Ref: IRDAI / Enf / ORD / ONS /082/04/2021

Order in the matter of Future Generali India Insurance Co Ltd

Based on

(i) Show Cause Notice ('SCN') bearing No.IRDA/Enforcement/2018/Enf/SCN/FGICL dated 28th October, 2020 in connection with the on-site inspection conducted by the Insurance Regulatory and Development Authority of India ('the Authority' or 'IRDAI') during 15th to 25th January, 2018.

(ii) Response of Future Generali India Insurance Co Ltd ("company" or "the insurer") dated 30th November, 2020.

(iii) The submissions made by the insurer during the personal hearing held on 11th January, 2021 at 3.00 PM, taken by the Chairman of the Authority through video conference.

Background:

1. The Authority had conducted an onsite inspection of Future Generali India Insurnace Co Ltd during 15th to 25th January, 2018. The inspection report, inter alia, revealed certain violations of provisions of the Insurance Act,1938, Regulations, Guidelines and various circulars issued thereunder.

2. A copy of the inspection report was forwarded to the insurer on 21st February, 2018 seeking their response. On examining the submissions made by the insurer vide its letter dated 23rd March, 2018, a show cause notice (SCN) was issued on 28th October, 2020. The insurer responded to it vide letter dated 30th November, 2020.

3. As requested by the insurer, an opportunity for personal hearing was granted on 11th January, 2021. Mr.Anup Rau, MD & CEO, Mr. Shreeraj Deshpande, COO, Mr. Devi Dayal Marg, CFO, Mr. Jatin Arora, Appointed Actuary, Mr.Ashish Lakhatia, CCO and Ms. Lakshmi Chaya, Sr.Manager-Compliance represented the insurer. On behalf of the Authority, Mr. Prabhat Kumar Maiti, GM (Enforcement), Mr. R.K.Sharma, GM (F&A-NL), Mr.K.Mahipal Reddy, GM (NL) and Mr. K.Sridhar, AGM (Enforcement) were present.

4. The submissions made by the insurer in reply to the SCN and those made during the personal hearing on 11th January, 2021 and subsequently on 19th and 29th January, 2021 have been carefully examined and the details are as follows:

5. Charge 1:

Violation of Clause 1(1) (i) of Schedule-I to IRDAI (Assets, Liabilities, and Solvency Margin of General Insurance Business) Regulations, 2016.

Inadmissible co-insurance balances of Rs.48.63 crore were considered by insurer in the calculation of Available Solvency Margin during the financial year 2016-17.

6. Summary of submissions by the insurer:

The company submitted that the amount is recoverable from a general insurer and pertains to FY 2014-15. The receivable is under dispute and is pending with a Mumbai court. The amount has not been considered for solvency calculation from FY 2018-19 after receiving an advisory from Authority vide letter dated 19th September, 2018. It was assured that such error will not be repeated.

7. Decision:

The insurer considered co-insurance balances outstanding for more than 90 days in arriving at solvency ratio till FY 2017-18. The Authority while reviewing the financial statements of the insurer of FY 2016-17 noticed this issue and has advised the insurer on 19th September, 2018 not to consider such inadmissible co-insurance receivables from FY 2018-19 in arriving at solvency margin calculation. In this regard, the insurer has confirmed dis-allowing such inadmissable receivables in solvency calculation from FY 2018-19 onwards. The insurer is hereby advised to ensure strict compliance to Clause 1(1) (i) of Schedule-I to IRDAI (Assets, Liabilities, and Solvency Margin of General Insurance Business) Regulations, 2016 at all times.

8. Charge 2:

Violation of

- Regulation No.12 (4) of IRDAI (Insurance Surveyors and Loss Assessors), Regulations, 2015; which envisages that the appointment of a surveyor for assessment of loss shall be made within 72 hours, from the time the occurrence of loss was known to the insurer. Notice of such appointment shall be sent in writing to the insured and shall form part of the claims settlement process.
- Regulation No. 9 (1) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 which envisages that in case a surveyor has to be appointed for assessing a loss, it shall be so done within 72 hours of the receipt of intimation from the insured.

On examining sample cases, delays of 3 to 12 days were observed in seven cases in the appointment of surveyor by the insurer against the stipulated time limit of 72 hours. Moreover, the insurer does not have the practice to send a written communication about the appointment of surveyor to claimants of motor claims.

9. Summary of submissions by the insurer:

The insurer submitted that the company appoints the surveyor within 72 hours upon receipt of complete information and documents from the claimant. The insured is regularly updated on the status of the appointment of surveyor. However, there may be occasions where there is a delay in appointing surveyor due to several reasons such as insufficient information provided by claimant, non availability of claimant to the surveyor, holiday/weekends, etc. The company stated that it also communicates the details of appointment of the surveyor to the insured as soon as the empanelled surveyor is available to conduct the survey at the relevant location. Of the sample seven cases referred in the charge, insurer submitted that incomplete claim details were received in 4 claim cases, intimation date was wrongly captured in one claim case, and the rest two were claims under project policy which were reported just before policy extension, which lead to delay. The insurer stated that the company has no intention or efforts to delay the appointment.

10. Decision:

The insurer is advised to ensure that the surveyor is appointed within 72 hours of the claim intimation for timely assessment of loss and settlement of claim. Proper guidance should be given to the claimant on the claim requirements. Intimation should be given to the claimant on the surveyor appointment.

11. Charge 3:

Violation of Regulation 9(5) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.

In case of motor theft claims, the insurer deducted 0% to 30% of the Insured Declared Value (IDV) from the claim payment when one key is not submitted by the claimant. There was inconsistency in the approach/procedure adopted by the insurer by deducting certain percentage of theft claim in case of one lost key, in an arbitrary and non-transparent manner.

12. Summary of submissions by the insurer:

The company submitted that during the vetting of documentation / investigation it noted that all the original keys were not available with insured when the vehicle was stolen and also neither the key set was replaced nor a complaint was filed in the police station regarding loss of key, which is essential for the customer to safeguard his vehicle from theft loss. The claims can be repudiated as per policy terms and conditions. However, claims were settled after investigation, obtaining claimant consent and according to Standard Operating Procedure (SOP) of the company. The deduction was to enforce future discipline amongst the claimant to act prudently as if he is uninsured. The company has revised the SOP to limit the percentage of deduction and ensures that it does not cross the maximum percentage specified in the SOP. The company informed that the motor theft claims comprise 1% of the total motor claims and again the lost key cases of theft claims comprise 1% of the total motor theft claims.

13. Decision:

Though there is possibility of contributory negligence and/or breach of material condition on the part of claimant by not taking appropriate care of the original keys to safeguard the insured vehicle, at the same time, the insurer also has the responsibility to build trust with the policyholders by laying down a clear policy on how to decide such cases unambiguously so that there is no scope for arbitrariness in settlement of claims.

As such, the insurer is directed to take the following measures:

(a) Have a Board approved policy on what constitutes a non-standard claim and what type of claims can be settled on non-standard basis.
(b) Have a more comprehensive SOP enabling uniformity and consistency in approach in claim deductions for claims settled on non-standard basis.
(c) Maintain transparency through appropriate communication to the claimants highlighting the relevant policy condition(s) which is/are invoked alongwith the rationale for deduction.
(d) Educate and orient the marketing staff and the prospects/policyholders at the point of sale/renewal on the need of original keys at the time of claim.
(e) Inform the requirement of original keys for claim settlement and timely intimation of claim, in its regular communications with the prospect/insured.
(f) Ensure that the the deduction from the theft claim is carried in a transparent, consistent manner only after communicating the rationale to the claimant.

14. Charge 4:

Violation of

a. Regulation No.9 (2 & 5) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.
b. Clause No. 6 of the Corporate Governance Guidelines issued by IRDAI vide Ref. No. IRDA/F&A/CIR/025/2009-10 dated 5th August, 2009.

In a sample of six claim cases, delay is observed in

- Submission of surveyor's report.
- Appointment of investigator.
- Raising a query/clarification, if any, immediately after receipt of survey/investigator report and no follow-up reminder.
- Settlement/repudiation of claim after receipt of all requirements.
- By seeking information in piece meal basis leading to delay in claim decision.

15. Summary of submissions by the insurer:

The insurer submitted various reasons for delay in submission of surveyor/investigation report. The insurer submitted that they were regularly in touch

with the insured and they further submitted that the delay was due to the time taken in the process followed by them or failure/non-co-operation on the part of the insured. The insurer submitted that all the sample cases were of motor theft claims where an investigator was appointed. The investigator was appointed after examining actual circumstances of each case requiring investigation based on the submissions of claimant/RTO, etc. If insufficient documents are submitted by claimant either to the company or to the investigator, the company follows-up for the pending requirements. The insurer submitted that they would inform the claimant in the follow-up letters that any delay in submission would lead to delay in claim settlement. In support of submission, insurer provided details/documents of the follow-up letters addressed to the claimants.

16. Decision:

The insurer is directed to ensure that the claimant is properly guided at the claim intimation stage on requirement of documents. This should be followed-up with the claimants till all requirements are fulfilled. The insurer should monitor the pending loss assessment reports from the surveyor/investigator and follow-up with them at periodic intervals for pending reports. In case of any delay in settlement of claim on the part of the insurer, the insurer shall settle the claim with penal interest in accordance with the provisions of Regulation 15(1) and 16 of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 read with Para 1(c) (i to iv) of Authority circular ref.no.IRDA/CAD/Cir/PPHI/059/04/2019 dated 10th April, 2019.

17. Charge 5:

Violation of

a) Regulation 27(iv & v) of IRDAI (Health Insurance) Regulations, 2016 by not following up with claimants for requirements, repudiating claims on the reason of non-receipt of documents, not settling claims based on merits/available documents as per the terms and conditions of the policy and non-receipt of a document shall not be the basis for rejection of claim nor claims shall be closed.
b) Regulation 8 (d) (v) of IRDA (Health Insurance) Regulations, 2013.
c) Regulation 13 (3) and 15 (1, 4, 8 & 9) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by not following up with claimant, not informing the claimant of mandatory claim requirements on claim notifications and not having an internal control mechanism to ensure that the clear reasons/grounds of rejection are properly communicated to the claimants, so as to enable them to respond appropriately and to claim the amount.

It was observed that after receipt of claim intimation from the insured with regard to health and individual personal accident claims, there was no further communication from insurer to claimants and the claims were closed under the category of "Closed with out Payment" or "Repudiation".

18. Summary of submissions by the insurer:

The company submitted that if a customer submits claim documents after a rejection of the claim, these documents are processed as per the policy terms to settle the claims. A proper communication is sent in writing to the insured member immediately after claim intimation asking for the documents to be submitted. The company sends 3 reminders in all the cases of pending health claim requirements, after intimation of claim and no repudiation is done for non-submission of documents. The matter is followed up for all cases with deficient documents. The company stated that only after multiple reminders, the claims were rejected duly recording the reasons.

19. Decision:

The Authority notes from the insurer's submission that the claims were re-opened and settled on receipt of mandatory claim documents and also reminders were sent at periodic intervals for pending requirements.

Taking note of the above submissions, the Authority directs the insurer to ensure compliance to

- Regulation 15 (8 & 9) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by having proper internal control mechanism to ensure that the clear reasons/grounds of rejection are properly communicated to the claimants, so as to enable them to respond appropriately and to claim the amount.

- Regulation 13(3) and 15(1) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 by keeping informed to the claimant of all the mandatory claim requirements at the time of receipt of claim form and to collect requisite contact details for follow-up.

- Regulation 15(4) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017 read with Authority circular with ref.no.IRDA/CAD/Cir/PPHI/059/04/2019 dated 10th April, 2019, by following up with claimants through intermediary, e-mail, mobile SMS and any other channel on the pending claim requirements.

- Regulation 27(v) of IRDAI (Health Insurance) Regulations, 2016 by settling claims based on merits/available documents and as per the terms and conditions of the policy and non-receipt of a document shall not be the basis for rejection of a claim nor shall claims be closed.

- Regulation 27 of IRDAI (Health Insurance) Regulations, 2016 by calling for all documents in the beginning and not in piece meal basis and by not calling for the information which is already collected at proposal stage.

20. Charge 6:
Violation of

- Para 11, Chapter III, of IRDAI/NL/GDL/F&U/030/02/2016 dated 18th February, 2016 and para 2, 11 & 28 of F&U guidelines dated 28/09/2006 read with circular ref.no.IRDA/NL/Cir/F&U/003/01/2011 dated 06-01-2011 by selling un-approved add-on covers without approval of the Authority.
- Regulation 3(2) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 for restricting the available options to the prospect at the point of sale.

In a sample of 17 motor insurance policies, it was found that an add-on cover referred as 'Plan 1-C' was offered by insurer without filing and taking approval from Authority under Product filing procedure. The add-on cover is not filed with the Authority under Product Filing guidelines. The add-on cover was offered without taking consent of the prospect.

21.Summary of submissions by the insurer:
The insurer in its initial submission has stated that the 'Plan 1C' is a bundle of four approved add-on covers, i.e Zero depreciation, loss of key, loss of personal belongings and road side assistance. The covers were bundled for easy identification purpose and the premium/bifurcation was displayed in the policy schedule against each add-on cover.

However, the Insurer in its submission made post personal hearing has stated that the add-on cover 'Plan 1-c' covers only one add-on cover viz. 'consumables' as approved by Authority on 8th December, 2017 and not the four add-on covers as referred in its submission to the show cause notice and as informed during the personal hearing. The insurer also accepted that the add-on cover 'consumables' was offered prior to filing and approval by the Authority.

22. Decision:

From the submissions of the insurer, it is evident that

a) The insurer offered the add-on cover 'Consumables' in the name of Plan 1-C with motor insurance policies, even before filing the add-on cover with the Authority for approval under Product filing procedure.

b) The insurer could only provide copies of proposal forms in 9 out of the sample of 17 cases referred in the charge. In none of the sample cases the insurer could provide any evidence of consent being taken from the prosect to offer the add-on cover 'Consumables'. As such, in all the 17 sample cases referred in the charge, the insurer offered the add-on cover 'Consumables' in the name

of Plan 1-C, without obrtaining the consent of the policyholder in the proposal form. Out of the 17 sample cases, 15 cases were on different dates and two proposals were on a single day. Thus the violation of offering the add-on cover without obtaining consent of policyholder happened on 16 different days which is in violation of Regulation 3(2) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.

For the violation of Product Filing guideline by offering the add-on cover prior to Authority's approval, the Authority levies a penalty of Rs. 1,00,000/- (Rupees One lakh only); by virtue of powers vested under Section 102 (b) of the Insurance Act, 1938.

For the violation of Regulation 3(2) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 on offering the add-on cover without obtaining consent of policyholder which took place on 16 different days, by virtue of powers vested under Section 102 (b) of the Insurance Act, 1938, the Authority levies a penalty of Rs. 16,00,000/- (Rupees sixteen lakh only).

The insurer is directed to ensure that the

i. The products/add-on covers should be offered only after taking the consent of the prospect.
ii. Any add-on cover or a product shall be offered only after filing under the Product filing guidelines and after approval by the Authority.

23. Summary of decisions:

	Violation of Provisions	Decision
1	Clause 1(1) (i) of Schedule-I to IRDAI (Assets, Liabilities, and Solvency Margin of General Insurance Business) Regulations, 2016.	Advisory
2	Regulation No.12 (4) of IRDAI (Insurance Surveyors and Loss Assessors), Regulations, 2015 and Regulation No. 9 (1) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.	Advisory
3	Regulation 9(5) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.	Direction
4	Regulation No.9 (2 & 5) of IRDA (Protection of Policyholders' Interests) Regulations, 2002.	Direction & Advisory
5	Regulation 27(iv & v) of IRDAI (Health Insurance) Regulations, 2016 and Regulation 13 (3) and 15 (1, 4, 8 & 9) of IRDAI (Protection of Policyholders' Interests) Regulations, 2017.	Direction & Advisory
6	Regulation 3(2) of IRDA (Protection of Policyholders' Interests) Regulations, 2002 and Product filing guidelines.	Penalty of Rs.17 lakh, advisory and direction

24. The penalty of Rs 17,00,000 (Rupees Seventeen Lakh) shall be remitted by the insurer through NEFT / RTGS (bank account details will be communicated separately) by debiting shareholders' account within a period of 45 days from the date of receipt of this Order. An intimation of remittance of penalty shall be sent to

Shri Prabhat Kumar Maiti, General Manager (Enforcement), IRDAI, Sy.no.115/1, Financial District, Nanakramguda, Hyderabad-500032.

The Order shall be placed before the Board of the insurer in the upcoming Board Meeting and the insurer shall provide a copy of the minutes of the discussion.

25. If the insurer feels aggrieved by this Order, an appeal may be preferred to the Securities Appellate Tribunal as per the provisions of Section 110 of the Insurance Act, 1938.

Sd/-

Place: Hyderabad
Date: 9th April, 2021

(Dr. Subhash C. Khuntia)
Chairman