Policy for Protection of Interests of Policyholders

Go Digit General Insurance Ltd

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Extract of Policy for protection of interests of Policyholders & Insurance Awareness

A. Introduction

The Company understands the importance of customer satisfaction as a key driver for successful business and will always strive to deliver the best in class experience to its customers through digitization, various touch points and well-defined policies and processes. The Company perceives customer centricity as one of the most important guiding principles of its overall business philosophy. This Policy lays down the Company's approach towards protection of interests of its policyholders as well as towards creating insurance awareness amongst the masses. While doing so, the Company shall ensure adherence to the guidelines, circulars and regulations issued by IRDAI with regards to service standards and other aspects of customer service and grievance redressal.

B. Steps taken at point of sale

The Company shall always endeavor to provide complete information during policy solicitation and sales stages and ensure that the prospects are fully informed and made aware of the benefits of the product being sold vis-à-vis the product features attached thereto and the terms and conditions of the product so that the benefits/returns of the product are not mis-stated or mis-represented. Advertisements, sales processes, etc., shall be designed keeping in mind the objective of providing a complete picture of benefits, exclusions and conditions of the insurance cover to the prospect to enable him/her to take an informed decision.

C. Steps taken to avoid mis-selling or unfair business practices

As mentioned above, appropriate steps shall be taken for providing adequate disclosures to the prospects in the context of direct sale through website/micro-sites/other electronic medium. In the context of distribution channels like agents/intermediaries etc., the Company shall lay emphasis on the aspect of right-selling while imparting training to the sales force.

D. Company touch-points for customer service/grievance redressal

The Company believes in providing prompt and efficient handling of customer servicing requests/grievances/complaints. Towards this, the Company shall equip following touch-points:

a. Customer Care Centre: Call center with toll free lines; where grievances/complaints are resolved by our Customer Care Executives. IVR tracks dropped calls and customer care executives shall contact such customers.
b. E-mail: Customers can e-mail their grievances/complaints to the dedicated e-mail id;
c. Website: Customers can also register their grievances/complaints on Company's self-service portal or through online chat
d. Letters: Customers can write to us; name & address given on every policy document.
e. Third Party Administrators (TPAs) with whom the Company has tie-ups

E. Customer service (Service parameters including turn-around times for various services rendered)

The customer, after policy issuance, may approach the Company for various requests for policy servicing matters. The Company will adopt a well-defined customer service approach in respect of various aspects of customer service as mentioned hereunder. The Customer may approach Company for matters such as changes in the existing policy, endorsements, cancellation of the existing policy, free-look cancellation, issuance of duplicate policy, claims, inquiries, etc.

I. Servicing Turn-around times (TATs):
The turnaround time for different aspects of policy servicing are listed below –

(i) Customer Inquiries:
   (a) Immediate response for regular inquiries and information on policy held when routed through the call center, or other live channels of communication such as chat on Website
   (b) Acknowledgement and response within 4 business hours for queries received via email.
   (c) 72 hours for any major queries for which additional inputs are required

(ii) Customer Requests: (Turnaround time from the logging of request to transmission to the customer)
   (a) Providing information on current status of policy related matters: Immediate, when routed through the call center or through Web
   (b) Noting a new nomination or change of nomination under a policy: 48-72 hours.
   (c) 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
   (d) NIL Endorsements having no impact on premium e.g. change in address: 48-72 hours
   (e) Non-NIL Endorsements having impact on premium e.g. installation of anti-theft device: 7 days
   (f) Issuance of duplicate policy: 72 hours

(iii) Claims Servicing
The Company believes that claim settlement is one of the most important functions of an Insurance Company which should address basic expectations of the customer as to simplicity, convenience and transparency. Following steps will be performed for servicing the claims request in case of all products other than Health insurance:

In case of Health Insurance, the Company will consider appointing TPA(s) to process the claims. The turn- around time for the same will be governed by the service level agreement with the TPA(s).

F. Claims

I. Procedure to be followed for claims:

1. Notice/Information to the Company about any event/loss giving rise to a claim under the contract of insurance shall be given by the insured promptly but in no case later than the timeline stipulated in policy terms and conditions from the date of alleged event/loss.
2. For any claim which is notified after such stipulated time, the Company may, at its sole discretion, condone the delay on merits based on reason for delay furnished by the Policyholder/claimant to the Company in writing.

3. The Company shall respond immediately to such intimation/notice by giving clear information to the insured/claimant about the procedure to be followed.
4. Appointment of surveyor, if required, shall be done immediately and in any case within 72 hours of receipt of the intimation from insured/claimant. Details of such surveyor, including roles and responsibilities shall be communicated to the insured/claimant by letter/email/any other electronic form immediately after appointment.
5. Irrespective of appointment of surveyor, the Company/Surveyor (if appointed) shall inform the insured/claimant within 7 days of intimation of claim about the essential documents and other requirements that the insured/claimant needs to submit in support of the claim.
6. In case documents are available in public domain or with a public authority, the same shall be obtained either by the surveyor, if appointed, or the Company itself.
7. In case of appointment of surveyor, the survey shall start immediately unless there is a contingency delaying immediate survey but in no case later than 48 hours of appointment. Interim report of physical details of the loss shall be recorded and uploaded/forwarded to the Company within the shortest time but not later than 15 days from date of first visit of the surveyor.
8. In the event that insured/claimant is unable to furnish particulars required by the Company and/or surveyor or does not fully co-operate in conducting the survey, the Company shall inform the insured/claimant through letter/email/any other electronic form about the consequent delay that may result in assessment of claim. The Company shall diligently follow up with the insured/claimant for pending information/documents and extend guidance regarding the submissions made/to be made. Document/information not relevant to the claim shall not be called for.
9. Subject to clause (7) above, the final report shall be submitted to the Company by the surveyor, if appointed, within 30 days of appointment. In case of commercial and large risks claims, the final report shall be submitted by the surveyor, if appointed, within 90 days of appointment.
10. Copy of interim/final report shall be furnished by the Company to the insured/claimant, if requested.
11. Additional information in case of incomplete report:
    (a) If the survey report is found to be incomplete, the Company shall, under intimation to the insured/claimant, require the surveyor to furnish an additional report on certain specific issues as may be required.
    (b) Such request shall be made by the Company within 15 days of receipt of final survey report and shall be made only once in each claim life cycle.
    (c) Additional report shall be submitted within 3 weeks from date of receipt of communication from insurer.
12. Claims shall be settled by the Company within 30 days of receipt of final survey report and/or last relevant and necessary document, as the case may be.
13. Decision for rejection of claim shall be recorded in writing and communicated to the insured/claimant through letter/email/any other electronic form within 30 days from receipt of final survey report and/or additional information/document or the additional survey report, as the case may be.

14. In case amount admitted is less than the amount claimed, the Company shall inform through letter/email/any other electronic form, the basis of settlement in particular, giving reasons for the same and drawing reference(s) to the specific terms and conditions of the policy document.

II. Payment of interest in case of delay

In the event of claim not being settled within 30 days as stipulated above, the Company shall make payment of interest at a rate which is 2% above bank rate computed from date of receipt of last relevant and necessary document from insured/claimant till actual date of payment.

III. Specific procedure in respect of Health insurance policy

1. The Company shall ensure adherence to the procedure laid down under IRDAI (Health Insurance) Regulations, 2016 for settlement of health insurance claims.

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

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

4. Investigation:

(a) Where circumstances warrant an investigation in the opinion of the Company, the Company shall initiate and complete such investigation at the earliest, in any case not later than 30 days from date of receipt of last necessary document. The claim in such case shall be settled within 45 days from date of receipt of last necessary document.

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

5. Return of premium on cancellation during free-look period shall be processed in accordance with the provisions of Reg. 14 of IRDAI (Health Insurance) Regulations, 2016. Such refund shall be processed with speed and within 15 days from date of receipt of request for free look cancellation.

G. Grievance Redressal (Procedure for expeditious resolution of complaints)

I. Mechanism

1. Grievances/Complaints from customers will be dealt in a timely manner and response on phone/e-mail/letter will be given to each and every grievance/complaint.
2. Customers can utilize any of the touch-points mentioned above to register a complaint.
3. A written acknowledgement (letter/e-mail/any other physical or electronic form) will be sent to the customer within 3 days of receiving the grievance/complaint containing name and designation of customer service officer dealing with the grievance, grievance redressal procedure and TAT for resolution.

4. If the grievance/complaint is resolved within 3 days, then the communication of resolution will be sent to the complainant along with the acknowledgement.
5. Where the grievance/complaint is not resolved within 3 working days, it shall be endeavored to be resolved within 2 weeks of receipt and a final communication (letter/email/any other physical or electronic form) of resolution shall be sent to the customer.
6. Where the Company sends a communication (letter/email/any other physical or electronic form) to the complainant within 2 weeks redressing or rejecting the complaint along with reason(s), the Complainant shall also be informed about how he/she may pursue the grievance/complaint further, if dissatisfied.
7. Complainant can escalate grievances to the Grievance Redressal Officer, in the manner as informed in the communication, if not satisfied with the response of customer service officer.
8. Information on Insurance Ombudsman shall be provided as a part of policy document, certificate of insurance, Company's website as well as communication rejecting/redressing the complaint/grievance.
9. Customers shall also be updated about the status of grievance through SMS wherever possible.
10. Confirmation/acknowledgement shall be sought from customer through letter/email/SMS/OTP wherever required to ensure discharge/closure of complaint/grievance.
11. Turn-around time for various grievances is as mentioned in **Annexure I** to this Policy.

II. Functionality

1. Company shall have in place necessary tools and systems in place for receiving, registering, tracking and disposing of grievances/complaints.
2. The automated systems will also enable the Company to generate periodical reports as prescribed by IRDAI from time to time.
3. The system will integrate seamlessly with IRDAI's system in the manner prescribed.
4. MIS on all outstanding open complaints will be tracked.
5. Reports built around various parameters shall be prepared and placed before the Head – Customer Experience, Principal Officer and the Protection of Policyholders' Interests Committee on a periodical basis.

III. Service Recovery

The Company would take service recovery as an integral part of customer care. Complaints shall be analyzed to find the root cause and to determine any measures that need to be taken to reduce/mitigate the root cause for such complaint(s).

IV. Closure of Grievance/Complaint

A grievance/ complaint shall be considered as disposed of and closed when:

(a) the Company has 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 response;
(d) where the Grievance Redressal Officer has certified that the Company has discharged its contractual, statutory and regulatory obligations and therefore closes the complaint.

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Annexure I

Following is the indicative list of complaints classification and tentative redressal servicing TATs adopted by the Company:

S. No	Description	Servicing TATs
(1) Proposal Related		
1	Insurer collected premium – Issued policy without any proposal or confirmation in writing from Insured	30 days
2	Insurer accepted premium and then rejected the proposal	10 days
3	Insurer not furnishing proposal copy after acceptance of risk	30 days
4	Insured does not know the scope of coverage and other terms where Proposal form was filled up by Agent	10 days
5	Proposal form given by Insured was tampered by Agent / Insurer	10 days
(2) Cover Note Related		
6	Cover Note not received	10 days
7	Scope of cover not explained	10 days
(3) Policy Related		
8	Certificate of Insurance / Policy not received by the Insured	10 days
9	Details incomplete in the policy such as:	10 days
	(a) the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance;	
	(b) full description of the property or interest insured;	
	(c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values;	
	(d) period of Insurance;	
	(e) sums insured;	
	(f) perils covered and not covered;	
	(h) any franchise or deductible applicable;	
	(i) Nomination details to be noted	
	(j) Financier's Interest to be shown in policy	
10	Details shown in policy or Add-on are incorrect.	10 days
11	Endorsement for modification of policy/add on not issued by the Insurer	10 days
12	Insured asked for cancellation of policy, Insurer failed to respond	10 days
13	Insured asked for issue of a duplicate policy – Insurer failed to issue	10 days
14	Nomination details given by Insured not noted in policy.	10 days
15	Insurer cancelled policy arbitrarily without serving notice	10 days

16	In the renewal policy, Insurer changed the terms & conditions without informing the Insured	10 days
17	Details shown in policy different from the Cover Note.	10 days
18	Insurer refused to accept Insured's request to enhance coverage mid-term.	10 days
19	While renewing the policy Insurer refused to enhance the Sum Insured sought by Insured.	10 days
20	Insurer forced Insured to switch over to a new policy.	10 days
21	Without the consent of Insured Insurer debited customer's bank A/c / credit card and issued policy.	10 days
22	Insurer refused to renew the policy without giving any reasons.	10 days
23	Change of address not noted	10 days
24	Product no longer available with Insurer	10 days
(4) Premium		
25	Premium receipt not received by Insured	10 days
26	Insurer calculated premium wrongly and over charged the Insured.	10 days
27	Insurer loaded premium arbitrarily	10 days
28	Premium paid through electronic modes/cheque not accepted	10 days
29	Where provisional premium is collected, final adjustment is not carried out	10 days
30	Premium cheque bounced. Without giving intimation to Insured Insurer. cancelled the policy	10 days
(5) Coverage		10 days
31	Insurer did not attach any clauses to the policy – coverage given under the policy not known to the Insured.	
		10 days
32	Dispute relating to Interpretation of perils/exclusions/conditions/warranties	10 days
33	Dispute relating to policy extension of term for Long term policies	10 days
34	Wrong add on policy wording	10 days
(6) Refund		
35	Refund of premium due under policy not received by Insured.	10 days
36	Dispute regarding quantum of premium refund.	10 days
(7) Product		
37	Product (policy) received by insured is not what it was negotiated at the time of sale.	10 days
38	Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	10 days
(8) Claim		
39	Insurer refusing to register claim	10 days
40	Insurer asking for irrelevant claim documents	10 days

41	Insurer asking for claim documents on a piecemeal basis.	10 days
42	Delay in appointment of surveyor	72 hours
43	Insurer not issued claim form.	10 days
44	Delay in conducing survey.	10 days
45	Surveyor delayed issue of his report.	30 days
46	Survey report copy not issued to the Insured by the surveyor.	30 days
47	Difference between assessed loss and amount settled by Insurer.	10 days
48	Insurer reduced the Quantum of claim for reasons not indicated in the policy.	10 days
49	Insurer failed to make offer of settlement to Insured after receipt of survey report.	30 days
50	Insurer not disposed of the claim	30 days
51	Insurer not issued claim cheque inspite of offer of settlement.	7 days
52	Cheque issued by Insurer is bounced.	10 days
53	Name of Insured wrongly written in the claim cheque.	10 days
54	Insurer closed the claim without advising the Insured any reasons.	10 days
55	Dispute between Insured and Insurer on (a)Rate of depreciation applied, (b) amount allowed towards Labour charges (Motor claim), (c) deduction of salvage value, (d) obsolete factor.	10 days
56	Dispute on mode of claim settlement – Total loss / cash loss vis-à-vis repair basis.	30 days
57	Claim denied due to alleged non-cooperation of Insured	30 days
58	Insurer repudiated claim due to delay in intimation of claim by Insured.	10 days
59	Insurer repudiated claim due to delay in submission of claim documents by the Insured.	10 days
60	Insurer repudiated the claim based on 2nd surveyor's recommendation.	10 days
61	Insurer repudiated the claim due to alleged breach of policy condition / warranty.	10 days
62	Insurer repudiated claim due to dispute on premium paid.	10 days
63	Insurer repudiated claim due to alleged fraud.	10 days
64	Claim repudiated without giving reasons	10 days
65	Insurer repudiated claim due to "pre-existing disease exclusion" (Health Insurance).	10 days
66	Claim repudiation by Insurer due to bouncing of premium cheque presented late by Insurer.	10 days
67	Insurer repudiated claim due to alleged carelessness of Insured.	10 days
68	Delay on the part of TPA to arrange claim reimbursement (Health claim).	30 days
69	TPA reduces estimate given by the hospital without any reason.	10 days
70	Delay on the part of TPA to provide cashless facility.	10 days

71	TPA refuses to extend cashless facility to the Insured.	10 days
(9) Distance marketing		10 days
72	Insurer calls for solicitation of business inspite of client registering in DNC	10 days
73	Insurer making repeated and unsolicited calls	10 days
74	Mis-selling on distant calling	10 days
75	Explaining excessive features of a policy to a prospect on calls	10 days
76	Insurer debiting premium on cards arbitrarily	10 days
77	Insurer not refunding amount debited arbitrarily on Credit cards	10 days
(10) Others		
78	IDV related disputes	10 days
79	Higher/wrong deductible imposed by Insurer	10 days
80	Insurer imposed additional conditions wrongly.	10 days
81	TPA not sent ID card to Insured (Health claim).	10 days
82	Insurer not considered the cumulative bonus in claim settlement (PA or Health claim).	10 days
83	Insurer not given no claim bonus (Motor Insurance)	10 days
84	Insurer gave premium quote but later went back on acceptance of risk.	10 days
85	Insurer failed to clarify the queries raised by Insured.	10 days
86	TPA not sending pre-authorization to the Hospital (denial of cashless facility).	10 days
87	Insurer not given eligible discount in premium (Family Discount on Health / PA policy/package policy)	10 days
88	Misbehavior of surveyor towards the Insured.	10 days
89	Insurer not taken any loss prevention measures upon reporting of a claim by Insured.	10 days
90	Failure of online transaction though premium was deducted through credit card.	10 days
91	Rebating resorted to by Agent.	10 days
92	Rebating resorted to by Insurer.	10 days
93	Fraudulent behavior on the part of Agent in claim matter	10 days
94	Errors in ID cards issued by TPAs.	10 days
95	Alleged misconduct of officials of TPA towards the Insured.	10 days
96	No response from TPA / Insurer for queries raised / clarifications sought by Insured.	10 days
97	IT /Network related / connectivity issue with TPA.	10 days
98	TPA delayed Health check-up.	10 days
99	TPA delayed issue of reports of Health check-up.	10 days
100	Alleged misconduct of officials of Insurer.	10 days
101	Alleged misconduct of surveyor / investigator.	10 days

102	Unsolicited calls made to Insured in spite of DNC registration.	10 days
103	Complaint of Insured relating to pre-inspection / pre-acceptance survey.	10 days
104	Cashless facility first sanctioned and withdrawn.	10 days
105	Where claim is repudiated, Bills / reports not returned to the customer.	10 days
106	Non-acceptance of health cards by network hospital.	10 days
107	Unable to register Grievance due to faulty systems	10 days