THE INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA (PROTECTION OF POLICYHOLDERS' INTERESTS) REGULATIONS, 2017[1]

In exercise of the powers conferred by clause (zc) of sub-section (2) of section 114A of the Insurance Act, 1938 (4 of 1938) read with clause (b) of sub-section (2) of section 14 and section 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), the Authority, in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:—

1. Short title and commencement.—(1) These regulations may be called The Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017.

(2) These regulations shall come into force from the date[2] of their publication in the Official Gazette of the Government of India and supersede Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002 and any clarification circulars/guidelines issued in this regard.

2. Applicability.—(1) These Regulations are complementary to any other regulations made by the Authority, which, *inter alia*, provide for protection of the interests of policyholders.

(2) These Regulations apply to all insurers, distribution channels, intermediaries, insurance intermediaries, other regulated entities and policyholders.

3. Objective.—(1) To ensure that interests of insurance policyholders' are protected.

(2) To ensure that insurers, distribution channels and other regulated entities fulfil their obligations towards policyholders and have in place standard procedures and best practices in sale and service of insurance policies.

(3) To ensure policyholder-centric governance by insurers with emphasis on grievance redressal.

4. Definitions.—In these regulations, unless the context otherwise requires:

(1) "Act" means the Insurance Act, 1938 (4 of 1938);

(2) "Authority" means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and development Authority Act, 1999 (41 of 1999);

(3) "Bank Rate" means "Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due";

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1. *Vide* Notification F. No. IRDAI/Reg/8/145/2017, dated 22nd June, 2017, published in the Gazette of India, Extra., Pt. III, Sec. 4, No. 262, dated 30th June, 2017.
2. Came into force on 30-6-2017.

(4) "Complaint" or "Grievance" means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities;

Explanation.—An inquiry or request would not fall within the definition of the "complaint" or "grievance";

(5) "Complainant" means a policyholder or prospect or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer or a distribution channel;

(6) "Cover" means an insurance contract whether in the form of a policy or a cover note or a Certificate of Insurance or any other form as approved by the Authority to evidence the existence of an insurance contract;

(7) "Distribution Channels" means persons and entities authorised by the Authority to involve in sale and service of insurance products;

(8) "Proposal form" means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted;

Explanation.—"Material Information" for the purpose of these regulations shall mean all important, essential and relevant information sought by insurer in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk;

(9) "Prospect" means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel;

(10) "Prospectus": means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products;

Explanation.—Insurance products referred herein shall also include the riders offered, if any. Where a rider is tied to a base policy all the terms and conditions of the rider referred in the definition shall be mentioned in the prospectus. Where a standalone rider is offered to a base product, a reference to the rider shall be made in the prospectus of the base policy indicating the nature of benefits flowing thereupon.

(11) Words and expressions used and not defined in these regulations, but defined in the Act, or the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) or the Insurance Rules, 1939 or any other regulations issued by the Authority shall have the meanings respectively assigned to them in those Acts or Rules or Regulations;

5. Board approved policy for protection of interests of policyholders.—(1) Every insurer shall have in place a board approved policy for protection of policyholders' interests which shall at the minimum, include:

(i) steps to be taken for enhancing Insurance Awareness so as to educate prospects and policyholders about insurance products, benefits and their rights and responsibilities;

(ii) service parameters including turnaround times for various services rendered;

(iii) procedure for expeditious resolution of complaints;

(iv) steps to be taken to prevent mis-selling and unfair business practices at point of sale and service;

(v) steps to be taken to ensure that during policy solicitation and sale stages, the prospects are fully informed and made aware of the benefits of the product being sold *vis-a-vis* the product features attached thereto and the terms and conditions of the product so that the benefits/returns of the product are not mis-stated/mis-represented.

(2) Every insurer shall display the service parameters and turnaround times as approved by the Board in its website and keep the same updated as and when the service parameters are revised by the Board.

6. Point of sale.—(1) A prospectus of any insurance product shall clearly state:

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

(b) the scope of benefits;

(c) the extent of insurance cover;

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

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

(b) the class or classes of lives or property eligible for insurance under the terms of such prospectus;

(c) a full statement of the circumstances, if any, in which rebates of the premiums quoted in the prospectus or table shall be allowed on the effecting or renewal of a policy, together with the rates of rebate applicable to each case; and

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

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

(iv) the premium pertaining to health related or critical illness riders shall not exceed 100% of premium under the basic product, the premiums under all other life insurance riders put together shall not exceed 30% of premiums under the basic product and any benefit arising under each of the above mentioned riders shall not exceed the sum assured under the basic product;

(v) in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits).

Provided that the benefit amount under riders in a life insurance policy shall be subject to section 2(11) of the Insurance Act, 1938.

Explanation.—The rider or riders attached to a life insurance policy shall bear the nature and character of the main policy, *viz.*, participating or non-participating and accordingly the life insurer shall make provisions, etc., in its books.

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

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

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

(5) The Insurers shall ensure, that a sale executed over distance-marketing modes such as Internet, SMS, Tele Marketing, interactive electronic medium etc., shall be undertaken by authorized and qualified sales persons who are specified in this behalf by the Authority. It is mandatory that the consent of the prospect be obtained before canvassing. Care should be exercised to ensure that the prospect contacted has clarity as to the identity of the insurer, the distribution channel, the product, benefits and conditions of offer etc. The canvassing so made shall not involve compulsion, inconvenience or nuisance of any kind to the prospect.

7. Products on offer/ products withdrawn.—(1) Every insurer shall place in its website the terms and conditions of every insurance product that is offered for sale by the insurer as it was approved by the Authority under File and Use procedure or filed with the Authority under Use and File procedure, including

products modified or products withdrawn. The UIN allotted by the Authority to every insurance product shall also be mentioned against each product.

(2) The insurer shall keep the list updated at all times.

8. Proposal for insurance.—(1) Except in case of a marine insurance cover, or such other covers approved by the Authority exempting usage of proposal form, a proposal for grant of insurance cover, either for life insurance business or for general insurance business or for health insurance business, must be evidenced by a document in written or electronic or any other format as approved by the Authority. It is the duty of the insurer to furnish to the insured, free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal submitted by the Insured.

(2) In case of marine insurance cover or other insurance covers where a proposal form is not used, the insurer shall record the information obtained orally or in writing or electronically, and confirm it within a period of 15 days thereof with the prospect and incorporate the information in its cover note or policy. Where the insurer claims that the prospect suppressed any material information or provided misleading or false information on any matter material to the grant of a cover, then the onus of proof rests with the insurer only in respect of any information not so recorded.

(3) Any proposal form seeking information for grant of life cover shall prominently state therein the requirements of Section 45 of the Act.

(4) While answering the questions in the proposal form for obtaining life insurance cover, the prospect is to be guided by the provisions of Section 45 of the Act.

(5) Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer or the distribution channel shall draw the attention of the proposer to it and encourage the proposer to avail the facility and inform him of the provisions of section 39 of the Act.

(6) Insurer shall process the proposals with speed and efficiency and the decision on the proposal thereof, shall be communicated in writing to the proposer within a reasonable period but not exceeding 15 days from the date of receipt of proposals or any requirements called for by the insurer.

(7) Where a proposal deposit is refundable to a prospect under any circumstances, the same shall be refunded within 15 days from the date of underwriting decision on the proposal.

9. Matters to be stated in life insurance policy.—(1) A life insurance policy shall clearly state:

(i) the name and UIN allotted by the Authority for the product governing the policy, its terms and conditions; name, code number, contact details of the person involved in sales process;

(ii) whether it is participating in profits or not, whether it is linked or non-linked;

(iii) the manner of vesting or payment of profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;

(iv) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;

(v) the name of Nominee(s), age of nominee(s) and their relationship and name of guardian in case of minor nominees;

(vi) the details of the riders being attached to the main policy;

(vii) the date of commencement of risk, the date of maturity and the date(s) on which survival benefits, if any, are payable;

(viii) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date of last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of guaranteed surrender value;

(ix) the details of revival schemes provided for reviving a lapsed policy and requirements to be submitted for revival there under. The insurers shall use term "revival" which is in vogue for renewing a lapsed insurance policy;

(x) Name, Address, Date of birth and age of the insured as at the date of commencement of the policy;

(xi) the policy conditions for,—

(a) conversion of the policy into paid up policy,

(b) surrender

(c) foreclosure

(d) non-forfeiture

(e) discontinuance provisions in case of Linked Policies.

(xii) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;

(xiii) the provisions for nomination, assignment, loans on security of the policy and a statement that the rate of interest payable on such loan shall be as prescribed by the insurer at the time of taking the loan;

(xiv) any special clauses, exclusions or conditions imposed on the policy;

(xv) the address, email id of the insurer to which all communications in respect of the policy shall be sent;

(xvi) the notes to policyholder highlighting the significance of notifying timely the change of his/her address;

(xvii) details of insurer's Internal Grievance Redressal Mechanism along with address and contact details of Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or

the residential address or place of residence of the policyholder is located;

(xviii) the list of documents that are normally required to be submitted by a claimant in case of a claim under the policy.

10. Free look cancellation of life insurance policies.—(1)(i) The insurer shall inform clearly by the letter forwarding the policy to the policyholder that he has a free look period of 15 days from the date of receipt of the policy document and period of 30 days in case of electronic policies and policies obtained through distance mode, to review the terms and conditions of the policy and where the policyholder disagrees to any of those terms or conditions, he has the option to return the policy to the insurer for cancellation, stating the reasons for his objection, then he shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.

(ii) In respect of a linked insurance product, in addition to the deductions under sub-regulation (i) above, the insurer shall also be entitled to repurchase the units at the price of the units on the date of cancellation.

(iii) A request received by insurer for free look cancellation of the policy shall be processed and premium refunded within 15 days of receipt of the request, as stated at sub-clause (i), (ii) above.

11. Matters to be stated in general insurance policy.—(1) A general insurance policy shall clearly state:

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

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

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

(iv) period of Insurance;

(v) sums insured;

(vi) perils covered and not covered;

(vii) any franchise or deductible applicable;

(viii) premium payable and where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;

(ix) policy terms, conditions and warranties, Exclusions, if any;

(x) action to be taken by the insured upon occurrence of a contingency likely to give rise to a claim under the policy;

(xi) the obligations of the insured in relation to the subject matter of insurance upon occurrence of an event giving rise to a claim and the rights of the insurer in the circumstances;

(xii) any special conditions attaching to the policy;

(xiii) the grounds for cancellation of the policy which in the case of a retail policy, for the insurer, can be only on the grounds of mis representation, non-disclosure of material facts, fraud or non co operation of the insured;

Explanation.—Products approved as retail policies under File and Use guidelines notified by the Authority from time to time fall within the purview of retail policy referred above:

Provided that in the case of Commercial policies alone, other circumstances under which the policy may be cancelled be given, along with the manner of calculation of refund and notice period for cancellation;

(xiv) the address of the insurer to which all communications in respect of the insurance contract should be sent;

(xv) the details of the endorsements, add-on covers attaching to the main policy;

(xvi) that, on renewal, the benefits provided under the policy and/or terms and conditions of the policy including premium rate may be subject to change; and

(xvii) details of insurer's internal grievance redressal mechanism along with address and contact details of Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

12. Matters to be stated in a health insurance policy.—(1) A health insurance policy shall clearly state:

(i) The name of the policyholder and the names of each beneficiary covered, UIN of the product, name, code number, contact details of the person involved in sales process;

(ii) Date of birth of the insured and corresponding age in completed years;

(iii) The address of the insured;

(iv) The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover in India from any of the insurers without break;

(v) The sums Insured;

(vi) The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross-reference to the concerned policy section;

(vii) Co-pay limits if any;

(viii) The pre-existing disease (PED) waiting period, if applicable;

(ix) Specific waiting periods as applicable;

(x) Deductible as applicable – general and specific, if any;

(xi) Cumulative Bonus, if any;

(xii) Periodicity of payment of premium instalment;

(xiii) Policy period;

(xiv) Policy terms, conditions, exclusions, warranties;

(xv) Action to be taken on the occurrence of a claim for cashless and reimbursement options separately;

(xvi) Details of TPA, if any engaged, their address, toll free number, website details;

(xvii) Details of Grievance Redressal mechanism of insurer;

(xviii) Free look period facility and portability conditions;

(xix) Policy migration facility and conditions where applicable;

(xx) that, on renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate;

(xxi) Provision for cancellation of the policy; and

(xxii) Address and other contact details of Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

13. General principles governing issuance of general and health insurance policies.—(1) In stipulating the exclusions of the policy, insurers shall endeavour to classify the exclusions, wherever possible as under:

(i) Standard exclusions applicable in all policies;

(ii) Exclusions specific to the policy which cannot be waived;

(iii) Exclusions specific to the policy, which can be waived on payment of additional premium.

(2) The insurers may also endeavour to broadly categorize policy conditions into following, so as to give clarity and understanding of the conditions to the policyholder:

(i) Conditions precedent to the contract;

(ii) Conditions applicable during the contract;

(iii) Conditions when a claim arises;

(iv) Conditions for renewal of the contract.

(3) Every insurer shall keep the insured informed on the requirements to be fulfilled regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him so as to settle claim early.

14. Claims procedure in respect of a life insurance policy.—(1) A life insurer, upon receiving a death claim, shall process the claim without delay. Any queries or requirement of additional documents, shall be raised all together

and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.

(2)(i) A death claim under a life insurance policy shall be paid or be rejected or repudiated giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and required clarifications. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate the same at the earliest and complete such investigation expeditiously, in any case not later than 90 days from the date of receipt of claim intimation and the claim shall be settled within 30 days thereafter.

(ii) If there is delay on the part of Insurer beyond the timelines mentioned in sub-regulation (i) above, the insurer shall pay interest at a rate, which is 2% above bank rate from the date of receipt of last necessary document.

(iii) Except in the case of claims where an application is made under section 47 of the Act to the court, if a claim is ready for payment but the payment cannot be made due to any reasons of proper identification of the payee, the life insurer shall pay interest on the claim amount at the bank rate from the date on which claim is ready for payment.

(iv) In respect of Maturity, Survival Benefit claims and Annuities, the Life Insurer shall initiate the claim process by sending intimation sufficiently in advance or send post-dated cheque or give direct credit to the bank account of claimant through any electronic mode approved by RBI, so as to pay the claim on or before the due date. In case of any delay on the part of the Insurer in settling the claim on due date, the life insurer shall pay interest at a rate, which is 2% above bank rate from the due date of payment or date of receipt of last necessary document from the insured/claimant, whichever is later.

(v) In respect of free look cancellation, surrender, withdrawal, request for refund of proposal deposit, refund of outstanding proposal deposit if any, shall be processed and paid within 15 days of receipt of request or last necessary document, failing which the insurer shall pay penal interest at a rate, which is 2% above bank rate from the date of request or receipt of last necessary document if any whichever is later, from the insured/claimant.

Explanation.—Administration of Health Insurance Policies issued by Life Insurers shall also be governed by Chapter IV of IRDAI (Health Insurance) Regulations, 2016.

(vi) The interest payments referred above in sub-regulations (ii), (iii), (iv), (v) shall be paid by the Life Insurer *suo moto* without waiting for specific demand from the insured/claimant.

15. Claim procedure in respect of a general insurance policy.—(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 information to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/claim, it shall do so immediately, in any case

within 72 hours of the receipt of intimation from the insured. Insurer shall communicate the details of the appointment of surveyor, including the role, duties and responsibilities of the surveyor to the insured by letter, email or any other electronic form immediately after the appointment of the surveyor.

(2) The insurer/surveyor shall within 7 days of the claim intimation, inform the insured/claimant of the essential documents and other requirements that the claimant should submit in support of the claim. Where documents are available in public domain or with a public authority, the surveyor/insurer shall obtain them.

(3) The surveyor shall start the survey immediately unless there is a contingency that delays immediate survey, in any case within 48 hours of his appointment. Interim report of the physical details of the loss shall be recorded and uploaded/forwarded to the insurer within the shortest time but not later than 15 days from the date of first visit of the surveyor. A copy of the interim report shall be furnished by the insurer to the insured/claimant, if he so desires.

(4) Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor, as the case may be, shall inform in writing to the insured under information to the insurer about the consequent delay that may result in the assessment of the claim. It shall be the duty equally of the insurer and the surveyor to follow up with the insured for pending information/ documents guiding the insured with regard to submissions to be made. The insurer and/or surveyor shall not call for any information/document that is not relevant for the claim.

(5)(i) The surveyor shall, subject to sub-regulation 4 above, submit his final report to the insurer within 30 days of his appointment. A copy of the surveyor's report shall be furnished by the insurer to the insured/claimant, if he so desires. Notwithstanding anything mentioned herein, in case of claims made in respect of commercial and large risks the surveyor shall submit the final report to the insurer within 90 days of his appointment. However, such claims shall be settled by the insurer within 30 days of receipt of final survey report and/or the last relevant and necessary document as the case may be.

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

(6) If an insurer, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor, under intimation to the insured/ claimant; to furnish an additional report on certain specific issues as may be required by the insurer. Such a request may be made by the insurer within 15 days of the receipt of the final survey report.

Provided that the facility of calling for an additional report by the insurer shall not be resorted to more than once in the case of a claim.

(7) The surveyor, on receipt of this communication, shall furnish an additional report within three weeks from the date of receipt of communication from the insurer.

(8) On receipt of the final survey report or the additional survey report, as the case may be, and on receipt of all required information/documents that are relevant and necessary for the claim, an insurer shall, with in a period of 30 days offer a settlement of the claim to the insured/claimant. If the insurer, for any reasons to be recorded in writing and communicated to the insured/claimant, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the final survey report and/or additional information/ documents or the additional survey report, as the case may be.

(9) In case, the amount admitted is less than the amount claimed, then the insurer shall inform the insured/claimant in writing about the basis of settlement in particular, where the claim is rejected, the insurer shall give the reasons for the same in writing drawing reference to the specific terms and conditions of the policy document.

(10) In the event the claim is not settled within 30 days as stipulated above, the insurer shall be liable to pay interest at a rate, which is 2% above the bank rate from the date of receipt of last relevant and necessary document from the insured/claimant by insurer till the date of actual payment.

16. Claim procedure in respect of a health insurance policy.—(1) Every insurer shall adhere to the procedure laid down under Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016 for settlement of health insurance claims.

(i) An Insurer shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.

(ii) In the case of delay in the payment of a claim, the insurer shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(2) However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.

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

(3) Return of premium on cancellation during Free Look Period shall be processed in accordance with the provisions of Regulation 14 of IRDAI (Health

Insurance) Regulations, 2016. Any refund shall be processed with speed and shall be refunded within 15 days from the date of receipt of request for free look cancellation.

Explanation.—Health Insurance claims for the purpose of this Regulation shall be claims arising under all insurance policies issued by Life, General and Health Insurers in respect of Health Insurance Business as defined in section 2(6C) of the Act.

17. Grievance redressal procedure.—(1) Every insurer shall have in place proper procedures and effective mechanism to resolve complaints and grievances of policyholders, claimants efficiently and with speed.

(2) The Grievance Redressal Procedure as outlined in Annexure - I shall be followed scrupulously by all Insurers.

18. Power to issue clarifications.—In order to remove any difficulties in respect of the application or interpretation of any of the provisions of these regulations, the Chairperson of the Authority may issue appropriate clarifications or guidelines, as and when required.

19. General principles.—(1) Every life insurer shall inform policyholders whose participating policies are in force, at least once in a year, the bonus accrued to their policies or the value of their ULIP policies as the case may be, through a letter/e-mail/any other electronic mode.

(2) The requirements of "disclosure of material information" regarding a proposal or policy apply, under these regulations, both to the insurer and the insured. As far as the insured is concerned, wherever required, he shall co-operate with the distribution channels to ensure this.

(3) The policyholder shall assist the insurer, if the insurer so requires, in any prosecution, proceeding or in the matter of recovery of claims by the insurer against third parties.

(4) The policyholder shall furnish all information that is sought from him by the insurer, either directly or through the distribution channels, which the insurer considers as having a bearing on the risk to enable the insurer to assess properly the risk covered under a proposal for insurance.

(5) Insurers shall at all times maintain total confidentiality of policyholder information, unless it becomes necessary to disclose the information to statutory authorities due to operation of any law.

(6) Any breach of the obligations cast on an insurer or distribution channels or surveyors 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.

20. Transitory provisions.—The insurers shall revise all the policy document formats which are not in compliance with provisions laid down at Regulation 9, 11, 12 of these Regulations and submit a compliance certificate to the Authority signed by CEO on or before 31.12.2017.

ANNEXURE I

GRIEVANCE REDRESSAL PROCEDURE

1. A complainant who wishes to make a complaint against insurer, intermediary, insurance intermediary, distribution channel or other regulated entities involved in insurance sales and services shall approach the respective grievance redressal officer of insurer. In case either grievance redressal officer of insurer does not respond or the resolution provided by him is not to the satisfaction of the complainant he may register a complaint in grievance redressal management system of the Authority. The Authority facilitates re-examination of the complaint so as to provide final resolution by insurer.

2. Every insurer shall have in place an effective grievance redressal procedure to address complaints of policyholders efficiently and with speed and communicate the action taken by the insurer on the complaint to the complainant along with the information in respect of Insurance Ombudsman as may be necessary.

3. Grievance Redressal Officer

i. Every insurer shall have a designated Grievance Redressal Officer (GRO) of a senior level at the corporate office. The GRO at the corporate office will be the contact person for the Authority.

ii. Every other office of the insurer shall also have a designated Grievance Officer who shall be head of that office. The details of the GRO/designated Grievance Officer along with the contact details in full shall be published in the website of the insurer and the name and contact details of designated Grievance Officer of respective office and the other Grievance Officers in hierarchy up to GRO at corporate office shall also be displayed in the notice board of respective offices.

iii. Every office of the insurer shall also display in prominent place, the name, address and other contact details of the insurance ombudsman within whose jurisdiction the office falls.

4. Grievance Redressal System/Procedure:

i. Every insurer shall have a system including IT systems and a procedure for receiving, registering and disposing of grievances in each of its offices. Every insurer shall publicize its grievance redressal procedure and ensure that it is specifically made available on its website.

ii. All insurers shall necessarily form part of the Integrated Grievance Management System (IGMS) put in place by the Authority to facilitate the registering/ tracking of complaint on-line by the policyholders. The Insurer's system, shall involve, mirroring of the Grievance database, of Insurers with IGMS and shall also facilitate analysis of complaints, mitigation, improvement of processes and system, through constant review.

iii. Insurers shall also have in place system to receive and deal with all kinds of calls including voice/e-mail, relating to grievances, from prospects and policyholders. The system shall enable and facilitate the required interfacing with the Authority's system of handling calls/e-mails

5. Closure of complaint/grievance:

i. A complaint shall be considered as disposed of and closed when

a. The insurer has acceded to the request of the complainant fully

(or)

b. Where the complainant has indicated in writing, acceptance of the response of the insurer.

(or)

c. Where the complainant has not responded to the insurer within 8 weeks of the insurer's written response.

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