HDFC ERGO GENERAL INSURANCE COMPANY LIMITED

Anti-Fraud Policy

Created by	Fraud Control Unit (FCU)								
Concurred by	Legal & Compliance								
Review Period	Annual								
Version	Version 1.0	Version 1.1	Version 1.2	Version 1.3	Version 1.4	Version 1.5	Version 1.6	Version 1.7	Version 1.8
Approved by Board of Directors on	August 18, 2017	January 24, 2018	October 22, 2018	October 23, 2019	January 22, 2020	January 21, 2021	January 25, 2022	October 20, 2022	October 12, 2023
Effective From	August 18, 2017	January 24, 2018	October 22, 2018	October 23, 2019	January 22, 2020	January 21, 2021	January 25, 2022	October 20, 2022	October 12, 2023

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Anti Fraud Policy

1. Introduction:

Fraud poses a serious risk to all segments of the financial sector. The insurance business by its very nature is susceptible to fraud. While it impacts the Company'sreputation, goodwill and finances, it can significantly erode the confidence of the policy-holders and shareholders. Customerstoo are directly impacted as the increase in premium to offset losses due to frauds is to be borne by them. The overall impact of fraud is therefore a significant cost to the industry as well as to the consumers.

In order to provide regulatory supervision and guidance on the adequacy of measures taken by insurers to address and manage risks emanating from fraud, the IRDAI vide its circular No. IRDA/SDD/MISC/CIR/009/01/2013 dated January 21, 2013 (Circular) laid down the Guidelines requiring insurance companies to have in place the Fraud Monitoring Framework. The Circular mandates all insurance companies to put in place, as part of their corporate governance structure, a Fraud Monitoring Framework.

Further, to address and manage risks emanating specifically from online e-commerce fraud, IRDAI vide its circular No. IRDA/INT/GDL/ECM/055/03/2017 dated March 9, 2017 laid down the Guidelines requiring insurance companies to include Insurance e-commerce in their Fraud Monitoring Framework. The Circular mandates the insurers to have a pro-active fraud detection policy for the insurance e-commerce.

2. Objectives of the Policy:

The key objectives of the Policy are as follows:

- To lay down appropriate Fraud Management Framework to minimise the incidences of frauds and other irregularities.
- To lay down appropriate pro-active fraud detection policy for the insurance e-commerce activities: Cases are detected proactively through analytics, mystery shopping and investigationof the cases received from various known and unknown sources / persons.
- To establish an independent department - Fraud Control Unit (FCU) to identify, detect and investigate fraud cases: Investigation of such suspect cases is to be carried out by
- To constitute a Fraud Management Committee (FMC) to take necessary remedial action on all fraudcases reportedor violation ofCode of Conduct duly assisted by FCU: Decision making process is done through duly constitutedFMC
- To Report to the Board of Directors and IRDAI the details of the frauds perpetrated against the Company and actions taken thereof:Monitoring is through ATR on all of the decisions of the FMC on a continual basis
- To establish information sharing mechanism amongst all Insurance companies under the aegis of the General Insurance Council.
- The policy shall amongst other things include following areas:
  i. Manner of detecting & identifying Frauds related to online e-commerce.
  ii. Follow up mechanism for prosecuting persons who committed fraud.
  iii. Cooperation amongst market participants to identify frauds.
  iv. Building a database of those committing frauds and sharing with other market participants.

3. Definition, meaning and understanding of fraud

Fraud is a term which generally refers to any act committed intentionally to secure an unfair or unlawful gain. This wrongful gain through deceit can be made either singly or jointly with others.

Insurance Fraud is an act or omission related to the conclusion of an insurance contract or to a claim; meant to gain unjustified enrichment for the fraudster or another party or meant to cause a loss to another party.

Frauds can be committed by clients, intermediaries, impostors, petitioners, third party administrators, vendors and even by the internal staff of the companies. Apart from that professional syndicates operate all over the country.

The frauds that could be perpetrated against the insurance company inter alia includes embezzlement, bribery, vendor related third party frauds, money laundering etc. The risk of employees tinkering with the confidential information and colluding with fraudsters is also seen.

Reasons for the frauds are mainly:

- Opportunity of getting very high rewards with minimal possibility of detection
- Penal provisions extremely soft having very low prosecution
- Victimless and easy to commit
- Insurance frauds are hardly considered as social stigma. In fact most of these are taken as accepted practice by the society
- Insurance frauds are very low on priority for law enforcement agencies
- Opportunity for the business houses in distress to compensate for the losses
- Weak internal systems & processes
- Lack of effective vigilance and investigation mechanism

Basic segments of frauds:

- **Premium siphoning:** This is generally done at the point of sale by the direct sales force and by the channel partners. Misuse of credit card details by the call centre executives for this purpose is also common. Modus operandi is simple i.e. to collect the premium in cash from the unsuspecting customers and pocketing it and in return hand them over fake or manipulated policy documents. This is noticed mostly when such customers prefer claims or at the time of endorsement / renewal of policy.

- **Commission siphoning:** Releasing excess commission and then subsequently receiving kickback out of it. Creation of dummy deals in the names of fictitious persons / family members to book direct business into indirect; consolidate commission under particular agent and then illegally pocketing it. Deals of agents who are no longer willing to work with the company are kept active and misused for diverting commissions.

- **Siphoning of operating expenses:** Suppliers /vendors /service providers offering kickbacks from the bill amount in return for the deficient services or for the services not provided with wilful connivance of the internal persons handling those portfolio.

- **Investment frauds:** Misappropriation and diversion of funds, unauthorized trading, manipulation of dealing room persons by the brokers and passing on consideration etc.
- **Underwriting frauds:** Ante dating of risks and providing excess cover in return for favours.
- **Claims frauds:** Claims perpetrated by manipulating or fabricating circumstances or documents for personal benefit with or without the connivance of internal staff of the company.
- **Internal frauds:** Violation of the Code of Conduct or any other policies of the Company

Department / Function wise illustrative list of frauds & control procedures:

Department / Function	Type of Fraud	Control Dept.	Control Activity
1. Business Teams	Premium siphoning, Mis-selling, Commission siphoning etc.	RMG, FCU	Audits, Investigation of suspected cases, Mystery Shopping
2. Claims	Settling ineligible claims or facilitating preferring of inflated / fraudulent claims etc.	FCU , RMG	Inherent maker-checker built through FCU, Investigations & Audits
3. Underwriting	Ante dating of risks, providing excess cover, Improper pricing activity etc.	FCU , RMG	Audits, Investigation of suspected cases
4. Finance	Irregular payments, manipulation of financial documents, embezzlement of funds, Concealment or misrepresentation of transactions and assets or liabilities, Tax evasion etc.	RMG, FCU, Analytics	Inherent maker-checker built in the department, Audits, Management authorization
5. Investment	Misappropriation and diversion of funds, unauthorized trading, manipulation of dealing room persons by the brokers and passing on of consideration etc.	RMG & Management	Investment Committee supervision, Audit

Department / Function	Type of Fraud	Control Dept.	Control Activity
6 HR and L&D	Nepotism in recruitment, consideration from vendors or from the candidates, pay roll manipulation etc.	FCU& RMG	Audits and Mystery Shopping
7. Admin	Consideration from vendors, disposal of company assets irregularly etc.	CMT	4 eye Checks provided through CMT and Audits
8. CMT	Consideration from vendors etc.	User Departments	4 eye Checks provided through user departments and Audits
9. Marketing	Consideration from vendors etc.	CMT & FCU	4 eye Checks provided through user CMT and Audits
10. Fraud Control Unit (FCU)	Overlooking misdeeds etc.	RMG & Management	Audits and RMC
11. Audit & Compliance	Intentional failure to record or disclose significant information accurately or completely, Overlooking misdeeds or False reporting etc.	RMG , FCU	Management Supervision
12. Operations & Policy Issuance	Process finance bearing documents for a consideration, irregular refunds, data leakage etc.	RMG	Inbuilt maker-check present , audits and suspected cases investigation
13. IT	Vendor / Business Partners exploits / Third party risks , Excess of access privileges , information data theft etc.	Fraud Control Unit , RMG	Inbuilt maker-check present, Audits, external VAPT
14. Legal, Corporate Legal	Connive with the opposite party for consideration etc.	Fraud Control Unit , RMG	Suspected cases investigation and audits
15. CEM & Grievance and Call Centres	Data leakage, Misselling etc.	Fraud Control Unit , RMG	Suspected cases investigation and audits
16.Reinsurance / Actuarial	Misrepresentation of financials / facts, placement of risks irregularly etc.	RMG & Management	Audits, RMC

Note: In all the above types of frauds, involvement of the employees shall be covered

Product wise segment of frauds & procedures for fraud monitoring:

- **Frauds in Health segment:** At the individual level, mostly there are impersonations, non-disclosure / hiding of material facts with regard to pre-existing diseases/other policies. The claims are based on totally fabricated/manipulated documents. High value Personal accident claims are made by manipulating the forms of death (like conversion of suicide into Road Accident) to bring it within the policy coverage. At the hospital level, they fabricate claims, inflate bills for services not provided, perform unwanted diagnostics/surgeries and convert OPD cases into IPD etc. In many cases the diseases outside the coverage are treated but substituted with those permitted. Cases of fake/non-existent hospitals running the rackets are also quite common.

- **Frauds in Motor segment:** In this segment, frauds can very broadly be classified under three categories i.e. under Third Party, Own Damage and Theft.

  In the **Third Party** segment, staging accident/ injury/ arson, antedating of cover note, collusion of internal/ external persons with the claimant to help him get inflated claim, granting cover but not depositing the premium are the most common types of frauds. A large number of fleet owners do not renew the policies of most of their vehicles, however, when accident occurs to any of those vehicles, they substitute it with those having insurance cover. Misrepresentations of facts with respect to permit violation, driving license validity etc are quite common. Staging of altogether fake claims by the fraudsters through implanting of fake petitioners/witnesses in connivance with the unscrupulous police officials, advocates are other areas of concern. Filing of double petitions, lodging claims with many companies, conversion of gratuitous passengers as pedestrians, conversion of other type of accidents to Road Traffic Accident, creation of fake employer-employee relationship for Workmen compensation are some of the other very commonly noticed frauds.

  In the **Own Damage** segment, staging of accidents, concealment of previous damages, substitution of ineligible person driving vehicle without a valid license are the major frauds. Misrepresentation of facts with respect to MLC, Post mortem reports, illegal hire & reward activity etc are some of the other areas of frauds found very commonly.

  The last one is **Motor Theft**. Vehicles impounded by the law enforcement agencies for illegal acts and those seized by the financers on account of default in payments are very conveniently reported as stolen to the insurance companies. Selling off the vehicle or hiding a vehicle in remote locations and then reporting it as stolen are another set of practices. In many cases, the vehicles are totally dismantled and then parts are sold in pieces leaving no trace of theft whatsoever. Non availability of centralized database with the RTOs makes execution of these acts very easy.

- **Frauds in Property segment:**The property claims are generally large by value and mostly the cause attributed to is accidental fire. More often than not through forensic investigation it is observed that companies in distress resort to arson.

- **Frauds in marine segment:** The transporters segment is highly disorganized where the fly-by night operators are plenty in the market. High value transit items like medicine are subjected to pilferage/ theft with their connivance leading to huge leakages. Recovery process through courts is not only very lengthy and time consuming but also expensive.

Procedure for fraud monitoring - Claim Frauds:

Claims Investigation Team - The Company shall have a separate team for investigation of suspected fraudulent claims. It shall be responsible for laying down appropriate investigation processes and procedures across the Company. It shall report the status of significant cases of suspected frauds detected to the Head of respective Claims on a regular basis.

- Fraudulent Claim – Thorough Investigation shall be carried out of all suspected fraudulent claims.
  - Verification of Incident & Documents - Dedicated Outsourced Agencies and in house personnel are deployed to carry out field verification as well as checking the authenticity of documents provided at the time of claim.
- Sharing of Fraudulent Data - Database of identified Fraud cases are also updated / De-duped with the data of the GI council.
- Industry Alert - As a collaborative approach suspected fraud data is shared with other companies.

Examples of some other important types of frauds:

- Vendor fraud (e.g. Consideration including the receipt of excessive gifts or accepting or seeking anything of material value from contractors, vendors or persons providing services/materials);
- Forgery or alteration of documents or accounts belonging to the Company;
- Concealment or misrepresentation of transactions, assets or liabilities;
- Expense report fraud (e.g. claims for services or goods not actually provided, seeking fake reimbursements);
- Loss of intellectual property (e.g. disclosing confidential and proprietary information to outside parties);
- Conflicts of Interest resulting in actual or exposure to financial loss;
- Embezzlement (e.g. misappropriation of money, securities, supplies, property or other assets);
- Cheque fraud (forgery or alteration of cheques, bank drafts or any other financial instrument);
- Payroll fraud;
- Bribery & corruption (misusing the vested authority to seek personal gains);
- Fraudulent financial reporting (e.g. forging or alteration of accounting documents or records; intentional concealment or mis-statement of transactions resulting in falsification of records or misleading statements;
- Intentional failure to record or disclose significant information accurately or completely
- Improper pricing activity;
- Unauthorized or illegal use of confidential information (e.g. profiteering as a result of insider knowledge of company activities);
- Electronic Fraud and/or illegal hacking, unauthorized or illegal manipulation of information technology networks or operating systems;
- Tax evasion;
- Destruction, removal or inappropriate use of records, furniture, fixtures and equipment of the Company;
- Sales or assignment of fictitious or misrepresented assets;

- Utilizing company funds for personal purposes.

Indicative methods of fraud identification:

A. Periodic data analytics of Vendors; channel partners; employees re-imbursements etc.

B. Periodic checks on processes and policies

C. Employee involvement in fraudulent practices or activities of channel partners or vendors etc.

D. Online frauds

Procedure for fraud monitoring - Other Frauds:

Any cases of embezzlement of cash / assets found shall be dealt with as per the provisions contained in the Code of Conduct through FCU

Trainings shall be imparted to all new joiners during induction program on arms length principles as contained in the Code of Conduct

The Company shall conduct regular awareness campaign on Frauds related to embezzlement of cash / assets to all employees including off roll employees, if any.

4. Definition, meaning and understanding of Cyber / Online frauds

Cyber / Online frauds refer to various kinds of frauds committed through internet, including phishing emails to gather personal data, hacking of servers/ computer systems, theft of data, password, cloning etc.

Cyber / Online frauds can lead to:

- **Loss of Confidential Data:** Personally identifiable information collected and stored by the Company, including personal information of policyholders and, in some cases, of third parties.
- **Sensitive Information being compromised:** Insurers may collect sensitive business information that could be valuable to corporate / foreign spies. In the case of certain lines such as cyber insurance products, the Company may possess information about a policyholder's network security controls and other cyber resilience information that could be valuable and could harm intellectual property rights of either party.
- **Disruption of Operations:** Cyber-attacks can result in disruption to normal business operation including emails, telephone directories, and voice mails amongst business records such as contract templates.
- **Loss of Trust:** The foundation of insurance business is policyholder trust : trust that the information collected by insurers will be protected, and trust that claims will be paid out in a timely way when appropriate. If an insurer were to suffer a cyber security incident that rendered it unable to make timely

claims payments that trust may also be shaken. The reputational risk could extend to the sector as a whole.

5. Scope:

The Anti Fraud Policy shall be applicable but not limited to all business groups, operations, support functions, channels, branches, directors, employees, agents, intermediaries, vendors, TPA's and all other third parties.

In case of conflict of this Policy with any internal Standard Operating Procedures, it will have an over-riding effect and shall prevail upon. Subsequently the user department should take steps to eliminate such conflict.

6. Consequences of failure to comply with Anti Fraud Policy:

The Company expects all its employees to act in full compliance with this Policy in conjunction with the Code of Conduct, Whistleblower Policy and such other policies in a manner consistent with the highest ethical standards. This Policy and its relevant provisions shall be adequately publicised and made known to all concerned including employees, agents, intermediaries and other channel partners.

Any employee found to have been involved in a fraudulent activity or other misconduct or to have failed to report a known or suspected instance of Fraud will be subject to disciplinary action up to and including termination. Furthermore, such conduct of the employees or other parties if found to be in violation of the law then it may result in civil or criminal action.

All vendors, intermediaries and others dealing with the Company shall adhere to this Policy. Failure to adhere to this Policy may result in appropriate actions as prescribed under this Policy including but not limited to termination of relationship.

The Policy shall be hosted on the intranet and website of the Company.

7. Constitution of Fraud Control Unit:

The Company shall constitute a separate department i.e. Fraud Control Unit (FCU) for implementing the Fraud Monitoring Framework FCU must be separated from other functions of the Company and must operate independently under a person from senior management. It will be responsible for laying down appropriate fraud management processes and procedures across the Company. It shall report the status of significant cases of fraud detected in the Company to the Fraud Management Committee and to the Board of Directors on a quarterly basis.

Functions of FCU shall include but not be limited to the following:

- Identify Potential areas of Fraud: FCU shall actively try to identify potential areas of fraud. It shall undertake data analytics to find any fraud patterns and subject the same to field investigation. Further, it shall also analyse the data based on frauds detected during field investigations.

- FCU shall collate all cases of frauds reported to it by the Whistleblower Complaints Committee (WBCC)or any other entities.

- FCU shall investigate all such cases and render report to the WBCC duly highlighting the breaches of conduct, process and system etc. Report shall also highlight the financial implication, if any.

- FCU shall be responsible for implementing the decisions by FMC

- FCU shall track the closure of the decisions through Action Taken Report (ATR).

- FCU shall get the cases having involvement of non-related entities reviewed and closed through President – Retail Business and submit details of such cases to the FMC.

- Due Diligence: The HR Department shall conduct due diligence of employees at the time of on-boarding. The due diligence of intermediaries, channel partners, vendors, Hospitals, Garages etc. shall be carried out by the respective departments.

- Reporting: FCU shall lay down the procedure for internal / external reporting from / and to various departments.

- Creating Awareness: FCU shall create awareness among the employees, intermediaries, policy-holders to counter insurance frauds.

- FCU shall take appropriate steps to share information pertaining to fraud cases amongst all insurers, regulators, government authorities and to establish co-ordination platforms through the General Insurance Council.

- In performing their duties under this Policy, the members of the ~~RLMU~~ FCU will have free and unrestricted access to all Company records and premises, whether owned or rented, and the authority to examine, copy and/or remove all or any portion of the contents of files, desks, cabinets and other storage facilities on the premises without prior knowledge or consent of any individual who might use or have custody of any such items or facilities when it is within the scope of their investigation, subject to approval FMC.

  The Department Heads shall be responsible to take actions as per the decision of the FMC. Further, the Departmental Heads shall be responsible to act on the recommendations of FCU which it may render from time to time to improve any System and Process gaps.

8. Reporting of Fraud:

All persons including employees, vendors, TPAs, agents, intermediaries are expected to take all reasonable steps to prevent the occurrence of Frauds including online Frauds and to identify and report instances of known or suspicious Fraud committed against the Company, whether by the employees or by outside parties. All employees should timely, expeditiously, unhesitatingly and fearlessly report any Fraud including Cyber / Online Fraud against the Company to his immediate senior or to the FCU at fraudintimations@hdfcergo.com

Complaints/disclosures made against or in relation to employees of the Company shall be dwelt in accordance with the Whistleblower Policy and complaints/disclosures against any person / entity other than employees of the Company shall be dwelt in accordance with the provisions of this Policy.

No employee shall investigate / interview / interrogate such cases of actual / suspected frauds himselfexcept the responsible person within FCU.

9. Principles to be followed in Anti-Fraud Framework:

- **Principle of proportionality**: In taking anti fraud measures, the Company must recognise the principle of proportionality i.e. the measures adopted to mitigate frauds must be in proportion to the risks involved.

- **Zero tolerance:** Any activity with the intention of perpetuating fraud against the Company shall not be tolerated. Any individual involved in a fraudulent activity will be subject to sanctions up to and including dismissal from services of the Company. The Company may further take criminal or civil proceedings under applicable laws. In case of agent/intermediary/Vendor/TPA who fail to adhere to this Policy, the Company may terminate its relationship with them or may further take criminal or civil proceedings under applicable laws.

- **Full investigation:** Suspected fraudulent activity must be investigated immediately by FCU. Where this cannot be done internally, FCU may use external consultants or seek assistance of government bodies. If the investigation establishes a strong suspicion of violation of the law, the Company reserves the right to take any action including but not limited to civil and criminal prosecution.

- **Compliance with law and internal policies:** The Company shall ensure that while implementing the anti-fraud measures, the applicable laws and internal policies of the Company must be strictly complied with. This also applies where the help of external consultants is taken to investigate a case of fraud.

- **Documentation:** Anti-fraud management activities and measures must be clearly documented and records maintained for 5 years. Where a case of fraud is the subject of investigation, care must be taken to ensure that, as far as possible, all evidences are available in a form admissible in court.

- **Regular review and refinement:** The components of anti-fraud management and associated measures, especially the effectiveness of internal controls, must be reviewed on a yearly basis.

10. Fraud Management Committee (FMC):

FMC shall be constituted to review the findings of the investigations done by FCU and to take appropriate actions thereupon.

Composition of FMC:

The FMC should atleast comprise of –

- Two Whole Time Directors

- President – Retail Business
- President – Bancassurance
- Chief Human Resources Officer

Head of the Department of the accused shall be invited at the meetings of the Committee without having any right to vote. In case a lady is summoned by the Committee then a lady employee of SM2 and above grade shall be co-opted as an observer. The Company Secretary and Chief Compliance Officer shall be the permanent invitees at the meetings of the Committee and inter-alia record the proceedings of the meeting and safe custody of said minutes ensuring its confidentiality.

The Committee shall be assisted by Vice President – Fraud Control Unit (employee at SM1grade or above) in discharging its duties.

Frequency of Meeting

The Committee shall meet atleast on a quarterly basis with a provision for seeking decision through circulation to decide on urgent cases. Such decisions shall be noted at the immediate next meeting of the Committee. The Committee shall be responsible inter-alia for effective implementation and to monitor and decide fraud cases.

Quorum:

The quorum for the meetings of the Committee shall be at least three members.

In case of Complaints against any members of FMC, the concerned member shall not attend the meetings of FMC wherein the subject matter is being discussed. Further, in case such matter requires investigation by FCU, the concerned member shall restrain from initiating any instruction to the FCU.

In case of Complaints against the Managing Director and Chief Executive Officer and other Whole-Time Directors, the same shall be reported to the Nomination and Remuneration Committee of Directors.

11. Handling of Frauds:

FCU shall be responsible for handling all Frauds that are reported to the Company. It shall take prompt and appropriate action with respect to such frauds to remediate the circumstances giving rise to occurrence of such frauds. While handling frauds, FCU shall be guided by directions issued by FMC.

12. Confidentiality and Non – Retaliation :

Under the Policy, every reasonable effort shall be made to ensure the confidentiality of the person who has reported the Fraud. The identity of those providing information shall be kept confidential in order to carry out an appropriate, fair and thorough investigation. If a fraud is reported anonymously, the person must provide credible and sufficient information to enable the FCU to investigate. The Company shall ensure that no retaliatory action is taken against any individual for reporting, in good faith, known or suspected Fraud.

13. Preventive Mechanism :

The Company shall inform both potential clients and existing clients about its anti-fraud policies. The Company shall appropriately include necessary caution in the insurance contracts/relevant documents, duly highlighting the consequences of submitting a false statements and/or incomplete statement for the benefit of the policyholders, claimants and the beneficiaries.

The Company shall periodically run appropriate awareness campaign against frauds for all its' employees.

A brief training on prevention of frauds shall be imparted to all new entrants during the induction training.

All employees shall be required to confirm their adherence to this Policy and declare any Conflict of Interest, once in a year.

14. Due diligence on the personnel and insurance agents and insurance intermediaries

The Company shall have requisitestandard operating procedures in place w.r.t. due diligence and empanelment of insurance agents and insurance intermediariesand should strictly abide by the same

Prior to empanelment of an insurance agent or entering into an agreement with any insurance intermediary, the Company shall carry out requisite due diligence taking into account factors such as security, business continuity, etc. wherever applicable.

The FCU may suggest documents/information(as indicated in AnnexureI)that may be collected from all/some or identified intermediaries (proposed to be empanelled), based on the judgement of the'Designated Person' (as authorized pursuant to IRDAI requirements).

In case of default, appropriate actionsshall be undertaken against the insurance agent / insurance intermediaries / TPA as per applicable IRDAI Regulations and terms of the agreement.

15. Reporting:

Based on the information provided by FCU and vetted by FMC, the Company shall submit report to IRDAI in forms FMR 1 and FMR 2 providing details of outstanding fraud cases and closed fraud cases every year within 30 days of the close of the financial year. The forms FMR 1 and FMR 2 is attached herewith as Annexure I & II respectively (as per the specific format stated in the IRDAI Circular)

Further, the above details shall be reported to Risk Management Committee of Directors / Board on a periodic basis and / or at least on an annual basis.

16. Applicability of the Policy :

The Policy shall be effective from the date of its approval by the Board. The Policy is to be read in conjunction with the Code of Conduct and Whistleblower Policy and is intended to supplement / compliment all applicable laws, rules and regulations and other corporate policies.

All employees shall confirm to having read and understood this Policy and not violated any of its provision, on an annual basis, in the form as may be advised by the HR Department. All new joiners shall adhere to this requirement also at the time of joining the Company.

Annexure I

The documents/information that may be collected from all/some or identified intermediaries

Insurance Agent:

Before recruiting an agent, below requisite documents as applicable from time to time shall be obtained

IRDAI Form - signed by proposed agent based on PAN:
Form IA (Fresh case)
Form IB (Composite case)
Form IA & IC (Transfer case)
Form IB & Form IC (Transfer+Composite case)

Other documents:

PAN card copy
Aadhaar card copy / Address proof
Education proof - 10th mark sheet(minimum)
Cancelled cheque
Photo & Signature

Corporate Agent:

Before entering into an arrangement with a Corporate Agent, following documents shall be obtained:

1. A written agreement shall be entered into between the Company and the Corporate Agent as required under and in terms of the provisions IRDAI (Registration of Corporate Agents) Regulations, 2015.Requisite stamp duty shall be paid on such agreement.

2. Copy of IRDAI registration certificate of the Corporate Agent, Corporate Agent's address proof and PAN card copy, Certificate from the Principal Officer Certificate and

3. Copy of Memorandum of Association and Articles of Association (MOA & AOA)

Third Party Administrator (TPA)

1. Only licensed Third Party Administrator shall be appointed to service Group Medical policies.
2. TPA shall issue personalized Identity Card along with the Guide Book to the insured. The Guide Book shall mention the various procedures to be followed by the Insured in the event of a claim.
3. Audits on TPAs shall be carried out once in 3 months with audit criteria as system audit, process audit and technical audit.