



Road Safety and Motor Insurance

- Towards safe driving and insuring uninsured vehicles

भारतीय बीमा विनियामक और विकास प्राधिकरण

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Accelerating Motor Insurance in India

- Prof. D.CHENNAPPA

ABSTRACT

Motor insurance is mandatory for all vehicles under the provision of Motor Vehicles Act 1988, be it for commercial or personal use. It is compulsory to have a valid Motor insurance policy before you can start driving your vehicle. Motor insurance comes with unique plans for four wheelers, two wheelers and commercial vehicles. In India, nearly 4 lakh people meet with accidents every year. Fatalities in road accidents in India are moving up at a compounded annual rate of four per cent. It is considering as the high number and the poor state of roads. In this background, Motor Insurance is essentially required.

An attempt is made in this paper to know the trend of motor insurance and to identify the reasons for accidents and grievance addressed by the insurer and the ombudsman. It concludes with suitable suggestions for accelerating motor insurance business in India.

INTRODUCTION

Motor insurance is mandatory for all vehicles under the provision of Motor Vehicles Act 1988¹, be it for commercial or personal use. It is compulsory to have a valid Motor insurance policy before you can start driving your vehicle. Motor insurance comes with unique plans for four wheelers, two wheelers and commercial vehicles.

Motor insurance protects the vehicle against losses arising from unforeseen risks. It basically covers financial losses arising from accidents, theft and other natural calamities. Motor insurance is a contract for an automobile in which the insurance company agrees to pay for financial loss resulting from a said specified event.

In India, nearly 4 lakh people meet with accidents every year². Fatalities in road accidents in India are moving up at a compounded annual rate of four per cent.

Considering the high number and the poor state of roads. Motor insurance is a necessary requirement. Motor Insurance protects from losses arising from natural calamities like cyclone, earthquake etc. The All India Motor Tariff governs motor insurance business in India. According to the tariff, all classes of vehicles use two types of policy forms. Like Form A and Form B.

TYPES OF MOTOR INSURANCE

a. Form A/ Third Party Insurance (Third Party)

Form A is known as Act policy, covers Act Liability, which is compulsory requirement of the Motor Vehicle Act. No vehicle can be used without this minimum insurance cover. Use without such insurance is a penal offence. This insurance is mandatory by law. It protects a policy holder against losses which arise due to bodily injury/death to a third party or any damage to property. Here third party includes

people travelling with you or whom the insured person injures and claims damages at the time of accident. But this insurance does not protect policy holder, vehicle and co-passengers against losses which arise due to bodily injury/ death³.

b. Form B/Comprehensive Insurance (Own Damage)

Form B is known as Comprehensive policy, is an optional cover, which takes care of the additional loss and liabilities - own damages. In addition to third party coverage, this policy covers the policy holder, car and co-passengers against damages /losses arising from unforeseen calamities, hence it is prudent to purchase this policy.

Most of the insurance companies do not cover mechanical breakdown,

consequential loss, depreciation, wear and tear, any contractual liability and intoxicated driving.

MOTOR INSURANCE BUSINESS IN INDIA

In Indian conditions, the vehicles are subject to many hazards like potholes, open manholes, puddle, untarred roads, poor traffic management system, poor pedestrian management, absence of footpaths for pedestrians, joywalkers, drunken driving, reckless driving, result in increasing number of accidents etc. and which accentuate the need for automobile insurance.

Motor Insurance is a financial safety net that can help the insured offset the cost of

bodily injuries to himself or others; Lost wages due to injury, Benefits to survivors when an accident results in death; Lawsuits brought against insured as the result of an accident; Repairs made to your car due to damage caused in an accident.

Motor insurance can be the insured party, the insured vehicle, third parties (car and people). The premium of the insurance is dependent on certain parameters like gender, age, vehicle classification, etc. There are 28 (6 public and 22 private) Non-Life Insurance companies have been functioning since liberalization on this sector. The IRDAI has de-tariffed this sector in 2007. Thus, the details of Own Damage and Third Party Premium Collections and Claims from 2006-07 to 2014-15 is presented in Table1.

Table 1: Motor Insurance business in India (Rs in Crore)

YEAR	OD	TP	OD-CLAIM	TP-CLIAM	OD-CL%	TP-CL%
2006-07	7739	3341	4117.148	5335.577	53.2	159.7
2007-08	8419	4644	4916.696	7671.888	58.4	165.2
2008-09	8756	5065	5778.96	6685.8	66	132.1
2009-10	10013	5573	6408.32	6854.79	64	123.6
2010-11	12400	6355	6478.411	10981.44	64.7	172.8
2011-12	15295	9679	9268.77	19948.419	60.6	206.1
2012-13	18090	12460	10347.48	16821	57.2	135.1
2013-14	19572	15237	11116.896	17370.18	56.8	114.6
2014-15#	23687	14518	13264.72	14989.13	56	103.2451
TOTAL	123971	76872	58432.681	91669.094		
MEAN	24794.20	15374.40	13013.01	19832.73	59.66	145.83
MAX	23687	15237	13264.72	19948.419	66	206.1
MIN	7739	3341	4117.148	5335.577	53.2	114.6
SD	5365.90	4283.19	2961.00	5194.99	4.17	30.76

source: Indian Non- Life Insurance Industry Year Book 2013-14, pp 78-79.

provisional and drawn from Consumer Affair Booklet; #OD= own damage;

TP= Third party insurance; OD-Cl= Own damage claims; TP-Cl= Third party Claims

Table 1 exhibits the Own Damage, Third Party Premium and claims paid by the General Insurance companies on a year to year basis during 2006-07 to 2014-15. This table also reveals Maximum, Minimum values of premium and claims and Claim Ratio, Mean and Standard Deviation over the period.

Under Form B/ Own Damage (OD) category the premium was increased from Rs 7,739 crore to Rs 23,687 crore in a span of nine years. And it has grown at a Compound Annual Growth Rate (CAGR) of 14.2 % over the period from 2006-07 to 2014-15. Similarly, in form A/ third party coverage, the premium was increased from Rs 3,341 crore to Rs 14,518 crore during same period. And it has also grown at a CAGR of 24.2% for the same period.

It is noticed that the average claims under Own Damage is 60 % and the minimum and maximum percentage of claims noticed 53.2% in 2006-07 and 64.7% in 2010-11. Third Party Average Claim is 151.15% and the minimum and maximum percentage of claims noticed in 2013-14 is 114.62% and in 2011-12 is 206.1%. It is significant to note that general insurance companies drastically reduced the claims rate by adopting innovative fraud checks/control methods.

Own damage claims are closely range from 53.2% to 66% but Third Party claims are widely spread from

114.6% to 206.1% during the same period. It is imperative to note that more consistency trend (Standard Deviation 4.17%) was observed in own damage claim ratio then that of Third Party claims (Standard Deviation 30.76%). It also contemplating to that the administered Premium prices is lower than the claims outgo, mainly increasing in claims ratios.

Therefore it is necessitating probing the grievance and frauds in the Motor Insurance. Hence, before probing the frauds, insured to report their grievance to the insurer and in case, insurer does not address the issues, then, they have to report to the ombudsman. Therefore, it is indispensable to cross verify grievances addressed by the insurer and the ombudsman.

GRIEVANCES ADDRESSED BY THE INSURANCE COMPANIES

With the liberalising of the insurance sector, global and private insurance giants have entered the industry. The products on offer are no doubt innovative but they also tend to be complex⁵. The intermediaries have become aggressive in selling the products. One common grievance of the consumers is that the insurers' agents/ representatives are at their best behavior until the policy is sold while they do not even show minimum courtesy when claims are lodged. The days of innocence

where the customer depended on the agent or the affable manager who believed in long term relationship with the customer are over. The customer has to contend with new players, new products and agents, mis-selling, rejection of claims fully or partly, poor or no after-sales service and the like. The insurers might not also deliver what had been promised at the time of selling the policy. Often, the well-healed and literate public too are confused by the fine print of the policy documents and find themselves totally at sea when they face repudiation of their claims. Therefore, signing the proposal form on the dotted line could spell disaster. The situation is much worse if the customers are illiterate or semi-literate. Their declarations, made in good faith, bind them even though they hardly understand the terms of the policy.

The insurance industry in India is well regulated. The IRDAI (Protection of Policyholders' Interests) Regulations, 2002 enjoin the insurers to set up internal grievance redressal mechanism. The insured person, therefore, can knock at the door of the insurer's internal grievance department for redressal of the grievance, when they realize that the claims have been unjustly repudiated? Therefore year wise grievances addressed by General Insurance Companies are presented in Table 2.

Table 2: Grievances addressed by the Non- Life Insurance Companies (%)

YEARS	2006-07	2007-08	2008-09	2009-2010	2010-11	2011-12	2012-13	2013-14	2014-15#	Mean	SD
Private co.	73.12	80.52	85.61	89.26	89.58	99.61	99.36	99.09	99	90.6	3.483688
public co	60.04	63.18	72.3	71.66	72.86	80.7	89.26	90	91	76.8	5.722647
AVERAGE	66.58	71.85	78.955	80.46	81.22	90.155	94.31	94.545	95	83.7	4.234

SOURCE: IRDAI HAND BOOK 2013-14; # provisional

Table 2 shows that on an average 83.7 % of grievances addressed by the respective non- life insurance companies within stipulated period⁶. However, private insurer cleared 90.6 % grievances at their level and settling grievance has steadily increased from 66.58 % in 2006-07 to 95 % in 2014-15.

Public sector insurers have cleared 76.8% of their grievance within stipulated time. The percentages of settling grievance have steadily progressed from 60.04% in 2006-07 to 91 % in 2014-15. Thus necessitating noticing the consistency in addressing the grievances by calculating Standard Deviation (SD). It indicates that the private insurers are maintained more consistency (SD is 3.48%) than that of public insurers (SD is 5.72).

It indicates private insurers are consistently settling their grievance to retain the competitive advantage and to sustain the policy holders' interest than that of public sector insurers. Even then, unsettled claims can be referred to Ombudsman for legal settlement of the claims.

OMBUDSMAN REDRESSAL MECHANISM

The government and the insurance industry have realized that the consumer is entitled to cost effective, efficient and impartial disposal of complaints not in lieu of but in addition to the regular legal remedies. With this as the objective, the Central Government, in exercise of the powers conferred under section 114(1) of the Insurance Act, 1938, has established the institution of Ombudsman for the insurance sector by framing the Redressal of Public Grievance Rules, 1998.

The Ombudsmen have the power to decide the procedure for disposal of complaints subject, however, to the requirement that they act fairly and equitably. Usually, the Ombudsman hears both the parties to the dispute before arriving at a decision. This requirement is not specifically mandated under the Rules but the requirement under the Rules to act fairly and equitably enjoins the Ombudsman to adhere to the principles of natural justice, the most important of which is that the parties are allowed the opportunity

of being heard. The ombudsman can redress grievances in different ways - make a recommendation if both parties to the dispute agree for mediation, make an award or grant ex gratia.

If the complaint has no merit, dismissal, of course, is the result. The Ombudsmen can mediate and record their recommendation on the dispute, if the insurer and the complainant agree for such mediation. The Ombudsman has to make the recommendation within a period of one month from the receipt of the complaint. Where mediation is not resorted to, the Ombudsman makes an award. The limitation is that the quantum of the award should not exceed the loss suffered by the complainant as a direct consequence of the insured peril or Rs.20 lakhs, whichever is lower. The Ombudsman has the power to award payment of ex gratia in suitable cases. The award or order allowing ex gratia has to be made in writing and it has to be a speaking order. The order has to be passed within a period of three months from the receipt of the complaint.

The Ombudsman's recommendation upon mediation or award or order granting ex gratia is binding on the insurer if the complainant accepts the same. If the complainant does not accept, the recommendation or award or order granting ex gratia has no effect and the insurer does not have to implement the same. The complainant's legal remedies are unaffected by non-acceptance of the Ombudsman's recommendation or award or order granting ex gratia.

The ombudsmen do not normally find fault with the insurer. Rather, their role is confined to adjudication of the complaint filed by a consumer, which they stick to. They are aware that Insurance is a business like any other business and do not expect the insurer to be charitable.. The ombudsmen hear the parties to the dispute and decide the complaints in favour of

the complainants if they are of the view that the insurer's decision is perverse or unreasonable or untenable. They, however, avoid the pitfall of rewriting the policy for the insured. If the ombudsmen direct the insurers to pay compensation where there exists no liability, they would be harming the business model of the insurer. A complainant cannot approach the Ombudsman straightway without exhausting the internal grievance redressal mechanism of the insurer. In other words, a complainant has to first make a written representation to the insurer. If the complainant is not satisfied with the reply of the insurer or if no reply has been received within one month from the insurer, only then can a person make a complaint to the Ombudsman. The monetary limit for an award or ex gratia under the Rules is Rs.20 lakhs. The Ombudsman also cannot award compensation for mental agony,

suffering and so on. An inherent limitation is that the Ombudsman cannot rewrite a policy (contract) in order to suit the interest of either party. Instead, the policy is treated as sacrosanct, the terms of which bind the parties and this premise is not disturbed by the Ombudsman.

The procedure for filing a complaint before the Ombudsman is simple. Paper work is kept to the minimum. There is no fee. The complainant does not require the assistance of professionals while filing the complaint. The hearing is conducted in an informal manner where procedure is kept to the bare minimum. Here again, professional assistance is not required. The decision on the complaint is rendered quickly. After obtaining the decision of the Ombudsman, the consumers have the choice to accept the decision or reject it. If the complainant rejects the

Table 3: Number of Cases reported to Ombudsman in Motor Insurance business in India

YEAR	out standing	reported	total	Resolved	%
2006-07	2177	4756	6933	4752	68.54
2007-08	2181	5300	7481	5615	75.06
2008-09	1866	5640	7506	5831	77.68
2009-10	1675	7097	8772	6554	74.72
2010-11	2218	10048	12266	7688	62.68
2011-12	4578	9987	14565	9335	64.09
2012-13	5230	9071	14301	8684	60.72
2013-14	5617	8803	14420	9627	66.76
2014-15#	4793	13974	18767	12172	64.86
TOTAL	30335	74676	105011	70258	
MEAN	6067	14935.2	21002.2	14051.6	68.34576
MAX	5617	13974	18767	12172	77.68
MIN	1675	4756	6933	4752	60.72
SD	1538.11	2769.39	3934.36	2238.46	5.73

source:IRDA HAND BOOK 2013-14

provisional and data being drawn from Consumer Affair 2015

decision, other legal remedies are not affected. But once the complainant accepts the decision, the insurer has to implement the decision within 15 days of receipt of the complainant's acceptance of the decision. The decision of the Ombudsman is binding on the insurer and has to be implemented within 15 days if the complainant accepts the verdict⁷. Those who have not satisfied with the settlement of insurers, than they can represent their case to Ombudsman. Therefore, the number of cases outstanding reported in particular year and resolved presented in Table 3.

Table 3 indicates that the maximum numbered of insured (13,974) reported their cases to ombudsman in 2014-15, followed by 10,048 insured persons in 2010-11. However, minimum number of cases (4756) reported in 2006-07. Correspondingly, maximum number of cases (12,172) in 2014-15 resolved by the Ombudsman. On average 68.76% cases cleared by the ombudsman during 2006-07 to 2014-15. And Maximum 77.68% of the cases in 2008-09 and minimum 60.72 % cases in 2012-13 However, inconsistency is noticed (SD is 5.73%) in addressing the critical or complicated cases by the Ombudsman in aforesaid period. In case, insured is unconvinced with the directions of Ombudsman, they are free to approach the Lokayukthas/ Lokpal or Courts.

ROOT CAUSES FOR VEHICLE ACCIDENTS⁸

Road accident is most unwanted thing to happen to a road user, though they happen quite often. The most unfortunate thing is that we don't learn from our mistakes on road. Most of the road users are quite well aware of the general rules and safety measures while using roads but it is only the laxity on part of road users, which cause accidents and crashes. Main cause of accidents and crashes are as follow:

- 1) Speeding beyond the allowable and posted limit set based on the traffic conditions.
- 2) Inappropriate or too much lane changing.
- 3) Driving with influence of alcohol or any illegal substances.
- 4) Tailgating
- 5) Rubbernecking
- 6) Unnecessary operation of stereo system.
- 7) Too much conversation with passengers
- 8) Improper use of cellphone
- 9) Failure to abide by the road signs and warnings.
- 10) Defective motor vehicle and poorly maintained roads and traffic control malfunction.

REASONS FOR REJECTING THE CLAIMS

A car accident is always distressful situation for the car owner. Not only is there the risk of physical injury and the inevitable damage to your car, but the possibility of the insurance company rejecting your claim is also a cause of aggravation. It is common for insurance companies to reject claims, but in most situations they have genuine reasons to reject the claim. In this paper, discuss the reasons for insurance companies to reject motor insurance claims.

- 1) Get the car repaired after accident on own and then intimate the insurance company about the settlement.
- 2) Installing a CNG/LPG kit and which are not covered the kit while buying the policy.
- 3) The driver driving the insured car at the time of accident should not have a valid driving license.
- 4) Registered a car as private vehicle and is used for commercial purpose.
- 5) Need to notify the claim within specified time. Usually it is 48 hours to 72 hours.
- 6) Specific cases like car parked in a no parking zone or loaded with passenger more than seating capacity,

- 7) Any consequential damage claims are liable for rejection.
- 8) The driver was under the influence of intoxicants like alcohol or drugs.
- 9) The insurance company may reject your claim, if an accident or theft happened beyond a single day after expiry of the policy.
- 10) The insurer may reject your claim related to the theft of the vehicle or items within, if it determines that driver was largely at fault with regards to the failure to prevent the theft. Furthermore, the insurance company may reject your claims of theft of items from your vehicle, if you are unable to provide receipts to backup your claims.
- 11) The insurance company may reject your claim if the accident occurs outside the geographical area as defined in the policy. There two geographical zones for automobile insurance, as defined by the IRDAI. Zone A, which covers the metro cities, like Delhi, Mumbai, Kolkata and Chennai, and Zone B, which covers the rest of India. Normally, automobile insurance is applicable throughout the country. Yet, insured should verify the same in your car insurance policy.

FRAUDS IN MOTOR INSURANCE

It is a myth that insurance fraud is a victimless crime. Any kind of insurance fraud impacts policy holders and insurer or both. Primary policy holders as Claim delay, Increased premium, Harassment in proceeding of payouts, free look cancellation. And the insurer will also effect as Increased costs, Decline in competitive advantage, Erosion of profit margin, Reputation loss, Jeopardized customer relations, Loss of business and Regulatory issues. Hence the most reputed frauds are listed as below¹⁰.

1) Non Claim Bonus (NCB)concealed:

Policy holders intentionally concealing the information or not providing form. For example, while switching from one insurer to another, if a customer does not disclose details of a claim made previously and attempts to avail NCB, discounts etc., are considered as fraud.

2) Number plate replacement:

There are instances where the uninsured vehicle meets with an accident causing loss to the owner. However, the policy is availed after the loss on a vehicle of similar make and model by replacing the number plate.

3) Fake Documents:

Fake documents frauds at the underwriting stage may also arise when insured submits fabricated documents or false information to avail a policy. For example, fabricated policy from previous insurer and fake reports in collusion with third parties.

4) Fake License:

There have been many incidents where the insured produces a fake driving license while making claim. The insured gives to this practice in case his license has expired which could result in repudiation of claim.

5) Driver Swapping:

In this case while intimating a claim the insured provides wrong information on the person who was driving the vehicle at the time accident.

6) Staged accident/thefts

Many a times claimant's stage thefts or accidents in order to avail claim. Occasionally, although the insured vehicle does not suffer any accidental loss/ damage, loss is claimed by fabricating the accident and damage.

7) Claims padding

It is also referred to as "legalized frauds". This is basically mean increasing the damages to a vehicle

in order to overstate the claim. This is usually done in collusion with motor dealers or garages.

8) Multiple claims

Motor insurance is generally an exclusive contract. If the insured take the multiple policies for the same vehicle and makes multiple claims for the vehicle for the same damage amounts.

9) Misrepresentation of facts:

The claimant misrepresentations the facts while claiming for an otherwise genuine loss like changing the spot of accident and the cause of loss.

10) False claims:

Often false claims of bodily injuries are made due to an accident. False reports and fake documents are presented in collusion with police, transport and other officials.

11) Cover note frauds:

These are amongst the most prevalent types of motor insurance frauds which involve issuing of backdated cover notes on already damaged vehicles. Cover note frauds also entail issuance of cover notes changing the details of the vehicles to give undue benefit to the customer or utilizing expired cover notes to issue policy.

12) Medical document related frauds:

Some of the most common types of medical frauds are those related to exaggerated injuries or disabilities, injuries being converted as death, cases of inflated or exaggerated medical bills, and soon.

13) Fake income certificates

Fake proof of income being submitted, often assisted by employees who provide customers with blank templates.

14) Motor vehicle related frauds

These types of frauds can usually be further segregated in to 3 sub-categories. i.e Vehicle related frauds, vehicle document related frauds, driver swapping related frauds.

The augmentation of these frauds is highly supported by syndicate consisting of authorities such as insurance companies agents/ employees, police, and medical/ hospital authorities.

15) To get over indemnification from another wise genuine loss by submitting escalated claim values.

16) Non-producing the documents, delay in notification, non-cooperation of the policy holder.

SUGGESTIONS

- 1) Fraud analytical and predictive modeling should be developed to predictive fraudulent claim and to hasten the process of paying the legitimate one.
- 2) Screening of policy holders from a consolidated database.
- 3) Due diligence for appointing new intermediaries/agents
- 4) Whistle blowing mechanism
- 5) Identifying the anomalies and processing the level of deficiencies using independent business intelligence and fraud scenario.
- 6) Developing and creating efficient communication and reporting channels to escalate issues on a timely basis.
- 7) Train the employees and make them accountable for frauds and maintaining zero tolerance environments to frauds.
- 8) Industry bodies and the insurance industry regulator need to take the lead in mandating reporting and sharing the information.
- 9) Constituting in house investigation team which should work dedicatedly towards checking the flow of frauds.

- 10) Utilizing of RTI Act at the maximum for collection of vital information which is necessary to derive at any action on the claims filed.
- 11) Reconciliation of every cover note book issued must be done every month before issuance of further indent.
- 12) Outsider must not have direct access to any claim file of the office even if he/she is company advocate/surveyor and spouse of the claim settlement officer must be posted in other sections.
- 13) Competition amongst insurer is one of the possible reasons for committing errors, therefore they should follow laid down procedures and standards while clearing the claims policies at any stage.
- 14) The traditional age old methods should be blended with innovative and technology driven tools such as SNA -Social Networking Analysis, predictive analysis and data mining.
- 15) Multiple techniques working in concert together offers best chance of detection of fraud. As majority of the frauds go undetected as the cost of detection of the fraudulent claim far exceeds the cost of the claim.
- 16) Establishment of Fraud Bureau and education of policyholders is the road ahead. The bureau should be focal point for dissemination of all fraud related information.
- 17) Companies should invest in educating the policyholders to beware and vigilant in all their dealings.
- 18) All companies should be mandated to share their suspicious and fraudulent activities on periodic basis. This information should be used to create knowledge bank and should be disseminated to all members of the bureau and public at large.

CONCLUSION

Motor insurance can be the insured party, the insured vehicle, third parties. Under Form B/ Own Damage category and form A/ third party coverage premium has grown at a Compound Annual Growth Rate (CAGR) of 14.2% and 24.2% over the period from 2006-07 to 2014-15. It is significant to note that general insurance companies drastically reduced the claims rate by adopting innovative controlling methods.

It indicates private insurers are more consistently settling the grievance than that of public sector insurers. On average 68.76% cases cleared by the ombudsman and still,

inconsistency is noticed in addressing the critical or complicated cases by the ombudsman.

Majority of the frauds are like Vehicle related frauds, vehicle document related frauds, driver swapping and the augmentation of these frauds is highly supported by syndicate consisting of authorities such as insurance companies agents/ employees, police, and medical/ hospital authorities.

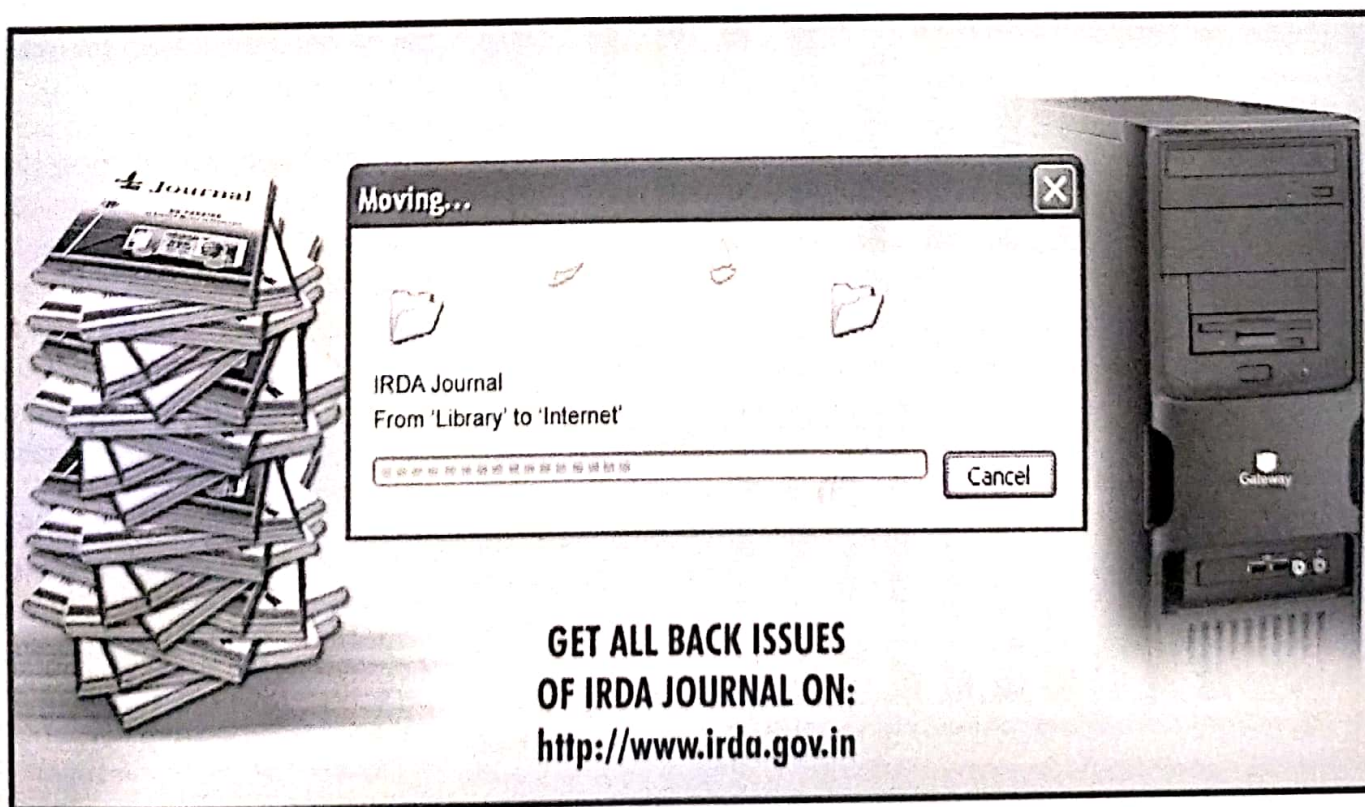
It is suggest to accelerate the motor insurance business in India is reconciliation of every cover note book issued must be done every month before issuance of further indent and the traditional age old methods should be blended with innovative and technology driven tools such as SNA -Social Networking Analysis, predictive analysis and data mining. All companies should be mandated to share their suspicious and fraudulent activities on periodic basis. This information should be used to create knowledge bank and should be disseminated to all members of the bureau and public at large.

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