LIFE INSURANCE CLAIMS - WHAT HAVE WE LEARNT IN THE START UP PHASE OF A NEW LIFE COMPANY IN INDIA

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1. Introduction :

This paper has been written to bring to the attention of the wider actuarial community what the claim experience of a new life company has been since it began operating four years ago. There are lessons that can be learned from the experience.

Life Insurance is an emotional business Unlike General Insurance, there are sentiments involved since its the question of a human being – whether he is dead [then for the family members] or he has a critical illness or a severe disability. If we delay the claim, they are unnerved and frustrated because a person is suffering and an insurer has not kept up his commitment. If we pay, then there is a feeling of gratitude, which can be personally seen in many eyes when they receive a cheque. If we reject, then the family members [in case of death / disability] feel low and dejected because there is a sense of being cheated [though from our point of view we may be technically correct]. In case of an illness, the customer feels that the purpose of his insurance is lost because the insurer has not paid his claim when required most. Customer doesn't want to step in the shoes of the insurer to see the correctness of the settlement. So either way [whether we pay or reject or keep it pending], there is always very emotional outcomes.

The primary role of an insurance company is to settle claims as that is the value add we provide our customers. However, this does not mean paying all claims promptly but rather to pay the genuine claims and reject the non genuine claims. Thus the most important aspect to be understood here is the word "Settle". "Settling a claim" does not necessarily mean paying a claim. A claim can and should be rejected if it is not legally payable. If an insurer pays all claims irrespective of the eligibility criteria, then either it will not remain in business or have to increase the rates for other policyholders. Thus by paying improper claims, the pool of genuine policyholders is disadvantaged.

Claim settlement is not a straight forward process. The basic premise is to pay all "right" claims and reject all "wrong" claims. However, deciding on what is right and what is wrong is not an easy task. In the following paragraphs, we raise the issues we have faced in determining what are fair claims and give some real cases as illustrations.

2. **Understanding of the Product:**

This is probably the first problematic area. In majority of the cases, the customer doesn't know what he has purchased and what the benefits are. Very few people read the actual policy contract and understand its requirements and implications. If this applies to the literate group in the Indian Society, the problems are compounded for the poorer sections of the society, which forms a vast majority of the country.

3. **Incomplete / Incorrect Proposal Form :**

If problems in claims settlement were to be given a rating, then probably this parameter would be rated at 99%. This is the most critical problem. A large number of proposal forms are not filled in with the spirit required

Many Proposal Forms are filled in just for the sake satisfying the insurer's needs to issue the policy – due regard and truthfulness is not given to the questions. A Life Insurance Proposal Form is filled in like a credit card application, where just the basic address etc. is given and then signed off without even pondering over the other fields in the larger proposal form. Questions are just ticked for the sake of completeness without an iota of a thought given to the facts required thereunder. At the time of claim, when the actual facts are revealed, then it is the Proposal Form which indicts the customer at a time when they don't want to accept the facts. Moreover, illiteracy causes more problems, whereby policyholders say that they were not aware of what was supposed to be given.

4. **Non-Disclosures & Mis-representations :**

This is a continuation of the previous point. It is not that the customer is always ignorant and has just committed errors unknowingly. Many times the customer does not want to disclose the facts and problems. Hence he purposely does not disclose information in the Proposal Form.

Illustration – Non Disclosure.

- Male [31 years old]
- Tested HIV +ve. Body had become completely weak and pale.
- Undergoing regular treatment. Knows that he is in his last stages.
- Applies for an insurance Policy.
- Obviously - the fact that he was HIV infected was not mentioned intentionally in the Proposal Form. Policy Issued.
- Life Insured dies within 70 days of issuance of policy.

- Claims Dept. investigates and finds out all health problems. Gets his complete medical history.
- Claim rejected.

Disclosure may mean mention of an existing condition. Sometimes, information is given which is incomplete and probably misleading with half the facts and half unsaid things. This is the worst scenario from the legal point for the insurer – because he had some information and the court may take a view that you should have dug into it further though it may be impractical to do so in each case at the time of underwriting.

The majority of the claims get rejected on the basis of non disclosure. A few examples:

i.) Life Insured was aware and already suffering from illness at the time of the application itself. But nothing mentioned in the Proposal Form.

ii.) Life Insured was a heavy smoker / habitual drinker at the time of application but it is mentioned in the Proposal Form that he does not smoke a single cigarette or that he does not consume alcohol at all.

iii.) Lives Assured consume a lot of tobacco or tobacco products, but they don't feel the necessity for disclosure. This is a particularly so in the rural areas where tobacco use is seen as part of everyday life.

iv.) Family history not disclosed correctly.

v.) Only partial information is given. He smokes only 2-3 cigarettes in a day or he is a social drinker, drinking only at parties once in a while etc. They probably forget to mention that they party almost everyday and too heavily. As mentioned above, partial information is worse since at the claim stage the beneficiary likes to take the stand that the issue had been mentioned to the insurer - the quantum and quality does not really matter to them. This leads to debate and legal disputes at the time of the claim, as to why the insurer did not investigate and try to seek all these necessary information at the time of underwriting itself.

5. Frauds

This is a more sophisticated and devious version of the earlier point. Here the intention itself is to blatantly cheat the company. The only limit here is the ingenuity of the human mind. It requires dishonesty both at the proposal and claim stage.

Illustration: Pre-existing illness and Fraudulent non-disclosure.

- Female [54 years old] with severe illnesses [unknown – since she is from a very rural village] is on death bed.
- The beneficiary [grandson] takes her finger prints on the Proposal Form and the policy is issued.
- No information of any illness given in the Proposal Form. Policy issued.
- She dies within 15 days of issue of policy.

- Beneficiary does not mention any such thing. Gives incorrect death information.
- Claims Department tracks all her problems. The lady was illiterate and she couldn't sign. Her finger prints were taken in this case without her knowledge, understanding or consent as she was on the bed in her last stages. The grandson filled in the form in her name and got it authenticated through her finger prints. Company rejects the claim.

Illustration : Pre-existing illness ,non-disclosure and fraudulent death claim information.

- Male [34 years old] with severe lung problems and is on death bed.
- No such information given in the Proposal Form. Policy issued.
- He dies within 40 days of issue of policy.
- Beneficiary smartly hides all hospitalization information.
- Gives incorrect death information. The Life Insured actually died in a hospital. But she says that he died at home. This was to avoid submission of hospital papers which would have revealed the Life Insured's existing ailments.
- Claims Department investigates and tracks all his problems, gets hold of all hospital information, rejects the claim.

Illustration : Non-existing Life Insured – Fraud.

- Proposal made on the life of male
- Quarterly Mode of Premium payment.
- Forged Ration Card for the person named was produced.
- Policy issued.
- Within 3-4 months of issue of policy, death claim lodged.
- Forged Death Certificate produced.
- Claims Department tracks all the links and proves the fraud

Other situations are

a) Somebody trying to insure a person who is already dead or dying.

Illustration : Insuring a Dead Person – Fraud.

- Proposal made on the life of male [Group Policy]
- Within 1 month from the date of commencement of cover, death claim lodged.
- Forged Death Certificate produced.
- On investigation, it is found that the person had been dead over a year, i.e. prior to insurance commencement date.
- A friend of this person, had applied for the insurance.
- In order to claim the money, he had made his wife the nominee stating that she was the sister of the life insured.
- Claims Department tracked all the links and proved the fraud. Immediately thereafter, the nominee withdrew the claim.

b) Somebody – trying to fake his own death?

Illustration : Midnight Accident case.

- A businessman
- Applies for large cover on himself and wife
- Financial and health statements sought.
- Policies issued.
- Within the year he applies for further substantial cover with other insurers.
- Father and friends are the beneficiaries on the policies.
- Wife and husband die in a late night motor car accident one year after the commencement of policy.
- Wife's body identified. Husband [who was driving] could not be identified.
- Police close the case as death of the business man and his wife.
- Rumours circulate the businessman is still alive
- Court Case is still pending.

c) Somebody – dies in suspicious circumstances

Illustration: Midnight Car Accident case.

- A man takes a policy on the life of his wife.
- His wife is shown to have agricultural income and hence based on that cover was sought along with a similar amount of accidental benefit cover.
- In addition, policies are taken from other insurers.
- Fact of other cover not disclosed in the Proposal Form.
- Within a month, the lady is reported dead in a car accident. Everybody except the husband [beneficiary] dies.
- Car accident is mysterious.
- Claim submitted.
- Husband is a very influential person.
- Investigation indicates that there is high possibility of fraud, but not easy to prove.

This is different to the case above as in the one above if the husband is alive the insurance company is not liable. In this case the insurance company is liable and it is just a matter of who the claim amount is paid to.

6. Rural Area Problems:

India consists of a large part of rural areas. The regulatory body requires that a certain percentage of business be compulsory done in the rural areas which is socially desirable. However, doing business in the rural areas is not a smooth road. The problems encountered are.

a) illiteracy and lack of understanding of the contracts.
b) inability to bear the costs of regular premiums.
c) collection of the premiums

d) non-availability of medical facilities and records
e) the cost of doing business in these rural places
f) verifying information.

Claims investigations become costly, time consuming and difficult affairs. Getting evidence in the rural areas is very difficult. The local panchayats and the doctors give death certificates in a free flowing manner. There is sometimes no authenticity involved in the issuance of a death certificate. The notification of claims to the insurer is sometimes 6 months after the event and the body has been cremated by which time the trail is very cold.

It is difficult to unearth frauds in the rural areas due to a small concentration of closed people, suspicious of outsiders.

Snake bites are a relatively common occurrence in the communities and if genuine would represent a proper claim. However if a person dies from a non disclosed illness but the body is bitten or reported to have been bitten by a snake it is impossible to disprove otherwise.

Illustration: Fraudulent Snake Bite Case.

- A 45 year old male takes an insurance cover on his own life.
- He applies to 4 different insurers and accordingly gets policies on his life. Of course, this fact was not mentioned to any other insurer.
- Within a month or so, his wife lodges a claim stating that her husband died of a snake bite.
- On investigation, it was revealed that there was some person in the village who had taken insurance policies in his name because he knew that this person was in his last stages.
- He was suffering from cancer as he was in the habit of heavy chewing of tobacco, which was obviously not disclosed.
- The Life Insured did not actually die of snake bite. It was a cooked up story.
- While lodging a claim, the existence of insurance policies with other companies was not disclosed.
- All the insurers collected evidence and then rejected the claim. But it was very difficult to get any evidence from the rural areas as there is no medical facility and people connive with each other, including the local doctors.

From an actuarial point of view we have to probably accept in the rural areas that certain amount of claims will be questionable and therefore rate accordingly.

7. Proposer & Life Insured are different:

There are problems where one person insures another person. Though the insurability criteria is looked into, it is not devoid of moral hazards. A husband insuring an ailing wife is not an uncommon scenario.

Illustration : Policyholder and Life Insured different people.

- A 30 year old lady was insured by her husband - who is the Policyholder.
- After about 1 ½- 2 years, the wife was reported to be dead due to drowning.
- Though circumstances do not fully and satisfactorily support the drowning, there is no evidence to disprove the same.
- To add to this, there are certain evidences which prove that the lady was under some psychiatric treatment in the past few months.
- Then there are certain varying statements in the police reports etc.
- However, there are no strong pin-pointing evidences to support the actual cause of death. Hence the claim had to be paid off.

As certain experts quote is ***"An insurer should not create a moral hazard by making the death of a person more valuable than his / her life",*** sometimes an insurer may create such an opportunity by insuring house wives. A warning sign is where the husband is himself not insured or is not insured for a big amount and he insures his wife for significant cover.

This is sometimes linked with misleading income being stated – e.g., income from tuitions, tailoring, cooking, catering etc. In reality, it is found on a majority of the occasions that the Life to be Insured was actually not earning anything.

There are people who are not the actual Policyholders but they take out insurance in the name of their ailing wives or parents and make them sign the application forms and making themselves as the nominee.

8. Multiple Insurance Policies from different insurers :

We have seen claims where the policyholder has taken a number of policies at different insurers.

Illustration: Insurance cover on the life of an ailing housewife.

- A 33 year old female takes insurance cover on her own life.
- She takes a cover to the maximum non-medical limits.
- She then applies to 4 other companies and takes up to the maximum non-medical limits.
- She does not disclose about her existing cover to any other insurer. She is reported to be a very healthy person doing business and earning around a Rs. 1 lac p.a.
- She dies within 45 days.
- On investigation, it is found that it was actually her husband who had taken various policies on her life and made himself the nominee. It was also found that she was a housewife and had some serious terminal health problems.
- After seeking complete information, all the insurers rejected the claim.

There is a high risk and a big financial underwriting issue with people taking insurance covers from various insurers without disclosing the facts of the existing covers. The industry is now recognizing this and is sharing claims information. If a number of claims on the same life are registering with different insurers but similar commencement dates investigations are made.

9. Group Business :

Group business is different to individual business as the member has to belong to that group before he can avail of the insurance benefit. Companies' schemes where cover is fixed for everyone and everyone has to be a member has produced straightforward claims.

Where the group is not a company and where the cover or membership of the group (e.g. affinity groups) is voluntary such groups have not exhibited good claims experience.

The pricing of such groups needs to recognize the element of anti selection.

10. Quality of Medical Records :

The developed countries around the world have Government health schemes which require public funding. Along with this go extensive computerized medical histories kept by the doctors and the government agencies. This is a critical tool in these countries for the discovery of non disclosures by insurance companies. This does not exist in India where the individual keeps the records and not the doctors.

The biggest problem in India is that we do not have a proper medical records system being kept. Hence, getting any medical history is very difficult.

11. Judicial System :

Last but not the least, the judicial system also poses problems for the insurers. We have two levels the ombudsman and the courts. In both levels the insurance companies have to have very strong cases as the tendency is to side with the member of the public who has suffered bereavement.

The ombudsmen scheme – though a very good one in principle – does have problems for the insurer. Customers create emotional scenes and present only one part of the story to them and the ombudsmen tend to support them more. They sometimes go beyond the legal definitions and act to give decisions in favour of the customers.

The insurers cannot challenge the decisions of the ombudsmen.

12. Accident Humps

When we have looked at our experience for ages under 35 we have seen a high proportion of deaths from motor accidents. This is in keeping with the number of motor cars now being sold to the target market for insurance.

However the pricing of our contracts are based like other companies on the Indian table LIC 94-96. If the trend is permanent, which would be consistent with the overseas markets it does mean we are undercharging for mortality for this age group. The industry and actuarial profession needs to get its mortality investigations organizations collecting the data quickly so that the correct pricing happens.

13. Conclusion:

Life Insurance business is an emotional business, meant to achieve a social cause. The insurers are striving hard to achieve this purpose. They need the best support from various systems and channels to achieve this goal so that the social security of our country can march in the right direction.

Although the majority of people are honest hard working people, if there is a way of people enriching themselves at another's expense a certain minority will take advantage of that especially if it a big impersonal insurance company who is seen as having a lot of money.

Issues for the industry to start to address are

1. We need to be ever vigilant in our underwriting and claims management of insurance risks if the insurance industry is to prosper and the population of India benefit.
2. We need to push for better medical records to be kept
3. We are seeing the motor car accidents becoming a significant cause of death in the younger age groups which has not been factored into pricing.
4. The pricing of our products needs proper industry mortality and morbidity statistics and investigations done. The ASI role in this is critical.