INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

NOTIFICATION

Hyderabad, the 16th February, 2013

Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

F. No. IRDA/Reg./14/72/2013.—In exercise of the powers conferred under Section 114A of the Insurance Act 1938 and Section 14 read with section 26 of the IRDA Act 1999 and in consultation with the Insurance Advisory Committee, the Authority hereby makes the following regulations, namely:-

1. **Short title and commencement.**

   a. These Regulations may be called Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2013

   b. They shall come into force from the date of their publication in the Official Gazette of the Government of India.

   c. Unless otherwise provided by this Regulation, nothing in this Regulation shall deem to invalidate the health insurance contracts entered prior to these Regulations coming into force

   d. These Regulations are applicable to all licensed life insurers, non-life insurers and health insurers, conducting health insurance business as defined under these regulations in India.

2. **Definitions.** In these Regulations, unless the context otherwise requires,--

   a. "Act" means the Insurance Act, 1938.
   b. "Agreement" means an agreement prescribing the terms and conditions of services, which may be rendered to the holders of health policies of an Insurance Company entered into between
      i. a Third Party Administrator (TPA) and an insurance company ; or
      ii. a Network provider and an Insurance Company, which may include a TPA as a third party.
      iii. a Network provider, a TPA, and the insurer.
   c. "Authority" means the Insurance Regulatory and Development Authority established under sub section 1 of section 3 of the IRDA Act 1999.
   d. "Break in policy" occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
   e. "Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
   f. "File and Use Procedure" means a procedure to be followed for health insurance product approval by the insurers in accordance with guidelines/circular issued by the Authority.
   g. "Health insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

h. "Health Services by TPA" means the services rendered by a TPA to an insurer under an agreement in connection with health insurance business but does not include the business of an insurance company or the soliciting either directly or indirectly, of health insurance business or deciding on the admissibility of a claim or its rejection.

i. "Health plus Life Combi Products" mean products which offer the combination of a Pure Term Life Insurance cover of a life insurance companies and a Health Insurance cover offered by non-life and/or standalone health insurance companies.

j. "Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

k. "Portability" means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

l. "Senior citizen" means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

m. "Third Party Administrators or TPA means any person who is licensed under the IRDA (Third Party Administrators – Health Services) Regulations,2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

n. All words or expressions not defined in these Regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 shall have the same meanings respectively assigned to them in those Acts.

3. Registration and Scope of Health Business

a. Health Insurance products may be offered only by entities with a valid registration under the Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations 2001.

b. Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.

c. Non-Life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium shall remain unchanged for the tenure.

d. Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts. However, the non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

e. Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.

4. **File and Use Procedure for health insurance products**

a. No health insurance product shall be marketed by any insurer unless it has the prior clearance of the Authority accorded as per the File and Use Procedure.

b. Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.

i. Any revision or modification in a policy which is approved by the Authority shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.

ii. The possibility a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus.

c. File & Use application for the prior approval of the Authority shall be certified by the Appointed Actuary and the CEO of the insurance company and shall be in such formats and accompanied by such documentation as may be stipulated by the Authority from time to time.

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d. **Withdrawal of Health Insurance Product**

i. To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing policyholders.

ii. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.

iii. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.

iv. The withdrawn product shall not be offered to the prospective customers.

e. All particulars of any product shall after introduction be reviewed by the Appointed Actuary at least once a year. If the product is found to be financial unviable, or is deficient in any particular the Appointed Actuary may revise the product appropriately and apply for revision under File and Use procedure.

f. Five years after a product has been accorded File and Use approval, the Appointed Actuary shall review the performance of the product in terms of morbidity, lapse, interest rates, inflation, expenses and other relevant particulars as compared to the original assumptions made while designing such product and seek fresh approval with suitable justifications or modifications of the earlier assumptions made.

5. **General Provisions relating to Health Policies**

a. Health insurance product may be designed to offer various covers

i. To specified age or gender groups

ii. To different age groups

iii. To treatment in all hospitals throughout the country, provided the definition of hospital is met

iv. To treatment in specified hospitals only, provided the morbidity rates used are representative

v. To treatment in specified geographies only, provided the morbidity rates used are representative etc

provided, such specifications are disclosed upfront and clearly in the product prospectus, documents and sale process.

b. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of insured.

c. Insurers shall ensure adequate dissemination of product information on all their health insurance products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the File and Use Procedure, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable.

d. **Nomination and Assignment**

i. All health insurance policies shall provide for a nomination registered at the time of the proposal in accordance with Section 39 of the Insurance Act, 1938.

ii. No assignment of health insurance policies shall be allowed irrespective of whether the coverage provided under such policies are indemnity based or benefit based. Provided that, in Life-Health Combi products, assignment may be allowed only for the life insurance component of the product in accordance with Section 38 of the Insurance Act, 1938.

e. **Entry and Exit Age**

i. Except as provided for in regulation j, all health insurance policies shall ordinarily provide for an entry age of at least up to 65 years.

ii. Except travel insurance products and for products in accordance with Regulation j and 4 (d) herein, once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on grounds of the age of the insured.

f. **Renewal of Policies**

i. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

ii. The renewal of a health insurance policy sought by the insured shall not be denied arbitrarily. If denied, the insurer shall provide the policyholder with cogent reasons for such denial of renewal.

iii. A insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the previous or earlier years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy following payment of the critical illness benefit, the policy terminates.

iv. The insurer shall provide for a mechanism to condone a delay in renewal up to 30 days from the due date of renewal without deeming such condonation as a break in policy. However coverage need not be available for such period.

v. The promotion material and the policy document shall explicitly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies.

g. **Free Look Period**

i. All Health insurance Policies shall have a free look period. The free look period shall be applicable at the inception of the policy and:

1. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable

2. If the insured has not made any claim during the free look period, the insured shall be entitled to-

a. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

d. In respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

h. Cost of pre-insurance health check up

i. The cost of any pre-insurance medical examination shall generally form part of the expenses allowed in arriving at the premium. However in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies where such costs need not be reimbursed.

ii. Insurers shall maintain a list of, and the fees chargeable by, institutions where such pre-insurance medical examination may be conducted, the reports from which will be accepted by them. Such list shall be furnished to the prospective policyholder at the time of pre-insurance medical examination.

i. Cumulative bonus

i. Insurers may offer cumulative bonuses on indemnity based health insurance policies, which shall be stated explicitly in the prospectus and the policy document.

ii. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it is accrued;

iii. Cumulative bonus shall not be allowed on benefit based policies.

j. Option to migrate to suitable health insurance policy

i. Insurers offering health covers specific to age groups such as maternity covers, children under family floater policies, students etc, shall offer an option to migrate to a suitable health insurance policy at the end of the specified exit age or at the renewal of the policy by providing suitable credits for all the previous policy years, provided the policy has been maintained without a break.

k. All health insurance policies shall allow the portability of any policy in accordance with Schedule:1

l. **AYUSH Coverage**:

i. Insurers may provide coverage to non-allopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.

ii. For benefit based products, (i) shall not be applicable.

m. Disclosures/Declarations:

i. Subject to the provisions of these regulations, prospectus of health insurance policy shall mandatorily contain all the information regarding:

1. disclosures about the terms of its renewal.

2. coverage and premium applicable as per the age progression

3. disclosure of the maximum age up to when the renewal would be available, if product is offered to specified age groups and the option available to migrate to other policies in all such cases.

4. any changes in the scope of the cover after certain duration of the policy or after a certain age- such as including but not limited to coverage for pre-existing diseases;

5. whether renewal premium would be guaranteed or subject to revision;

6. details of specific circumstances, if any, where premium could be loaded (or discount withdrawn) by the insurer and also to the extent to which it could be done;

7. procedure and terms for enhancing the sum insured or scope of cover , if any;

8. all the exclusions, cancellation conditions and

9. other aspects in accordance with the extant regulations, guidelines, circulars etc on advertisements and disclosure requirements.

ii. Declarations shall only form part of the proposal form and shall not be included in the policy document. The standard declarations in the proposal form shall be:

1. "I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.

2. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."

n. **Standard Definition of terms in health insurance policies**

i. Phrases and terms used in all health insurance policies shall carry the meaning attached to them as set out in 'Standard Definitions', if any, issued by the Authority from time to time.

o. **Standard Nomenclature and Procedures for Critical Illnesses**

i. The nomenclature and procedures incorporated into policies offering 'critical illness cover' shall be as defined by the Authority from time to time.

p. **Standard List of Excluded Expenses in Hospitalization Indemnity policies**

i. Hospitalization indemnity policies shall generally exclude from cover the Standard list of excluded items as may be stipulated by the Authority from time to time.

ii. However insurers may offer to cover as part of hospitalization expenses, items in the Standard excluded list or exclude items not in the list, provided that such modification is shall clearly stated and such modified list is annexed to the policy document.

q. **Special Provisions for Insured Persons who are Senior Citizens**

i. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.

ii. All health insurers and TPAs, as the case may be, shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

r. **Multiple Policies**

i. If two or more policies are taken by an insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/benefit offered:

1. is fixed in nature;

2. does not have any relation to the treatment costs;

ii. In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar polices.

iii. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the insurer shall not apply the contribution clause, but the policyholder shall have the right to require a settlement of his claim in terms of any of his policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the chosen policy.

2. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policy holder shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

3. Except in benefit policies, in cases where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the policy.

6. Underwriting

a. All Insurance Company's shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. The policy should among other matters prescribe the proposal form in which prospects may apply for purchasing a Health Policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Policy of the Company.

b. The Underwriting Policy shall be filed with the Authority. The Company retains the right to modify the Policy as it deems necessary, but every modification shall also be filed with the Authority.

c. Any proposal for health insurance may be accepted or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, recording the reasons for denial.

d. The insured shall be informed of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.

e. If an insurance company requires any further information, such as change of occupation, at any subsequent stage of a policy or at the time of its renewal, it shall

i. prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document

ii. Clearly state the events which will require the submission of such information.

iii. Clearly state the conditions applicable in such event.

f. Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience etc with the same insurer and disclose upfront such mechanism or incentives in the prospectus and the policy document, as approved under File and Use.

7. Principles of Pricing of Health Insurance Products

a. The premium for a health insurance policy shall be based on,

i. for individual policies, the completed age of the prospect on the date of inception of the policy or on the date of its renewal..

ii. for provision of cover under family floater, the impact of the multiple incidence rates of all family members proposed to be covered.

b. . The policy premiums shall be unchanged

i. for all group products and travel insurance products, for the entire period of cover.

ii. for all individual and family floater products, other than travel insurance products, for at least:

1. a period of one year in case of one year renewable policies and

2. for the period of the tenure as stipulated in Regulations 3 (b) and 3(c) herein in the case of multi-year policies..

c. For a period of three years after a product has been cleared under File and Use Procedure the premiums filed shall ordinarily not be changed. Thereafter the insurer may vary the premium rates depending on the experience, such rate shall not be changed for a period of at least one year from the date of clearance from the Authority.

d. Changes in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.

e. The reasonableness of the pricing as arrived at by the insurer will be assessed having regard to the financial sustainability and viability of the product with respect to the rates, loadings, guarantees and discounts, and the accuracy of the assumptions underlying the pricing model adopted.

f. At the time of filing the product under the File and Use procedure, the insurer shall provide:

i. complete pricing details including the methodology adopted to arrive at the premiums, together with the data sources utilized;

ii. assumptions made shall include the expected claim frequency and claim severities across age bands, expected expenses, lapse rates etc;

iii. specific loadings, if any, allowed;

iv. the profit margin at various model points or the expected loss ratios and the expected combined ratios across various model points across the entire portfolio;

v. the underwriting capacity required for the product and the actual capacity available with the insurer;

vi. the retention capacity to manage the business

vii. internal capacity building measures, if any, required to offer the proposed product and

viii. any other relevant metric for the product proposed.

g. Applications for revision of premium rates shall be filed before the Authority for approval under the File and Use Procedure and shall encompass

i. the justification for the revision in price;

ii. the claims experience of the three immediately preceding years compared to the expected experience duly explaining the variations, and the experience of any similar product.

iii. the expected claims experience, the assumptions underlying the proposed pricing along with an analysis of how the proposed pricing would address the adversities experienced sustainably.

h. **Loadings on Renewals**:

i. The loadings on renewals shall be in terms of increase or decrease in premiums offered for the entire portfolio and shall not be based on any individual policy claim experience.

ii. The discounts and loadings offered shall:

1. not be at the discretion of the insurer;

2. be based on an objective criteria;

3. be disclosed upfront in the prospectus and policy document along with the objective criteria, and shall be as approved under the File and Use.

i. **Upper Limit/Maximum Cover offered under a contract:**

i. If in a benefit based health insurance policy the insurer has prescribed any upper limit for any specified benefit or cover, the insurer shall not accept any proposal for a cover beyond such upper limit, unless the premium for such cover is separately charged.

ii. Complete pricing details on how such inbuilt limits are considered in arriving at the total premium shall be provided under the File and Use.

iii. If any proposal is accepted beyond such upper limit, the insurer shall not deny a claim on the ground that the policy exceeds the upper limit prescribed for that policy.

iv. However, the insurer may cancel the cover beyond such upper limit and shall return the proportionate premium, provided that

1. the policyholder, at the time of proposal, has not disclosed the existing and simultaneous policy details in the proposal form and

2. the existence of such policy is revealed only subsequently resulting in the cover accepted beyond the upper limit, and

3. Such other policy has been underwritten by another insurance company.

8. Protection of Policyholders' Interest

a. Unless otherwise provided, the IRDA (Policyholder Protection of Interest) Regulation, 2002 is applicable to all health insurance policies.

b. Every insured shall be provided with a Key Information Sheet setting out in simple language briefly but clearly all the important features of the policy, its claim limits, disallowances. The authority may prescribe such document.

c. The insurer shall establish necessary systems, procedures, offices and infrastructure to enable efficient issuance of pre-authorisations on a 24 hour basis and the prompt settlement of claims and grievances.

d. **Settlement/Rejection of claim by insurer:**

i. An insurer shall settle claims, including its rejection, within thirty days of the receipt of the last 'necessary' document.

ii. Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The insurer shall ensure that all the documents required for claims processing are called for at one time and shall not call for the documents in a piece meal manner.

iii. The information that the insurer has captured in the proposal form at the time of accepting the proposal, the terms & conditions offered under the policy, the medical history as revealed by earlier claims, if any, and the prior claims experience shall all be maintained by the insurer as an electronic record and shall not be called for again from the policyholder/insured at the time of subsequent claim settlements. If called, for such information will not be deemed 'necessary.'

iv. If the claim event falls within two policy periods, the claims shall be paid taking into

consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

v. Insurer may stipulate a period within which all necessary claim documents should be furnished by the policyholder/insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons for any delay.

e. **Minimum Disclosures in Policy Document**: In addition to the requirements stipulated in IRDA (Protection of Policyholders' Interest) Regulations, 2000 the policy document shall contain:

i. List of disclosures required as per this regulation.

ii. Procedure for claims submission, time lines and possible course of action, if time lines for claim submission are not adhered to along with all the claims documents required for claim processing.

iii. Sub-limits applicable on any of the covers offered in the health insurance product and the impact of such sub-limits on other covers provided in the product, if any, shall be clearly spelt out.

iv. Penal interest provision shall invariably be incorporated in the policy document as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

v. The TPA(s) details, if any along with complete address and contact numbers shall be attached to the policy document and shall be updated as and when there is a change in the TPA (s).

9. Administration of Health Policies

a. Subject to the terms of a policy, insurers shall extend to all policy holders a cashless facility for treatment at specified establishments or the reimbursement of the costs of medical and health treatments or services availed at any medical establishment.

b. Cashless facility shall be offered only at establishments which have entered into an Agreement with the insurer to extend such services. Such establishments will be termed as Network Providers. Reimbursement shall be allowed at any medical establishment. All such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable.

c. The administration of all health plus life-combi products shall be in accordance with the provisions of Schedule II to this Regulation as may be amended from time to time by the Authority.

d. Except in emergencies a cashless facility may require a Pre-Authorisation to be issued by the Insurer or an appointed TPA to the Network Provider where the treatment is to be undergone. The Authority may prescribe a Standard Pre-Authorisation form and standard reimbursement claims forms which shall be used for this purpose, as applicable.

e. To avail the benefit of cashless facility, insurers shall issue an Identification Card to the insured within 15 days from the date of issue of a policy, either through a TPA or directly.

f. The identification card shall, at the minimum, carry details of the policyholder and the logo of the insurer. The validity of card shall coincide with the term of the policy and mayas renewed from time to time. Insures may issue a Smart Card instead of an Identity Card.

g. Where a policyholder has been issued a pre-authorisation for the conduct of a given procedure in a given hospital or if the policyholder is already undergoing such treatment at a hospital, and such hospital is proposed to be removed from the list of Network Provider, then insurers shall provide the benefits of cashless facility to such policy holder as if such hospital continues to be on the Network Provider list.

h. Insurer shall keep the insured informed of the list of Network Providers and display the same on their website and the appointed TPA's office. Such list shall be updated as and when there is any change in the Network providers.

i. The insured shall have access to all the Network Providers of an insurer to avail cashless facility as long as the insurer has a valid service agreement with the Network Provider and such Network Providers shall remain unchanged irrespective of change in TPAs.

j. An insurance company may enter into arrangement with other insurance companies for sharing of Network Providers, transfer of claim & transaction data arising in areas beyond their service areas.

10. **Agreement between Insurers, Network Providers and TPAs**

a. Insurance companies may offer policies providing cashless services to the policyholders provided:

i. The services are offered in network providers who have been enlisted to provide medical services either directly under an agreement with the insurer or by an agreement between health services provider, the TPA and the insurer.

ii. The Authority may, from time to time, prescribe clauses to be included in such agreements as stipulated in (b).

iii. the Agreements which shall be entered into between insurers, network providers/TPAs shall cover the following amongst others:

1. the tariff applicable with respect to various kinds of healthcare services being provided by the network provider.
2. a clause empowering the insurer to cancel or otherwise modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation or modification shall be done by the insurer unless the concerned TPA/ network provider is given an opportunity of being heard.
3. a standard clause providing for continuance of services by a network provider to the insurance company if the TPA is changed or the agreement with TPA is terminated.
4. a clause providing for opting out of network provider from a given TPA for reasons of inadequacy of service rendered by the TPA to the network provider.
5. a clause specifying the fees and other charges leviable by an insurance company to the TPA for services rendered.
6. a clause specifically requiring only the insurance company the power to deny a claim.
7. a clause enabling insurer to inspect the premises of the network provider at any time without prior intimation.

b. The Authority may from time to time prescribe standard clauses to be included in such agreements.

c. The insurance company shall endeavour to enter into Agreements with adequate number of both public and private sector providers with adequate geographical spread.

11. **Payments to Network Providers and Settlement of Claims of Policyholders:**

a. For the purpose of claim settlement, insurer shall make direct payments to the Network provider and to the policyholders by integrating their banking system platform with the network provider or the insured,

as the case may be. Provided that, if a claimant opts for payment through a cheque or Demand Draft, the insurer shall not deny such request.

12. Services offered by TPA in relation to Health Insurance Policies

a. The insurer may enter into an Agreement for the provision of defined services with a TPA holding a valid license issued in accordance with the IRDA (Third Party Administrators) Regulations, 2001 as may be amended from time to time.

b. The services offered by a TPA shall not include

i. Claim settlements and rejections with respect to the health insurance policies; However, TPA may handle claims admissions and recommend to the insurer for the payment of the claim settlement, provided a detailed guideline is prescribed by the insurer to the TPA for claims assessments & admissions in terms of capacity requirements, internal control requirements, claim assessment & admissions procedure requirements etc under the agreement.

ii. Any services directly to the policyholder or insured or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the insurer.

c. The TPA shall have in place the infrastructure necessary to extend the health services as required to the policyholders at all times.

d. Settlement and Denial of Claims:

i. All documents submitted to TPA shall be electronically collected and shall be forwarded to the Insurers for taking a decision on the claim settlements or claim rejections.

ii. TPA shall, in the correspondence to the policyholder with respect to settlement/denial of the claims, state clearly the following:

"As per the instructions of the insurer <Name of the Insurer>, the claim is being settled/denied for Rs. <amount> on account of <specifics of treatment/grounds of denial>. For any further clarifications, you may directly contact the insurer."

iii. The above statement shall form the mandatory part of the communication to be sent to the policyholder in every case of settlement or denial of the claims.

iv. The insurer and the TPA shall be responsible for the proper and prompt service to the policyholders at all times.

e. Bar on Non-insurance healthcare schemes

i. The TPA shall offer health services only in accordance with the IRDA (Third Party Administrators) Regulations, 2001 and shall not provide any services:

1. directly or indirectly to non-insurance healthcare schemes or

2. directly to health insurance schemes promoted, sponsored or approved by entities not being insurance companies, such as Governments, PSU's etc.

3. directly or indirectly to the policyholder or insured, except the health services as per the agreement with the insurer.

13. **Agreement between a TPA and an Insurance company**

a. The insurer and the TPA shall themselves define the scope of the Agreement, the health and related services that may be provided by the TPA and the remuneration therefor. Provided that there shall be a clause in the Agreement for its termination by either party on grounds of mutual consent or any fraud, misrepresentation, inadequacy of service or other non-compliance or default fraud. Provided further that, there shall be no element in the Agreement which dilutes, restricts or otherwise modifies the

stipulations of the IRDA in respect of Policy Holder welfare, protection, service standards and turn-around-time parameters.

b. The remuneration to the TPA shall be based on the services rendered to the insurer and shall not be related to the product/policy experience or the reduction of claim costs or loss ratios of the insurer.

c. A copy of the Agreement entered into between the TPA and the Insurance Company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

d. More than one TPA may be engaged by an insurance company and, similarly, a TPA can serve more than one insurance company.

e. The Authority from time to time may prescribe minimum standard clauses to be included in the agreement between insurer and TPA.

14. Change of TPAs for servicing of Health Insurance Policies

a. A change in the TPA by the insurer shall be communicated to the policyholders 30 days before giving effect to the change.

b. The contact details like helpline numbers, addresses, etc. of the new TPA shall be made immediately available to all the policyholders in case of change of TPA.

c. The insurers shall take over all the data in respect of the policies serviced by the earlier TPA and make sure that the same is transferred seamlessly to the newly assigned TPA, if any. It shall be ensured that no inconvenience or hardship is caused to the policyholders as a result of the change. In this regard, the following aspects shall receive special attention:

i. Status of cases where pre-authorization has already been issued by existing TPA.

ii. Status of cases where claim documents have been submitted to the existing TPA for processing.

iii. Status of claims where processing has been completed by the TPA and payment is pending with the insurer/ TPA.

15. Data and related issues:

a. The TPA and the insurer shall establish a seamless flow of data transfer for all the claims.

b. The respective files shall be handed over to the insurer within 15 days of the claim settlement or rejection.

16. **Submission of Returns to the Authority**

a. All insurance companies carrying on health insurance business shall furnish the Returns to the Authority in accordance with Schedule-III.

17. Transitory Provisions

a. Withdrawal of Products

i. The Appointed Actuary shall examine every Health product, Group and Individual, in the Company's portfolio and list out those products which are not in compliance with the provisions in every particular of these Regulations. Such list shall be certified by the Appointed Actuary, counter signed by the CEO and submitted to the Authority on or before 30.06.2013.

ii. Products not in compliance with this Regulation shall all stand withdrawn and shall not be sold
   1. In the case of Group Products, from 1st July 2013
   2. In the case of Individual Products, from 1st October 2013

iii. No new members shall be enrolled into the existing group policies once the product stands withdrawn.

iv. Products which have been filed and are awaiting the approval of the Authority shall all be returned to the applicant to be refilled afresh after due examination for compliance

b. Remedial Measures

i. Insurers may on their own modify product features other than those relating to any benefits offered, premium bases, loading levied or discounts offered in the products. If such modifications suffice to render the product compliant in every particular of this Regulation, then on the basis of a certificate to that effect by the Appointed Actuary and the CEO, the Authority will record such change and allot the unique identification number where after such product may be introduced. The Authority reserves the right, in such cases to take appropriate action if it is established that this assertion of the Company was not well founded.

ii. Products which cannot be covered under the provisions of (i) above shall be appropriately modified and filed for a fresh approval under the File and Use. Such application shall be in a tabular format setting out the current provision and the revised provisions to render the product in compliance with this Regulation together with an analysis of the implications on pricing, reserving, profit margin and other relevant metrics.

iii. At renewal, all Group Policies shall be given an option

1. to switch over to a modified approved version of the group product, or
2. to continue to be renewed under the extant policy, provided that in such case no new members shall be enrolled after 1st June 2013 and the specific written consent is obtained by the group policyholder to continue in the old policy.

c. All the insurers shall inform the prospective policyholders about the possible changes in the products being sold during the transition period and give an option to the existing policyholders including prospective policyholders to switch over to the modified version if any, once introduced.

18. Repeal and Savings:

a. All the guidelines/clarifications/circulars/letters issued earlier in respect of the health insurance products shall abate from the date this regulation comes into force.

b. Unless otherwise provided by these regulations, nothing in these regulations shall deem to invalidate the health insurance contracts entered prior to these regulations coming into force.

Schedule: I

Portability of Health Insurance Policies offered by Life and General Insurers:

1. A policyholder desirous of porting his policy to another insurance company shall apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of his/her existing policy.

2. Insurer may not be liable to offer portability if policyholder fails to approach the new insurer at least 45 days before the premium renewal date.

3. Portability shall be opted by the policyholder only as stated in (1) above and not during the currency of the policy.

4. In case insurer is willing to consider the proposal for portability even if the policyholder fails to approach insurer at least 45 days before the renewal date, it may be free to do so.

5. Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal

   a. the existing policy shall be allowed to extend, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and

   b. shall not cancel existing policy until such time a confirmed policy from new insurer is received or at the specific written request of the insured

   c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.

d. if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.

6. In case the policyholder has opted as in 5 (a), and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.

7. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to these guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.

8. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.

9. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.

10. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.

11. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.

12. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.

13. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.

15. No commission shall be payable to any intermediary on the acceptance of a ported policy.

16. Portability shall be allowed in the following cases:

a. All individual health insurance policies issued by non-life insurance companies including family floater policies

b. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right mentioned in 1 above.

17. For any health insurance policy, waiting period with respect to pre-existing diseases and time bound exclusions shall be taken into account as follows:-

S. No	**No of years of continuous insurance cover with previous insurer (s)**	**Waiting period to be served with new insurer in number of days/years**				
		YY Days	1 Year	2 years	3 years	4 years
I.	XX Days at inception (XX-no of days as per the policy document)	(YY-XX) Days	N/A	N/A	N/A	N/A
II.	**For 1 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
III.	**For 2 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
IV.	**For 3 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
V.	**For 4 year period exclusion:**					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
	4 years	N/A	Nil	Nil	Nil	Nil

Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

Note 2: For group health insurance policies, the individual member's shall be given credit as per the table above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions.

18. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of RS 2lakhs and accrued bonus of Rs 50, 000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs 2.50lakhs by charging the premium applicable for Rs 2.50lakhs. If insurer B has no product for Rs 2.50lakhs, insurer B would offer the nearest higher slab say Rs 3lakhs to insured by charging premium applicable for Rs 3lakhs SI .However, portability would be available only up to Rs 2.50lakhs.

19. Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

a. all health insurance policies are portable;

b. policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

Annexure-I

Portability Form

PART-I

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of the product	
	ii. Sum Insured	
	iii. Cumulative Bonus	
	iv. Add-ons/riders taken	
	v. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for portability	

7)	No. of family member to be included I the policy to be ported.	
Enclosure: Photocopy of the existing policy documents		
Date:		Signature of the policyholder

PART –II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy: (Please indicate Yes / NO):
2. If yes, please give written consent to the declaration below:

"I am aware that the waiting period for the following disease(s)/treatment(s) is ….. days/years more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s)

Signature of the policyholder

Schedule: II

Administration of Health Plus Life Combi Products

1. The product of this class shall be named as '**Health plus Life Combi Products**' referred as 'Combi Products' hereinafter in this schedule.

2. This schedule does not apply to Micro Insurance Products which are governed by IRDA (Micro Insurance) Regulations, 2005.

3. All insurance companies that promote 'Health plus Life Combi products' shall adhere to the following:

   a. **Scope of Combi Product Class:**

      i) The 'Combi Products' may be promoted by all Life Insurance and Non-Life Insurance Companies.

      ii) The 'Combi Product' shall be the combination of Pure Term Life Insurance cover offered by life insurance companies and Health Insurance cover offered by non life insurance companies/stand alone health insurance companies.

      iii) The Products offered under the combi products shall be individually cleared under the File and Use procedure.

      iv) Riders / Add-on covers may be offered subject to File and Use clearance.

      v) The premium components of both risks are to be separately identifiable and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, sales literature.

      vi) The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

vii) The integrated premium amount of the 'Combi Product' shall be basis for reckoning the threshold limit / applicability of extant Regulations, guidelines and circulars etc. issued by the Authority or any other statutory body.

viii) Commission and Claim payouts in respect of 'Combi Products' shall be by respective insurers only.

ix) 'Combi product' shall have a free look option as outlined in IRDA (Health Insurance Regulations) 2010. Free Look option is to be applied to the 'Combi Product' as a whole.

x) The Health portion of the 'Combi Product' shall entitle its renewability at the option of policy holder from the respective Non-Life / standalone health Insurance Company

b. **Tie up between insurers:**

i) It is mandatory that insurance companies offering the 'Combi Product' shall have in place a Memorandum of Understanding covering the modus operandi of marketing, policy service and sharing of common expenses.

ii) Insurers forming the tie-up shall obtain prior approval of IRDA by duly filing the copy of the agreement entered in this regard. Approval may be obtained by any one of insurers.

iii) A tie up is permitted between one life insurer and one non-life insurer only. Thus a life insurer is permitted to tie up with only one non-life insurer and vice-versa.

iv) Between these two Insurers any number of 'Combi Products' may be promoted.

v) Insurance companies shall carry out an appropriate due diligence before establishing the business relationship for the purpose of promoting 'Combi Products'. Insurers are also expected to have a long-term understanding for effective policy service of the proposed 'Combi Products'.

vi) Withdrawal from the tie-up is generally not desirable. However, in exceptional cases where insurers desire to withdraw from MOU they shall obtain prior permission of the Authority.

vii) There shall be specific time frames / Turn around Times (TAT) to be agreed between the insurance companies as part of MOU for effective policy service, transmission of premiums received etc. at various stages of policy i.e., at pre-sale stage and post-sale stage.

viii) Filing the advertisements in accordance with IRDA (Insurance Advertisements and Disclosures) Regulations, 2000 within 30 days from the date of issuing the advertisement with Authority.

ix) Proposed procedures for obtaining the prior approval of IRDA for issuing Joint Sale Advertisements along with the common corporate agents.

x) The modus operandi of proposed policy service at various stages of the policy viz., proposal stage, policy servicing, premium collection arrangements and claims service etc.

xi) The Information Technology systems put in place for supporting the sale and policy service of the 'Combi Products'.

xii) Agreement on reimbursement of expenses in consideration of common services rendered by each other of insurance companies.

xiii) Distribution Channel wise maximum commission allowed under the 'Combi Products'.

xiv) The manner in which premium is proposed to be collected subject to provisions of Section 64 VB of Insurance Act, 1938.

xv) The procedures put in place for expeditious transfer of the portion of premium that pertains to the other insurer of the product.

xvi) Operational procedures put in place for updating premium on policy data base on a real time basis.

xvii) Options available to policyholders of 'Combi Products' to discontinue either portion of risk coverage while continuing with the other portion, subject to the extant law, regulations, guidelines etc.

xviii) Copy of proposed common Sales Literature / Sales Illustrations, proposal form to be issued by both the insurers in respect of 'Combi Products', subject to the conditions that these documents cleared under File and Use procedure are not modified.

xix) Common Advertisements of 'Combi Products', subject to the condition that this shall be restricted to the features, terms and conditions of the 'Combi Product'.

c. **Lead Insurer**:

i) As two insurance companies are involved in offering the 'Combi Product' one of the insurance companies may be mutually agreed to act as a lead insurer in respect of each 'Combi Product' marketed with agreed terms, conditions and considerations.

ii) The Lead Insurer for this purpose is the insurance company mutually agreed by both the insurers to play a critical role in facilitating the policy service as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy service.

iii) The role of lead insurer shall not deter in relying upon the existing operational infrastructure of the partner-insurance company for effective policy servicing of 'Combi Products'.

iv) Either of the insurers shall not be absolved of their responsibility of proactive settlement of claims and other obligations in accordance with the terms and conditions of their respective policies.

4. **Underwriting:** Under the 'Combi Product', underwriting of respective portion of risk shall be carried out by respective insurance companies, that is; Life Insurance risk shall be underwritten by Life Insurance Company and the Health Insurance portion of risk shall be underwritten by Non-Life/stand-alone health Insurance Company.

5. **File and Use:**

a. The life insurance product and the health insurance product to be offered as a combi product shall have prior approval under File and Use procedure.

b. Both the independent approved products shall be integrated as a single product and shall be filed with a common brand name.

c. The single product shall be offered without making any modifications to the cleared products.

d. 'Combi Product' is to be filed at the stage of integrating for getting File and Use approval irrespective of the earlier approval to either of products.

e. 'Combi Product' filing shall follow the File and Use guidelines in vogue and all such guidelines that would be issued from time to time.

f. Combi Product' is to be filed with Actuarial Department of Authority in File and Use formats that are in vogue.

g. The Combi Product shall be approved by the Authority at File and Use.

h. The File and Use application of the 'Combi Product' shall also specify the following:-

i) Lead Insurer for the 'Combi Product' and demarcation of functions between insurers for carrying out activities

ii) Procedures proposed for issuance of the premium notices, where applicable and final lapse notices in terms of Section 50 of the Insurance Act, 1938.

iii) Where the servicing is to be necessarily attended by the original insurer, the lead insurer shall facilitate the policy servicing. As far as the policyholder is concerned lead insurer shall be made as the single nodal point for receiving the servicing requests, fulfilling the services and issuing acknowledgements.

iv) Results of feasibility study, if any, in giving a limited access to the policy data base of policies for effecting over-the-counter policy service requests to the lead insurer.

v) The results of the cost benefit analysis carried out by both the insurers and the possibility of offering any discounts on the premium in the combi product.

vi)

6. Lead insurer in settlement of claims shall ensure:-

a. Based on the type of claim, the other insurer shall also take proactive measures for settlement of claims. In no case, the Lead insurer shall guarantee the settlement of claim on behalf of the other insurer.

b. The risks accepted by one insurer under 'Combi Product' shall not affect the business of other insurance company.

c. As far as health portion of 'Combi Policies' are concerned, the extant regulations and guidelines shall apply.

d. Where the policies are serviceable directly, the lead insurer shall play a facilitative role.

e. The operational procedures proposed to be put in place for timely dispatch of the policy bond of 'Combi Products'.

7. **Distribution Channel**:

a. The sale of 'Combi Product' shall be solicited through:-

i) Direct Marketing channels

ii) Brokers and

iii) Composite Individual and Corporate Agents, common to both insurers

b. 'Combi Products' shall not be marketed through 'Bank Referral' arrangements.

c. Insurers shall ensure that the 'Combi Product' is not marketed by those insurance intermediaries who are not authorized to market either of the products of either of the insurers.

8. **Mandatory Minimum Disclosures:**

a. The mandatory minimum disclosures for a Combi Product shall be:

i) The product is jointly offered by "abc insurance company" (specify non-life/ stand-alone health insurer name) and "xyz insurance company" (specify life insurer name).

ii) The risks of this 'Combi Product' are distinct and are assumed / accepted by respective insurance companies.

iii) The liability to settle the claim vests with respective insurers that is for health insurance benefits "abc insurance company" (specify non-life/ stand-alone health insurer name) and for life insurance benefits "xyz insurance company" (Specify life insurer name).

iv) The legal/quasi legal disputes, if any, shall be dealt with the respective insurers for respective benefits.

v) The policy holders of the 'Combi Product' under reference shall be eligible to continue with either part of the policy, discontinuing the other during the policy term.

vi) Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this 'Combi Product' is entitled to that facility.

vii) Specific Disclosures on the available premium payment options on these 'Combi Products'.

viii) Specific Disclosures about the available Policy Servicing facilities for these 'Combi Products'.

ix) Specific Disclosures about the proposed claims service of these policies under both the risks.

x) Specific Disclosures on the availability of services of 'Third Party Administrators (TPAs)' for health insurance portion of risk, if available.

xi) Specific Disclosures on the available Grievances Redressal Options including particulars of Ombudsman under these 'Combi products'.

xii) Policyholders are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.

b. Policy documents of 'Combi Products' shall contain the above referred points (iii) to, (xi) as minimum disclosures.

c. Declaration from the prospect shall be obtained and attached to proposal form that he / she has understood the disclosures mentioned above.

9. In respect of 'Combi Products' both the insurers shall comply with the provisions Insurance Act, 1938 and Regulations notified there under and other guidelines, circulars that are applicable to health insurance business and life insurance business respectively.

10. For the purpose of these guidelines non-life insurance company includes standalone health insurance Company also.

11. In order to monitor the progress of the penetration of the product class before enlarging the scope of the same all insurance companies that are marketing 'Combi Products' shall submit the information that is required by the Authority from time to time.

12. The Authority may stipulate such other terms and conditions from time to time for monitoring activities of insurance companies offering 'Combi Products'.

Schedule: III

Health Insurance Returns to be submitted by Insurance Companies

I. HARI NARAYAN, Chairman

[ADVT. III/4/161/12/Exty.]

660 GI/13-25

Health To-Be Forms

Forms	Description	Link	Frequency	Time limit for submission	1st Reminder Due Date	2nd Reminder Due date
	Returns (To be submitted by insurers)					
INPUT_HEALTH_1	Details of product performance for products	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_1(a)	Details of product performance for products with more than 1 year term	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_1.1	Details of product performance in terms of claims movement	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_2	Details of product information - TPA Share	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_3	Details of product information - Channelwise	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_4.1	Details of new business and renewal business - Statewise	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_5	Details of Due payable to TPA	View	Monthly	10th of the following month	2 Days before the due date	On due Date
INPUT_HEALTH_6	Details of Claims Handled directly	View	Monthly	10th of the following month	2 Days before the due date	On due Date
INPUT_HEALTH_6.1	Details of Claims Handled through TPA	View	Monthly	10th of the following month	2 Days before the due date	On due Date
INPUT_HEALTH_6.2	Details of Total Claims Handled directly and through TPA	View	Monthly	10th of the following month	2 Days before the due date	On due Date
INPUT_HEALTH_6.3	Details of claims data - state wise	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_6.4	Performance of Government sponsored Health Insurance Scheme	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
INPUT_HEALTH_7	State-wise Gross Premium	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
INPUT_HEALTH_8	State wise and channel wise claims reported	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
INPUT_HEALTH_9	Large Claim Details - Insurer-wise	View	yearly	Annual Audited – 30th of June	2 Days before the due date	On due Date
INPUT_HEALTH_10	Grievance movement	View	Quarterly	This Form is filled in by IRDA Users		
INPUT_HEALTH_INDIAN_OFFICE_1	Office Details in each state of each insurer	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
INPUT_HEALTH_FOREIGN_OFFICE_1	Details of foreign offices	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
EP_HEALTH_OFFICE_1	Office Details Quarterly	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
EP_HEALTH_OFFICE_2	Statewise Report of Distribution of Offices	View	Quarterly	15th of the month following end of quarter	2 Days before the due date	On due Date
EP_HEALTH_OFFICE_3	Growth of Offices in each State Yearly	View	yearly		2 Days before the due date	On due Date

INPUT_HEALTH_Foreign_Office_1

Details of foreign offices

Purpose and Frequency

This form collects the information on the foreign offices classified as representative offices, branches, subsidiaries, agency offices

This is a new form for capturing the information on foreign offices.

The frequency of this return is quarterly.

Filters and Parameters

Year [ ] **Quarter** [ ]

Name of insurer [ ]

Country [ ]

#	Particulars	No.	whether regulated by local authority
	Column Code	a	b
1	No. of representative branches * outside India		
2	No. of branches ** outside India		
3	No. of subsidiaries *** outside India		
4	No. of agency Offices **** outside India		
#	**Total No. of offices outside India**		

Note:

* A representative office is an office established by a company to conduct marketing and other non-transactional operations, generally in a foreign country where a branch office or subsidiary is not warranted.

** A branch of insurance companies is a retail location where an insurer offers a wide array of face to face and automated services to its customers.

*** A subsidiary, in business matters, is an entity that is controlled by a separate higher entity

**** An agency office is an entity where the business is carried out by agents of the insurance companies

INPUT_HEALTH_Office_3

Growth of Offices in Each State - Yearly

Purpose and Frequency

The purpose of this report is to provide a summary of the distribution of offices across each state.

The frequency of this report is yearly.

Filters and Parameters

Year

		Current Year		Previous Year		Second Previous Year		Third Previous Year		Fourth Previous Year	
#	State Name	No. of Rural Offices	No. of Urban Offices	No. of Rural Offices	No. of Urban Offices	No. of Rural Offices	No. of Urban Offices	No. of Rural Offices	No. of Urban Offices	No. of Rural Offices	No. of Urban Offices
	Column Code	a	b	c	d	e	f	g	h	i	j
	Source/Calculation	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1
1	Andhra Pradesh										
2	Arunachal Pradesh										
3	Assam										
4	Bihar										
5	Chhattisgarh										
6	Goa										
7	Gujarat										
8	Haryana										
9	Himachal Pradesh										
10	Jammu & Kashmir										
11	Jharkhand										
12	Karnataka										
13	Kerala										
14	Madhya Pradesh										
15	Maharasthra										
16	Manipur										
17	Meghalaya										
18	Mizoram										
19	Nagaland										
20	Orissa										
21	Punjab										
22	Rajasthan										
23	Sikkim										
24	Tamil Nadu										
25	Tripura										
26	Uttar Pradesh										
27	Uttrakhand										
28	West Bengal										
29	Andaman & Nicobar Is.										
30	Chandigarh										
31	Dadra & Nagra Haveli										
32	Daman & Diu										
33	Delhi										
34	Lakshadweep										
35	Puducherry										
#	*Total*										

INPUT_HEALTH_Indian_Office_1

OFFICE DETAILS-Quarterly

Purpose and Frequency

This form collects the information on the office (Branch) details in each state for each insurer.
This form is re-engineered on the basis of the existing Form VII of existing Office Information.
The frequency of this return is quarterly.

Filters and Parameters

Year _____ **Quarter** _____

Insurer Name _____

Business within India

				No. of branches							
#	State	No. of branches at the beginning of the quarter	No. of branches inprincipl e approved during the quarter	Out of approvals of previous quarter	Out of approvals of this quarter	No. of branches closed during the quarter	No of branches at the end of the quarter	No. of offices relocated	No. of offices merged	No. of existing branches in rural area	No. of existing branches in urban area
Column Code		a	b	c	d	e	f	g	h	j	k
1	Andhra Pradesh										
2	Arunachal Pradesh										
3	Assam										
4	Bihar										
5	Chhattisgarh										
6	Goa										
7	Gujarat										
8	Haryana										
9	Himachal Pradesh										
10	Jammu & Kashmir										
11	Jharkhand										
12	Karnataka										
13	Kerala										
14	Madhya Pradesh										
15	Maharasthra										
16	Manipur										
17	Meghalaya										
18	Mizoram										
19	Nagaland										
20	Orissa										
21	Punjab										
22	Rajasthan										
23	Sikkim										
24	Tamil Nadu										
25	Tripura										
26	Uttar Pradesh										
27	Uttrakhand										
28	West Bengal										
29	Andaman & Nicobar Is.										
30	Chandigarh										
31	Dadra & Nagra Haveli										
32	Daman & Diu										
33	Delhi										
34	Lakshadweep										
35	Puducherry										
#	*Total*										

Note:

1. Branches stand for place of business

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INPUT_HEALTH_1(a) *Yearly*

Details of product performance - Products with more than 1 year term (To be furnished by All insurers having health products)

Purpose and frequency

To collect product information for all products having term more than 1 year
To replace the existing form D to add more data elements on new business and expected business data
The frequency of the return is yearly and as and when.

Filters and Parameters

Year

Insurer Name

#	Particular		Product 1	Product 2	Product 3	Product 4	Product 5
		Column Code	a	b	c	d	e
		Product Details					
1	Product Name						
2	UIN						
3a	Scope of Cover(1)						
3b	Target Group						
4	Insured Type		Group	Group	Individual		
4a	Basis of Payout						
5	Date of clearance of product						
5a	Minimum Policy Period						
5b	Maximum Policy period						
6	Current Status of Product						
6a	Add-on covers included		No	Yes			
6b	No. of add on covers						
6c	Whether serviced by TPA?		Yes				
6d	Total no. of TPA involved						
		New Business Data					
7	No. of policies issued						
8	Gross Premium* Collected						
8.i	Total Premium Ceded						
9	No of persons/members/ lives covered		*Data to input*	*Data to input*	1		
10	Total Sum Insured						
11a	Reinsurance Commissions Received						
		Renewal Business Data					
7a	No. of policies due for renewal						
8a	No. of policies renewed						
9a	Total Renewal Premium Collected						
9a.i	Total renewal premium ceded						
10a	No of persons/members/ lives covered		*Data to input*	*Data to input*	1		
11a	Total Sum Insured in renewal						
11b	Reinsurance Commissions Received						
		In-force Business Data					
7b	No. of policies						
9b	Gross Premium Income						
9b.i	Total premium ceded						
10b	No of persons/members/ lives covered		*Data to input*	*Data to input*	1		
11b	Total Sum Insured						
12b	Reinsurance Commissions Received						
		Cancellation Data					
7c	No. of cancellation in free look period	Out of New Business					
8c.i	No. of cancellation*** during the policy term	Out of New Business					
8c.ii		Out of Renewal Business					
		Expected new business figures (for next year)					
6e	No. of policies						
6f	Total Gross Premium						
6g	Total no. of claims						
6h	Total amount of claims						
6i	Claims ratio						
6j	Combined ratio						

Note:

1. only predominant cover should be mentioned in scope of cover.

* Gross premium is defined as the premium amount before deducting service tax.

** This section is currently optional.

*** Other than free look cancellation

T_HEALTH_1.1 Yearly

ails of product performance in terms of claims development and aging (To be furnished by All insurers having health products)

se and frequency

To collect claims movement and claims aging data
To replace the existing form D to add more detailed level information on claims data
The frequency of the return is yearly and as and when.

and Parameters

Year | **Channel Type**

Insurer Name

	Particular		Product 1	Product 2	Product 3	Product 4	Product 5
		Column Code	a	b	c	d	e
		Claims Data					
	Claims pending at the beginning of the year	No.					
i		Amount					
	New claims registered	No.					
ii		Amount					
	Claims repudiated	No.					
iii		Amount					
	Claims closed due to other reasons	No.					
iv		Amount					
	Claims reopened	No.					
v		Amount					
	Claims pending at the end of the year	No.					
vi		Amount					
	Penal Interest Paid	No.					
vii		Amount					
.i	Incurred Claims Ratio						
ii	Combined Ratio						

Claims Ratio = (Total Amount of Claims Incurred)/ GWP
Combined Ratio = (Total Amount of Claims Incurred + Total Company Expenses Amount)/GWP

		Aging of pending claims*					
.i	Claims pending for less than 1 month	No.					
.ii		Amount					
.i	Claims pending for greater than 1 month and less than 3 months	No.					
.ii		Amount					
.i	Claims pending for greater than 3 month and less than 6 months	No.					
.ii		Amount					
.i	Claims pending for greater than 6 month and less than 12 months	No.					
.ii		Amount					
.i	Claims pending for greater than 1 year and less than 2 years	No.					
.ii		Amount					
.i	Claims pending for more than 2 yrs	No.					
.ii		Amount					

koned from date of first intimation

		**Aging of settled claims ** **					
2.i	Claims settled for less than 1 month	No.					
2.ii		Amount					
3.i	Claims settled for greater than 1 month and less than 3 months	No.					
3.ii		Amount					
4.i	Claims settled for greater than 3 month and less than 6 months	No.					
4.ii		Amount					
5.i	Claims settled for greater than 6 month and less than 12 months	No.					
5.ii		Amount					
6.i	Claims settled for greater than 1 year and less than 2 years	No.					
6.ii		Amount					
7.i	Claims settled for more than 2 yrs	No.					

		Amount					

ckoned from the date of receipt of last requirement

		Aging of repudiated claims ***					
	Claims repudiated for less than 1 month	No.					
		Amount					
	Claims repudiated for greater than 1 month and less than 3 months	No.					
		Amount					
	Claims repudiated for greater than 3 month and less than 6 months	No.					
		Amount					
	Claims repudiated for greater than 6 month and less than 12 months	No.					
		Amount					
	Claims repudiated for greater than 1 year and less than 2 years	No.					
		Amount					
	Claims repudiated for more than 2 yrs	No.					
		Amount					

ckoned from date of receipt of last requirement

urred Claims ratio = Total incurred claim/ Total Earned Premium

nbined Ratio = (Total claims paid+other operating expense)/total premium earned

product will be populated based on the selection of the target group

ictionary *

	Claims Data	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/ Description	Database/ Form level
	Claims pending at the beginning of the year											Closing of last year will be beginnin		Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
	New claims registered													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims settled fully without grievance													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims settled fully subsequent to grievance													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
a	Claims first rejected and subsequently settled fully													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
	2) Amount	Enable				Numeric	20		Yes	Input				Database
b	Claims first partially settled and subsequently settled fully													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims partially settled													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims repudiated													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims closed due to other reasons													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
	2) Amount	Enable				Numeric	20		Yes	Input				Database
	Claims reopened													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database

8.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
9.i	Claims pending at the end of the year													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
9.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
10.i	Penal Interest Paid													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
10.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
11.i	Incurred Claims Ratio	Enable				Numeric								Database
11.ii	Combined Ratio	Enable				Numeric								Database

#	Aging of pending claims*	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/ Description	Database
12.i	Claims pending for less than 1 month													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
12.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
13.i	Claims pending for greater than 1 month and less than 3 months													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
13.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
14.i	Claims pending for greater than 3 month and less than 6 months													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
14.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
15.i	Claims settled for greater than 6 month and less than 12 months													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
15.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
16.i	Claims settled for greater than 1 year and less than 2 years													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
16.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database
17.i	Claims settled for more than 2 yrs													Database
	1)No.	Enable				Numeric	20		Yes	Input				Database
17.ii	2) Amount	Enable				Numeric	20		Yes	Input				Database

#	Aging of Settled claims*	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/ Description	Remarks/ Description
12.i	Claims settled for less than 1 month													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
12.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both
13.i	Claims settled for greater than 1 month and less than 3 months													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
13.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both
14.i	Claims settled for greater than 3 month and less than 6 months													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
14.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both
15.i	Claims settled for greater than 6 month and less than 12 months													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
15.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both
16.i	Claims settled for greater than 1 year and less than 2 years													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
16.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both
17.i	Claims settled for more than 2 yrs													Both
	1)No.	Enable				Numeric	20		Yes	Input				Both
17.ii	2) Amount	Enable				Numeric	20		Yes	Input				Both

#	Aging of repudiated claims	Enable/Disable	Table Name	Column Name	Data Type	Size	Default Value	Mandatory/	Field Type	UI Validations	Business Logic	Remarks/ Description	Applicable Segment
12.i	Claims repudiated for less than 1 month												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
12.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both
13.i	Claims repudiated for greater than 1 month and less than 3 months												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
13.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both
14.i	Claims repudiated for greater than 3 month and less than 6 months												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
14.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both
15.i	Claims repudiated for greater than 6 month and less than 12 months												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
15.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both
16.i	Claims repudiated for greater than 1 year and less than 2 years												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
16.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both
17.i	Claims repudiated for more than 2 yrs												Both
	1)No.	Enable			Numeric	20		Yes	Input				Both
17.ii	2) Amount	Enable			Numeric	20		Yes	Input				Both

INPUT_HEALTH_1 | Yearly

Details of product performance - Products with 1 year or less than 1 year term (To be furnished by All insurers having health products)

Purpose and frequency

To collect product information for all products having term 1 year or less than 1 year

To replace the existing form D to add more data elements on new business and expected business data

The frequency of the return is yearly and as and when.

Filters and Parameters

Year

Insurer Name

#	Particular		Product 1	Product 2	Product 3	Product 4	Product 5
		Column Code	a	b	c	d	e
		Product Details					
1	Product Name						
2	UIN						
3a	Scope of Cover(1)		Hospital Care				
3b	Target Group		Others				
4	Insured Type		Individual+ group	Group	Individual		
4a	Basis of Payout						
5	Date of clearance of product						
5a	Minimum Policy Period						
5b	Maximum Policy period						
6	Current Status of Product			Launched			
6a	Add-on covers included		No	Yes			
6b	No. of add on covers						
6c	Whether serviced by TPA?		Yes				
6d	Total no. of TPA involved						
		New Business Data					
7	No. of policies issued						
8	Gross Premium* Collected						
8.i	Total Premium Ceded						
9	No of persons/members/ lives covered		*Data to input*	*Data to inpu*	1		
10	Total Sum Insured						
11a	Reinsurance Commissions Received						
		Renewal Business Data					
7a	No. of policies due for renewal						
8a	No. of policies renewed						
9a	Total Renewal Premium Collected						
9a.i	Total Renewal Premium Ceded						
10a	No of persons/members/ lives covered		*Data to input*	*Data to inpu*	1		
12a	Total Sum Insured in renewal						
11b	Reinsurance Commissions Received						
		Cancellation Data					
8b.i	No. of cancellation during the policy term	Out of New Business					
8b.ii		Out of Renewal Business					
		Expected new business figures (for next year)					
6e	No. of policies						
6f	Gross Premium						

List of scope of cover given and is mentioned below

1. Hospital Care
2. Critical Illness
3. Surgical Cash
4. Hospital Daily Cash
5. High Deductible
6. Outpatient cover
7. Dental cover
8. Health Savings
9. Domestic Travel
10. International Travel
11. International Comprehensive Cover
12. Specified disease / disease management cover (e.g. Cancer, HIV, Diabetes etc)
13. Personal Accident
14. Maternity and Fertility
15. Long term care
16. Disability and rehabilitation
17. Mental Illness
99. Any other

6g	**Total no. of claims**						
6h	**Total amount of claims**						
6i	Claims ratio						
6j	Combined ratio						

<these will be input by insurer>

Claims Ratio = (Total Amount of Claims Incurred)/ GWP
Combined Ratio = (Total Amount of Claims Incurred + Total Company Expenses Amount)/GWP
Claims O/s ratio = Total claims pending /total claims reported
Claims settlement ratio = Number of claims settled/total claims reported

Note:
1. only main cover should be mentioned in scope of cover.
* Gross premium is defined as the premium amount before deducting service tax.

[illegible]

[illegible]

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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INPUT_HEALTH_2 *Yearly*

Details of product performance in terms of claims management w.r.t TPA (To be furnished by insurers having health insurance business)

Purpose and frequency

To capture the performance of the products in terms of claims management w.r.t TPA
This form is a replacement of the existing form D to gather more detailed level information about TPA contribution.
The frequency of the return is yearly and as and when.

Filters and Parameters

Year

Insurer Name **Claims Handled Through** ◉ Inshouse ○ TPA

TPA Name

#	Name of product		No. of policies serviced	No. of claims handled	Amount of claims handled	No. of claims settled	Amount of claims settled		
	Column Code		a	b	c	d	e	f	g

Note:
1. All the products which have been approved during the period will be covered in this form.
2. Product Type can be Individual or Group.
3. Current Status of product will be - active, inactive or withdrawn.

Data Dictionary

Product	Values to be entered separately for No. of policies serviced=a No. of claims handled=,b, Amount of claims handled=c, No. of claims settled=d, Amount of claims settled=e

#	Particular	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/Description	database/Form level
C	Name of Product	Enable				VarChar	20		Yes	Input	Should not be Numeric		Need to Validate the input for Products and policies issued can come from Form # INPUT_Health_1	Databse
C(a)	No. of policies serviced	Enable				Numeric	20		Yes	Input	Should not be Negative		Need to Validate the input for Products and policies issued can come from Form # INPUT_Health_1	Databse
C(b)	No. of claims handled	Enable				Numeric	20		Yes	Input				Databse
C(c)	Amount of claims handled	Enable				Numeric	20		Yes	Input				Databse
C(d)	No. of claims se	Enable				Numeric	20		Yes	Input				Databse
C(e)	Amount of claims settled	Enable				Numeric								Databse

INPUT_HEALTH_3 **Yearly**

Details of product performance in terms of channels (To be furnished by insurers having health insurance business)

Purpose and frequency

To capture the performance of the products in terms of distribution channels
This form is a replacement of existing form D for capturing the data on Channelwise contribution
The frequency of the return is yearly and as and when.

Filters and Parameters

Year

Insurer Name

Channel Type (exclude referrals)

#	Name of product	No. of policies	Gross Premium	* Commissions / Fees Paid	Other Acquisition Costs
	Column Code	a	b	c	d

Note
* For referrals, fees is applicable

Data Dictionary

Product Values to be entered separately for No. of policies serviced=a Gross Premium=b.* Commissions / Fees Paid =c. Other Acquisition Costs=d

#	Particular	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/Description	Database/Form level
C	Name of the Product	Enable				VarChar	20		Yes	Input	Should not be Numeric		Need to Validate the Input for Products and policies issued can come from Form # INPUT_Health 1	Database
C(a)	No. of policies	Enable				Numeric	20		Yes	Input	Should not be Negative		Need to Validate the Input for Products and policies issued can come from Form # INPUT_Health 1	Database
C(b)	Gross Premium	Enable				Numeric	20		Yes	Input				Database
C(c)	* Commissions / Fees Paid	Enable				Numeric	20		Yes	Input				Database
C(d)	Other Acquisition Costs	Enable				Numeric	20		Yes	Input				Database

Note:
1. All the products which have been approved during the period will be covered in this form.
2. Product Type can be Individual or Group.
3. Current Status of product will be - active, inactive or withdrawn.

INPUT_HEALTH_5 **Monthly**

Details of Due payable to TPA

Purpose and frequency

To measure the effectiveness of functions of TPAs in terms of claim float and TPA Fees
This is the recreated form of the proposed format for collecting due information
The frequency of the form is monthly. The data is submitted by insurers in respect of every TPA enrolled with them.

Filters and Parameters

Year		**Month**	
Insurer Name		**TPA Name**	

#	Particulars	Claims Float	TPA Fees	Total
	Column Code	a	b	c
1	**Due outstanding at the beginning of month**		Amount	
2	Payment request received during the month			
3	Due paid during the month			
4	Due outstanding at the end of the month			
5	**Due outstanding at the end of the month**			
5.i	More than 0- 7 days			
5.ii	More than 7-15 days			
5.iii	More than 15- 30 days			
5.iv	**More than 2 months**			
5.v	**More than 4 months**			
5.vi	**More than 6 months**			

Closing balance of previous month will be opening balance of current month

Notes:

INPUT_HEALTH_6.1 **Monthly**

Details of Claims Handled directly- To be submitted by the Insurers having health business (Group)

Purpose and frequency

The purpose of the form is to collect the information of the claims handled directly by insurers having health business for the group business
This is a modification of proposed format for capturing the claims data
The frequency of the form is monthly

Filters and Parameters

Year		**Month**	
Insurer Name		**Business**	Group

Claims movement Details

Form Input_Health_6 and Form Input_Health_6.1 needs to be merged by giving drop down for Business

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending at the beginning of the month								
2	New Claims registered during the month								
3	Claims Settled During the Month								
4	Claims repudiated								
5	Claims pending at the end of the month								

***Aging of pending claims** **

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending for less than 1 month								
2	Claims pending for 1-3 months								
3	Claims pending for 3-6 months								
4	Claims pending for 6-12 months								
5	Claims pending for 1-2 years								
6	claims pending for more than 2 years								

* Reckoned from date of first intimation

***Aging of settled claims** ***

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims settled within less than 1 month								
2	Claims settled within 1-3 months								
3	Claims settled within 3-6 months								
4	Claims settled within 6-12 months								
5	Claims settled within 1-2 years								
6	claims settled within more than 2 years								

** Reckoned from the date of receipt of last requirement

Aging of repudiated claims*

#	Particulars	Cashless		Reimbursement		Benefit Paid		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims repudiated within less than 1 month								
2	Claims repudiated within 1-3 months								
3	Claims repudiated within 3-6 months								
4	Claims repudiated within 6-12 months								
5	Claims repudiated within 1-2 years								
6	claims repudiated within more than 2 years								

*** Reckoned from the date of receipt of last requirement

INPUT_HEALTH_6.2 **Monthly**

Details of Claims Handled through TPA- To be submitted by the insurers having health business

Purpose and frequency

The purpose of the form is to collect the information of the claims handled through TPA.
This is a modification of proposed format for capturing the claims data
The frequency of the form is monthly.

Filters and Parameters

Year _____ **Month** _____

Insurer Name _____ **TPA Name** _____

Division ○ Individual ● Group

Claims movement Details

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending at the beginning of the month								
2	New Claims registered during the month								
3	Claims Settled During the Month								
4	Claims repudiated								
5	Claims pending at the end of the month								

***Aging of pending claims** **

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending for less than 1 month								
2	Claims pending for 1-3 months								
3	Claims pending for 3-6 months								
4	Claims pending for 6-12 months								
5	Claims pending for 1-2 years								
6	claims pending for more than 2 years								

* Reckoned from date of first intimation

Aging of settled claims*

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims settled within less than 1 month								
2	Claims settled within 1-3 months								
3	Claims settled within 3-6 months								
4	Claims settled within 6-12 months								
5	Claims settled within 1-2 years								
6	claims settled within more than 2 years								

** Reckoned from the date of receipt of last requirement

Aging of repudiated claims*

#	Particulars	Cashless		Reimbursement		Benefit Paid		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims repudiated within less than 1 month								
2	Claims repudiated within 1-3 months								
3	Claims repudiated within 3-6 months								
4	Claims repudiated within 6-12 months								
5	Claims repudiated within 1-2 years								
6	claims repudiated within more than 2 years								

*** Reckoned from the date of receipt of last requirement

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INPUT_HEALTH_6.3 **Yearly**

Details of Claims for an Insurer- Statewise

Purpose and frequency

The purpose of the form is to collect the information of the claims for an insurer.
This is a new format for capturing state wise data
The frequency of the form is yearly

Filters and Parameters

Year

Insurer Name

#	State	Indemnity					
		Cashless		Reimbursement		Benefit Based	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f

INPUT_HEALTH_6 Monthly

Details of Claims Handled directly- To be submitted by the insurers having health business (Individual)

Purpose and frequency

The purpose of the form is to collect the information of the claims handled directly by insurers having health business for the individual business
This is a modification of proposed format for capturing the claims data
The frequency of the form is monthly

Filters and Parameters

Year _____ Month _____

Insurer Name _____

Claims movement Details

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending at the beginning of the month								
2	New Claims registered during the month								
3	Claims Settled During the Month								
4	Claims repudiated								
5	Claims pending at the end of the month								

***Aging of pending claims** **

#	Particulars	Casniess		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims pending for less than 1 month								
2	Claims pending for 1-3 months								
3	Claims pending for 3-6 months								
4	Claims pending for 6-12 months								
5	Claims pending for 1-2 years								
6	claims pending for more than 2 years								

* Reckoned from date of first intimation

Aging of settled claims**

#	Particulars	Cashless		Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims settled within less than 1 month								
2	Claims settled within 1-3 months								
3	Claims settled within 3-6 months								
4	Claims settled within 6-12 months								
5	Claims settled within 1-2 years								
6	claims settled within more than 2 years								

** Reckoned from the date of receipt of last requirement

Aging of repudiated claims**

#	Particulars	Cashless		Reimbursement		Benefit Paid		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Claims repudiated within less than 1 month								
2	Claims repudiated within 1-3 months								
3	Claims repudiated within 3-6 months								
4	Claims repudiated within 6-12 months								
5	Claims repudiated within 1-2 years								
6	claims repudiated within more than 2 years								

*** Reckoned from the date of receipt of last requirement

INPUT_Health_7

State-wise Gross Premium - For the quarter

Purpose and Frequency

To collect State wise information on Gross Premium, No. of Policies and Total Sum Assured across Channels
This form is re-engineered on the basis of existing Form I and Form II of gross premium.
The frequency of the form is Quarterly

Filters and Parameters

Year _____ Quarter _____

Name of Insurer _____ Division ○ Individual ● Group

		Direct Business (Internet)			Direct Business (Other than Internet)			Individual Agents			Banks			Other corporate agents			Brokers			Referrals					
#	State	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured	No. of policies	Premium Amount	Total Sum Insured
	Column Code	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x
1	Andhra Pradesh																								
2	Arunachal Pradesh																								
3	Assam																								
4	Bihar																								
5	Chhattisgarh																								
6	Goa																								
7	Gujarat																								
8	Haryana																								
9	Himachal Pradesh																								
10	Jammu & Kashmir																								
11	Jharkhand																								
12	Karnataka																								
13	Kerala																								
14	Madhya Pradesh																								
15	Maharasthra																								
16	Manipur																								
17	Meghalaya																								
18	Mizoram																								
19	Nagaland																								
20	Orissa																								
21	Punjab																								
22	Rajasthan																								
23	Sikkim																								
24	Tamil Nadu																								
25	Tripura																								
26	Uttar Pradesh																								
27	Uttrakhand																								
28	West Bengal																								
29	Andaman & Nicobar Is.																								
30	Chandigarh																								
31	Dadra & Nagra Haveli																								
32	Daman & Diu																								
33	Delhi																								
34	Lakshadweep																								
35	Puducherry																								
#	Total																								

INPUT_Health_8

State wise and channel wise claims reported

Purpose and Frequency

This return collects information on the claims reported in each state during the quarter.
This form is re-engineered on the basis of Form IV
The frequency of this return is quarterly

Filters and Parameters

Year _____ **Quarter** _____

Name of Insurer _____ **Division** ○ Individual ◉ Group

#	State	Direct Business (Internet)		Direct Business (Other than Internet)		Individual Agents		Banks		Other Corporate Agents		Brokers		Referrals			
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of policies	Amount of premium
	Column Code	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p
	1 Andhra Pradesh	10 Cr max.	100000 Cr max.														
	2 Arunachal Pradesh																
	3 Assam																
	4 Bihar																
	5 Chhattisgarh																
	6 Goa																
	7 Gujarat																
	8 Haryana																
	9 Himachal Pradesh																
	10 Jammu & Kashmir																
	11 Jharkhand																
	12 Karnataka																
	13 Kerala																
	14 Madhya Pradesh																
	15 Maharasthra																
	16 Manipur																
	17 Meghalaya																
	18 Mizoram																
	19 Nagaland																
	20 Orissa																
	21 Punjab																
	22 Rajasthan																
	23 Sikkim																
	24 Tamil Nadu																
	25 Tripura																
	26 Uttar Pradesh																
	27 Uttrakhand																
	28 West Bengal																
	29 Andaman & Nicobar Is.																
	30 Chandigarh																
	31 Dadra & Nagra Haveli																
	32 Daman & Diu																
	33 Delhi																
	34 Lakshadweep																
	35 Puducherry																
#	Total																

Data Dictionary

#		Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validation	Business Logic	Remarks/ Description	Form Level/DB level
	Direct Business (Internet)	Disable												
a	No. of Claims	Enable				Numeric	20		Yes	Input				Both
b	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Direct Business (Other than Internet)	Disable												

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c	No. of Claims	Enable				Numeric	20		Yes	Input				Both
d	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Individual Agents	Disable												
e	No. of Claims	Enable				Numeric	20		Yes	Input				Both
f	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Banks	Disable												
g	No. of Claims	Enable				Numeric	20		Yes	Input				Both
h	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Other corporate agents	Disable												
i	No. of Claims	Enable				Numeric	20		Yes	Input				Both
j	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Brokers	Disable												
k	No. of Claims	Enable				Numeric	20		Yes	Input				Both
l	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Referrals	Disable												
m	No. of Claims	Enable				Numeric	20		Yes	Input				Both
n	Amount of Claims	Enable				Float	15		Yes	Input				Both
	Microinsurance Agents(MFI, SHG, NGO)	Disable												
o	No. of Claims	Enable				Numeric	20		Yes	Input				Both
p	Amount of Claims	Enable				Float	15		Yes	Input				Both
	(For Health Insurance - Individual), No. of lives covered	Enable				Numeric	10		Yes	Input				Both
	(For Health Insurance - Group), No. of lives covered	Enable				Numeric	10		Yes	Input				Both
1	Andhra Pradesh	Disable												
2	Arunachal Pradesh	Disable												
3	Assam	Disable												
4	Bihar	Disable												
5	Chhattisgarh	Disable												
6	Goa	Disable												
7	Gujarat	Disable												
8	Haryana	Disable												
9	Himachal Pradesh	Disable												
10	Jammu & Kashmir	Disable												
11	Jharkhand	Disable												
12	Karnataka	Disable												
13	Kerala	Disable												
14	Madhya Pradesh	Disable												
15	Maharasthra	Disable												
16	Manipur	Disable												
17	Meghalaya	Disable												
18	Mizoram	Disable												
19	Nagaland	Disable												
20	Orissa	Disable												
21	Punjab	Disable												
22	Rajasthan	Disable												
23	Sikkim	Disable												
24	Tamil Nadu	Disable												
25	Tripura	Disable												
26	Uttar Pradesh	Disable												
27	Uttrakhand	Disable												
28	West Bengal	Disable												
29	Andaman & Nicobar Is.	Disable												
30	Chandigarh	Disable												
31	Dadra & Nagra Haveli	Disable												
32	Daman & Diu	Disable												
33	Delhi	Disable												
34	Lakshadweep	Disable												
35	Puducherry	Disable												
#	**Total**	Disable				Float	20		Yes	Derived		Sum(No. of Claims/ Ar		Both

INPUT_Health_9

Large Claim Details - Insurer-wise

Purpose and frequency

This form captures the claim details of large claims in for all insurers
This is a new form
The frequency of this form is yearly and as and when

Filters and Parameters

Year | **Quarter**

Insurer Name

#	State	Reported Claims		Fully Settled claims		Partially settled claims		Outstanding Claims	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h
1	Andhra Pradesh								
2	Arunachal Pradesh								
3	Assam								
4	Bihar								
5	Chhattisgarh								
6	Goa								
7	Gujarat								
8	Haryana								
9	Himachal Pradesh								
10	Jammu & Kashmir								
11	Jharkhand								
12	Karnataka								
13	Kerala								
14	Madhya Pradesh								
15	Maharasthra								
16	Manipur								
17	Meghalaya								
18	Mizoram								
19	Nagaland								
20	Orissa								
21	Punjab								
22	Rajasthan								
23	Sikkim								
24	Tamil Nadu								
25	Tripura								
26	Uttar Pradesh								
27	Uttrakhand								
28	West Bengal								
29	Andaman & Nicobar Is.								
30	Chandigarh								
31	Dadra & Nagra Haveli								
32	Daman & Diu								
33	Delhi								
34	Lakshadweep								
35	Puducherry								
#	*Total*								

Input_HEALTH_10 | *Quarterly*

Grievance movement

<this form is filled by Insurer>

Purpose and Objective

ThisFormt represents the grievance movement through out the period for each insurer against different types of complaints
The frequency of this form is quarterly

Filters and Parameters

Year | **Quarter**

Complaint Type

Complaint Type
Delay in Payment
Refusal of claim
Deduction
Policy not received
Any Other

#	Name of Insurer	No. of complaints pending at the beginning	No. of new complaints registered	No. of complaints resolved	No. of complaints rejected	No. of complaints pending at the end
	Column Code	a	b	c	d	e
	Source/Calculation	Grievance Management System	Grievance Management System	Grievance Management System	Grievance Management System	Grievance Management System
1						
2						
3						
4						
5						
6						

#	Name of Insurer	No. of complaints pending for < 1 month	No. of complaints pending for 1-3 months	No. of complaints pending for 3-6 months	No. of complaints pending for 6-12 months	No. of complaints pending for > 1 yr
	Column Code	a	b	c	d	e
	Source/Calculation					

INPUT_HEALTH_4.1 Yearly

Details of new business and renewal business - Statewise

Purpose and frequency

To capture the statewise new business and renewal business activities for each insurer
This form is a new format.
The frequency of the return is yearly.

Filters and Parameters

Year

Business Individual

Insurer Name

Individual Business Needs to be removed; create the drop down as shown above

#	State	New Business			Renewal Business			In-Force Business		
		No. of policies	Gross Premium Amount	Total Sum Assured	No. of policies	Gross Premium Amount	Total Sum Assured	No. of policies	Gross Premium Amount	Total Sum Assured
	Column Code	a	b	d	e	f	h	e	f	h
1	Andhra Pradesh									
2	Arunachal Pradesh									
3	Assam									
4	Bihar									
5	Chhattisgarh									
6	Goa									
7	Gujarat									
8	Haryana									
9	Himachal Pradesh									
10	Jammu & Kashmir									
11	Jharkhand									
12	Karnataka									
13	Kerala									
14	Madhya Pradesh									
15	Maharasthra									
16	Manipur									
17	Meghalaya									
18	Mizoram									
19	Nagaland									
20	Orissa									
21	Punjab									
22	Rajasthan									
23	Sikkim									
24	Tamil Nadu									
25	Tripura									
26	Uttar Pradesh									
27	Uttrakhand									
28	West Bengal									
29	Andaman & Nicobar Is.									
30	Chandigarh									
31	Dadra & Nagra Haveli									
32	Daman & Diu									
33	Delhi									
34	Lakshadweep									
35	Puducherry									
#	*Total*									

Group Business *

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#	State	New Business				Renewal Business				In-Force Business Data			
		No. of policies	No. of lives covered	Gross Premium Amount	Total Sum Assured	No. of policies	No. of lives covered	Gross Premium Amount	Total Sum Assured	No. of policies	Gross Premium Amount	Total Premium Amount	Total Sum Assured
	Column Code	a	b	c	e	f	g	h	j	f	g	h	j
1	Andhra Pradesh												
2	Arunachal Pradesh												
3	Assam												
4	Bihar												
5	Chhattisgarh												
6	Goa												
7	Gujarat												
8	Haryana												
9	Himachal Pradesh												
10	Jammu & Kashmir												
11	Jharkhand												
12	Karnataka												
13	Kerala												
14	Madhya Pradesh												
15	Maharasthra												
16	Manipur												
17	Meghalaya												
18	Mizoram												
19	Nagaland												
20	Orissa												
21	Punjab												
22	Rajasthan												
23	Sikkim												
24	Tamil Nadu												
25	Tripura												
26	Uttar Pradesh												
27	Uttrakhand												
28	West Bengal												
29	Andaman & Nicobar Is.												
30	Chandigarh												
31	Dadra & Nagra Haveli												
32	Daman & Diu												
33	Delhi												
34	Lakshadweep												
35	Puducherry												
#	*Total*												

Note:

* Group include family floaters and any policy with more than one insured person

INPUT_HEALTH_6.4 *Quarterly*

Performance of Government sponsored Health Insurance Scheme

Purpose and frequency

This form is used to capture the details of the Performance of Goverement Health Insurance sponsered Scheme

This is a new format

The frequency of the form is quarterly

Filters and Parameters

Year _____ **Quarter** _____

Insurer Name _____

#	Product / Scheme	No. of policies issued	No.of BPL families covered	No of others covered in BPL Families	Total number of beneficiaries covered	Gross Premium (In 000s)	No.of claims reported	Amount of Claims reported	No.of claims settled	Claim Amount settled	No. of claims O/s	Amount of Claims O/s.	Incurred Claim Ratio (%)
	Column Code	a		b	c	d	e	f	g	h	i	j	k
1			1	4	5								
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													

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Data Dictionary

#	Particular	Enable/Disable	Reference Form	Table Name	Column Name	Data Type	Size	Default Value	Mandatory?	Field Type	UI Validations	Business Logic	Remarks/Description	Database/Form level
C	Product/Scheme	Enable					20		Yes	Input				Database
C(a)	No. of policies issued	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(b)	No.of BPL families covered	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(c)	Total number of beneficiaries covered	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(d)	Gross Premium (In 000s)	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(e)	No.of claims reported	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(f)	Amount of Claims reported	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(g)	No.of claims settled	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(h)	Claim Amount settled	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(i)	No. of claims O/s	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(j)	Amount of Claims O/s.	Enable				Numeric	20		Yes	Input	Should not be Negative			Database
C(k)	Incurred Claim Ratio (%)	Enable				Numeric	20		Yes	Input	Should not be Negative			Database

REP_HEALTH_Office_2

Statewise Report of distribution of offices - Quarterly

Purpose and Frequency

The purpose of this report is provide information on the distribution of office locations in each state for each insurer

The frequency of this report is quarterly

Filters and Parameters

Year _____ **Quarter** _____

State _____

			Rural Area		Urban Area	
#	Name of Insurer	No. of branches approved but not opened	No. of rural branches	% of rural Branches	No. of urban branches	% of Urban Branches
	Column Code	a	b	c	d	e
	Source/Calculation	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	=100*b/(b+d)	INPUT_NON_LIFE_Office_1	=100*d/(b+d)
1						
2						
3						
4						
5						
6						
.....						
#	*Total*					

REP_HEALTH_Office_1

OFFICE DETAILS-Quarterly

Purpose and Frequency

The purpose of this report is to provide the office details of each insurer in each state and at an overall level

The frequency of this report is quarterly

Filters and Parameters

Year | Quarter

State

				No. of branches opened during the year			
#	Name of Insurer	No. of offices at the beginning of the year	No. of branches approved during the year	Out of approvals of previous year	Out of approvals of this year	No. of branches closed during the year	No of branches at the end of the year
	Column Code	a	b	c	d	e	f
	Source/Calculation	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1	INPUT_NON_LIFE_Office_1
1							
2							
3							
4							
5							
6							
.....							
#	*Total*						

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