SBI General Insurance Company Limited

Customer Complaint Management Policy Version 3.0

A document to detail Grievance Redressal Process

Operations Department
16th April 2013

Foreword

Any organisation to succeed and build a brand of repute needs to stay focussed on Customer. Though a great deal of Customer trust and confidence builds during any sales process, it is sustained and emphasised by the quality of product or service delivery. Any disconnect between the two leads to disenchantment of the Customer.

In this era of cut-throat competition where companies are vying for a bigger share of the cake, all out efforts are made to minimise Customer dissatisfaction. Companies are also going all out to ensure that all such cases of dissatisfaction are captured, investigated, processed and cured. This is called the Complaints Management.

Besides, regulators of almost all industries also expect organisations to build a strong Customer Grievance Redressal Process.

This document spells out the proposed Customer Complaints Management process of SBI General. On one hand it deals with the transactional aspects of Complaints Management cycle; on the other it also ensures that regulatory requirements are met. You will find a detailed process maps and process elaborations in a simple, readable and easy to understand format.

Lately, IRDA has issued 'Guidelines for Grievance Redressal by Insurance Companies' vide it's Circular No 3/CA/GRV/YPB/10-11 dated 27th July 2010. Our Customer Complaint Management document stands updated to comply with the guidelines.

Lastly, but most prominently, this Process or Policy keeps the focus on one aspect of its intention – ***Customer Care***.

Head - Operations

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Introduction

A Complaint is an expression of dissatisfaction by a Customer, with the organization's procedures, charges, employees, agents or quality of service. Complaints are a critical form of communication; these are the alerts for corrective actions on products or services in line of business. Complaints are neither made for the purpose of pointing out who is right and who is wrong nor are defined by the decibel levels & the phrases used by the Customer. They provide an opportunity to fix immediate problems, offer constructive ideas for improving products and extending first-rate Customer Service that will keep our Customers our friends for life.

The Customer who does not complain and does not come back is the one that hurts business most of all. This silently siphons off profits. Various surveys conducted by professional agencies indicate that:

- A majority of Customers who are dissatisfied with service don't complain - They think companies don't care and nothing (much) will come of their complaints. An uncaring treatment is the most commonly cited reason.
- 90% of those Customers will not come back again, each one of these will tell a minimum of 9 to as many as 20 other people about his or her experience. This is severe market damage for the brand.

- Research by various agencies indicate that, if you receive 1 complaint:
  24 customers have not complained
  22 customers do not come back,
  198 people - or many more - are told about the experience

Complaints are expensive, both in direct and indirect costs. But for this price, companies can extract priceless knowledge, because complaints contain the direct Voice of Customer. If complaints are transformed into knowledge about Customers, they can provide a valuable amount of capital for enterprises. If these complaints are addressed strategically, they are a goldmine of information for the organisation for continual improvement and service excellence.

IRDA has defined the Grievance /Complaint as below and has distinguished the same from "Inquiry" and "Request" as below in the Guidelines for *Grievance Redressal by Insurance Companies.*

Grievance/Complaint: A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard of service/deficiency of service of an insurance company and/or any intermediary or asks for remedial action.

Inquiry: An "Inquiry" is defined as any communication from a Customer for the primary purpose of requesting information about a company and/or its services.

Request: A "Request" is defined as any communication from a Customer soliciting a service such as a change or modification in the policy.

The Company believes in the line of thinking of the Regulator and will ensure meeting of the expectations in both letter and spirit.

Complaints Management

Customer complaints management has become an integral part of business, both from a regulatory perspective and a Customer Service standpoint. Regulatory bodies have established specific requirements for capturing, investigating, resolving and reporting Customer complaints. Simply stated, Complaints Management is the formal process of recording and resolving a customer complaint.

An effective Complaints Management system is integral to providing quality customer service. Often, customers are the first to identify gaps between service proposition and service delivery when things are not working properly.

Importance: The importance of a good Complaints Management process need not be over-emphasised. Any efficient process will add to a high level of Customer satisfaction and trust thereby enhancing brand image. Some very tangible gains that a good process will result into are –

- Creation of a Customer focused culture – Documentation and adherence to a well defined process will help merge Customer Focus into the DNA of an organisation. This will also entail taking a holistic and organizational approach.
- Operating cost reduction – Indirectly, Complaints Management will help in operations cost reduction. Though managing complaints will entail some investments, following returns will compensate the costs –
  - Opportunity to fix deficient business processes and procedures, combined with management issues.
  - Prevention of recurrence and thereby siphoning of profits.
  - Long lasting positive impact on cost of operations, employee morale and productivity
- Reduction of brand and market damage – In other words this is building of Customer trust. This will result into -
  - Increased yield of marketing and sales budgets.
    - Reduced the silent profit siphoning!
- Customer acquisition cost reduction and retention - It costs five times more to acquire a new customer than retaining one. Bad management of Customer issues is a disservice and can lead to a good Customer walking away from organisation.
- Increased Customer loyalty - Handling customer complaints in a positive and caring way leads to at higher retention and a long term relationship.
- Bolstered Customer Experience – A well handled complaint and service recovery can create 'service legends' – a well treated Customer will be the ambassador of Company's products and services. On the contrary a mistake could take away a few prospects.
- Increased sales and profitability – Needless to mention, a good Customer Experience rendered in the interactions at complaint handling is both a top-line and bottom-line contributor.

Our Approach

Our Complaints Management process will be a mechanism through which Customer feedback is incorporated in our policies and procedures on an ongoing basis. This will also help us build quality service by minimising complaints and maximising output.

We envision influencing effectiveness of services delivery and providing ease of Complaint redressal to the Customer.

We propose to follow two-tier policy in respect of complaints received from Customer and those received through regulatory bodies.

Complaints Received from Customers: We propose the P.A.C.T. (Process, Attitude, Communication, Time) philosophy in handling Complaints.

- **Process:** We will have an easy to understand Complaint Management Process for the Customer's allowing them to express their dis-satisfaction in a simple manner. Multiple channels like e-Mail, Web, Chat, Telephony, Front-Desk at our Branch Offices, Facsimile and traditional snail-mail will be available for the Customer to reach us. In order to facilitate an efficient internal complaints management procedure, we will also design a robust set of activities internally to ensure faster, fair and just resolution to customer complaints. A dedicated Customer Complaints Management Unit (CCMU) will be set up within the Operations Department. This Team will continually seek complaint resolution by the respondent department. CCMU will be the custodian of Customer's interest. CCMU will also give a feedback to departments to minimize or eliminate repeat of complaints from time-to-time.

  The HOD's of the respective departments will ensure that their relevant department responds quickly to the complaints raised by CCMU and minimize the need for escalation.

  We shall always integrate and stay updated on Integrated Grievance Management System of IRDA and all such channels set up by regulator or any such authorities from time-to-time and serve as additional channel for our Customers to approach us.

- **Attitude:** We intend to bring **a Positive Attitude** in to our approach to complaints handling. We believe that it is only positive attitude that will enable co-operative understanding of the complaint rather than defensive one. This will also send a message to the Customer that he is being cared for.

- **Communication:** Effective communication is the key to successful Complaint Management and customer engagement. We believe in not only **Acknowledging** the complaint, but also **keeping the customer informed** on the progress and resolution of the complaint with a defined TAT committed. We intend to keep the Customer updated at periodic intervals or on any status change.

  We shall post/update/share status of the case and any other communication with our Customer on our web-site's Customer Portal/Interface and feed them to IGMS or any such information dissemination interface developed and deployed by any authority/ies in future.

- **Integration** with IGMS and any such future development and deployment by any authority/ies in future will be ensured to disseminate live and latest information to our Customer approaching us through such interface. This will enhance our commitment and transparency to the Customer grievances.

- **Time:** The focus of our Complaints Management process is timely and effective Complaints resolution to our Customers by complying with the TATs. Each department of the Company will ensure that the TAT is adhered to by ensuring that the complaints raised to their department are resolved within the set timelines.

  Whilst adherence to clearly defined timeline helps in generating a higher Customer trust, satisfaction and retention, it also internally helps reduce complaints inventory.

Complaints received through Regulator, GIC and Ombudsman: We propose to handle complaints forwarded by these bodies in a manner that it is in line with the expectations laid out by the respective body. In addition to the observance of PACT philosophy, the following additional elements will integrate in our process to meet expectations of these authorities:

- **Resources**: We will have **one point contact**, the Compliance Officer, with certain decision making authority for prompt and effective response to the complaint/query received from IRDA/Ombudsman.

- **Complaint Classification**: Our Complaints Management process will set the level of emergency of complaints and protocol to be followed. This will be in line with guidelines received from IRDA/Ombudsman from time-to-time.

- **Communication** on the resolution to the Authorities (IRDA/Ombudsman) will be responsibility of the Compliance Officer. The resolution to be communicated to the Customer will be the responsibility of the CCMU.

- **Data Collection & Reporting** of complaints will be done by CCMU along with Compliance Officer. Submissions of various periodic statistics and statutory MIS will be from the desk of the Compliance Officer.

- **Awareness and encouragement:** The Company shall always strive to record every case of Customer dissatisfaction on our CRM application. Awareness initiatives, drives and training intervention will be conducted periodically to sensitise employees, intermediaries and partners to record Customer matters to us. This will help us have early visibility, better reflection on our services vis-a-vis Customer expectations and an opportunity to improve our service delivery.

Complaint Management Process

We will develop our internal processes to reflect our guiding principles and philosophy discussed earlier. From the perspective of distribution of tasks as also ascertaining the level of fulfilment, the process will be designed into different stages. Proposed processes steps and automations within stages are discussed in paragraphs below.

Complaint Logging: In this stage we will capture the area of discontentment. Guided by our philosophy to be available to the Customer in an easy to approach manner, we will provision for multiple modes of reaching us. Incoming communication modes for receiving complaints/feedback are -

- Phone – local Branch phone network and Toll Free Contact Centre
- Email – dedicated ID of customer.care@sbigeneral.in
- Snail Mail [Letters/Telegrams/Feedback Forms, etc]
- Branch Offices (walk-ins)
- Web Site
- Chat
- Facsimile
- SMS
- Integrated Grievance Management System Portal/Interface of IRDA
- Any other future portals/interfaces mandated by IRDA or such authorities

Every complaint, irrespective of the mode of reaching us, will be registered into a single database provisioned in the CRM application. Complaints will be given an automated and unique "ticket" number or Complaint Number which will be identifier for further tracking and movement.

Complainant will also be given IGMS generated 'IRDA Token Number'. We shall also feed IRDA with our unique reference number on live basis. Such integration will be ensured with any future developments of on-line complaint registration by any authority/ies.

In addition to the modes of Customer interaction with us, Company will make all effort to publicise and propagate the channel of grievance redressal by visual display at Branches and need based publications / mailers to the Policyholders.

Acknowledging: Customers do not register complaints with only a casual interest in their disposition. Complaining involves some inconvenience and possibly expense, so we will acknowledge each of such complaints after registering through CRM with the Complaint Number and IRDA Token Number. Acknowledgements will be instant – dependent upon the mode of incoming complaint. A written acknowledgement of complaint will be sent within three working days of the receipt/registration of the grievance, of the officer who will deal

with the grievance. Contact will also be maintained with the Customer throughout the investigation by various channels and modes.

Complaint Categorisation: It is important to classify and put complaints into different buckets from a resolution responsibility stand-point. Another advantage of categorisation is also to set criticality and thereby define resolution TAT expectations. The Company will aim at meeting the expectations of the Regulator as enshrined in the IRDA Regulations and Guidelines issued from time to time.

We will also take care to synchronise our classification with that of the Integrated Grievance Management System (IGMS) proposal of IRDA. We will set the resolution ownership/responsibility and TAT and will be defined for each of the category. Care will be taken for auto-classification of certain complaints.

We shall always strive to be in synchronisation with IGMS classification and keep our systems and classifications updated from time-to-time.

Detailed list of categorisation of complaints as prescribed by the Authority is appended as Annexure I.

Complaint Routing: Once the complaint is received, registered, acknowledged and categorised, the complaints will routed to the respective department who are responsible to work upon them and resolve within TATs. CCMU at the backdrop will monitor cases. This will be to ensure that the resolution or the corrective actions are taken within the time prescribed or communicated to the Complainant.

Provisions will be made in the software tool to assign a matter to the next level of authority or channelize it to a different department for opinion or decision making.

Complaint will be first routed to the respective Department basket to work upon and if the TAT exceeds the same matter will be routed to the next higher authority. This will ensure a dual check and monitoring mechanism leading to faster resolutions.

Complaint Processing: Complaint will be processed primarily by the respondent department. They will investigate, analyse and capture all the comments of conversations and findings, record their side of interpretation or details against the CRM ticket. Actions taken or proposed to be taken will be recorded and resolution provided. Expected timelines for complete resolution, in cases where instantaneous resolution is not possible, will also document. This capture of details will act as base for an interim communication, if any, to the Customer.

In case there are internal escalations, they will also be captured. This will keep CCMU updated on the processing.

Complaint Processing Steps:

(a) The CCMU shall send a written acknowledgement to a complainant within three working days of the receipt of the grievance. Where the complaint is resolved within three days, the CCMU will communicate the resolution along with the acknowledgement.
Acknowledgement will contain the name and designation of the officer who will deal with the grievance. Acknowledgement shall contain the details of the Company's grievance redressal procedure and the time taken for resolution of disputes.
Where the grievance is not resolved within 3 working days, Company will attempt to resolve the grievance within two weeks of its receipt and send a final letter of resolution.

(b) Where, within 2 weeks, the Company sends the complainant a written response which offers redress or rejects the complaint and gives reasons for doing so,

(c) Company will inform the complainant about how he/she may pursue the complaint, if dissatisfied.

(d) Company will inform that it will regard the complaint as closed if it does not receive a reply within 8 weeks from the date of receipt of response by the insured/policyholder.

Complaint Resolution: This is the stage where final decision and/or corrective action are taken on the complaint. Corrective action can be reflected in the form of corrected document, settlement of a claim, payment of balance amounts or refunds, explanations or details, etc.

Every corrective action will be recorded on the complaint history and related document number generated will be available there in. This will give CCMU the visibility on all facts to comprehensively respond to the Customer.

Respondent department may communicate the resolution directly to the Customer, dependent upon the nature and seriousness.

Resolution Communication: Complainants will be communicated the resolution or action taken on their complaints. Instant resolutions ('Done-in-One') will be communicated to the Customer over the same call.

Complaints that are required to be processed internally for resolution may be responded by the respective Department. However, a formal resolution communication is made by CCMU in a written form. Further, as required by IRDA's mandate on Protection of Policyholder's Interest regulation a communication about alternate remedy available through the scheme of Insurance Ombudsman under RPG Rules 1998 will be sent with this letter.

Though our letter will need to be legally accurate and protect Company's interest on any subsequent legal remedy sought by the Complainant, we will also make an attempt to explain our legal position in simple to understand language for the benefit of Customer.

IGMS Status Update: We shall at all time feed relevant and necessary status update to IGMS System for its display and communication on the IGMS Portal.

In case any authority develops and deploys such self-service portals for Customers, we shall strive our best to feed live and latest updates to such interfaces.

Feedback Collection: It is important to gauge the aggrieved Customer's reaction to the manner of handling and their satisfaction on the resolution provided. CCMU will record Customer Feedback on to the systems/record files for any future reference or analysis.

Feedback will be collected by CCMU for all the complaints registered and resolved.

Closure: Complaint closure is a final and very critical stage in the lifecycle of Complaints Management. A great responsibility rests with this stage where we will ensure that all issues raised have been fully and comprehensively addressed, resolutions formally communicated and Customer feedback on resolutions is captured.

A complaint shall be considered as disposed of and closed when

(a) The company has acceded to the request of the complainant fully.
(b) Where the complainant has indicated in writing, acceptance of the response of the Company.
(c) Where the complainant has not responded to the Company within 8 weeks of the Company's written response.
(d) Where the Grievance Redressal Officer has certified that the Company has discharged its contractual, statutory and regulatory obligations and therefore closes the complaint.

The Compliance Officer of the Company shall be the designated Grievance Officer of the Company. Further, Branch Operations Head shall be nominated as Grievance Officer for the respective branch.

Rights to 'Close' a complaint on the CRM Application will rest only with CCMU who will ensure adherence to the process before acting. Till such time CCMU will be the owners and responsible for such matters.

We will measure the Complaint TAT from the time of registration of Complaint till its closure on software system.

As mandated by IGMS, complaints registered through IGMS Portal will be closed by IRDA.

Record-keeping: Complaint will be identified by the unique Complaint Number. There will be a provision to tag complaints to respective Customer's interactions with us as also to the

specific transaction to which it relates. Our unified communication protocol will ensure that all responses, irrespective of mode of communication, rest as a single repository to this Complaint Number.

Record keeping will help us in -

- Tracking of the complaint end to end.
- Follow up with the Customer
- Trend analysis of the complaints raised, along with reasons
- Know the Customer better
- Get tips for improvements in terms of services offered by doing the root cause analysis and thereby BPR
- Regulatory requirement reporting

Reporting and Analytics: This element is bifurcated into two aspects –

1. MIS and submissions, and
2. Analytics and inferences to trigger BPR activities

Regular and periodic reporting will be submitted to the PPIC, Board, Regulator and Management. This will be in the standard format prescribed and will be submitted at following timelines –

1. Management – need basis
2. Grievance Redressal Committee – monthly basis
3. PPIC – detailed report for the quarter
4. Board – high-level view of Grievances
5. Regulator – as prescribed

We will strive for automation of MIS to avoid people dependency and ensure timely availability.

Powerful and in-depth analytics and reporting capability with graphical dashboards will help us perform trend analysis and spot recurring problems to drive root cause analysis in a timely manner. We will also trigger internal Corrective and Preventive Actions (CAPA). These will be shared as constructive feedback to departments to help them review their business processes in order to contain or eliminate repeat complaints.

IRDA proposes to publish company performance on Complaints Management on live basis on the IGMS Portal based on the information and data shared on status and movement by respective companies. We shall always apprise ourselves of this information and ensure that it reflects true and accurate picture of our performance. We shall promptly resolve with the authority in case of any inconsistency. Such an approach will also be ensured with any other authority/ies that may set up such interfaces and portals in future.

Customer Complaint Management Unit – CCMU

CCMU will be a part of HO Operations who would centrally monitor the complaints received and registered in CRM till resolution. The presence of central cell will help to speed the resolution, ensure standardisation of process and track customer satisfaction on resolutions. This neutral agency will also ensure protection of Customer interest inside the Company.

This Team will also be interface between Customer and departments for collection of additional information to resolve the Complaint faster.

In addition, they will also be the final communicators of formal resolution to the Complainant. Effectively, a registered Complaint can be 'Closed' only by the CCMU.

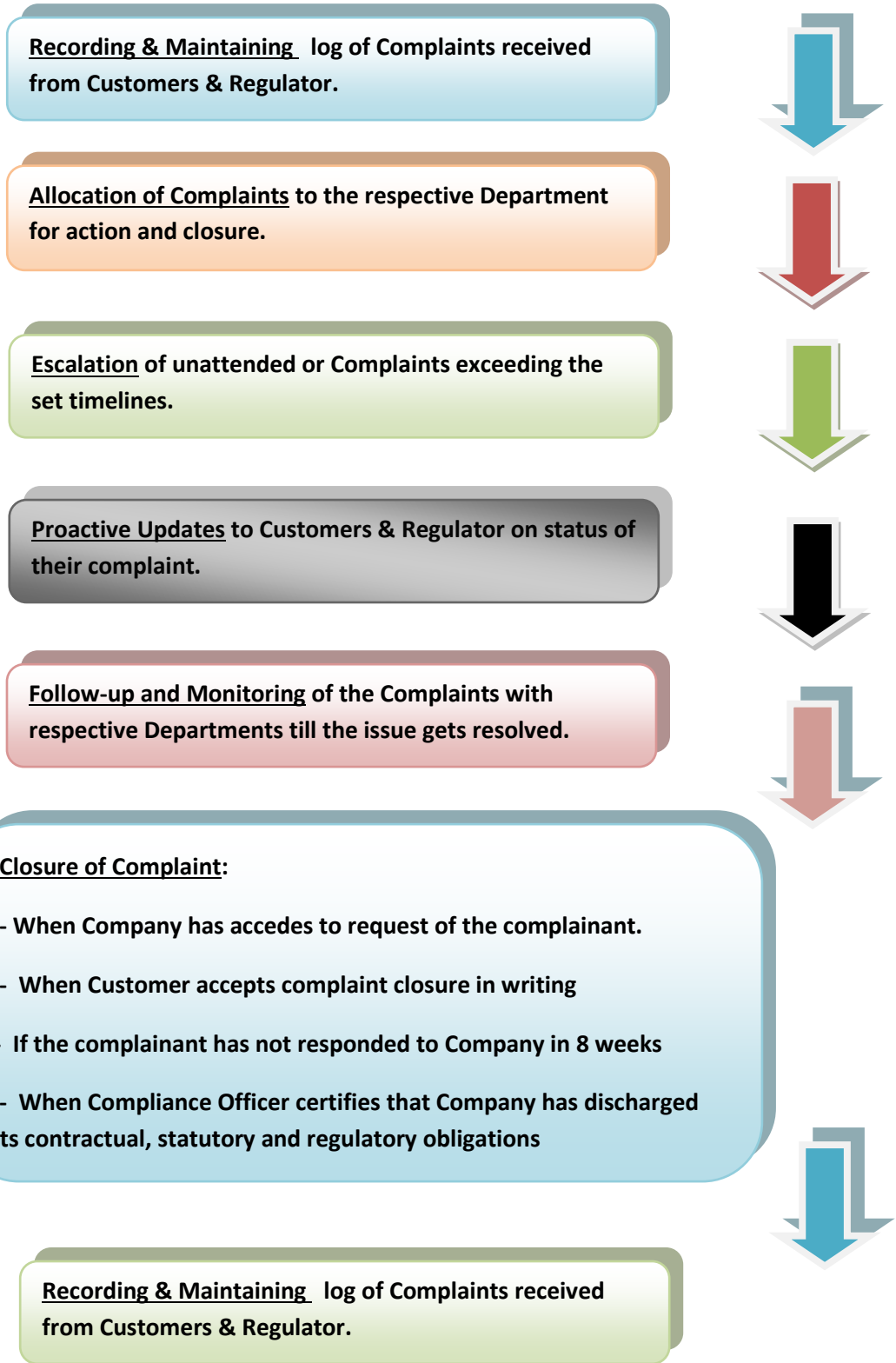
Role of CCMU

- Ensure that all channels of lodgement of Complaint are functional and active
- Map flow of registered Complaints
- Re-routing and assignment of Complaints where required
- Timely escalation for delays in resolution
- Monitor turn-around time
- Follow-up with Complainant for any additional information required
- Formal communication to Complainant
- Collection of Customer feedback on resolution provided
- Co-ordinate with Grievance Committee for advice on unsatisfactory feedback
- Report generation and analytics
- Root cause analysis and recommendations

Internally CCMU will play the role of a nodal agency in the entire process. They will be custodians of the Complaints repository. For the Customer, CCMU is the advocate for their cause and protector of their interest.

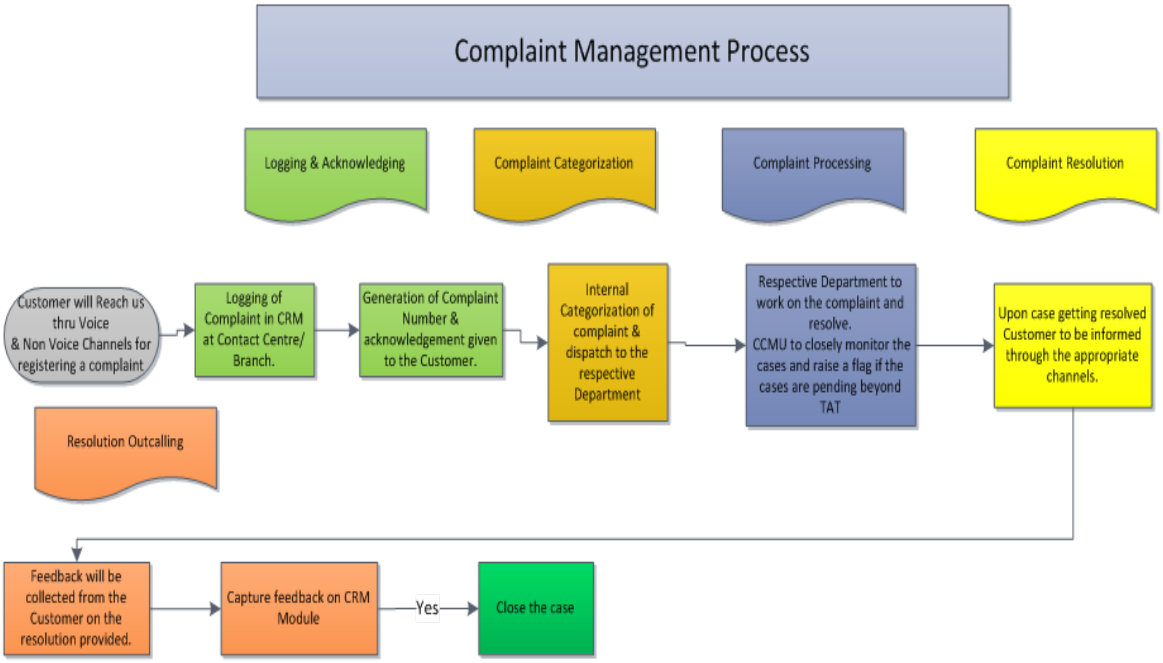
CCMU will report to Head – Operations.

Complaints Management – High-level View



Complaint Management Process Activity Flow-Chart

Following is the broken-down diagram of the process that shall be followed. The colour combinations denote the closely coupled activities within the broader process stage appearing at the top.



Grievance Redressal Committee

Grievance Redressal Committee is a high level committee required to be constituted as per the enabling provisions of IRDA (Protection of Policyholder's Interests) Regulations 2002, Redressal of Public Grievances Rules, 1998, and further mandates in the Corporate Governance Guidelines.

This Committee will be an internal appellate committee to redress the representations made by complainants not satisfied by the resolution provided to them. CCMU will have a log of such matters with them and will help compilation of background for the GRC's review.

The Committee will also entertain and dispose of complaints directly made to the Chairman, Board of Directors, MD & CEO or Shareholders which have potential reputational risk. Such matters will invariably be escalated to Grievance Redressal Committee before sending the final communication to the Customer in the event they are not settled in favour of Complainant. The CCMU shall send a monthly report to the Committee on complaints which have been closed by the Grievance Officer (i.e. Compliance Officer) giving a monthly analysis of complaints closed as such. The Committee shall feedback to the respective Heads of Departments such remedial measures as deemed fit by the Committee to make necessary changes in relevant processes or to take such steps as may be necessary to avoid recurrence of similar complaints.

The Committee will act as an empowered committee to take a final decision at its discretion to protect the interest of Policyholders as well as reputation of the Company. The Committee shall make its recommendations to the MD & CEO for execution of decisions having financial outgo if the recommendations are averting the resolution provided by the Company erstwhile or where they are in nature of ex-gratia payments in order to protect reputation of the Company.

It is proposed to have heads of following departments as members of Company's Grievance Redressal Committee –

a. Underwriting
b. Claims
c. Distribution
d. Legal & Compliance
e. Operations

The Committee will be chaired by Head – Operations and at least three members personally present shall constitute necessary quorum. Presence of Head – Operations and Head – Compliance & Legal shall be necessary to constitute a valid quorum.

The Committee will meet on need basis with at least one meeting every fortnight.

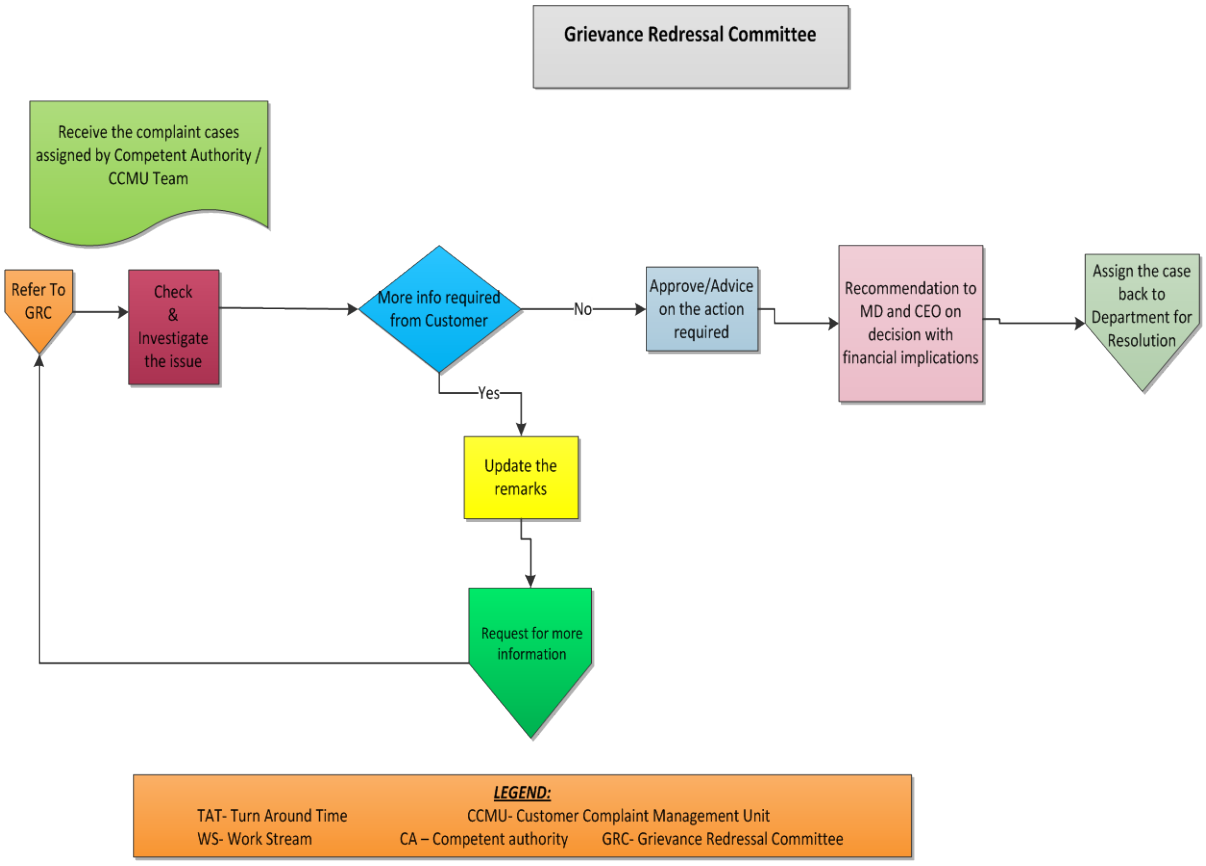
The Committee may invite representation from the concerned department to present their views on any complaint under consideration.

The Committee shall be entitled to take such external legal opinion as it may deem necessary and the budgetary support for the same shall be provided by the MD & CEO.

Decisions of the Committee shall be taken by majority.

Process Flow-chart of Grievance Redressal Committee Referrals

Block-diagram of the Grievance Redressal Committee's process is enumerated below.



Control & Review

Authorisation, Ownership and Document Control	
Owner	Head – Operations
Approver and Date	Board of Directors of SBI General
Effective Date for Version 1.0	02nd July 2010

Review History

Date of Review	Action Taken	New Version	Date Approved	New Effective Date
23-10-2010	Incorporation of IGMS Directives issued by IRDA on 26-07-2010	-	23-10-2010	23-10-2010
20-04-2011	Review on launch of IGMS	-	20-04-2011	20-04-2011
19-04-2012	Annual Review of the Policy	Version 2.0	19-04-2012	19-04-2012
23-07-2012	Taking on record amendments approved by the Committee	Version 3.0	23-07-2012	23-07-2012
16-04-2013	Annual Review of the Policy	-	16-04-2013	16-04-2013
22-04-2014	Annual Review of the Policy		22-04-2014	22-04-2014
26-05-2015	Annual Review of the Policy	-	26-05-2015	26-05-2015

Further Information

Contact	Head - Operations, SBI General Head Office, Mumbai

We propose a scheduled review of this Policy/Process after capture of reasonable experience. The first review of the process will be carried out in April 2011.

Revision History

Version History	Date	Prepared/Modified by	Significant Changes
0.1	22-06-2010	Atul Deshpande	Draft
0.2	02-07-2010	Atul Deshpande	Approved by Board
0.3	22-09-2010	Atul Deshpande	Incorporation of mandates of Guidelines issued by IRDA under Circular No 3/CA/GRV/YPB/10-11
0.4	23-10-2010	Atul Deshpande	Amendments Proposed by the Committee on 22nd June 2010 were approved by the Board
0.5	20-04-2011	Atul Deshpande	Integration with IGMS
0.6	19-04-2012	Atul Deshpande	Annual Review of the policy
0.7	23-07-2012	Atul Deshpande	Taking on record amendments approved by the Committee
0.8	16-04-2013	Atul Deshpande	Annual Review of the policy
0.9	22-04-2014	Atul Deshpande	Annual Review of the policy
1.0	26-05-2015	Atul Deshpande	Annual Review of the policy

Annexure I: IRDA Categorisation of Complaints

S.No	Description	Mapping of PPI Provisions to classification structure	TAT
(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.	
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	**3 (1)** Notwithstanding anything mentioned in regulation 2(e) above, 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 non-participating (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, under these regulations, 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.	
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	
7	Scope of cover not explained	**3 (1)** Notwithstanding anything mentioned in regulation 2(e) above, 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 non-participating (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.	
(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;	10 days

		(f) perils covered and not covered; (h) any franchise or deductible applicable;	
10	Details shown in policy or Add-on are incorrect.	Refer S.No.9	
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	Important clauses deliberately shown in small print		
13	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
14	Insured asked for issue of a duplicate policy – Insurer failed to issue	**10(f)** issuance of duplicate policy;	10 days
15	Nomination details given by Insured not noted in policy.	**10(b)** noting a new nomination or change of nomination under a policy;	10 days
16	Insurer cancelled policy arbitrarily without serving notice		
17	In the renewal policy, Insurer changed the terms & conditions without informing the Insured	**7(j)** policy terms, conditions and warranties;	
18	Details shown in policy different from the Cover Note.	Refer S.No.17	

19	Insurer refused to accept Insured's request to enhance coverage mid-term.		
20	While renewing the policy Insurer refused to enhance the Sum Insured sought by Insured.		
21	Insurer forced Insured to switch over to a new policy.		
22	Without the consent of Insured Insurer debited customer's bank A/c / credit card and issued policy.	Refer S.No. 2	
23	Insurer refused to renew the policy without giving any reasons.	Refer S.No. 2	
24	Change of address not noted	**10 (1) (a)** recording change of address;	10 days
25	Product no longer available with Insurer		
(4) Premium			
26	Premium receipt not received by Insured	Refer S.No. 2	
27	Insurer calculated premium wrongly and over charged the Insured.	Refer S.No. 2	
28	Insurer loaded premium arbitrarily		
29	Premium paid through electronic modes/cheque not accepted		

30	Where provisional premium is collected, final adjustment is not carried out	**7(i)** premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;	
31	Premium cheque bounced. Without giving intimation to Insured Insurer. cancelled the policy		
(5) Coverage			
32	Insurer did not attach any clauses to the policy – coverage given under the policy not known to the Insured.	**7(1)** A general insurance policy shall clearly state: **(f)**perils covered and not covered;	
33	Insured asked for add on coverage and paid premium. Insurer did not issue Endorsement.	Refer S.No. 11	10 days
34	Dispute relating to Interpretation of perils/exclusions/conditions/warranties	Refer S.No. 2	
35	Dispute relating to policy extension of term for Long term policies	Refer S.No. 2	
36	Wrong add on policy wording	Refer S.No. 2	
(6) Refund			
37	Refund of premium due under policy not received by Insured.		
38	Dispute regarding quantum of premium refund.		
(7) Product			

39	Product (policy) received by insured is not what it was negotiated at the time of sale.	Refer S.No. 2	
40	Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	Refer S.No. 2	
(8) Claim			
41	Insurer refusing to register claim	**9 (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 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.	
42	Insurer asking for irrelevant claim documents	Refer S.no. 41	
43	Insurer asking for claim documents on a piecemeal basis.	Refer S.no. 41	
44	Delay in appointment of surveyor	Refer S.no. 41	72 hours
45	Insurer not issued claim form.	Refer S.no. 41	
46	Delay in conducing survey.		

47	Surveyor delayed issue of his report.	**9 (2)** 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
48	Survey report copy not issued to the Insured by the surveyor.	Refer S.No. 47	30 days
49	Difference between assessed loss and amount settled by Insurer.		
50	Insurer reduced the Quantum of claim for reasons not indicated in the policy.		

51	Insurer failed to make offer of settlement to Insured after receipt of survey report.	**9 (5)** 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
52	Insurer not disposed of the claim		
53	Insurer not issued claim cheque inspite of offer of settlement.	**9 (6)** 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.	
54	Cheque issued by Insurer is bounced.		
55	Name of Insured wrongly written in the claim cheque.		
56	Insurer paid claim to a wrong person.		
57	Insurer closed the claim without advising the Insured any reasons.		

58	Dispute on rate of depreciation applied.		
59	Dispute between Insured and Insurer on amount allowed towards Labour charges (Motor claim).		
60	Dispute on deduction of salvage value.		
61	Dispute on mode of claim settlement – Total loss / cash loss vis-à-vis repair basis.		
62	Dispute on obsolete factor.		
63	Claim denied due to alleged non-cooperation of Insured		
64	Insurer repudiated claim due to delay in intimation of claim by Insured.		
65	Insurer repudiated claim due to delay in submission of claim documents by the Insured.		
66	Insurer repudiated the claim based on 2nd surveyor's recommendation.		
67	Insurer repudiated the claim due to alleged breach of policy condition / warranty.		
68	Insurer repudiated claim due to dispute on premium paid.		

69	Insurer repudiated claim due to alleged fraud.	Refer S.No. 2	
70	Claim repudiated without giving reasons		
71	Insurer repudiated claim due to "pre-existing disease exclusion" (Health Insurance).		
72	Claim repudiation by Insurer due to bouncing of premium cheque presented late by Insurer.		
73	Insurer repudiated claim due to alleged carelessness of Insured.		
74	Delay on the part of TPA to arrange claim reimbursement (Health claim).		
75	TPA reduces estimate given by the hospital without any reason.		
76	Delay on the part of TPA to provide cashless facility.		
77	TPA refuses to extend cashless facility to the Insured.		
(9) Others			
78	IDV related disputes		
79	Higher deductible imposed by Insurer		

80	Deductible wrongly imposed by Insurer.		
81	Insurer imposed additional conditions wrongly.		
82	TPA not sent ID card to Insured (Health claim).		
83	Insurer not considered the cumulative bonus in claim settlement (PA or Health claim).		
84	Insurer not given no claim bonus (Motor Insurance)		
85	Insurer gave premium quote but later went back on acceptance of risk.		
86	Insurer failed to clarify the queries raised by Insured.		
87	TPA not sending pre-authorization to the Hospital (denial of cashless facility).		
88	Insurer not given eligible discount in premium (Family Discount on Health / PA policy/package policy)	Refer S.No. 13	
89	Misbehavior of surveyor towards the Insured.		
90	Financier's interest not reflected in the policy.		

91	Insurer not taken any loss prevention measures upon reporting of a claim by Insured.		
92	Failure of online transaction though premium was deducted through credit card.		
93	Rebating resorted to by Agent.		
94	Rebating resorted to by Insurer.		
95	Fraudulent behavior on the part of Agent in claim matter		
96	Errors in ID cards issued by TPAs.		
97	Alleged misconduct of officials of TPA towards the Insured.		
98	No response from TPA / Insurer for queries raised / clarifications sought by Insured.		
99	IT /Network related / connectivity issue with TPA.		
100	TPA delayed Health check-up.		
101	TPA delayed issue of reports of Health check-up.		
102	Alleged misconduct of officials of Insurer.		
103	Alleged misconduct of surveyor / investigator.		

104	Unsolicited calls made to Insured in spite of DNC registration.		
105	Complaint of Insured relating to pre-inspection / pre-acceptance survey.		
106	Cashless facility first sanctioned and withdrawn.		
107	Where claim is repudiated Bills / reports not returned to the customer.		
108	Non-acceptance of health cards by network hospital.		
109	Insurer repudiated the claim but not returned original bills to the Insured.		
110	Refusal to renew Insurance		
111	Unable to register Grievance due to faulty systems		