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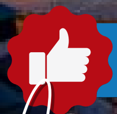

EXCLUSIVE

Conversation with

SANJEEV MANTRI
MD & CEO
ICICI LOMBARD GENERAL INSURANCE

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JATIN PUNJANI

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#INSURANCE BROKER
Hai Toh Bharosa Hai

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Happy New year 2025

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PRESIDENT MESSAGE

Dear Esteemed Members of the Insurance Brokers Association of India (IBAI),

I would like to extend my warmest New Year wishes to you and your teams. As we embark on this new year, I am optimistic that we will witness better traction in the market. Reflecting on the past year, I am proud of our accomplishments, particularly the publication of the Claims Handbook and Brokers Voice. These initiatives have created significant traction across various sectors of society.

I would like to extend my congratulations to ICICI Lombard, TATA AIG, and Go Digit for their exceptional performance in becoming the preferred choice of brokers. The insights from these reports were picked up by leading news channels and publications across the country. Although some media channels misinterpreted the report, our association clarified the findings at different forums. Our intention was never to demean any insurer or show anyone in a poor light. Our sole objective was to transparently share data with the public, enabling them to make informed decisions.

The growth in the last nine months has been muted, largely due to the denotification of tariffs and the resulting challenges in the property market. However, I believe that some stability will return as current rates are unsustainable in the long term. I think the growth can only be achieved with continuous innovation which has been lacking from the Industry and urgent attention is required on the subject. We cannot afford to have age old policies with new age premium. Proper risk assessment followed by continuous risk management should be given importance to reduce the frequency losses.

Our fortnightly workshops are gaining momentum, with participation exceeding 500 attendees. The topics of discussion and the quality of our faculty have been top-notch, earning appreciation from all sections of society.

In closing, I encourage all members to continue upholding the highest standards of professionalism and ethics. Together, let us strive to build a more resilient and sustainable insurance brokerage industry in India.

Thank you for your ongoing commitment and best wishes for a successful year ahead.

Warm regards,

Sumit Bohra
President IBAI

8TH EDITION

BROKERS VOICE SURVEY AWARDS

A PLATFORM THAT AMPLIFIES BROKERS' EXPERIENCES WITH INSURERS.

Who understands an insurer's strengths and weaknesses better than brokers? We interact closely with most insurers, gaining deep insights into their products, technology, servicing, and claims handling.

That's why the Broker Voice Survey is an invaluable guide for assessing insurers. We included questions about brokers' exposure to specific insurers, captured responses region-wise, and simplified the options presented. These changes have made the results even more representative.

Conducting the survey annually allows us to see how insurers respond to feedback over time. Notably, some insurers previously ranked lower have improved their standings—a positive trend for the industry.

While insurers often reward select brokers for performance, this survey turns the spotlight back on them, allowing brokers to recognize top-performing insurers. In fact, the highest-rated insurers receive a coveted award.

8TH EDITION

BROKERS VOICE SURVEY AWARDS

A PLATFORM THAT AMPLIFIES BROKERS' EXPERIENCES WITH INSURERS.

HIGHLY RECOMMENDED INSURERS TO WORK WITH

ICICI LOMBARD GENERAL INSURANCE

TATA AIG GENERAL INSURANCE

GO DIGIT GENERAL INSURANCE

EXCLUSIVE
INTERVIEW

SANJEEV *Mantri*

MANAGING DIRECTOR & CHIEF EXECUTIVE OFFICER
ICICI LOMBARD GENERAL INSURANCE

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Congratulations on being rated the No. 1 insurance company in the Brokers Voice Survey.

What does this recognition mean for ICICI Lombard and its stakeholders?

We are thrilled to be adjudged as the No. 1 insurance company in the 'Brokers Voice Survey'. It is an acknowledgement by our partners that as an entity we are moving in the right direction, serving them and the customers in their risk management journey.

Recognitions such as these motivate us and we shall continue to strive to do what is right for our stakeholders. Indian insurance industry has already embarked on a journey for "Insurance for all by 2047"and we are well poised to play a meaningful role in this.

What do you believe were the key factors that contributed to ICICI Lombard's top ranking?

It has been a long journey. While our commercial practice has always been unique and strong, over last few years we have endeavoured hard and aligned our broking practice as well. We have collaborated with our partners and strengthened this with proactive engagement, co-creating customised product offerings, tech interventions and data analytics for enhanced service delivery and responsiveness.

At ICICI Lombard, we look at this as an ongoing journey: staying agile and nimble, rapidly adapting to meet the needs of our brokers and customers and nurturing strong relationships with them.

The survey highlights the voice of brokers.

How does ICICI Lombard collaborate with brokers to address market needs and challenges?

We are aligned with our brokers on 'first principle basis' following a three pronged approach encompassing Products, Processes and People.

We understand each partner and their clientele are unique, requiring product/solutions that best meet their needs and offer them customised solutions enabling them to serve their customers across businesses.

Talking about processes, for us Technology has been a key enabler. Streamlining processes and fast tracking service delivery from policy issuance to claim settlement, helping our partners to serve their clients efficiently. We are the first large insurance company to move to the cloud, resulting in increased agility, efficiency, reliability and security. Early digitization is helping drive business insights including forecasting models, customer understanding and efficient fraud models- enabling product customisation, strengthening services and enhancing retention.

Last but not the least, at ICICI Lombard, relationships are key, we view brokers as strong pillars in our growth journey, integral in navigating the complexities of the insurance landscape. We maintain continuous dialogue through structured forums like Milaap, ensuring we understand market dynamics and broker insights intimately. This collaboration allows us to co-create tailored solutions that address both current and emerging needs.

In what ways does broker feedback influence your operational strategies?

We attach a lot of gravitas to our brokers' inputs and feedback, considering it as the final voice on multiple fronts from enhancing our solution offerings to risk pricing strategies and service processes.

Consistent brokers' inputs allows us to quickly identify pain points and make necessary adjustments, ensuring that our operations are effectively aligned with market expectations and challenges.

What are the emerging market trends for Indian economy and insurance industry?

I would like to start with the global economy, which continues to remain resilient, despite supply chain disruptions, geopolitical tensions, a surge in inflation and monetary policy tightening. According to the International Monetary Fund's (IMF) projections, growth for 2024 and 2025 is expected to hold steady around 3.2%.

Back home, India continues to be the fastest-growing economy in the world, with an estimated growth rate of over 6% in 2025. In fact, the country is projected to remain strong, with the continuing strength in domestic demand and a rising working-age population. On the back of continued reforms, strong public infrastructure investment and a strengthening financial sector, India is expected to become the third-largest economy in the world with a GDP of US$ 7 trillion by 2030. However, one must acknowledge that change is accelerating all around us, possibly at a faster pace than in any period in history and it has resulted in newer risks. These challenges have also intensified focus on the insurance industry's capacity and readiness to react as society's financial safety nets.

Notably, along with being the fastest-growing economy, India is also one of the fastest-growing insurance markets in the world. According to the Economic Survey 2022-23, aided by a favourable regulatory environment, India is poised to grow at the fastest pace and become the sixth largest insurance market globally, turning into a remarkable US$ 222.00 billion market by 2026.

Further, fuelled by economic development, an expanding middle class, technological innovation and a favourable regulatory environment, the Indian General Insurance (GI) industry is expected to achieve a Gross Written Premium (GWP) of ₹ 4.75 trillion by 2028.

We as an institution are geared up and well-positioned to play key role in this evolving and expanding sector.

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How is ICICI Lombard innovating to help its clients tackle risks effectively?

At ICICI Lombard, we have always believed that managing risk effectively is essential to safeguarding business' assets, reputation, and long-term success. Over the years, our focus has evolved from merely providing insurance to recommending comprehensive risk management strategies tailored to the unique needs of businesses across industries.

Our emphasis on Cloud, Data, Artificial Intelligence (AI), Machine Learning (ML), and Internet of Thigs (IoT) has enabled digital transformation; enhancing agility, efficiency, reliability and security, of service delivery to customers. IoT, telematics and data-led preventive insurance solutions for marine, such as sensors for temperature, GPS tracking, fuel sensor and e-locks, have strengthened our risk underwriting practice. Further, our IoT solutions for property loss prevention have been a benchmark in effective risk management. Our cyber-risk assessment tools and dashboards enable clients to assess their vulnerabilities, and incident response readiness.

The health and wellness app IL Take Care is powered with multiple features like health risk assessment, doctor on call and Face-scan, allowing users to track their health vitals real time.

These bespoke solutions are empowering our broking partners to effectively manage their customers' risks. Our goal is to provide peace of mind to our clients for risks that are beyond their control.

For instance, during the Israel-Hamas conflict, the Suez Canal, became a high-risk zone, leading to many underwriters withdrawing war coverage from active policies, creating widespread panic in the market. We at ICICI Lombard continued to support our clients for war coverage, providing much-needed relief. Our marine advisory team was in constant communication with clients, offering guidance on how to manage the situation and proceed with their shipments safely.

We continue to stay committed to navigating the emerging risks with resilience, foresight, adaptability and collaboration while staying agile and developing solutions for a dynamic and diverse market like India.

The role of technology and data is growing in the insurance landscape

How has ICICI Lombard leveraged technology to enhance customer experience, underwriting, and claims management?

India is currently one of the fastest-growing markets for insurance technology. InsurTech has been powering the creation, distribution and administration of the insurance business in the country.

For ICICI Lombard technology and data have been a means to an end, revolutionizing our ways of working. We have embraced digital-led and tech-first approach and are adopting new technologies across our value chain to stay ahead of the curve and embed this in our organizational DNA. Cloud, data and new-age technologies such as AI/ML and IoT are driving the transformation of the organisation to being more agile, efficient, reliable and secure.

The early adoption of technology, with the distinction of being the 1st large insurer to move all core applications to the Cloud, has enabled the organization to be future-ready, leading to the introduction of innovative products and services, increasing efficiency of distribution channels and customer service and streamlining processes.

We have seen numerous benefits accrue as we continue to invest in deep tech or innovative technologies. Market share forecasting models are helping us identify micro-segments to drive profitable growth. Customer One View is helping us understand our customers better and has improved our policy density and wallet share. Real-time notification of risk has helped us in limiting our catastrophe losses. Generative AI is helping us serve customers better with sharper messaging and a better comprehension of their claim related queries.

What role do you see artificial intelligence and big data playing in the future of insurance?

Talking about data, I would like to give you a sneak peek into the amount of data that gets generated at ICICI Lombard in 60 minutes: 5 Tb+ of data, 90K+ emails, 8,000+ calls, 1,100+ claims, 18,000+ policies and 1,50,000+ quotes.

This big data is helping drive business insights, empowering us to understand customer behaviour through granular insights, allowing hyper-personalised solutions, dynamic pricing, and proactive risk management.

As we move into the future, the convergence of AI and big data will not only revolutionise underwriting and claims but also enable us to become true risk partners for our customers, embracing technologies responsibly, building trust, enhancing transparency, and creating a more resilient and inclusive ecosystem.

In India, where insurance penetration remains low, AI led, data-driven micro-insurance solutions can expand coverage to underserved markets, fostering financial inclusion.

Sustainability is becoming a major focus globally.

How is ICICI Lombard integrating ESG (Environmental, Social, and Governance) principles into its business operations?

Sustainability is integral to the purpose of ICICI Lombard and we are committed to making a positive impact on the environment and the society. We analyse emerging risks and opportunities and incorporate them in our ESG-based strategies. Our core values revolve around sustainable practices, firmly rooted in our ESG standards. These principles guide our conscious decision-making, resulting in positive effects on the environment, society and individuals.

Policy and Regulatory Environment

The government has introduced the concept of a composite insurance license. How do you view this decision, and what potential impact do you foresee on the insurance ecosystem?

For any industry to thrive, the regulatory environment and guardrails can be a major enabler. I echo the sentiment of the entire insurance industry: we are fortunate to have a transformative and progressive regulator in the Insurance Regulatory Development Authority of India (IRDAI).

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The slew of revolutionary reforms and various initiatives announced by the IRDAI reflect its commitment to realising the inspiring vision of 'Insurance for All by 2047'. Steps like these will enhance distribution and product offerings for customers at large.

100% FDI in the insurance sector is another significant development.

How do you see this policy change impacting the competitive landscape and growth prospects of the industry?

The introduction of 100% FDI is a landmark shift that will likely draw significant foreign investment into the Indian insurance market, fostering innovation and competition. This influx can lead to enhanced product quality and diversification, benefiting consumers through broader choices and improved services.

The Insurance Regulatory and Development Authority of India (IRDAI) has been pushing for reforms.

How do you evaluate recent regulatory initiatives?

IRDAI has envisioned a comprehensive insurance framework where every stakeholder is united in the mission of a fully insured India by 2047, with a strategic focus on tailoring products and innovations and transitioning to a principle-based regulatory system. While India has set her sights on becoming a 'developed nation' by 2047, it is well aligned with IRDAI's vision of 'Insurance for All by 2047.'

We at ICICI Lombard are aligned to the regulator's vision and the landmark reforms and are committed to implement them in letter and spirit.

The Bima Trinity – Bima Sugam, Bima Vistaar, and Bima Vahak, is set to create unprecedented opportunities - simplifying customer insurance processes, providing comprehensive insurance products and building insurance awareness with last-mile connectivity.

Its reforms like Risk-Based Capital (RBC) and International Financial Reporting Standards (IFRS), promise to strengthen the financial health, transparency and competitiveness of insurance companies in India.

RBC not only aligns India with global regulatory standards but it also reduces the insurers' financial distress by linking capital requirement to risk profiles.

The decision on change of policy wordings has encouraged product innovation meeting larger customer needs and has also provided flexibility allowing insurers to offer customized and relevant insurance solutions, especially in segments such as fire, motor (third party) and accident insurance.

Further, the transition from a rule-based framework to a principle-based approach has facilitated ease of doing business and fostered growth opportunities.

The favourable regulatory framework has offered the flexibility to collaborate with brokers offering bespoke solutions designed to best meet their customers' requirements.

Future Outlook

ICICI Lombard has consistently been an industry leader. What are your strategic priorities for the company in the next 3–5 years?

We are committed to enhancing our digital capabilities, fostering deeper partnerships, expanding our product portfolio, co-creating bespoke insurance solutions and forging long-term customer relationships through data-driven insights. We aim to consolidate our leadership position by continuously innovating while remaining agile in response to market changes.

How do you plan to maintain your leadership position in an increasingly competitive environment?

Being in leadership position is an output, personally if you ask me we are more focussed on input of what we can offer to our stakeholders which can add value. As long as we continue to focus on being customer-centricity, strategic partnerships and harnessing the power of technology the outcome will take care of itself.

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The customer profile and needs are changing rapidly.

How is ICICI Lombard adapting to the evolving expectations of millennials and Gen Z customers?

ICICI Lombard is proactively engaging with millennials and Gen Z by developing user-friendly digital platforms and personalised product offerings tailored to these demographics' unique needs. Education and awareness campaigns are also critical as we strive to build financial literacy within these demographics: encouraging proactive engagement with insurance. Introduced earlier this year, the gamified approach of our Game of Life campaign was more than just a creative storytelling technique. It was a strategic move aimed at resonating with the younger generation, and educating them about the importance of insurance early in their lives through a disruptive campaign.

What role does financial literacy play in expanding insurance penetration in India?

Financial literacy is fundamental in expanding insurance penetration. By equipping consumers with understanding and knowledge of insurance products, they are more likely to seek coverage suitable for their needs. We have been working at multiple levels to do our bit in this regard, from insurance awareness sessions, media outreach and promotion in Bihar and Tripura (states allocated to ICICI Lombard by the IRDAI) to 'insurance simplified' series on social media and digital outreach programs.

Closing Remarks

As a leader in the industry, what is your message to your customers, brokers, and the insurance fraternity following this recognition?

This recognition is an honour and a testament to our collective commitment to serve the industry. To our customers, we pledge to continuously uphold our standards of integrity and service. To our brokers, we value your partnership and insights in co-creating solutions, which are integral to our success. Together, we will navigate the evolving insurance landscape with unwavering trust, innovation and collaboration. That being said the journey is long and such acknowledgment from our partners makes us believe that our direction is right.

Looking ahead

What is your vision for ICICI Lombard's role in shaping the future of insurance in India?

We would like to play a meaningful role in making IRDAI's vision of 'Insurance for All by 2047' a reality- leveraging technology, forging long-term partnerships for enhanced access, co-creating hyper-personalised solutions to democratise insurance, creating seamless customer experiences and frictionless claims management, operational excellence and holistic risk management. We aspire to set new benchmarks in customer experience, while actively contributing to a more resilient and responsible insurance ecosystem that meets the diverse needs of all Indians.

UNLOCKING THE FOUNDATION

The Vital Role of a Well-Structured Proposal Form in Liability Insurance

JATIN PUNJANI
FOUNDER & CEO, PROFOUND RISKS SERVICES LLP

How Relevant is the Proposal Form Under Liability Insurance Products?

The proposal form in liability insurance is a critical tool in assessing and rating risks. Unlike property or motor insurance, where the risks are more visible and measurable, liability risks are far less tangible. Insurers rely heavily on the information provided by the insured to assess exposures, such as potential claims related to third-party injuries, property damage, or professional negligence, Also, most important that the liability class of business is categorized as “Long Tail Risk”

The challenge with liability risks is that they are largely based on the operations, conduct, and contractual obligations of the insured, making them more complex to quantify. The proposal form becomes the primary source for insurers to understand these nuances. Details regarding the nature of the business, prior claims history, scope of operations, and potential exposures are crucial. This helps insurers rate the risk appropriately and determine suitable coverage terms, especially, also, ensure that terms are met with the liability treaty coverage's, exclusions and conditions.

What Challenges Does the Insurance Broker/Agent Face?

Brokers and agents often struggle with incomplete or inconsistent information from clients. Many businesses either lack awareness of the importance of full disclosure or are unable to provide precise data. Additionally, complex liability exposures in niche industries may require specialized knowledge that both the client and intermediary might lack, making it difficult to collect comprehensive information. Tight deadlines and competition in the market is contributing to huge claims volumes.

Loss notification arising during the gap between submitting the updated Proposal Form and Issuance of Policy

One of the critical challenges faced in liability insurance is the gap between submitting the updated proposal form and the actual issuance of the policy.

This period of uncertainty often leads to significant disputes when a loss occurs before the proposal form is submitted or the policy is issued. The insurer's position is clear: the acceptance of risk is based on the "duly filled, signed, and dated proposal form." However, delays in submitting these forms, sometimes even months after the risk has commenced, create a grey area that can be highly problematic.

The gap arises primarily because of placement challenges. In many cases, brokers or agents are under pressure to bind coverage quickly to meet the insured's requirements. However, the necessary proposal form may not be finalized or submitted in time, leading to coverage being placed based on incomplete information. During this period, if a loss occurs, it results in a dispute, as the insurer may question the validity of the claim due to the absence of a properly completed proposal form.

This issue becomes particularly alarming because insurers rely heavily on the proposal form to evaluate the risk profile of the insured. Without this critical document, insurers are left with incomplete or outdated information, which can lead to misunderstandings about the coverage terms and the risk exposures. As a result, any loss notification during the gap may trigger extensive scrutiny, delays in claims processing, or even outright denial of the claim. Reinsurers in these placements typically require complete and accurate documentation to assess the risk properly

in case if they have condition of “Claim Control Clause” or “Claim Cooperation Clause”, Without a duly filled proposal form, reinsurers may reject the claim, leaving the insurer to bear the full burden of the loss. This exposes insurers to financial strain and reputational damage, as the ability to process claims is a key aspect of maintaining trust with clients.

This issue is not restricted to facultative placements. Liability treaty, which cover a broader portfolio of risks, often include conditions that allow reinsurers to inspect records and documents related to the policies they underwrite. Many reinsurers incorporate "inspection of records clauses” condition, which grant them the right to review all relevant documents, including proposal forms, underwriting files, and claim records. These inspections ensure that the risks were placed in accordance with the agreed terms and that the insurer has met its obligations. Failure to comply with these conditions can result in claim denials or disputes during the settlement process.

While this trend has been more common in natural catastrophe (Nat Cat) claims, it is becoming increasingly relevant in liability claims as reinsurers begin to recognize and address the mistakes made during the initial placement of liability policies. Reinsurers are becoming more stringent, knowing that incomplete or inaccurate documentation at the time of policy placement can lead to significant underwriting missteps and exposure to unanticipated risks. As a result, reinsurers are likely to demand more thorough documentation, even in liability cases.

Conclusion

The liability proposal form is an essential document in the insurance process, providing the basis for risk assessment and coverage terms. However, brokers, agents, and insurers face challenges related to incomplete data, market pressure, and competition. Ensuring the accuracy of the proposal form is critical for smooth claim handling and successful reinsurance settlements. In this competitive landscape, collaboration and transparency among all parties are key to overcoming these challenges.

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Empowering India's Insurance Future

The Role of PoSP Agents

As India moves toward becoming a global economic powerhouse, Point of Sale Persons (PoSPs) are key to boosting insurance penetration

RAKESH GOYAL,
DIRECTOR, PROBUS INSURANCE BROKERS

India stands out as an outlier amid the geopolitical tensions that have slowed down many developed economies. The International Monetary Fund (IMF) projects India's gross domestic product (GDP) growth at 6.8 percent in FY2024–25.

According to the Ministry of Finance, India is on track to become the third-largest economy in the world, with a GDP of $ 7 trillion by 2030. However, in terms of insurance penetration, the nation remains vastly under-insured. For instance, the life insurance penetration in India is only 3.2 percent, one of the lowest among developing countries.

The Insurance Regulatory and Development Authority of India (IRDAI) has committed to enabling 'Insurance for All' by 2047. An entire ecosystem of insurance companies, agents, web aggregators, and policyholders exists, but to improve insurance penetration among the uninsured, the Point of Sale Person (PoSP) will remain a critical link between the industry and policyholders.

PoSPs: The Bridge to Enhanced Insurance Penetration

PoSPs are individuals with the minimum qualifications, training, and certification required to solicit basic and pre-written insurance products as specified in the PoSP guidelines. The introduction of the PoSP role aims to simplify the process for individuals to become insurance agents and promote straightforward and comprehensible insurance offerings. These products often include basic health insurance, motor insurance, personal accident insurance, and term life insurance.

The PoSP agents play a pivotal role in helping new policyholders navigate the insurance process. One of the biggest advantages of PoSPs is their ability to have personal interactions with potential policyholders to understand their specific needs and financial situations. This personalized approach ensures that policyholders choose insurance products that are most suitable for their circumstances.

Simplifying and Demystifying Insurance

PoSPs provide clear and concise explanations of different insurance products, helping new policyholders understand the benefits, coverage, exclusions, and terms of each policy. This demystifies the insurance process and makes it easier for individuals to make informed decisions. They also assist new policyholders in managing their policies post-purchase, including helping with premium payments, updating personal information, and understanding policy renewals. In the event of a claim, PoSPs can guide policyholders through the claims process, ensuring they understand the steps involved and what documentation is required. This support can be invaluable during stressful times.

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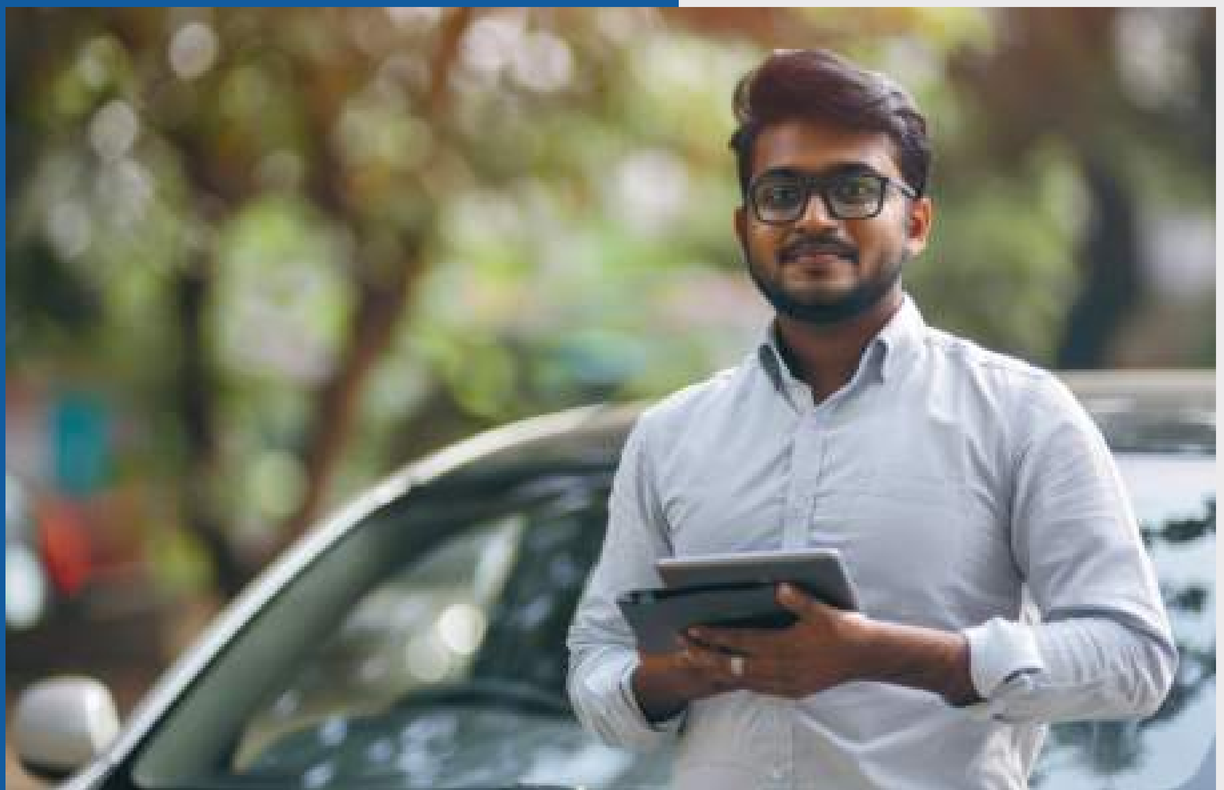
Financial Guidance and Long-term Relationships

PoSPs help new policyholders understand the financial aspects of insurance, including premium payment options and potential tax benefits, making it easier for individuals to incorporate insurance into their financial planning. They often maintain long-term relationships with their clients, conducting regular check-ins to ensure that their insurance coverage continues to meet their evolving needs. As new products and options become available, PoSPs can inform their clients and help them update or upgrade their policies to better suit their current circumstances.



Leveraging Digital Platforms

PoSP agents often use digital platforms provided by insurance companies or intermediaries to sell policies. This includes online portals and mobile apps, which simplify the sales process and make it easier for agents to reach potential customers. The PoSP initiative has been a positive step towards making insurance more accessible and increasing the number of insurance agents in India. It provides a flexible and low-barrier entry point for individuals interested in selling insurance products.

Continuous Support and Flexibility

Many insurance companies and intermediaries provide continuous support to PoSP agents through digital platforms, helplines, and mentorship programs. This helps new agents gain confidence and improve their sales skills. PoSP agents can work part-time, allowing them to start selling insurance while maintaining other jobs or businesses. This flexibility is attractive to those exploring the insurance industry without committing full-time.

Simplifying and Demystifying Insurance

As PoSP agents gain experience and build a customer base, they can gradually scale up their operations, eventually transitioning to full-time if desired. The PoSP model provides a pathway for growth without significant initial investment.

PoSPs help new policyholders by providing personalized guidance, simplifying the enrolment process, offering ongoing support, building trust and confidence, assisting with financial planning, fostering long-term relationships, and addressing concerns and queries. Their localized, accessible, and personal approach makes the insurance experience smoother and more positive for new policyholders. As India strides towards becoming a global economic powerhouse, PoSP agents will be instrumental in ensuring that the benefits of insurance reach every corner of the nation.

Boosting Insurance Penetration through a Collaborative Approach

Targeting MUDRA Loan Beneficiaries

NARENDRA KUMAR BHARINDWAL,
VICE PRESIDENT, IBAI

In India, the financial ecosystem has witnessed a paradigm shift in empowering micro, small, and medium enterprises (MSMEs), thanks to initiatives like the Pradhan Mantri MUDRA Yojana (PMMY). The MUDRA scheme, with its focus on micro-entrepreneurs, has extended formal credit to millions of businesses that were previously underserved. While this has catalyzed entrepreneurial growth, an equally critical facet remains underdeveloped: financial protection through insurance.

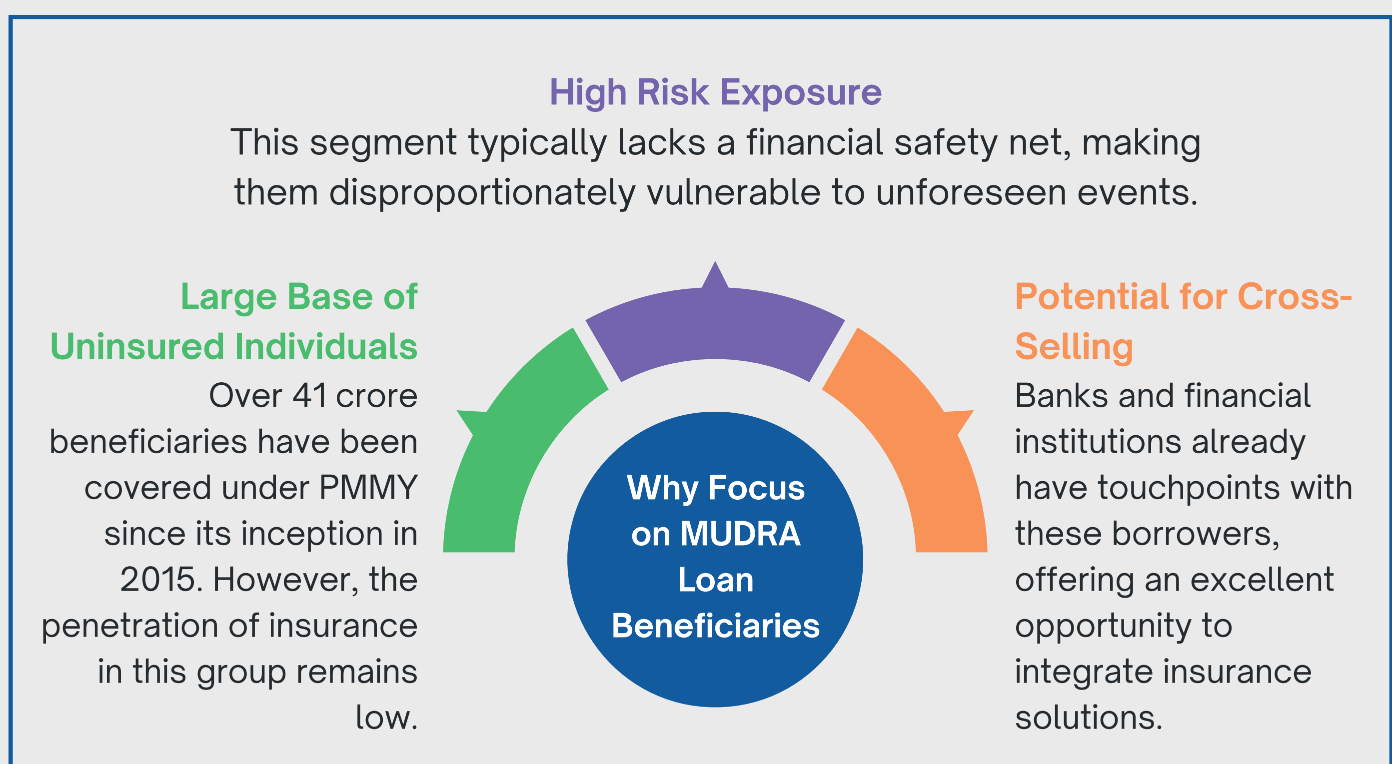
The beneficiaries of MUDRA loans, many of whom belong to vulnerable economic strata, often face substantial risks, including health emergencies, natural disasters, and business interruptions. A collaborative approach between the Government of India, banks, insurance companies, and intermediaries can bridge this gap by seamlessly integrating insurance with the financial ecosystem.

A Collaborative Framework

Government as the Enabler

The Government of India can play a pivotal role by:

- **Integrating Insurance in Loan Programs**: Making insurance coverage mandatory or optional but incentivized for MUDRA loan borrowers.
- **Subsidies and Premium Support**: Allocating funds to subsidize premiums for economically weaker borrowers under schemes like Pradhan Mantri Suraksha Bima Yojana (PMSBY) or Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY).
- **Digital Platforms for Outreach**: Leveraging platforms like the JAM Trinity (Jan Dhan, Aadhaar, Mobile) for seamless enrollment, premium payment, and claim settlements.



Role of Banks

Banks, as the first point of contact for MUDRA beneficiaries, can:

- **Promote Insurance** Awareness: Incorporate insurance literacy as part of financial literacy programs.
- **Bundle Insurance Products:** Offer pre-packaged insurance solutions tailored to specific risks like business loss, personal accident, and health.
- **Simplify Processes:** Use digital banking solutions to automate enrollment and ·policy issuance for loan borrowers.

Contribution of Insurance Companies

Insurance providers can:

- **Design Tailored Products:** Create products specifically addressing the needs of micro-entrepreneurs, such as asset protection, business interruption, and group health policies.
- **Flexible Premium Options:** Introduce affordable and installment-based premium structures for low-income groups.
- **Digital Innovations:** Employ AI and analytics to identify high-risk areas and streamline claims processing.

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Role of Intermediaries (Insurance Brokers)

Intermediaries are crucial in bridging the gap between insurance providers and end-users. Their contributions include:

- Education and Outreach: Conduct grassroots-level awareness campaigns in local languages to educate beneficiaries about the importance of insurance.
- Customized Solutions: Assist beneficiaries in choosing policies that align with their specific needs.
- Claim Support: Provide handholding support to ensure timely claim settlements, building trust in the system.

Expected Outcomes

A collaborative approach has the potential to:

- Enhance Penetration: Increase the insurance penetration rate, particularly in rural and semi-urban areas.
- Reduce Vulnerability: Strengthen the financial resilience of MUDRA beneficiaries by mitigating risks.
- Foster Trust and Awareness: Build a culture of insurance adoption, ensuring long-term sustainability.

The MUDRA scheme represents a significant step toward financial inclusion, but true inclusivity demands comprehensive financial protection. By combining the efforts of the Government, banks, insurance companies, and intermediaries, we can create an integrated ecosystem that empowers MUDRA beneficiaries not just to grow, but to grow securely.

This collaborative model can serve as a blueprint for propelling insurance penetration in other underserved sectors, making India a global leader in inclusive financial protection.

Gaps in technical skills and talent within General Insurance industry in India

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One can arguably say that the Indian general insurance industry has gone through two major inflection points in the last 70 years of its growth and development.

The first one was the nationalisation of the industry in 1972, when the existing private insurance companies were nationalised and amalgamated into one of the four public sector insurance companies, viz., The New India Assurance Co Ltd., United India Insurance Co Ltd., Oriental Insurance Co Ltd and National Insurance Co Ltd., with the General Insurance Corporation of India becoming the holding company.

The second inflection point was the opening of the industry to private competition in 2001 with the setting up of the Insurance Regulatory and Development Authority (IRDA). This opening up of the industry was accompanied by deregulation and tariffs being progressively dismantled. The Tariff Advisory Committee (TAC) was converted into the Insurance Information Bureau (IIB).

The era of nationalisation of general insurance industry (1972 - 2000)

During the nationalised phase of the general insurance industry, the business was governed by tariffs in most classes of business such as motor, fire, engineering, marine and workman compensation. For miscellaneous classes of business which were not subject to tariff, there were “market agreements” which the insurance companies by and large followed.

The technical knowledge in those days meant mastery of the various tariffs or market agreement rules and provisions. The tariffs were amended by the TAC by issuing circulars from time to time to respond to demands from the market.

“Expertise” to a large extent meant, the knowledge of the various tariff provisions by rote and the amendments introduced through the circulars. Since internet and online resources were not available, a tendency amongst the experts to “hoard knowledge” and become indispensable or important, was also fairly common.

A drawback of the overreliance on tariff was the inability of the market to develop talent with critical thinking skills. The skill to operate in an environment where there were no tariffs was sadly not developed. Thinking out of the box was also not encouraged given the work culture of conformity with rules and regulations in the public sector. Without the crutch of tariffs, the industry could not walk.

Recruitments during nationalised era

While the general insurance industry suffered from lack of real underwriting skills due to the presence of tariff scriptures, there was a robust process for recruitment and training of officers and staff. There was a standardised process of common recruitment of direct recruit officers through open competitive examinations followed by personal interviews. The industry attracted quality talent as a high esteem was placed on civil service or public sector jobs when compared to the private sector ones.

Unfortunately, the direct recruitments on a large scale for all four companies were frozen after 1991, after which limited special recruitments were made.

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The effects are today being seen in PSU insurers, as they are facing senior management talent shortage, due to the direct recruit officers hired upto 1991, retiring at a rapid pace with no subsequent batches to replace them.

Training during the nationalised era

The PSU insurers had a great training architecture in place, during the nationalised era which still continues to this day, albeit in a weakened form and shape.

All the four companies had their own officer's training colleges, with permanent faculty drawn from the company cadre. New officer recruits were trained for 6 months, split equally between classroom and on–job-training at various regional offices of the companies. The institutes also provided specialised training besides induction training for new joinees. The PSU culture placed a great deal of emphasis on compliance with rules and regulations. This required officers to be trained thoroughly in tariff provisions, policy wordings and manuals of the companies. Aside from the officers' training institutions all companies had their own regional training centres (RTC), with their own permanent establishments, which conducted regular year round training for staff and agents

Post-nationalisation from 2001 till today

Most of the new private companies that were established post deregulation were joint ventures with foreign insurers. Amongst brokers, several multinational broking entities also set shop in India. In the initial stages,

the foreign partners invested in skill development of their JV's by providing underwriting, claims and product development support. Many new products, particularly in the liability segment were developed.

However, over time, the foreign insurers started withdrawing from the day to day management of the JV's. This also impacted the skill development in the local entities as the involvement of foreign insurers became more of investors rather than operational partners to Indian promoters in running of the companies.

Aside from new product and process introduction, new subjects also got opened up like actuarial and business analytics. The regulatory requirement for actuarial guidance to the insurance companies opened up the professional to a section of statistically and mathematically inclined young talent. While there has been an over supply of actuarial talent in the insurance industry, the same could not be said about hard functions like sales, where talent is always in short supply.

Recruitments after opening up of the market

The deregulation and opening up of the market led to a war for experienced talent in the industry. Many experienced hands from PSU's joined these newly formed entities. The new private entities also started recruiting talent from other industries as well as campus hiring from institutions.

Many entities did not hire, but poached from other larger entities who did fresh recruit hiring. So the available talent started circulating from one company to another. The companies who did hire fresh talent, did so in a limited way since they were not confident of retaining the talent on a long term basis to justify their investment in hiring and training. Consequently, the talent pool has gotten shallower with time. Many new recruits reached high positions that are not justifiable given their talent or subject knowledge, but due to their playing their cards smartly or being at the right place at the right time.

Training in the deregulated era

The training standards in the market have dropped considerably when compared to the nationalised era, with focus being on speed rather than depth. Many new recruits are thrust into their jobs in sales, underwriting or claims with very less intensive training and they are expected to learn things on the job. In the absence of formal training and mentoring programmes, the skill development has faltered. Further, unlike the nationalised era, when new recruits got opportunity to work in diverse fields such as underwriting, claims, reinsurance or marketing, the new hires in the post nationalised era have largely been pigeon-holed into one job profile, without opportunity for rotation and gaining lateral skills and experience.

Current situation

In the nationalised era where the PSU companies could attract talent due to lack of attractive career options in the private sector, the liberalization of the Indian economy saw the emergence of the private sector in a big way. Private sector jobs with more pay and better perks became more attractive career options for a large pool of talent. Insurance industry had to fight for talent with the private sector segments like banking and financial services, IT, FMCG and other high paying segments of the economy. Consequently, the industry cannot attract the same quality of talent which it used to in the nationalised era.

The inability of the insurance industry to attract talent coupled with retirement of experienced hands has led to a serious talent gap. But this situation is not unique to India but across the world. Insurance business is not seen as a career of choice by the Gen Z cohorts. Insurance jobs are seen as boring and sales driven, with little scope for individual initiative or excellence. Insurance industry has also not been able to meaningfully utilize the new generation talent which they have hired.

There is a feeling amongst new hires that they are being used as mules or beasts of burden with no job enrichment. They are attracted to new and emerging areas like Artificial Intelligence, Investment Banking or Hedge Funds which are more fashionable and challenging holding a lot of appeal. On the other hand, some of the industry old timers feel that the new generation is an entitled bunch with high expectations and unwilling to do the hard work and long term application needed in the insurance business to succeed.

Suggestions for bridging the talent gap

Talent and skill gap cannot be addressed on a piecemeal basis. There is little purpose in focusing just on hiring or training alone. It needs a holistic approach that includes investment in talent, hiring, training, mentoring and long term career development. Unless this realisation is not there in the insurance industry, nothing much can be achieved to resolve the gap issue.

The insurance industry needs to work with the academic institutions to come up with a comprehensive programme on insurance education starting at the school level leading to graduation. We have been having university graduation programmes across the country in specialised subjects like Geology, but not in insurance, when the number of insurance folks far outnumber geologists by several multiples. There may be some tens of thousands of geologists in India, where there are lakhs of insurance practitioners in the country working as agents, brokers, loss adjusters or in insurance companies or TPA's.

Once the pipeline of talent is established in association with academia, the next stage is to ensure that the talent that is hired is properly trained and mentored. Currently, the training programmes are not properly designed with a few days or weeks of induction training with little follow up or evaluation of long term learning milestone achievement.

General insurance is a vast subject and for the new joinees to develop and mature, it will take a considerable amount of time. Hence learning by osmosis is also necessary where the new recruits work with experienced people and learn on the job with continuous evaluation.

Lastly, the skill development is inextricably linked to how the skills are put to use by the organisation. General insurance is application based. If the skills unutilised for a long time, they will be blunted. Human resources planning whereby talent is deployed in the right manner is also extremely important to keep skill and talent gaps to the minimum possible

Non-Disclosure of Material Facts in Health Insurance in India

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Health insurance is a vital component of financial planning in India, providing individuals with a safety net against unexpected medical expenses. However, the issue of non-disclosure of material facts, particularly pre-existing conditions, remains a significant challenge within the industry. This article explores the implications of non-disclosure, recent regulatory changes including the new five-year moratorium period, and the responsibilities of policyholders.

Understanding Non-Disclosure of Material Facts

Non-disclosure refers to the failure of an insured individual to provide complete and accurate information regarding their health status when applying for insurance coverage. This can include pre-existing conditions such as diabetes or hypertension, thyroid, past surgeries et al, which are critical for insurers to assess risk accurately. According to recent data, approximately 25% of health insurance claims are rejected due to non-disclosure of pre-existing conditions.

Additionally, many claims are denied because policyholders are unaware of the terms and exclusions within their policies

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The principle of utmost good faith (uberrima fides) governs insurance contracts in India, requiring that all material facts be disclosed by the insured. The National Consumer Disputes Redressal Commission (NCDRC) has upheld this principle in various rulings, emphasizing that failure to disclose relevant medical history can render a policy voidable at the insurer's discretion.

For instance, in a recent case involving SBI Life Insurance, the NCDRC ruled that the company had valid grounds to reject a claim due to undisclosed medical history related to drug addiction

Consequences of Non-Disclosure

The consequences for policyholders who fail to disclose material facts can be severe. Claims may be denied even if the non-disclosure is unrelated to the cause of hospitalization. This highlights the importance for individuals to thoroughly understand their health status and disclose all relevant information when applying for coverage

Insurers have a duty to seek complete details about an applicant's medical condition; however, it is ultimately the responsibility of the insured to ensure transparency during the application process

The New Five-Year Moratorium Period

In response to ongoing issues surrounding non-disclosure and its implications for claim rejections, the Insurance Regulatory and Development Authority of India (IRDAI) has implemented a new regulation effective April 1, 2024.

The moratorium period has been reduced from eight years to five years. During this period, insurers cannot reject claims based on non-disclosure or misrepresentation related to pre-existing conditions, provided that five annual premiums have been paid.

This change aims to protect consumers while balancing the financial risks for insurers. After the five-year moratorium period, insurers can only deny claims related to fraudulent activities or permanent exclusions outlined in the policy

This regulatory shift encourages individuals to purchase health insurance earlier in life, ensuring they are covered before any significant health issues arise.

Impact on Existing Health Insurance Policies

- **Coverage for Pre-Existing Conditions**: Under the new guidelines, once the five-year moratorium period is completed, insurers are obligated to cover claims related to pre-existing conditions (PEDs) that were disclosed or even undisclosed at the time of policy issuance. This marks a substantial shift in favour of policyholders, as previously, claims could be denied based on non-disclosure even if the condition was unrelated to the hospitalization

- **Alignment with New Regulations**: Existing policyholders will benefit from this change as their policies will automatically align with the new five-year moratorium. This means that any ongoing policies will now have a

reduced waiting period for claims related to PEDs, providing enhanced coverage options and peace of mind

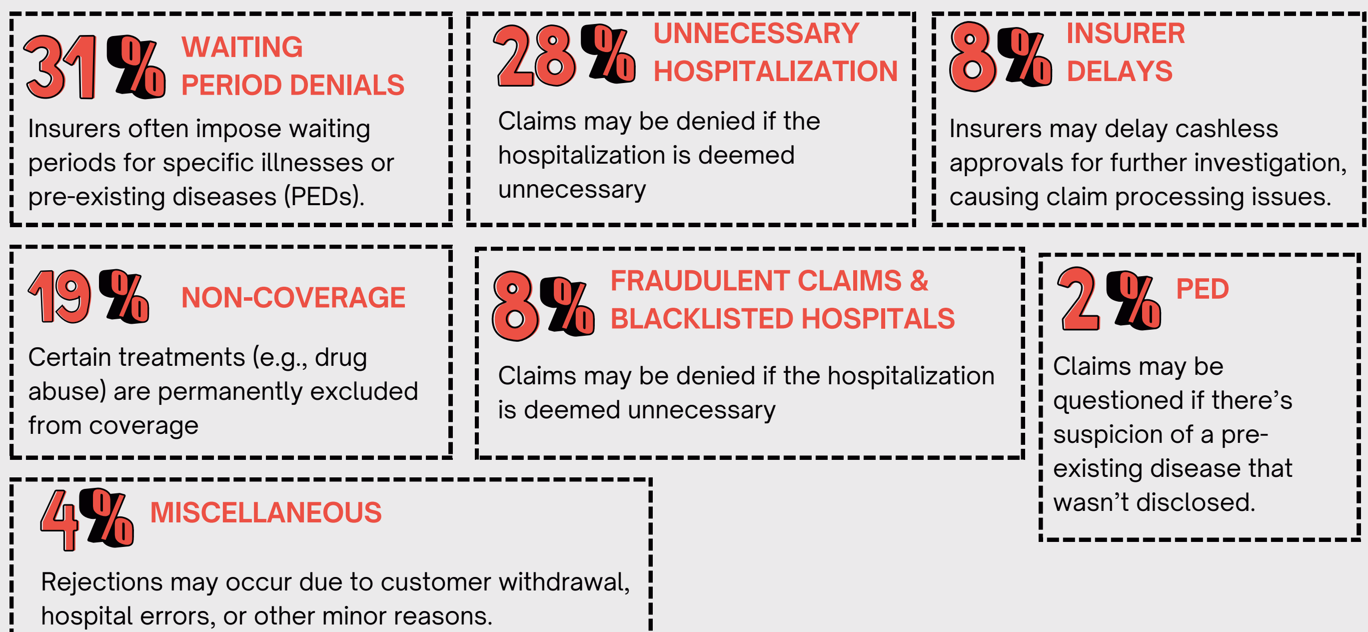
- **Financial Security:** The moratorium period allows insurers to collect premiums for five years before they are liable for claims related to PEDs. This financial buffer helps maintain affordable premium rates across the board. By preventing individuals from purchasing insurance only after being diagnosed with a serious illness, it reduces the overall financial risk for insurers and helps keep premiums manageable for all policyholders

- **Encouragement of Early Insurance Purchase:** The new moratorium period encourages individuals to secure health insurance earlier in life rather than waiting until they develop health issues. This proactive approach not only benefits consumers by providing coverage sooner but also helps maintain a balanced risk pool within the insurance industry.

- **Limitations Remain:** It is crucial for policyholders to understand that while claims related to PEDs will be honoured after the five-year period, exclusions specified in their policies still apply. Claims deemed fraudulent or those related to permanently excluded conditions will not be covered

The introduction of a five-year moratorium period represents a significant improvement in health insurance regulations in India, benefiting both existing and new policyholders. By ensuring coverage for pre-existing conditions after this period and promoting transparency and early purchase of insurance, the IRDAI's guidelines aim to create a more equitable health insurance landscape. Policyholders should remain vigilant about their policy terms and ensure they disclose all relevant medical information to maximize their coverage benefits.

KEY REASONS FOR CLAIM REJECTION



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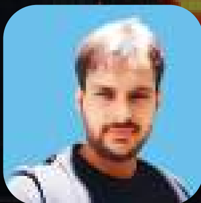
How AI is Redefining Claims Processing for TPAs



VISHAL DEVALIA
PRODUCT MANAGER, ACCENTURE

Work of Third-Party Administrators (TPAs) in insurance often goes unnoticed, yet it is critical. They are the bridge between insurers and customers, ensuring claims are processed fairly and efficiently. But with rising claims volumes and increasing customer expectations, the cracks in traditional systems are becoming visible. This is where Artificial Intelligence (AI) steps in not as a magic wand, but as a transformative tool that can empower TPAs to handle claims faster, more accurately, and with greater consistency.

Take fraud detection, for instance. Fraudulent claims have always been a major challenge, costing insurers and TPAs time, money, and trust. With the help of AI, TPA's can analyze historical data, detect patterns, and flag anomalies far faster than a human ever could. Think about identifying a pattern of repeated claims from similar accounts across different regions, something that could easily slip through manual processes. With AI, such red flags are raised in real time, saving resources and enabling proactive responses.

Another game changer is AI's ability to simplify data integration. TPAs often juggle information from emails, WhatsApp, digital forms, and more. Manually consolidating this data is labor intensive and prone to errors. AI can pull it all together, structure it, and even highlight actionable insights. Picture a scenario where accident details from multiple sources are instantly compiled into a coherent claim file. What once took days can now happen in minutes

Speed is another area where AI shines. In today's world where customers expect instant solutions, manual claims processing often feels painfully slow. AI can help in automating repetitive tasks, like document verification or initial assessments, allowing TPAs to focus on complex, high value claims

Of course, no technology is perfect, and AI is no exception.
Challenges remain.
Biases in AI systems can lead to unfair claim denials, eroding trust in the process. Data privacy concerns loom large, especially when sensitive customer information is at stake. Many TPAs also face the uphill battle of integrating AI with outdated systems, and employees often fear being replaced by machines. But these challenges are not insurmountable. To tackle biases, insurers and TPAs must collaborate to train AI models on diverse datasets and continuously monitor their performance. On data privacy, robust cybersecurity measures and strict compliance with global laws can help build trust. Upgrading legacy systems doesn't have to be overwhelming, modular AI solutions can be introduced gradually, ensuring minimal disruption. And when it comes to the workforce, the focus should be on empowerment.AI is not here to replace people but to support them.

With the right training, employees can work alongside AI, leveraging its strengths while applying their own expertise to nuanced cases. At its heart, AI is about creating a better experience for everyone involved TPAs, insurers, and customers. For TPAs, it's an opportunity to handle claims with speed and precision. For insurers, it means optimizing risks and improving profitability. And for customers, it promises faster, fairer outcomes. But as we embrace AI, we must ensure that the human element remains central. Ethical deployment, transparency, and collaboration will be the keys to unlocking AI's full potential in claims processing. But as we embrace AI, we must ensure that the human element remains central. Ethical deployment, transparency, and collaboration will be the keys to unlocking AI's full potential in claims processing.

Bharat Hirji Dedhia Vs Union of India and
The Oriental Insurance Company Ltd.

Landmark Judgment on Insurance Ombudsman Compliance

In a significant judgment, the Court addressed the gross misconduct of an insurance company in failing to comply with an Insurance Ombudsman's award. The case, involving Writ Petition Nos. 2903 of 2021 and 706 of 2024, highlights critical issues in the insurance sector, particularly concerning the enforcement of Ombudsman awards, the accountability of public sector insurance companies, and the rights of policyholders. This article delves into the Court's observations, the legal principles applied, and the broader implications for insurance law and governance.

Background of the Case

The dispute arose when Bharat Dedhia, the policyholder, approached the Insurance Ombudsman regarding the partial repudiation of his health insurance claim. The Ombudsman issued an award in Bharat's favor on 03 May 2021, directing the insurance company to settle the claim. However, the insurance company failed to comply with the award within the stipulated 30-day period as mandated by Clause 17(6) of the IRDA's Notification dated 25 April 2017.

Instead of honoring the award, the insurance company delayed compliance, citing frivolous reasons and filing Writ Petition No. 706 of 2024 to challenge the award. This petition remained pending for over three years due to the company's failure to clear procedural objections. Meanwhile, Bharat filed Writ Petition No. 2903 of 2021 to enforce the Ombudsman's award

Key Observations by the Court

Suppression of Material Facts: The Court noted that the insurance company willfully suppressed relevant documents, including an email dated 17 June 2021, in which the company assured Bharat that his file was being processed for payment. This suppression was deemed a deliberate attempt to mislead the Court and harass the policyholder.

Non-Compliance with IRDA Regulations: The Court emphasized the mandatory nature of Clause 17(6) of the IRDA's Notification, which requires insurance companies to comply with Ombudsman awards within 30 days. The company's failure to do so, coupled with its lack of interim relief from the Court, was a clear violation of the regulation. The Court observed that such conduct undermines the purpose of the Ombudsman mechanism, which is designed to provide expeditious resolution of disputes.

Frivolous Challenges and Delay Tactics:
The insurance company's challenge to the Ombudsman's jurisdiction and reliance on an unsigned proposal form were dismissed as frivolous. The Court noted that these arguments were never raised before the Ombudsman and were introduced as an afterthought. Furthermore, the company's deliberate delay in clearing procedural objections for over three years was criticized as an attempt to avoid compliance with the award

Accountability of Public Sector Insurance Companies: The Court expressed strong disapproval of the insurance company's conduct, stating that public sector entities have a higher responsibility to act fairly and transparently. The company's actions were described as grossly unreasonable, and its argument about protecting public money was rejected. The Court observed that such delays and frivolous defenses ultimately result in greater financial losses, including interest and exemplary costs, which are borne by public funds.

Court's Directions and Penalties

The Court dismissed Writ Petition No. 706 of 2024 with exemplary costs of Rs. 1,00,000, to be paid to Bharat within four weeks. Additionally, the company was directed to pay interest at 7% per annum on the awarded amount, commencing from 01 July 2021, the date by which the award should have been complied with.

To ensure accountability, the Court directed the Regional Manager or a high-ranking officer of the insurance company to conduct an inquiry to identify the officials responsible for the delay. The costs and interest paid to Bharat were to be recovered from these officials, with appropriate entries made in their confidential records. The Court emphasized that such measures are necessary to deter irresponsible decision-making and harassment of policyholders

Broader Implications and Recommendations

Strengthening Compliance Mechanisms: The Court highlighted the need for stricter enforcement of IRDA regulations. It suggested that the IRDA consider implementing a digital monitoring system to track the status of Ombudsman awards and ensure timely compliance. The Court also recommended that the IRDA issue further directions or advisories to health insurance providers to prevent similar instances of non-compliance

Protecting Policyholders' Rights: The judgment underscores the importance of protecting policyholders, particularly senior citizens, from harassment and delays in claim settlements. The Court noted that such delays not only cause financial hardship but also erode trust in the insurance sector

Accountability in Public Sector Entities: The Court's insistence on fixing personal accountability for officials responsible for delays sets a significant precedent. It reflects the principle that public sector entities must prioritize the welfare of citizens and act in accordance with constitutional and statutory provisions.

The judgment is a clear wake-up call for public-sector insurers to honor their legal obligations and act in good faith. The Court's directives demand reforms that ensure prompt claim settlements and enforce accountability for wrongdoing. By underlining policyholders' rights and insurers' duties, the decision reinforces fairness, transparency, and accountability in the insurance sector. The ruling also recognizes the evolution of administrative law, ensuring that public authorities are held responsible and policyholder protections aren't undermined by bureaucracy or deliberate non-compliance.

Click Here or scan the QR Code to access the Judgement

LEGAL INSIGHTS

Insurance Liability for Paid Cleaner in MACT

The Patna High Court, in its judgment dated 06.08.2024 in Shri Ram General Insurance Co. Ltd. v. Radha Devi & Ors. (Miscellaneous Appeal No. 443 of 2019), addressed critical issues concerning the liability of insurance companies in motor accident claims, particularly in cases involving paid employees such as cleaners. The judgment, delivered by Hon'ble Justice Sunil Dutta Mishra, provides significant insights into the interpretation of insurance policies, statutory liabilities under the Motor Vehicles Act, 1988, and the rights of claimants in motor accident cases.

Case Background

The case arose from a tragic motor accident on 26.03.2017 near Vaura Bridge on Gangta Main Road, where a tractor with a trailer overturned due to rash and negligent driving, resulting in the death of the cleaner, Premshankar Modi. The deceased's wife and minor children (respondents 1 to 4) filed a claim petition under the Motor Vehicles Act, 1988, seeking compensation for the loss of their breadwinner. The learned Additional District Judge-V-cum-Motor Accident Claims Tribunal (MACT), Munger, awarded compensation of ₹11,93,000/- with 6% interest per annum to the claimants. The insurance company, Shri Ram General Insurance Co. Ltd., challenged this award before the Patna High Court.

Key Issues Raised

The appellant insurance company raised several objections, including:

1. **Status of the Deceased:** The insurance company argued that the deceased was not a cleaner but a gratuitous passenger, as the tractor had a seating capacity of only one person.
2. **Purpose of the Vehicle:** It was contended that the tractor, insured for agricultural purposes, was being used for commercial purposes (transporting iron rods), violating the terms of the insurance policy.
3. **Quantum of Compensation:** The appellant challenged the assessment of the deceased's income at ₹7,200/- per month and the addition of 25% towards future prospects, arguing that the deceased was not a permanent employee.

Court's Observations and Findings

Status of the Deceased: The Court rejected the appellant's contention that the deceased was a gratuitous passenger. It held that the deceased was a paid cleaner employed by the owner of the tractor, as evidenced by the insurance policy (Exhibit 8), which included a premium for the legal liability of a paid cleaner. The Court emphasized that a cleaner employed by the owner cannot be categorized as a gratuitous passenger. The Court referred to Section 147 of the Motor Vehicles Act, 1988, which mandates insurance coverage for paid employees, including drivers and cleaners, under a valid insurance policy. By accepting an additional premium for the cleaner's liability, the insurance company had extended its coverage to include the deceased

Purpose of the Vehicle: The insurance company's argument that the tractor was being used for commercial purposes was dismissed. The Court noted that the appellant had not raised this objection before the Tribunal and failed to provide any evidence to substantiate the claim. The insurance policy explicitly covered third-party liability, including risks associated with the paid cleaner, irrespective of the vehicle's use at the time of the accident.

Quantum of Compensation: The Court upheld the Tribunal's assessment of the deceased's income at ₹7,200/- per month, based on the minimum wages for unskilled labor at the relevant time. It observed that the insurance company had not presented any evidence to contradict this assessment.

Further, the addition of 25% towards future prospects was deemed appropriate, in line with the Supreme Court's guidelines in National Insurance Company Ltd. v. Pranay Sethi & Ors. (2017) 16 SCC 680. The Court reiterated that compensation under the Motor Vehicles Act is intended to be just and fair, and mathematical precision is not required.

Liability of the Insurance Company: The Court emphasized that the insurance company could not evade its liability after accepting an additional premium for the cleaner's coverage. It held that the insurer's liability extends to risks covered under the policy, including the death of a paid cleaner. The Court distinguished the present case from earlier judgments cited by the appellant, where the deceased were gratuitous passengers, and clarified that those precedents were not applicable to the facts of this case

Court's Decision

The Patna High Court dismissed the appeal, affirming the Tribunal's award of ₹11,93,000/- with interest to the claimants. The Court directed the insurance company to deposit the awarded amount within eight weeks, after deducting any amount already paid. It also ordered the statutory deposit made by the appellant to be transmitted to the Tribunal for disbursement to the claimants

Legal Implications

This judgment underscores several important principles in insurance law:

- **Coverage of Paid Employees:** When an insurance policy includes an additional premium for paid employees such as cleaners, the insurer is liable to indemnify the owner for claims arising from their employment
- **Gratuitous Passenger vs. Paid Employee:** The distinction between a gratuitous passenger and a paid employee is crucial in determining the insurer's liability. A cleaner employed by the owner cannot be treated as a gratuitous passenger.
- **Purpose of Vehicle Use:** Insurers must raise objections regarding the misuse of insured vehicles at the earliest stage and provide evidence to support such claims.
- **Assessment of Compensation**: Courts adopt a liberal approach in assessing compensation under the Motor Vehicles Act, ensuring that claimants receive just and fair compensation for their loss

The Patna High Court's judgment in Shri Ram General Insurance Co. Ltd. v. Radha Devi & Ors. is a landmark decision that reinforces the statutory liability of insurance companies under the Motor Vehicles Act, 1988. It highlights the importance of adhering to the terms of insurance policies and provides clarity on the insurer's obligations towards paid employees. This case serves as a significant precedent for future disputes involving the liability of insurers in motor accident claims

Click Here or scan the QR Code to access the Judgement

LEGAL INSIGHTS

From Clerical Errors to Credibility

A Detailed Look at GNE Exports Pvt. Ltd. vs. The New India Assurance Co. Ltd.

When administrative mishaps intersect with contractual obligations, the court's interpretation can shape the very contours of consumer rights. In M/s GNE Exports Pvt. Ltd. ("the Complainant") vs. The New India Assurance Co. Ltd. ("the Opposite Party"), the Delhi State Consumer Disputes Redressal Commission dissected how "clerical errors," if left unaddressed, can nullify—or unjustly deny—legitimate insurance claims. The judgment illuminates core consumer law principles, especially regarding "deficiency in service" within the insurance sector.

Case Background

The Complainant, a company engaged in manufacturing and trading of garments, purchased a Standard Fire and Special Peril Insurance Policy from the Opposite Party for the period of 08 January 2013 to 07 January 2014. The sum insured was set at INR 1 crore in respect of the premises at Room No. 6–10, B-31–32, G-32, Ground Floor, Masjid Moth, South Extension, New Delhi-110049.

However, once issued, the policy erroneously mentioned “First Floor” instead of “Ground Floor” and even referred to “Gurgaon-110049” instead of New Delhi. On 14 January 2013, an endorsement was issued to correct these details, backdated to the original date of the policy.

On 14 January 2013, a fire broke out at the ground floor of the insured premises, causing the Complainant estimated damages of approximately INR 95 lakhs. The Delhi Fire Service, when called to the scene, confirmed the fire took place on the ground floor.

The insurer appointed M/s Sanjay Dwivedi & Associates as surveyor, who eventually assessed the loss at INR 73,57,656/-. The Complainant lodged the claim on 21 January 2013. The insurer, despite being made aware of the address issues and having already issued a policy endorsement, delayed its response. Ultimately, by letter dated 08 August 2014, it repudiated the claim on grounds that the policy covered the first floor, not the ground floor.

The Complainant first approached the National Consumer Disputes Redressal Commission (NCDRC) but withdrew the complaint once it became clear that the dispute’s value did not meet the National Commission’s threshold. Consequently, it refiled before the Delhi State Consumer Commission, demanding ₹73,57,656/- plus 18% interest, as well as ₹4 lakhs for compensation and litigation costs.

Key Contentions

- Whether the Complainant qualified as a “consumer” under the Consumer Protection Act, 1986.
- Whether the complaint involved such complex facts and law that it could not be decided under summary proceedings of the Consumer Protection Act.
- Whether there was any deficiency in service on the part of the insurer, given the address discrepancy and related factual matrix

Complainant as Consumer

The insurer objected to the Commission’s jurisdiction, insisting that the Complainant was not a “consumer” under Section 2(1)(d) of the Consumer Protection Act, 1986. Citing Regional Provident Fund Commissioner vs. Shiv Kumar Joshi (2000) 1 SCC 98 and other precedents, the Commission held that a person who avails services of an insurer for consideration indeed qualifies as a consumer—even if these services relate to a commercial activity. Hence, the State Commission did have jurisdiction over the matter.

Complexity of Issues

The Opposite Party argued that the matter involved complex questions necessitating a civil trial. Relying on J.J. Merchant vs. Shrinath Chaturvedi (2002) 6 SCC 635, the Commission clarified that consumer fora, especially at the State and National levels, are headed by senior judicial figures entirely competent to adjudicate complex factual and legal disputes. Therefore, State and National Commissions ensures that complex issues can be appropriately analyzed in consumer proceedings.

Deficiency in Service

Under Section 2(1)(g) of the Consumer Protection Act, deficiency in service is defined as a fault, imperfection, or inadequacy in performance. The Commission found that the Opposite Party had indeed committed such a deficiency.

Despite having surveyed the premises before issuing the policy, the insurer inserted an incorrect address ("First Floor" and "Gurgaon-110049"). The Complainant alerted them of these mistakes, and a corrective endorsement was made on 14 January 2013—retroactive to the policy's start date. The insurer nonetheless repudiated the claim, asserting the policy did not cover the ground floor.

Judgment & Reliefs Granted

The Commission directed the Opposite Party to pay the Complainant ₹73,57,656/-, in line with the surveyor's assessment, along with interest at 6% per annum from the time the complaint was lodged until judgment; if payment is not made within the specified grace period, the interest rate increases to 9% per annum from the original due date.

Referencing Oriental Insurance Co. Ltd. vs. Ozma Shipping Company & Anr, the Commission critiqued how insurers' reluctance to settle valid claims erodes trustworthiness. The Commission's stance was that an insurer must embrace a good-faith approach to avoid undue litigation and additional interest liabilities

Takeaway & Broader Significance

In this ruling, the Commission underscores several pivotal consumer law principles, particularly in the context of insurance disputes.

Enhanced Accountability for Insurers: The judgment makes it clear that insurers will be subject to rigorous scrutiny if they repeatedly cite "administrative" mistakes. Such persistent errors can easily cross over into negligence. In cases where the policy covers a substantial amount, insurers bear an even higher responsibility to verify the accuracy and completeness of policy documentation before issuing it to the client.

Endorsements Relate Back to Original Policy Term: A key finding is that endorsements intended to rectify errors generally take effect from the inception date of the policy, rather than from the date the mistake was discovered or corrected. This principle applies especially when the record shows no intent on the insured's part to deceive. Essentially, a crucial policy detail that was mistakenly omitted (or included

incorrectly) will still be seen by the law as if it were correct from the start.

Consumer-Focused Jurisdiction Despite Complexity: The Commission reinforced that the “complexity” of a case—such as involving extensive evidence or large financial stakes—does not exclude jurisdiction under consumer protection laws. The Consumer Protection Act is designed to offer swift, specialized remedies, ensuring that both individuals and commercial entities can seek relief without being forced into protracted litigation in more formal courts.

Practical Lessons for Policyholders: From the policyholder’s standpoint, the decision highlights the importance of routinely examining every page of a newly issued insurance policy and promptly requesting changes when errors are spotted. The policyholder in this case diligently pursued corrections, and that consistent paper trail significantly strengthened their position in the dispute.

Broad Definition of “Consumer”: Another cornerstone of the decision is that the term “consumer” is to be interpreted liberally. Explicitly, those who purchase insurance are classified as consumers, regardless of whether the insured property or service is intended for commercial use.

Jurisdiction & Complexity: The Commission pointed out that calling an insurance dispute “complex” isn’t sufficient grounds to route it away from consumer forums. Experienced judicial officers in these forums are well equipped to handle intricate factual issues, thereby preventing unnecessary diversion to other legal avenues.

Deficiency in Service & Claim Validity: Once the insurer formally takes responsibility for a technical or administrative mistake, it cannot later use that same oversight to repudiate a claim that would otherwise be valid. Essentially, an insurer cannot have it both ways: if they acknowledge an error, they must stand by the policyholder if a legitimate claim arises.

Good Faith & Policy Rectification: Backdating endorsements to reflect the correct coverage from the outset is common practice in the insurance industry. Once an endorsement is issued for a past inaccuracy, the coverage effectively spans the entire original duration, rather than starting from the date of rectification.

The judgement collectively underscore the Commission’s commitment to safeguarding policyholders against unjust claim denials. Insurers are thereby encouraged to adopt a fair and transparent approach and to resolve legitimate claims swiftly, rather than seeking refuge in technical ambiguities or administrative loopholes.

Click Here or scan the QR Code to access the Judgement

General Insurance News In Brief

The Economic Times Industry

India's non-life Insurance industry may register double-digit growth in 2025

Despite flat general insurance penetration in the country, the non-life insurers are expecting to register double-digit growth in 2025 with a conducive regulatory environment and launch of innovative products catering to specific customer needs, stakeholders said on Thursday. The

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India's non-life insurance industry anticipates robust double-digit growth in 2025, supported by a conducive regulatory environment, product innovation, and potential GST relief and revisions to motor third-party rates. Health insurance remains a key driver; however, insurers also see a surge in non-motor and non-health segments such as pet, liability, professional indemnity, and housing insurance. Digital technologies are expected to enhance affordability and accessibility, with Bima Sugam, Bima Vistaar, and Bima Vahaks boosting coverage and efficiency.

Increased insurance density—from USD 22 to USD 25—reflects growing market maturity, and removing GST on health insurance could further improve penetration. Overall, the sector is expected to emerge as a "true partner in progress," integrating digital solutions, expanding product offerings, and leveraging public infrastructure to meet rising consumer needs and sustain its position as one of the fastest-growing insurance markets among the G20 nations.

In 2025, the Indian insurance sector will drive growth by expanding into rural areas, embracing AI- and ML-based technologies, and strengthening distribution and human capital. Companies plan to launch simpler, bite-sized products delivered through hybrid channels ("phygital") to better engage untapped regions. Regulators are also introducing reforms like Bima Sugam, IFRS adoption by FY25, and revisions to FDI and GST rules. These changes, along with composite licenses and increased presence in Tier II and III cities, are expected to transform the industry. Overall, insurers aim to enhance customer experience, streamline processes, and broaden coverage across the country.

Insurers to double down on tech, rural expansion for growth in '25

Industry will also focus on strengthening distribution networks and human capital

GROWTH PLANS

2025: THE OUTLOOK

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> All our knowledge begins with the senses, proceeds then to the understanding, and ends with reason. There is nothing higher than reason.
>
> **–Immanuel Kant**

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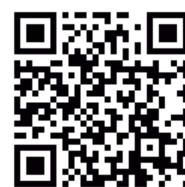

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