out in the early 18th century. The first company to offer life insurance was the Amicable Society for a Perpetual Assurance Office, founded in London in 1706 by William Talbot and Sir Thomas Allen. The first plan of life insurance was that each member paid a fixed annual payment per share on from one to three shares with consideration to age of the members being twelve to fifty-five. At the end of the year a portion of the "amicable contribution" was divided among the wives and children of deceased members and it was in proportion to the amount of shares the heirs owned. Amicable Society started with 2000 members.

Amicable Society for a Perpetual Assurance Office, established in 1706, was the first life insurance company in the world.

The first life table was written by Edmund Halley in 1693, but it was only in the 1750s that the necessary mathematical and statistical tools were in place for the development of modern life insurance. James Dodson, a mathematician and actuary, tried to establish a new company that issued premiums aimed at correctly offsetting the risks of long term life assurance policies, after being refused admission to the Amicable Life Assurance Society because of his advanced age. He was unsuccessful in his attempts at procuring a charter from the government before his death in 1757.

His disciple, Edward Rowe Mores was finally able to establish the Society for Equitable Assurances on Lives and Survivorship in 1762. It was the world's first mutual insurer and it pioneered age based premiums based on mortality rate laying “the framework for scientific

insurance practice and development" and "the basis of modern life assurance upon which all life assurance schemes were subsequently based".

Mores also specified that the chief official should be called an actuary - the earliest known reference to the position as a business concern. The first modern actuary was William Morgan, who was appointed in 1775 and served until 1830. In 1776 the Society carried out the first actuarial valuation of liabilities and subsequently distributed the first reversionary bonus (1781) and interim bonus (1809) among its members. It also used regular valuations to balance competing interests. The Society sought to treat its members equitably and the Directors tried to ensure that the policyholders received a fair return on their respective investments. Premiums were regulated according to age, and anybody could be admitted regardless of their state of health and other circumstances.

The sale of life insurance in the U.S. began in the late 1760s. The Presbyterian Synods in Philadelphia and New York founded the Corporation for Relief of Poor and Distressed Widows and Children of Presbyterian Ministers in 1759; Episcopalian priests created a comparable relief fund in 1769. Between 1787 and 1837 more than two dozen life insurance companies were started, but fewer than half a dozen survived.

Accident insurance

In the late 19th century, "accident insurance" began to become available. This operated much like modern *disability* insurance. The first company to offer accident insurance was the Railway Passengers Assurance Company, formed in 1848 in England to insure against the rising number of fatalities on the nascent railway system. It was registered as the Universal Casualty Compensation Company to grant assurances on the lives of persons travelling by railway and to grant, in cases, of accident not having a fatal termination, compensation to the assured for injuries received under certain conditions.

The company was able to reach an agreement with the railway companies, whereby basic accident insurance would be sold as a package deal along with travel tickets to customers. The company charged higher premiums for second and third class travel due to the higher risk of injury in the roofless carriages.

National insurance

By the late 19th century, governments began to initiate national insurance programs against sickness and old age. Germany built on a tradition of welfare programs in Prussia and Saxony that began as early as in the 1840s. In the 1880s Chancellor Otto von Bismarck introduced old age pensions, accident insurance and medical care that formed the basis for Germany's welfare state. His paternalistic programs won the support of German industry because its goals were to win the support of the working classes for the Empire and reduce the outflow of immigrants to America, where wages were higher but welfare did not exist.

In Britain more extensive legislation was introduced by the Liberal government, led by H. H. Asquith and David Lloyd George. The 1911 National Insurance Act gave the British working classes the first contributory system of insurance against illness and unemployment.

All workers who earned under £160 a year had to pay 4 pence a week to the scheme; the employer paid 3 pence, and general taxation paid 2 pence. As a result, workers could take sick leave and be paid 10 shillings a week for the first 13 weeks and 5 shillings a week for the next 13 weeks. Workers also gained access to free treatment for tuberculosis, and the sick were eligible for treatment by a panel doctor. The National Insurance Act also provided maternity benefits. Time-limited unemployment benefit was based on actuarial principles and it was planned that it would be funded by a fixed amount each from workers, employers, and taxpayers. It was restricted to particular industries, cyclical/seasonal industries like construction of ships, and neither made any provision for dependants. By 1913, 2.3 million were insured under the scheme for unemployment benefit and almost 15 million insured for sickness benefit.

This system was greatly expanded after the Second World War under the influence of the Beveridge Report, to form the first modern welfare state.

In the United States, until the passage of the Social Security Act in 1935, the federal government did not mandate any form of insurance upon the nation as a whole. With the passage of the Act the new program expanded the concept and acceptance of insurance as a means to achieve individual financial security that might not otherwise be available. That expansion experienced its first boom market immediately after the Second World War with the original VA Home Loan programs that greatly expanded the idea that affordable housing for veterans was a benefit of having served. The mortgages that were underwritten by the federal government during this time included an insurance clause as a means of protecting the banks and lending institutions involved against avoidable losses. During the 1940s there was also the GI life insurance policy program that was designed to ease the burden of military losses on the civilian population and survivors.

COMPARISON OF LIFE INSURANCES WITH OTHER INSURANCES

Life insurance v/s health insurance

Life insurance is a contract between an insurance policy holder and an insurer, where the insurer promises to pay a designated beneficiary a sum of money (the "benefits") upon the death of the insured person. Depending on the contract, other events such as terminal illness or critical illness may also trigger payment. The policy holder typically pays a premium, either regularly or as a lump sum. Other expenses (such as funeral expenses) are also sometimes included in the premium.
Life-based contracts tend to fall into two major categories:

Protection policies – designed to provide a benefit in the event of specified event, typically a lump sum payment. A common form of this design is term insurance.

Investment policies – where the main objective is to facilitate the growth of capital by regular or single premiums

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Life insurance v/s General insurance

"Life Insurance" is an Insurance of a person's life. So, if he were to die, his family would receive an amount of money called the Sum Assured, which would help the family to take care of the financial crisis which had arisen from the sudden stop in income. To get this benefit, he would have to pay a certain amount of money called Life Insurance Premium to the Insurance Company every year as per the contract.

"General Insurance" means non life Insurance. Every asset has a value and it provides for some benefit to the owner. The benefit may be income or in some other form. So if the asset is destroyed, there would be some financial loss to the owner. To protect this financial loss, insurance is done.
There are basically 3 types of Non Life or General Insurance- Fire, Marine and Miscellaneous. Motor Insurance, Health Insurance and Travel Insurance are the 3 most common types of insurance under Miscellaneous Insurance of General Insurance.

UNIT 2

BASIC PRINCIPLES OF INSURANCE

KEY CONCEPTS

The main objective of every insurance contract is to give financial security and protection to the insured from any future uncertainties. Insured must never ever try to misuse this safe financial cover.

Seeking profit opportunities by reporting false occurrences violates the terms and conditions of an insurance contract. This breaks trust, results in breaching of a contract and invites legal penalties.

An insurer must always investigate any doubtable insurance claims. It is also a duty of the insurer to accept and approve all genuine insurance claims made, as early as possible without any further delays and annoying hindrances.

ECONOMIC PRINCIPLES OF INSURANCE

1. **Principles of Cooperation**:- Insurance is a co-operative method. Thus the shares of loss took the form of the Present 'Premium'. Today all the insured pay a premium to join the scheme of Insurance. Thus the insured are co-operating to share the loss of an individual by payment of a premium in advance. Fundamental principles of cooperation.
2. **Theory of Probability**:- Probability is the ratio of chances favorable to success in the test to the total chances.
Probability of occurring a event can be calculated by dividing the total number of occurring the events to the probability of occurring a special event.

Probability = Probability of Occurring a Special Event / Probability of occurring all the Events

Principles of Large Number – The Larger the number of exposed persons, the better and more practical would be the finding of the Probability.

SEVEN PRINCIPLES OF INSURANCE

The seven principles of insurance are:-

- Principle of Uberrimae fidei (Utmost Good Faith),
- Principle of Insurable Interest,
- Principle of Indemnity,
- Principle of Contribution,

- Principle of Subrogation,
- Principle of Loss Minimization, and
- Principle of Causa Proxima (Nearest Cause).

UTMOST GOOD FAITH

- Principle of *Uberrimae fidei* (a Latin phrase), or in simple English words, the Principle of Utmost Good Faith, is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e. insurer and insured) in an absolute good faith or belief or trust.
- The person getting insured must willingly disclose and surrender to the insurer his complete true information regarding the subject matter of insurance. The insurer's liability gets void (i.e. legally revoked or cancelled) if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured.
- The principle of Uberrimae fidei applies to all types of insurance contracts.

INSURABLE INTEREST

- The principle of insurable interest states that the person getting insured must have insurable interest in the object of insurance. A person has an insurable interest when the physical existence of the insured object gives him some gain but its non-existence will give him a loss. In simple words, the insured person must suffer some financial loss by the damage of the insured object.
- **For example**: - The owner of a taxicab has insurable interest in the taxicab because he is getting income from it. But, if he sells it, he will not have an insurable interest left in that taxicab.
- From above example, we can conclude that, ownership plays a very crucial role in evaluating insurable interest. Every person has an insurable interest in his own life. A merchant has insurable interest in his business of trading. Similarly, a creditor has insurable interest in his debtor.

INDEMNITY

- Indemnity means security, protection and compensation given against damage, loss or injury.

- According to the principle of indemnity, an insurance contract is signed only for getting protection against unpredicted financial losses arising due to future uncertainties.

Insurance contract is not made for making profit else its sole purpose is to give compensation in case of any damage or loss.

- In an insurance contract, the amount of compensations paid is in proportion to the incurred losses. The amount of compensations is limited to the amount assured or the actual losses, whichever is less. The compensation must not be less or more than the actual damage. Compensation is not paid if the specified loss does not happen due to a particular reason during a specific time period. Thus, insurance is only for giving protection against losses and not for making profit.
- However, in case of life insurance, the principle of indemnity does not apply because the value of human life cannot be measured in terms of money.

SUBROGATION

- Subrogation means substituting one creditor for another.
- Principle of Subrogation is an extension and another corollary of the principle of indemnity. It also applies to all contracts of indemnity.
- According to the principle of subrogation, when the insured is compensated for the losses due to damage to his insured property, then the ownership right of such property shifts to the insurer.
- This principle is applicable only when the damaged property has any value after the event causing the damage. The insurer can benefit out of subrogation rights only to the extent of the amount he has paid to the insured as compensation.
- **For example**: - Mr. John insures his house for $ 1 million. The house is totally destroyed by the negligence of his neighbor Mr. Tom. The insurance company shall settle the claim of Mr. John for $ 1 million. At the same time, it can file a law suit against Mr. Tom for $ 1.2 million, the market value of the house. If insurance company wins the case and collects $ 1.2 million from Mr. Tom, then the insurance company will retain $ 1 million (which it has already paid to Mr. John) plus other expenses such as court fees. The balance amount, if any will be given to Mr. John, the insured.

CONTRIBUTION

- Principle of Contribution is a corollary of the principle of indemnity. It applies to all contracts of indemnity, if the insured has taken out more than one policy on the same subject matter. According to this principle, the insured can claim the compensation only to the extent of actual loss either from all insurers or from any one insurer. If one insurer pays full compensation then that insurer can claim proportionate claim from the other insurers.
- **For example**: - Mr. John insures his property worth $ 100,000 with two insurers "AIG Ltd." for $ 90,000 and "MetLife Ltd." for $ 60,000. John's actual property destroyed is

worth $ 60,000, then Mr. John can claim the full loss of $ 60,000 either from AIG Ltd. or MetLife Ltd., or he can claim $ 36,000 from AIG Ltd. and $ 24,000 from MetLife Ltd.

- So, if the insured claims full amount of compensation from one insurer then he cannot claim the same compensation from other insurer and make a profit. Secondly, if one insurance company pays the full compensation then it can recover the proportionate contribution from the other insurance company.

PROXIMITY CAUSE

- Principle of *Causa Proxima* (a Latin phrase), or in simple English words, the Principle of Proximate (i.e. Nearest) Cause, means when a loss is caused by more than one causes, the proximate or the nearest or the closest cause should be taken into consideration to decide the liability of the insurer.
- The principle states that to find out whether the insurer is liable for the loss or not, the proximate (closest) and not the remote (farest) must be looked into.
- **For example**: - A cargo ship's base was punctured due to rats and so sea water entered and cargo was damaged. Here there are two causes for the damage of the cargo ship - (i) The cargo ship getting punctured because of rats, and (ii) The sea water entering ship through puncture. The risk of sea water is insured but the first cause is not. The nearest cause of damage is sea water which is insured and therefore the insurer must pay the compensation.
- However, in case of life insurance, the principle of Causa Proxima does not apply. Whatever may be the reason of death (whether a natural death or an unnatural death) the insurer is liable to pay the amount of insurance.

LOSS MINIMIZATION

- According to the Principle of Loss Minimization, insured must always try his level best to minimize the loss of his insured property, in case of uncertain events like a fire outbreak or blast, etc. The insured must take all possible measures and necessary steps to control and reduce the losses in such a scenario. The insured must not neglect and behave irresponsibly during such events just because the property is insured. Hence it is a responsibility of the insured to protect his insured property and avoid further losses.
- **For example**: - Assume, Mr. John's house is set on fire due to an electric short-circuit. In this tragic scenario, Mr. John must try his level best to stop fire by all possible means, like first calling nearest fire department office, asking neighbors for emergency fire extinguishers, etc. He must not remain inactive and watch his house burning hoping, "Why should I worry? I've insured my house."

UNIT 3

INSURANCE MARKET

INDIAN INSURANCE MARKET

The insurance industry of India consists of 52 insurance companies of which 24 are in life insurance business and 28 are non-life insurers. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company.

Out of 28 non-life insurance companies, there are six public sector insurers, which include two specialized insurers namely Agriculture Insurance Company Ltd for Crop Insurance and Export Credit Guarantee Corporation of India for Credit Insurance. Moreover, there are 5 private sector insurers are registered to underwrite policies exclusively in Health, Personal Accident and Travel insurance segments. They are Star Health and Allied Insurance Company Ltd, Apollo Munich Health Insurance Company Ltd, Max Bupa Health Insurance Company Ltd, Religare Health Insurance Company Ltd and Cigna TTK Health Insurance Company Ltd.

In addition to 52 insurance companies, there is sole national re-insurer, namely, General Insurance Corporation of India. Other stakeholders in Indian Insurance market include licensed Agents (Individual and Corporate), Brokers, Common Service Centres, Web-Aggregators,Surveyors and Third Party Administrators servicing Health Insurance claims.

Insurance Laws (Amendment) Act, 2015 providesfor enhancement of the Foreign Investment Cap in an Indian Insurance Company from 26% to an Explicitly Composite Limit of 49% with the safeguard of Indian Ownership and Control.

Insurance penetration of India i.e. Premium collected by Indian insurers is 3.90% of GDP in FY 2013-14. Per capita premium underwritten i.e. insurance density in India during FY 2013-14 is US$ 52.0.

THE ORGANIZATION STRUCTURE OF INSURANCE COMPANY

Components of the Organizational Structure and Functional Processes

Coordination of activities takes place through the organizational structure of the business. An effective organizational structure benefits a company by

•Enabling the business to assign responsibilities throughout the organization. A responsibility is a duty or task assigned to an employee.

•Providing employees with the proper authority to meet their responsibilities. By authority, we mean the right of an employee to make decisions, take action, and direct others to fulfill their responsibilities.

•Providing a process for holding employees accountable for their job performance. Accountability means the employees are answerable for how well they use their authority and how effectively they carry out their responsibilities.

•Setting clear guidelines for the delegation of authority and accountability. Delegation is the process of assigning to another employee the accountability for completing a specific task.

The Organization Chart

An organization chart also shows the company's chain of command, or the structure of authority that flows downward in the organization from the higher levels to the lower levels.

According to the principle of unity of command, each employee should be under the authority of only one person and be accountable to only that person. In today's organization environment, however, insurance companies typically cannot adhere strictly to the unity of command principle.

Pyramidal Structure and Levels of Authority

The pyramidal structure illustrates that the authority in a company starts at the top with one person or a small group of people, Authority is then distributed through the chain of command to ever-larger numbers of people throughout out the company.

Policy owners or stockholders

The owners of a company- the policy owners in mutual companies or the stockholders in stock companies – are the ultimate source of authority over a life insurance company. Here the owners elect a board of directors and delegate their authority to the board.

Board of Directors

Is the primary governing body of a corporation? In representing the owners of the corporation, the board has a primary responsibility to review the activities and finances of the company and to set company policies.

A board member who holds a position with the company in addition to his position on the board is known as an inside director. A board member who does not hold another position with the company is known as an outside director.

Duties of the Board of Directors

•Setting the major policies for the firm.

•Evaluating the firm's operating results.

•Authorizing major transactions, such as mergers and acquisitions.

•Declaring the dividends to be paid to stockholders/policyowners.

•Appointing the officers who operate the company.

•Setting the compensation for the firm's top-level executives.

Company Management

Employees whose primary responsibility is to guide the work of other employees are said to be members of management. Their major functions include

- Planning what should be done.
- Organizing the human & technical resources to get the job done.
- Influencing and directing the people during the work.
- Controlling the work process so that work is performed in a satisfactory manner.

The most senior manager in a company, and the person located just beneath the board of directors is the CEO. In most companies, the CEO is also the company's president.

A COO manages the day-to-day operations of a company and a CFO oversees an insurer's financial management policies and functions. The CFO & COO report to the president. Also reporting to the president are executives known as vice presidents. Below vice presidents in the chain of command are the company's middle level managers. Managers are less involved in strategic planning and more involved in tactical planning, also called operational planning, which is the process of determining how to accomplish the specific tasks that need to be performed to carry out the organization's strategic plans.

Centralized & Decentralized Organizations

In a centralized organization, top management retains most decision-making authority for the entire company. In a decentralized organization,

Top management shares decision making authority with employees at lower hierarchical levels.

Company policies and actions in a centralized organization tend to be consistent because one central, high-level authority makes the decisions. Also centralization reduces certain administrative costs because a single centralized department usually handles administrative services for the company. One advantage of a decentralized organization is that managers can respond quickly to situations because they have more authority to make decisions.

Line Units and Staff Units

A line unit, also called a production department or an operating department, is an area of an organization that produces or administers the firm's products or services. In a life insurance company major line units include marketing, actuarial, underwriting, customer service, claim administration and annuity administration. A staff unit also called a service department, is an area that provides support services to line units and other staff units but does not itself produce or administer products and services. They include accounting, legal, compliance, human resources, and IT.

Line Authority, Staff Authority, and Functional Authority

Three important types of authority in an organization are line authority, staff authority, and functional authority.

Line Authority is direct authority over workers. It corresponds directly to the chain of command. Both line unit managers and staff unit managers exercise line authority over the employees that directly supervise.

Staff Authority is authority held by staff unit personnel to advise or make recommendations to line unit personnel. Staff authority is less concrete and is frequently directly upward.

Functional Authority is a staff unit member's formal or legitimate authority over line units in matters related to the staff member's functionality. One example is compliance officer who requires an individual life insurance product manager to change the wording in a new policy form so that it conforms to applicable insurance regulations.

Traditional Ways Insurers Organize Work Activities

Organization by Function

An insurance company that is organized by function differentiates its major divisions by the work that the divisions perform.

Organization by Product

A life insurance that is organized by product distributes work according to the company's line of insurance products. A major division of the company administers each line of business and handles most of the functional activities for that line of business only. However a few functions such as investments, legal, compliance, and human resources – may be handled through centrally administered departments.

Organization by Territory

A company that is organized by territory determines its major divisions according to the geographic areas in which it operates. An insurer operating in several countries may have a separate division for each country.

Organization by Profit Center or Strategic Business Unit

Another way to organize a company is by profit center. A profit center is a line of business that [1] is evaluated on its profitability, [2] is responsible for its own revenues and expenses, and [3] makes its own decisions regarding its operations. In a company organized into profit centers, a unit or department that is not itself a profit center but that performs activities to support profit centers is known as cost center. Typical cost centers are HR, accounting, legal, compliance, and IT.

A strategic business unit (SBU) is an organizational unit that acts like an independent business in all major respects. An SBU [1] faces outside competition,[2] controls its own strategic planning and new product development, [3] has its own management, and [4] is responsible for its own costs & revenues. The head of a SBU is division vice president.

A disadvantage of the profit center/SBU approach is that it may lead to duplication of effort, particularly among support functions. To avoid such duplication, some insurers are organized that are organized by SBU have established shared services for one or more supporting functions. A shared service is a functional area that performs specified business processes for multiple SBUs and that shares accountability for the costs, timing and quality of those processes with the SBUs that it serves.

Alternative Organizational Shapes

Hourglass Organization

This structure consists of three basic layers with the middle layer being much narrower than the top and bottom layers. The top layer contains executives who are responsible for formulating the organization's strategic plans. The middle layer consists of a small group of middle-level managers who coordinate the functions of the bottom layer, which typically consists of a diverse

group of technical/professional employees. A distinguishing characteristic of the hourglass organization is that the middle-level managers are generalists, rather than functional specialists.

Cluster Organization

This structure is comprised of a number of work teams. Employees do not have permanent job responsibilities. Instead, they progress from team to team as projects warrant. Key to the success of this type of organization is hiring employees who have a wide range of technical skills and who can handle flexible work assignments.

Network Organization

This structure is designed for the coordination of subcontracted production and marketing operations. The company itself includes only a small number of employers, whose primary responsibility is administrative oversight.

Committees

To address cross-jurisdictional operations, most companies establish special committees to bring together a number of people, each of whom has other responsibilities within the firm. A permanent committee that company executives use as a source of continuing advice is called a standing committee. A company's key executives and members of its board of directors make up several of the most important standing committees of any business.

An adhoc committee also called a project team, work group, or task force, is a temporary committee that is established for a specific purpose, such as planning a new information system, establishing a subsidiary company, developing a new product, or revising the company's accounting system.

DISTRIBUTION CHANNELS IN INSURANCE

An insurance cover is an intangible product evidenced by a written contract known as the 'policy'. Insurers market various insurance covers either directly or through various distribution channels—individual agents, corporate agents (including Bancassurance) and Brokers. The marketer in the distribution network is in direct interface with the prospect and the customer.

Life insurance products are sold through individual agents and many of them have this as their only career occupation. General insurance products are sold through individual agents, corporate agents and brokers.

Distribution channels such as agents are licensed by the IRDA. To get an agency license, one has to have certain minimum qualifications; practical training in insurance subjects and pass an examination conducted by the Insurance Institute of India.

IRDA regulations on licensing of agents/brokers lay down the code of conduct for individual agents, corporate agents and brokers. A separate note on the code of conduct is appended to this note.

Thus it is seen that the dos and don'ts for these intermediaries are given clearly at the point of sale as well as in the event of a claim. Service does not end with the customer receiving his document; it in fact only begins here. After sales service is as important or even more important – like when a refund has to be made or when a claim has to be made.

One of the issues that is of great concern affecting professionalism in insurance activities is resorting rebating by intermediaries. Rebating is prohibited as per Section 41 of the Insurance Act, 1938 and the public are advised not to deal with intermediaries offering rebate of any kind.

Rebating means a share of commission receivable by the agent/broker is given to the prospect/client. This is done to attract the client in the purchase of insurance contract by offering cash. Competition among agents/brokers is so cut-throat, some agents indulge in such unethical practices. Public are advised not to ask for any prohibited rebates in premium since commission payment to an agent is the only income for some to take care of their families. Similarly, agents are also advised not to indulge in such practices which could cause them loss of agency income.

TYPES OF INSURANCE

Insurance can be classified as under:-

From business point of view – Insurance on the business point of view can be divided as under:-

Life Insurance Business:- Under Life Insurance Business the subject matter of insurance is life of human being. The insurance company will pay the fixed amount of insurance money at the time of death or at the expiry of certain period. The life insurance provides protection to the family at the premature death or gives adequate amount at the old age when earning capacities are reduced. The life insurance is not only a protection but is a sort of investment because a certain sum is returnable to the insured at the death or at the expiry of a period. At present, life insurance enjoys maximum scope.

General Insurance:- The General Insurance includes property insurance, Liability insurance and other forms of insurance. Fire and Marine insurance are strictly called property insurance. Motor, theft, fidelity and machine insurance include the extent of liability insurance.

General Insurance Business includes the following:
a. Marine Insurance
b. Fire Insurance
c. Miscellaneous Insurance

The property, goods, machine, furniture, automobile, valuable articles etc. can be insured against the damage due to accident. There are different forms of insurance for each type of the said property.

Social Insurance – The social insurance is to provide protection to the weaker section of the society, who are unable to pay the premium for adequate insurance. Pension plans, disability benefits, unemployment benefits. Sickness insurance and industrial insurance are the various forms of social insurance. The government must provide social insurance to its masses.

Insurance from the risk points of view:-

Personal Insurance: Includes insurance of human life which may suffer loss due to death, accident and disease. The Personal insurance may further divided into life insurance, Personal Accident insurance and health insurance.

Property Insurance:- The property of an individual and of the society is insured against the loss of fire and Marin perils
Liability Insurance:- Liability insurance covers two risks of third party – Composition of employees, liability of the Automobile owners and reinsurance.
Guarantee Insurance:- Guarantee Insurance covers the loss arising due to dishonesty, disappearance and disloyalty of the employers or second party.

Pension Schemes (Plans)
Now a days several schemes, providing regular pensions to the employees after their retirement which may continue even after his death, this pension schemes may be for a specified time or during the life time of his wife as was chosen. The pension plan can be purchased through the employer or it can be purchased individually. Differed annuity Plan is the effective method to provide for the pension. In case of non contributory plan, participation
by all eligible employees in specified categories is compulsory.

Health Insurance
Health insurance would provide protection to social development. The insurance industry should come forward to provide health to the masses like life insurance and property insurance. The commercial basis of health insurance will be more suitable for health development of people. There is need of products, designs, structural facilities and
sustainability of insurance product.

Adequate environment is to be provided for the development of health insurance. Health insurance requires sufficient information and data for development of a good product, proper pricing and health management. Many insurers are interested to provide health insurance provided consumers are properly educated in this area. Recently with the break of joint family system, the need of health insurance is more thrusting. There is need of well designed health insurance product that may protect family saving in case of unexpected medical charges. People are interested in higher achievement then paid by them in the form of premium. The insurance cover should be reasonably comprehensive without counterproductive gaps.

Medi-claim policies provide coverage of Medical Services rendered during hospitalization. But there is need of broader set of services. Health insurance provides preventive measures by health education and quality life. Premium may be reduced on such types of proposals. Additional incentives should be provided for purchasing health insurance.

INSURANCE POLICY FORMS

Various Forms in uses

In insurance, the **insurance policy** is a contract (generally a standard form contract) between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay. In exchange for an initial payment, known as the premium, the insurer promises to pay for loss caused by perils covered under the policy language.

Insurance contracts are designed to meet specific needs and thus have many features not found in many other types of contracts. Since insurance policies are standard forms, they feature boilerplate language which is similar across a wide variety of different types of insurance policies.

The insurance policy is generally an integrated contract, meaning that it includes all forms associated with the agreement between the insured and insurer. In some cases, however, supplementary writings such as letters sent after the final agreement can make the insurance policy a non-integrated contract. One insurance textbook states that generally "courts consider all prior negotiations or agreements ... every contractual term in the policy at the time of delivery, as well as those written afterwards as policy riders and endorsements ... with both parties' consent, are part of written policy". The textbook also states that the policy must refer to all papers which are part of the policy. Oral agreements are subject to the parol evidence rule, and may not be considered part of the policy if the contract appears to be whole. Advertising materials and circulars are typically not part of a policy. Oral contracts pending the issuance of a written policy can occur.

GENERAL FEATURES (Construction, parts, terms/conditions, exclusions, clauses, memos, orders and Warranties)

The insurance contract or agreement is a contract whereby the insurer will pay the insured (the person whom benefits would be paid to, or on behalf of), if certain defined events occur. Subject to the "fortuity principle", the event must be uncertain. The uncertainty can be either as to when the event will happen (e.g. in a life insurance policy, the time of the insured's death is uncertain) or as to if it will happen at all (e.g. in a fire insurance policy, whether or not a fire will occur at all).

- Insurance contracts are generally considered contracts of adhesion because the insurer draws up the contract and the insured has little or no ability to make material changes to it. This is interpreted to mean that the insurer bears the burden if there is any ambiguity in

any terms of the contract. Insurance policies are sold without the policyholder even seeing a copy of the contract. In 1970 Robert Keeton suggested that many courts were actually applying 'reasonable expectations' rather than interpreting ambiguities, which he called the 'reasonable expectations doctrine'. This doctrine has been controversial, with some courts adopting it and others explicitly rejecting it. In several jurisdictions, including California, Wyoming, and Pennsylvania, the insured is bound by clear and conspicuous terms in the contract even if the evidence suggests that the insured did not read or understand them.

- Insurance contracts are **aleatory** in that the amounts exchanged by the insured and insurer are unequal and depend upon uncertain future events. In contrast, ordinary non-insurance contracts are commutative in that the amounts (or values) exchanged are usually intended by the parties to be roughly equal. This distinction is particularly important in the context of exotic products like finite risk insurance which contain "commutation" provisions.

- Insurance contracts are **unilateral**, meaning that only the insurer makes legally enforceable promises in the contract. The insured is not required to pay the premiums, but the insurer is required to pay the benefits under the contract if the insured has paid the premiums and met certain other basic provisions.

- Insurance contracts are governed by the principle of **utmost good faith** (uberrima fides) which requires both parties of the insurance contract to deal in good faith and in particular it imparts on the insured a duty to disclose all material facts which relate to the risk to be covered. This contrasts with the legal doctrine that covers most other types of contracts, caveat emptor (let the buyer beware). In the United States, the insured can sue an insurer in tort for acting in bad faith.

Structure

Early insurance contracts tended to be written on the basis of every single type of risk (where risks were defined extremely narrowly), and a separate premium was calculated and charged for each. This structure proved unsustainable in the context of the Second Industrial Revolution, in that a typical large conglomerate might have dozens of types of risks to insure against.

In the 1940s, the insurance industry shifted to the current system where covered risks are initially defined broadly in an insuring agreement on a general policy form (e.g., "We will pay all sums that the insured becomes legally obligated to pay as damages..."), then narrowed down by subsequent exclusion clauses (e.g., "This insurance does not apply to..."). If the insured desires coverage for a risk taken out by an exclusion on the standard form, the insured can sometimes pay an additional premium for an endorsement to the policy that overrides the exclusion.

Insurers have been criticized in some quarters for the development of complex policies with layers of interactions between coverage clauses, conditions, exclusions, and exceptions to

exclusions. In a case interpreting one ancestor of the modern "products-completed operations hazard" clause, the Supreme Court of California complained:

> The instant case presents yet another illustration of the dangers of the present complex structuring of insurance policies. Unfortunately the insurance industry has become addicted to the practice of building into policies one condition or exception upon another in the shape of a linguistic Tower of Babel. We join other courts in decrying a trend which both plunges the insured into a state of uncertainty and burdens the judiciary with the task of resolving it. We reiterate our plea for clarity and simplicity in policies that fulfill so important a public service.

Parts of an insurance contract

- Declarations - identifies who is an insured, the insured's address, the insuring company, what risks or property are covered, the policy limits (amount of insurance), any applicable deductibles, the policy period and premium amount. These are usually provided on a form that is filled out by the insurer based on the insured's application and attached on top of or inserted within the first few pages of the standard policy form.
- Definitions - define important terms used in the policy language.
- Insuring agreement - describes the covered perils, or risks assumed, or nature of coverage, or makes some reference to the contractual agreement between insurer and insured. It summarizes the major promises of the insurance company, as well as stating what is covered.
- **Exclusions** - take coverage away from the Insuring Agreement by describing property, perils, hazards or losses arising from specific causes which are not covered by the policy.
- Conditions - provisions, rules of conduct, duties and obligations required for coverage. If policy conditions are not met, the insurer can deny the claim.
- Endorsements - additional forms attached to the policy form that modify it in some way, either unconditionally or upon the existence of some condition. Endorsements can make policies difficult to read for non lawyers; they may modify or delete clauses located several pages earlier in the standard insuring agreement, or even modify each other. Because it is very risky to allow non lawyer underwriters to directly rewrite core policy language with word processors, insurers usually direct underwriters to modify standard forms by attaching endorsements preapproved by counsel for various common modifications.
- **Policy riders** - A policy rider is used to convey the terms of a policy amendment and the amendment thereby becomes part of the policy. Riders are dated and numbered so that both insurer and policyholder can determine provisions and the benefit level. Common riders to group medical plans involve name changes, change to eligible classes of employees, change in level of benefits, or the addition of a managed care arrangement such as an Health Maintenance Organization or Preferred Provider Organization (PPO).

- Policy jackets - A policy jacket is a cover, binder, envelope, or presentation folder with pockets in which the policy may be delivered. Historically, standard boilerplate provisions common to an entire family of policies were often printed on the jacket itself; then the underwriter would type up the declarations form and insert that form along with insuring agreement and endorsement forms into the jacket to assemble a complete policy. They are increasingly rare because jackets do not feed through automatic document feeders and must be manually copied or scanned in order to produce a complete image of the entire policy text. They can be difficult to physically store and scan, since they are essentially containers and are hence larger or bulkier than regular paper or have boilerplate text printed in odd layouts. Some insurers now use the term "jacket" for a set of papers appended to all policies which serve the same purpose as a traditional policy jacket.
- **Warranties**: Warranty is the very important condition in the insurance contract which is to be fulfilled by the insured; on breach of warranty the insurance company becomes free from his liability. The contract can continue only when warranties are fulfilled. If warranties are not followed, the contract may be cancelled by the other party whether risk has occurred or not of the loss has occurred due to other reasons than the waiving of warranties. However, when the warranty is declared illegal and there is no reverse effect on the account, the warranty can be waived. According to Marine Insurance Act, a warranty is that by which the assured undertakes that some particular thing shall or shall not be not done or that some conditions shall be fulfilled. Warranties which are mentioned in the policy are called express warranties. Warranties whichare not mention in the contract are called implied warranties.

Industry standard forms

In the United States, property and casualty insurers typically use similar or even identical language in their standard insurance policies, which are drafted by advisory organizations such as the Insurance Services Office and the American Association of Insurance Services. This reduces the regulatory burden for insurers as policy forms must be approved by states; it also allows consumers to more readily compare policies, albeit at the expense of consumer choice. In addition, as policy forms are reviewed by courts, the interpretations become more predictable as courts elaborate upon the interpretation of the same clauses in the same policy forms, rather than different policies from different insurers.

In recent years, however, insurers have increasingly modified the standard forms in company-specific ways or declined to adopt changes to standard forms. For example, a review of home insurance policies found substantial differences in various provisions. In some areas such as directors and officers liability insurance and personal umbrella insurance there is little industry-wide standardization.

Manuscript policies and endorsements

For the vast majority of insurance policies, the only page that is heavily custom-written to the insured's needs is the declarations page. All other pages are standard forms that refer back to terms defined in the declarations as needed.

However, certain types of insurance, such as media insurance, are written as **manuscript policies**, which are either custom-drafted from scratch or written from a mix of standard and nonstandard forms. By analogy, policy endorsements which are not written on standard forms or whose language is custom-written to fit the insured's particular circumstances are known as manuscript endorsements.

UNIT 4

RATING PRACTICES

RISK MANAGEMENT AND RATINGS PRACTICES

Strategy

• An insurer should have a sound strategy to manage risks arising from its core activities. The insurer should first determine its risk tolerance, i.e. the level of risk that it is able and prepared to bear, taking into account its business objectives and available resources. In formulating its risk management strategy, the insurer should consider the following:
• the prevailing and projected economic and market conditions and their impact on the risks inherent in its core activities;
• the available expertise to achieve its business targets in specific market segments and its ability to identify, monitor and control the risks in those market segments; and
• its mix of business/type of risks written and the resultant concentration risks which may lead to volatility in profitability.

The insurer should periodically review its risk management strategy taking into account its own financial performance and market developments. When there are material changes to the insurer's operations or its business strategy, the insurer should review its risk management strategy appropriately to take account of the changes. The strategy should be properly documented and effectively communicated to all relevant staff. There should be a process to approve proposed deviations from the approved strategy, and systems and controls to detect unauthorized deviations.

POLICIES AND PROCEDURES

Risk policies should set out the conditions and guidelines for the identification, acceptance, monitoring and management of risks. These policies should be well-defined and consistent

with the insurer's risk strategy, as well as adequate for the nature and complexity of its activities. They should also help explain the relationship of the risk management system to the insurer's overall governance framework and to its corporate culture. The policies should, at a minimum, cover the following:

• the process by which the Board decides on the maximum amount of risk the insurer is able to take, as well as the frequency of review of risk limits;
• the roles and responsibilities of the respective units and staff involved in acceptance, monitoring and management of risks;
• the approval structure for product development, pricing, underwriting, claims handling and reinsurance management, including authority to approve deviations and exceptions;

• the principles and criteria relating to product development, pricing, underwriting, claims handling and reinsurance management; and • the management of concentration risk and exposures to catastrophic events, including limits, reinsurance, portfolio monitoring and stress testing.

RISK MANAGEMENT PROCESS

An effective risk management process to address risks arising from core insurance activities; namely product development, pricing, underwriting, claims handling and reinsurance management should include the following:

• **Risk Identification and Measurement** : An insurer should have effective means of Obtaining pertinent information to identify and measure its exposure to risks inherent in its core activities. Where a risk is not readily quantifiable, for instance some operational risks, an insurer should undertake a qualitative assessment that is appropriate to the risk and sufficiently detailed so that it can be useful for risk management.

• **Risk Evaluation**: The estimated risks should be compared against the insurer's risk criteria to decide on the priority to be assigned to address each of the risks and the appropriate responses.

• **Risk Control and Mitigation:** The insurer should implement necessary measures to control and mitigate the identified risks. Risk control/mitigation measures include setting appropriate standards and limits that are clearly documented and assigning limits to relevant staff that are commensurate with the experience and competence of the respective individual.

• **Risk Monitoring and Review:** There should be an effective monitoring system to track whether any risk indicators have been triggered, and to ensure that risk standards and limits are complied with as intended and any deviation is duly approved and documented. The insurer should also establish clear procedures to investigate non-compliances with the intent of preventing such incidents from recurring. The consequences for non-compliance with established limits should be clear and pre-determined. The insurer should regularly review whether it has correctly assessed the impact and probability of material risks and effectively

treated or mitigated the risks, including identification of lessons that could be learned for future assessment and management of risks.

Sound practices for the management of emerging risks include:

- identifying emerging risks through an early warning system where information could be gathered either through internal or external sources;

- Assessing the significance of the emerging risks within the insurer's portfolio by identifying which business class and policies are likely to be affected by the materialization of the risk. In evaluating the potential financial impact, the insurer needs to take into account the degree of concentration and potential correlation with other risks already present in the portfolio; and

- Defining appropriate responses to emerging risks. For example, a response could be to mitigate the risk with an appropriate reinsurance programme.

PREMIUM PAYMENT REGULATIONS

Section 64VB in The Insurance Act, 1938 discloses the premium payment regulations. No risk to be assumed unless premium is received in advance.—

(1) No insurer shall assume any risk in India in respect of any insurance business on which premium is not ordinarily payable outside India unless and until the premium payable is received by him or is guaranteed to be paid by such person in such manner and within such time as may be prescribed or unless and until deposit of such amount as may be prescribed, is made in advance in the prescribed manner.

(2) For the purposes of this section, in the case of risks for which premium can be ascertained in advance, the risk may be assumed not earlier than the date on which the premium has been paid in cash or by cheque to the insurer. Explanation.—Where the premium is tendered by postal money order or cheque sent by post, the risk may be assumed on the date on which the money order is booked or the cheque is posted, as the case may be.

(3) Any refund of premium which may become due to an insured on account of the cancellation of a policy or alteration in its terms and conditions or otherwise shall be paid by the insurer

directly to the insured by a crossed or order cheque or by postal money order and a proper receipt shall be obtained by the insurer from the insured, and such refund shall in no case be credited to the account of the agent.

(4) Where an insurance agent collects a premium on a policy of insurance on behalf of an insurer, he shall deposit with, or dispatch by post to, the insurer, the premium so collected in full without deduction of his commission within twenty-four hours of the collection excluding bank and postal holidays.

(5) The Central Government may, by rules, relax the requirements of sub-section (1) in respect of particular categories in insurance policies.] 1[(6) The Authority may, from time to time, specify, by the regulations made by it, the manner of receipt of premium by the insurer.]

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

RISK ASSESSMENT AND SURVEY

Risk assessment is the determination of quantitative or qualitative estimate of risk related to a concrete situation and a recognized threat (also called hazard). *Quantitative risk assessment*

requires calculations of two components of risk *(R)*: the magnitude of the potential loss *(L)*, and the probability *(p)* that the loss will occur. **Acceptable risk** is a risk that is understood and tolerated usually because the cost or difficulty of implementing an effective countermeasure for the associated vulnerability exceeds the expectation of loss."Health risk assessment" includes variations, such as risk as the type and severity of response, with or without a probabilistic context.

In all types of engineering of complex systems sophisticated risk assessments are often made within Safety engineering and Reliability engineering when it concerns threats to life, environment or machine functioning. The nuclear, aerospace, oil, rail and military industries have a long history of dealing with risk assessment. Also, medical, hospital, social service and food industries control risks and perform risk assessments on a continual basis. Methods for assessment of risk may differ between industries and whether it pertains to general financial decisions or environmental, ecological, or public health risk assessment.

Risk assessment consists of an objective evaluation of risk in which assumptions and uncertainties are clearly considered and presented. Part of the difficulty in risk management is that measurement of both of the quantities in which risk assessment is concerned – potential loss and probability of occurrence – can be very difficult to measure. The chance of error in measuring these two concepts is high. Risk with a large potential loss and a low probability of occurrence, is often treated differently from one with a low potential loss and a high likelihood of occurrence. In theory, both are of near equal priority, but in practice it can be very difficult to manage when faced with the scarcity of resources, especially time, in which to conduct the risk management process. Expressed mathematically,

$$R_i = L_i p(L_i)$$
$$R_{total} = \sum_i L_i p(L_i)$$

Financial decisions, such as insurance, express loss in terms of dollar amounts. When risk assessment is used for public health or environmental decisions, loss can be quantified in a common metric such as a country's currency or some numerical measure of a location's quality of life. For public health and environmental decisions, loss is simply a verbal description of the outcome, such as increased cancer incidence or incidence of birth defects. In that case, the "risk" is expressed as

$$R_i = p(L_i)$$

If the risk estimate takes into account information on the number of individuals exposed, it is termed a "population risk" and is in units of expected increased cases per a time period. If the risk estimate does not take into account the number of individuals exposed, it is termed an "individual risk" and is in units of incidence rate per a time period. Population risks are of more use for cost/benefit analysis; individual risks are of more use for evaluating whether risks to individuals are "acceptable".

METHODS, TYPES AND FUNCTIONS INVOLVED

As part of managing the health and safety of your business you must control the risks in your workplace. To do this you need to think about what might cause harm to people and decide whether you are taking reasonable steps to prevent that harm. This is known as risk assessment and it is something you are required by law to carry out. **If you have fewer than five employees you don't have to write anything down.**

A risk assessment is not about creating huge amounts of paperwork , but rather about identifying sensible measures to control the risks in your workplace. You are probably already taking steps to protect your employees, but your risk assessment will help you decide whether you have covered all you need to.

Think about how accidents and ill health could happen and concentrate on real risks – those that are most likely and which will cause the most harm.

For some risks, other regulations require particular control measures. Your assessment can help you identify where you need to look at certain risks and these particular control measures in more detail. These control measures do not have to be assessed separately but can be considered as part of, or an extension of, your overall risk assessment.

How to assess the risks in your workplace

- Identify the hazards
- Decide who might be harmed and how
- Evaluate the risks and decide on precautions
- Record your significant findings
- Review your assessment and update if necessary

Many organizations, where you are confident you understand what's involved, can do the assessment themselves. You don't have to be a health and safety expert.

When thinking about your risk assessment, remember:

- a **hazard** is anything that may cause harm, such as chemicals, electricity, working from ladders, an open drawer etc.
- the **risk** is the chance, high or low, that somebody could be harmed by these and other hazards, together with an indication of how serious the harm could be.

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