Why India needs ?

Insurance Frauds Control Act

IFI
INSURANCE FOUNDATION OF INDIA

Insurance Foundation of India
(A not for profit organization under Trust Registration Act, 1882)

Why India Needs?

Insurance Frauds Control Act

This Booklet is an outcome of what was discussed in "Training Programme on Insurance Frauds – How to Control it?"

This programme was organized by **Insurance Foundation of India** on 24 August 2018 at PHD House New Delhi and was attended by:

Participants From	Number	%age Wise
Insurance Companies	44	62%
Insurance Brokerage Firms	12	17%
Insurance Buyers	2	3%
Insurance Surveyors/ Loss Assessors	7	10%
Academics	6	8%
Total	**71**	

During detailed discussions it emerged that the facts about Insurance Frauds in India are:

- In our country Insurance Frauds figure during the year 2017-18 is estimated to be Rs 45000 Crores and the worrying point is that it is increasing at a rapid pace.
- On an average an insurance company loses 8.5% of its revenues to the frauds.
- Indian Regulatory Bodies as well as various government agencies, Insurance Companies are anxious to bring Insurance Frauds under control so that the benefits in the form of reduced premium to genuine insurance clients, higher profits to the company, and higher tax revenue can accrue to the Government. All of us know that this can be utilized for the growth of the Indian Economy and for the benefit of the masses.

The participants during discussions decided that we as NGO should take up the matter with the Authorities for bringing Insurance Frauds Control Act in the country so that growing Insurance Frauds can be controlled. Many participants volunteered with their time/effort/financial support in supporting this cause.

This Booklet is being sent to various:

- Prime Minister of India
- Chief Justice of India
- Ministers and Ministries of Government of India

- Members of Parliament
- Insurance Regulatory and Development Authority
- General Insurance Council
- Life Insurance Council
- All Insurance Companies
- All Reinsurance Companies/Branches
- Third party Administrators and Service Providers
- Insurance Ombudsman
- Chambers of Commerce & Industry
    - ❖ CII
    - ❖ FICCI
    - ❖ ASSOCHAM
    - ❖ PHD Chamber
- NGOs
- Insurance Brokers Association of India
- Institute of Insurance Surveyors & Loss Assessors
- Law Firms
- Various Insurance Agents Associations

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Insurance Foundation of India

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September 18, 2018

Shri Arun Jaitley
Hon'ble Finance Minister
Government of India
New Delhi – 110001

Sub: Insurance Fraud Control Act is needed to Control the Fraud Losses of Rs 45000 Crores being incurred by Indian Insurance Industry

Full Day Training Programme was conducted by Insurance Foundation of India on 24 August 2018 at PHD House, New Delhi. Participants came from all over India comprising from all spheres of

- Insurance Company's Senior Management/Managers responsible for Business Strategy/ Fraud Control/Claim settlement
- Finance, Audit, Internal Audit and Legal staff who support insurance practitioners in keeping watch on frauds
- Managers involved in the strategic overview of how to approach risk, fraud within the organization.
- Insurance Surveyors & Loss Assessors
- Third party Administrators and other Service Providers
- Insurance Brokerage Firms/Corporate Agents/Agents
- Law Firms

Participants From	Number	%age Wise
Insurance Companies	44	62%
Insurance Brokerage Firms	12	17%
Insurance Buyers	2	3%
Insurance Surveyors/ Loss Assessors	7	10%
Academics	6	8%
Total	**71**	

Faculty comprised of experts drawn from Industry/ Investigators/ Academics/ Forensic Experts (List Attached)

Discussions during the day resulted in realizing following facts:

1. According to the estimates in our country the Insurance Frauds have reached to a figure of Rs 45000 Crores per year and is increasing at a rapid pace. In other words, in India on an average every insurance company loses 8.5% of its revenues to the frauds.

2. Insurance Frauds can occur at any stage of an insurance transaction. Various stakeholders who may be connected with Insurance frauds are:

   - Insurer Employees
   - Insurance Intermediates and their employees
   - Insurance Brokerage Firm
   - Insurance Marketing Firm
   - Corporate Agents
   - Web Aggregators
   - Insurance Surveyors & Loss Assessors
   - Insurance Service Providers to Insurance Surveyors & Loss Assessors
   - Service providers to Insurance Companies
   - Automobiles Workshops
   - Health Care providers
   - Third Party Administrators
   - Insurance Clients (Corporates as well as Individuals)
   - Criminals in association with anti social elements

3. There is no specific provision in Indian penal code for insurance fraud. Only available sections that have some relevance are:
   - Section 205 - False personation for purpose of act or proceeding in suit or prosecution
   - Section 420 - Cheating and dishonestly inducing delivery of property
   - Section 464 - Making a false document including signs and seals and forgery
   - Section 405 - Criminal breach of trust.

4. It is realized that the damage due to leakages on account of frauds is not limited to insurance companies but is ultimately borne by the common insured persons since the premium rates are set higher in the following year to offset the losses of last year. If we can contain the loss due to frauds, insurance companies, both in the life and non-life segments can reduce premium rates which will be of great benefit to Crores of policy holders.

5. Experts and participants felt that Central and State governments should seriously think of having specific laws to counter insurance frauds and setting up of Insurance Fraud Bureaus (IFBs). Reporting to external bodies such as IRDA, Medical Council of India and Corporate Human Resources Departments should

be explored. A new legal framework is needed since the Indian Insurance Act does not contain definition of 'Insurance Fraud'. Neither does India have specific laws connected to insurance frauds which are spelt out in the Indian Penal Code (IPC). Also, the Indian Contracts Act 1872 does not have any specific laws pertaining to Insurance frauds. Governments should make provision so that just as banks can determine the creditworthiness of an individual through credit information agencies like CIBIL, insurers in future may be able to get details of an individual's insurance history and his claims records whenever they get a new proposal

6. The Indian Insurance Industry should be an active participant in this exercise. Insurers need to put in place strong Fraud Investigation Teams with the right credentials that work in tandem with law enforcement agencies to weed out fraudulent claims. It is also important for industry to build a shared or centralized database to share information related to frauds. This data should include fraud patterns and case studies, fraud customer list and intermediaries, fraudulent providers and investigators,

We are attaching the following:

- Research Paper prepared by **Shri Sandeep Malik**, Independent Insurance Management Consultant. This document was the discussion document in the programme on 24 August,2018.
- Copy of "**New Jersey Insurance Fraud Prevention Act**" from one of the states of USA. They have such an Act at State Level.

We are ready to meet you to discuss this suggestion. You may also like to invite representatives from:

- Insurance Regulatory and Development Authority Hyderabad
- Few Life Insurance Companies
- Few General Insurance Companies
- Few Health Insurance Companies
- Lawyers
- NGOs
- Police Officials, who are specializing in Fraud Cases

Best Regards

S. K. Sethi
Vice President
Insurance Foundation of India

Full Day Training Programme
"Insurance Frauds - How to Control it?"

Date: Friday, 24 August 2018

Place: PHD House, New Delhi

List of Faculty

S.No.	Name of Speakers	Designation	Organization
1	Mr. G.V.H.V Prasad	Director	Truth Labs, Hyderabad
2	Mr. S.G. Afzal Biya Bani	Senior Insurance Specialist	Al-Muhaidib Corporate, Saudi Arabia
3	Mr. Thondup Tshering	Vice President, North	Futurisk Insurance Broking Pvt Ltd
4	Mr. Mathivanan Raj	Insurance claims Investigator	Insurance Claims Investigator
5	Ms. Neha Vikas Varsheney	Investigator for Health/ Life Insurance Claims.	V – India Investigators International
6	Mr. Sameer Nandwani	Advocate and Legal Consultant Supreme Court Of India	Nandwani & Associates Law Firm
7	Mr. Sandeep Malik	Insurance & Risk Management Consultant	Independent Consultant Specializing in Claims
8	Mr. Naveen Tandon	Vice President – Motor, HDFC ERGO General Insurance Company	HDFC ERGO General Insurance Company Ltd
9	Mr. R R Grover	Chief Advisor, Insurance Foundation of India	Former Advisor, Amity School of Insurance, Banking & Actuarial Sc., Amity University
10	Mr. Anshul Srivastav	Chief Information Officer & Digital Officer	Union Insurance UAE and Oman
11	Mr. Nirmal Paul	Head-FPU	Bajaj Allianz Life Insurance, Pune

INSURANCE ANTI FRAUD LAWS – AN INEVITABLE & URGENT NEED

BY
Shri. SANDEEP MALIK

Independent Insurance & Risk Management Consultant

INSURANCE ANTI FRAUD LAWS – AN INEVITABLE & URGENT NEED

Insurance fraud has existed since the beginning of insurance as a commercial enterprise. **Insurance fraud** is so ancient and some preventative measures date back to Middle Ages. Back then, non-compliance with ethical rules could trigger extremely stiff sanctions. Prevention measures were then gradually introduced. In 1380 compulsory excess was introduced so as to protect goods whereas in 1435 an ordinance prohibited the insurance of the same product several times.

Fraudulent claims account for a significant portion of all claims received by insurers, and cost billions of dollars annually across the globe. Insurance frauds pose a significant problem, and governments and other organizations are making efforts to deter such fraudulent activities which affect the lives of innocent people, both directly through accidental or intentional injury or damage, and indirectly as these crimes cause insurance premiums going higher every year. Honest customers should not have to pay the price for fraudsters through higher premiums.

Those who commit insurance fraud view it as a low-risk, lucrative enterprise. Even drug dealers have entered in the insurance fraud arena thinking it as a safer and more profitable than working at street corners. Compared to other crimes, court sentences for insurance fraud are lenient, reducing the risk of severe or extended punishment. Though insurers try to fight fraud but end up paying many suspicious claims as it is often cheaper than a legal action which is anyway not adeterrent. It is hard to place an exact value on the money stolen through insurance frauds as it is deliberately undetectable, unlike visible crimes such as robbery or murder. As such, the number of cases of insurance fraud that are detected is much lower than the number of acts that are actually committed.

Only an estimate for the losses that insurers across the world suffer due to insurance frauds can best be provided. As per various studies, it is roughly estimated that due to insurance frauds annually a total of about $80 billion to $100 billion is lost in the United States, $ 4 billion in Australia, $ 3 billion in UK, $ 2 billion - $ 3 billion in other European countries and almost $ 2 billion in India. In percentage terms most of the Insurers loose anything between 10% to 15% across all lines of business, whereas the Health Insurance Frauds reach a level of even 30% to 35%.The global economic slowdown, combined with advances in technology and global corporate competitiveness, has raised a storm for all the elements of the fraud triangle — pressure, opportunity and rationalization — to proliferate in today's economic environment.

Fraud risk poses a very big challenge for the insurance sector. Business leaders are aware of the need to address this risk, but the lack of a comprehensive and integrated approach to fraud risk management continues to be a concern. The increasing number of frauds and the growing degree of risk necessitates that insurance companies regularly review their policies, build in checks and use new and advanced technology to avoid such issues. Organizations are waking up to the fact that frauds are driving up the overall costs of insurers and premiums for policyholders, which may threaten their viability and also have a bearing on their profitability. However, no system can be foolproof, but a proactive and dynamic approach can make a company ready to counter fraudsters and gain an edge over its competitors. Hence, companies need a more vigorous fraud management framework.

Fraud impacts organizations in several areas including financially, operationally and psychologically. While the monetary loss due to fraud is significant, its full impact of fraud on an organization can be staggering. Its loss of reputation, goodwill and customer relations can be devastating. As fraud can be perpetrated by any employee within an organization or by those outside it, it is important for companies to have an effective fraud management program in place to safeguard their assets and reputation. Fraud can be perpetrated in many ways. Therefore, an insurer should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk. For an insurance organization, its fraud management strategy should form part of its business strategy and be consistent with its overall mission and objectives. To discover fraud, it is critical to establish the appropriate source and implement the medium to make the process robust and effective. Some of the areas that a good fraud risk management process should cover include: • A well-defined whistle-blowing policy • Periodic fraud risk assessments • A pre-employment screening • Vendor background checks • strong internal audit.

Internationally, national and local governments, especially in the last half of the twentieth century, have recognized insurance fraud as a serious crime, and have made efforts to punish and prevent this practice:

United States of America: Insurance Fraud is specifically classified as a crime in all states. More than 19 states require mandatory Insurer fraud plans. This requires companies to form programs to combat fraud and in some cases to develop investigation units to detect frauds. 41 states have their own Insurance Fraud Bureaus. These are law enforcement agencies where “investigators review fraud reports and begin the prosecution process. Frauds related to their health care benefit program, can lead to afine under the law or imprisonment upto 10 years, or both. If the fraud results in bodily injury, the violator may be imprisoned up to 20 years, and if the fraud results in death on any person then the violator may be imprisoned for life.

Canada: The Insurance Crime Prevention Bureau was founded in 1973 to help fight insurance fraud. This organization collects information on insurance fraud, and also carries out investigations. Approximately one third of these investigations result in criminal conviction, one third result in denial of the claim, and one third result in payment of the claim.

United Kingdom: The Fraud Act 2006 specifically defines fraud as a crime. This act also defines the penalties for fraud as imprisonment up to ten years, a fine, or both. Insurance Fraud Bureau (IFB) focuses on detecting and preventing organized and cross-industry insurance fraud. The IFB leads or co-ordinates the industry response to the identification of criminal fraud networks and works closely with the police and other law enforcement agencies. There is Insurance Fraud Enforcement Department (IFED) which is funded by insurers.

Denmark: Insurers are urged to report every documented fraud to the police. F&P organizes exercises at the Danish Police Academy on how to combat insurance fraud. Former police officers are often employed in the insurance industry to assist with detection and evidence-gathering.

India: There is no specific provision in Indian penal code for insurance fraud. Only available sections that have some relevance are:

1. Section 205 - False personation for purpose of act or proceeding in suit or prosecution
2. Section 420 - Cheating and dishonestly inducing delivery of property
3. Section 464 - Making a false document including signs and seals and forgery
4. Section 405 - Criminal breach of trust

All these legal provisions are not adequate to prosecute a fraudster legally under the current scenario of organised insurance frauds. Due to the mounting backlog of pending cases in the judicial machinery of our state, taking legal action against fraud is not a common occurrence and fraud of amounts not big enough are let go off as opposed to the heavy investment of time and energy in pursuing the same. Even if legal remedies are taken or help of the court is availed due to various reasons and the design and process of the law sometimes make the recovery of the money lost by fraud a rare occurrence.

Government should make provisions so that just as banks can determine the creditworthiness of an individual by querying the Credit Information Bureau of India (CIBIL), insurers in future may be able to get details of an individual's insurance history and his claims records whenever they get a new proposal.

Conclusion

As India's insurance industry matures, fraud risk management is going to be a major concern for insurers and business leaders. Insurers will need to continuously reassess their processes and policies to manage and mitigate the risk of fraud. Fraud risk in the insurance value chain can emanate from internal and external factors. The risk of employees misusing confidential information and colluding with fraudsters is on the rise and insurers will need to put in place internal checks and balances to minimize such issues. External fraud risk can arise at various stages, e.g., registration of clients, underwriting, reinsurance and the claims process. The severity of fraud can range from a slight exaggeration to deliberately causing loss of insured assets.

Insurers need to put in place fraud investigation teams (with the right credentials) that work in tandem with law enforcement agencies to weed out fraudulent claims. It is also important for the industry to build a shared or centralized database to share information related to frauds. The overall impact of frauds is a significant cost for the industry as well for policyholders. The question, “Who owns fraud?” To address this issue, we need more proactive plans that are “real” and include training of employees, vetting of vendors, as well as testing of controls and executive sponsorship from the top down. Today, when India’s insurance industry is working toward reducing costs, one of its main focus areas to control or reduce costs is by proactively arresting fraud, which can be achieved through an effective Fraud Risk Assessment (FRA) program& having Special Investigating Units (SIU) in each organisation.

Sharing of knowledge and data should be amongst all insurers, regulator &more prevalent with the victims of fraudulent insurance claims, this data should include fraud patterns and case studies, fraud customer list and intermediaries, fraudulent providers and investigators etc. Insurers can be transparent about this and operate in compliance with data protection and privacy requirements. Most importantly awareness should be brought about the due legal process to be followed before reporting a case. Reporting to external bodies such as Medical Council of India, IRDA, and corporate Human Resources can also be explored.

The Central & State Governments shall also have to seriously think about having specific laws to counter the Insurance Frauds & setting up of Insurance Fraud Bureaus (IFB). It is required as the Indian Insurance Act does not contain definition for ‘insurance fraud’. Neither we have any specific laws connected to insurance frauds which are spelled out in the Indian Penal Code,1860(IPC). The Indian Contract Act,1872 (ICA) also doesn’t have any specific laws pertaining to insurance frauds. Even though sections related to forgery or fraudulent acts can be applied in the IPC, it does not succeed to deter the commission of the frauds.

There has been a growing instance of fraudulent insurance claims and the Supreme Court also in January 2017 has stressed on the need for framing guidelines with the suggestions of the states and the insurance companies to rule out such cases. In some cases, claims are also filed wrongly under different acts. It is important to evolve an efficient legal framework and take recourse to the existing one as well to prevent such plunder of the money of the public.

Sandeep Malik

This is a Specimen of
“New Jersey Insurance Fraud Prevention Act”

From one of the State of USA. They Have such an Act at State Level

§ 17:33A-1. Short title

This act shall be known and may be cited as the "New Jersey Insurance Fraud Prevention Act."

§ 17:33A-2. Purpose of act

The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.

§ 17:33A-3. Definitions

As used in this act:

"Attorney General" means the Attorney General of New Jersey or his designated representatives.

"Commissioner" means the Commissioner of Banking and Insurance.

"Director" means the Director of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance.

"Division" means the Division of Insurance Fraud Prevention established by this act.

"Hospital" means any general hospital, mental hospital, convalescent home, nursing home or any other institution, whether operated for profit or not, which maintains or operates facilities for health care.

"Insurance company" means:

a. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to Subtitle 3 of Title 17 of the Revised Statutes (*C.17:17-1* et seq.), or Subtitle 3 of Title 17B of the New Jersey Statutes (*C.17B:17-1* et seq.);

b. Any medical service corporation operating pursuant to P.L.1940, c.74 (*C.17:48A-1* et seq.);

c. Any hospital service corporation operating pursuant to P.L.1938, c.366 (*C.17:48-1* et seq.);

d. Any health service corporation operating pursuant to P.L.1985, c.236 (*C.17:48E-1* et seq.);

e. Any dental service corporation operating pursuant to P.L.1968, c.305 (*C.17:48C-1* et seq.);

f. Any dental plan organization operating pursuant to P.L.1979, c.478 (*C.17:48D-1* et seq.);

g. Any insurance plan operating pursuant to P.L.1970, c.215 (*C.17:29D-1*);

h. The New Jersey Insurance Underwriting Association operating pursuant to P.L.1968, c.129 (*C.17:37A-1* et seq.);

i. The New Jersey Automobile Full Insurance Underwriting Association operating pursuant to P.L.1983, c.65 (*C.17:30E-1* et seq.) and the Market Transition Facility operating pursuant to section 88 of P.L.1990, c.8 (*C.17:33B-11*); and

j. Any risk retention group or purchasing group operating pursuant to the "Liability Risk Retention Act of 1986," *15 U.S.C. 3901* et seq.

"Pattern" means five or more related violations of P.L.1983, c.320 (*C.17:33A-1* et seq.). Violations are related if they involve either the same victim, or same or similar actions on the part of the person or practitioner charged with violating P.L.1983, c.320 (*C.17:33A-1* et seq.).

"Person" means a person as defined in *R.S.1:1-2*, and shall include, unless the context otherwise requires, a practitioner.

"Principal residence" means that residence at which a person spends the majority of his time. Principal residence may be an abode separate and distinct from a person's domicile. Mere seasonal or weekend residence within this State does not constitute principal residence within this State.

"Practitioner" means a licensee of this State authorized to practice medicine and surgery, psychology, chiropractic, or law or any other licensee of this State whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

"Producer" means an insurance producer as defined in section 2 of P.L.1987, c.293 (*C.17:22A-2*), licensed to transact the business of insurance in this State pursuant to the provisions of the "New Jersey Insurance Producer Licensing Act," P.L.1987, c.293 (*C.17:22A-1* et seq.).

"Statement" includes, but is not limited to, any application, writing, notice, expression, statement, proof of loss, bill of lading, receipt, invoice, account, estimate of property damage, bill for services, diagnosis, prescription, hospital or physician record, X-ray, test result or other evidence of loss, injury or expense.

§ 17:33A-4. Violations

a. A person or a practitioner violates this act if he:

(1) Presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (*C.39:6-61* et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or

(2) Prepares or makes any written or oral statement that is intended to be presented to any insurance company, the Unsatisfied Claim and Judgment Fund or any claimant thereof in connection with, or in support of or opposition to any claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (*C.39:6-61* et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or

(3) Conceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to (a) any insurance benefit or payment or (b) the amount of any benefit or payment to which the person is entitled;

(4) Prepares or makes any written or oral statement, intended to be presented to any insurance company or producer for the purpose of obtaining:

(a) a motor vehicle insurance policy, that the person to be insured maintains a principal residence in this State when, in fact, that person's principal residence is in a state other than this State; or

(b) an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract; or

(5) Conceals or knowingly fails to disclose any evidence, written or oral, which may be relevant to a finding that a violation of the provisions of paragraph (4) of this subsection a. has or has not occurred.

b. A person or practitioner violates this act if he knowingly assists, conspires with, or urges any person or practitioner to violate any of the provisions of this act.

c. A person or practitioner violates this act if, due to the assistance, conspiracy or urging of any person or practitioner, he knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this act.

d. A person or practitioner who is the owner, administrator or employee of any hospital violates this act if he knowingly allows the use of the facilities of the hospital by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this act.

e. A person or practitioner violates this act if, for pecuniary gain, for himself or another, he directly or indirectly solicits any person or practitioner to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action, against any person, for damages for negligence, or, for pecuniary gain, for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, or for pecuniary gain, for himself or another, directly or indirectly solicits other persons to make a claim for personal injury protection benefits pursuant to P.L.1972, c.70 (*C.39:6A-1* et seq.); provided, however, that this subsection shall not apply to any conduct otherwise permitted by law or by rule of the Supreme Court.

§ 17:33A-5. Remedies; penalties; fund established

a. Whenever the commissioner determines that a person has violated any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.), the commissioner may either:

(1) bring a civil action in accordance with subsection b. of this section; or

(2) levy a civil administrative penalty and order restitution in accordance with subsection c. of this section.

In addition to or as an alternative to the remedies provided in this section, the commissioner may request the Attorney General to bring a criminal action under applicable criminal statutes. Additionally, nothing in this section shall be construed to preclude the commissioner from referring the matter to appropriate state licensing authorities, including the insurance producer licensing section in the Department of Banking and Insurance, for consideration of licensing actions, including license suspension or revocation.

b. Any person who violates any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.) shall be liable, in a civil action brought by the commissioner in a court of competent jurisdiction, for a penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $ 15,000 for each subsequent violation. The penalty shall be paid to the commissioner to be used in accordance with subsection e. of this section. The court shall also award court costs and reasonable attorneys' fees to the commissioner.

c. The commissioner is authorized to assess a civil and administrative penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $ 15,000 for each subsequent violation of any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.) and to order restitution to any insurance company or other person who has suffered a loss as a result of a violation of P.L.1983, c.320 (*C.17:33A-1* et seq.) . No assessment shall be levied pursuant to this subsection until the violator has been notified by certified mail or personal service. The notice shall contain a concise statement of facts providing the basis for the determination of a violation of P.L.1983, c.320 (*C.17:33A-1* et seq.), the provisions of that act violated, a statement of the amount of civil penalties assessed and a statement of the party's right to a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (*C.52:14B-1* et seq.). The noticed party shall have 20 calendar days from receipt of the notice within which to deliver to the commissioner a written request for a hearing containing an answer to the statement of facts contained in the notice. After the hearing and upon a finding that a violation has occurred, the commissioner may issue a final order assessing up to the amount of the penalty in the notice, restitution, and costs of prosecution, including attorneys' fees. If no hearing is requested, the notice shall become a final order after the expiration of the 20-day period. Payment of the assessment is due when a final order is issued or the notice becomes a final order.

Any penalty imposed pursuant to this subsection may be collected with costs in a summary proceeding pursuant to "the penalty enforcement law," *N.J.S.2A:58-1* et seq. The Superior Court shall have jurisdiction to enforce the provisions of the "the penalty enforcement law" in connection with P.L.1983, c.320 (*C.17:33A-1* et seq.). Any penalty collected pursuant to this subsection shall be used in accordance with subsection e. of this section.

d. Nothing in this section shall be construed to prohibit the commissioner and the person or practitioner alleged to be guilty of a violation of this act from entering into a written agreement in which the person or practitioner does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may contain a provision that it shall not be used in a subsequent civil or criminal proceeding relating to any violation of this act, but notification thereof shall be made to a licensing authority in the same manner as required pursuant to subsection c. of section 10 of P.L.1983, c.320 (*C.17:33A-10*). The existence of a consent agreement under this subsection shall not preclude any licensing authority from taking appropriate administrative action against a licensee over which it has regulatory authority, nor shall such a consent agreement preclude referral to law enforcement for consideration of criminal prosecution.

e. The New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility Auxiliary Fund (hereinafter referred to as the "fund") is established as a nonlapsing, revolving fund into which shall be deposited all revenues from the civil penalties imposed pursuant to this section. Interest received on moneys in the fund shall be credited to the fund. The fund shall be administered by the Commissioner of Banking and Insurance and shall be used to help defray the operating expenses of the New Jersey Automobile Full Insurance Underwriting Association created pursuant to P.L.1983, c.65 (*C.17:30E-1* et seq.) or shall be used to help defray the operating expenses of the Market Transition Facility created pursuant to section 88 of P.L.1990, c.8 (*C.17:33B-11*).

§ 17:33A-5.1. Surcharge for insurance fraud

In addition to any other penalty, fine or charge imposed pursuant to law, a person who is found in any legal proceeding to have committed insurance fraud shall be subject to a surcharge in the amount of $ 1,000. If a person is charged with insurance fraud in a legal proceeding and the charge is resolved through a settlement requiring the person to pay a sum of money, the person shall be subject to a surcharge in an amount equal to 5 percent of the settlement payment. The amount of any surcharge under this section shall be payable to the Treasurer of the State of New Jersey for use by the Department of Banking and Insurance to fund the department's insurance fraud prevention programs and activities.

§ 17:33A-6. Statement on insurance claim forms

a. Insurance claim forms shall contain a statement in a form approved by the commissioner that clearly states in substance the following: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

b. (Deleted by amendment, P.L.1987, c.342.)

c. Insurance application forms shall contain a statement in a form approved by the commissioner that clearly states in substance the following: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

17:33A-7. Actions by insurance companies against violators

a. Any insurance company damaged as the result of a violation of any provision of this

act may sue therefor in any court of competent jurisdiction to recover compensatory damages, which shall include reasonable investigation expenses, costs of suit and attorneys fees.

b. A successful claimant under subsection a. shall recover treble damages if the court determines that the defendant has engaged in a pattern of violating this act.

c. A claimant under this section shall mail a copy of the initial claim, amended claim, counterclaims, briefs and legal memoranda to the commissioner at the time of filing of such documents with the court wherein the matter is pending. A successful claimant shall report to the commissioner, on a form prescribed by the commissioner, the amount recovered and such other information as is required by the commissioner.

d. Upon receipt of notification of the filing of a claim by an insurer, the commissioner may join in the action for the purpose of seeking judgment for the payment of a civil penalty authorized under section 5 of this act. If the commissioner prevails, the court may also award court costs and reasonable attorney fees actually incurred by the commissioner.

e. No action shall be brought by an insurance company under this section more than six years after the cause of action has accrued.

§ 17:33A-8. Division of Insurance Fraud Prevention

a. There is established in the Department of Insurance the Division of Insurance Fraud Prevention. The division shall assist the commissioner in administratively investigating allegations of insurance fraud and in developing and implementing programs to prevent insurance fraud and abuse. The division shall promptly notify the Attorney General of any insurance application or claim which involves criminal activity. When so required by the commissioner and the Attorney General, the division shall cooperate with the Attorney General in the investigation and prosecution of criminal violations.

b. The commissioner shall appoint the full-time supervisory and investigative personnel of the division, including the director, who shall hold their employment at the pleasure of the commissioner without regard to the provisions of Title 11A of the New Jersey Statutes and shall receive such salaries as the commissioner from time to time designates, and who shall be qualified by training and experience to perform the duties of their position.

c. When so requested by the commissioner, the Attorney General may assign one or more deputy attorneys general to assist the division in the performance of its duties.

d. The commissioner shall also appoint the clerical and other staff necessary for the division to fulfill its responsibilities under this act. The personnel shall be employed subject to the provisions of Title 11A of the New Jersey Statutes, and other applicable statutes.

e. The commissioner shall appoint an insurance fraud advisory board consisting of eight representatives from insurers doing business in this State. The members of the board shall serve for two year terms and until their successors are appointed and qualified. The members of the board shall receive no compensation. The board shall advise the commissioner with respect to the implementation of this act, when so requested by the commissioner.

f. The Director of the Division of Budget and Accounting in the Department of the Treasury shall, on or before September 1 in each year, ascertain and certify to the commissioner the total amount of expenses incurred by the State in connection with the administration of this act during the preceding fiscal year, which expenses shall include, in addition to the direct cost of personal service, the cost of maintenance and operation, the cost of retirement contributions made and the workers' compensation paid for and on account of personnel, rentals for space occupied in State owned or State leased buildings and all other direct and indirect costs of the administration thereof.

g. The commissioner shall, on or before October 15 in each year, apportion the amount so certified to him among all of the companies writing the class or classes of insurance described in Subtitle 3 of Title 17 of the Revised Statutes (*C.17:17-1* et seq.), and Subtitle 3 of Title 17B of the New Jersey Statutes (*C.17B:17-1* et seq.), within this State in the proportion that the net premiums received by each of them for such insurance written or renewed on risks within this State during the calendar year immediately preceding, as reported to him, bears to the sum total of all such net premiums received by all companies writing that insurance within the State during the year, as reported, except that no one company shall be assessed for more than 5% of the amount apportioned. The commissioner shall certify the sum apportioned to each company on or before November 15 next ensuing, and to the Division of Taxation in the Department of the Treasury. Each company shall pay the amount so certified as apportioned to it to the said Division of Taxation on or before December 31 next ensuing, and the sum paid shall be paid into the State Treasury in reimbursement to the State for the expenses paid.

"Net premiums received" means gross premiums written, less return premiums thereon and dividends credited or paid to policyholders.

h. The total appropriations recoverable under this section for the operation of the division shall not exceed $ 500,000.00 during its first full fiscal year of operation.

§ 17:33A-9. Alleged violations; civil liability; records

a. Any person who believes that a violation of this act has been or is being made shall notify the division immediately after discovery of the alleged violation of this act and shall send to the division, on a form and in a manner prescribed by the commissioner, the information requested and such additional information relative to the alleged violation as the division may require. The division shall review the reports and select those alleged violations as may require further investigation. It shall then cause an independent examination or evaluation of the facts surrounding the alleged violation to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists.

b. No person shall be subject to civil liability for libel, violation of privacy or otherwise by virtue of the filing of reports or furnishing of other information, in good faith and without malice, required by this section or required by the division as a result of the authority conferred upon it by law.

c. The commissioner may, by regulation, require insurance companies licensed to do business in this State to keep such records and other information as he deems necessary for the effective enforcement of this act.

17:33A-10. Subpena powers; violations by persons licensed by State

a. If the division has reason to believe that a person has engaged in, or is engaging in, an act or practice which violates this act, or any other relevant statute or regulation, the commissioner or his designee may administer oaths and affirmations, request or compel the attendance of witnesses or the production of documents. The commissioner may issue, or designate another to issue, subpenas to compel the attendance of witnesses and the production of books, records, accounts, papers and documents. Witnesses who are not licensees of the Department of Banking and Insurance shall be entitled to receive the same fees and mileage as persons summoned to testify in the courts of the State.

If a person subpenaed pursuant to this section shall neglect or refuse to obey the command of the subpena, a judge of the Superior Court may, on proof by affidavit of service of the subpena, of payment or tender of the fees required and of refusal or neglect by the person to obey the command of the subpena, issue a warrant for the arrest of said person to bring him before the judge, who is authorized to proceed against the person as for a contempt of court.

b. If matter that the division seeks to obtain by request is located outside the State, the person so required may make it available to the division or its representative to examine the matter at the place where it is located. The division may designate representatives, including officials of the state in which the matter is located, to inspect the matter on its behalf, and it may respond to similar requests from officials of other states.

c. If (1) a practitioner, (2) an owner, administrator or employee of any hospital, (3) an insurance company, agent, broker, solicitor or adjuster, or (4) any other person licensed by a licensing authority of this State, or an agent, representative or employee of any of them is found to have violated any provision of this act, the commissioner or the Attorney General shall notify the appropriate licensing authority of the violation so that the licensing authority may take appropriate administrative action. The licensing authority shall report quarterly to the commissioner through the Division of Insurance Fraud Prevention about the status of all pending referrals.

§ 17:33A-11. Handling of documents, records of investigations

Papers, documents, reports, or evidence relative to the subject of an investigation under this act shall not be subject to public inspection except as specifically provided in this act. The commissioner shall not detain subpenaed records after an investigation is closed or, if a claim for a civil penalty is filed by the commissioner pursuant to section 5 or subsection d. of section 7, upon final disposition of the claim by a court of competent jurisdiction, whichever shall be the later date. Subpenaed records shall be returned to the persons from whom they were obtained. The commissioner may, in his discretion, make relevant papers, documents, reports, or evidence available to the Attorney General, an appropriate licensing authority, law

enforcement agencies, an insurance company or insurance claimant injured by a violation of this act, consistent with the purposes of this act and under such conditions as he deems appropriate. Such papers, documents, reports, or evidence shall not be subject to subpena, unless the commissioner consents, or until, after notice to the commissioner and a hearing, a court of competent jurisdiction determines that the commissioner would not be unnecessarily hindered by such subpena. Division investigators and insurance company fraud investigators shall not be subject to subpena in civil actions by any court of this State to testify concerning any matter of which they have knowledge pursuant to a pending insurance fraud investigation by the division, or a pending claim for civil penalties initiated by the commissioner.

§ 17:33A-12. Regulations

The commissioner may promulgate such regulations as he deems necessary for the effective implementation of this act.

§ 17:33A-13. Annual report on activities and cost effectiveness

The commissioner shall report annually to the Senate Labor, Industry and Professions Committee and the Assembly Banking and Insurance Committee as to the activities of the division and the cost effectiveness of the programs established by the division.

§ 17:33A-14. Criminal prosecution

The imposition of any fine or other remedy under this act shall not preclude prosecution for a violation of the criminal law of this State.

§ 17:33A-15. Filing of plan for prevention, detection of fraudulent health, auto insurance claims

a. Every insurer writing health insurance or private passenger automobile insurance in this State shall file with the commissioner a plan for the prevention and detection of fraudulent insurance applications and claims. The plan shall be deemed approved by the commissioner if not affirmatively approved or disapproved by the commissioner within 90 days of the date of filing. The commissioner may call upon the expertise of the director in his review of plans filed pursuant to this subsection. The commissioner may request such amendments to the plan as he deems necessary. Any subsequent amendments to a plan filed with and approved by the commissioner shall be submitted for filing and deemed approved if not affirmatively approved or disapproved within 90 days from the filing date.

b. The implementation of plans filed and approved pursuant to subsection a. of this section shall be monitored by the division. The division shall promptly notify the Attorney General of any evidence of criminal activity encountered in the course of monitoring the implementation and execution of the plans. Each insurer writing health insurance or private passenger automobile insurance in this State shall report to the director on an annual basis, on January 1st of each year, on the experience in implementing its fraud prevention plan.

c. In addition to any other penalties provided pursuant to P.L.1983, c.320 (*C.17:33A-1* et seq.), the commissioner may impose a penalty of up to $ 25,000 per violation on any insurer for: failure to submit a plan; failure to submit any amendments to an approved plan; failure to properly implement an approved plan in a reasonable manner and within a reasonable time period; failure to provide a report pursuant to subsection b. of this section; or for any other violation of the provisions of this section.

d. For the purposes of this section, "insurer" means an insurance company as defined in subsections a., b., c., d., e., and f. of section 3 of P.L.1983, c.320 (*C.17:33A-3*).

§ 17:33A-16. Office of the Insurance Fraud Prosecutor

There is established in the Division of Criminal Justice in the Department of Law and Public Safety the Office of the Insurance Fraud Prosecutor. The Insurance Fraud Prosecutor shall be appointed by, and serve at the pleasure of, the Governor with the advice and consent of the Senate and be under the direction and supervision of the Attorney General. Any person appointed as Insurance Fraud Prosecutor shall have had prosecutorial experience, including experience in the litigation of civil and criminal cases. The Attorney General shall establish standards of performance for the Office of Insurance Fraud Prosecutor, which shall include standards of accountability.

§ 17:33A-17. Appointment; transfer of personnel

The Attorney General may appoint such personnel, including attorneys and clerical personnel, as necessary to carry out the duties of the office. The personnel charged with investigatory work in the Division of Insurance Fraud Prevention in the Department of Banking and Insurance shall be transferred to the Office of the Insurance Fraud Prosecutor as determined by the Commissioner of Banking and Insurance and the Attorney General, in accordance with a plan of reorganization, and shall become the Fraud Investigatory Section of the Office of the Insurance Fraud Prosecutor. Personnel transferred from the Division of Insurance Fraud Prevention in the Department of Banking and Insurance to the Office of the Insurance Fraud Prosecutor pursuant to this section and any such reorganization plan shall be

transferred with all tenure rights and any rights or protections provided by Title 11A of the New Jersey Statutes or other applicable statutes, as provided in section 8 of P.L.1983, c.320 (*C.17:33A-8*), and any pension law or retirement system.

§ 17:33A-18. Establishment of liaison between office, other departments; responsibilities

a. A section of the Office of Insurance Fraud Prosecutor shall be designated to be responsible for establishing a liaison and continuing communication between the office and the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, every county prosecutor's office, such local government units as may be necessary or practicable and insurers.

b. The section of the office responsible for such liaison shall establish procedures: (1) for receiving notice from all entities enumerated in subsection a. of this section of any case in which fraud is suspected or has been substantiated; (2) for receiving referrals for the investigation of alleged fraud; (3) for receiving referrals for the prosecution of fraud by the office; (4) for receiving and referring information regarding cases, administrative or otherwise, under investigation by any department or other entity to the appropriate authority; and (5) for providing information to and coordinating information among any referring entities on pending cases of insurance fraud which are under investigation or being litigated or prosecuted. The liaison section of the office shall maintain a record of every referral or investigation.

§ 17:33A-19. Duties of Insurance Fraud Prosecutor

The Insurance Fraud Prosecutor shall investigate and, if warranted, prosecute, cases referred to it by insurers, State agencies, or county and municipal governments. The Insurance Fraud Prosecutor may assist county prosecutors in the investigation and prosecution of fraud, and shall give county prosecutors access to the data base maintained pursuant to section 38 of this amendatory and supplementary act.

§ 17:33A-20. Establishment of Statewide fraud enforcement policy

The Attorney General shall, in consultation with county prosecutors, establish a Statewide fraud enforcement policy for all State and local agencies, including guidelines for the investigation and prosecution of fraud, which shall include standards for detecting fraud, for the investigation of alleged fraud and standards for the submission of cases for prosecution. Priorities shall be established among the cases referred to the office for prosecution or other litigation and the office shall assist referring entities in establishing priorities among investigations or cases to be disposed

of by the entities themselves. The Insurance Fraud Prosecutor shall prosecute criminal cases, litigate civil cases as appropriate, or assist county prosecutors in prosecuting criminal cases in accordance with the guidelines and priorities so established.

§ 17:33A-21. Standards of performance for Fraud Investigatory Section.

Standards of performance shall be established for the Fraud Investigatory Section, which shall include, but not to be limited to, recording the cases referred by insures, local government agencies and others which are assigned to the Fraud Investigatory Section, investigatory Section, investigating cases of alleged fraud in accordance with te priorities established by the Insurance Fraud Prosecutor, recording the disposition of the cases referred to the section, and making recommendations to the Insurance Fraud Prosecutor as to any procedural, regulatory, or statutory changes which may be necessary to carry out the provisions of this amendatory and supplementary act.

§ 17:33A-22. Maintenance of data base; reporting of claims information

a. The Insurance Fraud Prosecutor shall maintain a data base which includes referrals, reports of fraud investigations, prosecution, or litigation, and the results of such proceedings, which shall include: (1) identification of the referring entity; (2) type of fraud; (3) disposition of case; and (4) such other data as may be necessary to the work of the office and the referring entities.

b. The Insurance Fraud Prosecutor shall provide for the reporting of claims information by insurers writing at least $ 2,000,000 in direct insurance premiums in any calendar year, in a standard reporting form, which shall include, but shall not be limited to, information on stolen vehicles, including the owners of such vehicles, information on automobile accidents, including date and location of accidents, persons involved in accidents, the kinds of injuries sustained in accidents and treating health care providers, for the purpose of identifying patterns of possible fraudulent activity, which information shall be shared with county prosecutors, local law enforcement officials, and the New Jersey State Police. Every insurer shall submit the data required by the Insurance Fraud Prosecutor for all claims closing with payment during a period established by the Insurance Fraud Prosecutor.

§ 17:33A-23. Access to information provided to Insurance Fraud Prosecutor

The Insurance Fraud Prosecutor shall have access to all necessary information in the possession of the State or local public entities, including agency inspection reports, motor vehicle records and license information, individual case files, and intelligence information compiled and maintained by the Division of State Police in the Department of Law and Public Safety. Upon the request of the Insurance Fraud Prosecutor, any insurer which has referred a case to the Insurance Fraud Prosecutor

or to any county or local government agency shall make available to the Office of the Insurance Fraud Prosecutor all information on the case in the insurer's possession.

§ 17:33A-24. Additional duties of office; annual report

The Attorney General shall direct the Office of the Insurance Fraud Prosecutor to:

a. Confer from time to time with departments or other units of State government which have units which investigate fraud, in order to coordinate activities, share information, and provide any assistance necessary to any State agency in overseeing administrative enforcement activities;

b. Formulate and evaluate proposals for legislative, administrative and judicial initiatives to strengthen insurance fraud enforcement;

c. In connection with insurance fraud enforcement activities, act as the liaison for the Executive Branch of government with agencies involved in insurance fraud enforcement outside the Executive Branch, including federal agencies and the Judiciary;

d. Provide an annual report to the Governor and the Legislature, no later than March 1 of each year, as to the activities of the Insurance Fraud Prosecutor for the preceding twelve months, including, but not limited to, the number of cases referred, the number of cases investigated, the number of cases in which professional licenses were suspended or revoked, by type of license, the number of cases prosecuted, the number of convictions procured, and the aggregate amount of money collected in fines and returned in restitution to insurers or others.

§ 17:33A-25. Recommendation for suspension, revocation of professional license

In the case of a professional licensed or certified by a professional licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety who is guilty of fraud, the Insurance Fraud Prosecutor may recommend to the appropriate board a suspension or revocation of the professional license.

§ 17:33A-26. Restitution; seizure of assets

The Insurance Fraud Prosecutor shall consider the restitution of moneys to insurers and others who are defrauded as a major priority, in order that policyholders may benefit from the prosecution of those persons guilty of insurance fraud, and to that end, any assets of any person guilty of fraud shall be subject to seizure.

§ 17:33A-27. Specific goals, strategies

The Insurance Fraud Prosecutor shall have access to all information concerning insurance fraud enforcement activities in the possession of all State departments and agencies. The office shall meet on a regular basis with representatives of State departments and agencies and county prosecutors to set specific goals and strategies for the most effective resolution of insurance fraud cases, whether by criminal, civil, or administrative enforcement action, or a combination thereof.

§ 17:33A-28. Application for reimbursement

Any county prosecutor may apply to the Office of the Insurance Fraud Prosecutor for reimbursement for activities undertaken in connection with investigating and prosecuting insurance fraud. The Attorney General shall allocate such funds as he deems necessary from such moneys as may be appropriated for the operation of the Office of the Insurance Fraud Prosecutor to a fund dedicated for the purpose of reimbursing county prosecutors or sharing in fines levied by the Attorney General, which reimbursement or sharing may be made by the Attorney General at his discretion.

§ 17:33A-29. Provision of information from accident report

Every state and local law enforcement agency, including the New Jersey State Police, shall make available to investigators employed by insurers, upon presentation of appropriate identification, information from any accident report, as set forth in this section, no later than 24 hours following the time of occurrence. The information may include, but need not be limited to, the names and addresses of the owners of the vehicles, insurance information recorded on the accident report, and the names and addresses of passengers in the vehicles at the time of the occurrence and, if applicable, the name of any pedestrian injured in an accident. Every accident report form shall contain the names and addresses of any person occupying a vehicle involved in an accident, and any pedestrian injured in an accident.

§ 17:33A-30. Certification of amount allocable to office expenses

The Attorney General shall annually, on or before October 1, certify to the State Treasurer an amount allocable to the expenses of the Office of the Insurance Fraud Prosecutor for the preceding fiscal year, which amount shall be transferred to the Department of Law and Public Safety by the State Treasurer from the amounts assessed and collected for the operation of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance pursuant to section 8 of P.L.1983, c.320 (*C.17:33A-8*).

Invitation

Any Organization/individual ready to support this campaign is welcomed to contact us.

Your views may please be sent to concern Ministry, IRDA or any one whom you think fit. Your articles /comments in publications or on Social Media (LinkedIn, Face book, Twitter) will encourage discussion on this important topic so that suitable Bill is introduced in Lok Sabha or Rajya Sabha for discussion.

Contribution to support Logistics, Cost of Meetings & Seminars, and Publications on this topic can be sent to our NGO:

Bank Transfer can be sent to:
Beneficiary: Insurance Foundation of India
Bank Name: - Bank of Baroda
Bank Address: East of Kailash Branch, East of Kailash, New Delhi – 110065
Bank Account No: 09630100010847
IFSC Code/ NEFT Code: BARB0KAIDEL (fifth character is zero)
Swift Code: BARBINBBNND

We have 80(G) certificate and receipt will be issued to you.

Insurance Foundation of India (IFI) is set up under Trust Registration Act 1882 of Government of India as a Not for Profit Organization. The main objective of IFI is to promote awareness of Insurance among masses. IFI has successfully organized various Executive Development Programmes/Skill development Programmes of International standards in India with world-class faculty.

Under CSR project supported by PNB MetLife India Insurance Company Ltd we produced a Film **"Khushiyon Ki Suraksha"** for spreading awareness of insurance in rural areas. It is available on https://www.youtube.com/watch?v=hzbADuIcWuU

Our project **"Bima Jagrukta Abhiyan"** has been awarded Skoch Award as one of the 100 top Projects undertaken in India during 2016.

The best part of the Training Programmes being organized by us is that faculty comprises of those, who have up to date knowledge of working in Insurance Companies, Insurance Brokerage Firms, Insurance Surveyors & Loss Assessors, Law Firms or Insurance Buyers. This results in the sharing of practical and up to date knowledge by all stakeholders and hence up gradation of the skill in Indian Insurance Industry. This aspect is being highly appreciated in Social Media on global basis and now Insurance Foundation of India is rated as the top NGO in Insurance Training in the country and that too without Government support.

We are granted 80G approval by Tax Authorities. IFI will be pleased to be associated with CSR Project to be undertaken by you.

In short, we can say that the main activities of this NGO are to organize thought provoking Seminars/ Training Programme for the growth of Indian Insurance Industry.

For any more information please contact us:

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