1.0 Introduction

Man has always been in search of security and protection from the beginning of civilization. At the same time “Risk” is inevitable in life and any business activity. Again risk is closely connected with “ownership”. It is the owners who want to save themselves from risk and it is out of this desire, the concept of insurance has originated.
The aim and objective of insurance is to protect the owner from financial losses that he suffers for the risks that he has taken. The basis of insurance is sharing of losses of a few amongst many. Insurance provides financial stability and security to both individuals and organizations by this distribution of losses of a few among many by building up a fund over a period of time.

General insurance as a whole, developed with the industrial revolution in the West and with the consequent growth of seafaring trade and commerce in the seventh century. In India too, evidence of insurance in some form can be traced as early as from the Aryan period. The British and some of the other foreign insurance companies through their agencies transacted insurance business in India. The first general insurance company in India was the Triton Insurance company Ltd., established in Calcutta in 1850 AD, with the British holding major share. The first general insurance company by Indian promoters was the Indian Mercantile Insurance company Ltd. started in Bombay in 1906-07. Following the First World War, several foreign insurance companies started insurance business in India, capturing about 40 percent of the insurance market in India at the time of Independence.

Insurance business in India is governed by the Insurance Act of 1938, which was amended later in 1969. However, in 1971, the government by an ordinance nationalized the general insurance business, under the General insurance Nationalization Act, 1972 to ensure orderly and healthy growth of the business. The then existing 107 companies were brought under the aegis of General Insurance Corporation (GIC) of India. The GIC was thus entrusted with the responsibility of superintending, controlling, and ensuring smooth and healthy conduct of the general insurance business in India along with its four subsidiaries in all the zones in India.

1.1 Principles of general insurance

Both the parties to a commercial contract are by law required to observe good faith. Let us say that you go to a shop to buy an electrical appliance. You simply will not enter, pay and pick up any sample piece but will check two, three or even more pieces. You may be even ask the shopkeeper to give a demonstration to ensure that it is in working condition and also ask several questions to satisfy yourself about what you are buying. Then when you go home you find it does not work or is not what you were looking for exactly so you decide to return the item but the shopkeeper may well refuse to take it back saying that before purchasing you had satisfied yourself; and he is possibly right. The common law principle “Caveat Emptor” or let the buyer beware is applicable to commercial contracts and the buyer must satisfy himself that the contract is good because he has no legal redress later on if he has made a bad bargain.
The seller cannot misrepresent the item he has sold or deceive the buyer by giving wrong or misleading information but he is under no obligation to disclose all the information to the buyer and only selective information in reply to the buyers queries is required to be given. But in Insurance contracts the principles of “Uberrima fides” i.e. of Utmost Good Faith is observed and simple good faith is not enough.

Firstly, in Insurance contracts the seller is the insurer and he has no knowledge about the property to be insured. The proposer on the other hand knows or is supposed to know everything about the property. The condition is reverse of ordinary commercial contracts and the seller is entirely dependent upon the buyer to provide the information about the property and hence the need for Utmost Good Faith on the part of the proposer.

It may be said here that the insurer has the option of getting the subject matter of Insurance examined before covering the risk. This is true that he can conduct an examination in the case of a property being insured for fire risk or of getting a medical examination done in the case of a health policy. But even then there will be facts which only the insured can know e.g., the history of Insurance of the property whether it has been refused earlier for Insurance by another company or whether it is also already insured with another company and the previous claim experience.

Similarly a medical examination may not reveal the previous history i.e. details of past illness, accidents etc. Therefore Insurance contracts insist on the practice of Utmost Good Faith on the part of the Insured. Secondly, Insurance is an intangible product. It cannot be seen or felt. It is simply a promise on the part of Insurer to make good the loss incurred by the Insured if and when it occurs.

Thus the Insurer is also obliged to practice Utmost Good Faith in his dealings with the Insured. He cannot and should not make false promises during negotiations. He should not withhold information from the Insured such as the discounts available for good features e.g., fire extinguishing Appliances discount in fire policies or that Earthquake risk is not covered under the standard fire policy but can be covered on payment of additional premium.

In the recent Earthquake disaster in Gujarat a number of Insured failed to get any relief from Insurance Companies as Earthquake risk was not covered. Utmost Good Faith can be defined as “A positive duty to voluntarily disclose, accurately and fully all facts material to the risk being proposed whether requested for or not”.
In Insurance contracts Utmost Good Faith means that “each party to the proposed contract is legally obliged to disclose to the other all information which can influence the others decision to enter the contract”.

The following can be inferred from the above two definitions

1. Each party is required to tell the other, the truth, the whole truth and nothing but the truth.

2. Unlike normal contract such an obligation is not limited to any questions asked and

3. Failure to reveal information even if not asked for gives the aggrieved party the right to regard the contract as void.

How is this duty of Utmost Good Faith to be practiced? And what are the facts that the proposer has to disclose? The answer to both the question is simply the proposer must disclose to the insurer all material facts in respect of the subject matter of Insurance.

1.2 Insurance Documents

Documents are necessary to evidence the existence of a contract. In life insurance several documents are in vogue. The documents stand as a proof of the contract between the insurer and the insured. The major documents in vogue in life insurance are premium receipt, insurance policy, endorsements etc.

Life insurance is a legally enforceable contract between two parties both of whom are legally qualified to contract. It is therefore, necessary that the terms and conditions of the agreement must be suitably documented in a manner that would make it clear that both parties to the contract are Ad idem i.e., of the same mind. Ad-Idem means that both the parties understand the same thing in the same sense or are of the same mind on the same subject. There must be consensus or Ad-Idem between the parties to the contract. This is possible provided all the terms and conditions, rights and duties - privileges and obligations are properly documented in terms which can be clearly interpreted in a court of law.

Between two human beings sometime silence means an acceptance. But as the insurer is a legal personality entitled to contract verbal discussion between parties to the contract is not possible and hence there is a need for documentation. Insurance is also a contract of utmost good faith and enforced only in the distant future. It is therefore necessary that the declarations made by both the parties should be put in black and white for future reference. Any suppression, wilful and material shall make the contract void.
The insured, therefore, has a duty to declare all that he knows about himself, his health, his financial status in answering questions contained in the proposal form and other ancillary documents which may be required by the insurer.

We shall discuss in this unit, the various kinds of documents which become necessary at three stages of a policy –

1. At the stage of proposal, which if accepted result into a policy,
2. During the duration of the policy where several alterations may become necessary
3. At the end of the policy contract when insurer pays the final claim.

**Documents needed at the stage of the proposal**

Proposal form is the basic format which is filled in by the proposer who wants to take an insurance policy. It can be defined as the application for insurance.

**A proposal form has three portions**

1. The first gives details about the proposer, his name, address, occupation, the details about the type of insurance that he wants to take and the name of the nominee to whom the money is payable in case the policyholder does not survive to take the maturity amount.

2. The second portion relates to the details of the insurance policy that the proposer already possesses, the present health conditions and the personal history of his health, any sickness or accident he might have had. This is a detailed questionnaire and the proposer is expected to reply to each question truthfully and honestly. A female proposer has to reply to certain additional questions specific to her gender.

3. The last portion of the proposal form relates to the **declaration**. Through this declaration, the proposer

   (i) Affirms the veracity of the statements made in the proposal form in replying to the question

   (ii) Affirms that he/she has not suppressed, misrepresented or concealed any fact which may be material to the risk

   (iii) Agrees that this declaration along with the proposal form shall form the basis of the contract and if any information is found to be false the contract will be null and void thus reinforcing the principle of “Uberimma Fides” (Utmost good faith).
(iv) further agrees to take the insurance on the terms and conditions decided by the insurer. The proposer further agrees to keep the insurer informed of any changes in the position relating to his health or his occupation between now and the issuance of the first premium receipt.

It is thus clear that after the insurer has issued the first premium receipt, the contract is said to have concluded and there after the insurer has no right to change the terms of the contract.

However, the insurer has a right to offer any term and condition before the final acceptance of the insurance. For example, in case of a female proposer, the insurer may not agree to accept the risk of the childbirth. In case of certain hazardous occupation like commercial pilots, the insurer may like to exclude the risk to life due to such occupation. In case of certain deformity, the risk of accident can be excluded. These exclusions of risks are not normal terms of the policy contract and therefore have to elicit consent of the proposer. In case of a substandard health, the insurer may like to accept a reduced risk during the first one or two years of the insurance. The consent of the insured is a must for such limitations to be imposed.

**Age proof**

Age is an important factor in deciding the quantum of premium against a policy. The document proving the age, i.e. age proof must be reliable and the insured has to undertake as to its truthfulness. An insurer accepts these documents as standard age proof –

1. Certified extract from municipal records, recorded at the time of birth.
2. Certificate of baptism or extract from Family Bible
3. Extract from school or college records.
4. Extract from service register in case of employees - Government or semi government or such other reputed institutions which insist on conclusive evidence of age at the time of recruitment.
5. Identity card issued by Defence department.
6. Marriage certificates issued by Roman Catholic Church.
7. Domicile certificate.
8. Passport.
Proof of income

This document may become necessary whenever the sum proposed is very high. Normally a sum proposed which is seven to eight times of the declared income is acceptable for insurance. But proposals do come to the insurer when the known source of income of the proposer is much less compared to the amount of insurance desired. A service holder normally does not face this problem as his sources of income are verifiable.

In case of business people, the assessed income is at times much less compared to what is a desirable income for the amount of insurance desired. In such cases the insurer at times calls for assessed income tax returns, or Chartered Accountant’s certificate etc. Such precautions are necessary to eliminate the possibility of moral hazard.

Documents needed during the continuance of the policy

First Premium Receipts and Renewal Premium Receipts

The First Premium Receipt (FPR) is the confirmation of insurance. This document is important as it gives the date of assumption of the risk but its value is nil once the policy document has been issued.

Policy Contract

Policy document is a detailed document and it is the Evidence of the insurance contract which mentions all the terms and conditions of the insurance. The insured buys not the policy contract, but the right to the sum of money and its future delivery. The insurer on its part promises to pay a sum of money, provided of course the insured keeps its part of promise of paying the installments of premium as scheduled.

The pre-amble to the insurance contract makes the above statement clear and states that this policy is issued subject to the conditions and privileges printed on the back of the policy. The endorsements placed on the policy shall also be part of the policy and it also makes a reference to the proposal form saying that that the statements given in the proposal form are the basis of the contract.

The schedule which is printed on the policy document identifies the office which has issued the policy. It states the name of the policyholder, the date of commencement of the policy, an identification number of the policy called policy number. This number is extremely useful for making any reference to the insurer relating to this policy. This shall avoid needless delay. Beneficiary’s name is also...
mentioned along with address. It is necessary to check that it is correct and any mistake should be immediately pointed out for correction. A mistake in the address may misdirect the premium notices and any other future correspondence. It also states the name of the nominee and the date upto which premium has to be paid.

The schedule goes on to mention, the type of policy, on the happening of which, the sum assured is payable and to whom it is payable. It of course also mentions when and how long the premium is to be paid.

The policy document is signed by an official of the insurer and dated and stamped as per the provision of the Stamp Act to make it a completely legally enforceable document.

Renewal Premium Receipts

Though it is the duty of the insured to pay the renewal premium on the due date the insurer sends a renewal premium notice to the insured out of courtesy and on receiving the premium issues a renewal premium receipt (RPR) which is an important document and has to be preserved as it is the only documentary proof that the due payment has been made.

1.3 Basis of Rate Making

The process of establishing rates used in insurance or other risk transfer mechanisms. This process involves a number of considerations including marketing goals, competition and legal restrictions to the extent that they affect the estimation of future costs associated with the transfer of risk (i.e., claims, claim settlement expenses, operational and administration expenses, and the cost of capital).

Rate making (aka insurance pricing) : Is the determination of what rates, or premiums, to charge for insurance. A rate is the price per unit of insurance for each exposure unit, which is a unit of liability or property with similar characteristics. For instance, in property and casualty insurance, the exposure unit is typically equal to Rs. 100 of property value, and liability is measured in Rs. 1,000 units.

Because an insurance company is a business, it is obvious that the rate charged must cover losses and expenses, and earn some profit. However, all states have laws that regulate what insurance companies can charge, and thus, both business and regulatory objectives must be met.

The main business objective is to charge an adequate premium to cover losses, expenses, and allow for a profit; otherwise the insurance company would
not be successful. The pure premium, which is what is determined by actuarial studies, consists of that part of the premium that is necessary to pay for losses and loss related expenses. Loading is the part of the premium necessary to cover other expenses, particularly sales expenses, and to allow for a profit. The gross rate is the pure premium and the loading per exposure unit and the gross premium is the premium charged to the insurance applicant, and is equal to the gross rate multiplied by the number of exposure units to be insured. The ratio of the loading charge over the gross rate is the expense ratio.

\[ \text{Gross Rate} = \text{Pure Premium} + \text{Load} \]
\[ \text{Gross Premium} = \text{Gross Rate} \times \text{Number of Exposure Units} \]
\[ \text{Expense Ratio} = \frac{\text{Load}}{\text{Gross Rate}} \]

**Other business objectives in setting premiums are**

1. Simplicity in the rate structure, so that it can be more easily understood by the customer, and sold by the agent;

2. Responsiveness to changing conditions and to actual losses and expenses; and

3. Encouraging practices among the insured that will minimize losses.

The main regulatory objective is to protect the customer. A corollary of this is that the insurer must maintain solvency in order to pay claims. Thus, the 3 main regulatory requirements regarding rates is that.

1. They be fair compared to the risk.

2. Premiums must be adequate to maintain insurer solvency; and

3. Premium rates are not discriminatory—the same rates should be charged for all members of an underwriting class with a similar risk profile.

Although competition would compel businesses to meet these objectives anyway, the states want to regulate the industry enough so that fewer insurers would go bankrupt, since many customers depend on insurance companies to avoid financial calamity.

The main problem that many insurers face in setting fair and adequate premiums is that actual losses and expenses are not known when the premium is collected, since the premium pays for insurance coverage in the immediate future. Only after the premium period has elapsed, will the insurer know what its true
costs are. Larger insurance companies maintain their own databases to estimate frequency and the dollar amount of losses for each underwriting class, but smaller companies rely on rating bureaus for loss information.

A rating bureau is a company that collects loss information to sell to insurance companies, and may even suggest the rates to charge. A major rating bureau in the United States is the Insurance Services Office (ISO). Although the suggestion of rates to charge is generally against antitrust laws, rating bureaus are exempt under the McCarran-Ferguson Act of 1945, which states that federal antitrust laws only apply to the extent that insurance is not regulated by state law. Nonetheless, ISO, for instance, does not suggest what rates to charge, but only sells the loss data, letting the companies determine what rates to charge.

**Rate Making for Property and Liability Insurance**

There are 3 methods for determining rates in property and liability insurance: judgment rating, class rating, and merit rating. Merit rating can be further classified as schedule rating, experience rating, and retrospective rating.

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

Class rating is used when the factors causing losses can either be easily quantified or there are reliable statistics that can predict future losses. These rates are published in a manual, and so the class rating method is sometimes called a manual rating. Class ratings are often used in pricing insurance products sold to the consumer because there are copious statistics and a large enough population of similar situations that make class ratings effective. It also allows agents to give an insurance quote quickly.

**There are 2 methods to determine a class rated premium or to adjust it**

In the pure premium method, the pure premium is 1st calculated by summing the losses and loss-adjusted expenses over a given period, and dividing that by the number of exposure units. Then the loading charge is added to the pure premium to determine the gross premium that is charged to the customer.
Pure Premium Formula

\[
\text{Pure Premium} = \frac{\text{Actual Losses} + \text{Loss-Adjusted Expenses}}{\text{Number of Exposure Units}}
\]

Gross Premium = Pure Premium + Load

The loss ratio method is used more to adjust the premium based on the actual loss experience rather than setting the premium. The loss ratio is the sum of losses and loss-adjusted expenses over the premiums charged.

If the actual loss ratio differs from the expected loss ratio, then the premium is adjusted according to the following formula.

Loss Ratio Method for Adjusting Premiums for a Class Rating

\[
\text{Rate Change} = \frac{\text{Actual Loss Ratio - Expected Loss Ratio}}{\text{Expected Loss Ratio}}
\]

Merit Rating

Merit rating is based on a class rating, but the premium is adjusted according to the individual customer, depending on the actual losses of that customer. Merit rating often determines the premiums for commercial insurance, and, in most of these cases, the customer has some control over losses hence, the name. Merit rating is usually used when a class rating can give a good approximation, but the factors are diverse enough to yield a greater spread of losses than if the composition of the class were more uniform. Thus, merit rating is used to vary the premium from what the class rating would yield based on individual factors or actual losses experienced by the customer. There are 3 methods to determine merit rating.

Schedule rating uses a class rating as an average base, then the premium is adjusted according to specific details of the loss exposure. Some factors may increase the premium and some may decrease it the final premium is determined by adding these credits and debits to the average premium for the class. For example, schedule rating is used to determine premiums for commercial property insurance, where such factors as the size and location of the building, the number of people in the building and how it is used, and how well it is maintained are considered.
Experience rating uses the actual loss amounts in previous policy periods, typically the prior 3 years, as compared to the class average to determine the premium for the next policy period. If losses were less than the class average, then the premium is lowered, and if losses were higher, then the premium is raised.

The adjustment to the premium is determined by the loss ratio method, but is multiplied by a credibility factor to determine the actual adjustment. The credibility factor is the reliability that the actual loss experience is predictive of future losses. In statistics, the larger the sample, the more reliable the statistics based on that sample. Hence, the credibility factor is largely determined by the size of the business, the larger the business, the greater the credibility factor, and the larger the adjustment of the premium up or down. Because the credibility factor for small businesses is small, they are not generally eligible for experience rated adjustments to their premiums.

Experience rating is typically used for general liability insurance, workers compensation and group insurance. It is also extensively used for auto insurance, including personal auto insurance, because losses obviously depend on how well and how safely the insured drives.

Retrospective rating uses the actual loss experience for the period to determine the premium for that period, limited by a minimum and a maximum amount that can be charged. Part of the premium is paid at the beginning, and the other part is paid at the end of the period, the amount of which is determined by the actual losses for that period. Retrospective rating is often used when schedule rating cannot accurately determine the premium and where past losses are not necessarily indicative of future losses, such as for burglary insurance.

**Rate Making for Life Insurance**

Rate making for life insurance is much simpler, since there are mortality tables that tabulate the number of deaths for each age, which includes a population of many people. Age is the most important factor in determining life expectancy, but there are other well known factors that have a significant effect, such as the sex of the individual and smoking. Thus, an actuary can reasonably estimate the average age of death for a group of 25-year old males, who don’t smoke.

The simplest case is determining the net single premium, which is the premium that would need to be charged to cover the death claim, but does not cover expenses or profit. Although most people don’t pay a single premium because of the cost, all life insurance premiums are based on it. Annual level premiums can easily be calculated from the net single premium. The net single premium is simply the present value of the death benefit. The net single premium
is less than the death benefit because interest can be earned on the premium until the death benefit is paid. The gross premium for life insurance includes the premium to cover the death claim plus all expenses, a reserve for contingencies, and profit.

1.4 Other acts relating to General insurance

Various legislations and acts influencing transaction of general insurance business in India and also loss minimization and risk management.

The Aircraft Act, 1934: To make better provision for the control of the manufacture, possession, use, operation, sale, import and export of aircraft.

Aircraft Rules, 1937: The Rules extend to the whole of India and apply to (i) aircrafts (including persons on board) registered in India, wherever they may be, and to (ii) all aircrafts (including person on board) for the time being in or over India. However, the regulations relating to registration, licensing of personnel, airworthiness and log-books provided in the Rules do not apply to foreign aircrafts which are governed by the relevant regulations of the respective countries in which the air-craft are registered.

The Bill of Lading Act, 1855: This Act defines the character of the bill of lading as an evidence of the contract of carriage of goods between the shipowner and the shipper, as an acknowledgement of the receipt of the goods on board the vessel and, as a document of title. The bill of lading is one of the various documents required in connection with settlement of marine cargo claims.

Carriage by Air Act, 1972: The Act gives effect to the provisions of the Warsaw Convention, 1929 and the Hague Protocol, 1955 relating to international carriage of passengers and goods by air. The Act defines the liability of the air carrier for death of or injury to passengers and for loss of or damage to registered luggage and cargo. The provisions of the Act also apply, with some changes, to domestic carriage, i.e, carriage within India.

Carriage of Goods by Sea Act, 1925: This act defines the minimum rights, liabilities and immunities of a shipping Co. in respect of loss or damage to cargo carried.

The Carriers Act, 1865: This Act defines the rights and liabilities of truck-owners or operators who carry goods on public hire, in respect of loss or damage to goods carried by them. The Act also prescribes the time limit within which notice of loss or damage must be filed with the road carriers.

Employees’ State Insurance Act, 1948 (ESI): This is an Act to provide for certain benefits to employees in cases of sickness, maternity and employment injury and to make provision for certain other matters in relation
thereof. Under the Act, the Employees’ State Insurance Corporation has been set up to administer the insurance Scheme. The scheme is applicable to industrial employees as defined.

**Foreign Exchange Regulation Act, 1973 (FERA)**: Exchange control regulations governing general insurance business written in India are set out in a Memorandum which is issued by the Reserve Bank of India under Sec. 73(3) of the Foreign Exchange Regulation Act.

**General Insurance Business (Nationalization) Act, 1972**: This Act came into force on 1st January, 1973 with the following objectives:

- To provide for the acquisition and transfer of shares of Indian Insurance companies and undertakings of other existing insurers.
- To serve better the needs of the economy by securing the development of general insurance business in the best interest of the community.
- To ensure that the and activities of the economic system does not result in concentration of wealth to the detriment of common interest.
- For the regulation and control of such business and for matters connected therewith or incidental thereto.

**Note**

The transactions of general insurance business in India is governed by and is subject to this Act.

**Indian Arbitration Act, 1940**: Disputes regarding insurance claims relating to the amounts payable under the policy are settled through the process of arbitration provided in this Arbitration Act.

**Indian Boiler Act, 1923**: The manufacturing, supply, operation, registration of Boilers in India are governed by this Act.

**Indian Contract Act, 1872**: To codify laws of contract.

**Indian Factories Act, 1948**: This Act defines Factory and provides for regulations for governing factories. This Act also provides for various provisions of safety for various types of machinery, plant etc. in factories.

**Indian Mines Act, 1952**: Similar to Factories Act, defines mines and provides for regulations to ensure safety and security in mines.

**Indian Ports (Major Ports) Act, 1963**: This Act defines the liability of Port Trust authorities for loss of or damage to goods whilst in their custody and prescribes time limits for filing monetary claim on, or suit against the Port Trust authorities.
**Indian Post Office Act, 1898**: This Act defines the liability of the Government for loss, misdelivery, delay of or damage to any postal article in course of transit by post.

**Indian Railways Act, 1890**: The Act deals with various aspects of Railways administration also relevant to Marine Insurance practice as it deals with the responsibility of Railways administration as carriers.

**Indian Stamp Act, 1899**: The Act provides that a policy of Insurance be stamped in accordance with the schedule of rates prescribed.

**Inland Steam-Vessels Act, 1917**: The Inland Steam-Vessels Act, 1917 as amended in 1977, provides for the application of the provisions of Chapter VIII of the Motor Vehicles Act, 1939 in relation to insurance of mechanically propelled vessels against third party risks. The Act makes it compulsory for owners or operators of inland vessels to insure against legal liability for death or bodily injury of third parties or of passengers carried for hire or reward and for damage to property of third parties. The limits of liability are also prescribed.

**Insurance Act, 1938**: The Act applies to the General Insurance Corporation of India and the four Subsidiary companies subject to exceptions, restrictions and limitations as specified by the Central Government under powers conferred by Section 35 of the General Insurance Business (Nationalization) Act. The important provisions of the Act relate, among other things, to registrations, accounts and returns, investments, limitations in expenses of Management, prohibition of rebates, powers of investigation, licensing of agents, licensing of surveyors, advance payment of premium and Tariff Advisory Committee etc.

**Marine Insurance Act, 1963**: This Act codifies the law relating to Marine Insurance. With a few exceptions this Act closely follows the UK Marine Insurance Act, 1906.

**Motor Vehicles Act, 1939**: Chapter VIII provides for compulsory insurance of motor vehicles. According to this Act, no motor vehicle can be used in public places unless there is, in force, in relation to that vehicle, a policy of insurance issued by an authorized insurer.

**Motor Vehicles Act, 1988**: The Motor Vehicles (Amendment) Act, 1988 has introduced changes which have far-reaching consequences. The changes also affect Third Party Liability arising out of the use of the Motor Vehicles in a public place.
Workmen’s Compensation Act, 1923: The Act provides for the payment of compensation by employers to their workmen for injury by accident arising out of and in the course of employment.

Short Answer Type Questions
1. What is General Insurance (S.A)?
2. Define Rate making.
3. Rate making of life insurance.

Long Answer Type Questions
1. Explain the principle of General Insurance.
2. What are document need to take general insurance policy?
3. Explain other acts relating general insurance.
2.1 Fire Insurance

A fire insurance is a contract under which the insurer in return for a consideration (premium) agrees to indemnify the insured for the financial loss which the latter may suffer due to destruction of or damage to property or goods, caused by fire, during a specified period. The contract specifies the maximum amount, agreed to by the parties at the time of the contract, which the insured can claim in case of loss. This amount is not, however, the measure of the loss. The loss can be ascertained only after the fire has occurred. The insurer
is liable to make good the actual amount of loss not exceeding the maximum amount fixed under the policy.

Fire Insurance is designed to provide protection for property against loss or damage by fire and other specified perils.

**Examples of Insurable property**

- Buildings
- Electrical installation in buildings such as machinery, plant and equipment, accessories etc.
- Goods (raw materials, stock in-process, semifinished, finished, packing materials, etc.) in factories, godowns.
- Goods in the open
- Contents in dwellings, shops, hotels, etc.
- Furniture, fixture and fittings
- Pipelines, (including contents) located inside or outside the compound, etc.

**2.2 General Conditions**

A fire insurance policy cannot be assigned without the permission of the insurer because the insured must have insurable interest in the property at the time of contract as well as at the time of loss. The insurable interest in goods may arise out on account of (i) Ownership, (ii) Possession, or (iii) Contract. A person with a limited interest in a property or goods may insure them to cover not only his own interest but also the interest of others in them. Under fire insurance, the following persons have insurable interest in the subject matter:-

- Owner
- Mortgagee
- Pawnee
- Pawn broker
- Official receiver or assignee in insolvency proceedings
- Warehouse keeper in the goods of customer
- A person in lawful possession e.g. common carrier, wharfinger, commission agent.
The term ‘fire’ is used in its popular and literal sense and means a fire which has ‘broken bounds’. ‘Fire’ which is used for domestic or manufacturing purposes is not fire as long as it is confined within usual limits. In the fire insurance policy, ‘Fire’ means the production of light and heat by combustion or burning. Thus, fire, must result from actual ignition and the resulting loss must be proximately caused by such ignition. The phrase ‘loss or damage by fire’ also includes the loss or damage caused by efforts to extinguish fire.

The types of losses covered by fire insurance are

• Goods spoiled or property damaged by water used to extinguish the fire.

• Pulling down of adjacent premises by the fire brigade in order to prevent the progress of flame.

• Breakage of goods in the process of their removal from the building where fire is raging e.g. damage caused by throwing furniture out of window.

• Wages paid to persons employed for extinguishing fire.

The types of losses not covered by a fire insurance policy are

• Loss due to fire caused by earthquake, invasion, act of foreign enemy, hostilities or war, civil strife, riots, mutiny, martial law, military rising or rebellion or insurrection.

• Loss caused by subterranean (underground) fire.

• Loss caused by burning of property by order of any public authority.

• Loss by theft during or after the occurrence of fire.

• Loss or damage to property caused by its own fermentation or spontaneous combustion e.g. exploding of a bomb due to an inherent defect in it.

• Loss or damage by lightening or explosion is not covered unless these cause actual ignition which spread into fire.

A claim for loss by fire must satisfy the following conditions

• The loss must be caused by actual fire or ignition and not just by high temperature.

• The proximate cause of loss should be fire.

• The loss or damage must relate to subject matter of policy.
• The ignition must be either of the goods or of the premises where goods are kept.

• The fire must be accidental, not intentional. If the fire is caused through a malicious or deliberate act of the insured or his agents, the insurer will not be liable for the loss.

2.3 Tariff System

Fire business is governed by All India Fire Tariff.

All India fire Tariff contains totally eight section and they are as follows

<table>
<thead>
<tr>
<th>Section</th>
<th>General Rules and Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Standard Fire and Special Perils Policy</td>
</tr>
<tr>
<td>II</td>
<td>Dwellings, Offices, Hotels, Shops etc. located outside the compounds of Industrial/Manufacturing Risks</td>
</tr>
<tr>
<td>III</td>
<td>Industrial/Manufacturing Risks</td>
</tr>
<tr>
<td>IV</td>
<td>Utilities located outside the compounds of Industrial/Manufacturing Risks</td>
</tr>
<tr>
<td>V</td>
<td>Storage Risks outside the compounds of Industrial/Manufacturing Risks</td>
</tr>
<tr>
<td>VI</td>
<td>Tank Farms/Gas Holders outside the compounds of Industrial/Manufacturing Risks</td>
</tr>
<tr>
<td>VII</td>
<td>Add-on covers</td>
</tr>
</tbody>
</table>

How to Use Tariff

**Step 1:** Identify the Risk i.e., whether it is Dwelling, Hotel, Industry, Utilities or Storage area or Tanks located inside or outside the manufacturing risk etc.

**Step 2:** Refer the appropriate Section for rating i.e., Sec.III to Sec.VIII under which the risk Category falls.

**Step 3:** The Premium rates are given in alphabetical order under each section and the rate applicable to a particular risk can be found out

**Step 4:** In case the Insured opts for additional cover, Sec VIII of All India Fire Tariff may be referred and the Rate can be found out directly.
**Step 5:** In case the insured desires to opt out Riot, Strike, Malicious Damage and/or Storm, Tempest Flood & Inundation at the inception of the policy, the appropriate rate may be deducted from the basic premium rate which is given separately under each section.

**Step 6:** The discount, if any is to be allowed loading, if any to be charged, are as given under Fire Insurance Rating Computation, which is furnished below.

**Computation of rate**

The following sequence shall be adopted for computation of the rate

- Basic rate.
- 5% Reduction for Sprinklered blocks if applicable (for risk rateable under Sec.III, IV, V and VI)
- Reduction in rates for deletion of STFI and/or RSMD perils, if opted out.
- Tariff extra for ‘Kutcha’ Construction, if applicable (to be applied on 1-2-3)
- Discount/loading for claims experience (to be applied on 1-2-3-4)
- Discount for FEA on protected blocks (to be applied on 1-2-3-4)
- Discount for voluntary deductible to be applied on the total premium calculated on the basis of final rate worked out as above

**General Rules and Regulation**

**Section-I:** General rules and Regulations

**1. Policy**

Fire business is governed by All India Fire Tariff. Only standard Fire and special perils policy with the permitted “Add on” covers can be issued. Unless otherwise specifically provided for, this Tariff is applicable to land-based properties only.

Any risk, which has not been provided for in the Tariff shall be referred to the Committee for rating. Provisional rate of Rs.2.50 per mile shall be charged in such cases for covering the risks under Standard Fire and Special Perils Policy. No discounts shall be allowed on this rate.
2. Valued Policy(ies)

Valued policy(ies) can be issued only for properties whose market value cannot be ascertained, e.g. Curios, Works of Art, Manuscripts, Obsolete machinery and the like subject to the valuation certificate being submitted and found acceptable by the insurers.

3. Long term policies

Fire policies for a period exceeding 12 months shall not be issued “Except for Dwellings”. Long term policies shall be issued to house/flat owners only based on either of the following 2 methods subject to the conditions below:

- The policy shall be issued for a minimum period of 3 years.
- No refund shall be allowed for mid-term cancellation of such policies.
- Mid-term inclusion of perils shall be not be allowed.
- Premium for entire policy period shall be collected in advance.

Method A

Premium shall be charged in full without any discount. However sum insured under the policy shall be deemed to have increased by 10% of the original sum insured at the end of every 12 months period.

Method B

There shall be not be any automatic increase in sum insured as in method A. However appropriate discounts shall be allowable on applicable gross premium as per table below.

<table>
<thead>
<tr>
<th>Duration of Policy</th>
<th>Premium To Be Charged</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years policy</td>
<td>3 years premium in advance less 15% discount</td>
</tr>
<tr>
<td>4 years policy</td>
<td>4 years premium in advance less 20% discount</td>
</tr>
<tr>
<td>5 years policy</td>
<td>5 years premium in advance less 25% discount</td>
</tr>
<tr>
<td>6 years policy</td>
<td>6 years premium in advance less 30% discount</td>
</tr>
<tr>
<td>7 years policy</td>
<td>7 years premium in advance less 35% discount</td>
</tr>
<tr>
<td>8 years policy</td>
<td>8 years premium in advance less 40% discount</td>
</tr>
<tr>
<td>9 years policy</td>
<td>9 years premium in advance less 45% discount</td>
</tr>
<tr>
<td>10 years &amp; above</td>
<td>Entire premium in advance less 50% discount</td>
</tr>
</tbody>
</table>
4. Mid-Term Cover

Generally it is not permissible to grant mid-term cover for STFI and/or RSMD perils. The following provisions shall apply, where such covers are granted mid-term.

- Insurers must receive specific advice from the insurance accompanied by payment of the required additional premium in cash or by draft. This additional premium shall not be adjusted against existing Cash deposits or debited to Bank guarantee.

- Mid-term cover shall be granted for the entire property at one complex compound location covering the entire interest of the insured under the one or more policy (ies). Insured shall not have any option for selection.

- Cover shall commence 15 days after the receipt of the premium.

- The premium rates as under shall be charged on short period scale on full sum insured at one complex/compound/location covering the entire interest of the insured for the balance period up to the expiry of the policy.

<table>
<thead>
<tr>
<th>Mid-Term Inclusion of</th>
<th>Section III</th>
<th>Section VI</th>
<th>Section IV V and VII</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Materials In Godown</td>
<td>Materials In Open</td>
<td></td>
</tr>
<tr>
<td>STFI</td>
<td>0.20%</td>
<td>0.35%</td>
<td>2.00%</td>
</tr>
<tr>
<td>RSMD</td>
<td>0.15</td>
<td>0.15%</td>
<td>0.15%</td>
</tr>
</tbody>
</table>

5. Payment of Premium

Premium shall be paid in full and shall not be accepted in installments or by deferred payments in any form.

6. Minimum Premium

Minimum premium shall be Rs. 100/- per policy except for risks ratable under Section III and Tiny Sector Industries under section IV in which case the minimum premium shall be Rs. 50/- per policy.

7. Partial Insurance

It is not permissible

- To issue a policy covering only certain portions of a building. Notwithstanding this, the plinth and foundations or only the foundation of a building may be excluded.
• To issue a policy covering only specified machinery (except boilers) parts of machine or accessories there of housed in the same block/building.

8. Rates For Short Period Insurance

Polices for a period of less than 12 months shall be issued at the rates set out hereunder.

<table>
<thead>
<tr>
<th>For a period not exceeding</th>
<th>15 days</th>
<th>10% of the Annual rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>-do-</td>
<td>1 month</td>
<td>15% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>2 month</td>
<td>30% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>3 month</td>
<td>30% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>4 month</td>
<td>40% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>5 month</td>
<td>50% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>6 month</td>
<td>60% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>7 month</td>
<td>70% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>8 month</td>
<td>75% of the annual rate</td>
</tr>
<tr>
<td>-do-</td>
<td>9 month</td>
<td>80% of the annual rate</td>
</tr>
</tbody>
</table>

For a period exceeding 9 month The full annual rate

2.4 Types of Policies

There are different insurance policies covered by the insurers.

**Specific policy:** Is a policy which covers the loss up to a specific amount which is less than the real value of the property. The actual value of the property is not taken into consideration while determining the amount of indemnity. Such a policy is not subject to ‘average clause’. ‘Average clause’ is a clause by which the insured is called upon to bear a portion of the loss himself. The main object of the clause is to check under-insurance, to encourage full insurance and to impress upon the property owners to get their property accurately valued before insurance. If the insurer has inserted an average clause, the policy is known as “Average Policy”.

**Comprehensive policy:** Is also known as ‘all in one’ policy and covers risks like fire, theft, burglary, third party risks, etc. It may also cover loss of profits during the period the business remains closed due to fire.
Valued policy: Is a departure from the contract of indemnity. Under it the insured can recover a fixed amount agreed to at the time the policy is taken. In the event of loss, only the fixed amount is payable, irrespective of the actual amount of loss.

Floating policy: Is a policy which covers loss by fire caused to property belonging to the same person but located at different places under a single sum and for one premium. Such a policy might cover goods lying in two warehouses at two different locations. This policy is always subject to ‘average clause’.

Replacement or Re-instatement policy: Is a policy in which the insurer inserts a re-instatement clause, whereby he undertakes to pay the cost of replacement of the property damaged or destroyed by fire. Thus, he may re-instate or replace the property instead of paying cash. In such a policy, the insurer has to select one of the two alternatives, i.e. either to pay cash or to replace the property, and afterwards he cannot change to the other option.

2.5 Rules for cancellation of policy

For cancellation of insurance policy at the option of the insured.

Three different calculation methods are commonly used. Cancellation methods are typically calculated using an online wheel calculator.

Pro Rata

A non-penalty method of calculating the return premium of a canceled policy. A return premium factor is calculated by taking the number of days remaining in the policy period divided by the number of total days of the policy. This factor is multiplied by the written premium to arrive with the return premium.

Short Rate (Old Short Rate)

A penalty method of calculating the return premium often used when the policy is canceled at the insureds request. It uses a table of factors that results in penalties that can be lower or higher than short rate (90% pro rata) depending upon the date of cancellation.

Short Rate (90% Pro Rata)

A penalty method that where the penalty is 10% of the unearned premium.

- In case of short period policies, premium shall be retained at a the applicable short period scale.

For cancellation of insurance policy at the option of the insurer, refund of premium shall be on pro-rate basis for the unexpired term.
Short Answer Type Questions

1. What is Fire Insurance?

2. What is Tariff System?

Long Answer Type Questions

1. Explain General conditions in fire insurance.

2. Explain the types of fire insurance policies.

3. What are the reasons for cancellation of policy?
3.0 Introduction

Marine insurance may be defined as an agreement where the insurer undertakes to indemnify the assured, in the manner and to the extent hereby agreed, against marine loses, that is to say, the losses incidental to marine adventure. Though, to begin with, Marine insurance evolved as a contract insuring
ocean transit of cargoes, overland and air transits also came to be insured under marine policies, in course of time. Accordingly, all types of transits, i.e., sea, road, rail, air and registered post are now insured under marine policies.

### 3.1 Marine Insurance

Marine insurance is the indemnity for the loss of cargo or damage to ships during the shipment. The risks that marine insurance covers are fire, seizures, wars, accidents or causalities which take place over the sea. The winds and waves are not included as risks in the marine insurance.

The Indian Marine Insurance Act, 1963 is imbibed from the Marine Insurance Act, 1906. Though the Marine Insurance Act is deep in its insurance coverage, it does not provide for losses that occur while the ship is sailing the waters. This has led to the introduction of another insurance called the Marine Cargo Insurance, which provides for losses to cargo while the ship is sailing the waters. This is very beneficial to oil tankers and heavy cargo ships.

#### Types of Marine Insurance

Since Marine Insurance is very vast, it provides for various types of insurance as per the need, specification and requirement. They are:

**Hull Insurance**: This insurance covers for both vessel and its apparatus such as fuel, tools, furniture, machinery etc.

**Freight Insurance**: This insurance usually covers for the loss of freight. If the goods are safely shifted to the destination port, the owner of goods will have to pay the freight charges but if the ship faces any damages and losses, the shipping company will be under loss. Hence this insurance becomes a necessity to the owner company.

**Cargo Insurance**: This insurance covers the personal goods of the passengers and crew of the ship. It also covers the goods that are transported.

**Liability Insurance**: This is the insurance which is utilized when the insured suffers losses due to liability to third party. This liability may be caused due to risks such as collision of ships or any other similar causality that may take place in voyage.

### 3.2 Marine Policies

#### Types of Marine Insurance Policies

**Voyage policy**: Is a policy in which the subject matter is insured for a particular voyage irrespective of the time involved in it. In this case the risk attaches only when the ship starts on the voyage.
**Time policy**: Is a policy in which the subject matter is insured for a definite period of time. The ship may pursue any course it likes, the policy would cover all the risks from perils of the sea for the stated period of time. A time policy cannot be for a period exceeding one year, but it may contain a ‘continuation clause’. The ‘continuation clause’ means that if the voyage is not completed within the specified period, the risk shall be covered until the voyage is completed, or till the arrival of the ship at the port of call.

**Mixed policy**: Is a combination of voyage and time policies and covers the risk during particular voyage for a specified period of time.

**Valued policy**: Is a policy in which the value of the subject matter insured is agreed upon between the insurer and the insured and it is specified in the policy itself.

**Open or Un-valued policy**: Is the policy in which the value of the subject matter insured is not specified. Subject to the limit of the sum assured, it leaves the value of the loss to be subsequently ascertained.

**Floating policy**: Is a policy which only mentions the amount for which the insurance is taken out and leaves the name of the ship(s) and other particulars to be defined by subsequent declarations. Such policies are very useful to merchants who regularly despatch goods through ships.

**Wagering or Honour policy**: Is a policy in which the assured has no insurable interest and the underwriter is prepared to dispense with the insurable interest. Such policies are also known as ‘Policy Proof of Interest (P.P.I).

### 3.3 Rating & Underwriting

In the insurance industry, the practice of underwriting refers to the process of accepting or rejecting risks. It is the very heart of insurance and is the first step taken by an insurance company to generate premiums. Originally, insurance and underwriting were synonymous. That is, underwriting referred to the operation of the insurance business. As the insurance industry developed, underwriting took on a more specialized meaning.

In the early days insurance was more personal than it is today. A contract was drawn up between a property owner and a second party, who was willing to insure the specified property, or between the insured and the insurer. The contract specified the terms under which the property would be insured. The property owner placed his name at the top of the contract, stating that he was the owner of the property and beneficiary of the contract if the property was subsequently damaged. The other party, who guaranteed the contract and was the insurer, signed his name below, at the bottom of the contract. Literally, he “underwrote” the contract.
An underwriter is the person who decides whether or not to insure risks for which applications have been submitted. The underwriter’s task is to evaluate a risk, estimate the potential exposure, determine the likelihood of loss, then make a decision whether or not to accept the application for insurance.

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

The process of underwriting involves four basic functions

1. Selection of risks,
2. Classification and rating,
3. Policy forms, and
4. Retention and reinsurance.

By performing these four functions the underwriter increases the possibility of securing a safe and profitable distribution of risks.

Rating

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

3.4 Increased value Insurance

Increased Value Insurance (also called Freight Interest Insurance) is a cover designed to insure additional 20% over the Insured Value of the vessel in case of her total loss.

Compensation under Hull & Machinery Policy in the event of Total Loss is not enough to cover expenses for replacement of the vessel, which may result in a difficult situation for the Shipowner.
Increased Value Insurance makes it possible to replace the vessel and minimize economic consequences of the Total Loss. Indemnity paid under Increased Value Insurance policy will also protects the Shipowner against loss of freight.

If any Increased Value insurance is effected by the Assured on the cargo insured herein the agreed value of the cargo shall be deemed to be increased to the total amount insured under this insurance and all Increased Value insurances covering the loss, and liability under this insurance shall be in such proportion as the sum insured herein bears to such total amount insured. In the event of claim the Assured shall provide the Underwriters with evidence of the amounts insured under all other insurances.

3.5 Tariff policies Claims

In the insurance industry tariff policies claims transferred by assignment unless the terms of the policy expressly prohibit the same. The policy maybe assigned either before or after loss. The insured need not give a notice or reformation to the insurer or underwriter about assignment. In case of death of the insured marine policy is automatically assigned to his heirs.

The marine insurance tariff policies claims can be assigned freely to any person the assignor merely transfer his own right to claims to the assignee.

Short Answer Type Questions

1. Marine Insurance.

2. Define Rating.

3. Underwriting.

Long Answer Type Questions

1. Explain the Marine Insurance policies.

2. Increased values insurance.

3. Tariff policies claims.
UNIT 4

Motor Insurance

Structure

4.0  Introduction
4.1  Types of Motor Insurance
4.2  Legal aspects I & II
4.3  Motor policies I & II
4.4  Motor Tariff – Documents – underwriting
4.5  Claims – Own Damage claims
4.6  Claims – II – Third party liability claims

Learning Objectives

After studying this unit the student will be able to

• Understand about motor insurance
• Understand about different types of motor insurance policies
• Understand about motor tariff
• Understand about claiming own damage claim
• Understand about third party damage claim
4.0 Introduction

Vehicle insurance (also known as auto insurance, GAP insurance, car insurance, or motor insurance) is insurance purchased for cars, trucks, motorcycles, and other road vehicles. Its primary use is to provide financial protection against physical damage and/or bodily injury resulting from traffic collisions and against liability that could also arise there from. The specific terms of vehicle insurance vary with legal regulations in each region. To a lesser degree vehicle insurance may additionally offer financial protection against theft of the vehicle and possibly damage to the vehicle, sustained from things other than traffic collisions.

Motor insurance gives protection to the vehicle owner against (I). Damages to his/her vehicle and (ii). pays for any Third Party Liability determined as per law against the owner of the vehicle. Third Party Insurance is a statutory requirement. The owner of the vehicle is legally liable for any injury or damage to third party life or property caused by or arising out of the use of the vehicle in a public place. Driving a motor vehicle without insurance in a public place is a punishable offence in terms of the Motor V ehicles Act, 1988.

4.1 Types of Motor Insurance

The word Motor broadly covers a lot of classes of vehicles plying on the roads. These may be two-wheelers like scooters and motorbikes, three-wheelers or four wheelers like private cars, jeeps, buses, trucks, commercial taxis and other vehicles.

Car Insurance

This is the fastest growing segment in the insurance sector as car insurance is mandatory while buying a new car. Major car manufacturers are tying up with leading insurance companies to provide quick insurance to its customers. Car insurance covers loss or damage by accident, fire, lightning, riots, earth quake, hurricane, terrorist attacks, explosion, theft, third party’s claims and damages (like liability for third party injury or death, third party property and liability to paid driver). On payment of appropriate additional premium it covers loss or damage to electrical or electronic accessories and other significant items.

Two Wheelers Insurance

Two wheeler insurance is another type of popular auto insurance in India. It is governed by the Indian Motor Tariff. This insurance provides protection against natural and manmade calamities like: fire, rockslide, landslide, storm,
hurricane, flood, earthquake, burglary, theft, riots or any damage caused to the vehicle in transit by road, air, inland waterway or rail. Two wheeler insurance provides mandatory personal accident cover of Rs. 1 lakh to the insurer. This accident cover can also be opted for passengers. It also protects against legal liabilities arising due to third party’s injury/death or damage caused to its property.

**Commercial Vehicle Insurance**

This type of insurance covers all those vehicles which are not used for personal purpose. Trucks, buses, heavy commercial vehicles, light commercial vehicles, multi utility vehicles, agricultural vehicles, ambulances etc are covered under this insurance. The premium is calculated on the basis of the make and model of the commercial vehicle, place of registration, year of manufacture, current showroom price and whether the insurer is individual or corporate. Insurance Companies in collaboration with the automobile manufacturing companies chalk out different kind of easy and less complicated plans for safe and easy insurance policy. HSBC India, New India Assurance, United India Insurance, Bajaj Allianz, ICICI Lombard etc are some of the prominent companies in India which provide commercial vehicle insurance.

4.2 Legal aspects I & II

Section 110 of motor vehicle Act1939 empowers the state government is establishing motor claims tribunals. The legal aspects will help in settling the third party claims for the minimum amount.

In the first stage the insured will inform the insurer about loss. The loss is registered in claim register. The another stage the automobile surveyor will assess the causes of loss and extent of loss. The insurance company may them authorize the repairs. The motor vehicle, repaired, insurance company pays the charges directly to insured.

4.3 Motor policies I & II

The India Motor Tariffs, as amended in July 2002 provided for two types of Policy forms. These were.

1. Liability Only
2. Package policy

1. Liability Only

When a car insurance policy covers liability only, it means that the policyholder chooses only bodily injury and property damage coverage. These limits would be paid to another party in the event that the policyholder is found
at fault for that party’s injuries or for any damage done to that party’s property. This portion of a car insurance policy is mandatory.

**Limitations of Coverage**

With this type of policy, damage to the policyholder’s car is not covered. This means that if he is found at fault for any incident, while the other party’s damages would be covered under his policy, the policyholder would have to pay for the repairs to his vehicle.

This form covers “Act: Liability and PA to owner/driver. The Insurance Regulatory and Development Authority has withdrawn the Tariff with effect from 1st April 2009. However, the wordings of “Liability Only Policy” will continue and the rates for “Liability Only” policy are regulated by the IRDA.

**When to Choose Liability Only**

Liability only car insurance may be appropriate for vehicles that have depreciated significantly in value. As a general rule of thumb, once a vehicle reaches seven years of age, it is a good time to take physical damage coverage off the policy and choose liability only coverage if it is available. Since vehicle values depreciate differently depending on make and model, it is best to consult the Kelley Blue Book to determine if the cost of the insurance is beginning to outweigh the car’s actual cash value.

Vehicles that are already damaged should also be insured for liability coverage only. In fact, car insurance companies will usually insure a vehicle with existing damage for only liability and any required state coverage.

**When Liability Only Coverage is Unavailable**

There are other circumstances when liability only coverage is not available. Even on older vehicles, if the car is being leased or financed, the policyholder usually cannot choose liability only coverage. The financial institution holding the vehicle’s title will require comprehensive and collision coverage on the vehicle until the loan or lease is satisfied. This is to protect their collateral in case any damage does come to the vehicle that would render it a total loss.

**2. Package Policy**

This covers loss or damage to the vehicle insured in addition to liability only policy. Restricting the scope of cover under Section-I (loss of or damage to the vehicle insured) of the Package policy without any reduction in Tariff rates is permitted. Excepting this, no alteration or extension of any of the Covers, Terms, Conditions, Exclusions, etc. of any of the Policies/Endorsements laid down in this tariff is permitted without prior approval of the TAC.
This form covers ‘Own Damage” losses and “Act Liability.” It can also be extended to cover additional liabilities as provided in the Tariff, for example, liability to employees of the insured who may be travelling in or driving the employer’s cars, increased Third Party Property Damage Liability, etc.

Formerly these were known as Act only and Comprehensive Policy respectively. Insurers could, restrict the cover under the Own Damage section of package Policy without reduction in premium or increase the premium for the same Policy. “Liability only” cover could not be reduced in any way.

With regards to “Own Damage” cover the existing policy wording are to be continued but insures are given freedom of pricing and permitted to provide additional covers after obtaining the Regulators clearance to the changes. The two policy forms i.e. i) Liability only and ii) package policy continues to be used. The authority has prescribed proposal forms for third party “Liability Only Policy “for private car, two wheelers and commercial vehicles.

**4.4 Motor Tariff – Documents – underwriting**

The Tariff Advisory Committee (TAC) have laid down rules, regulations, rates, advantages, terms and conditions as contained herein, for transaction of motor insurance in India in accordance with the provisions of part ii b of the insurance act, 1938.

A tariff is a document approved by the TAC that contains the motor carrier’s rules and regulations, rates, and charges. All motor carriers are required to publish and file their tariffs with the Commission.

**Documents needed in Motor Tariff**

**4.4.1 Underwriting**

Insurance companies really operate on the concept of risk. Every time they take on a new customer they are taking a risk that you will not have an accident. When you have an accident then they are obligated to pay for the damages which can amount of several hundred thousands of Rupees. By operating a motor vehicle there is an inherent amount of assigned risk involved that both you and the insurance company take on.

**The Barter of Risk**

With this assigned risk that runs under the involvement of both the insurance company and the insured, the insurance company charges a premium. This premium, as well as the deductibles for each policy, are there to help minimize the losses sustained in the event of accidents and lawsuits. Besides the risk of an accident, there is also the risk of losing customers due to overcharging as well as not making enough to pay for claims through undercharging.
Enter Underwriting

If the insurance companies were to take on this risk all by themselves, then we would have to pay exorbitant prices for our auto insurance policy. Underwriting helps leverage the risk by helping the insurance company with a balance between price and risk. Underwriters are charged with the task of backing up the insurance company with the power of their investments and money so that they can help shape prices of policies and what will be covered.

Important to Customers

Underwriting, even if you do not fully understand it, is important to the customer because it can affect your insurance future. Because underwriters also inherit a lot of the assigned risk of an auto insurance policy, they have a lot of say in who is approved, or not approved, for car insurance through a particular insurance company. On the surface this might be overlooked, but it has penetrating results. Your insurance records are open to the public and can be looked at by other insurance companies. If you are denied by a certain insurance company, then chances are other underwriters will see this and either deny you again when you apply through another insurance company, or levy higher premiums. This is because the risk involved in insuring you is more than the risk of insuring someone without a lot of traffic violations or previous accidents.

What Do Underwriters Consider?

Underwriters, because they have the task of working for the insurance company will look at several items as to whether or not you should be given insurance. Some of these factors include place of residence, age of driver, car being insured and your overall driving record. Any of these can cause the underwriters to choose to deny your application. Underwriters are a largely unnamed force behind insurance companies, but are very influential in the overall policies that are offered by insurance companies.

4.5 Claims – Own Damage claims

Motor insurance claims nowadays include availing cashless facility for repairing an insured vehicle at any of the cashless garage network of an insurer. If the vehicle is serviced at a garage outside the purview of the insurer’s network, the owner can claim expenses as reimbursement.

The following procedure has to be adopted for claiming the motor insurance

- Claim Should be intimated to the Insurance company immediately with the policy particulars.
• No repair before survey of the vehicle
• Survey will be arranged on receipt of claim intimation and submission of detailed estimate of repairs from the repairer
• Original Registration Certificate and Driving licence to be submitted to the company for verification and return
• Duly filled in & Signed claim form to be submitted to the Repairer/Surveyor. For company owned vehicles, company seal and authorised person signature should be affixed in the claim form.
• FIR to be filed wherever Third party injury/death/property damage is involved.
• Company may ask for additional documents and/or clarification/Information if any, depending on the requirement of the claim.
• Cashless facility will be arranged if required documents are in order.
• Based on the Surveyors instruction, Vehicle to be produced for re-Inspection on completion of repair works.
• Original bill along with Satisfaction voucher for cashless claims is required for processing of the claim.
• For Non-cash-less Claims (Reimbursement claims) Original cash bill or Invoice with Cash receipt is required for processing of the claim.
• The detailed theft claim process letter will be sent to the Insured’s policy/claim form address through Registered Post offer intimation of theft claim.

**Own Damage claim**

In the event of an own damage claim, that is, where your own vehicle is damaged due to an accident, you must immediately inform insurance company and police, wherever required, to enable them to depute a surveyor to assess the loss.

Do not attempt to move the vehicle from the accident spot without the permission of police and the insurance company.

Once you receive permission for removal of the vehicle and for repairs, you can do so.

If your policy provides for cashless service, which means you do not have to pay out of your pocket for covered damages, the insurance company will pay the workshop directly.
In either of these situations, you must intimate the insurance company immediately.

4.6 Claims – II – Third party liability claims

In India, under the provisions of the Motor Vehicles Act, 1988, it is mandatory that every vehicle should have a valid Insurance to drive on the road. Any vehicle used for social, domestic and pleasure purpose and for the insurer’s business motor purpose should be insured.

A third party insurance policy is a policy under which the insurance company agrees to indemnify the insured person, if he is sued or held legally liable for injuries or damage done to a third party. The insured is one party, the insurance company is the second party, and the person you (the insured) injure who claims damages against you is the third party.

Section 145(g) “third party” includes the Government. National Insurance Co. Ltd. v. Fakir Chand, “third party” should include everyone (other than the contracting parties to the insurance policy), be it a person travelling in another vehicle, one walking on the road or a passenger in the vehicle itself which is the subject matter of insurance policy.

**Salient Features of Third Party Insurance**

1. Third party insurance is compulsory for all motor vehicles. Third party risks insurance is mandatory under the statute. This provision cannot be overridden by any clause in the insurance policy.

2. Third party insurance does not cover injuries to the insured himself but to the rest of the world who is injured by the insured.

3. Beneficiary of third party insurance is the injured third party, the insured or the policy holder is only nominally the beneficiary of the policy. In practice the money is always paid direct by the insurance company to the third party (or his solicitor) and does not even pass through the hands of the insured person.

4. In third party policies the premiums do not vary with the value of what is being insured because what is insured is the ‘legal liability’ and it is not possible to know in advance what that liability will be.

5. Third party insurance is almost entirely fault-based. (means you have to prove the fault of the insured first and also that injury occurred from the fault of the insured to claim damages from him)

6. Third party insurance involves lawyers aid.
7. The third party insurance is unpopular with insurance companies as compared to first party insurance, because they never know the maximum amounts they will have to pay under third party policies.

Motor Vehicles Acts, 1939 and 1988

Motor Vehicles Act, 1939 (4 of 1939) consolidates and amends the law relating to motor vehicles. This has been amended several times to keep it up to date. The need was, however felt that this Act should, now interalia take into account also changes in the road transport technology, pattern of passenger and freight movements, development of the road network in the country and particularly the improved techniques in the motor vehicles management.

Insurer’s liability to Vehicle-owner

A contract of insurance is a personal contract between the insurer and the insured. It is for the purpose of indemnifying the insured for damage caused due to accident by the vehicle, to a third party. To make the insurer liable the policy of insurance must be in the name of the owner of the vehicle. Owner of the vehicle as defined in Section 2(30) is a person in whose name the motor vehicle stands registered. A person in possession of a vehicle under a hire-purchase agreement or an agreement of lease or hypothecation is also covered by the definition, no matter he has exercised his option to purchase the vehicle or not.

Section 157(1) makes it clear that when the owner of a vehicle transfers the ownership of the vehicle, the policy of insurance and the certificate of insurance shall be deemed to have been transferred in favour of the purchaser of the vehicle with effect from the date of its transfer. This deemed transfer shall include transfer of rights and liabilities of the said certificate of insurance and policy of insurance.

Section 152. Settlement between insurers and insured persons.

(1) No settlement made by an insurer in respect of any claim which might be made by a third party in respect of any liability of the nature referred to in clause (b) of sub-section (1) of section 147 shall be valid unless such third party is a party to the settlement.

(2) Where a person who is insured under a policy issued for the purposes of this chapter has become insolvent, or where, if such insured person is a company, a winding up order has been made or a resolution for a voluntary winding up has been passed with respect to the company, no agreement made between the insurer and the insured person after the liability has been incurred to a third party and after the commencement of the insolvency or winding up, as
the case may be, nor any waiver, assignment or other disposition made by or payment made to the insured person after the commencement aforesaid shall be effective to defeat the rights transferred to the third party under this chapter, but those rights shall be the same as if no such agreement, waiver, assignment or disposition or payment has been made.

**Short Answer Type Questions**

1. Define Motor Insurance.
3. What is third party liability?
4. What is claims?

**Long Answer Type Questions**

1. Explain the types of Motor Insurance policies.
2. Explain the salient features of third party insurance.
3. Explain motor insurance policies.
5.1 Personal Accident Insurance

A Personal Accident Insurance plan are policies which covers a person from accidental death, accidental disability and several other features. There can be very bad consequences of meeting an accident like death or pause in income, ranging from few weeks, months to even years.
Below is the personal accident insurance coverage

**Accidental Death** : It indicates death of the policyholder in an accident. The Sum Assured under this plan is payable if death occurs from an accident.

**Accidental Disability** : It indicates that the policyholder is disabled from work, either partially or wholly.

**Accidental Dismemberment** : It indicates that a part of the policyholder’s body has been severed or dismembered. It means, if the policyholder loses his hand or leg or eyes, then he would be eligible to get a claim under Accidental Dismemberment.

Below policies are the best personal accident insurance in India and their coverage too

**Individual Personal Accident Insurance Policy**

This policy covers an individual in the event of any accident.

**Group Personal Accident Insurance Policy**

This policy covers a group of people in the event of any accident. Group personal insurance accident policy is the policy which covers whole group. A policy can be bought to insure a group of individuals. This policy has same features as of individual personal accident insurance. Generally, group insurance accident policy can be taken to insure whole family by an individual or employers can buy this policy to provide insurance to their employers.

### 5.2 Types of Disablement

| 1. Death | In case of a death due to accident, the policy would pay 100% Sum Assured to the nominee. Some companies also pay a “Childrens Education Bonus” of 5000 or 10000 for maximum of 2 children. |
| 2. Permanent Total Disablement | In case of a permanent total disability, in which a person is disabled for life, the SUM assured is paid to the person. Some companies also pay around 125% or 110%, depending on the company. Example – Loss of 1. both hands or both feet 2. one hand and one feet 3. one (hand or foot) and an eye 4. loss of sight of both eyes OR speech OR Hearing of both ears |
5.3 Policy Conditions

The policy conditions differ from one insurance company to another. There are various insurance companies where the insurer can insure his personal accident insurance.

The following are the key policy conditions, the insurer has to check in order to gain maximum advantage of the insurance.

a. Benefits

If at any time during the currency of this Policy, the Insured Person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Company shall pay to the Insured or Insured Person’s legal personal representative(s) as the case may be, the sum or sums hereinafter set forth, that is to say:

1. Death

If such injury shall within Twelve calendar months of its occurrence be the sole and direct cause of the death of the Insured Person, the Capital Sum Insured (CSI) stated in the Schedule hereto.

2. Permanent Total Disablement (PTD)

(a) If such injury shall within Twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

| 3. Permanent Partial Disablement | In this case, a small percentage of SUM assured is paid on weekly or monthly basis. For example – 1% of sum insured is paid every week up to 100 weeks. Example below:
|                               | 1. Loss of Index Finger or thumb
|                               | 2. Loss of hearing in 1 ear
|                               | 3. Loss of 1 eye sight
|                               | 4. Loss of 1 hand. |

| 4. Temporary Total Disablement | This means that for some weeks or months a person is totally disabled and will not be able to work and earn money. In this case most of the companies pay a part of sum assured, some pay 100% and some pay 50%, there is also a cap in this case, like maximum 5 lacs or 10 lacs. Example below:
|                               | 1. A bed rest of next 3 months
|                               | 2. Fracture in hands or legs |
• Sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand and one entire foot, or such loss of sight of one eye and such loss of one entire hand or one entire foot, the Capital Sum Insured stated in the Schedule hereto

• Use of two hands or two feet or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot, the Capital Sum Insured stated in the Schedule hereto.

(b) If such injury shall within Twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of

The sight of one eye, or of the actual loss by physical separation of one entire hand or of one entire foot, fifty percent (50%) of the Capital Sum Insured stated in the Schedule hereto

• Use of a hand or a foot without physical separation, fifty percent (50%) of the Sum Insured stated in the Schedule hereto. Note: ‘physical separation’ of a hand means separation at or above the wrist and of the foot means separation at or above the ankle.

(c) If such injury shall, as a direct consequence thereof, immediately, permanently, totally and absolutely, disable the Insured Person from engaging in any employment or occupation of any description, whatsoever, then a lump sum equal to hundred percent (100%) of the Capital Sum Insured.

3. Permanent Partial Disablement (PPD)

If such injury shall within Twelve calendar months of its occurrence be the sole and direct cause of the total and / or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the percentage of the Capital Sum Insured as indicated below shall be payable

4. Temporary Total Disablement (TTD)

If such injury shall be the sole and direct cause of the temporary total disablement (TTD) then, so long as the Insured Person shall be totally disabled from engaging in any employment or occupation of any description whatsoever, a sum prorated for the period of disablement at the rate of one percentage (1%) of the Capital Sum Insured stated in the Schedule hereto per week but in any case not exceeding Rs.3000 per week in all, under all Policies. Provided that the compensation payable under BENEFIT shall not be payable for more than 100 weeks in respect of any injury calculated from the date of commencement of disablement and in no case shall exceed the Capital Sum Insured. In case of Multiple policies providing TTD Benefit, the policy with the highest TTD benefit shall only be considered for the claim payment.
5.4 Raising

Rating In personal accident insurance, the rating factor used is the occupation. Generally speaking exposure to personal accidents at home, on the street etc. is the same for all persons, But the risks associated with occupation vary according to the nature of work performed. For example, an office manager is less exposed to risk at work than a civil engineer working at a site where a building is constructed.

It is not practicable to fix a rate for each profession or occupation. Hence, occupations are classified into groups, each group reflecting, more or less, similar risk exposure.

Risk Group I: (Lowest Premium rate)

Accountants, Doctors, Lawyers, Architects, Consulting Engineers, Teachers, Bankers, Persons engaged in administration functions. Persons primarily engaged in occupations of similar hazards.

Risk Group II: (Higher Premium rate)

Builders, Contractors and Engineers engaged in superintending functions only, Veterinary Doctors, paid drivers of motor cars and light motor vehicles and persons engaged in occupation of similar hazards and not engaged in manual labour.

All persons engaged in manual labour (Except those falling under Group III), Cash Carrying Employees, Garage and Motor Mechanics, Machine Operators, Drivers of trucks or lorries and other heavy vehicles. Professional Athletes, and Sportsmen, Woodworking Machinists and Persons engaged in occupations of similar hazards.

Risk Group III: (Highest Premium Rate)

Persons working in underground mines, explosives, magazines, workers involved in electrical installation with high tension supply. Jockeys, Circus Personnel, Persons engaged in activities like racing on wheels or horseback, big game hunting, mountaineering, winter sports, skiing, ice hockey, ballooning, hang gliding, river rafting, polo and persons engaged in occupations/activities of similar hazard.

5.5 Personal Accident Policy – Claims – New Schemes

Personal accident policy pays compensation to the insured in the event of happening of one or more of the following listed below which may be selected by insured at the time of taking policy.
• On death
• On permanent total and partial disability and
• On temporary total disability

In case of accident death during the policy period, the policy in addition cover funeral expenses of the insured person.

Personal accident policy does not cover the injuries resulting out of war, self-inflicted injury, disease or insanity, death due to war operation, attempted suicides, accident in armed forces, aircraft accidents, accidents due to nuclear weapons etc.

Janata personal accident policy is meant for weaker section of the society. Thus premium charged under this policy is comparatively less. Gramin personal accident policy is designed for the rural people in the country.

**Short Answer Type Questions**

1. Define personal accident insurance.
2. What is Disablement?
3. Group personal accident policy.

**Long Answer Type Questions**

1. Explain the types of disablement.
2. Policy conditions in personal accident insurance.
3. Explain about Risk Groups.
6.1 Health Insurance

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system 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.

Health insurance (popularly known as Medical Insurance or Mediclaim) protects you and your dependents against any financial constraints arising on account of a medical emergency. It sometimes includes disability and long term medical needs. In Mediclaim, you pay a premium and in return the insurer commits to pay a predetermined sum of money to meet the claims. Health insurance is new in Indian context and is slowly catching up with the consumers. Consumers understand the objective of health insurance and it’s offering to cover the ever rising medical expenses.

Health insurance is available to both individual and groups. However, premium for individual policy is costlier than that of the group policy. An individual is the owner of his personal policy. Whereas in group plans, the sponsor is the owner of the policy and the registered members are covered by the policy. You can take advantage of group health insurance to overcome the shortage of your individual insurance. People with no policy or are uninsurable due to one or the other reason can take good advantage of the group plans and be covered.

6.2 Medi Claim policies

The mediclaim insurance policies are those policies which covers hospitalisation expenses for the treatment of illness / injury as per the terms and conditions of the policy. These policies may also cover pre-hospitalisation expenses for few days prior to hospitalisation and post hospitalisation expenses for the specified days as per policy terms. Some other expenses that are also covered by some of the insurers are :-

(a) Day-care treatment : The Medical expense towards specific technologically advanced day-care treatments / surgeries where even 24 hour hospitalisation is not required.

(b) Ambulance Charges for shifting the insured from residence to hospital.

(c) Ayurvedic / Homeopathic and Unani system of medicine charges

(d) Pre-existing diseases after a specified period of the policy or on payment of additional premium

The following are the silent features of the medi claim policies which are featured in most of companies which provides the medi claims.
1. Salient Feature

Hospitalisation for illness, disease or accident, whether including surgery or not, imposes heavy financial burden on individuals, families, employers and welfare bodies.

2. Scope of Cover

Mediclaim insurance policy has been devised under the aegis of the Government of India. The policy provides the following benefits.

1. Reimbursement of hospitalisation expenses which are reasonably and necessarily incurred, under the following heads
   a) Room, boarding expenses as provided by the hospital/nursing home
   b) Nursing expenses.
   c) Fees of surgeon, anaesthetist, medical practitioner, consultant and specialist.
   d) Expenses on account of anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, diagnostic material, X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and cost of organs and similar expenses.

3. Introduction of Sub-Limits

The following provisions have been introduced:

a. Room, Board and Nursing Expenses as provided by the Hospital / Nursing Home- Room Rent limit 1 % of the Sum Insured per day subject to maximum of Rs.5000/-. I.C. Unit expenses : 2 % of Sum Insured per day subject to maximum of Rs. 10,000/-. Over all limits under this head : 25% of S.I. per illness.

b. Surgeon, Anesthetist, Medical Practitioner, Consultants Special fees – maximum limits per illness – 25% of S.I.

c. Anesthesia, Blood, Oxygen, OT charges, Surgical appliance, Medicines, drugs, Diagnostic Material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of pacemaker, artificial limbs and cost of stent and implant. Maximum limit per illness – 50% of Sum Insured.
d. Ambulance services - 1% of the sum insured subject to maximum of Rs 1000/- provided registered ambulance is used for shifting patient from residence to hospital if admitted to ICU or emergency ward OR from one hospital to another subject to sub-limits under ‘c’ above.

e. Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub-limits under ‘c’ above.

4. Premium paid for the policy towards self, spouse, dependent children and dependent parents are exempt from Income Tax under Sec. 80D of the I.T. Act.

Exclusions

The most important exclusion relates to pre-existing illness. If the insuring person had a health condition, existing prior to taking the policy, which required medical treatment, the same gets automatically excluded in the policy. To ensure that in subsequent renewals medical conditions incepting since the policy was taken do not get excluded, the insuring person must renew the policy without break. The other exclusions for illustrative purposes are :-

a. Exclusion of certain named diseases in the first year of the policy.

b. Congenital external disease, sterility, venereal disease, intentional self-injury, use of drugs, alcohol, rest cure etc.

c. Aids

d. Charges primarily for diagnostic, laboratory examinations, and not related to any treatment in hospital. So also for vitamins and tonics unless prescribed for treatment.

e. Dental treatment not requiring hospitalisation.

f. Treatment arising from or traceable to pregnancy, childbirth, including caesarean.

g. Naturopathy treatment.

Exclusion 4.a, 4.b & 4.c have been amended. Pre-existing diseases shall be covered after 4 continuous claims free Policy years with ‘National’. However, in case of exclusion 4.3, for renewals, existing condition shall apply, i.e. the one year exclusion applicable earlier shall be valid.
6.3 Proposal Form

Name of the Insurance Company

Claim No. Issuing Office

MEDICLAIM POLICY - CLAIM FORM

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers.

Please give the following information correctly and completely to enable the company to process your claim promptly.

<table>
<thead>
<tr>
<th>1. Name of the Insured</th>
<th></th>
<th>For office use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>(In whose name policy is issued)</td>
<td>(Surname)</td>
<td>(Initial)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Details of the Insured Person</th>
<th>In respect of whom claim is made</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Name &amp; relationship with the insured</td>
<td></td>
</tr>
<tr>
<td>b. Present completed age</td>
<td>DOB</td>
</tr>
<tr>
<td>c. Occupation</td>
<td></td>
</tr>
<tr>
<td>d. Residential Address</td>
<td></td>
</tr>
<tr>
<td>Telephone No.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Policy No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. Nature of Disease/illness contracted or injury suffered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. Date of injury sustained or disease/illness first detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Name and address of the attending Medical Practitioner</td>
</tr>
<tr>
<td>b. Qualification</td>
</tr>
<tr>
<td>Telephone No.</td>
</tr>
<tr>
<td>c. Registration No.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6a. Name &amp; Address of the Hospital / Nursing Home / Day care Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Date of admission</td>
</tr>
<tr>
<td>B. Date of Discharge</td>
</tr>
</tbody>
</table>

I have incurred on the treatment of Disease / illness / injury referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim I enclose the following documents (please indicate by / )

1. Discharge certificate/card from the Hospital.
2. Bill, Receipt and Cash Memos from the Hospital/Chemist(s), supported by the proper prescription and duly attested by me.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner/Surgeon demanding such Pathological test(s).
4. Surgeon’s certificate stating nature of operation performed and Surgeon’s bill and receipt.
5. Attending Doctor’s Consultant’s / Specialist’s/ Anaesthetist’s bill and receipt and certificate regarding diagnosis.
6. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement / suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme or Insurance.

Dated at this day of 200

NAME OF THE CLAIMANT _______________________________ SIGNATURE OF THE CLAIMANT
### Schedule of Expenses Incurred by the Claimant

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount Claimed (1)</th>
<th>Amount not payable (2)</th>
<th>Net Payable (1) - (2) = (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Hospitalisation Benefits:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Room, Board Nursing expenses provided by Hospital for ______ days @ Rs ______ per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. IC Unit for ______ days @ Rs ______ per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Emergency Ambulance charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Amount under I, II &amp; III</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Hospitalisation Benefits (Other than Room, Board &amp; Nursing Expenses &amp; ICU (including pre &amp; post Hospitalization)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Surgeon’s, Anaesthetist’s, Medical Practitioner’s, Consultant’s, Specialist’s fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines &amp; Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Maternity Expenses Benefit Extension</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Room, Board Nursing expenses for ______ days @ Rs ______ per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Gynaecologist/ Obstetrician/ Surgeon/ Physician / Anaesthetist Fees ______ and Normal delivery, Miscarriage and Abortion, Caesarean Section / Abdominal Opening for extra uterine pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III. Diagnostic materials, X-Ray, Medicines and drugs, injections etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of the claimant**

**Signature of the Claimant:**

**For Office Use**

- Prepared by: ____________________  Total amount claimed Rs ________________  in case entire claim is not admissible reasons thereof
- Checked by: ____________________  Net amount Payable Rs ________________
- Approved by: ____________________  Passed for payment of Rs ________________

**Competent Authority**
6.4 Schedule 10 of the policy TPAs – their role

A Third Party Administrator (TPA) is an organization which processes claims or provides cashless facilities as a separate entity. Seen as an outsourcing of claim processing, TPA processes claims for both retail and corporate policies. The risk of loss incurred remains with the insurance company. The insurance company usually contracts a reinsurance company to share its risk. An insurance company hires TPA to manage its claims processing, provider network and utilization review. While some TPA operates as units of insurance companies, most are often independent.

The Insurance Regulatory and Development Authority of India (IRDA) defines TPA as a Third Party Administrator who, for the time being, is licensed by the Authority, and is engaged, for a fee or remuneration, in the agreement with an insurance company, for the provision of health services. TPA was introduced by the IRDA in 2001.

Being one of the prominent players in the managed care industry, it has the expertise and capability to administer all or a portion of the claims process. The services include claims processing, premium collection, enrollment and cashless processing. Insurance companies setting up its own health plan often outsource certain responsibilities to a TPA.

The TPA acts like a claims adjuster for the insurance company. In some cases the insurance company sets up an entire department within their own company to act as TPA as opposed to hiring a commercial TPA company.

Role of TPA

Cashless Service

Cashless Service is one of the important functions of the TPA in India today which means that if you are hospitalized in a hospital among the ones listed by the insurance company, the bill is paid directly by the Insurance Company and you don’t have to shell out anything. But, policyholders find it difficult to avail the cashless Service in a network hospital because there is very less awareness regarding TPAs. Policyholders mostly rely on their health insurance agents who don’t inform them about it.

Claim Settlement

TPAs health insurance are the ones concerned with dealing with Claims-complete from taking intimations of claims, advising customers on network hospitals, approving cashless and reimbursement claims, to finally disbursing the claims to the customer.
Maintaining Database

Once the policy has been issued, all the records are passed on to the TPAs and all further communication of the Policyholders is with the TPA health insurance and not with the insurance companies. It is the responsibility of the Third Party Administrator to maintain databases of policyholders and issue them identity cards with unique identification numbers. Policyholders have to make sure that they receive the identity cards from the TPA health insurance within 30 days and have it ready in case of any emergency.

It is essential that you know your TPA list name and contact number since it is the TPA that the Policyholders are supposed to contact in the case of hospitalization or claim settlement.

Toll Free number

TPAs have to run a 24-hour toll-free number, which can be accessed from anywhere in the country. They have full-time medical practitioners under their employment who will immediately take a decision on whether the ailment is covered under the policy.

Value Added Services

TPAs also perform some of the additional value-added services to the consumers, like arranging ambulance services, medicines and supplies, guiding policy holders for specialized consultation, and providing information about 24-hour help lines, health facilities, bed availability, organization of lifestyle management and well-being programs.

With the advent of TPA India is the health insurance companies aim at ensuring higher efficiency, standardization of charges, greater awareness and penetration of health insurance to a larger section of the people. There also a trend among the insurance Companies today to terminate the contracts of TPAs and having in-house TPA due to the rising claims and losses.

6.5 Settlement of the claims

In most cases, the Insurance companies appoint a Third Party Administrator (TPA) for claims processing. That means once the health insurance policy is sold, the insurer passes on the complete details to the TPA. In case of a claim, the insured has to get in touch with the TPA for all verification and formalities.

Two Ways By Which Health Insurance Claims Are Settled: Cashless

For planned hospitalization at authorized network hospitals, the TPA has to be notified in advance for availing cashless treatment or within the stipulated
time limits for emergencies. The insurance desk at hospitals will generally help with all the paperwork. The TPA has to approve the claim amount and the hospital settles the amount with the TPA/Insurer. There will be exclusions which will have to be settled directly at the hospital by the insured.

Reimbursement: Reimbursement facility can be availed at both the network and non-network hospitals. The hospital bills are directly settled at the hospital after the insured avails the treatment. The insured can then claim reimbursement for hospitalization by submitting relevant bills/documents for the claimed amount to the TPA.

The TPA mode of claims settling has its own problems. The TPA is incentivized to limit insurance claims and they are not the ones who sell the policy. There are many cases where the insured had a tough time to claim for his hospital expenses. So before taking a health insurance policy, check who the TPA is and how good they are when it comes to claims processing. Internet search and a friendly chat with the hospital staff can give you good insight on the insurer/TPA. There are also some health insurance providers who do not employ TPAs and manage claims settlement directly which is called In-House TPA.
6.6 Liaoning with Hospitals & Nursing Homes

A systematic plan for financing medical expenses is an important and integral part of risk management plan. Medical policy is offered to individual and group exceeding 50 member. It covers the hospitals for disease or sickness and for injuries.

Nursing homes the medical expenses will be reimbursed only if the insured is adjusted in the hospital for a minimum duration of 24 hours. Cost of treatment includes consultation fee of doctors, cost of medicine and hospitalization charges. It is very suitable for self employed persons because of cover risks against several general and serious disease.

Short Answer Type Questions

1. What is a health insurance?
2. Define proposal form.
3. What is mediclaim policy?
4. What is TPA?

Long Answer Type Questions

1. Explain the TPA’s role in settlement of the claims.
Structure

7.1 Overseas Medical Policy
7.2 Burglary Insurance
7.3 Money Insurance
7.4 Fidelity Guarantees

Learning Objectives
After studying this unit the student will be able to

- Know meaning of overseas medical policies
- Know about burglary insurance, money insurance

7.1 Overseas Medical Policy

Overseas medical insurance policies are unique insurance options for travellers going to foreign countries. Travellers can look for financial assistance in case of an emergency while travelling overseas. There are numerous overseas medical insurance policies in the market and travellers need to shop around to learn about the nuances of different policies. Insurance companies now offer overseas medical insurance online to make the purchase process simple and money saving for the travellers.
Overseas Mediclaim policy covers Medical Expenses whilst traveling abroad for business/holiday. The policy will be valid only if the insured journey commences within 14 days of the first day of insurance as indicated in the policy schedule.

Cancellation of the policy may be done ONLY in cases where a journey is not undertaken and ONLY on production of the insured person’s PASSPORT as a proof that the journey has not been undertaken. Any request for cancellation will be entertained not less than 14 days after the First Day of Insurance as indicated in the policy schedule. Such cancellation will be subject to deduction of cancellation charges by the underwriters as applicable.

Partial refund in premium is permitted on trip band basis provided cover is for a minimum period of 60 days and unexpired period is not less than 14 days subject to there being no claim under the policy.

**Exclusions**

1. No claim will be paid where the Insured Person
   a. Is traveling against the advice of a Physician; or
   b. Is receiving or on a waiting list for specified medical treatment declared in the Physician’s report or certificate; or
   c. Is traveling for the purpose of obtaining treatment; or
   d. Has received a terminal prognosis for a medical condition.

2. No claim will be paid arising from suicide attempted suicide or willfully self inflicted injury or illness, mental disorder, anxiety, stress or depression, venereal diseases, alcoholism, drunkenness or the abuse of the drugs, or any loss arising directly or indirectly from any injury, illness, death, loss expenses or other liability attributable to HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or any mutant derivative or variation thereof however caused.

3. No claim will be paid arising from the insured person taking part in Naval, Military or Airforce operations.

4. No claim will be paid arising from War, invasion, acts of foreign enemy, hostilities (Whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or destruction of or damage to property by or under the order of any government or local authority.
5. This insurance does not cover any claim arising from the loss or destruction or damage to any property whatsoever or any loss or expenses whatsoever resulting or arising therefrom or any consequential loss directly or indirectly caused by or contributed to by or arising from:

   a. Ionizing radiation or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel; or

   b. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

6. No claim will be paid arising from the participation of the Insured person engaging in Air Travel unless he or she flies as a passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion, Air Travel means being in or on, or boarding an aircraft for the purpose of flying therein or alighting therefrom following a flight.

7. No claim will be paid arising from the participation of the Insured person in winter sports, mountaineering (where ropes or guides are customarily used), riding or driving in races or rallies, caving or potholing, hunting or equestrian, skew diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles). Further no claim will be paid in case Insured Person participates in professional sports or any other hazardous sports. The claim is neither payable if arises from participation in potentially dangerous sports for which the Insured Person is either untrained or physically unfit or using improper equipment.

8. No claim will be paid for losses arising from accidents on two wheeled motorized vehicles unless at the time of the accident the driver is duly qualified, is in possession of a current full International driving license and the injured person is wearing a safety crash helmet, or losses arising from accidents on two wheeled motorized vehicles over 50cc.

9. No claims will be paid for losses arising directly or indirectly from manual work or hazardous occupation, self exposure to needless peril (except in an attempt to save human life) or if engaging in any criminal or illegal act.

7.2 Burglary Insurance

The criminal law of the country does not speak of an offence called burglary. Hence it becomes necessary for the insurers to lay down in the policy the definition of the term. As normally understood burglary is:

   (a) Theft of property from the premises following upon felonious entry of the said premises by violent and forcible means.
(b) Theft by a person in the premises who subsequently breaks out by violent and forcible means provided there shall be visible marks made upon the premises at the place of such entry or exit by tools, explosives, electricity or chemicals. Use of force may be against property and person.

Theft

Indian Penal Code in Section 378 defines theft as follows: “whoever intending to take is honestly any movable property out of the possession of any person without the consent of that person or of any person having for that purpose authority, moves that property in order to such taking is said to commit theft.”

House-breaking

The word in practice is equal to ‘Burglary’. Section 445 of the Indian Penal Code has laid down a definition of the term.

A person is said to commit housebreaking who commits house trespass if he effects his entrance into the house (or any part of it), or if being in the house (or any part of it) for the purpose of committing an offence, or having committed an offence therein he quits the house, such entrance or exit being made by use of force in one of the six ways as described in the Indian Penal Code.

Robbery

Section 390 of the Indian Penal Code laid down, “If in order to the commission of or in committing of the theft or in carrying away property obtained by theft, the offender, for that end, voluntarily causes (or attempts to cause) to any person death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint or fear of instant death or hurt or wrongful restraint”.

Dacoits

Section 391 of the Indian Penal Code states dacoits as “where five or more persons conjointly commit or attempt to commit a robbery or are present and aid such commission or attempt, every one of them is said to commit dacoits”

Coverage

Business premises are generally covered against burglary and house breaking only. Mere theft without the use of force and violence is not covered, robbery and dacoits being aggravated forms of theft.

It also covers risk of holdup. Burglary and house breaking fall within the scope of this cover. Under policies issued for private dwellings, the contents are covered against burglary, house-breaking and theft risks. Similarly Jewellery and valuables are also insured in the same manner.
Money in Transit

Policies, as a matter of rule, cover robbery, hold-up and dacoits in addition to burglary, house-breaking and theft.

Business Premises Insurance Policies

Policies issued to business premises cover stock-in-trade, goods in trust or on commission, fixtures and fittings, tools of trade such as typewriters, calculators and other similar property and cash and currency notes in locked safe against the risk of burglary and house-breaking.

Loss or damage to contents or to any part of the building caused by burglary or any attempt therefore is also covered. In regard to stock-in-trade and other goods the policy may be issued on full value basis or on “first loss” basis.

A “First Loss” Policy insures the property up to a specified amount only which is calculated to be the maximum likely loss on any one occasion. This type of policy is taken where a total loss is a physical impossibility.

First loss policies are usually taken for bulk commodities. The amount insured is always specified as a certain percentage of the full value, say, 10% or 12.5% of the full value.

Exclusions

The exceptions peculiar to a burglary (business premises) policy are

(i) Loss or damage where any member of the insured’s household or his business staff is concerned as principal or accessory or resulting from any act committed by any other person lawfully on the premises wherein the property may happen to be;

(ii) Loss or damage which can be insured against by a fire or a plate glass or a motor insurance policy;

(iii) loss of or damage to deeds, bonds, bills of exchange, promissory notes, cash, treasury, bank notes, cheques, securities for money, stamps, stamp collections, books of accounts, manuscripts, documents of any kind and medals and coins, unless specially mentioned and agreed to be covered.

7.3 Money Insurance

Money Insurance protects companies against loss of cash, cheques, credit card slips, bank notes, traveller’s cheques, money orders, unused postage stamps and revenue stamps as a result of burglary or robbery whilst in direct
transit between the premises and bank or post office when carried by the insured or authorised employees.

Money Insurance also covers money in the insured’s premises during and outside normal business hours. However, money in premises outside normal business hours must be secured in a locked safe. The policy also extends to money in a bank night safe, and even a small amount of cash at the homes of directors.

Who needs Money Insurance?

Whilst the majority of business transactions today are conducted electronically, there are a number of businesses that still handle money. If your company directly deals with cash, bank drafts, currency notes, treasury notes, postal orders, money orders and postage stamps, you need Money Insurance.

7.4 Fidelity Guarantees

A Fidelity Guarantee as issued by the insurers is a contract of insurance and also a contract of guarantee to which the general principles of insurance apply. It does not guarantee the employees honesty but it guarantees that if the employer suffers any direct financial loss arising out of the employees dishonesty the insurers share indemnify the said loss to the employer within the limitations prescribed by the contract.

Insurable Interest

The term “Fidelity Guarantee Insurance” embraces Policies indemnifying employers against pecuniary losses on account of forgery, defalcation (misappropriation of money), embezzlement (diversion of money to one’s use) and fraudulent conversion by employees. The object is to provide protection against losses arising out of the default of an individual acting in some capacity such as Cashier, Accountant and Store-keeper, etc.

Scope of Cover

The Policy covers the loss sustained by the employer by reason of any act of forgery and/or fraud and/or dishonesty of monies and/or goods of the employer on the part of the employee Insured committed on or after the date of commencement of the Policy during uninterrupted service with the employer. The loss should be detected during the continuance of the Policy or within 12 calendar months of the expiry of the Policy and in the case of death, dismissal or retirement of the employee within 12 calendar months of such death or dismissal or retirement whichever is earlier.
The cover may be required in respect of a single employee or a group of employees. There are three types of Policies normally issued by the Insurer for this clause of business namely “Individual Policy”, “Collective Policy” and “Floating Policy”.

Main factors considered for issuance of Fidelity Guarantee policy

- The extent of control over the work of the person to be guaranteed necessarily to form the relationship of master and servant.
- The record, standing and reputation of the employee.
- The “bonafides” of the employer.
- The system of checking of the accounts and general supervision of the employee.

It is essential to obtain the Private Reference and/or Former employer’s Report forms in addition to completed Employer and Employees application form as appropriate.

It should be noted that

1. The cover granted is against a direct pecuniary loss and not a consequential one.
2. The loss should be in respect of moneys or goods of the insured;
3. The act should be committed in the course of the duties specified;
4. If the employee guaranteed under the policy had left the services of the employer and was re-engaged by him, no liability attaches to the policy, unless the consent of the insurers was obtained.
5. No loss that may have been caused by bad accountancy is payable: the loss must be supported by evidence of any of the specified acts of dishonesty.

Types of Fidelity Guarantees

**Individual Policy** : This Policy covers an individual for a stated amount.

**Collective Policy** : This Policy covers a group of employees. The Insured decides the amount of guarantee required for each individual according to his or her responsibility and position. A schedule is included in the Policy.

**Floater Policy** : A single amount is shown in the Policy which represents the Insurer’s liability in respect of any one individual and its total liabilities in respect of all the employees guaranteed who are individually named in the
schedule. Such type of Policies is granted where the number of persons to be guaranteed is not less than 5.

**Blanket Policy**: The Insurer in certain selected cases, issues Blanket Policies without the names of the guaranteed persons being shown, in respect of all employees who are grouped according to categories, e.g. employees handling cash, other clerical staff etc. They are issued to large well established business houses conducting business with sound practices.

In case the Policy is required to be issued without mentioning the name of the employee/s i.e. on unnamed basis, then in such circumstances all the employees dealing with the cash/goods, whether permanently or temporarily or by rotation must be covered.

Further the limit can be fixed for each employee separately or for the group of the employees as the case may be and the liability of the Insurer in case of the loss will be restricted to the same limit irrespective of the sum insured. However, the wider limit in the line of the sum insured can be considered by the Insurer depending upon the requirement of the Insured after taking into account other relevant factors.

**Fidelity Guarantee Insurance Claim Procedure**

- Insured should take immediate steps against the defaulting employee for the recovery of cash/goods as the case may be and also other disciplinary action required, depending on the case.

- Insured must establish the “act of infidelity” committed by the particular employee covered under the Policy.

- In many cases, the loss noticed at the time of stock taking in case of stock is not covered.

- The Insurer shall not be liable, if at the time of any loss, any other Security Guarantee or insurance existing covering the same loss.

- The policyholder must submit a “proof of loss” to the insurance company detailing the amount of its claim.

**Short Answer Type Questions**

1. Burglary insurance.
2. Money insurance
3. Fidelity Guarantees.
4. What is insurable interest?
Long Answer Type Questions

1. Explain about Overseas Medical policies.
2. Explain about claim procedure of fidelity guarantee.
3. Type of Fidelity guarantee.
UNIT 8

Bankers Blanket & Jewellers Block Policies

Structure

8.1 Bankers Blanket & Jewellers Block Policies
8.2 Pedal Cycle Insurance
8.3 Plat glass Insurance
8.4 Missing Documents Indemnity
8.5 Blood stock Insurance
8.6 Pet Dog Insurance
8.7 Sport Insurance
8.8 Shop Keepers Insurance Policy
8.9 House holders Insurance policy

Learning Objectives

After studying this unit the student will be able to

• Understand about bankers blanket
• Understand about Jewellers Block policies
• Learn about pedal cycle insurance, plat glass insurance, blood stock insurance, Pet dog insurance, sport insurance, shop keepers insurance, and house hold insurance policies.
8.1 Bankers Blanket & Jewellers Block Policies

The Bankers Blanket Bond Policy (BBB) covers direct losses (actual damage) sustained by financial institutions as a result of wrongful acts of their employees or third parties. The policy provides protection against a wide range of risks inherent in business operations performed by financial and lending institutions, though such risks can be insured separately, without being pooled.

The main purpose of the BBB policy is to provide blanket protection to a financial institution against losses resulting from its employees’ dishonest or fraudulent acts (performed individually or in collusion with other persons) and from third parties’ acts committed with the intent to obtain a financial gain or cause damage.

Objects of Insurance

The object of insurance are property interests that do not contravene the laws of the Russian Federation and are exposed to risks involving loss of profit (incidental expenses), which a financial institution may encounter due to dishonesty of its employees, forgery and other fraudulent alterations in documents further used in unlawful actions, or may be exposed to the risk of loss or damage of/to the property of the institution or third parties during their banking operations.

Risks

1. Losses caused through dishonesty of the employees of the insured financial institution
2. Loss or damage of/to property in the premises of the insured financial institution
3. Loss in transit, including theft or physical destruction of property during transportation
4. Losses caused by forged cheques
5. Losses caused by forgery of securities and similar instruments
6. Damage sustained by the insured financial institution in its ordinary course of business related to transactions (operations) with securities and similar instruments
7. Losses arising out of counterfeit currency
8. Damage caused to property in the premises of the insured financial institution as a result of unlawful acts performed by third parties
8.2 Pedal Cycle Insurance

The Insurance covers loss or damage to pedal cycle by any accidental external means or by fire burglary, theft only and also liability to the third parties which the insured may incur in respect of

(i) Death of or bodily injury to any person

(ii) Damage to property.

Covers loss or damage to pedal cycles by

1. Fire & allied perils
2. Burglary, housebreaking, theft
3. Accidental external means
4. Third party personal injury or Third party property damage for Rs.10,000/-

8.3 Plat glass Insurance

Basic Cover

The Plate Glass policy provides coverage for accidental breakage of glass with fracture extending through the entire thickness of the glass.

Eligible Proposer

Any person or business organisation that requires coverage for Plate Glass mounted or fixed onto buildings such as showrooms, offices, doors, etc.

Premium & Extensions

Premium is calculated based on the location of the building and the thickness of the plate glass. At an additional premium, this policy can be extended to cover: Strike, riot and civil commotionShoring or propping up expenses

8.4 Missing Documents Indemnity

Legal indemnity insurance is obtained in order to offer protection to a buyer (and a lender) where there is a defect in the title which cannot be resolved. In theory indemnity insurance should only be used as a last resort, however in practice it often provides a quick and low cost alternative to the work required to correct a defect (varying a lease for example will usually cost several hundred pounds in legal fees and will take several weeks).
Unlike a conventional insurance policy the premium for a legal indemnity insurance policy is paid only once, and in most cases is automatically transferred to successors in title and lasts for the life of the property, save that the limit of the cover will be the purchase price of the property and since the indemnity policy will not be index linked, a premium will usually need to be paid by the insured when they come to sell to increase the limit of cover (assuming that the property is sold for a profit).

It should be remembered, and be pointed out to clients, that legal indemnity insurance does not remedy the insured defect, but merely offers financial compensation. You should also check each policy individually to see what actions might invalidate the cover. For all indemnity policies however, it is a condition that their existence must not be revealed to third parties.

8.5 Bloodstock Insurance

A bloodstock insurance contract may cover a number of different risks. The principal risks is likely to be all risks mortality covering the value of the animal if it dies as a result of accident, disease or illness. Theft can also be covered as well as loss of use (covering financial loss) and public liability. For location of risk purposes, and despite animals being “property”, many authorities treat bloodstock contracts in a similar way to miscellaneous financial loss contracts. This pragmatic approach is probably taken because the animals frequently move between countries and to use any other method, i.e. the location of the horse, would create difficulties.

8.6 Pet Dog Insurance

Pet Dog insurance takes care of the veterinary costs if the dog becomes ill or is injured in an accident. However, the insurance policy does not pay for routine or preventative treatment. Some policies also cover death, theft or if the pet is lost. A dog insurance policy can help you cover losses to a third party in case your pet accidentally bites them or destroys their property.

How does it help?

The purpose of dog insurance is to mitigate the risk of incurring significant expense to treat ill or injured dog. As veterinary medicine is increasingly employing expensive medical techniques and drugs, and owners have higher expectations for their dogs’ health care and standard of living than previously, the market for pet insurance has increased.

Types of coverage available

One can select different types of pet insurance policies, based on individual needs, dogs and budgets. The following are the various types of pet insurance policies.
Lifetime cover: This policy covers expenses related to a pet contracting any long-term or chronic illness. The illnesses covered in this policy include arthritis, eczema or any other sickness that requires your pet to be treated by a vet for a long period of time. Under this type of policy, a policyholder is entitled to a specific sum of money every year. This maximum limit can be reset when the policy is renewed. This cover is especially available for pet insurance bought for dogs and cats.

Time-limited cover: Through this cover, pet owners receive financial protection for a specific period after a pet suffers an injury or contracts any disease that requires him/her to be treated by a vet. This cover is usually cheaper than the lifetime cover and is extremely popular among people who own crossbreed cats and are worried about incurring high treatment costs.

Money-limit cover: Through this cover, pet owners can receive monetary benefit for every condition that falls under the purview of pet insurance coverage. There is no time limit and a policyholder can claim for as long the money limit is not reached. This cover is generally costlier than the lifetime cover, but cheaper than the time-limited cover.

8.7 Sport Insurance

Everyday, amateur athletes of all ages participate in practices, clinics, games, and tournaments. As fans, we hope it will never happen, but accidents and injuries do occur on the field. As a result, lawsuits are sometimes filed against the league and its participants.

Why do I need sports liability insurance?

If an accident or injury occurs during the operations of your sports organization, and the injured person files a claim against your organization, you’ll need to cover the resulting costs. Few sports organizations can cover these costs without help. Sports liability insurance protects your league or organization including you, your employees, and your volunteers from the cost of liability claims. We offer a wide range of liability programs for sports teams, leagues, and associations. For more information, visit our sports liability insurance page.

How am I covered with sports liability insurance?

A comprehensive sports insurance program will protect your organization against bodily injury and property damage claims that arise as a result of operations, premises, products, completed operations, advertising, or participant injuries.
The three main areas of sports insurance coverage include

1. Accident Insurance accident medical coverage reimburses medical expenses for an athletic participant resulting from an accidental injury while participating in covered activities. Coverage is triggered after the exhaustion of all other medical coverage for which a participant may be eligible.

2. General Liability Insurance a commercial general liability policy provides coverage for civil claims, including legal defense costs. Coverage includes: allegations of bodily injury, personal injury, and property damage. Without accidental insurance, a general liability policy will not provide legal liability to athletes.

3. Directors & Officers Liability this area covers lawsuits that claim that the sports league’s mismanagement has resulted in economic injury to another person or that another person’s rights have been violated. Examples include: discrimination, wrongful termination, or failure to follow your own rules or bylaws. Coverage includes the sports organization, directors, officers, and volunteers.

Other benefits of sports liability insurance include

- Zero deductible for liability claims
- Umbrella policies
- Hired Auto and Employers’ Non-ownership Liability coverage
- Additional options to meet your organization’s insurance needs

8.8 Shop Keepers Insurance Policy

The shopkeeper insurance policy is specifically designed to cover all the risks and contingencies faced by small or medium-sized shop owners. It provides protection for the property and the interests of the insured (and their partners) in the business venture.

The sum insured depends on the value of your shop and the value of the contents of the shop. The value of the shop is calculated on the basis of the estimated cost of rebuilding it completely. The contents of the shop are assessed according to their value at the time of purchasing the shop insurance policy. The valuation would also include electrical and mechanical appliances in the shop.

Shopkeeper Insurance Policy has been devised in the form of complete policy to cater the needs of small shopkeepers. Originally this cover was framed under Market Agreement and the Policy contained 10 Sections, out of which Fire & Allied Perils for contents and Burglary and Housebreaking are compulsory and form the remaining sections insured is free to opt, any number of sections as per his need subject to selection of minimum four sections.
8.9 Householders Insurance policy

Householder’s policy saves you from uncertain events and provides you risk cover for your home. Insurance cover for household items and for a house is a sensible option. These covers can be of few types and can be taken as per capacity of the person and effectiveness of the policy. The premiums differ from scheme to scheme.

**Structural Insurance**

This type of householder policy covers the entire structure of the house and any damage to the same. If your house gets damaged due to unforeseen event, the insurance company can bear the amount of expense. Individual policies can be taken in case of a house that was built after purchasing the land. In case of multistoried apartments, policy is taken by the society. However, in case such society does not have the insurance, a person can insure his own flat. In case the building collapses, the person who has cover for his house will get the loss amount.

**Rental Insurance**

In case the house gets damaged by natural calamity and the insured has to live in rented premises, then the rent paid by the insured till the house gets repaired, is repaid by the insurance company.

**Household insurance**

The householder’s insurance policy takes care of both house damage and to household valuables like furniture, jewelry, electronic appliances along with losses due to theft or pilferage.

Home insurance policies available in the country offer insurance on the basis of reinstatement value of property and don’t take the market value into account. The reinstatement value means the expense that will be incurred to rebuild the property at current cost. Market value includes location, construction cost and land value of the location. This means that the sum insured in the householder’s policy doesn’t take account of land value and location.

**How the sum insured is calculated?**

The sum insured is calculated on the basis of per square foot cost of construction multiplied by built up area. Insurance company calculates the value of household things like furniture, electronic gadgets and clothes after deducting the depreciation.
Replacement value Vs Depreciated value

Replacement value is the cost of your product in the market while depreciated value is the worth after the amount of depreciation is charged on the product. A person has the option to either insure his product on the basis of depreciated value that will cost him less premium or he can take cover on the replacement value, which is the sum you will have to pay in case you purchase a similar product in the market.

What is not included?

Always make sure that you check all the exclusions in the policy. Make sure you are aware of all the factors because the whole purpose of the exercise is that one gets a cover. Ignorance is dangerous as you can lose your belongings and asset and also end up getting nothing from the insurance company. Always learn the exclusions before taking a policy. Some companies do not cover wilful destruction of property or loss or damage due to wear and tear. In most of the cases, insurance amount is not cleared in case the house is unoccupied by the owner for a period of thirty days without notice or intimation to the insurance company.

Short Answer Type Questions

1. What is Pedal Cycle Insurance?
2. Plat glass insurance.
5. Sports insurance.

Long Answer Type Questions

1. Explain Bankers Blanket and Jewellers Block policies.
2. Explain about House holder insurance policies.
3. Briefly explain Shop Keepers insurance policy.