

ASSIGNMENT 2

1. Three broad categories of distribution channels

Marketing intermediaries

Includes agents and brokers. They sell insurance products, on a face to face basis with customers for a commission on each sale.

Direct response

No face-to-face contact is involved, with the customer responding to some type of solicitation directly from the insurer, such as through the mail, television, or telephone.

Financial institutions

Include commercial banks, investment banks, thrifts, credit unions, mutual fund organizations and other insurers sell insurer's products.

2. Rate adequacy

To avoid financial problems and insolvency, insurance company rates must be adequate in the light of benefits promised under the company's insurance products. Rate adequacy means that, for a given block of policies, total payments collected now and in the future by the insurer plus the investment earnings attributable to any net retained funds are sufficient to fund the current and future benefits promised plus cover related expenses.

Rate equity

Equity means charging premiums commensurate with the expected losses and other costs that insured bring to the insurance pool. The pursuit of equity is one of the goals of **underwriting** classification and selection of insured.

Rates not excessive

Rates should not be excessive in relation to the benefits provided. By establishing a ceiling on the rates, this objective is achieved. Competition discourages excessive pricing.

3. Premium Payment Plan — **a payment plan or installment plan that does not require an insured to pay the entire annual premium at the beginning of the policy period.**

4.

Whole Life vs. Universal Life: Key Differences

Whole life	Universal life
Fixed premiums	Flexible premiums
Guaranteed death benefit	May allow you to increase or decrease the death benefit
Offers cash value to use while you're still living	Offers cash value potential
Dividends are guaranteed	Interest rates can change over time
Higher premiums	Lower premiums
Can never become underfunded	May become underfunded and lapse

5. Basically, the following are the different types of claims which come up before an Insurance Company.

1. Maturity Claims and Survival Benefits
2. Death Claims
3. Accident and Disability Claims and
4. Annuity Payments

Settlement of claims under life insurance policies depend upon the nature of a claim, eligibility to policy moneys, proof of the happening of the event insured against, proof of title, etc.

Maturity Claims

Payment of Maturity Claims is by far the easiest to manage. These include benefits payable during the period of assurance called '*Survival Benefits*' under certain types of policies popularly known as 'Money Back' policies. Payment in these cases is easy because (a) there is no need on the part of the policyholder to prove the happening of the event (b) the policyholder is alive so Proof of Title does not pose any problem, and (c) the Insurance company need not await any claim from the policyholder and take initiative to settle the claims expeditiously.

The requirements for settlement of these claims are very simple. They are:

5. A Discharge Voucher to be sent in advance
6. Policy Document
7. Any Deed of Assignment, if the same was executed on a separate Stamp Paper.

Death Claims

Life insurance is basically for providing financial security to the families of deceased policyholders.

Death claim settlement naturally assumes very great importance in the total operations of any Life Insurance Company. Despite several problems encountered, still Life Insurance Companies struggle to efficiently and effectively attend to this function. Unlike in Maturity and Survival Benefit Claims, the Policyholder is not alive. This itself poses many problems. Broadly the problems in settlement of Death claims are

8. Obtaining satisfactory Proof of Death, and
9. Obtaining satisfactory Proof of Title

6. Advantages of an IT system in claims management

- i. Elimination of duplication: Once all the details regarding the insurance policies issued are entered into the electronic data entry systems, the data can be stored and becomes available to multi-use. Thus it eliminates duplication of both the data and the effort.
- ii. Reduced paper work: In such a system the claims are created electronically. Supporting documents, images of damages and reports of loss assessors can also be stored electronically. This eliminates the necessity to maintain a number of claims manually and expedite the settlement process.
- iii. Electronically communicated information leads to quicker communication of the origination of risk, the occurrence of loss etc.
- iv. Electronic authorization, accompanied by payments made through central settlement system results in expediting the claims payment.
- v. The use of electronic funds transfer. This leads to faster settlement of claims.
- vi. It helps in reducing administration costs. As paper work decreases the need to maintain piles of stationery decreases.
- vii. Faster agreement of valid claims and faster settlement of claims leads to a greater satisfaction of the insured. This adds to the goodwill of the insurer.
- viii. An automated check against fraudulent, exaggerated and repeated claims.
- ix. Expediting payments to be made to brokers, intermediaries, loss adjusters, etc.
- x. Information on fingertips for decision making purpose is available.

Disadvantages

- i.** There may be an adverse effect on the cash flow position, as the claims settlement is expedited but the premium collections and the reinsurance recoveries may be delayed.
- ii.** IT systems are more suited to standardized insurance products. They are less suited to big, more complex liability claims and non-standardized insurance claims.
- iii.** These systems are less flexible, difficult to operate.
- iv.** IT is rapidly changing and the pace is so fast that even experts in this field are finding it difficult to cope with. This results in hardware and software products becoming obsolete in ridiculously short periods of time.
- v.** Difficulty may arise in finding the right type of personnel to handle the systems and data.

7.

BASIS FOR COMPARISON	NOMINATION	ASSIGNMENT
Meaning	Nomination implies appointment of a person, by the policy holder to receive the policy benefits, on the event of death.	Assignment, alludes to, ceding of right, title and interest of the policy to another person.
Attestation	Attestation is not required in nomination.	Attestation is required in assignment.
Consideration	It does not involve consideration.	It may involve consideration.
Right to sue	Nominee has no right to sue under the policy.	Assignee has the right to sue under policy.
Purpose	To help beneficiary recover the policy amount when it becomes due for payment.	To transfer all rights and interest in favor of the assignee.
Revocation	Can be changed or revoked several times.	Can be revoked one or two times during the term of policy.
Favor	Generally, made in favor of immediate relatives.	Can be made in favor of immediate relatives or to external party.

8. We know that during the early years of a policy the premium received by an insurance company surpasses the required amount due to the Level Annual Premium system. Thus there is collective excess, corresponding to the premiums of all the policies. This excess then constitutes a funds pool, which enables the company to, settle claims and meet deficit during years when the premium is not sufficient. It now becomes essential to determine whether the premium accumulated is on the

same lines as the calculated premium. This enables the company in determining its solvency. Thus the process by which the value of all the existing policies is ascertained is called **valuation**.

It is also called valuation of liabilities of the insurance company. And since the process of valuation is taken up by an 'actuary' by applying actuarial principles it is termed as **actuarial valuation**.

9. Default risk is the chance that a company or individual will be unable to make the required payments on their debt obligation. Lenders and investors are exposed to default risk in virtually all forms of credit extensions. A higher level of risk leads to a higher required return, and in turn, a higher interest rate.

Default risk can be gauged using standard measurement tools, including FICO scores for consumer credit, and credit ratings for corporate and government debt issues.

Default risk can change as a result of broader economic changes or changes in a company's financial situation. Economic recession can impact the revenues and earnings of many companies, influencing their ability to make interest payments on debt and, ultimately, repay the debt itself. Companies may face factors such as increased competition and lower pricing power, resulting in a similar financial impact. Entities need to generate sufficient net income and cash flow to mitigate default risk.

In the event of a default, investors may lose out on periodic interest payments and their investment in the bond. A default could result in a 100% loss on investment.

10. In life insurance the word 'surplus' signifies an estimated profit. This is because the calculation of profit in insurance business is slightly different from other businesses. We all know that normally profit is the excess over the cost price of a product. Thus in regular businesses, the difference between the cost price and the selling price decides the profit made or loss incurred. But it is not the same in the case of an insurance business. Profit in insurance business is a result of margin kept on the basis adopted for the calculation of premium with regard to mortality, expenses, interest and other factors like surrender and lapse. Profits are also made when the actual earning is more than the projected value at the time of premium calculations.

Likewise if the actual experience of the insurer is the same as the projected value at the time of premium calculations then the difference between the liability of the insurer and the life fund is considered as profit achieved on the basis of margin provided while calculating premium.

11. **Surplus from investment earnings:** Life insurance policies are long term contracts, thus it becomes essential for the insurance company to maintain a conservative rate of interest, so that there is a steady income as long as the policy is in force. The interest rates are often conservative. For example if the insurance company bases the reserves expecting to earn 4% but actually earns 7% then there is an excess of 3%, which should go to the policyholders.

Surplus from mortality: Usually the rate of mortality considered during reserve calculations is much higher than what exists on ground. This is because insurers employ conservative methods thereby retaining a broad margin to meet any eventuality. Usually the projected mortality is

higher than the experienced, thus the surplus after settling all mortality claims is considered a gain.

Two factors required for the calculation of mortality surplus are expected death strain and actual death strain.

Death strain = $(S - V)$, in this equation S is the sum insured, and V is the policy value.

Now if we consider a situation where all the policies are of the age x , and if Q_x is the evaluation rate of mortality and q_x is the actual rate of mortality,

$Q_x (S - V)$, represents the expected death strain; and

$q_x (S - V)$, represents the actual death strain

Thus mortality surplus is the difference between the expected death strain and the actual death strain. Mathematically, mortality surplus = $(Q_x - q_x) (S - V)$

Surplus from Loading: If an insurance company has to do well then the gross premium earned by the company should be sufficient to meet not only the regular expenses but any unforeseen expenditure also. Thus loading on policies is inclusive of policyholders' dividend and gains from other sources.

Surplus from surrenders: The surplus gain as a result of the difference between the policy reserves released due to surrender and the surrender values permitted is called surrender surplus. This form of surplus also represents the amount that was originally taken from the surplus to replenish the reserves. In reality, this surplus is on paper i.e. it is the repayment of borrowed surplus, in a situation when the asset share is below the surrender value of the policy. But there is a gain when the asset share is far greater than the surrender value of the policy. These gains are often channelised for expenses incurred while distributing the divisible surplus to the policyholders.

Distribution of surplus

At the end of a year's business the insurance company determines the surplus accumulated in addition to the surplus carried on from the previous years. After such a calculation, the company decides the percentage of surplus, which has to be retained as contingency fund, and also the percentage that should be distributed to policy owners. The amount set aside for distribution as dividend to policy owners is called

Divisible surplus.

The percentage to be set aside for distribution is decided by the trustees or directors of the insurance company. Once the divisible surplus is decided it is no more a surplus but a liability for the insurer.

12. The main parties who might perpetrate fraud are as follows:

- Directors or staff – these parties will have special access to the financial (including banking) systems of the insurer and to the computer programs and data which support the business.
- Policyholders – the main risk here relates to fraudulent claims, the risk increasing in proportion to the difficulty of detection. Countries with secure processes for certifying deaths represent reduced risks. There is also a risk to the insurer arising from criminal activities such as money laundering.
- Other outside parties – such parties may effectively obtain some access to the computer systems of the insurer, particularly where there are external components such as website access. Money laundering is the process that criminals use to conceal the source of their assets. It is not unknown for criminals to attempt to buy insurance contracts with stolen money. They can then surrender the insurance contract to give the impression that their assets were from a legitimate source. Most countries require insurance companies to have strict controls in place to identify suspicious transactions which may be connected to criminal activity.