Protection of Policyholders' Interests Policy

Version 1.5

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1.0	2017	Draft Prepared	Mr. Anil D'souza, Head Customer Service Mr. Ashwani Gaba, Head Claims
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I. Policy Preamble

IT IS THE POLICY OF Universal Sompo to ensure that:

- All customers are treated fairly and promptly at all times.
- Interests of insurance policyholders' are protected.
- Any complaints/requests raised by customers are dealt with promptly and Professionally.
- Customers are fully informed of their rights to resolution and are encouraged to seek judicial or third party opinion wherever there is any interpretational uncertainty through appropriate consumer forum or otherwise.

II. DEFINITIONS:

1. "Act" means the Insurance Act, 1938 (4 of 1938);
2. "Authority" means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999);
3. "Complaint" or "Grievance" means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities;
4. "Complainant" means a policyholder or prospect or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer or a distribution channel
5. "Cover" means an insurance contract whether in the form of a policy or a cover note or a Certificate of Insurance or any other form as approved by the Authority to evidence the existence of an insurance contract;
6. "Distribution Channels" means persons and entities authorized by the Authority to involve in sale and service of insurance products;
7. "Proposal form" means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted;
8. "Prospect" means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel;
9. "Prospectus": means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products;

III. SCOPE OF POLICY

Protection of Policyholders' Interests Policy

This policy covers all steps taken for enhancing Insurance awareness, to educate prospects and policy holders about Insurance products, prospectus are fully informed at sale stage, their terms and conditions, Turnaround time for all the services rendered, procedure for expeditious resolution of complaints, to prevent mis-selling and unfair business practices at point of sale and service.

1.1 Customer Service: -

The Customer Service department shall be the overall custodian of all Queries, Requests and complaints received at the Branch/Zone level or the Head office. The Customer Service Department shall be inter alia responsible;

a. To ensure timely Redressal of grievances logged in Call Logging system
b. To ensure compliance with the processes laid down by organization and regulator from time to time Universal Sompo General Insurance Co. Ltd Grievance Redressal Policy

c. To escalate cases not actioned within set timelines to ensure Customer satisfaction.
d. To address escalated grievances and undertake steps for timely closure
e. To interact with the Grievance Redressal Officer at Corporate office for closure of Customer Grievances

f. To maintain record of all customer complaints & provide reports based on internal compliance & regulator guidelines and share the same in the Policy Holder's Protection Committee.

1.2 Service parameters including turnaround time –

Various TATs for resolution of complaints are defined as guidelines are mentioned in annexure 2 attached and it is also available on USGIC website under USGIC Grievance Redressal policy and updated as and when approved by the Board.

Service	**Maximum Turn Around Time**
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy /Cancellation. (from the date all requisite documents and sufficient premium is received by the Company)	15 Days
Obtaining copy of the proposal (from date of acceptance of proposal/policy issuance)	30 Days
Post Policy issue service requests concerning mistakes/refund of proposal deposit and also Non-Claim related service requests .(from the date of request /required documents received)	10 Days
General Insurance	

Survey report submission (From the dated of surveyor appointment)	30 days
Insurer seeking addendum report (from receipt of final report)	15 days
Settlement/rejection of Claim after receiving first/addendum survey report	30 days
Grievances	
Acknowledge a grievance (from the date of grievance received)	3 days
Resolve a grievance (from the date of grievance received)	15 days

The service parameters and turnaround times as approved by the Board shall be displaced on the Website and the same shall be updated as and when the service parameters are revised by the board.

1.3 Procedure for expeditious resolution of complaints –

As most of the complaints and grievances are related to Claims/Operations/Marketing, the Company has included all the Heads of the Departments in the Grievance Redressal Mechanism. Any customer, who wishes to approach the company with any complaint or query, is facilitated with the following modalities:

Call Center: Customers can contact Customer Service Call Centers on Toll free numbers.

- 1800-22-4030 & 1800-200-4030
- 1800-200-5142 (Crop Toll Free)
- 1800-267-4030 (Sr. Citizen)

Branch: Customers can walk into any branch of the Company.
E-mail: Customers can e-mail their issues to

- contactus@universalsompo.com
- Nitesh.Pandey@universalsompo.com
- Melvin.Dsouza@universalsompo.com

To register complaints

- Grievance@universalsompo.com
- GRO@universalsompo.com
- Varsha.Gujarathi@universalsompo.com

Integrated Grievance Management System Portal/Interface of IRDAI

Any other future portals/interfaces mandated by IRDAI or such authorities

Letters:
Customers may send a letters to:

Any of Universal Sompo GICL offices/ Grievance Department of Corporate Office.

Universal Sompo General Insurance Company Limited
103, First Floor, Ackruti Star,

MIDC Central Road,

Andheri (East), Mumbai-400093

Upon receipt the Following procedures is adopted:

i. Prioritizing :
References through DPG/Ministry/VIP/IRDAI are attended on top priority basis and replies are sent through Corporate Office to the concerned authorities

ii. Registration of Complaint/Grievance:
The grievance of the policy holder received shall be registered in our Customer Interaction Management System (CIMS) module and a unique number known as Service Request (SR) will be allotted to the grievance.

As per the regulatory guidelines CIMS module is fully integrated with Integrated Grievance Management System (IGMS) of IRDAI wherein grievances logged in CIMS are mirrored in IGMS and IRDAI Token Number is generated in real time. Similarly grievances logged at IGMS are mirrored in CIMS for registration of these grievances. This system also facilitates analysis of complaints, improvement of processes and system, through constant review.

iii. Acknowledgement:
An acknowledgement in writing or through email/ recorded call shall be sent/ Made to the complainant within 3 working days from date of receipt of grievance. In case grievance is resolved within three days, resolution letter will be sent to the complainant along with the acknowledgement.

iv. Referring to concerned office/officer:
Once the complaint is received, registered, acknowledged and categorized, the complaints will be routed to the respective department/ offices who are responsible to work upon them and resolve within TATs and/or report to the Grievances handling team in the prescribed format, whereby they can respond to the customer within TATs.

v .Information to controlling office:

Observations on the complaint/grievance are reported to controlling office for advice.

vi. Time bound settlement:

In respect of grievances not resolved within 3 working days, the same will be resolved within 2 weeks of its receipt and USGIC will arrange to forward the final resolution letter to the complainant on the date of resolution. Various TATs for resolution of complaints are defined as per guidelines mentioned in annexure 2 attached.

vii. Grievance satisfaction and closure:

The resolution letter will redress or reject the grievance and the reasons for the same will be advised to the client. The complainant will also be advised that if no escalation is received from the complainant within 8 weeks from the date of receipt of response from USGIC the grievance will be treated as closed.

A complaint shall be considered as disposed of and closed, when a.
USGIC has acceded to the request of the complainant fully

(or)

b. Where the complainant has indicated in writing, acceptance of the response of the USGIC.
(or)

c. Where the complainant has not responded to the USGIC within 8 weeks of the USGIC written response.
ii. Where the grievance is not resolved in favour of the policyholder or partially resolved in favour of the policyholder, the USGIC shall inform the complainant of the option to take up the matter before insurance ombudsman giving details of the name and address of the Ombudsman of competent jurisdiction.

1.4 Policyholder Protection Committee:-

- Policyholder Protection Committee also has been formed headed by NON Executive Chairman , Managing Director & CEO, One Board Director with members as Chief Grievance Redressal Officer and Head-OPS, Customer Service & Customer Grievance/Head Claims and an expert/representative of customers with a view to put in place systems for addressing the various compliance issues relating to protection of the interests of the policyholders, as also relating to keeping the policyholders well informed of and educated about insurance products and complaint handling procedures and to ensure that policyholders have access to redressal mechanisms and establish policies and procedures, to deal with customer complaints and resolve disputes expeditiously and the same are placed before the board with complete resolution in BOD on quarterly basis.

Protection of Policyholders' Interests Policy

The main objectives of the committee are:

- Adopt standard operating procedures to treat the customer fairly including time-frames for policy and claims servicing parameters and monitoring implementation thereof.
- Establish effective mechanism to address complaints and grievances of policyholders including misselling by intermediaries.
- Put in place a framework for review of awards given by Insurance Ombudsman/Consumer Forums. Analyze the root cause of customer complaints, identify market conduct issues and advise the management appropriately about rectifying systemic issues, if any.
- Review all the awards given by Insurance Ombudsman/Consumer Forums remaining unimplemented for more than three (3) months with reasons therefor and report the same to the Board for initiating remedial action, where necessary.
- Review the measures and take steps to reduce customer complaints at periodic intervals.
- Ensure compliance with the statutory requirements as laid down in the regulatory framework. Ensure adequacy of disclosure of "material information" to the policyholders. These disclosures shall comply with the requirements laid down by the Authority both at the point of sale and at periodic intervals.
- Provide details of grievances at periodic intervals in such formats as may be prescribed by the Authority.
- Ensure that details of insurance ombudsmen are provided to the policyholders.
- Review of Claims Report, including status of Outstanding Claims with ageing of outstanding claims.
- Reviewing Repudiated claims with analysis of reasons.
- Status of settlement of other customer benefit payouts like Surrenders, Loan, and Partial withdrawal requests etc.
- Review of unclaimed amounts of Policyholders, as required under the Circulars and guidelines issued by the Authority. The Board shall review the status report on policyholders' protection issues, submitted by the Committee, in each of its meeting.

1.5 Enhancing Insurance Awareness –

In order to enhance Insurance Awareness USGIC is taking few more steps to support the concept of insurance among people.

- Social media promotions, road shows and customer meets. The focus here is not the brand promotion or advertising, but purely for insurance awareness.
- USGIC would also be using their mobile applications for creating awareness about not only basic policies but also helping potential policyholders.
- USGIC Shares general insurance information through various mediums like TV advertisements, on Radio channels etc, to develop the skills and knowledge to purchase the policy effectively and responsibly.
- Explain the importance of insurance benefits and savings.(Brochure Distribution, Health Camps)
- Programs carried out for consumer education by organizing Health Camps – with Bank partners, Direct Mailers – Ways to secure the property from various perils and vehicle from natural disasters and theft, Brochure S – Products information.
- Initiatives taken to educate consumers in rural areas by Banners, Distribution of pamphlets, posters in regional language

- USGIC shall also take part in more Marathons and distribute Insurance Brochures to create insurance awareness with give away gifts.
- USGIC has also launched products under Common Service Center (CSC) platform to create insurance awareness and to penetrate insurance at rural areas.
- USGIC shall participate in more such exhibition as International Agricultural Trade Fair- Krishithon 2016 to give momentum to the growth of Common Service Center- CSC channel
- Create awareness about Grievance Redressal Mechanisms by initiating a Login on the company website (www.universalsompo.com) as Customer Login.
- USGIC also actively participates in Road safety weeks to create awareness about Insurance.
- Company actively takes part in the consumer awareness programs organized by brokers / Intermediary forum etc
- USGIC has initiated a Quick Link on the Company website (www.universalsompo.com) as Policy Holders Link – IRDAI. Also communicate in vernacular language over phone With PH.
- USGI established Five Agency Recruitment centres in four States namely West Bengal, UP, Karnataka (Bangalore), Maharashtra (Mumbai), Karaikudi (Tamil Nadu) with the approval of IRDAI for recruitment and training of agents. USGI is in the process of establishing two more agency recruitment centres in the states of Uttar Pradesh and Madhya Pradesh. USGI have recruited & trained agents to provide self employment to unemployed youth in rural and semi urban area and improve Insurance penetration.

1.6 To prevent Mis-Selling and Unfair business practices –

- We ensure that we collect completely filled and duly signed proposal forms from the insured.

- Insured Signature is mandatory and nobody should try to sign on behalf of customer on any document.NO proposal shall be accepted based on the declaration by the agent for incomplete proposals.
- A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover. The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits.

- An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest.
- Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect evenly.

- Where, for any reason, the proposal and other connected papers are not filled by the prospect, a certificate may be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract.

In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by:

- The Authority
- The Councils that have been established under section 64C of the Act and
- The recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.

As per the guidelines on AML, USGI have formed a Sales Monitoring Committee to monitor the unfair sales practice followed by the Agents. The sales monitoring committee shall comprise of Head operation, Head claims and Head underwriter. The Agency Team shall convene the meeting as per requirement.

1.7 POINT OF SALE-

1. A prospectus of any insurance product shall clearly state

(i) (a) the Unique Identification Number (UIN) allotted by the Authority for the concerned insurance product

(b) the scope of benefits;

(c) the extent of insurance cover;

(d) warranties, exclusions/exceptions and conditions of the insurance cover along with explanations.

(ii) (a) a description of the contingency or contingencies to be covered by insurance;

(b) the class or classes of lives or property eligible for insurance under the terms of such prospectus; (c) a full statement of the circumstances, if any, in which rebates of the premiums quoted in the prospectus or table shall be allowed on the effecting or renewal of a policy, together with the rates of rebate applicable to each case; and

(d) a copy of Sec. 41 of the Act but not including the proviso to sub-section (1) thereof.

(iii) the allowable riders or add-on covers on the insurance products shall be clearly spelt out with regard to their scope of benefits,

(iv) the premium pertaining to health related or critical illness riders shall not exceed 100% of premium under the basic product and any benefit arising under each of the above mentioned riders shall not exceed the sum assured under the basic product.

2. An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest.

3. Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately.

4. Where for any reason, the proposal and other connected papers are not filled in by the prospect, the insurer or the distribution channel shall explain the contents of the form, and a certificate shall be incorporated at the end of the proposal form from the prospect that the contents of the proposal form and connected documents have been fully explained to him and he has fully understood the significance of the proposed contract.

5. The Insurers shall ensure, that a sale executed over distance-marketing modes such as Internet, SMS, Tele Marketing, interactive electronic medium etc., shall be undertaken by authorized and qualified sales persons who are specified in this behalf by the Authority. It is mandatory that the consent of the prospect be obtained before canvassing. Care should be exercised to ensure that the prospect contacted

has clarity as to the identity of the insurer, the distribution channel, the product, benefits and conditions of offer etc. The canvassing so made shall not involve compulsion, inconvenience or nuisance of any kind to the prospect.

1.8 PRODUCTS ON OFFER/ PRODUCTS WITHDRAWN –

The terms and conditions of every insurance product that is offered for sale and approved by the Authority under File and Use procedure or filed with the Authority under Use and File procedure, including products modified or products withdrawn are available on our USGIC website along with the UIN no. as allotted by IRDAI. The list of products are also updated on the website as and when there is any addition and deletion and duly informed to all our customers, Agents, Bank Partners and channel partners.

1.9 USGIC Proposal form for Insurance –

1. Except in case of a marine insurance cover, or such other covers approved by the Authority exempting usage of proposal form, a proposal for grant of insurance cover, either for life insurance business or for general insurance business or for health insurance business, must be evidenced by a document in written or electronic or any other format as approved by the Authority. It is the duty of the insurer to furnish to the insured, free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal submitted by the Insured.
2. In case of marine insurance cover or other insurance covers where a proposal form is not used, the insurer shall record the information obtained orally or in writing or electronically, and confirm it within a period of 15 days thereof with the prospect and incorporate the information in its cover note or policy. Where the insurer claims that the prospect suppressed any material information or provided misleading or false information on any matter material to the grant of a cover, then the onus of proof rests with the insurer only in respect of any information not so recorded.
3. Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer or the distribution channel shall draw the attention of the proposer to it and encourage the proposer to avail the facility and inform him of the provisions of section 39 of the Act.
4. Insurer shall process the proposals with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to the proposer within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by the insurer.
5. Where a proposal deposit is refundable to a prospect under any circumstances, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

1.10 Matters to be stated by USGIC in General insurance policy:

(i) the name(s) and address(s) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance, UIN of the product, name, code number, contact details of the person involved in sales process;

(ii) full description of the property or interest insured;

(iii) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;

(iv) period of Insurance; sums insured; perils covered and not covered; any franchise or deductible applicable; premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;
(v) policy terms, conditions and warranties, Exclusions, if any.
(vi) action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy; the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;
(vii) any special conditions attaching to the policy; the grounds for cancellation of the policy which in the case of a retail policy, for the insurer, can be only on the grounds of mis – representation, non-disclosure of material facts, fraud or non co-operation of the insured.

Explanation: Products approved as retail policies under File and Use guidelines notified by the Authority from time to time fall within the purview of retail policy referred above. Provided that in the case of Commercial policies alone, other circumstances under which the policy may be cancelled be given, along with the manner of calculation of refund and notice period for cancellation.

(viii) the address of the insurer to which all communications in respect of the insurance contract should be sent;
(ix) the details of the endorsements, add-on covers attaching to the main policy;
(x) that, on renewal, the benefits provided under the policy and/or terms and conditions of the policy including premium rate may be subject to change; and
(xi) details of insurer's internal grievance redressal mechanism along with address and contact details of Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

1.11 Matters to be stated by USGIC in Health insurance policy:

(i) The name of the policyholder and the names of each beneficiary covered, UIN of the product, name, code number, contact details of the person involved in sales process; Date of birth of the insured and corresponding age in completed years;

(ii) The address of the insured; The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break; (iii) The sums Insured; The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross-reference to the concerned policy section; Co-pay limits if any; The pre-existing disease (PED) waiting period, if applicable; Specific waiting periods as applicable; Deductible as applicable – general and specific, if any; Cumulative Bonus, if any; Periodicity of payment of premium instalment;
Policy period; Policy terms, conditions, exclusions, warranties;

(iv) Action to be taken on the occurrence of a claim for cashless and reimbursement options separately;
(v) Details of TPA, if any engaged, their address, toll free number, website details;
(vi) Details of Grievance Redressal mechanism of insurer; Free look period facility and portability conditions; Policy migration facility and conditions where applicable;
(vii) that, on renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate;

(viii) Provision for cancellation of the policy; and
(ix) Address and other contact details of Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

1.12 USGIC CLAIM PROCEDURE IN RESPECT OF A GENERAL INSURANCE:

1. An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by USGIC. On receipt of such a communication, USGIC shall respond immediately and give clear information to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/claim, it shall do so immediately, in any case within 72 hours of the receipt of intimation from the insured. Insurer shall communicate the details of the appointment of surveyor, including the role, duties and responsibilities of the surveyor to the insured by letter, email or any other electronic form immediately after the appointment of the surveyor.
2. USGIC / surveyor shall within 7 days of the claim intimation, inform the insured / claimant of the essential documents and other requirements that the claimant should submit in support of the claim. Where documents are available in public domain or with a public authority, the surveyor/insurer shall obtain them.
3. The surveyor shall start the survey immediately unless there is a contingency that delays immediate survey, in any case within 48 hours of his appointment. Interim report of the physical details of the loss shall be recorded and uploaded/forwarded to the USGIC within the shortest time but not later than 15 days from the date of first visit of the surveyor. A copy of the interim report shall be furnished by the USGIC to the insured/claimant, if he so desires.
4. Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, USGIC or the surveyor, as the case may be, shall inform in writing to the insured under information to the insurer about the consequent delay that may result in the assessment of the claim. It shall be the duty equally of the insurer and the surveyor to follow up with the insured for pending information/documents guiding the insured with regard to submissions to be made. USGIC and/or surveyor shall not call for any information/document that is not relevant for the claim.
5. (i) The surveyor shall, subject to sub-regulation 4 above, submit his final report to USGIC within 30 days of his appointment. A copy of the surveyor's report shall be furnished by USGIC to the insured/claimant, if he so desires. Notwithstanding anything mentioned herein, in case of claims made in respect of commercial and large risks the surveyor shall submit the final report to USGIC within 90 days of his appointment. However, such claims shall be settled by USGIC within 30 days of receipt of final survey report and/or the last relevant and necessary document as the case may be.

(ii) Where special circumstances exist in respect of a claim either due to its special / complicated nature, or due to difficulties associated with replacement/reinstatement, the surveyor shall, seek an extension from insurer for submission of his report. In such an event, USGIC shall give the status to the insured/claimant fortnightly wherever warranted. USGIC may make provisional/ on account payment based on the admitted claim liability.

6. If USGIC, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor, under intimation to the insured/claimant; to furnish an additional report on certain

specific issues as may be required by the insurer. Such a request may be made by USGIC within 15 days of the receipt of the final survey report.
Provided that the facility of calling for an additional report by the USGIC shall not be resorted to more than once in the case of a claim.

7. The surveyor, on receipt of this communication, shall furnish an additional report within three weeks from the date of receipt of communication from USGIC.
8. On receipt of the final survey report or the additional survey report, as the case may be, and on receipt of all required information/documents that are relevant and necessary for the claim, USGIC shall, with in a period of 30 days offer a settlement of the claim to the insured/claimant. If USGIC, for any reasons to be recorded in writing and communicated to the insured/claimant, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the final survey report and/or additional information/documents or the additional survey report, as the case may be.
9. In case, the amount admitted is less than the amount claimed, then USGIC shall inform the insured/claimant in writing about the basis of settlement in particular, where the claim is rejected, USGIC shall give the reasons for the same in writing drawing reference to the specific terms and conditions of the policy document.
10. In the event the claim is not settled within 30 days as stipulated above, USGIC shall be liable to pay interest at a rate, which is 2% above the bank rate from the date of receipt of last relevant and necessary document from the insured/claimant by insurer till the date of actual payment.

1.13 CLAIM PROCEDURE IN RESPECT OF A HEALTH INSURANCE:

USGIC shall adhere to the procedure laid down under Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016 for settlement of health insurance claims.

(i) USGIC shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.
(ii) In the case of delay in the payment of a claim, USGIC shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
2. However, where the circumstances of a claim warrant an investigation in the opinion of USGIC, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, USGIC shall settle the claim within 45 days from the date of receipt of last necessary document.

(i) In case of delay beyond stipulated 45 days USGIC shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

3. Return of premium on cancellation during Free Look Period shall be processed in accordance with the provisions of Regulation 14 of IRDAI (Health Insurance) Regulations, 2016. Any refund shall be processed with speed and shall be refunded within 15 days from the date of receipt of request for free look cancellation.

1.14 GRIEVANCE REDRESSAL PROCEDURE – USGIC already has in place a Board approved Grievance Redressal policy as outlined in Annexure - 1 of IRDAI(Policy Holder Protection Interest, regulation)2017with with proper procedures and effective mechanism to resolve complaints and grievances of policyholders, claimants efficiently and with speed.

Protection of Policyholders' Interests Policy

The Grievance cell will be responsible for handling, management and Redressal of all Customer complaints received by the Company. Any complaint received by the Company in any mode (including letters, phone calls, e-mails etc.) is referred to the Grievance within 24 hours from the time of the receipt of the Complaint. The Grievance Cell would follow the procedures for resolving the complaint as Instructed by IRDAI.

Escalation matrix for resolution & redressal of customer's complaint/ queries

- Head – Claims
- Chief Grievance Redressal Officer and Head-OPS, Customer Service & Customer Grievance **Process:**

- Once we receive a complaint we email the detailed complaint to the concerned department (Claims, Marketing, Operations) with the IRDAI token no.
- Acknowledgement sent to the complainant via SMS / Email / Call as per details available.
- On receipt of the resolution from the concerned team we update the remarks in IGMS and the complaint status changes from "PENDING" to "ATTENDED TO" and after 8 weeks the complaint status changes to "CLOSED" if if the complainant does not respond the complaint.
- Further we also send a detailed letter informing him/her the status of the complaint and copy to IRDAI.
- Where the grievance is not resolved in favour of the policyholder or partially resolved in favour of the policyholder, the insurer shall inform the complainant of the option to take up the matter before insurance ombudsman giving details of the name and address of the Ombudsman of competent jurisdiction.
- We also sent reply to the officials of IRDAI for the complaint emails received from IRDAI with details of the complaint and copy of resolution letter sent to the insured with copy to Chief Grievance Redressal Officer and Head-OPS, Customer Service & Customer Grievance and Head Claims

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USGIC has also integrated IGMS with Customer Interaction Management System (CIMS)

- Updating complaint status on CIMS with the remarks gets recorded on Real – Time basis at IGMS.
- The Insurer, Customer and IRDAI can view and get to know the status of the Complaint being carried out by the Insurer as and when they login in IGMS
- TAT for settling complaints have been defined as per Policyholder's Protection Committed prescribed by IRDAI.

IV. Amendment to the Policy

This policy is subject to annual review and the policy can be revised and approved by the Board of Directors through MD & CEO as and when changes are taken place.

Annexure - I

Grievance Redressal Procedure

1. A complainant who wishes to make a complaint against insurer, intermediary, insurance intermediary, distribution channel or other regulated entities involved in insurance sales and services shall approach the respective grievance redressal officer of insurer. In case either grievance redressal officer of insurer does not respond or the resolution provided by him is not to the satisfaction of the complainant he may register a complaint in grievance redressal management system of the Authority. The Authority facilitates re-examination of the complaint so as to provide final resolution by insurer.
2. Every insurer shall have in place an effective grievance redressal procedure to address complaints of policyholders efficiently and with speed and communicate the action taken by the insurer on the complaint to the complainant along with the information in respect of Insurance Ombudsman as may be necessary.
3. Grievance Redressal Officer
   i. Every insurer shall have a designated Grievance Redressal Officer (GRO) of a senior level at the corporate office. The GRO at the corporate office will be the contact person for the Authority.
   ii. Every other office of the insurer shall also have a designated Grievance Officer who shall be head of that office. The details of the GRO/designated Grievance Officer along with the contact details in full shall be published in the website of the insurer and the name and contact details of designated Grievance Officer of respective office and the other Grievance Officers in hierarchy up to GRO at corporate office shall also be displayed in the notice board of respective offices.
   iii. Every office of the insurer shall also display in prominent place, the name, address and other contact details of the insurance ombudsman within whose jurisdiction the office falls.
4. Grievance Redressal System/Procedure:
   i. Every insurer shall have a system including IT systems and a procedure for receiving, registering and disposing of grievances in each of its offices. Every insurer shall publicize its grievance redressal procedure and ensure that it is specifically made available on its website.
   ii. All insurers shall necessarily form part of the Integrated Grievance Management System (IGMS) put in place by the Authority to facilitate the registering/ tracking of complaint on-line by the policyholders. The Insurer's system, shall involve, mirroring of the Grievance database, of Insurers with IGMS and shall also facilitate analysis of complaints, mitigation, improvement of processes and system, through constant review.
   iii. Insurers shall also have in place system to receive and deal with all kinds of calls including voice/e-mail, relating to grievances, from prospects and policyholders. The system shall enable and facilitate the required interfacing with the Authority's system of handling calls/e-mails
5. Closure of complaint/grievance:
   i. A complaint shall be considered as disposed of and closed when
      a. The insurer has acceded to the request of the complainant fully
         (or)
      b. Where the complainant has indicated in writing, acceptance of the response of the insurer.
         (or)
      c. Where the complainant has not responded to the insurer within 8 weeks of the insurer's written response.

ii. Where the grievance is not resolved in favour of the policyholder or partially resolved in favour of the policyholder, the insurer shall inform the complainant of the option to take up the matter before insurance ombudsman giving details of the name and address of the Ombudsman of competent jurisdiction.

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ANNEXURE - 2

Non-life Insurance Complaints Classification

S.No	Description	Mapping of PPI Provisions to classification structure	Servicing TATs
(1) Proposal Related			
1	Insurer collected premium – Issued policy without any proposal or confirmation in writing from Insured	4 (1) Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document. It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.	30 days
2	Insurer accepted premium and then rejected the proposal	3(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by: i) the Authority ii) the Councils that have been established under section 64C of the Act and iii) the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.	10 days
3	Insurer not furnishing proposal copy after acceptance of risk	Refer S.No. 1	30 days
4	Insured does not know the scope of coverage and other terms where Proposal form was filled up by Agent	A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or nonparticipating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to all the riders put together shall exceed 30% of the premium of the main product. 11 (1) The requirements of disclosure of "material information" regarding a proposal or policy apply, both to the insurer and the insured. (2) The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties. (3) The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy. (4) Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.	10 days
5	Proposal form given by Insured was tampered by Agent / Insurer	Refer S.No. 2	
(2) Cover Note Related			
6	Cover Note not received	Refer S.No. 2	10 days
7	Scope of cover not explained	A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover	10 days
(3) Policy Related			
8	Certificate of Insurance / Policy not received by the Insured	Refer S.No. 2	
9	Details incomplete in the policy.	**7(1)** A general insurance policy shall clearly state: (a) the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance; (b) full description of the property or interest insured; (c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values; (d) period of Insurance; (e) sums insured; (f) perils covered and not covered; (h) any franchise or deductible applicable;	10 days
		(i) Nomination details to be noted	

		(j) Financier's Interest to be shown in policy	
10	Details shown in policy or Add-on are incorrect.	Refer S.No.9	10 days
11	Endorsement for modification of policy/add on not issued by the Insurer	**10 (g)** issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and	10 days
12	Insured asked for cancellation of policy, Insurer failed to respond	**10 (1)** An insurer carrying on life or general business, as the case may be, shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters	10 days
13	Insured asked for issue of a duplicate policy – Insurer failed to issue	**10(f)** issuance of duplicate policy;	10 days

14	Nomination details given by Insured not noted in policy.	**10(b)** noting a new nomination or change of nomination under a policy;	10 days
15	Insurer cancelled policy arbitrarily without serving notice	It will be fair to issue notice to Insured, before cancellation of Policy	10 days
16	In the renewal policy, Insurer changed the terms & conditions without informing the Insured	Policy terms, conditions and warranties; should not be changed arbitrarily	10 days
17	Details shown in policy different from the Cover Note.	Refer S.No.17	10 days
18	Insurer refused to accept Insured's request to enhance coverage mid-term.	If this request cannot be accepted, Insurer to write to Insured giving reasons.	10 days
19	While renewing the policy Insurer refused to enhance the Sum Insured sought by Insured.	Reasons for refusal to be communicated to Insured	10 days
20	Insurer forced Insured to switch over to a new policy.		
21	Without the consent of Insured Insurer debited customer's bank A/c / credit card and issued policy.	Refer S.No. 2	10 days
22	Insurer refused to renew the policy without giving any reasons.	Refer S.No. 2	10 days
23	Change of address not noted	**R**ecording change of address;	10 days
24	Product no longer available with Insurer		
(4) Premium			
25	Premium receipt not received by Insured	Refer S.No. 2	10 days
26	Insurer calculated premium wrongly and over charged the Insured.	Refer S.No. 2	10 days
27	Insurer loaded premium arbitrarily	Insured to be advised in advance	10 days
28	Premium paid through electronic modes/cheque not accepted	Insurer to make arrangements to accept Premium in all accepted modes	10 days
29	Where provisional premium is collected, final adjustment is not carried out	Where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;	10 days
30	Premium cheque bounced. Without giving intimation to Insured Insurer. cancelled the policy		10 days
(5) Coverage			10 days
31	Insurer did not attach any clauses to the policy – coverage given under the policy not known to the Insured.	A general insurance policy shall clearly state: perils covered and not covered;	10 days
32	Dispute relating to Interpretation of perils/exclusions/conditions/warranties	Refer S.No. 2	10 days
33	Dispute relating to policy extension of term for Long term policies	Refer S.No. 2	
34	Wrong add on policy wording	Refer S.No. 2	
(6) Refund			
35	Refund of premium due under policy not received by Insured.	Insurer to make refund of premium on their own	10 days
36	Dispute regarding quantum of premium refund.	Insurer to convey to Insured as to how they arrived at the quantum of refund	10 days
(7) Product			
37	Product (policy) received by insured is not what it was negotiated at the time of sale.	Refer S.No. 2	10 days
38	Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	Refer S.No. 2	10 days
(8) Claim			

39	Insurer refusing to register claim	An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 72 hours of the receipt of intimation from the insured.	10 days
40	Insurer asking for irrelevant claim documents	Refer S.no. 39	
41	Insurer asking for claim documents on a piecemeal basis.	Refer S.no. 39	
42	Delay in appointment of surveyor	Refer S.no. 39	72 hours
43	Insurer not issued claim form.	Refer S.no. 39	10 days
44	Delay in conducing survey.	Insurer should advise the Surveyor to stick to the time -frame	10 days
45	Surveyor delayed issue of his report.	Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where, in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report.	30 days
46	Survey report copy not issued to the Insured by the surveyor.	Refer S.No. 45	30 days
47	Difference between assessed loss and amount settled by Insurer.	Insurer should explain to the Insured the reasons	10 days
48	Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Refer S.No. 47	
49	Insurer failed to make offer of settlement to Insured after receipt of survey report.	On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.	30 days
50	Insurer not disposed of the claim	Without valid reasons, Insurer should not keep any Claim beyond the time frame	30 days
51	Insurer not issued claim cheque inspite of offer of settlement.	Upon acceptance of an offer of settlement as stated in sub-regulation (5) by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.	7 days
52	Cheque issued by Insurer is bounced.	Insurer should send fresh cheque /draft, the moment they come to know about the bouncing of the cheque	10 days
53	Name of Insured wrongly written in the claim cheque.	Insurer should doubly make sure not allow such errors	10 days
54	Insurer closed the claim without advising the Insured any reasons.	Refer S.No. 47	10 days
55	Dispute between Insured and Insurer on (a)Rate of depreciation applied, (b) amount allowed towards Labour charges (Motor claim), (c) deduction of salvage value, (d) obsolete factor.	Insurer should write to the Insured and resolve the disputes	10 days
56	Dispute on mode of claim settlement – Total loss / cash loss vis-à-vis repair basis.		30 days
57	Claim denied due to alleged non-cooperation of Insured		30 days
58	Insurer repudiated claim due to delay in intimation of claim by Insured.	It would be proper to ascertain the reasons for delayed intimation and consider admission of claim on merits	10 days
59	Insurer repudiated claim due to delay in submission of claim documents by the Insured.	Without giving notice in advance calling for required documents, Insurer not repudiate a claim	10 days
60	Insurer repudiated the claim based on 2nd surveyor's recommendation.	Insurer should give reasons in the letter of repudiation	10 days
61	Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Refer S.No. 55	10 days

62	Insurer repudiated claim due to dispute on premium paid.	Refer S.No. 55	10 days
63	Insurer repudiated claim due to alleged fraud.		
64	Claim repudiated without giving reasons	Refer S.No. 59	10 days
65	Insurer repudiated claim due to "pre-existing disease exclusion" (Health Insurance).		10 days
66	Claim repudiation by Insurer due to bouncing of premium cheque presented late by Insurer.		
67	Insurer repudiated claim due to alleged carelessness of Insured.		
68	Delay on the part of TPA to arrange claim reimbursement (Health claim).		30 days
69	TPA reduces estimate given by the hospital without any reason.		10 days
70	Delay on the part of TPA to provide cashless facility.		10 days
71	TPA refuses to extend cashless facility to the Insured.		10 days
(9) Distance marketing			
72	Insurer calls for solicitation of business inspite of client registering in DNC		
73	Insurer making repeated and unsolicited calls		
74	Mis-selling on distant calling		
75	Explaining excessive features of a policy to a prospect on calls		
76	Insurer debiting premium on cards arbitrarily		
77	Insurer not refunding amount debited arbitrarily on Credit cards		
(10) Others			
78	IDV related disputes		10 days
79	Higher/wrong deductible imposed by Insurer		10 days
80	Insurer imposed additional conditions wrongly.		10 days
81	TPA not sent ID card to Insured (Health claim).		10 days
82	Insurer not considered the cumulative bonus in claim settlement (PA or Health claim).	Cumulative bonus relevant to PA or Health policy should be allowed	10 days
83	Insurer not given no claim bonus (Motor Insurance)	Insurer should allow No Claim Bonus as per entitlement	
84	Insurer gave premium quote but later went back on acceptance of risk.	The quote should indicate the validity period	
85	Insurer failed to clarify the queries raised by Insured.	Refer S.No. 12	
86	TPA not sending pre-authorization to the Hospital (denial of cashless facility).		
87	Insurer not given eligible discount in premium (Family Discount on Health / PA policy/package policy)	Refer S.No. 12	
88	Misbehavior of surveyor towards the Insured.		

89	Insurer not taken any loss prevention measures upon reporting of a claim by Insured.		
90	Failure of online transaction though premium was deducted through credit card.		
91	Rebating resorted to by Agent.		
92	Rebating resorted to by Insurer.		
93	Fraudulent behavior on the part of Agent in claim matter		
94	Errors in ID cards issued by TPAs.		
95	Alleged misconduct of officials of TPA towards the Insured.		
96	No response from TPA / Insurer for queries raised / clarifications sought by Insured.		
97	IT /Network related / connectivity issue with TPA.		
98	TPA delayed Health check-up.		
99	TPA delayed issue of reports of Health check-up.		
100	Alleged misconduct of officials of Insurer.		
101	Alleged misconduct of surveyor / investigator.		
102	Unsolicited calls made to Insured in spite of DNC registration.		
103	Complaint of Insured relating to pre-inspection / pre-acceptance survey.		
104	Cashless facility first sanctioned and withdrawn.		
105	Where claim is repudiated, Bills / reports not returned to the customer.		
106	Non-acceptance of health cards by network hospital.		
107	Unable to register Grievance due to faulty systems	.	

Note - The TAT and classification are mentioned as per IRDAI guidelines. The complaint where specific TAT is not mentioned above will have TAT as per IRDAI regulations