POLICYHOLDER'S PROTECTION POLICY – LIBERTY GENERAL INSURANCE LIMITED

Version No	Date of Review/Approval	Approved by
Version I	7th May 2013	Board of Directors
Version I	6th May 2014	Board of Directors
Version I	8th May 2015	Board of Directors
Version I	27th May 2016	Board of Directors
Version I	10th May 2017	Board of Directors
Version II	10th August 2017	Board of Directors
Version II	11th May 2018	Board of Directors
Version II	8th May 2019	Board of Directors
Version III	27th May 2020	Board of Directors
Version IV	21st May 2021	Board of Directors
Version IV	13st May 2022	Board of Directors
Version IV	17th May 2023	Board of Directors
Version V	7th June 2024	Board of Directors

***Name of policy changed from Grievance Redressal Policy to Policyholder's Protection Policy**

TABLE OF CONTENTS:

1. Background:

Insurance is a legal contract between the Insurer and the Insured, wherein the Insurer promises to make good the loss suffered by the Insured for a price known as premium. Insurance protects people from the financial costs resulting from loss of life, health, lawsuits, or property damage etc. In providing the insurance services to the Customers there could be occasions wherein the Insured is not happy or satisfied with the service received from the Insurance Company either directly or indirectly through its Agents and or distribution channel. Hence, there is a need to provide a policy framework to deal with complaints/grievances of the Customers.

With the objective of protecting the interests of the Policyholders the insurance regulator, IRDAI has framed (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 (the Regulations) and circulars and guidelines issued from time to time. The Regulation requires insurance companies to put in place policies, proper procedures, /and effective mechanisms to address complaints and grievances of policyholders efficiently and with speed. Further, IRDAI vide its Circular dated 27th July 2010 has issued guidelines for Grievance Redressal by Insurance Companies (the Guidelines). The said Guidelines inter-alia prescribe the minimum time frames and uniform definitions and classifications of complaints.

Liberty General Insurance Limited (the Company) has formulated a Policyholder's Protection Policy (Policy).

2. Effective date for implementation of the policy:

The effective date of the Policy shall be the date of approval by the Board of Directors of the Company. The Company shall periodically review the Policy from time to time in accordance with the IRDAI regulations in this regard.

3. Objective of the policy:

The key objective of the Policy is to provide a mechanism to speedily process the service requests and redress the grievances and complaints of the customers to their satisfaction in accordance with the applicable laws and to educate prospects and policyholders about insurance products, benefits, and their rights and responsibilities.

4. Scope:

The Policy shall cover the service requests, complaints/grievances received from Policyholders and beneficiaries under the insurance policies issued by the Company relating to the issuance, servicing, claims, and other issues pertaining to insurance policies. The Policy specifically excludes Inquiry.

5. Definitions & abbreviation:

a) **Authority** shall mean the Insurance Regulatory and Development Authority of India (IRDAI) established under sub-section (1) of Section 3 of the IRDA Act, 1999.
b) **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.
c) **Company** means Liberty General Insurance Limited, incorporated under the provisions of the Companies Act, 1956 and registered with the Authority as an Insurer.
d) **"Complainant"** means a policyholder or prospect or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer or a distribution channel.
e) **"Complaint" or "Grievance"** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

Explanation: An inquiry or service request would not fall within the definition of the "complaint" or "grievance".

f) **Designated Grievance Officer** shall mean the official appointed by the Company in each branch to redress the grievance of the Complainant.

g) **Distribution Channels** include insurance agents, intermediaries or insurance intermediaries, and any persons or entities authorized by the Authority to involve in sale and service of insurance policies.

h) **Grievance Redressal Officer (GRO)** shall mean the senior level official appointed by the Company at the corporate office.

i) **Inquiry** means any communication from a customer for the primary purpose of requesting information about a company and/or its services.

j) **Mis-selling** includes sale or solicitation of policies by the insurer or through distribution channels, directly or indirectly by

a. exercising undue influence, use of dominant position or otherwise, or
b. making a false or misleading statement or misrepresenting the facts or benefits, or
c. concealing or omitting facts, features, benefits, exclusions with respect to products, or
d. not taking reasonable care to ensure suitability of the policy to the prospects/policyholders.

k) **Policy** shall mean this 'Complaints and Grievance Redressal Policy' of the Company, as amended from time to time.

l) **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

m) **Prospect** means any person who is a potential customer of an insurer and likely to enter an insurance contract either directly with the insurer or through a distribution channel.

n) **Request** means any communication from a customer soliciting a service such as a change or modification in the policy.

o) **Solicitation** means the act of approaching a prospect or a policyholder by an insurer or by a distribution channel with a view to persuading the prospect or a policyholder to purchase or to renew an insurance policy.

p) **Unfair trade practice** shall have the meaning ascribed to such term in the Consumer Protection Act, 2019, as amended from time to time.

6. Steps taken to prevent mis-selling:

- The Company shall always provide complete information during policy solicitation and that the prospects are fully informed of the benefits of the product being proposed and the corresponding the terms and conditions.
- Prospectus, Advertisements, marketing material, etc., shall be designed to provide in a clear and transparent manner, all benefits, exclusions, and conditions of the insurance cover to enable the prospect to take informed decision.
- Product training for all customer facing employees, agents, and other intermediaries.
- Insurance awareness activities to educate policyholders and the general public.
- Any other activities as may be deemed fit.

7. Insurance awareness initiatives:

The Company has in place a separate Insurance Awareness Policy which outlines the initiatives to be undertaken by the Company for creating awareness amongst the public related to insurance products, benefits, their rights, and responsibilities.

8. Claim settlement:

The Company believes that a “settled claim is the best claim” – Every effort should be made to proactively settle all the claims in a transparent, just & equitable manner. Hence, the Company had put in place robust systems and procedures for speedy and fair settlement of claims and ensuring compliance with the timelines prescribed by the Authority.

Policyholders/Claimants can notify the claim through any of the following options:

- Calling us at 1800 266 5844
- Through website www.libertyinsurance.in
- By writing to care@libertyinsurance.in
- Written information to any of our branch offices

Detailed claim procedure is also published on the Company website for easy reference of the policyholders.

Liberty365 - The claims services are available 365 days including weekends and holidays.

The Company has a tie-up with 5000+ hospitals and garages across India on its network to provide cashless claim settlement.

9. Service requests:

The Customer may register any post policy issuance service request concerning mistake in policy, claim related, or any other service requests through any of the following platforms:

- Visiting the branch office
- Call Center (Toll free helpline) 1800 266 5844 (accessible from any Mobile and Landline within India)
- Email – care@libertyinsurance.in
- Company website www.libertyinsuance.in

All the service requests received by the Company are acknowledged within 3 (three) days of receipt and tracked to ensure that all the requests shall be processed within 10 days of receipt of the request.

The model service requests, and their turnaround time (TAT) are provided in Annexure I.
TAT for servicing Policyholders is provided in Annexure II.

10. Source of complaints:

The Company may receive the complaint/grievance from any of the following sources:

- Policyholder
- Beneficiary under the Policy
- Claimant/Nominee under the Policy
- Insurance Regulatory and Development Authority of India
- Ombudsman
- Government Redressal Portals
- Distribution channels

11. Lodging of complaints:

The Complainant can lodge his/her Complaint/Grievance with any of the following:

- Call Center (Toll-free helpline) 1800 266 5844
- Email – care@libertyinsurance.in

- Designated email ID for Senior Citizen Customers: seniorcitizen@libertyinsurance.in
- Designated Grievance Officer in each branch.
- Company website www.libertyinsurance.in
- Bima Bharosa portal of IRDAI
- By sending a written communication.
- Grievance Redressal Officer

12. Complaint handling:

i. Complaints and Grievance Redressal Team

The Complaints & Grievance Redressal Team will be responsible for handling, management, and redressal of all Customer complaints received by the Company. Any complaint received by the Company in any mode (including letters, phone calls, e-mails, etc.) shall be referred to this team within 24 hours from the time of the receipt of the Complaint through the Customer Relationship Management System (CRM). This Team shall follow the below procedure/s for resolving the complaint.

ii. Intimation of complaint

On receipt of a complaint, the Complaints & Grievance Redressal Team shall take the following steps:

- A written acknowledgment shall be sent to the Complainant within three (3) days from the date of receipt of any Complaint/Grievance.
- Where the Company resolves the grievance /complaint within 3 days, acknowledgment will be provided with the resolution.
- The acknowledgment shall mention the unique reference number recorded in the CRM, grievance redressal procedure, and the time limit for resolution of the same.

iii. Complaint resolution

The Company shall endeavor to resolve the Complaint/Grievance within T+ two (2) weeks, where "T" is the date of receipt of the Complaint/Grievance. The Complaints & Grievance Team shall communicate the Company's decision and the same would inter-alia contain the following:

- The details of the resolution offered or reasons of rejection.
- Process to pursue further if the complainant is dissatisfied with the resolution.

The Complaints & Grievance Team shall treat the Complaint/Grievance as closed if there is no response from the Complainant to the communication sent by the Company, within eight (8) weeks from the date of receipt of the said communication.

iv. Escalation:

In case the Complainant is not satisfied with the response / resolution given / offered by the Complaints & Grievance Redressal Team, then the complainant can escalate his complaint/grievance to Manager@libertyinsurance.in and further to ServiceHead@libertyinsurance.in, in case of unsatisfactory reply. The Complainant can further escalate by writing to the Grievance Redressal Officer of the Company at gro@libertyinsurance.in. The complainant can also communicate in writing to address:

Grievance Redressal Officer
Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg
Prabhadevi, Mumbai – 400013

v. Office of the Insurance Ombudsman:

With the objective of amicable settlement of all complaints relating to settlement of claims arising out of insurance contract, the Central Government had notified the Insurance Ombudsman Rules, 2017 as amended from time to time ('the Rules'). The Rules inter-alia provide for establishment of Insurance Council comprising of representatives of all insurance companies. In terms of Rule 5 of the Rules, the Executive Council of Insurers shall appoint one or more persons as the Ombudsman for achieving the objectives of the Rules.

As per the provisions of Rule 13 of the Rules, any person who has a grievance against an insurer, may himself or through his legal heirs, nominee, or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located. Such complaints shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

The updated list of Insurance Ombudsman(s) is available at https://www.cioins.co.in/

Accordingly, in case even after escalating the Grievance / Complaint as provided under Para 9.4 above, if the Customer is not satisfied with the resolution, then he may approach the office of the Insurance Ombudsman for redressal of his Complaint / Grievance.

It is pertinent to note that:

1. The Ombudsman will not entertain any complaint unless the complainant had, before making a complaint to the Ombudsman, made a written representation to the Company and either the Company had rejected the complaint or the complainant had not received any reply within a period of one month after the Company received his representation or the complainant is not satisfied with the reply given to him by the Company.
2. The complaint to the Ombudsman shall be made within a period of one year after the Company had rejected the representation of the complainant or after receipt of decision of the Company which is not to the satisfaction of the complainant.
3. The complaint is not on the same subject matter, for which any proceedings are pending before any court or consumer forum or arbitrator.

13. Closure of Grievance:

The Company shall consider the Complaint as disposed of and closed when:

- The Company has acceded to the request of the Complainant fully.
- Where the Complainant has indicated in writing, acceptance of the response of the Company.
- Where the Complainant has not responded to the Company within 8 weeks of the Company's written response.

14. Categorization of Complaints / Grievances:

The Company shall categorize the complaints / grievances as prescribed by the Authority from time to time.

15. Publicizing Grievance redressal Procedure:

The Company shall adequately publicize its grievance redressal policy at the branches and shall upload the same on its website i.e., www.libertyinsurance.in

16. Policyholder Protection, Grievance Redressal and Claims Monitoring Committee:

The Company shall constitute **Policyholder Protection, Grievance Redressal and Claims Monitoring Committee** to monitor the effective implementation of this policy.

17. General

- The Company shall ensure that no point of sales/ sales manager mis-sell the Company Policies. To ensure compliance, the welcome call will be made to select policyholders, to cross verify the information provided to the prospect at the time of sale.
- Appropriate action will be taken in respect of all proven mis-selling cases.

Annexure I

S.No	Description	Servicing TATs
1	**Acceptance or rejection of proposal form**	**15 days**
2	**Refund of proposal deposit, if proposal is not accepted/ extra premium charged**	**15 days**
3	**Appointment of Surveyor**	**72 hours**
4	**Commencement of work by Surveyor**	**48 hours from the time of appointment**
5	**Interim report by Surveyor**	**15 days from the date of appointment**
6	**Final report by Surveyor**	**30 days from the date of appointment** **90 days in respect of commercial/ large risk**
7	**Claim Settlement**	**30 days from the receipt of last required document**
8	Health Claims settlement / Repudiation (without investigation)	30 days from the date of receipt of last required document
9	Health Claims settlement / Repudiation (with investigation)	45 days from the date of receipt of last required document
10	**Other Service requests**	**10 days from the date of receipt of last required document**

Annexure II

S.No	Description	Mapping of IRDAI(Protection of Policyholders Interest) Regulations 2017 provisions	Servicing TATs
(1) Proposal Related			
1	Insurer collected premium – Issued policy without any proposal or confirmation in writing from Insured	4 (1) Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document. It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.	30 days
2	Insurer accepted premium and then rejected the proposal	3(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by: i) the Authority 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.	15 days
3	Insurer not furnishing proposal copy after acceptance of risk	Refer S.No. 1	30 days
4	Insured does not know the scope of coverage and other terms where Proposal form was filled up by Agent	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 (withprofits) 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 all the riders put together shall exceed 30% of the premium of the main product.	10 days

		11 (1) The requirements of disclosure of "material information" regarding a proposal or policy apply, both to the insurer and the insured.	
		(2) The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties.	
		(3) The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy.	
		(4) Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.	
5	Proposal form given by Insured was tempered by Agent / Insurer	Refer S.No. 2	10 days
(2) Cover Note Related			
6	Cover Note not received	Refer S.No. 2	10 days
7	Scope of cover not explained	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	10 days
(3) Policy Related			
8	Certificate of Insurance / Policy not received by the Insured	Refer S.No. 2	10 days
9	Details incomplete in the policy.	7(1) A general insurance policy shall clearly state:	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.	Refer S.No.9	10 days
11	Endorsement for modification of policy/add on not issued by the Insurer	10 (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	10 days
12	Insured asked for cancellation of policy, Insurer failed to respond	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
13	Insured asked for issue of a duplicate policy – Insurer failed to issue	10(f) issuance of duplicate policy;	10 days
14	Nomination details given by Insured not noted in policy.	10(b) noting a new nomination or change of nomination under a policy;	10 days
15	Insurer cancelled policy arbitrarily without serving notice	It will be fair to issue notice to Insured, before cancellation of Policy	10 days

16	In the renewal policy, Insurer changed the terms & conditions without informing the Insured	Policy terms, conditions and warranties; should not be changed arbitrarily	10 days
17	Details shown in policy different from the Cover Note.	Refer S.No.17	10 days
18	Insurer refused to accept Insured's request to enhance coverage midterm.	If this request cannot be accepted, Insurer to write to Insured giving reasons.	10 days
19	While renewing the policy Insurer refused to enhance the Sum Insured sought by Insured.	Reasons for refusal to be communicated to Insured	10 days
20	Insurer forced Insured to switch over to a new policy.		
21	Without the consent of Insured Insurer debited customer's bank A/c / credit card and issued policy.	Refer S.No. 2	10 days
22	Insurer refused to renew the policy without giving any reasons.	Refer S.No. 2	10 days
23	Change of address not noted	Recording change of address;	10 days
24	Product no longer available with Insurer		
(4) Premium			
25	Premium receipt not received by Insured	Refer S.No. 2	10 days
26	Insurer calculated premium wrongly and over charged the Insured.	Refer S.No. 2	10 days

27	Insurer loaded premium arbitrarily	Insured to be advised in advance	10 days
28	Premium paid through electronic modes/cheque not accepted	Insurer to make arrangements to accept Premium in all accepted modes	10 days
29	Where provisional premium is collected, final adjustment is not carried out	Where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;	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.	A general insurance policy shall clearly state:	
		perils covered and not covered;	10 days
32	Dispute relating to Interpretation of perils/exclusions/conditi ons/warranties	Refer S.No. 2	10 days
33	Dispute relating to policy extension of term for Long term policies	Refer S.No. 2	10 days
34	Wrong add on policy wording	Refer S.No. 2	10 days
(6) Refund			
35	Refund of premium due under policy not received by Insured.	Insurer to make refund of premium on their own	15 days
36	Dispute regarding quantum of premium refund.	Insurer to convey to Insured as to how they arrived at the quantum of refund	10 days

(7) Product			
37	Product (policy) received by insured is not what it was negotiated at the time of sale.	Refer S.No. 2	10 days
38	Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	Refer S.No. 2	10 days
(8) Claim			
39	Insurer refusing to register claim	An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 72 hours of the receipt of intimation from the insured.	10 days
40	Insurer asking for irrelevant claim documents	Refer S.no. 39	10 days
41	Insurer asking for claim documents on a piecemeal basis.	Refer S.no. 39	10 days
42	Delay in appointment of surveyor	Refer S.no. 39	72 hours
43	Insurer not issued claim form.	Refer S.no. 39	10 days
44	Delay in conducing survey.	Insurer should advise the Surveyor to stick to the time –frame – 48 hours – from the time of appointment	48 hrs

45	Surveyor delayed issue of his report.	The surveyor shall submit interim report of physical details of the loss within 15 days from the date of first visit of the surveyor. Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where, in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report.	15 days
46	Survey report copy not issued to the Insured by the surveyor.	Refer S.No. 45 **30 days from the date of appointment** **90 days in respect of commercial/ large risk**	30 days
47	Difference between assessed loss and amount settled by Insurer.	Insurer should explain to the Insured the reasons	10 days
48	Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Refer S.No. 47	30 days
49	Insurer failed to make offer of settlement to Insured after receipt of survey report.	On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.	30 days

50	Insurer not disposed of the claim	Without valid reasons, Insurer should not keep any Claim beyond the time frame	30 days
51	Insurer not issued claim cheque in spite of offer of settlement.	Upon acceptance of an offer of settlement as stated in sub-regulation (5) by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest 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.	7 days
52	Cheque issued by Insurer is bounced.	Insurer should send fresh cheque /draft, the moment they come to know about the bouncing of the cheque	10 days
53	Name of Insured wrongly written in the claim cheque.	Insurer should doubly make sure not allow such errors	10 days
54	Insurer closed the claim without advising the Insured any reasons.	Refer S.No. 47	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.	Insurer should write to the Insured and resolve the disputes	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		
58	Insurer repudiated claim due to delay in intimation of claim by Insured.	It would be proper to ascertain the reasons for delayed intimation and consider admission of claim on merits	10 days

59	Insurer repudiated claim due to delay in submission of claim documents by the Insured.	Without giving notice in advance calling for required documents, Insurer not repudiate a claim	10 days
60	Insurer repudiated the claim based on 2nd surveyor's recommendation.	Insurer should give reasons in the letter of repudiation	10 days
61	Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Refer S.No. 55	10 days
62	Insurer repudiated claim due to dispute on premium paid.	Refer S.No. 55	10 days
63	Insurer repudiated claim due to alleged fraud.		
64	Claim repudiated without giving reasons	Refer S.No. 59	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.		
67	Insurer repudiated claim due to alleged carelessness of Insured.		
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			
72	Insurer calls for solicitation of business in spite of client registering in DNC		
73	Insurer making repeated and unsolicited calls		
74	Mis-selling on distant calling		
75	Explaining excessive features of a policy to a prospect on calls		
76	Insurer debiting premium on cards arbitrarily		
77	Insurer not refunding amount debited arbitrarily on Credit cards		
(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).	Cumulative bonus relevant to PA or Health policy should be allowed	10 days
83	Insurer not given no claim bonus (Motor Insurance)	Insurer should allow No Claim Bonus as per entitlement	
84	Insurer gave premium quote but later went back on acceptance of risk.	The quote should indicate the validity period	
85	Insurer failed to clarify the queries raised by Insured.	Refer S.No. 12	10 days
86	TPA not sending preauthorization to the Hospital (denial of cashless facility).		
87	Insurer not given eligible discount in premium (Family Discount on Health / PA policy/package policy)	Refer S.No. 12	10 days
88	Misbehavior of surveyor towards the Insured.		
89	Insurer not taken any loss prevention measures upon reporting of a claim by Insured.		
90	Failure of online transaction though premium was deducted through credit card.		
91	Rebating resorted to by Agent.		
92	Rebating resorted to by Insurer.		

93	Fraudulent behavior on the part of Agent in claim matter		
94	Errors in ID cards issued by TPAs.		
95	Alleged misconduct of officials of TPA towards the Insured.		
96	No response from TPA / Insurer for queries raised		
	/ clarifications sought by Insured.		
97	IT /Network related / connectivity issue with TPA.		
98	TPA delayed Health check-up.		
99	TPA delayed issue of reports of Health checkup.		
100	Alleged misconduct of officials of Insurer.		
101	Alleged misconduct of Surveyor / Investigator		
102	Unsolicited calls made to Insured in spite of DNC registration.		
103	Complaint of Insured relating to pre-inspection / pre-acceptance survey		
104	Cashless facility first sanctioned and withdrawn		
105	Where claim is repudiated Bills / reports not returned to the customer		
106	Non-acceptance of health cards by network hospital		
107	Unable to register Grievance due to faulty systems		

** Wherever are servicing TATs are not provided, it shall be considered as complaint and shall be resolved within T+ two weeks, where “T” is the date of receipt of such Compliant.