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IDBI Federal Life Insurance Co Ltd

Grievance Redressal Policy

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Signature:	Signature:

IDBI FEDERAL LIFE INSURANCE CO LTD. MUMBAI

POLICY ON CUSTOMER GRIEVANCE REDRESSAL

1. Introduction

1.1. The purpose of this policy is to ensure that the customers are treated fairly at all times and their grievances are dealt with in a prompt and efficient manner. The attempt is to translate the company's ethical values of enhancing customer experience through dedicated relationship management, customer friendly approach and superior service delivery, while dealing with a customer grievance.

1.2. To achieve the above objective, this policy prescribes:

1.2.1. The avenues available to the customer to lodge or escalate his grievance within the company; and

1.2.2. The timelines within which each customer grievance is required to be resolved.

2. Avenues available to the customer

2.1. The company's service strategy is to enable the customer to avail the services through multiple avenues. The avenues available to the customer are:

2.1.1. **Customer Care**: The customer can contact the company's Call Centre at the Toll free Nos 1800 102 5005 (non MTNL subscribers) & 1800 22 1120 (MTNL subscribers)

2.1.2. **E-mail**: The customer can send a email at support@idbifederal.com

2.1.3. **Branch**: The customer can contact the local IDBI Federal Branch

2.1.4. **Partner's Branch**: The customer can contact the nearest IDBI Bank or Federal Bank branch to forward the grievance to IDBI Federal.

2.1.5. **Customer may also send a letter to**: IDBI Federal Life Insurance Co Ltd, Tradeview, Oasis complex, Kamala City, P. B. Marg, Lower Parel (West) Mumbai 400 013.

2.2. Customer Support executives shall record all grievance in the Company's system to monitor the quality of resolution as well as the turnaround time for resolution of the grievances.

3. Process and Time frame for response:

3.1 The process for handling the grievance will be as follows

(a) The company shall send a written acknowledgement to the customer within 3 working days of the receipt of the grievance.
(b). The acknowledgement shall contain the name and designation of the officer who will deal with the grievance.
(c). It shall also contain the details of the insurer's grievance redressal procedure and the time taken for resolution of disputes.
(d). Where the company resolves the complaint within 3 days, it may communicate the resolution along with the acknowledgement.
(e). Where the grievance is not resolved within 3 working days, the company shall resolve the grievance within 2 weeks of its receipt and send a final letter of resolution.
(g). Where, within 2 weeks, the company sends the complainant a written response which offers redress or rejects the complaint and gives reasons for doing so,

(i). the company shall inform the complainant about how he or she may pursue the complaint, if dissatisfied.

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

3.2 For each and every office of the company a system of grievance registration and disposal is put in place

3.3 The company has an escalation matrix in place to ensure that unresolved complaints and grievances are escalated to the next authority level.

3.4 If the Zonal Head or VP – Operations is unable to resolve the grievance, the same will be escalated to the Grievance Redressal Officer at Head Office in Mumbai. If the **Grievance Officer** is still unable to resolve the customer grievance, the same will again be escalated to the **Grievance Redressal Committee.**

3.5 The Grievance Redressal Committee consisting of the Senior Management Members shall review and resolve the customer complaints escalated to it.

3.6 If the customer is unsatisfied with the company's efforts to resolve the grievance, he may take the matter up with the Insurance Ombudsman within one year under the Redressal of Public Grievances Rules, 1998.

3.7 The company has nominated the Manager – Customer & Sales Support to be the officer for implementation of all the necessary processes for customer service, complaint & grievance handling.

4 Grievance Officers

4.3 The Grievance Officer for the company would be the Chief Compliance Officer

4.4 The Branch Manager of the Agency branch shall be the officer nominated as the Grievance Officer for that office.

4.5 The VP Operations shall be the officer nominated as the Grievance Officer for all other grievance as not addressed to a branch.

4.6 The names and contact details of the Grievance Officers shall be published on the website of the company.

5 The Customer Service Committee

5.1 The Customer Service Committee comprises of members of the Senior Management of the IDBI Federal. The customer service committee acts as the Grievance Redressal Committee of the company.

Chairman	Chief Operating Officer
Members	Chief Financial Officer, Head–Legal Secretarial & Compliance, National Head–Agency & Alliances President–Bancassurance, National Head – Marketing & Product, Appointed Actuary
Secretary	VP (Operations) to act as secretary to the Committee

5.2 Each Member shall appoint a representative from his/her team who can attend the meetings on their behalf only in case of their absence from the place of such a meeting. The committee shall consist of all such officers stated above. In case the Chairman is unable to attend the meeting, the members shall elect a Chairman amongst themselves.

5.3 The Committee may invite any person to be in attendance to assist in its deliberations.

5.4 The Frequency of Meetings shall be at least once in a month.

5.5 All the members/ their representatives should be present to comprise a valid quorum.

5.6 The Committee shall submit a Report on its performance to the Policyholder Protection Committee of the Board at quarterly intervals.

5.7 Role and functions of the Customer service committee are

1) To put in place proper procedures and effective mechanism to address customer complaints and grievances of policyholders and prospects, including mis-selling by intermediaries.
2) To ensure compliance with the statutory requirements as laid down in the regulatory framework.
3) To review claims intimation, repudiation and special cases, received and requiring attention.
4) To review the standards for policy holders servicing from time to time.
5) To put in place systems to ensure that policyholders have access to redressal mechanisms.
6) To address the various compliance issues relating to protection of the interests of Policyholders.
7) To keep the policyholders well informed and educated about insurance products and complaint-handling procedures.
8) To address concerns in respect of any special or exceptional cases of complaints / claims received.
9) Identifying root causes of complaints and initiating process changes, if required.
10) To review existing processes and suggest improvements from time to time.
11) To look into customer complaints involving mis-selling, fraud, etc.; agent related complaints and complaints made by agents or intermediaries of the Company.
12) Track the processes for handling the issue, verify whether the current process is followed, and track impact of process changes.
13) To look into the Claims status of the Company from time to time pertaining to intimation, repudiation, etc.
14) Consider unresolved complaints/grievances escalated to it and offer their advice.
15) To suggest, initiate and monitor projects for improvement of customer service.
16) Prepare Annual Policy holders Report.

6 Policyholder Protection Committee

Policyholder Protection Committee, as stipulated in the guidelines for Corporate Governance issued by the regulator will be receiving and analyzing the required reports from the management and will be carrying out all other requisite monitoring activities.

Grievance Redressal Procedure Manual

1. Grievance Redressal Procedure

The purpose of this procedure manual is to outline the process of receiving the customers' complaints & grievance.

The procedure manual covers the following

- Definitions
- Registration of complaints by Customers
- Modes of receipt of complaints
- Categorisation of complaints
- Complaint handling
- Turnaround time for resolution of complaints department wise
- Escalation Matrix department & Overall

2. Definitions

"Complaints/ Grievances "

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

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

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

3. Registration of complaints

The complaints and grievance will be logged in by the following on behalf of the customers

- Bancassurance Channel Partners
- Bancassurance Sales Force
- Branch Operations
- Financial Advisors
- Corporate Agencies & Brokers
- Agency Sales Force

In addition the existing policy holders and prospective customers can directly log in complaints relating to their policies or proposals.

4. **Modes of receipt**

The customer can communicate his complaints/grievance in the following manner

- Send a letter at the registered office "The Grievance Officer, IDBI Federal Life Insurance Company Ltd, Tradeview, Oasis complex, Kamala City PB Marg, Lower Parel (West) Mumbai 400 013. "
- Send a email at support@idbifederal.com or grievance@idbifederal.com
- Contact our Call centre at the Toll free Nos 1800 102 5005 (non MTNL subscribers) & 1800 22 1120 (MTNL subscribers)
- Contact the local IDBI Federal Area Agency Head or branch Manager (Zonal Head is the next level in escalation)
- Contact the nearest IDBI Bank or Federal Bank branch to forward the same to IDBI Federal.

5. **Categorisation of complaints/grievances**

Categorisation of complaints as prescribed by the Authority from time to time shall be adopted by the company and incorporated in their Customer Contact Service System.

The present classification prescribed by the Authority is placed at **Annexure B**

6. **Complaint handling**

- In case of email complaints acknowledgement communication sent to client through support@idbifederal.com and grievance@idbifederal.com
- Complaint is recorded in a system based on mode, category & department for allocation to concerned teams.
- There is a specified maximum turnaround time for each team depending on type of complaints.
- All the complaints received at the agency branches and partner banks should be forwarded to the Customer Support team at Head office. The communication related to the acknowledgment and resolution will be sent from the Customer Support team at HO.
- Operations & distribution channel related complaints are resolved by concerned departments , revert goes back to the support team and is logged in the system.
- In case the client had contacted through call centre, the call centre will call the client and inform him about the resolution.
- For legal complaints, these are routed to Corporate Legal department & the resolution is done with their help in wording the communication.
- In case of complaints where the clients allege Unfair business practices, Misselling, Fraud or Forgery the case will be forwarded to the Compliance and Legal department for investigation and appropriate action
- After investigation with its findings and recommendations the report will be placed before the Committee for taking appropriate decision.
- The Customer Service Committee acts as a Grievance redressal committee.

- For complaints not resolved within the defined Turnaround time automatic escalations are made to next level in the escalation matrix and finally to Grievance Redressal Committee.
- On resolution of all complaints a written communication is sent to client by the Manager-Customer & Sales support.

7. **Closure of grievance:**
   - A complaint shall be considered as disposed of and closed when
     (a) the company as acceded to the request of the complainant fully.
     (b) where the complainant has indicated in writing, acceptance of the response of the company.
     (c) where the complainant has not responded to the company within 8 weeks of the company's written response.
     (d) where the Grievance Officer has certified that the company has discharged its contractual, statutory and regulatory obligations and therefore closes the complaint.

8. **Turnaround Time**

Departments	Inquiry	Servicing request	Complaint/ Grievance	Responsible
Call centre	1 day	7 days	10 days	Manager-Customer & sales support
Email	2 days	7 days	10 days	Manager-Customer & sales support
New Business	2 days	7 days	10 days	Sr. Manager- New Business
Policy servicing	3 days	7 days	10 days	Manager- Policy Servicing
Claims	3 days	7 days	15 days	Sr Manager-Claims
Channel support	3 days	7 days	10 days	Sr. Manager- Channel support
Underwriting	2 days	7 days	10 days	Head - Underwriting
Agency sales support	2 days	7 days	10 days	Manager- Agency Sales Support
Banca sales support	2 days	7 days	10 days	Manager- Banca Sales Support

- Each of the departmental managers is responsible for the Turnaround times for the queries, complaints & grievances.
- In case they are unable to resolve the same within promised Turnaround time , they have to escalate to the next level as per the Escalation matrix
- There is a system in place to monitor the Turnaround time and mark cases which are beyond the promised Turnaround time for the category.
- There are two types of turnaround times involved.
  (i). The service level turnaround times, which are mapped to each classification of complaint (which is itself based on the service aspect involved).

(ii). The turnaround time involved for the grievance redressal.

- As to (i), the TATs are as mapped to the classification and prescribed by the regulator to the company. These TATs reflect the time-frames as already laid down in the IRDA Regulations for Protection of Policyholders Interests and more, as, wherever considered necessary(for certain service aspects not getting specifically reflected in the regulations), specific TATs are indicated in the classification and mapping provided by the regulator in **Annexure A & B**
- As regards (ii) above, the minimum TATs required to be followed shall be as prescribed in guidelines published by the regulator.

9. Escalation Matrix

The following are the various levels as per the escalation matrix

	First level	Second Level	Third Level	Final Level
Operations	Manager-Customer & Sales support	VP Operations	Grievance Officer	Grievance Redressal Committee
Agency Channel	Manager-Agency Support	Zonal Head	Grievance Officer	Grievance Redressal Committee
Banca Channel	Manager-Banca Support	Zonal Head	Grievance Officer	Grievance Redressal Committee
Complaints received at Agency Branches/ Partner Bank branches	Customer Support team – Head office	VP Operations	Grievance Officer	Grievance Redressal Committee

All requests for compensation by the customers should be represented to the Chief Operating Officer along with the recommendations of the Channel Heads. The Chief Operating Officer will be approving all compensation requests based on the Compensation Policy of the company.

In case of deviation from internal process and if it has any compliance implication, then the same needs to be approved by Compliance.

10. Adherence to IRDA's Policy holders protection regulations

We have also ensured adherence to the Policy holders protection regulations while designing and implementation of policy holder's communication and documentation as well as our internal processes. The details are placed in Annexure A.

Annexure A

COMPLIANCE CHECKLIST

IRDA (Protection of Policyholder's Interests) Regulations, 2002

#	Requirement	Mode of compliance	Status
1	**Reg 2(e)**: Prospectus to be issued to the customers. The same shall contain particulars mentioned in rule 11 of the Insurance Rules, 1939. It should also specify riders and its benefits.	The Brochures provided by the Company details the product and the riders	Complied
2	**Reg 3(1)**: The Prospectus shall clearly state the scope of benefits, the extent of insurance cover, the warranties, exceptions and conditions of the insurance cover, whether the product is participating (with-profits) or non-participating (without-profits).	The Brochure clearly states the scope of benefits, insurance cover and other details mandated.	Complied
	The Prospectus shall also spell out the rider/s and its scope of benefits.	The Brochure details the riders and its benefits.	
	The premium for health or critical illness riders in case of term or group products shall exceed 100% of the premium under the basic products. Total rider premium shall not exceed 30% of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product. The benefit amount under riders shall be subject to section 2(11) of the Insurance Act 1938 ("**Act**")	The rider/s is/are structured to ensure compliance with these requirements.	
3	**Reg 3(2)**: The insurer/agent/ other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest	All sales tools are prepared to ensure clear and qualitative communication. Further, this perspective is imbibed during training and other meetings.	Complied
4	**Reg 4(1)**: The proposal form shall be in writing and a copy of the same shall be provided free of cost to the customer within 30 days of acceptance.	Copy of the proposal form is provided to the customer free of cost.	Complied
5	**Reg 4(2)**: Forms and documents shall be provided in languages mentioned in the Constitution of India.	Company has the necessary facilities to provide such forms and documents upon customer request.	Complied
6	**Reg 4(3)**: The proposal form shall prominently state the requirements of Section 45 of the Act.	The proposal form used by the Company states the	Complied

		requirements of section 45	
7	**Reg 4(5)**: The insurer shall encourage the proposer to appoint nominee/s.	The proposal form specifically provides for nomination. Further, this requirement is also checked at the underwriting stage.	Complied
8	**Reg 4(6)**: The decisions on the proposal form shall be communicated to the customer in not more than 15 days.	The Company has 15 days turn-around-time for the said requirement.	Complied
9	**Reg 6(1)**: The insurance policy shall state the following: (a) name of the plan and its terms & conditions; (b) whether participatory or not; (c) specify the basis of participation (d) benefits payable, the contingencies triggering payment and other terms & conditions; (e) details of the riders; (f) specify the dates such as commencement of risk, maturity, payment of benefits; (g) state the premiums payable, periodicity, grace period, date of last installment, the implication of discontinuing the payment and provisions on guaranteed surrender value. (h) age at entry and whether the same has been admitted; (i) policy requirements for (a) conversion into paid up policy, (b) surrender (c) non-forfeiture and (d) revival; (j) exclusion of contingencies from the cover, both in main policy and riders; (k) provision for nomination, assignment, and loans on security of the policy and a statement on the insurer's right to prescribe the rate of	The Company forwards the policy to the customer in a docket form, which meets all the mandated requirements	Complied

	interest on the loan; (l) special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; (m) insurer's address for communications; and (n) documents to be submitted in support of a claim.		
10	**Reg 6(2)**: When the policy is forwarded to the customer, the covering letter should state that the customer may cancel the policy within 15 days of receipt of the same, if he disagrees with any of the terms. The amounts deductable in such cases will be proportionate risk premium, cost of medicals & stamp duty.	The Company forwards the policy with a welcome letter, which provides for a free-look cancellation period of 15 days.	Complied
11	**Reg 6(3)**: In case of ULIPs, the insurer shall also state that it is entitled to repurchase the units as on the date of free-look cancellation.	The welcome letter issued by the Company specifically provides for such a clause.	Complied
12	**Reg 6(4)**: When premium is dependent on age, the insurer shall ensure that the age is admitted before the issuance of the policy. If age is not admitted, the insurer shall obtain proof of age.	The said requirement is ensured at the underwriting stage.	Complied
13	**Reg 8(1)**: The policy shall state the documents to be submitted in support of the claim.	The policy document issued by the Company to the customer states such requirement.	Complied
14	**Reg 8(2)**: Any query / additional documents required to process a claim shall be raised at once within 15 days of receipt of claim.	The Company has internal turn-around-time mechanisms to meet this requirement.	Complied
15	**Reg 8(3)**: A claim shall be paid within 30 days of receipt of relevant papers. However, if any investigation is required, the same shall be completed within 6 months of the claim.	The Company has internal turn-around-time mechanisms to meet this requirement.	Complied
16	**Reg 8(4)**: If the claim amount cannot be paid due to lack of identification of the claimant, the claim amount shall be held by the insurer together with interest at the savings account rate of a scheduled bank. The interest shall be payable from the 30 day of submission of all relevant papers.	The Company has made arrangements for the said requirement.	Complied
17	**Reg 8(5)**: In case of delay in processing the claim, the insurer shall pay interest 2% above the bank rate prevalent at the beginning of the FY.	The Company has internal turn-around-time mechanisms to ensure that the claims are paid on time. However, in case of delay the Company shall comply	Complied

		with the mandated requirement.	
18	**Reg 10**: The insurer shall respond within 10 days of receipt of any of the following communication: (a) recording change of address; (b) noting a new nomination or change of nomination under a policy; (c) noting an assignment on the policy; (d) providing information on the current status of a policy indicating matters, such as, accrued bonus, surrender value and entitlement to a loan; (e) processing papers and disbursal of a loan on security of policy; (f) issuance of duplicate policy; (g) issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and (h) guidance on the procedure for registering a claim and early settlement thereof.	The Company has customer service systems to ensure compliance with this requirement.	Complied
19	**Reg 11(1)**: The insurer has to disclose 'material information'.	Company ensures that the 'material information' is disclosed to the customer by ensuring compliance with the applicable regulations, following industry practice and internal systems.	Complied

Annexure B

LIFE CLASSIFICATION OF COMPLAINTS – IRDA GUIDELINES

LIFE INSURANCE COMPLAINTS CLASSIFICATION			
S.No.	**Description**	**Mapping of PPI Provisions to classification structure**	**Servicing TATs**
(1) PROPOSAL PROCESSING INCLUDING REFUNDS -Proposal (NB) Related issues (from receipt of proposal until results in to policy) including Refunds			
1	Proposal papers submitted but misplaced by Insurer	4 (6) Proposals shall be processed by the insurer with speed and efficiency and all decisions thereof shall be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.	15 days
2	Cancellation of proposal & refund of deposit at proposal stage not attended	Refer S.No.1	15 days
3	After submission of proposal to the insurer no response received regarding acceptance/further requirements/rejections.	Refer S.No. 1	15 days
4	After Submission of all requirements,no communication was received.	Refer S.No. 1	15 days
5	Excess Propasal deposit not refunded	Refer S.No. 1	10 days
6	Policy bond not received.	10 (1) An insurer carrying on life or general business, as the case may be, shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters.	10 days
7	Mistake in age.	6 (1) A life insurance policy shall clearly state:	10 days
		(a) the name of the plan governing the policy, its terms and conditions;	10 days

		(b) whether it is participating in profits or not;	10 days
		(c) the basis of participation in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus;	10 days
		(d) the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract;	10 days
		(e) the details of the riders attaching to the main policy;	10 days
		(f) the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable;	10 days
		(g) the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date the last installment of premium, the implication of discontinuing the payment of an installment(s) of premium and also the provisions of a guaranteed surrender value.	10 days
		(h) the age at entry and whether the same has been admitted;	10 days
		(i) the policy requirements for (a) conversion of the policy into paid up policy, (b) surrender (c) non-forfeiture and (d) revival of lapsed policies;	10 days
		(j) contingencies excluded from the scope of the cover, both in respect of the main policy and the riders;	10 days
		(k) the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan;	10 days
		(l) any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and	10 days
		(m) the address of the insurer to which all communications in respect of the policy shall be sent.	10 days

		(n) the documents that are normally required to be submitted by a claimant in support of a claim under the policy.	10 days
8	Mistake in Date of Commencement (DOC).	Refer S.No. 6	10 days
9	Mistake in Term of the policy.	Refer S.No. 6	10 days
10	Mistake in name of the Nominee/ Beneficiary.	Refer S.No. 6	10 days
11	Mistake in Date of Maturity (DOM)/DOLP/others.	Refer S.No. 6	10 days
12	Mistakes in the name and address of the insured.	Refer S.No.6	10 days
13	Mistakes in any other policy schedule item.	Refer S.No. 6	10 days
14	Mode of payment not shown correctly.	Refer S.No. 6	10 days
15	Next Premium due is not shown correctly.	Refer S.No. 6	10 days
16	Wrong Policy Bond is issued	Refer S.No. 10(1)	10 days
(2) POLICY SERVICING DELAYS/DENIALS - Policy Servicing issues related to service / delays excludig S.V., S.B, Maturity claims and Death claims			
17	No Response for recording Change of address	10 (1) (a) recording change of address;	10 days
18	No Response for noting nomination/ change of nomination	10 (1) (b) noting a new nomination or change of nomination under a policy;	10 days
19	No response for noting an assignment /reassignment	10 (1) (c) noting an assignment on the policy;	10 days
20	Statement of account not received	10(1) d Providing information on the current status of a policy indicating matters,such as accrued bonus surrender value and entitlement to loan;	10 days
21	Premium payment position statement not received	Refer S.No. 20	10 days
22	Response for issuance of duplicate policy is not	10 (1) (f) issuance of duplicate policy;	10 days

	sent		
23	Payment of premium not acted upon or wrongly acted upon including Top up premium / Premium Redirection.	Refer S.No. 20	10 days
24	Reinstatement requirements raised by Insurer not acceptable	Refer S.No. 20	10 days
25	Requirements for revival not communicated or raised	Refer S.No.20	10 days
26	Non-receipt of Premium receipt	Refer S.No. 20	10 days
27	Non-receipt of Duplicate policy	Refer S.No. 10(1)(f)issuance of duplicate policy;	10 days
28	Insurer failed to send lapse intimation	Refer S.No. 20	10 days
29	After submission of all reinstatement (revival) requirements, there is no response from the Insurer.	Refer S.No. 20	10 days
30	Request for Servicing Branch transfer is not effected	Refer S.No. 6	10 days
31	Auto Cover continuation option not effected/Applicable for conventional and ULIP cases.	Refer S.No. 6	10 days
32	Policy conversion option not effected	10 (1) (g) issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests.	10 days
33	Policy Benefit option not effected	Refer S.No. 32	10 days
34	Alteration in policy not effected.	Refer S.No. 32	10 days
35	Dispute concerning statement of account or	Refer S.No. 20	10 days

	premium position statement		
36	Response for processing or payment of Policy Loan is not sent	Refer S.No. 20	10 days
37	Reinstatement denied	Refer S.No. 6	10 days
(3) SURVIVAL CLAIMS - S.B claims / Maturity claims / S.V. payment & connected issues including (Pension) Annuity Payments			
38	Surrender Value not paid	Refer S.No. 20	10 days
39	Disputes concerning correctness of surrender value	Refer S.No. 20	15 days
40	Disputes concerning eligibility of surrender value	Refer S.No. 20	15 days
41	Survival Benefit is not paid	8 (2) A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim.	15 days
42	Maturity claim is not paid	Refer S.No. 41	15 days
43	Annuity/pension instalments not paid	Refer S.No. 41	15 days
44	Commutation value/cash option not paid	Refer S.No. 41	15 days
45	Dispute concerning claim value	Refer S.No. 41	15 days
46	Non-payment of penal interest	8 (4) Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30	

		days following the submission of all papers and information).	
		(5) Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.	15 days
(4) DEATH CLAIMS - Death Claims & Connected Issues			
47	Requirement in respect of Death Claim not raised by Insurer	Refer S.No. 41	15 days
48	Death claim not paid / disputed	8 (3) A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.	30 days
49	Death claim investigation not completed	Refer S.No. 48	6 months

50	Non-payment of penal interest in case of Death claim	Refer S.No. 46	15 days
51	Repudiation of Claim not communicated after investigation	Refer S.No. 48	10days
(5)Insurers' Unfair Business Practices/ Mis sales / Mis representation / Tampering Records/Forging Signature etc			10 days
52	Product differs from what was requested or disclosed.	3 (1) a prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to health related to critical illness riders in the case of term or group products shall exceed 100 per cent of premium under the basic product. All other riders put together shall be subject to a ceiling of 30 per cent of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product.	10 days
		(2) An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest.	10 days
		(3) Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately.	10 days

		(4) Where, for any reason, the proposal and other connected papers are not filled by the prospect, a certificate may be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract.	10 days
		(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by:	10 days
		i) the Authority	10 days
		ii) the Councils that have been established under section 64C of the Act and	
		iii) the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.	
53	Term(Period) of the policy is different/altered without consent	Refer S.No. 52	10 days
54	Mode of premium payment differs from requested or disclosed	Refer S.No. 52	10 days
55	Annuity/Commutation/Cash Option /Rider/other Options not included as requested	Refer S.No. 52	10 days
56	Proposed Insurance not in the interest of proposer	Refer S.No. 52	10 days
57	Intermediary did not provide material information concerning proposed cover	Refer S.No. 52	10 days
58	Single premium Policy issued as Annual premium policy	Refer S.No. 52	10 days
59	Tampering, Corrections, forgery of proposal or	Refer S.No. 52	10 days

	related papers		
60	Credit/Debit card debited without consent of Consumer	Refer S.No. 52	10 days
61	Premium paying period projected is different from actual	Refer S.No. 52	10 days
62	False promises made regarding surrender value by intermediers	Refer S.No. 52	10 days
63	Free-look refund not paid	6 (2) While forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges.	10 days
		(3) In respect of a Unit Linked Policy, in addition to the deductions under sub-regulation (2) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.	10 days
64	Cancellation of policy other than Free Look Period not responded.	Refer S.No.6	10 days
65	Advice concerning Exclusions/limitations of cover not communicated	Refer S.No. 52	10 days
66	Illegitimate inducements offered	Refer S.No. 52	10 days
67	Malpractices or unfair	Refer S.No. 52	

	business practices		
68	Misappropriation of premiums	Refer S.No. 52	10 days
(6)UNIT LIKED POLICIES- Complaints regarding Charges, Improper Allocation of Units, NAV Related Complaints Switching and Partial Withdrawals			**10 days**
69	Disputes concerning NAV	Refer S.No. 6	10 days
70	Charges recovered in violation of regulations	Refer S.No. 6	10 days
71	Complaints related to improper allocation of Units	Refer S.No. 6	10 days
72	Disputes concerning switching	Refer S.No. 6	10 days
73	Hidden charges not explained to Consumer	Refer S.No. 52	
74	Partial withdrawal benefit not paid	Refer S.No. 41	10 days
75	Poor disclosures of various Charges	Refer S.No. 52	10 days
76	Foreclosure notice not given to policyholder/forefuture of premium not communicated to policy holder.	Refer S.No. 6	10 days
77	Disputes concerning pre-existing illnesses not covered	Refer S.No. 6	10 days
78	Disputes concerning policy privileges denied	Refer S.No. 52	10 days
79	Definitions of eligibility misinterpreted	Refer S.No. 52	10 days
80	Claim benefit excluded due to policy definition	Refer S.No. 52	10 days
81	Disputes concerning the limits of expenses including deductible	Refer S.No. 6	10 days
7 Distant Marketing / Call centre Marketing / Website Marketing			

82	The insurer calls for solicitation of business in spite of client registered in DNC (Regulation of TRAI will also apply)	Refer S.No.52	10 days
83	Insurer making repeated and unsolicited calls	Refer S.No.52	10 days
84	Mis-selling on distant calling	Refer S.No.52	10 days
85	Explaining excessive features of a policy to a prospect on calls	Refer S.No.52	10 days
86	Insurers debiting the premium on cards arbitrarily	Refer S.No.52	10 days
87	Insurers not refunding the money debited arbitrarily on credit cards	Refer S.No.52	10 days
88	Proposal form not collected by Insurer within stipulated period (case of misselling) through telecall system.	Refer S.No.52	10 days
89	Issues pertaining to c all centers (poor response by call center)	Refer S.No.52	10 days
(8) OTHERS-Other Issues not covered under headings 1 to 7			
90	Advertisements regulations violation		
91	Violation of other IRDA regulations		
92	Complaint raised with Insurer not addressed	Refer S.No. 6	10 days