NEWSTRACK

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BAJAJ | Allianz

Fraud is a breach of one of the most important principles of insurance i.e. utmost good faith.

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Greetings.

Fraud is something which insurance companies have to deal with on a day to day basis. What is surprising about frauds is that most people become 'flexible' about integrity when dealing with insurance companies. Fraud in insurance terms would mean anything which makes a claimed amount payable which otherwise wouldn't have been. It would also include cases where the customer gives wrong information so as to pay a lower premium.

When thinking about fraud one always links it to some big conspiracy or the fact that it is done only by customers. However, most of the time insurance companies deal with small frauds which we call leakage and some times the fraud is committed by some third parties like workshops / garages or hospitals without knowledge of customers. Let me give a few examples.

In motor at the time of renewal; customers give a declaration that 'no claim was lodged in the previous policy' to avail no claim bonus. Experience suggests that 10% of these declarations are wrong. This is done to save some premium payable in policy. In case of health or life insurance reducing the age than what is the correct age is done to save some premium. At times people don't declare pre-existing illness in health / travel etc so that they can avail comprehensive coverage. Over a period of time once UID (Unique Identity Number) starts becoming a single source of information related to an individual and establishes a common linkage across sectors misrepresentation/ concealment of facts will come down.

Going 'up the value chain' in frauds entail exaggerating claims. For example, in motor, routine maintenance expenditure is converted to claims; replacement of parts is claimed while they are repaired. In health, some hospitals charge more for insured customers as compared to others or in Business Units, stocks are shown higher than what they actually were after a fire / flood loss.

The final stage is when uncovered losses are manipulated to cover them. For example, when a loss happens and vehicle doesn't have cover, insurance is taken to cover this loss. In motor third party one comes across large number of cases where normal accidents at home / work are converted to road accidents. In health people impersonate someone who has insurance to take treatment. In rural areas natural deaths are converted to accidental deaths due to 'snake bite or drowning'. Unsold stocks for companies facing downturn are more prone to fire! Thus typically when economic conditions are bad, frauds become more prevalent.

Combating fraud is important as this increases the cost of insurance for genuine customers. Secondly, insurance companies have to spend a large amount of time and effort to prove a fraud. Insurance companies have skill set to handle bigger frauds but due to lack of common database the leakages are difficult to minimize. My guess is that wrong declaration of no claim bonus (NCB) in motor is causing a loss of over ₹500 cr a year. Some time back banks were losing a lot of money in credit cards and personal loans due to fraud, this has started coming down as CIBIL (Credit Information Bureau (India) Limited) became more prevalent. We need a massive effort across insurance companies as well to create this wealth of history. IRDA has already taken the first step towards this by setting up IIB (Insurance Information Bureau).

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Frauds

Malady of the Insurance Industry

Frauds are something that insurers deal with everyday in most of its offices. In this Special Feature, Newstrack attempts to study the frauds in each line of business in the insurance industry and bring you a brief on the steps taken by insurers to minimize them.

"There are three things in the world that deserve no mercy - hypocrisy, fraud and tyranny." When Frederick William Robertson, an English theologian said these lines, it seems he too understood how detrimental frauds were for the society, especially in financial terms. According to the Oxford dictionary, ***fraud*** *is a wrongful or criminal deception intended to result in financial or personal gain.* Found in all severity and sizes, fraudulent activities may result in benefits for a very small fraction of the population, but at times the volume of these frauds amount to alarming numbers.

Research shows that the insurance sector is amongst the most vulnerable to frauds. According to the Annual Fraud Indicator of UK's National Fraud Authority, frauds cost the UK over $48 billion a year. Across the board in motor, fire and other property related claims, fraud is now costing the industry an estimated $2.5bn a year compared with $997mn in 2000. "Dishonest insurance claims alone cost around $3.23 billion a year, which adds on an average $71 a year to every household's general insurance budget," said Mr. Nick Starling, Director of General Insurance and Health in UK. In India, insurers are estimated to be losing nearly ₹15,000 crore every year due to exaggerated claims, as per India Forensic Research, a Pune based research agency. However, there is no agency nor repository of fraudulent claims in India to assess the losses due to frauds.

The high number of frauds in the Indian insurance industry may be attributed to the perception of customers that an insurance company always pays less than what is claimed, even if the quantum of damage assessed is true. This often motivates customers to exaggerate. Moreover, the lack of fear among fraudsters, a slow legal mechanism and the absence of adequate fraud control measures makes it difficult to track and curb this malady in India.

Insurance Fraud Awards

The Insurance Fraud Bureau of UK organises an annual award ceremony recognising excellence in counter-fraud and fraud prevention in the general insurance industry. These Awards recognise the industry's continued efforts to combat and prevent fraud and encourage the spread of best practice and excellence across the sector in UK. Allianz Insurance has bagged the award for "Fraud Investigation Team of the Year" in 2009.

Insurance Frauds: Lose-Lose Situation

Insurance industry is the most vulnerable to frauds as they deal with the facts as mentioned in a piece of paper called proposal form. Physical or medical inspection is done only when the magnitude of the loss insured is substantial. Frauds are in complete breach to one of the most important principles of insurance – *ubberimae fides* i.e. utmost good faith – which means complete honesty while disclosing facts relevant to the person being insured. This magnitude varies from minor to major and mostly depends on the insured and insurer's attempts to detect them. Insurance frauds can pose serious risk to insurers and may result in significant costs to its stakeholders. If not mitigated, insurance fraud can potentially affect the financial soundness of insurers and erode both consumers' and shareholders' confidence in these insurers as well as the insurance sector at large.

When an insurer experiences a fraudulent claim, the amount is paid towards an illegitimate cause which is otherwise meant for covering a genuine loss. This superfluous depletion of the pool can skew the calculations made by actuaries and underwriters while estimating future risks, resulting in inflated premiums for the customer.

Further, the process of detecting frauds, conducting investigations and repudiating claims is a massive cost in itself, which is incurred by insurers.

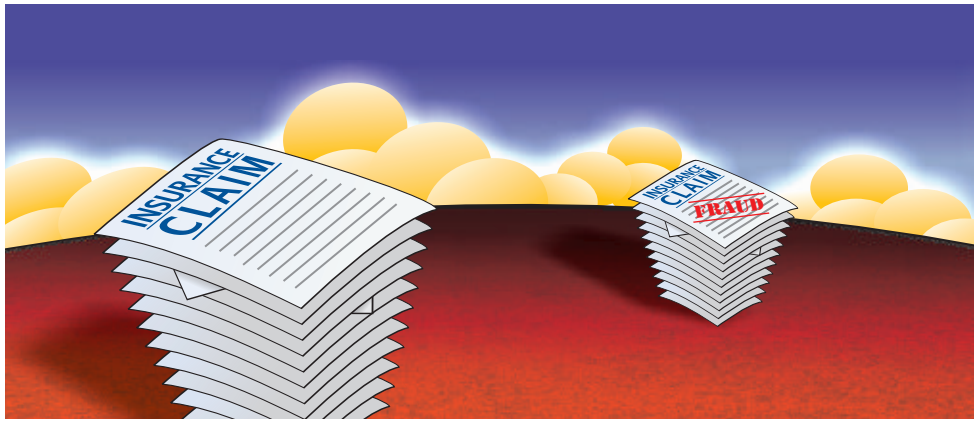
Types of Frauds

There are various types of frauds like the loss not taken place i.e. fake claims, loss has taken place but was self-inflicted or loss has taken place genuinely but there was a mis-representation of facts.

Insurance frauds can be broadly classified as either hard fraud or soft fraud. Hard fraud occurs when someone deliberately plans or invents a loss, such as a collision, auto theft or fire that is covered by their insurance policy in order to receive payment for damages. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars.

Soft fraud, which is far more common than hard fraud, is sometimes also referred to as opportunistic fraud. This type of fraud consists of policyholders exaggerating otherwise legitimate claims. For example, when involved in a collision an insured person might claim more damage than was really done to his or her car. Soft fraud can also occur when, while obtaining a new insurance policy, an individual misreports previous or existing conditions in order to obtain a lower premium.

Life Insurance



Bajaj Allianz office at Bellary (Karnataka) received a claim for a life insurance policy worth ₹6 lakhs within 27 days of the commencement of the policy i.e. 13th March '09. As this was an early claim, the claim executive decided to investigate the claim. On investigation, it was found that the policyholder had been admitted to a hospital complaining of chest pain and breathlessness and succumbed to a heart attack on 7th April. However, further investigation revealed that the policyholder had actually died in a road accident on 4th February, which was almost a month before the insurance was taken. It was clear that this was an attempt of fraud. Needless to say, the claim was rejected.

This is just one of the many cases that Bajaj Allianz and probably other life insurers come across involving forgery of death certificates, medical reports etc. with the attempt to avail a claim from the company. According to a survey by India Forensic Research, a Pune-based research agency, life insurance frauds are the most prevalent, after motor and health insurance.

Life insurance is a long-term contract between a policyholder and insurer, which assures the policyholder's family/ dependants a certain amount of money in the case of death of the policyholder.

Some of the common fraudulent activities are:

- **Age proofs** – All insurance policies have an eligible age at which the policy can be taken. To accommodate oneself in to the product or enjoy a lower premium, age proofs are modified to show a reduced age.
- **Address proofs** – Many insurers accept bank statements as a valid address proof. But these are often a victim of manipulation to show a false account in a particular bank.
- **Medical tests** – Some cases require medical tests to issue the policy. However, to substantiate non-disclosed or misrepresented medical conditions, an different person may be sent at the time of the tests. While this may work to get the policy, it would create discrepancy at the time of claims, even leading to repudiation.
- **Fabricating date of death** – The benefit of keeping your policy in force by paying regular premiums cannot be understated. Not doing so, results in the policy to lapse and becoming illegible to avail the death benefit on the policy. However, cases have been seen where the date of death as on the death certificate has been fraudulently changed to a date before the actual death when the policy was in force, so as to register a claim.

Frauds in Life insurance occur mainly due to:

- Fabrication of documents to save on premiums
- Avail covers which are not allowed for a particular age group
- Obtain the death benefit through unfair means.
- Some extreme cases have also found to involve murder by kin for monetary benefit

- **Forgery of death certificates** – To avail the death benefit, a false death certificate is created on the name of a living person.
- **Manipulating reasons of death** – If a history of an ailment which had been diagnosed before or at the time of filling the proposal is detected, the claim can be repudiated. To safeguard oneself from this situation, the reasons of death are modified so as to fabricate a genuine claim.

Some of the frauds pertaining to age proofs, address proofs can be detected at the underwriting stage, while others may be detected during the policy term or at the time of processing the claim. If detected at the underwriting stage, the proposal form is

P. Ravi Kutumbrao, Sr. VP - Claims, Bajaj Allianz Life Insurance says, *"We investigate all early claims and for claims assessment process we follow an internal two-level process wherein all claim applications are scrutinized by two people and approved by the higher authority only. Apart from this, we have built a fraud database and all the fraud documents detected are flagged. We monitor areas / intermediaries which are in the fraud database list and also monitor areas / intermediaries which have high loss ratios. This helps to detect any fraudulent documentation or discrepancies in events and validations submitted. We specifically carefully scrutinize early claims as these are found to be most prone to frauds."*

rejected and policy is not issued. If detected mid-term, the policy can be cancelled.

There are various factors which trigger suspicion and hence an investigation on fraudulent claims. The income/occupation details furnished at issuance stage & actuals found at investigation stage, pattern of insurance coverage availed i.e. at what age did customer started buying and within what span of time how much coverage was bought, time of death, medical case sheets, comments in post-mortem report and co-relating the various sources of information often help to smell a wrong-doing.

Steps taken by Bajaj Allianz to minimize frauds include:

- Informal network with other insurers to verify fraudulent activities
- Two-level approval process
- Manual scrutiny of all supporting documents received to check discrepancy

One person, six Policies from different insurers

The Background

A claim was received for policyholder Mr. Rao who was a business man. He held six policies with Bajaj Allianz insurer, out of which two policies were bought on 31st July and the others a week later on 8th August. The total sum assured was nearly ₹20 lakhs. His daughter was the nominee in all the above mentioned policies.

The reason of death given was that he was hit by a bull and admitted to the local hospital with minor injuries. He died of the injuries on the same night.

Suspicion triggers

The date of death as per the death certificate was about 3 months after commencement of all the policies. Since this was an early claim, we investigated further. Also, the reasons for death mentioned seemed strange.

The investigation

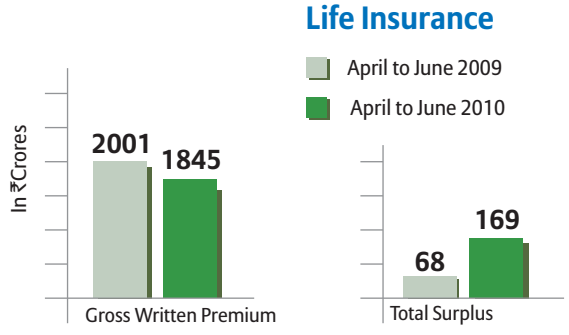
On verifying the claimant's medical history, we found MRI findings dated 18th July suggesting brain tumor. We found he had been admitted to a hospital on 23rd July with symptoms like headache, slurring of speech and ride-side weakness and was advised to undergo craniotomy. He was also diagnosed with diabetes. The surgery was conducted on 24th July.

On informal communication with other insurers, we came to know that the claimant had taken policies from 8 other private players of around total ₹1.049 crores. All these polices had been applied for in Sept-October. Also, there are two death certificates - one with date of death as 29th October (from Greater Hyderabad municipal corporation) and the other from govt. of Karnataka with date of death as 28th November. The death certificate of Karnataka is verified as authentic from the online service of Bellary Municipal Corporation. Hence, the other was proved forged.

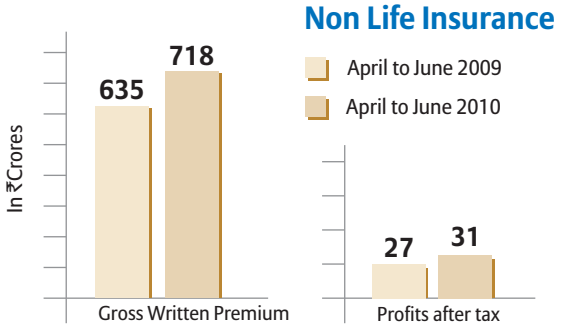
The result

With the various evidences mentioned above, fraudulent intentions were proved. Bajaj Allianz repudiated the claim.

Financial results of Bajaj Allianz



Profits increased by 149%
GWP down by 8% due to focus on profitability



GWP grew by 13% while profits grew by 15%

Property

A fire took place in a shoe factory near Pune. Most of the stock stored in the godown was destroyed in the accident. While filing a claim with the insurance company, the factory owner over-stated the value of his loss. At the time of inspection of the site of accident, there was hardly any debris available for assessing the damage as the leather had completely perished. But the surveyor and the claims team of the insurance company sensed something wrong. They conducted a volumetric analysis of the little debris that was available and calculated the total stock that could have been stored in the godown considering the space available. Their estimate was much lesser than what the policyholder was attempting to claim.

Property insurance is a highly specialized line which requires various kinds of technical expertise in assessing a loss as well as settling a claim. The 'insured' in this case are usually commercial buildings, factories, godowns etc. and the goods/assets stored therein. Property insurance is also a high-value sector as it provides cover to heavy engineering projects, machinery, construction etc. which is often spread over a large geographical area. Valuation of the asset at the underwriting and the claims stage involves complicated stock accounting process which makes the nature of this business scientific and impersonal in comparison to other retail lines of insurance.

The quantum of loss in property insurance is usually very large with the value of claims can be very high worth hundreds of crores in a single location. For any damage exceeding ₹20,000, IRDA approved surveyors are appointed who serve as independent experts and are able to assess the damage on the basis of their technical knowledge and experience in the field. These surveyors are specialists in various disciplines of engineering, chartered accountancy, cost accountancy, along with an insurance background. Bajaj Allianz has over 200 IRDA approved surveyors on its panel.

Due to its basic nature, sum assured in property insurance is very high. Moreover, the bandwidth of exaggerating the value of loss is also very high, which can be one of the possible motivations for making a fraud. For example, if a genuine claim worth ₹1 crore is overstated as ₹3-5 crores, so the extra income for the fraudster is a sizeable amount. This is called as "Deep Pocket Syndrome" which leads to a morale hazard. Other possible motivations can be to intentionally destroy and subsequently receive payment for goods that could not have otherwise be sold or does not have a market.

It is difficult to maintain data on fraudulent claims but a rough estimate confirmed that 10 out of 100 claims are fraudulent in nature. But it is not necessary that all such frauds are successfully realized by the insured. To correctly assess the loss and detect the possibility of a fraud, it is crucial to appoint a surveyor with the appropriate knowledge and skillset in the investigation. This makes it a rather subjective assessment, as a lot is dependant on the observations made by the surveyor.

Common types of frauds include:

- **Exaggerated claims** – Property insurance is based on the principle of indemnity i.e. covering the financial loss to the extent of the damage. This means in case of a fire, the insurer will pay only the value of the damage and not necessarily the entire sum insured of the policy. This makes it more prone to the extent of damage being inflated to attempt to claim amount more than value of the loss. For example, in a fire accident, goods worth ₹1 lakh are damaged. However, the claimant registers a claim for ₹10 lakh.
- **Location related** – The policy is taken for a shop or factory at a particular location. However, while registering a claim, it is shown that the loss occurred at multiple locations.
- **Undamaged goods are removed from site** – To increase the extent of loss, goods maybe shifted out from the site so as to include them in the 'damage'. This can also be justified/defended by manipulating account books wherein the procurement of the good is recorded.

- **Wrong declaration of value of goods** – While valuating the losses in the industrial sector, damage to combustible substances can pose a challenge and therefore are susceptible to be played up. While assessing the loss during the survey, claimant may inflate the value of the goods or exaggerate the number/stock of goods damaged, so as to obtain higher amount from the insurer.

While handling a claim suspected to be a fraud, it is important for the surveyor and claims team to think one-step ahead of the fraudsters to understand the type and extent of fraud being dealt with. Detecting frauds in property insurance requires a deep understanding of what the policy covers and what it doesn't. A keen eye is often enough to suspect a fraudulent activity or a deliberately caused loss.

There are a number of ways that frauds are detected in property claims but the main indication comes on the initial stage of surveyors visits. Some of these indications are:

- **Delay in notification** – unexplained delay in notifying the loss or cause of loss like fire.
- **Non-cooperation** – resistance from the claimant to share information or cooperate with surveyor
- **Missing of debris** – Conspicuous absence of debris in case of a fire or accident. This debris may have been intentionally removed from the site prior to surveyor's visit.
- **Non availability of document** – Various documents need to be produced to help evaluate the loss. These include bank/loan papers, purchase invoices, contracts, book of accounts etc.
- **Huge number of recent purchases** – abnormality detected in the account books on the amount of stock purchased before the loss.

Capt. Sanjay Moholkar, Head-Claims, Bajaj Allianz General Insurance says *"It is important to cross-verify the documents submitted for claim registration with a physical inspection of the location. We have put in place a comprehensive checklist to be considered while assessing a property insurance claim, by the claims executive in any of the offices."*

Fire Alarm in the mind, not in the fire station

What happened

Intimation was received about a fire in an insured garments factory. As soon as the news was received, representatives from the Bajaj Allianz claims team rushed to the location along with the surveyor. On reaching the location, it was seen that no serious efforts were being made to extinguish the fire and the fire brigade had been notified very late. However, on raising an alarm by the Bajaj Allianz team, a few people started splashing water from the available underground water tank.

Suspicion Triggers

Lack of efforts to put out the fire was the first point of suspicion. The claimant's hesitation in sharing information on the loss and non-cooperation during the investigation and debris count also prompted us to probe deeper.

The investigation

Based upon available space for storage and debris count, the surveyor provided an estimate of ₹ 1.2-1.5 crores for the loss. However, when the claimant submitted the claim, it was for ₹ 14 crores. When asked for documentary evidence of the value of the goods, the claimant said that the same had been destroyed in the fire. However, on physical investigation, it was found that the place where the papers were kept had been untouched by the fire. Moreover, the area which was shown as damaged was too small to store goods worth ₹ 14 crore.

Subsequently, the claimant submitted a large number of purchase invoices along with transporters lorry receipt. After detailed investigation, it was found that these supporting documents were fraudulent and fabricated.

The Result

With the evidence found during the investigation, it was concluded that the claimant had submitted fraudulent documents with the objective to dupe the insurance company in paying the huge claim. Bajaj Allianz got ample evidence of fraudulent intentions, and so the claim was repudiated.

Health

The Bajaj Allianz HAT team received a pre-authorization request for Mr. S. Pandey (name changed). The pre-authorisation request mentioned that the patient was admitted for severe Pharyngitis and was being treated with intra-venous IV antibiotics and stated that the patient needed close medical monitoring. Since the information received on the Pre-auth stage seemed fabricated as hospitalisation may not be required in the particular health condition, the insurer thought of having the case investigated. On reaching the location, the receptionist denied the admission of any such patient. The investigator then immediately called up the insurer who said that he was in the hospital receiving IV fluids and IV antibiotics since the previous morning. On calling the treating doctor, he also confirmed that the 'patient' was in the hospital. The investigator, using the recordings of the two calls as evidence visited the hospital again the next day. On asking for Mr. Pandey, the doctor said he had gone home for dinner. On his return, the investigator asked him to show the room where he was admitted. But he saw that a female patient was admitted there. On being confronted, Mr. Pandey admitted that he had tried to lodge a fraudulent claim as he was in need of money.

This is just one the situations that may be used by claimants to dupe insurers. As per an article published in Express Healthcare, a leading TPA found that the estimated number of false claims in the industry is estimated at around 10-15% of total claims. This can be translated into losses worth approximately ₹600 crores on false claims every year.

Health insurance, because of its basic nature, deals with trauma-related situations making it a highly and emotive sensitive issue for both the insured and the insurer. It therefore requires the insurer to not only be quick in response and claim settlement, but also do so with compassion.

Health insurance is essentially a bleeding sector with very high claim ratios and thus, fraudulent claims become a matter of concern. As per IRDA figures, the health insurance industry paid out claims worth ₹4087 crores in 2008-09, which was almost double of claims paid in 2007-08, worth ₹2904 crores. In both the years, the industry recorded a claim ratio of more than 100% implying that the claims being paid exceeded the premium earned.

In the long run, such high claim ratios affect the pool of resources, thereby resulting in an increase in premiums for the customer in the future, since premium is arrived on the basis of actuarial estimates and past experience. So, it is important for the customer to be completely honest about existing health conditions at the time of applying for a health insurance, as well as while registering a claim.

The main frauds in Health insurance pertain to overstating claims or involve manipulating documents of non-existing hospitals, pharmacies etc. or to cover-up non-disclosure of facts at the proposal stage. It has been seen that hospitalization benefit policies and personal accident policies are more subject to frauds.

Some of the common health insurance frauds:

- **Exaggerated claims** – Research reports say that 20-30% customers overstate their loss since they believe that insurance companies will always pay lesser than what you claim, even if the damage assessment is true.

  A legitimate claim can be exaggerated by including services that weren't used, for example, surgery not done on patient but shown on bill; services were used but charges are inflated, for example, general room was used but rates of deluxe room are being claimed.

- **Manipulation of documents** – India Forensic Research states that medical bills are the most commonly forged or fraudulent documents. Other forged documents could be fake discharge certificates, impersonated medical reports, fake letterheads of non-existent

"At times 'too perfect' documentation can also be the starting point of a fraud investigation. Cases where the hospital, pharmacy and laboratories are shown to be under the same roof also invite suspicion. The documents submitted by the claimants give us the initial clues of an exaggerated or false claim. The claims team manually scrutinizes each bill, medical report and discharge details to check for inconsistencies. The suspicious claims are then investigated further through an external investigator," says **Dr. B.S. Powdwal, Head – Health Administration Team, Bajaj Allianz General Insurance.**

hospitals, fabricated bills of a fictitious provider etc. At times, details on the discharge certificate could be modified to fit the claim application. A trend has been seen in frauds of personal accident policies where false x-rays are submitted to show disability.

- **Multiple Claims** – Holding multiple health insurance policies from various insurers does not amount to fraud. However, in case of a claim, the claim amount payable is divided proportionately in the ratio of the sum insureds of each of the policy. Attempts to claim the full sum insured on each of the policy will be treated as fraud.
- **Non-disclosure** – The importance of disclosing complete details while purchasing health insurance cannot be stated enough. A common method of making a fraudulent claim is to withhold information on pre-existing health conditions. This has seen to be common in Hospitalization expenses as well as Critical Illness policies. However, in cases where the intermediary maybe involved in the fraud, they may choose not to disclose details of pre-existing conditions of the customer on the proposal form. This would come as a surprise to the customer also in times of a claim.
- **Caught unaware** - A fraud situation that may arise while dealing with intermediaries is claims made in the name of the customer, without their knowledge. There may also be a possibility where a policy is taken in the name of a customer without their knowledge. These are more prevalent in group policies.

Suspicion triggers for investigating Health insurance frauds can be:

- Similar handwriting on all forms
- Style of printing of receipts
- Letterheads of the hospitals
- Health conditions which may not require hospitalisation

With the involvement of multiple entities such as hospitals, laboratories, pharmacies, TPA's etc., the health insurance becomes prone to frauds. However, insurers as well as the regulators have started to maintain a database of hospitals involved in frauds, which is published for the customer's information. Insurers maintain an informal network of customers found to be indulging in wrongdoings, which is shared amongst them.

Steps taken by Bajaj Allianz to minimize frauds include:

- **Scrutiny Team** – To minimize the clearance of fraudulent claims, Bajaj Allianz has set-up a three-man team which manually check all documents submitted by claimant.
- **Verify against Decline List** - IRDA publishes a 'decline list' comprising of blacklisted hospitals as well as policyholders. While handling a new proposal, this decline list is used as a reference to verify the genuity of the proposer. The list includes details such as name, date of birth and location of the blacklisted claimant, and so is easy to use. The list has also helped to spot cases where notorious hospitals are involved.
- **Review of hospitals** – Bajaj Allianz has a network of over 2500 hospitals. The hospitals are regularly reviewed to check for exorbitant pricing or other fraudulent activities. In case a hospital is found to be involved in a wrongdoing, first a warning is given and then blacklisted if there is no change in the hospital's behaviour.

Treatment in a non-existent Hospital

What happened

A reimbursement claim was received from one of our Individual Health policyholders. According to the claim papers, the policyholder had been admitted in a local hospital in Phaltan (Maharashtra).

Suspicion Triggers

At the time of assessment, we found that all the documents submitted by the claimant were printed on an inkjet printer on plain paper. Suspecting malpractice we decided to get the matter investigated. An investigator was appointed for the job. This investigator tried to locate the hospital where the claimant was admitted but could not find any hospital by that name in the whole village.

The Investigation

On visiting the claimant, we came to know that surprisingly the claimant was a doctor himself; a fact that was very conveniently omitted from the proposal form. This doctor has his own hospital in the same location.

On confronting the claimant that the hospital of which the documents were submitted did not exist, he agreed that the claim was fraudulent but challenged the investigator to prove it in a court of law. However, he soon softened his stand and tried to bribe the investigator to settle the matter 'amicably'. The investigator did not comply and set out further on his investigation to find concrete evidence against the claimant.

Thereafter, a team was sent from the Bajaj Allianz Health Administration Team (HAT) to take the matters in their own hands. On visited the address mentioned of the hospital, the Gram Panchayat and Gram Sevak officers confirmed that there is no such hospital in the area. This confirmation was taken in writing and the team made a visit to the claimant. The claimant once again defied his fraudulent intentions but revealed that the hospital does exist, but in a different location in Satara (near Pune), which is owned by his in-laws. The HAT team officials tried to get him to convince him to withdraw the claim, to which he made repeated attempts to bribe them to pass his claim.

The Result

On repeated visits and talks from our Legal team and threats to complain to the medical Council to withdraw his license, the claimant complied and withdrew his claim.

Motor

Motor insurance is one of the largest lines of business in general insurance and the most visible form of retail business, after health. Motor insurance contributes to over 40% of a general insurer's portfolio. In 2007-08, the industry paid claims worth ₹7969 crores and worth ₹6553 crore in 2008-09 towards motor insurance claims, which is nearly 70% of the total premium earned on motor insurance in the years (as per IRDA figures). These claims are categorized into own damage (OD) and third party (TP) claims, where own damage refers to loss only to the owner's vehicle, while third party would involve damage to another vehicle, property or person. OD claims can usually be resolved between the insurer and the insured, while TP cases might need legal interference to come to a mutually agreeable resolution.

According to a survey conducted by India Forensic Research, frauds in motor insurance are the most prevalent in the industry. These frauds could be 'padded' or exaggerated claims, or even a result of staged accidents or false thefts. Each of these frauds can be explained as below:

- **NCB Fraud** - NCB or 'no claim bonus' is the reward given to the insured in the form of a discount, for not making a claim in the previous policy year. While switching from one insurer to another, if a customer does not disclose details of a claim made previously and attempts to avail NCB discount, it is considered a fraud. This, however, can be easily detected as the new insurer will check with the previous insurer to verify the same.
- **Staged Thefts** – Bajaj Allianz has received 431 theft related claims for private cars and 2419 for two-wheelers in FY 09-10, in comparison to 259 private cars and 799 two-wheelers stolen in FY 08-09, which indicates a huge increase in the number of thefts. Out of these, Hyundai Santro, Chevrolet Tavera and Tata Indica are the most commonly stolen cars, while Hero Honda Passion, Bajaj Discover and Bajaj Pulsar are the commonly stolen two-wheelers. But at times the thefts may be staged in order to avail a claim. For example, in the case of theft of an uninsured vehicle, the number plates are put to a different vehicle to get an insurance policy and thereafter register a claim on the same.
- **Claims Padding** - Also referred to as 'legalized frauds', this basically means increasing the damages to a vehicle in order to over-state the claim. This has been seen to done in collusion with motor dealers or repair garages.
- **Multiple Claims** – Motor insurance, generally, is an exclusive contract, implying that a vehicle can be insured with only one insurer under a single policy for a particular year. Multiple claims made on the same vehicle which has undergone total loss, for the same damage will amount to fraud.
- **Cash Loss** – In the case of cashless settlement of claims or reimbursement, the insurer settles the claim in good faith that customer will use the amount to get vehicle repairs. But, the customer does not get the repairs done and amount is pocketed.

  While most of the frauds can be detected at the inspection stage when a claim has been registered, NCB frauds can be caught at the time of issuing the policy itself. In case this fraud is detected once the policy is in force, the insurer will reclaim the amount from the customer.

In most cases, incongruity in the documentation or description of the incident can trigger suspicion. A delay in intimating the claim can also prompt the insurer to investigate deeper.

Steps taken by Bajaj Allianz to minimize frauds:

- Co-relating information from various sources
- Verification of vehicle details with RTO
- Physical inspection is an integral part of processing a claim
- Pan India tie-up with an external agency for NCB verification

Vijay Kumar, Head – Motor Insurance, Bajaj Allianz General Insurance said, *We rely on our surveyors as well as external investigators to probe some of the suspicious cases. Checking the previous service history of the customer or job cards can give clues in some cases. Documents in 'too perfect' condition also arouse suspicion."*

Tampered Odometer for a claim of ₹4.5lakhs

What happened

A claim was received by one of the motor dealers in Delhi for repairs on a Skoda car.

Suspicion Triggers

The first step was to verify the vehicle with the photographs that were taken at the time of proposal stage or renewal stage. This is called the pre-inspection stage. It was seen that the wheel rims of the vehicle were different as seen in the pre-inspection photographs. In fact, the photographs taken of the vehicle and the chassis number carried different dates. This prompted the team to probe further.

The investigation

On further investigation of the vehicle history and the pre-inspection reports (signed by the insured), it was found that the odometer reading at the time of the latest pre-inspection was 56445km. But the reading recorded during the inspection previous to that was 58321km. This implied that there had been a reversal in the kilometer reading.

When communicated to the policyholder, he threatened the claim team for the claim. After listening to his grievance, he was sent back. After various pressures from the IMD, relationship officer at the motor dealer and the pre-inspection agency, the insured accepted to withdraw the claim.

The result

The pre-inspection agency was asked to register an FIR against the surveyor and the IMD has been asked to stop business with the sub-IMD under him. The company has saved ₹4.5 lakhs on this fraudulent claim.

Cover Notes

As per the Motor Vehicles Act, a vehicle cannot ply on the road without a valid insurance cover. But at times, a policy cannot be issued immediately. In such cases, the insurance company issues a cover note. Cover note is a legally valid instrument given in lieu of a motor policy that covers all the risk associated with motor insurance issued by the insurance company. Hence, a cover note is handed over which is almost like a policy but with certain terms and conditions. Usually, a cover note has a validity of 60 days and so, a proper policy has to be issued within a week or so after which the cover note is rendered invalid. Cover notes are used by all motor insurance distributors including agents, motor dealers, far flung offices and other distribution channels.

Hence, it is almost just like a blank cheque which can cause both premium loss and / or claim loss on being misused. According to data with Bajaj Allianz, 15-20% of the cover notes has been found to be used for fraudulent activities, or is being investigated due to suspicion. The company has issued around 1.5-2 million cover notes in the last one year alone.

Some of the common frauds associated with cover notes are:

- Issuance of cover notes and pocketing of premium by not submitting the money to the company
- Changing sum insured of vehicles, period, make model etc to adjust premium and give undue benefits to customers
- Issuance of cover notes on already damaged vehicles or backdating of accident
- Issuance of cover notes to cover vehicles who have caused injury/death to life
- Fabrication of cover notes in collusion with IMD or employee
- Utilizing expired cover notes

These frauds can be detected at the time of payment premium or when a claim is registered against them.

Cover note frauds result in huge losses to the company both in terms of premium and claims. There is also a huge expenditure incurred in taking counter measures to prevent loss to the company.

Steps taken by Bajaj Allianz to minimize frauds:

- Reporting internally on missing cover notes, pending cover notes, problematic cover notes on a monthly basis and being the criteria for new indents
- Track each unused book issued more than a month and insistence on intermediary to complete the cover note book in three months
- Recovery of premium where money has not been received from intermediaries but cover notes have been issued
- Rationing of indents or complete stoppage of indents where cover note control is not in order
- Putting expiry dates on cover notes from last year – Both beginning date and last date with in which risk has to commence. All books beyond the period are recalled.
- Lodging FIRs and taking indemnity bonds from intermediaries to cover for possible fraud risks
- Giving training to all the staff to handle cover notes properly

Ketul Patel, Head – Internal Audit, Bajaj Allianz General Insurance explains, *"To prevent misuse of cover notes and notify the general public, we publish advertisements/notices in newspapers on the expiry of particular series of cover notes and hence, to avoid insurance on the same. This also involves a huge exercise of reconciliation of each and every leaf of cover notes across the country to come to missing figures."*

Heady mix of Forgery and hi-profile witnesses

What happened

A truck (insured vehicle) dashed into a third-party motorcycle causing death of 3 persons. FIR and all criminal papers were in order and the accident seemed to be genuine.

Suspicion Triggers

The first step of processing a claim is to verify whether the policy is in force at the date of accident. It was found that the policy was still in the cover note stage. Date of commencement of policy mentioned on cover note was 2nd February which was the same day on which the accident took place. But the premium for the policy was received on 5th February and policy was issued on 6th February.

The investigation

The location where the vehicle was inspected is 450 km away from place of accident. When the case was taken to the court, dependants of all three deceased were examined. To prove occurrence of accident, sitting MLA of the town was examined as eye-witness who stated that 2-3 ministers including Home Minister of the state were also present on the spot. On cross-examination, he stated that the offending vehicle was of black colour, whereas it was actually red. With the help of a special investigator, it was found that that the documents were faxed on 4th February from a PCO.

A detailed investigation report was filed, the evidence of which led to the grounds that Insurance policy of offending vehicle was obtained by fraud. On examining our accountant, it was proved that premium was received in our office after date of accident i.e. 5th February. The services of the accountant were thereafter terminated with the company.

The Result

It was thus concluded that this was an attempt of fraud in backdating the policy. The tribunal court finally pardoned the insurer with the liability and saddled the same on the insured amounting to a total of ₹11,56,000.

Third Party Frauds

Capt. Sanjay Moholkar | Head-Claims, Bajaj Allianz General Insurance

Frauds in Third Party (TP) claims are usually well-planned and involve a number or people. Such rackets are active in almost all parts of the country. The people involved in the racket use innovative methods for claiming under the provisions of Motor Vehicle Act, which in legal parlance is called as social beneficial legislation for the victims of Road Traffic Accident (RTA). This is a serious crime often committed by the white collared people wherein they make a fortune out of somebody else's misfortune.

Some common types of frauds in TP Claims observed over the years are –

- **Fake documents** – FIR, driving license, phony endorsements on driving licenses, fake medical bills, fabricated cover note or policy
- Change/replacing driver, or same driver involved in multiple accidents; Change / replacing of vehicle, showing involvement of vehicles having insurance or addition of vehicles in hit-and-run cases
- Passengers of Goods Vehicle shown as pedestrians, or unauthorized passengers in goods vehicle shown as owner of goods.
- Natural deaths converted to accidental death on road due to vehicle hits
- Non-traffic accident converted into road accident, suicidal cases or natural death cases shown as accidental deaths, adding entries in police papers for persons not involved in accident
- Two cases filed for the same person
- Fake police stations and fake courts have also been seen in extreme cases.

Such frauds often include the claimant; claimant's advocate, hospitals, doctors, owners of vehicles and even the police are equally involved in the fraud / fabricated cases as it would be difficult to get away without their help. Sometime they manage to make a case in such manner that it becomes so perfect that their identity often remains undisclosed.

Third-party frauds need to be taken very seriously as they are not only vitiating the society but also putting the policyholders' money at risk. In such cases, the insurer has an unlimited liability towards the damage, thereby making these more prone to be manipulated.

Steps taken by Bajaj Allianz to minimize frauds:

- Carefully scrutinizing the claim petition, investigation report, police papers, medical documents and all other relevant documents.
- If we suspect that there is some thing unusual, we dig into the matter to know the real facts. If required we reinvestigate the matter on specific issues and ask the investigator to bring on record certain documents which are necessary to distinguish the fake one.
- When there is a suspicion, we check the claimant's documents with the certified copies brought by the investigator to verify any manipulations. If it is revealed that story given in the claim form is not correct or driver was changed for sake of claim or insured has suppressed material facts, a legal notice is sent to the insured for manipulation / cheating and we ask him to pay back the settled amount. At times we also put pressure of filing a criminal complaint and most of the times they relent and withdraw the claim if it is a fake one.
- For TP cases, on intimation we appoint an investigator with specific instructions. If investigation of hospital records reveals that a non-traffic accident was converted into road accident or rider of the vehicle was shown as pillion, we take a proper plea, produce proper documentary evidence and call the proper witness before the court to prove our case. In few cases, the court has dismissed the case and given us the liberty for filing criminal complaints against the culprits.
- We also involve advocates by holding seminars or meets and thereby explaining the nuances of TP claims and related frauds.

Capt. Sanjay Moholkar, Head-Claims, Bajaj Allianz General Insurance says, *"It is important to defend such cases before courts or tribunals so as bring to their notice that such frauds are a drain of public money which ultimately results in increase in cost of third party premium due to increased pay outs for such claims. Insurers need to be more innovative to bring these frauds to the notice of all concerned; then only will it be possible to defend them and avoid the drain on public funds. We have been successful in getting back money paid towards 'own damage' claim of vehicles in many cases where it was found that insured misrepresented the facts about name of the driver by showing fear of criminal complaint. In few cases, money has been recovered even after lapse of more than a year when things were revealed at the times of lodging a TP claim."*

Bajaj Allianz ensures Investigating agency for TP frauds

Third Party (TP) frauds are many a times the scale of rackets and involve investigations and legalities similar to those in criminal cases, due to the number of entities involved like the insured, third party, police, doctors, witnesses etc. Not only do TP frauds pose a social malady, but are also a cause of huge financial drain to insurers. TP claims can arise 1-2 years after the first intimation of accident was received. This requires insurers to make provision for funds in case the claim needs to be paid, which results in blocking of funds that can be used for investments or other purposes.

In a meeting of all public and private sector insurers and the Criminal Branch of CID (CB-CID) held on 9th March 2010, it was revealed that nearly 1200 complaints on fraudulent insurance cases were still pending. In a writ filed previously by National Insurance Company, all false insurance claim cases were to be investigated by CBI. However, it was not possible to CBI to investigate all cases and they were not taking new cases for investigation due to the large back-log. On approaching the CB CID, they too refused to entertain insurance fraud cases by giving the excuse that as per orders from High Court, all such cases would be investigated by CBI only.

To overcome this problem, **Mr. V S Dhurairaj & Mr. Balaji from the Bajaj Allianz Legal Team** took the initiative, with the help of other private insurers, to plead the CBI for a re-investigation of certain cases. The Counsel for CBI however objected that they did not have manpower to investigate further cases. Counsel for CB-CID also expressed the similar situation but used the word that they have "less infrastructure". Moreover, since CBI was already in the picture, they did not want to get involved in the matter.

On behalf of the insurance industry, the counsel for **Bajaj Allianz** argued the matter in brief and explained that the situation was back to square-one, with no one to resolve the fraud cases. Considering the line of reasoning, the Court passed the order as below:

- CB-CID has to investigate the future fraud complaints referred by insurers, including the pending complaints before them
- CBI has to investigate the pending matters referred to them
- Copy of final report has to be made available to insurers upon payment of prescribed fees
- In case of any infrastructure required by CB-CID/CBI the same may be provided by the concerned insurer
- To aid the CB-CID in these investigations, **Bajaj Allianz has provided infrastructure in the form of office equipment like Computer, printer etc. in the Tamil Nadu branch of CB-CID.** The model is being replicated in other cities across the country.

Some of the success stories of the CB-CID are:

- Total 25 cases referred by Bajaj Allianz to CB-CID
- In 15 cases CB-CID has registered FIR's mainly against claimant, insured, driver & in some cases against police officers too
- Recently in one fraud case complaint against four private persons, one doctor of a medical college and two police officials U/S 420 IPC has been filed by CB-CID

Claimstrack A quarterly review of claims handled

Life

Claims Settlement | April - June 2010

	Claims Outstanding as on 1 Apr 2010	Claims intimated	Claims settled	Claims repudiated	Claims Outstanding as on 30 Jun'10
Death	1524	5848	3710	234	3428
Riders	18	132	40	29	81
Health care	4	15	11	2	6
Total number	1546	5995	3761	265	3515
Total amount*	32.71	84.04	49.20	5.52	62.02
Claims Settlement Ratio - 93%					

*in ₹Lakhs

Claims Paid Analysis - Turn-around-time (TAT) | April-June 2010

	Count of days					Total no. of claims decided
	0 - 15	16 - 30	31 - 45	46 - 60	> 60	
Number of claims	901	1420	866	299	540	4026
Claims paid within 45 days - 75%						

Cases referred to Consumer Forum & Ombudsman | April - June 2010

Total no. for Cases received	No. of cases settled	Bajaj Allianz Won	Bajaj Allianz Lost
92	6	6	0

"During the first quarter, we have decided 4026 claims, out of which 93% claims were paid amounting to ₹4920 lacs.

There has been a 9% increase in claims decided within 30 days and overall improvement of 48% in total cases decided as compared to the corresponding period of last year. Continued efforts are being put to drastically bring down pendency numbers, which will also help in reducing timelines further."

P Ravi Kutumbrao,
Sr. VP - Claims
Bajaj Allianz life Insurance

Non Life

Paid Turn-around-time (TAT) | April - June 2010

	0 - 30	31 - 90	91 - 180	> 180		
	Count of claims				Total no. of claims	Total amount paid in ₹Crore
Motor (excluding TP)	82,970	9,347	1,381	668	94,366	145
Property & Engineering	568	433	179	181	1,361	19.2
Health	13,828	4,555	887	537	19,807	40.4
Miscellaneous & Others	3,337	1,636	601	386	5,960	31.3
Total	100,703	15,971	3,048	1,772	121,494	236
Claims paid within 90 days - 96%						

Claims Settlement | July 2009 - June 2010

	Outstanding as on 30th Jun'09	Registered from 1 Jul'09 to 30 Jun'10	Paid from 1 Jul'09 to 30 Jun'10	Outstanding as on 30th Jun'10
Motor (OD)	20,169	384,265	388,753	18,040
Motor (TP)	38,495	25,906	14,407	50,643
Property & Engineering	2,449	7,296	7,767	2,112
Health	6,643	89,570	91,518	5,700
Miscellaneous and others	5,286	27,930	29,674	4,404
Total	73,042	534,967	532,119	80,899
Claims settlement ratio (excluding TP Claims) - 95%				

Cases referred to Consumer Forum & Ombudsman | April - June 2010

Total no. of cases received	No. of cases settled	Bajaj Allianz won	Bajaj Allianz lost
451	273	163	110

"Inspite of an increase in the inflow of claims to the extent of 10% as a result of the Cyclone Laila, we could maintain a settlement ratio of above 90% (excluding TP claims), every quarter for the last 2-3 years."

Capt. Sanjay Moholkar,
Head - Claims
Bajaj Allianz General Insurance

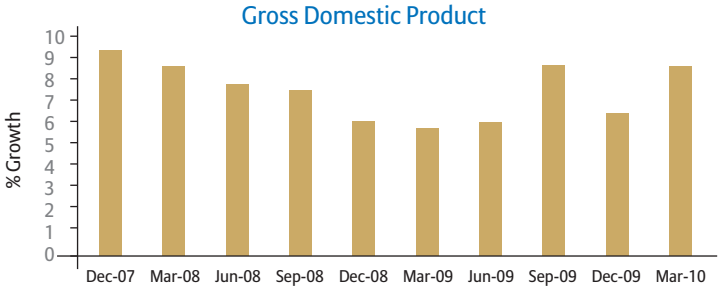
India Market Outlook

Sampath Reddy | Head Equity
Bajaj Allianz Life Insurance

The performance of equity markets performance stays stable in FY10-11. While the Nifty and Sensex are up by about 2% for the current year (from 1st April to 9th July 2010), this performance is on the back of strong returns in FY09-10. Sensex at 17,900 is about 15% away from its all time high of 20,870 on 9th Jan 2008. While Sensex is yet to catch its peak, several of our equity funds have surpassed the previous peak NAVs. See the table below:

Name	9-Jan-08	9-Jul-10	Return (%)
Equity Mid Cap Plus Pension Fund	29.38	42.62	45.06
Equity Mid Cap Plus Fund	28.63	38.47	34.38
Pure Equity Fund	17.70	22.54	27.38
Pure Stock Fund	16.91	21.11	24.88
Accelerator Mid Cap Pension Fund	18.68	22.44	20.11
Accelerator Mid Cap Fund	18.95	21.65	14.25
Asset Allocation Fund	11.26	12.68	12.64
Equity Mid Cap Fund	27.40	30.83	12.52
Equity Plus Pension Fund	33.19	35.84	8.00
Premier Equity Gain Fund	19.91	20.09	0.91
Equity Plus Fund	37.98	35.81	(5.73)
Equity Growth Pension Fund	18.02	16.84	(6.53)
Equity Gain Fund	36.40	33.84	(7.05)
Premier Equity Growth Fund	17.88	15.70	(12.18)
Equity Growth Fund	17.88	15.66	(12.40)
CNX Midcap 100	9417.00	8130.00	(13.00)
BSE Sensex	20873.00	17700.00	(16.00)
Nifty 50	6287.00	5312.00	(16.00)
Nifty Midcap 50	3900.00	2766.00	(29.00)

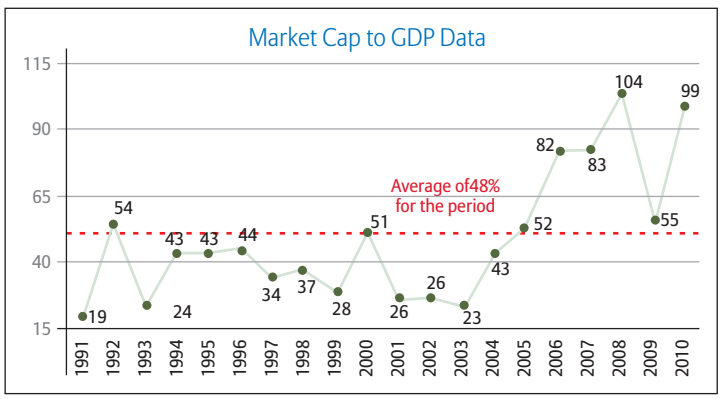
India's Macroeconomic outlook is improving gradually. The recovery is well established with the stimulus still in place. Index for Industrial production has grown by 11.5% for the month of May. The IIP growth rate at about 10% is expected to be sustainable. GDP growth has rebounded to 8.6% in Jan- March quarter of 2010 from the low of 5.8% in Jan-March quarter of 2009. The growth is broad based encompassing both infrastructure and consumer discretionary sectors. Governments thrust on road and power sector has lead to continued growth in order inflows to the companies in the sector. Automobiles such as passenger cars and two wheelers are maintaining their strong growth rate of upwards of 15%. Credit growth also remains strong at over 19%, and our interactions with banks suggest that the risk to NPA is receding. Given the strong recovery in the economy and due to rising inflation fears, Government is already rolling back some of the stimulus measure taken during the time of global credit crisis. Reserve Bank of India has increased both repo and reverse repo rates by 25 bps each to 5.5% and 4% respectively on 2nd June 2010. Further tightening in the monetary policy is anticipated in the forthcoming credit policy on July 27th.



Fiscal situation of the central government is improving. Government has raised `67,700 crores from the 3G spectrum auctions and another `38,540crores from broadband/Wimax license auctions in the current quarter. This has eased the government financials and improved the visibility on controlling the fiscal deficit as estimated in the budget statement. Further, the Government has announced reforms for the oil pricing mechanism by stating that petrol prices would be market linked and also increased the prices of both auto fuels and cooking fuels. This bold move of increasing fuel prices for petrol, diesel, LPG and kerosene in a coalition government in a scenario of rising inflation inspires confidence. Due to these measures and overall improved financials of the government bond yields have softened from about 8% at the beginning of the financial year to current level of 7.6%.

Role of Emerging markets in world GDP growth is increasing. IMF in its recent forecast has upped the growth forecast for world GDP from 4.2% in April to 4.6% now for the year 2010 though it has cautioned that the risks to the growth exist from financial markets. IMF has also mentioned in its forecast that India will be the second fastest growing economy at 9.4% growth for this year. Due to strong growth in Emerging markets, it is anticipated that the capital flows to the emerging markets expected to remain strong. FII's have put in USD 21bn in Indian equities during the last financial year. The net FII investments continue to be strong at USD 2.3bn in first quarter of the current financial year. The strong FII flows has been the key driver of equity markets in the recent few months as the fund flow from Mutual funds and Insurance sectors is relatively muted.

As the macroeconomic indicators have been showing a strong recovery in our economy, over the past couple of quarter, the corporate financials have also been mirroring the similar trend in growth. Sales and profits growth trends have turned into positive for the last couple of quarters, and the profits are estimated to grow at about 19% for the 1st quarter of the current financials year. The growth



in earnings is broad based encompassing sectors like automobiles, Capital goods, Financials, Consumers sectors

However, the Sensex at the 18,000 level is factoring in most of the positive developments in the corporate sector. Market cap to GDP ratio at about 99% is just 600 bps away from its all time high, indicating that valuations are closer to the higher end of the band. While the economic outlook continues to be good, we believe, the return expectations should be moderate given the higher valuations. Indian equity market is trading at 17x to FY11 earnings estimate. This in comparison with other emerging market is on the higher end. Our approach to investing would continue to be on risk adjusted returns. We currently cautious on deploying funds in equities and have raised the cash levels in our funds.

1 year Return as on 30th June 2010

Cash Funds	1 Year
Cash Plan	5.80%
Cash Plus	7.66%
Cash Plus Pension	8.19%
Liquid Fund	7.24%
Liquid Pension Fund	7.47%
Crisil Composite Liquid Index	**3.29%**

Debt Fund	
Debt Plan	6.00%
Debt Plus	8.23%
Debt Plus Pension	8.90%
Premier Debt Fund	7.11%
Life Long Gain	4.50%
Bond Fund	8.00%
Premier Bond Fund	6.30%
Bond Pension Fund	7.44%
Crisil Composite Bond Index	**4.69%**

Equity Funds	
Equity Gain	27.00%
Equity Plus	28.88%
Equity Plus Pension	36.96%
Premier Equity Gain	36.37%
Equity Growth Fund	27.91%
Premier Equity Growth Fund	32.42%
Equity Growth Pension Fund	35.97%
Unit Gain Mid Cap	40.99%
Unit Gain Mid Cap Plus	64.46%
Unit Gain Mid Cap Plus Pension	63.59%
Accelerator Mid cap Fund	61.60%
Accelerator Mid Cap Pension Fund	61.37%
Pure Equity Fund	35.31%
Pure Stock Fund	33.29%
Pure Stock Pension Fund	51.65%
CNX NSE Nifty Index	**23.80%**

Asset Allocation Fund	17.04%
Asset Allocation Pension Fund	15.60%

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Bajaj Allianz Easy Householders Package Policy

Arnav Pandya

Bajaj Allianz Easy Householders Package policy is an insurance policy for the coverage of risk present in the house of an individual. It is a policy designed to simplify the householders insurance offering that will ensure the required insurance cover is available for households. Here are some of the features and its implications for the prospective policyholders.

Ease of purchase

This is a very simple policy to purchase because there is just a one page form that needs to be filled in while taking the policy. Usually when it comes to a householder's policy there is a lot of details that have to be filled in because of the large number of appliances and other items that has to be insured in the home. However, with the Easy Householders Package policy everything is adjusted in a one page simple format that has all the details covered.

This is an over the counter product and is available in the form of a kit which adds to the comfort level of the buyer. Once the details and form is filled, the product is easily activated through the call centre or through an SMS. The time taken in completing all this is also not very long which also helps the individual in their efforts of purchase.

Flexibility

There are three options that are available for the customer when it comes to the Easy Householders package policy. The premium for each of these areas is clearly mentioned (₹650, ₹1,030 and ₹1,910) and at the same time the extent of the coverage for various areas like fire, burglary, breakdown of equipments and even domestic appliances and baggage is mentioned. The coverage of personal baggage while travelling in India also ensures that there is a wider coverage that is available for the individual. The other side is that those who want a higher cover for their property would not find this very useful. Hence its flexibility would be restricted once the range provided for in the policy is crossed.

There is a choice for the individual to have various items covered including domestic and other electrical appliances but what is not covered and the conditions under which this would be applicable is also clearly mentioned. All this ensures that the policyholder knows the details making it less complex and this also becomes a plus point for the buyer while looking at the policy.

The policy can be cancelled by the company or the policyholder after giving 15 days notice. When the company cancels the policy, the pro rata premium for the remaining period would be returned. On the other hand, when the customer cancels the policy then depending upon the time period that has passed a part of the premium would be returned. In case of cancellation after 6 months, no premium will be returned.

Target market

The target market for this policy is the house owner who would like to ensure that there is protection for their items that they own. Several of the areas that are covered include fire, lightning, explosion, implosion, aircraft, riots strike and malicious damage, storm, cyclone, hurricane, flood, bush fire, earthquake and bursting and or overflowing of water tanks. This covers a wide range of events ranging from natural causes to other that are experienced as a part of living in the country and hence need protection against. There are specific exclusions like war, invasion, civil war, depreciation due to wear and tear, loss or damage due to nuclear weapons and terrorism.

There are also several items that are not covered like Air Conditioners as well as those appliances that are over 10 years old. In addition the replacement cost of the items would be covered and in several areas there is an initial specified percentage amount that will have to be paid by the individual in case of loss. So these need to be kept in mind because these will impact the decision making process of the house owners as they evaluate the policy.

Ease of claims settlement

The claim intimation process will require that the claim form along with basic details be given to the company. Based on this information, the company decides whether a surveyor is required. In some cases additional documents like statement about the loss incidence, Fire brigade/FIR report and list of damaged items along with repair bill might have to be given. Once all this along with the surveyor report is received then the company will decide on whether the claim is to be accepted or rejected. For the policy holder, all this is not very tough to complete.

Cost aspect

On one hand there is the premium that is known beforehand as there are specific levels that are covered under the policy and this has a known figure that is attached to it. At the same time, there is also the additional cost in terms of the payment that they would have to make for the initial claim upto a certain level. This is highlighted as the initial 5 per cent cost arising out of Act of God perils like lightning, storm, flood etc has to be paid by the policy holder. In case of computers, the first 10 per cent or ₹2,500 (whichever is higher) and 10 per cent or ₹500 (whichever is higher) in case of other electronic equipment would have to be paid by the individual policyholder. All this ultimately represents a cost for the individual.

★★★★☆

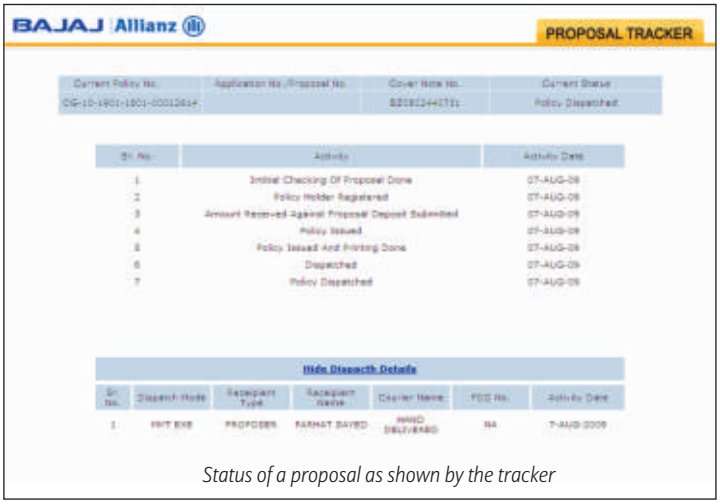
★	*Not recommended*
★★	*Invest with caution*
★★★	*Average investment*
★★★★	*Good investment*
★★★★★	*Must invest*

The reviewer is a Certified Financial Planner and a columnist with leading publications in India. He has professional qualifications as a Chartered Accountant and a MBA from IIM Bangalore with specialisation in Finance. His columns have appeared in The Economic Times, Times of India, Hindustan Times and Business Standard. He has nearly a decade of experience in the financial planning field covering activities like training, creating study material, preparing practical user guides and conducting seminars.

Track your Insurance Online

Bajaj Allianz provides a simple solution to track your insurance proposals online. This Proposal Tracker is available on the 'Customer Service Menu' section of the corporate website www.bajajallianz.com.

The Proposal Tracker can be used to find the status of a particular proposal or an application submitted with the operations team. Any particular proposal can be identified using various criteria, which have been provided with, as per practical requirements. It is ideal for all types of customers and reduces manual intervention in retrieval of data.



Status of a proposal as shown by the tracker

Benefits

The Proposal Trackers helps in the following ways :

- Customers and IMDs can get to know the status of their application any time, from anywhere. They need not approach any office.
- Since the search is provided on various criteria, it is very easy for the user, who can use any information to find the status of the proposal such as registration number of the vehicle, application number, cheque number, chassis number, number of the previous Bajaj Allianz policy etc.
- Customers can also know the status of the proposal and the reason and details of Delay or dispatch etc.
- The intermediaries can come to know about any requirements raised or deficiencies of any proposal immediately and thus act to resolve at the earliest.
- Intermediaries can also gain access to the data using their Agents' Portal Login. In this secured link, they can access data pertaining to their customers only.
- The time spent by operations team on attending enquiries from the customers, intermediaries or other departments is significantly reduced by the tracker.

Bajaj Allianz website gets a makeover

Bajaj Allianz introduces a new face to its corporate website. The features of the new website www.bajajallianz.com include:

- Buying insurance online made easy
- Blogs by CEO of Bajaj Allianz Life insurance
- Claims assistance
- Manage your life insurance policy online

Microinsurance: India shares learning

Kamesh Goyal, Country Manager-Allianz and MD & CEO-Bajaj Allianz Life Insurance addressed a forum of international journalists in Brazil on "Microinsurance: India experience and examples to Brazil". The event, organised by Allianz-Brazil was attended by over 100 journalists and received a good response from the media with 106 news clippings appearing in the local media.

Health cover for Art of Living Teachers

Bajaj Allianz General Insurance has covered the teachers of Art of Living (AOL) under its group mediclaim policy. This group master policy has been offered to 637 teachers across the country working with the Vyakti Vikas Kendra of AOL. The policy was handed over to Sri Sri Ravi Shankar by Kamesh Goyal in Bangalore.

Rain Water Harvesting

With the objective of saving the precious resource of water, Bajaj Allianz has implemented rain water harvesting in its Head Office. This eco-friendly initiative will help get rid of the dependance on tankers to supply water to the facility in Pune accommodating 1200 employees.

Tie up with ING Financial Services

Bajaj Allianz has tied-up with ING Financial Services to offer its general insurance portfolio of products through their network of 68 branches. The MoU was signed by Mr. Rajan Pathak, VP & National Head, ING Financial Services and Mr. Hemant Kaul, CEO, Bajaj Allianz General Insurance.

ING is a global financial institution offering banking, investments, life insurance and retirement services to over 85 million private, corporate and institutional clients in more than 40 countries.

Two Bright Futures

Bajaj Allianz has launched a unique initiative called 'Two Bright Futures', wherein the company will set aside ₹100 for every child insurance plan sold towards funding the education of under-privileged children. The funding corpus would be handed over to select NGO's across the country, which are working for a similar cause.

In the first phase of the program, Bajaj Allianz has tied-up with Aseema Trust, a Mumbai-based organization working towards providing holistic education to children living on the streets or in slum communities. Aseema works in partnership with the Municipal Corporation of Greater Mumbai to impart value-based and quality education to children from pre-primary to Standard 10.

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*10% of each Net Premium added as Loyalty Additions from the 11th Policy Year provided all due regular premiums have been paid in full. **Refund of 75% of the cost of life insurance risk premium at maturity till the due date of first unpaid regular premium (excluding any extra premium).

UINs: Bajaj Allianz Invest Plus Premier: 116N093V01

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