BIMTECH
BIRLA INSTITUTE
OF MANAGEMENT TECHNOLOGY

PGDM (Insurance Business) - 2018-20

Sub: Insurance Laws and Regulations

(INS-102)

Trimester – 1, End – Term Examination: September, 2018

[Time Allowed: 2.30 Hours] **[Max Marks: 50]**

Roll No: _____

Instruction: Students are required to write their Roll No. on the question paper. Writing anything other than the Roll No. will be treated as **unfair means.** For rough work, please use answer sheet.

Note: ***- Please be brief and relevant in your answers.***
- Section C is compulsory.
- Also be aware of time constraints

Section-A

[There are 5 Questions in this section. Attempt any 3 Questions. Each Question carries 5 marks.]

[3x5=15 Marks]

[A1]
[a] What briefly are the characteristics of an insurance contract? **[3]**
[b] Narrate the 3 unique features which must find mention in writing in an insurance contract. **[2]**

[A2]
[a] How does the principle of insurable interest operate in property, casualty and marine insurance? Illustrate with examples. **[5]**

[A3]
[a] What do you understand by the Incontestability Clause Sec. 45 of the Insurance Act, 1938? Give examples. **[5]**

[A4]
[a] Examine critically the provisions and significance of Sec. 64 VB of the Insurance Act, 1938? **[5]**

[A5]
[a] Distinguish between "intentional tort" and "tort of negligence" citing suitable examples. **[3]**

[b] What do you understand by the term "strict liability"? Give an example. **[2]**

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Section-B

[Note: Answer any 2 out of the 3 Questions given below. Each Question carries 10 marks]

[2x10=20 Marks]

[B1]
[a] Discuss the salient features (at least 8 items) of the code of conduct to be observed by a TPA. **[10]**

[B2]
[a] Discuss the concepts of "negligence", "professional negligence" and "contributory negligence" in tort. **[10]**

[B3]
[a] What are the salient features of the IRDAI Regulations with regard to the protection of policy holders' interest in reference to Proposal for insurance and claim processing of a General Insurance Company. **[10]**

Section-C

Case Study

[Marks - 15]

- **This section is compulsory.**
- ***Read the annexed case study and answer the questions given at the end.***
- ***Be careful about the time needed to do the case study.***

[See Annexure]

Case Study- CASELET-I [7.5]

Manish Chadha a Pune hotelier had taken out a medical policy from BAGIC which refused to entertain his medical claim had chosen to approach the insurance ombudsman instead of the district consumer forum after the insurance company refused to acknowledge that panic and anxiety, for which he was treated, were not the commonly perceived psychiatric disorder but a condition arising out of cardiac complications. "All these when the company itself had settled a similar claim in 2008," Chadha said.

Chadha, who also owns a legal consultancy firm, was at a popular jewellery shop on Karve Road on October 5, 2010, when he started to sweat profusely, had severe palpitations besides suffering giddiness. "I was rushed to the nearby Sanjeevan Hospital and was discharged the next day. The discharge card

stated 'panic disorder and anxiety' and advised Chadha to do a cardiac review from Jehangir Hospital as the required equipment was not available there." Chadha filed a claim under the Health Guard Policy for Rs 8,311 with a copy of the discharge card and other documents on October 7. The company repudiated the claim, citing 'Psychiatric illness/ psychiatric treatment' that is excluded from the policy. "I wrote back to them and attached letters from Sanjeevan Hospital's doctors that the panic disorder and anxiety were related symptoms to cardiac ailments and that I was not given any psychiatric treatment," he said. "Though the amount was not big, I decided to pursue the claim because of discrepancies shown by BAGICL. After I filed the claim, I received a letter on October 25 asking for more documents. Within 24 hours, the same person sent me another letter repudiating the claim."

On December 28, 2010, Chadha received another communique from the company that he needs to complete the cardiac review in Jehangir Hospital. Though the cardiac review reports indicated 'sinus tachycardia' as the final diagnosis, the company continued to refuse the claim.

Chadha approached the Insurance Ombudsman (Maharashtra and Goa) in Mumbai on November 10, 2010. Assistant manager Vikram Ravindranathan and Dr Rashmi Sachdev represented BAGICL before Insurance Ombudsman S Vishwanathan. After hearing both sides, the Ombudsman — in the order dated July 29, 2011 — observed that Chadha's case was of 'tachychardia manifested by way of severe palpitations and increased heart rate with panic attack which cannot be termed as 'psychiatric illness' and hence repudiation of the claim was not justified.' The Ombudsman directed the company to settle the claim of Rs 8,311 and pay the balance of Rs 1,000 under cash benefit scheme within three working days.

Sudhakar Velankar, former president and trustee of consumer rights' group Grahak Hitvardhini, said the case was important considering that the decision came from the ombudsman. "Only a few people approach the insurance ombudsman and the percentage of cases disposed in favour of the consumer is even lower."

Questions

Answer the following queries after studying the case given above. Please be brief and to the point in your answers:

1. What was the stand of the insurance company while rejecting Mr. Chadha's Claim? **[2]**
2. How do you assess stand of the company in its reading of Chadha medical condition? **[2]**
3. What needs to be done to prevent other companies from acting in a manner similar to BAGICL in this case? **[3.5]**

CASELET – II **[7.5]**

Ms. Jaya Harikrishnan's world fell apart on 11 August 1999. That was the day her husband, an employee in Apollo Tyres, Gurgaon, drowned in the Ganga at Garhmukteshwar, near Delhi, while on a pilgrimage. His body was never recovered: in December that year, the municipal authorities issued a death certificate, after the police confirmed a case of death due to drowning.

Grief wasn't all that the young widow had to contend with: in one of life's bitter moments, she found herself grappling with red tape. Harikrishnan had taken an insurance policy with LIC (Life Insurance Corporation) and was also covered under a group accident insurance policy, taken by Apollo Tyres, with National Insurance Company (then a subsidiary of General Insurance Corporation). While LIC settled the claim promptly and Apollo Tyres processed Harikrishnan's terminal dues speedily, National Insurance kept the claim on hold for 15 months. The insurer first said it was waiting for the 'verification' of the death certificate. Even after it received the report, it sat on the claim, on the ground that Harikrishnan had been insured for an extremely large amount–Rs 8.4 lakh, or 60 times his basic salary.

In despair, Jaya Harikrishnan turned to the insurance ombudsman for help, on 22 September 2000: that's the office established by the Insurance Regulatory and Development Authority to arbitrate insurance-related disputes quickly and at low cost. The invocation of this authority worked in Jaya Harikrishnan's favour. In a little over a month, after going through the claims and counter-claims, the ombudsman directed National Insurance to pay the Rs 8.4 lakh along with 12 per cent penal

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interest with effect from 1 January 2000. In his order, the ombudsman said there were "no extenuating circumstances" to explain the delay in the settlement of a "crystal-clear" claim.

Questions

Answer the following queries after studying the case given above. Please be brief and to the point in your answers:

1. Critically examine the stand of National in denying the claim. **[3]**
2. In view of the fact that LIC did not find anything unusual in either in the claim or documents submitted, while National took a dubious stand, what measures can IRDAI take to bring some kind of uniformity among companies in settling claims? **[4.5]**

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